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Resiliency in lesbians with a history of childhood sexual abuse: Implications for clinical practice

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Resiliency in Lesbians with a History of Childhood Sexual Abuse:

Implications for Clinical Practice

by

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Dedication

I would like to dedicate this to my parents and my grandparents. For without them, this would not be possible.

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Thank you to my parents and grandparents for all the love, guidance, and encouragement you've given me all my life. I could not have done this without all your wisdom.

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ABSTRACT

This was a collective case where lesbian survivors of childhood sexual abuse were studied. Resiliency is a combination of personality traits and environmental influences that serve to protect an individual from the harmful psychological effects of trauma (Bogar & Hulse-Killaky, 2006). The focus of this study was resiliency skills that lesbians used in working through childhood sexual abuse and clinical applications. Using a qualitative approach, specific inquiries included (a) what resiliency skills were used to work through childhood sexual abuse, (b) how counselors can be helpful and unhelpful, (c) what were some barriers to getting counseling, (d) what are the current resiliency skills, and (e) what advice a lesbian survivor of childhood sexual abuse would give to another survivor.

Participants were interviewed about their level of satisfaction in various areas of their lives, their history of childhood sexual abuse, and their resiliency. Themes were revealed addressing the specific inquiries. Results are reported within the various categories suggesting that coping with childhood sexual abuse is possible. Clinical implications were concluded from the results and recommendations for clinical practice given.

Chapter 1

Introduction

Childhood sexual abuse is a phenomenon reportedly effecting approximately one out of every six men and one out of every four women (Dube et al., 2005). The magnitude of this problem may be even larger due to underreporting and different criteria for abuse (Finkelhor & Browne, 1986). However the statistics read, there is little debate that childhood sexual abuse has lasting effects for both men and women (Brier & Elliot, 2003). Long-term effects in both men and women include sexual disturbance, anxiety, depression, increase rate of suicidality, revictimization, (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992), social anxiety (Feerick & Snow, 2005), and negative effects on mental well being (Brayden, Deitrich-Maclean, Dietrich, Sherrod, & Altemeier, 1995).

Women are over represented in the population effected by childhood sexual abuse (Dube et al., 2005; Vogeltanz et al., 1999). Consequently, childhood sexual abuse is a problem in the lesbian community. It has been noted in the literature that lesbians have a higher rate of childhood sexual abuse than heterosexual women (Hughes, Haas, Razzano, Cassidy, & Matthews, 2000; Robertson & Sorenson, 1999). However, lesbians do persevere and overcome the lasting effects (Baker, 2003).

Childhood Sexual Abuse and Women

In order to better understand this complex problem, the effects of childhood sexual abuse on women will be reviewed. Effects of childhood sexual abuse on women can last a lifetime and have emotional, cognitive, behavioral (Finkelhor & Brown, 1986), interpersonal (Fleming, Mullen, Sibthorpe, & Bammer, 1999), spiritual (Baker, 2003) and physical (Thakkar & McCanne, 2000) implications. The emotional and cognitive effects include an altering of their perception to the world (Finkelhor & Browne, 1986). These effects may result in mental health problems and comorbid mental disorders in women (Fleming et al., 1999; Katerdahl, Burge, & Kellogg, 2005a) such as depression (Beitchman, Zucker, Hood, daCosta, Akman, & Cassavia, 1992), PTSD (Feerick & Snow, 2005), or panic disorder (Gladstone et al., 2004). Women in this population are also at risk for being diagnosed (or misdiagnosed) with personality disorders (Bradley, Heim, & Westen, 2005) and have a higher incident of anxiety, guilt, feelings of inferiority, and helplessness (Wonderlich et al., 2001). Behavioral indications include an increase in revictimization, substance abuse, suicidality and numerous other symptoms that can be associated with childhood sexual abuse (Neumann, Houskamp, Pollock, & Briere).

Relationships are also affected by a history of childhood sexual abuse in women (Fleming et al., 1999). These women experience more disruption in their relationships (Dube et al., 2005); they are at higher risk for experiencing domestic violence (Griffin et al., 2005) or being in a relationship with an alcoholic (Fleming et al., 1999). They also experience higher levels of relationship dissatisfaction than those without an abuse history (Liang, Williams, & Siegal, 2006).

Childhood sexual abuse may also impact one's spirituality. Individuals may be conflicted about their spirituality, struggle with feelings of hopelessness, or lack a sense of purpose. They may struggle with aspects of forgiveness (Ganje-Fling & McCarthy, 2001). Childhood sexual abuse has influenced survivors, at times producing spiritual discomfort (Gall, 2006). It may also impact survivors' trust and faith in God and religion (Rosetti, 1995).

In addition to psychological and interpersonal implications, long-term effects can be physical as well. Women with a history of childhood sexual abuse are more likely to experience physical problems (Thakkar & McCanne, 2000) such as chronic pain (Finestone et al., 2000), and problems related to respiratory, gastrointestinal, musculoskeletal, neurological, and gynecological functions (Lechner, Vogel, Garcia-Shelton, Leichter, & Steibel, 1993). In addition, they had more visits to the emergency room and family physicians, and more hospitalizations and surgeries (Anrow et al, 1999; Finestone et al.). These symptoms will be reviewed in detail in chapter two.

Childhood Sexual Abuse and Resiliency

There are numerous definitions for resiliency in the literature. For the purpose of this work, resiliency will be defined as a combination of personality traits and environmental influences that serve to protect an individual from the harmful psychological effects of stress or traumatic events (Bogar & Hulse-Killaky, 2006). Resiliency also refers to an individual's capacity to successfully adapt to a traumatic or adverse event (Wilcox, Richards, & O'Keefe, 2004). It has been seen as both a state and a skill. For the purpose of this work, both of these terms will both be

recognized, as will be alternative terms for resiliency such as coping, protective factors, or hardiness.

Successful coping with childhood sexual abuse is possible (Binder, McNiel & Goldstone, 1996). There are both psychological and social defenses against the long term effects of childhood sexual abuse that take on many forms (Bogar & Hulse-Killacky, 2006; Feinauer, Hilton, & Callahan, 2003; Himelein & McElrath, 1996). Research has indicated that cognitive defenses such as having an internal locus of control (Himelein & McElrath) and external attributions of blame (Valentine & Feinauer, 1993) guard against the long term effects of abuse. Interpersonal relationships, spirituality, individual characteristics, (Bogar & Hulse-Killacky), employment or school (Werner & Smith, 2001) and social support (Feinauer et al.) also take the form of resilience. These skills are elaborate and paramount in the defense against the long term consequences of childhood sexual abuse. They will be reviewed in detail in chapter two.

Childhood Sexual Abuse and Lesbians

Although the impact of childhood sexual abuse on adult women has long been studied, the sexual orientation of these adult survivors has not been taken into account. It is probable that self-identified lesbians have been participants in the samples of these studies, but they rarely have been studied separately from their heterosexual counterparts (Baker, 2003). As a result of being a sexual minority, lesbians may fall victim to additional stress such as hate crimes (Herek, Cogan, & Gillis, 1999) and prejudice (Balsam, Rothblum, & Beauchaine, 2005), as well as psychological (Meyer, 2003; Szymanski, 2005), and social stress (Eskin, Kaynak-

Demir, & Demir, 2005). However, despite this added stress, research in the area of sexually abused lesbians is scarce (Balsam, 2003a; Hall, 1999; Robohm, Litzenberger, & Pearlman, 2003). Resiliency skills in women from the general population have received attention from researchers. However, resiliency among lesbians from the same population is under researched (Bogar & Hulse-Killacky, 2006).

There are several reasons for the lack of research. First, fear of perpetuating the myth that childhood sexual abuse causes homosexuality may have resulted in research not being conducted in this area (Balsam, 2003a). Second, public attitudes about homosexuality are still negative (Bradford, Ryan, & Rothblum, 1994; Saewyc et al., 2006). Very few researchers have examined the specific emotional or behavioral effects of childhood sexual abuse on lesbians (Robohm et al., 2003). Even fewer have reviewed resiliency in lesbians who have survived childhood sexual abuse. It may be these public attitudes and added stress that make lesbians a special population to address, separate from their heterosexual counterparts.

Purpose of the Study

The purpose of this study is to conduct qualitative interviews of lesbians to identify the resiliency skills they used to mediate the after effects of childhood sexual abuse. In addition, this study will examine how counselors can or have fostered lesbian's resiliency skills and what about counseling is either helpful or not helpful to a lesbian with a history of childhood sexual abuse. Finally, the study will identify what women have done to work through their abuse.

Statement of the Problem

There is little research about the resiliency of lesbians with a history of childhood sexual abuse. Yet, there are numerous studies suggesting that the incidence of childhood sexual abuse occurs at a higher rate in homosexuals than in heterosexuals (Doll et al., 1992; Gudlach, 1977; Hughes, 2003; Hughes et al., 2001; Tjaden et al., 1999). Studies also show that there is a higher rate among women in the general population than men (Dube et al., 2005). This indicates that childhood sexual abuse is a problem in the lesbian community.

Several studies have examined the effects of childhood sexual abuse specifically among the population of lesbians (Balsam, 2003a; Hall, 1999; Robohm et al., 2003). These studies suggest that childhood sexual abuse affects the coming out process, feelings about one's sexuality, and produces emotional and behavioral difficulties such as eating disorders, problems related to anxiety, depression, and suicide (Robohm et al.). However, there is little research as to the resiliency skills used by lesbians to mediate these effects. It is crucial for counselors to understand what assists lesbians to enhance the resiliency skills in this under researched population. Therefore, a qualitative study will be conducted to reveal themes of resiliency skills that enhance a lesbian's ability to work through her childhood sexual abuse. In doing so, counselors can better assist lesbians who may seek treatment for childhood sexual abuse.

Significance of the Study

It is hoped that this study will contribute to scholarly research in the area of resiliency in lesbians with a history of childhood sexual abuse. This study may

expand our knowledge of the resiliency skills of lesbians who have experienced childhood sexual abuse use. Implications for clinical practice will be drawn by assessing themes of resiliency and examining what was helpful or not helpful in the counseling relationship. By adding scholarly research in this area, this study may serve as a means to more clearly identify the specific clinical needs of this population and to subsequently provide better services. This study may promote mental health in a population that has been oppressed, misunderstood, and assumed to be mentally unstable.

In 2003, the American Counseling Association's Governing Counselor adopted competency domains regarding advocacy and empowerment. This study is in line with those competency domains as it will result in counseling implications of working with lesbians with a history of childhood sexual abuse. Consequently, counselors will be able to act as agents to change a system that directly affects lesbian clients (Advocacy Competency Domains, 2003). This study may also promote a socially responsible approach to mental health care for lesbians with a history of childhood sexual abuse (ACA, 2005).

Social justice is promoted by selecting an oppressed group which has been excluded in the literature and giving them a voice. This study endeavors to give lesbians a voice by asking them to identify what was helpful and not helpful in the counseling relationship. Thus, this study will promote social equality for lesbians within the counseling community. Finally, social justice will be promoted by turning a disadvantaged group of women into "powerful intellectual resources" (Harding & Norberg, p. 2013).

Research Questions

The major research questions guiding this inquiry are "what has assisted lesbians in working through their childhood sexual abuse issues?" and "what are the clinical implications of these resiliency skills?" The study will employ several specific questions to allow the participants to establish rapport and begin revealing information on their childhood sexual abuse, resiliency skills, and counseling experiences. Demographic questions will be asked initially to obtain information and to determine whether or not the participants will be eligible for the study.

To be eligible for the study, the women must meet the criteria of being sexually abused as a child, be a lesbian, and be age 30 or older. No upper age limit was set as resiliency has been found in an advanced age (Blieszner & Ramsey, 2002). In addition to this, the individual must answer 5 or higher on the question "on a scale from 1 to 10, with one being 'I haven't worked through my childhood sexual abuse at all' and ten meaning 'I have completely worked through my childhood sexual abuse, where would you place yourself on this scale?'." It is recognized that 5 or above is an arbitrary number and has no statistical validity. It is being used in this research as a gauge of whether or not they feel they have worked through their issues. A follow up question will be asked as to what this number means to them. In addition, the participant must meet criteria of endorsing satisfactorily on several different dimensions of resilience (Bogar & Hulse-Killacky, 2006). Bogar & Hulse-Killacky's research is used as it is current and suggests further research with gay and lesbian individuals who have a history of childhood sexual abuse. These dimensions are the ability to maintain stable relationships; pursue and maintain a career, volunteer, or

leisure activities; feel relatively content with themselves and their current life circumstances; and believe that their lives have meaning. Finally, the participant must be free from active drug or alcohol abuse. This will be determined by using a modification of the CAGE instrument to assess for abuse (Bush, Shaw, Cleary, Delbanco, & Aronson, 1987). All of these questions will be asked via a telephone interview. Further information on the details of the interview can be found in Chapter 3 and in appendix C and E.

Conceptual or Substantive Assumptions

Several assumptions underpin this study. This first is that childhood sexual abuse may carry effects for individuals lasting years. Secondly, being a lesbian may exacerbate having a history of childhood sexual abuse as there are additional issues involved with being a sexual minority such as coming out or not being accepted within families or in the community (Baker, 2003). Therefore, it is assumed that the lesbian community is a unique population and resiliency skills may be different in this community. It is anticipated that some of the resiliency skills may be the same as the literature on assumedly heterosexual women. However, there may be differences in the types of assets they use to overcome different types of experiences.

Conceptual Framework

Feminist theory

The counseling community is still far from eliminating all personal psychological suffering (Kaschak, 2001). However, in giving voice to those who have suffered in the past, hopefully others will be prevented from suffering in the future. The heart of the problem in abuse is an inequity of power. In creating a voice for

those who had none in the past, power can be re-established and provided to others in the future. The feminist viewpoint holds just this.

Third wave feminism examines the intersection between feminism and other identities (Rubin & Nemeroff, 2001). The viewpoint of this research is looking at women and advocating for this population, but moreover looking at the lesbian population who is a minority within the female population. In looking at the intersection between lesbianism and being a woman, the conceptual framework of this study is feminist theory as it is consistent with elements of contemporary feminist therapy driven by feminist theory (Negy & McKinney, 2006). It also identifies the effects of oppression and places an emphasis on gender and power (Purvis & Ward, 2006). Consistent with feminist theory, it respects women and their experiences through acknowledging and validating their subjective reality. There is also attentiveness to the participant expressing and constructing their experience with the researcher paying attention to layers of meaning within the narrative (Negy & McKinney). In this study, there is collaboration and equal power between the researcher and the participant through full disclosure of what the study is about and details about the researcher. Finally, there is a commitment to social change. This study hopes to make clinical implications to change the way lesbians are treated in therapy.

Resiliency

Resiliency is another part of this conceptual framework. The literature supports that resiliency can be broken down into various domains. The domains are cognitive (Bogar & Hulse-Killacky, 2006; Himelein & McElrath, 1996; Valentine &

Feinauer, 1993; Werner & Smith, 2001), employment / school (Werner & Smith), individual characteristics (Bogar & Hulse-Killacky; Werner & Smith); interpersonal characteristics (Valentive & Feinauer, 1993), intimate relationships (Werner & Smith), social support (Feinauer et al., 2003), and spirituality (Baker, 2003). These domains are the foundation of the conceptual framework.

Although childhood sexual abuse affects personal development in numerous areas (Finkelhor & Browne, 1986), adaptive coping is possible (Binder et al., 1996). For some women, cognitive coping skills such as having a greater sense of optimism (Bogar & Hulse-Killacky, 2006; Werner & Smith, 2001), or a more positive or self-enhancing perception have been shown to enhance resiliency. For others, it was important to have more of an internal locus of control (Himelein & McElrath, 1996). Some women had to find meaning in the adversity of their childhood sexual abuse so they no longer dwell on the past. This was done by talking about the abuse (Heimelein & McElrath) and achieving closure (Bogar & Hulse-Killacky). By talking about the abuse and working through it, women were able to refocus and move on from the abuse and moving from "victim" to "survivor" by attributing blame to the perpetrator (Valentine & Feinauer, 1993).

Individual characteristics are also important factors in resiliency. Characteristics such as enhanced social maturity and self-efficacy were found to be helpful in maintaining resiliency. A more positive heal status was also important (Werner & Smith, 2001). Feeling competent and having high self-regard also assisted women in overcoming the trauma of childhood sexual abuse. Taking an active role in healing was also significant (Bogar & Hulse-Killasky, 2006).

Interpersonal characteristics were paramount in resiliency as well. Positive relationships with parents, siblings, and children were a predicator of resiliency (Werner & Smith, 2001). Individuals who were interpersonally skilled and possessed verbal ability and the capacity for emotional intimacy, as well as being independent minded, assertive, and optimistic about relationships were found to be more resilient when dealing with childhood sexual abuse (Bogar & Hulse-Killacky, 2006). Individuals who had more supportive relationships in their life were also found to be more resilient (Valentime & Feinauer, 1993). This can be fostered by gainful employment or school (Werner & Smith).

Social support was significant in fostering resiliency in women with a history of childhood sexual abuse (Feinauer et al., 2003). Central to many women's recovery was having positive role models or mentors. This was sometimes found in churches or spiritual practices. Spirituality was found to be an important role in fostering resiliency in women with a history of childhood sexual abuse (Baker; 2003; Bogar & Hulse-Killacky, 2006).

It is predicated that the resiliency skills revealed in this study will be in the preceding domains. However, as this is a unique population, it is possible that additional domains may arise or that certain characteristics may be utilized more than others. The conceptual framework is located below in diagram form.

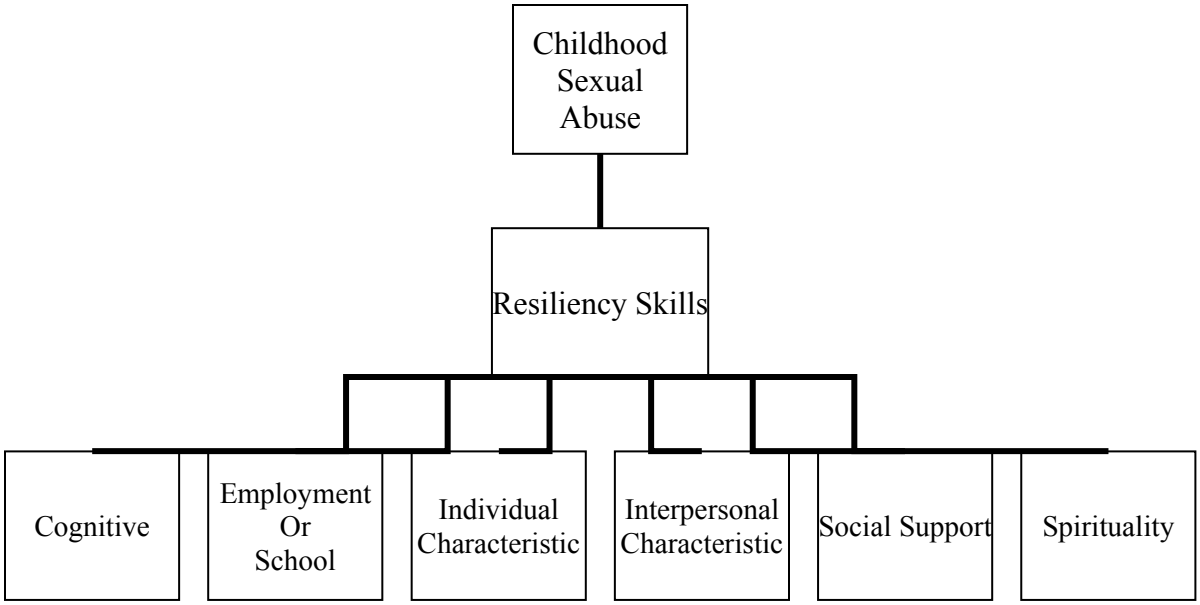

Figure 1. *Conceptual Framework*

Definition of Major Terms

Lesbian. The term lesbian will be determined by the participant. However, the definition used for this research is "a woman who experiences the human need for warmth, affection, and love from other women. Sometimes this includes sexual contact" (Child Welfare, 2006, p. 112).

Heterosexism. A belief in the inherent superiority of heterosexuality thereby giving the right to cultural dominance (Sanders, 2000).

Homophobia. Any negative attitude, belief, or behavior directed toward gays and lesbians based on their love/sexual orientation (Sanders, 2000).

Homosexual. Homosexual individuals are sexually attracted to persons of their own sex (Francoeur, 1991). This is not to suggest that the only thing that constitutes homosexuality is sexual feelings. It may also be romantic feelings towards one's own gender as well. This definition does not address the frequency of these

feelings. Therefore, for the purpose of this research, the definition of homosexual will be used if these feelings are predominant.

Bisexual. A term used for individuals who are erotically and or affectionately oriented to both males and females (Francoeur, 1991).

Gay. This is a term often applied to both men and women who are attracted to the same gender as themselves (Child Welfare, 2006).

Coming Out. Coming out is a process of self-acceptance of one's own homosexuality. Individuals may create a lesbian or gay identity first to themselves before they may reveal it to others (Child Welfare, 2006). "Coming out" is a process where individuals reveal their homosexuality, bisexuality, or transgendered nature to others.

Childhood Sexual Abuse. The criteria for childhood sexual abuse ranges in age of victim as well as what is considered to be sexual abuse. For this study, childhood sexual abuse is defined as unwanted sexual experience with someone before the age of 14 years or completed or attempted rape from the age of 14 to 17 years (Russell, 1983) with someone 5 or more years older than the participant (Balsam et al., 2005).

Sexual Experience. Sexual experiences vary in the literature. In this research, sexual experiences range from touching or attempts at touching of the breasts or genitals to rape on at least one occasion (Russell, 1983).

Rape. When someone is forced or threatened with force to have sexual intercourse, anal intercourse, or oral sex (McMullin & White, 2006).

Resilience. A combination of personality traits and environmental influences that serve to protect an individual from the harmful psychological effects of stress or traumatic events (Bogar & Hulse-Killaky, 2006), which is defined as an individual's capacity for successfully adapting to traumatic or adverse events (Wilcox et al., 2004).

Scope and Delimitation of the Study

This study is about resiliency skills and clinical applications in self-identified lesbians over the age of 30 who have a history of childhood sexual abuse. This population does not include homosexual males, bisexual females, heterosexual women and heterosexual men. As the nature of the study is for self-identified lesbians, the study may exclude those who are lesbian yet do not reveal it publicly. This is also known as "closeted" lesbians. This study focuses on adult women who choose to be with women as intimate partners. Participants for this study must be at least 30 years old as this is a study about resiliency in lesbians who have reached adulthood. The third decade of life is noted in the literature to be an age at which individuals are in their adulthood (Keyes, 2004). It has also been noted that competence in major life roles becomes significant in a person's thirties (Gralinski-Bakker, Hauser, Stott, Billings, & Allen, 2004), therefore, it was assumed that more resiliency would be found at a more advanced age. There is no upper age limit as resiliency has been noted in senior women (Blieszner & Ramsey, 2002). This study is for adults who are deemed to be resilient at this time in their life. It is not for adults who are currently undergoing extreme amounts of stress and not found to be stable in work, relationships, and mental health. It does not address lesbians with alcohol or

drug problems. It does not address adults currently being sexually abused or who have recently been raped, nor does it address other childhood trauma such as domestic violence, physical, or psychological abuse.

The remainder of this dissertation will review resiliency in lesbians who have a history of childhood sexual abuse through a qualitative study. Chapter 2 will outline the literature on this subject highlighting the prevalence of childhood sexual abuse in a community sample of women in addition to homosexuals. It will also review the effects childhood sexual abuse has on women, specifically on lesbians. Finally, it will examine resiliency skills found in women in the general population who have a history of childhood sexual abuse. Chapter 3 will review the methodology for this research. Chapter 4 will review the results of the research and Chapter 5 will review and discuss the clinical implications.

Chapter 2

Literature Review

Childhood sexual abuse is a deeply private issue affecting people around the world at an alarming rate. Studies suggest that one in every four women and one out of every six men have experienced childhood sexual abuse (Dube et al., 2005; Lechner et al., 1993). The incidence and prevalence of childhood sexual abuse in the gay community is also high. There are estimates that the gay community has suffered more childhood sexual abuse than their heterosexual counterparts (Hughes et al., 2001; Hughes et al., 2000; Tomeo et al., 2001).

Research regarding resiliency within the gay and lesbian community who have been sexually abused as children is scarce (Balsam, 2003a). Perhaps it is the myth that childhood sexual abuse causes homosexuality that limits research in this area (Balsam, 2003a; Robohm et al., 2003). It may be the result of heterosexist attitudes among the general population which results in a lack of research as well as most studies assuming heterosexuality (Balsam, 2003b). The existing research on women suggests that childhood sexual abuse may have long term consequences in numerous areas (Fleming et al., 1999). The scope of the repercussions of it are broad including emotional, psychological, behavioral (Finkelhor & Browne, 1986), relational (Fleming et al.), physical, and spiritual (Baker, 2003) ramifications (Thakkar & McCanne, 2000).

This section will review the prevalence of childhood sexual abuse among the general population to gain perspective on the growing problem affecting women. After this, the prevalence in the homosexual community will be evaluated. The effects on women in the general population will be reviewed to gather an overview of the problem. Then, the research specific to lesbians will be examined to provide background and information on what is already known about the effects of childhood sexual abuse on this population. After this, resiliency in women in the general population will be examined followed by resiliency in lesbians.

The Prevalence of Childhood Sexual Abuse

The prevalence of childhood sexual abuse is difficult to quantify as it often goes unreported (Lundqvist, Hansson, & Svedin, 2004). Nonetheless, researchers have conducted studies to show the prevalence of childhood sexual abuse among the general public (Dube et al., 2005; Vogeltanz et al., 1999). Interested in the long-term consequences of childhood sexual abuse by sex of victim, Dube et al. (2005) surveyed individuals from the Health Appraisal Center (HAC) in San Diego, CA. The population was drawn over a 4 year period by giving surveys to adult members of Kaiser Health Plan in San Diego County who received complete and standardized medical, psychosocial, and health evaluations. A total of 17,337 surveys were completed. Seventy-five percent of the participants were white. Results from this study showed that childhood sexual abuse was reported by 16% of the males and 25% of the females (Dube et al.).

Dube et al.'s (2005) study did not include sexual orientation as a variable. It did indicate that a higher percentage of females rather than males reported childhood

sexual abuse. However, it is important to note that the findings in this study can only be generalized to people who live on the Western Coast of the United Stated and have health insurance. Also, convenience sampling compromised the integrity of the findings. One may argue that this sample could over estimate (individuals seeking health services are more likely to be survivors) or under-estimate (excludes lower income people who lack health insurance) the incidence of childhood sexual abuse among the public.

In another study, Lechner et al. (1993) sought information on the self-reported medical problems of adult female survivors of childhood sexual abuse. The researchers distributed a questionnaire to adult women in the waiting room of a large Midwestern family practice residency model clinic. A total of 523 questionnaires were collected. Sexual abuse was assessed by asking "as a child 16 years or younger were you ever a victim of sexual abuse?" (Lechner et al., p. 644.) A total of 26% of the women indicated a history of childhood sexual abuse. Although these findings can only be generalized to a population of individuals who have the ability to attend a family practice residency clinic, the percentage of women reporting childhood sexual abuse in this study was consistent with Dube et al.'s (2005) findings. Again, sexual orientation in this study was not assessed.

As with the other study (Dube et al., 2005), Lechner et al. (1993) is prevented in estimating childhood sexual abuse among the larger population due to a nonrandomized sample. Even with a randomized sample, childhood sexual abuse may be under reported (Lundqvist et al., 2004). It is not clear whether women attending a residency clinic may be more likely to report or are more likely to have experienced

childhood sexual abuse than women in the larger population. These results indicate that 26% of these individuals are willing to attend a clinic and disclose their childhood sexual abuse on an anonymous questionnaire.

Accuracy of Statistics with Prevalence Studies

Accurate findings of the frequency of childhood sexual abuse are also limited by the multiple ways childhood sexual abuse is measured. For example, Lechner et al. (1993) considered a participant a victim if she experienced sexual related acts with a person more than two years older. Dube et al. (2005) used Wyatt's (1985) definition of childhood sexual abuse which stipulates the perpetrator needs to be 5 years older than the survivor. It is clear that different criteria for the age of the perpetrator may result in different estimates of the amount of sexual abuse in a population.

The effects of criteria chosen on results may best be illustrated by a study by Vogeltanz et al. (1999). Vogeltanz et al. sampled 1,099 women from a national probability sample of women aged 21 and older in 1991. This sample was assessed specifically for childhood sexual abuse. Two different criteria—one developed by Wyatt (1985) and one developed by Russell (1983)—were used to determine whether or not an individual was sexually abused. The Wyatt criteria included "(a) any intrafamiliar sexual activity before the age of 18 and that was unwanted or (b) any extrafamilial sexual activity that occurred before age 18 and was unwanted, or that occurred before age 13 and involved another person 5 or more years older than the respondent" (Vogeltanz et al., p. 582). The Russell criteria included "(a) any intrafamilial sexual activity before the age of 18 that was unwanted or involved a family member 5 or more years older than the respondent; and (b) any unwanted

extrafamilial activity that occurred before age 14, or any unwanted sexual intercourse occurring at ages 14-17" (Vogeltanz et al., p. 582). The prevalence of childhood sexual abuse among women in this national sample ranged from 15.4% to 32.1% depending on the criteria used for abuse and interpretation of cases with incomplete data. Estimates for childhood sexual abuse in women from other literature range from 25% (Dube et al., 2005) to 32.3% (Briere & Elliott, 2003) based on the population studied and criteria used.

These studies suggest the difficulty in measuring the prevalence of childhood sexual abuse among the general population. Studies attempting to document the prevalence of childhood sexual abuse among homosexuals suffer similar shortfalls. Nevertheless, several researchers estimate that the percentage of people who have experienced childhood sexual abuse is higher among homosexuals than heterosexuals (Balsam et al., 2005; Tomeo et al., 2001). These estimates are based on various studies over the past three decades that assessed for past sexual abuse and included sexual orientation as a variable.

Prevalence of Childhood Sexual Abuse Among Homosexuals

Literature on childhood sexual abuse among homosexuals generally falls into two categories: Those who were looking directly at the relationship between childhood sexual abuse and homosexuality (Baker, 2003; Cameron & Cameron, 1995; Doll et al., 1992; Gudlach, 1977; Roberts & Sorensen, 1999; Simari and Baskin, 1982; Tjaden, Thoeness, & Allison, 1999; Tomeo et al., 2001), and those who focus on a different relationship (e.g. alcohol abuse) but included childhood sexual abuse and sexual orientation as variables (Hughes, 2003; Hughes, Haas, Razzano,

Cassidy, & Matthews, 2000; Hughes et al., 2001). As with many studies on childhood sexual abuse, these studies also have several methodological concerns regarding sampling and definitions of childhood sexual abuse.

Tomeo et al. (2001) compared data of childhood and adolescent molestation in heterosexual and homosexual persons by administering a short "sexuality questionnaire" designed to determine sexual orientation and history of inappropriate sexual contact. They obtained 942 responses to questionnaires, 675 of which were from graduate or undergraduate students currently enrolled in classes in colleges and universities in central California. Data from these responses indicated that 46% of homosexual men and 22% of homosexual women surveyed reported being molested by a person of the same sex, whereas only 7 % of heterosexual men and 1 % of heterosexual women surveyed had reported being molested by a person of the same sex. Of note, however, is that 97.6% of the men in the sample were obtained solely from the homosexual pride event. The fact that the majority of questionnaires were drawn from a homosexual pride event suggests a problem with generalizability. Attending a homosexual pride event suggests that you are "out" with your sexuality to the community. This suggests that this research may only be generalized to homosexuals who may disclose their sexuality to others. Being out may suggest a certain degree of resolution with sexual orientation issues therefore they may feel more comfortable disclosing issues surrounding sexuality.

Prevalence in the lesbian community

Roberts and Sorensen (1999) conducted research on the prevalence of childhood sexual abuse specifically in the lesbian population. Questionnaires were

distributed through the Boston Lesbian Health Project. The specific questions on childhood sexual abuse were (a) "have you ever been molested or sexually attacked, (b) if yes, who molested you? and (c) at what age?" (Roberts & Sorenson, p. 13). A total of 1,633 lesbians returned the questionnaire. Of the lesbians surveyed, 45.8% answered "yes" to being molested or sexually attacked. Among these women, 26.8% indicated being molested before the age of 12 and 12.1% between the ages of 12 and eighteen. These results put the estimated total of 39% of lesbians answering "yes" to the question of being molested as a child (Roberts & Sorensen). This study involves a problem with the operational definition of childhood sexual abuse. Roberts and Sorensen included individuals under the age of 18 while other studies include those under the age of 16 years (Hughes et al., 2000).

Incest

Other studies on childhood sexual abuse among homosexuals have focused specifically on incest. Incest is intrafamilial sexual abuse, and some studies examine incest separately from non-familial sexual abuse. Simari and Baskin (1982) investigated incestuous experiences within homosexual populations. They sampled 29 lesbians and 54 homosexual males who enlisted to participate through social and friendship networks in New York City. Participants completed a 16 page anonymous questionnaire that explored sexual feelings and first sexual experiences. Questions were asked about incestuous experiences including incidence, frequency, and description. In this study, the male homosexuals showed a higher rate of incest (46%) than females (38%). This finding is not consistent with the literature that states that women have a higher rate of childhood sexual abuse than males (Roberts & Sorensen,

1999). However, the Simari and Baskin (1982) article had relatively small numbers (29 lesbians and 54 gay men) whereas other studies had several thousand (Dube et al.; Roberts & Sorensen).

Attempts at causation

Some researchers have suggested that childhood sexual abuse may actually cause homosexuality. An attempt at a link was made by Gudlach in 1977, only four years after the American Psychological Association removed homosexuality as a mental disorder from the Diagnostic and Statistical Manual of Mental Disorders (Razzano, Cook, Hamilton, Hughes, & Matthews, 2006). Gudlach studied 225 lesbians and 223 heterosexual women across the United States. Questionnaires included queries concerning rape or attempted rape and the age of the incident. Gudlach's findings indicated that 30% of lesbians and 21% of heterosexual women surveyed reported rape one or more times. Of note is that the researchers did not differentiate childhood sexual abuse from rape as an adult. Based on this limited sample, Gudlach questions: "would an examination of the details of the rape incident provide clues as to why so many of these 35 [the amount that reported rape] *became* [emphasis added] lesbians" (Gudlach, 1977).

Today, many researchers are more cautious about suggestions of causation and attempt to shed light on the reasons why there is more abuse in a homosexual's childhood (Corliss, Cochran, Mays, 2002; Tomeo et al., 2001). However, one more recent study also attempted to link childhood sexual abuse to the development of a gay identity. Cameron and Cameron (1995) completed a study of 5,182 adults from a one-wave, systematic cluster sampling from five United States metropolitan areas.

Questionnaires were given to individual households, one adult was asked to complete the survey. The participants were told that they were being given a "nationwide sexuality survey."

The participants self-identified as heterosexual, homosexual, or bisexual. These results showed that 1.2% of heterosexual males compared to 22.3% of homosexual males surveyed experienced some type of incest including extended family members. For females, 0.3% of heterosexuals and 3.4% of homosexuals reported some type of incest including an extended family member (Cameron & Cameron, 1995). This study later suggests that given the apparent relationship between incest and homosexuality, incest should be investigated as a possible alternative to genetic explanations. "These facts would seem to point away from genetics and toward learning as a basis for homosexuality" (Cameron & Cameron, p. 620). This study may be an example of how individuals willing to disclose that they are a sexual minority may also be inclined to disclose other sensitive information. This may be a reason why there is such a higher rate of childhood sexual abuse reported by homosexuals than heterosexuals.

Lesbians and drinking

Studies focusing on other mental health issues have also noted a correlation between homosexuality and childhood sexual abuse. These studies also have methodological flaws and sampling problems. An example is Hughes (2003) who examined lesbians and their drinking patterns. The sample consisted of almost 2000 women from the United States. Participants were given the Health and Life

Experiences of Women questionnaire which contains more than 400 questions to assess the individual effects of variables related to a woman's drinking.

Because the questionnaire also asked questions about past sexual abuse, an unanticipated finding was high rates of childhood sexual abuse among lesbians. The results of this study showed rates of childhood sexual abuse for homosexual and heterosexual women of 68% and 47% respectively. These rates are higher than rates previously reported in the literature (Roberts & Sorensen, 1999). Although this study is consistent with the literature suggesting homosexuals having a higher rate of childhood sexual abuse (Tomeo et al., 2001), it should be noted that this research was done primarily as a screening instrument and study for lesbian's drinking patterns.

Hughes et al. (2001) examined the relationship between sexual assault and alcohol abuse. Their sample comprised of 120 (63 lesbians and 57 heterosexual) women. An adapted version of the interview questionnaire from the National Study of Health and Life Experiences of Women, a longitudinal study of women's drinking, was given to each participant. A portion of this instrument assessed for childhood sexual abuse based on the work of Russell (1983) and Wyatt (1985). The results of this study showed that more than a third of lesbians, compared to 19% of the heterosexual women, felt that they had experienced some form of childhood sexual abuse (Hughes et al).

Additional studies

Hughes et al. (2000) conducted a multi-level survey comparing lesbians' and heterosexual women's mental health. To assess for childhood sexual abuse, Hughes et al. calculated responses from questions asking whether someone had ever forced them

to engage in any form of sex. In this study, 41% of lesbians compared to 24% of heterosexual women in the study reported having such an experience before the age of fifteen. As the majority of childhood sexual abuse studies assess for abuse under the age of 18, these rates may be underestimated (Hughes et al.).

Tjaden et al. (1999) compared violence over the life span in same-sex and opposite-sex cohabitants. This study found that same-sex cohabitating women were more likely to report being forcibly raped as a minor. A total of 16.5% of same-sex cohabitating women reported forcible rape compared to 8.7 percent of opposite-sex cohabitating individuals. Although this study shows results comparable to other studies with regard to a higher rate of sexual victimization, it was not specific to gender or self-identified sexual orientation. This study simply identified individuals who had lived together "as a couple" in the past, not individuals who self-identified as gay or lesbian.

Summary of Prevalence of Childhood Sexual Abuse in Homosexuals

The prevalence of childhood sexual abuse without querying for sexual orientation is estimated to be 16% of males and 25% of females (Dube et al., 2005). However, when using different criterion, the numbers varied from 15.4% to 32.3% in women (Vogeltanz et al., 1999). When reviewing the prevalence of childhood sexual abuse in homosexuals, the numbers vary even more and when alcohol was a factor, rates as high as 68% for lesbians and 47% for heterosexual women were found (Hughes, 2003). Other studies place the childhood sexual abuse rate for lesbians at approximately 40% (Hughes et al., 2000; Robertson & Sorenson, 1999). Many studies found homosexuals to have a higher rate of childhood sexual abuse than their

heterosexual counterparts (Cameron & Cameron, 1995; Gudlach, 1977; Hughes, 2003; Hughes et al., 2001; Hughes et al., 2000; Tomeo et al., 2001). Despite the differences in studies, the overall rate for lesbians appears to be higher than their heterosexual counterparts (Hughes; Hughes et al.; Robertson & Sorenson).

A Word of Caution When Reporting Results

Researchers should be cautious in reporting the prevalence of childhood sexual abuse in homosexuals for several reasons. It is important that discussion of childhood sexual abuse in the context of homosexuality does not serve to perpetuate any myth that one causes the other. Although the literature discussed suggests that gay men and lesbians are overrepresented as survivors of childhood sexual abuse (Hughes et al., 2000; Tomeo et al., 2001) including incest (Cameron & Cameron, 1995), few claim a causal link between such abuse and the development of a homosexual identity. Other possible explanations include the possibility that gays and lesbians are more vulnerable to sexual abuse than heterosexuals for social and societal reasons. They may be isolated more as children therefore making them more vulnerable to perpetrators (Balsam, 2003b).

The disparities may also be the result of sampling bias or the possibility that gays and lesbians are more likely to disclose childhood sexual abuse. Corliss et al. (2002) suggests gay men and lesbians are more willing to disclose stigmatized information than heterosexual men and women. Hughes et al. (2003) also speculated that the higher reports of childhood sexual abuse among lesbians may be attributed to lesbians' greater willingness to disclose, acknowledge, and report this experience. Of lesbians surveyed, 52.1% (Roberts and Sorensen, 1999) compared to 78% (Lundqvist

et al., 2004) of assumedly heterosexual or a mixed group of women never told anyone of the abuse. This willingness may be due to gay men and lesbians having more experiences with mental health issues. In fact, one study suggested that 80.7% of lesbians utilized mental health services at one point in their lives (Welch, Collings, Howden-Chapman, 2000). Another suggested that 78% of lesbians compared to 56% of heterosexual women reported receiving therapy (Hughes et al., 2000). With so many in therapy, lesbians may be more apt to identify childhood sexual abuse in their past and be able and willing to disclose it in a survey.

Another possible reason for more willingness to disclose is that most studies on homosexuality and childhood sexual abuse are based on samples of homosexual men and women who are "out," (i.e., willing to openly disclose their sexual orientation). It is plausible that homosexual men and women who are willing to disclose their sexuality may also be willing to disclose other sensitive information. As discussed in this review, research on childhood sexual abuse and homosexuality has been based on samples of homosexual men and women who are willing to identify themselves as homosexual, and engage in a study where their homosexuality is at times a focal point of the study. This leaves out a large portion of the homosexual population that does not choose to be a part of the homosexual community yet live a gay lifestyle.

In sum, although several studies suggest homosexuals are more likely to have experienced childhood sexual abuse (Hughes et al., 2000; Tomeo et al., 2001), only two claim childhood sexual abuse causes homosexuality (Cameron & Cameron, 1995; Gudlach, 1977). Instead, most researchers pose other reasons why there may be

an increase in reported childhood sexual abuse among homosexuals than their heterosexual counterparts. However, what may be of equal, if not more importance is the effects childhood sexual abuse has on women to include lesbians. Research suggests that lesbians experience many of the same effects of childhood sexual abuse as heterosexual women (Baker, 2003). Following will be a review of research surrounding the effects of childhood sexual abuse among women.

Effects of Childhood Sexual Abuse on Women

Although there are variations in the literature surrounding definitions of childhood sexual abuse (Browne & Finkelhor, 1986), there is little variation that there are long-term effects. Finkelhor and Browne (1986) propose a model called *traumagenic dynamics* that suggest the effects of abuse can be analyzed in terms of four trauma causing factors. These suggested traumagenic dynamics alter a child's perception both emotionally and cognitively creating a distorted view of the self, world, and affective capacities. Survivors of childhood sexual abuse then attempt to cope as adults using these distorted views leading to long-term consequences of abuse (Finkelhor & Browne). The four traumagenic dynamics include sexualization, stigmatization, betrayal, and powerlessness. The effects of childhood sexual abuse will be reviewed in the context of these four traumagenic dynamics.

Traumatic sexualization

Traumatic sexualization refers to a process where a child's sexuality, including sexual feelings and attitudes, are shaped in a dysfunctional way as a result of sexual abuse. Traumatic sexualization results from the exchange of affection or attention for sexual behavior. With childhood sexual abuse, part of a child's anatomy

may be given a certain meaning or importance by the abuser. Therefore, misconceptions and confusion of sexuality may result as well as frightening memories associated with sexual activity (Finkelhor & Browne, 1986).

The link between adult sexuality and early abuse has received little attention in the research community (Meston, Heiman, & Trapnell, 1999). Studies are often geared toward heterosexual women as evidenced by questions about birth control (Noll et al., 2003) or their relationship to their male partners (Testa, WanZile-Tamzsen, & Livingston, 2005). However, studies show that there is a direct link between sexual problems and a history of childhood sexual abuse. For example, women with a history of childhood sexual abuse have almost twice as many sexual problems as women without a history of childhood sexual abuse (Fleming et al., 1999). This illustrates the diversity of symptoms related to this event.

Childhood sexual abuse can lead to numerous sexual "distortions." A longitudinal study aimed to identify the long-term effects of childhood sexual abuse on adult women showed that women with a history of childhood sexual abuse were more preoccupied with sex. They were also younger at the time of their first intercourse. In this study, there was no mention of sexual orientation although some items reviewed were clearly geared toward the heterosexual such as the use of birth control (Noll, Trickett, & Putnam, 2003). Women with a history of childhood sexual abuse scored significantly higher than the comparison group on a sexual preoccupation factor. At the same time, women who were sexually abused as children by their biological father experienced more sexual aversion as well as more sexual ambivalence.

Childhood sexual abuse was also found to be a risk factor for early or risky sexual activity (Greenberg, 2001; Noll et al., 2003). This can often be mistaken for promiscuity. This is in contrast to Hall (1999) who found that sexual aversion may be a result of childhood sexual abuse in women (note that this study was specific to lesbians). This illustrates the spectrum of reactions to childhood sexual abuse from sexual preoccupation to aversion thus supporting the notion that childhood sexual abuse may produce maladaptive processing when it comes to sexuality as well as numerous psychological and behavioral consequences (Browne & Finkelhor, 1986).

Meston et al. (1999) conducted a study with 656 females who had been sexually abused and who were taking an undergraduate course in psychology. In this study, women with a history of childhood sexual abuse reported more liberal sexual attitudes and behavior. This finding was evidenced by an increased frequency of intercourse and masturbation, a greater range of sexual experiences and fantasies, and a greater likelihood of engaging in unrestricted sexual behavior. These phenomenon relate to Finkelhor and Browne's (1986) concept of traumatic sexualization whereas relationships may become oversexualized. This is not to suggest that all women with a history of childhood sexual abuse become oversexualized; nor does it suggest that young adults who engage in sexual activity are unhealthy. It does, however, highlight the broad range of sexual side effects child sexual abuse has on women. Research has indicated the other side of the spectrum, sexual aversion, may be a result of childhood sexual abuse as well (Hall, 1999). These two polarities magnify the spectrum of effects childhood sexual abuse has on women.

Women who have been sexually abused may fall victim to misguided sexual practices as well. Women with this history may act out sexually or become overly promiscuous (Kinnear, 2007). They may confuse boundaries between them and another person overly sexualizing the relationship. Widom and Ames (1994) found that women with a history of childhood sexual abuse were overrepresented in a sample of women who were arrested for prostitution.

Betrayal

This blurring of boundaries may also pose problems in other areas. In addition to sexual desire, long-term relationships may be affected (Fleming et al., 1999; Meston et al. 1999). A disruption in interpersonal relationships may be the result of an underlying dynamic that influences how a child views other individuals. The dynamic of *betrayal* refers to the idea that children may learn that someone whom they are dependent on has caused them harm. Individuals may realize that they have been lied to or manipulated and treated with total disregard. Distrust of family members may result even though they were not the ones abusing the child. This distrust may result from feelings that the family member did not protect them from the abuse (Finkelhor & Browne, 1986).

Disillusionment may accompany the experience of childhood sexual abuse. This disillusionment can lead to later problems such as extreme dependency in relationships or impaired judgment in the ability to trust later in life. These may lead to disruptive relationships (Dube et al., 2005). For example, research has demonstrated that women with a history of childhood sexual abuse are at an increased risk for revictimization in intimate relationships later in life (Griffin et al., 2005).

Griffin et al. (2005) conducted a study of women with and without a history of childhood sexual abuse to determine the rate of which a partner returns to their relationship after domestic violence had occurred. Having a history of childhood sexual abuse influenced whether or not an individual returned to their abuser. Women with a history of childhood sexual abuse reported a greater number of separations and returns to their abusers than did women who did not have a history of childhood sexual abuse.

The results of this study suggest that the presence of childhood sexual abuse plays a role in revictimization as an adult. Women with a history of childhood sexual abuse experienced more difficulty leaving their abuser, returning twice as often as those without a history of childhood sexual abuse (Griffin et al., 2005). Another study suggests that women with a history of childhood sexual abuse involving intercourse are 3.5 times more likely to experience domestic violence (Fleming et al., 1999). This may be the result of the level of trust that is broken within the betrayal dynamic described by Browne & Finkelhor (1986). Griffin et al. suggest that the emotional connection to the abuser is much stronger in women with a history of childhood sexual abuse than those without a history. To illustrate, survivors of domestic violence with a history of childhood sexual abuse were more likely to return due to the abuser being apologetic or feeling as if the abuser needed them.

Fleming et al. (1999) reviewed the long-term impact of women with a history of childhood sexual abuse noting relational problems as well. Women who reported a history of childhood sexual abuse perceived their partners to be less caring than did those without a history of childhood sexual abuse. In addition, having a history of

childhood sexual abuse significantly predicted dissatisfaction with their current relationship. Finally, the rates of women with a history of childhood sexual abuse were elevated significantly (26% versus 16%) with respect to being in a relationship with an alcoholic partner.

Many studies may not intentionally preclude lesbians, yet their selection criteria appear heterosexist when participants are asked about birth control, unplanned pregnancies, etc. One study required participants to meet the criteria of being in a relationship with a male, and therefore excluding lesbians (Testa et al., 2005). Even fewer studies indicate minority women as the population. Liang, Williams, and Siegel (2006) conducted a study to examine the effects of childhood sexual abuse on intimate and marital relationships from a sample composed of primarily African American women. Their findings suggest that the trauma severity of childhood sexual abuse had a direct effect on marital satisfaction. The more severe the trauma, the less satisfied the individual was in the marriage.

Liang et al. (2005) identified relational outcomes in minority women (African American) with a history of childhood sexual abuse. It would benefit the therapeutic as well as research community to replicate some of these studies using homosexual women. By not including sexuality in the literature, lesbians seem to have a lesser status than their heterosexual counterparts. This lack of status may be directly related to the next dynamic and may result in issues affecting the lesbian population.

Powerlessness

Childhood sexual abuse often leaves an individual feeling a lack of control. This lack of power contributes to the dynamic of *powerlessness*. This dynamic refers

to the process where a child's sense of self-will, desires, and self-efficacy are contained (Finkelhor & Browne, 1986). During childhood sexual abuse, a child's body is intruded upon leaving them with a sense of insecurity. Attempts to halt the abuse may be futile. Children may also feel powerless in getting adults to understand what is happening. This can result in a culture of secrecy. Many adult survivors of childhood sexual abuse stated that as children, they did not disclose the abuse out of fear of not being believed Other individuals were afraid that they themselves would be blamed for the abuse. There are other reasons woman remain silent about their abuse including a continued fear of punishment by the abuser and the continued desire to remain loyal to their perpetrator (Lundqvist et al., 2004).

Mental health consequences

Having a sense of impotence may be associated with despair and depression in later adulthood (Finkelhor & Browne, 1986). Although causality cannot be established, women with a history of childhood sexual abuse are more likely to experience major depression than those without such a history (Beitchman et al., 1992). Gladstone et al. (2004) showed that women with a history of childhood sexual abuse developed a state of depression earlier in life than those without a history of childhood sexual abuse. In Gladstone et al.'s study, significantly more women with a history of childhood sexual abuse had also attempted suicide in the past or had engaged in self-injurious behavior both in the past and recently.

Significantly more women with a history of childhood sexual abuse also received a diagnosis of panic disorder than those without a history (Gladstone et al., 2004). This is consistent with other literature suggesting that individuals with a

history of childhood sexual abuse have a higher rate of comorbid disorders (Katerndahl, Burge, & Kellogg, 2005a) and other psychological problems (Neumann et al., 1996) including Post Traumatic Stress Disorder (Feerick & Snow, 2005). One study suggests that the majority of individuals (69%) with a history of childhood sexual abuse had at least one disorder as specified by the Diagnostic and Statistical Manual of Mental Disorders (Katerdahl et al.).

Fleming et al. (1999) identified additional long-term consequences of childhood sexual abuse. This study found that having a history of childhood sexual abuse significantly predicted mental health problems. Women with a history of childhood sexual abuse experience depression, sexual problems, eating disorders as well as dependency on alcohol and drugs. All these can contribute to additional axis I disorders as referenced by the Diagnostic and Statistical Manual of Mental Disorders.

Stigmatization

In addition to a potential increase in emotional and mental disorders (Finkelhor & Browne, 1986), women with a history of childhood sexual abuse also may suffer from internal discord. stigmatization refers to a dynamic contributing to the negative connotations brought on by the sexual abuse. For example, when children are sexually abused, it is often communicated that they are "bad", should be ashamed, and feel guilty about the act that "they" started. This leads some children to blame themselves for the abuse. They may be asked to keep secrets therefore reinforcing the notion that the abuse is something of which to be ashamed (Finkelhor, & Browne, 1986). This may result in a numerous reactions. Women with a history of

childhood sexual abuse may display more negative affectivity expressed in feelings of depression, anxiety, guilt, inferiority, and helplessness (Wonderlich et al., 2001).

A sense of identity may be influenced by childhood sexual abuse. Women with a history of childhood sexual abuse involving intercourse reported having lower self-esteem (Brayden, Dietrich-MacLean & Dietrich, 1995). When asked what they thought the long-term consequences of childhood sexual abuse were, distrust was reported by 25% of the women who had a history of childhood sexual abuse. Women with a history of childhood sexual abuse reported lower well-being and self-concept scores. Brayden and colleagues believe that their findings results from the sexual violation inherent in the experience of childhood sexual abuse, and the social stigma and derogatory labels attached to early female sexual behavior.

Effects on personality

All these factors may influence the personality itself. Research has suggested that early childhood sexual abuse may have an impact on the development of the personality (Bradley et al., 2005; Wonderlich et al., 2001). Bradley et al. conducted a study to determine the personality constellation of the female with a history of childhood sexual abuse. Women with a history of childhood sexual abuse were found to have four different prototypes; internalizing dysregulated, high functioning internalizing, externalizing dysregulated, and dependent. The internalizing dysregulated group was characterized by having intense distress, interpersonal neediness and desperation, difficulty regulating affect, and a tendency to experience intrusive memories and dissociative symptoms. The high-functioning internalizing prototype had more strengths. They were capable of forming relationships with

others, expressing themselves articulately, and were able to set and achieve goals. However, the high-functioning internalizing also suffered from problems related to negative affectivity such as anxiety, and a tendency to discount their successes therefore blaming themselves for difficulties (Bradley et al.).

The externalizing dysregulated individuals were found to have a difficult time regulating strong affect. They appear to be primarily angry at others rather than blaming themselves and manage their emotions in a way that places blame on external rather than internal resources. Women with the dependent prototype had many features of the dependent and histrionic personality disorder according to the DSM-IV. They tend to idealize others and fantasize about finding someone who understands, loves, and protects them in a way that they were not in the past. Individuals with this prototype are suggested to repeatedly make bad decisions in relationships (Bradley et al., 2005).

The two emotionally dysregulated prototypes showed strong association with borderline personality disorder. The externalizing dysregulated group was associated with paranoid and antisocial dynamics. The internalizing dysregulated group showing a tendency toward social withdrawal indicated stronger indexes of schizoid, schizotypical, and avoidant personality disorder ratings (Bradley et al., 2005). These data do not suggest that individuals with a history of childhood sexual abuse will develop personality disorders. It rather suggests the type of coping that may be available to the women with a history of childhood sexual abuse.

Wonderlich et al. (2001) found that a group of women who had a history of childhood sexual abuse also had a high level of personality disturbance. This study

found that women with a history of childhood sexual abuse differentiated themselves from the controls on suspiciousness, intimacy problems, and restriction of expression. Elevations on these scales suggest a history of childhood sexual abuse may negatively influence self-disclosure, emotional expression, interpersonal trust, and sexual behavior. Women with a history of childhood sexual abuse also showed greater elevations on cognitive dysregulation, identity problems, affect lability, social avoidance, and self-destructive behavior (Wonderlich et al.). These characteristics may also be construed or misconstrued as the borderline personality disorder (Trippany, Helm, & Simpson, 2006). This research supports Katerndahl, Burge, and Kellogg (2005b) who found childhood sexual abuse to be a risk factor for borderline personality disorder. In their research, 29.3% of women with a history of childhood sexual abuse met criteria for borderline personality disorder. This is in contrast to the numbers of 10% in a general sample of outpatient patients (American Psychiatric Association, 2000).

Physical effects

In addition to psychological effects, a history of childhood sexual abuse can have effects on a woman's physical health (Golding, 1999; Leserman, 2005; Thakkar & McCanne, 2000). Research indicated that women with a history of childhood sexual abuse may be susceptible to the effects of heightened daily stress and may be more susceptible to physical symptoms (Thakkar & McCanne). Distressed women with a history of childhood sexual abuse also used more visits to the ER and had more pain complaints than their controls (Anrow et al., 1999).

Finestone et al. (2000) found that a greater number of women with a history of childhood sexual abuse reported a current chronic painful condition compared to a control group. They also reported more symptoms of current chronic pain. These women also reported their pain to be present over larger areas of their body over the control group. In addition, they reported more surgical procedures than non-abused women.

Summary and Conclusion of Childhood Sexual Abuse and Women

Childhood sexual abuse poses many risk factors for women. Consequences manifest themselves in emotional, behavioral, and physical forms. *Traumagenic dynamics* explain the alteration of a child's emotional and cognitive perceptions that may lead to a certain behavioral and psychological consequences (Chirsto, 1997). *Traumatic sexualization* can lead to numerous sexual problems as a result of the misconceptions of sexuality. *Betrayal* refers to a child's discovery that someone has betrayed their trust. This can lead to family discord and interpersonal problems. *Powerlessness* reflects a child's sense of self-will and desires being contained leading to a lower sense of self-efficacy. This sense of powerlessness may lead to nightmares, phobias, or dissociation. *Stigmatization* refers to the negative connotations that come with childhood sexual abuse. The stigma associated with the abuse may lead to guilt, shame, or lower self-esteem (Finkelhor & Browne, 1986).

The studies reviewed here are focused primarily on the heterosexual community as there is no mention of the homosexuality. The majority of studies are geared toward heterosexuals as evidenced by questions asked and information presented. The general effects on women, however, would include lesbians. The

effects of childhood sexual abuse can last far beyond the actual event. In this review, it has been revealed that women with a history of childhood sexual abuse are at a greater risk for relational problems (Fleming et al., 1999; Meston et al., 1999) including domestic violence and revictimization (Griffin et al., 2005), problems related to sexuality (Browne & Finkelhor, 1986), depression (Beitchman et al., 1992), suicide (Gladstone et al., 2004), comorbid disorders (Katerndahl et al., 2005a), mental health problems (Fleming et al., 1999), personality dysfunction (Bradley et al., 2005; Wonderlich et al., 2001) and health problems (Finestone et al., 2000).

The effects of childhood sexual abuse are obviously extensive and can be described using behavioral or psychological terms. The scope of the research on women and childhood sexual abuse is broad as evidenced by this review. Despite the findings that lesbians allegedly have a higher rate of childhood sexual abuse, the research in this area is lacking. The studies conducted on lesbians and childhood sexual abuse will be reviewed next.

Effects of Childhood Sexual Abuse on Lesbians

The impact of childhood sexual abuse on women has long been studied without querying about sexual orientation. In the samples of women who have participated in these studies, it is highly probable that lesbians have been a part of this research. The fact that sexual minorities have probably been a part of these studies illustrates the influence that lesbians have had on the knowledge base of childhood sexual abuse while at the same time being invisible (Baker, 2003). Women with a history of childhood sexual abuse are at risk for a host of difficulties later in life.

Lesbians are not exempted from this group, however, they have been exempt from many of the studies researching this phenomenon.

Childhood sexual abuse, in addition to being a sexual minority, often directly or indirectly carries certain shame and stigma to it (Rohbohm, et al., 2003). Finkelhor and Browne (1986) describe something similar called the dynamic of stigmatization. Stigmatization references the negative connotations brought on by the abuse. Negative connotations can also be attached to being homosexual. Therefore, lesbians may carry a "double secret" and may have to "come out of the closet" on both issues. They may find themselves carrying shame about the two or feeling as if one caused the other (Rohbohm et al.).

Emotional and Behavioral Effects

Although many studies have not included lesbians specifically, a few studies have demonstrated the specific effects that childhood sexual abuse has on lesbians. Robohm et al. (2003) researched the association between childhood sexual abuse and emotional and behavioral difficulties, feelings about one's sexuality, and the coming out process among lesbians. Their sample consisted of 433 individuals (227 lesbian women – 86 of which had a history of childhood sexual abuse) recruited from a posting to an electronic mail message board to lesbian/gay/bisexual college organizations nationwide. Participants completed an online questionnaire containing quantitative and qualitative items. To determine whether or not a participant was sexually abused, they asked "when you were a child or adolescent (below the age of 18) did someone(s) who was at least 5 years older than yourself or someone(s) whom you perceived as being more powerful ever encourage you or force you to have

sexual contact with them?" (Rohbohm et al., p 35). This question was adapted from earlier literature (Rohbohm et al. citing Bartholow et al., 1994).

Results from the participants showed that those with experience of childhood sexual abuse reported 13 of 19 emotional/behavioral difficulties with strong associations between childhood sexual abuse and four sexual risk-taking behaviors. Among the emotional / behavioral difficulties were depression, anxiety, suicide with no intent to die, suicide attempt with intent to die, self-injury, compulsive exercise, substance-use problems, body image disturbance, dangerous activity, illegal activity, and running away. In addition, lesbians practiced unsafe sex, had sex-pain or injury, participated with sex with strangers, had dangerous sex, and had multiple sex partners (Rohbohm et al., 2003). This would confirm the research discussed earlier that women who had a history of childhood sexual abuse suffer from more sexual problems (Greenberg, 2001; Noll et al., 2003). In addition, lesbians with a history of childhood sexual abuse reported significantly more total problems than those who did not have a history with childhood sexual abuse (Rohbohm et al.).

The vast majority of individuals surveyed stated that their childhood sexual abuse had a negative effect on their sexual experience(s). Only 3.6% stated that it had no effect on their sexual experience(s). About half of the lesbians stated that their abuse had an effect on their feelings about their sexuality or coming out process. A few participants stated that the experience affected their coming out process in a positive way remarking that it made them more open about their sexuality (Robohm, et al, 2003).

Another aspect to consider was that a history of childhood sexual abuse contributed to earlier knowledge of their sexuality. Comments on the qualitative section suggested that it was easier to open up to or accept their lesbianism due to their childhood sexual abuse. It was reported that it was easier to address being a lesbian or understand their attraction. In some instances it was a way to get their power back. In other instances, it made the coming out process longer as they did not want to fall into the myth of being abused then becoming a lesbian (Robohm et al., 2003).

Some women commented that they felt were abused because of their orientation. Few made comments that they were assaulted because they looked or acted like the opposite sex. Many participants stated that they felt that it was because they were a lesbian that they were abused. There were some who felt that their relationship with men has been compromised by the abuse. Some had a greater sense of safety with women versus the sex of their perpetrator (Robohm et al., 2003).

According to Robohm et al. (2003), there are numerous effects of childhood sexual abuse on lesbian women. Rohbohm et al. maintains that childhood sexual abuse has an impact on their sexuality but not their sexual orientation. Many made comment that the reason why they are a lesbian has nothing do with their childhood sexual abuse. Others commented that coming to terms with the abuse influenced their ability to accept their lesbianism. This information would contradict earlier literature (e.g. Cameron & Cameron, 1995) suggesting that homosexuality may be learned from childhood sexual abuse.

One behavioral characteristic of survivors of childhood sexual abuse is an increase in substance abuse (Robohm et al., 2003). In a comparison of lesbians and heterosexual women with sexual assault and alcohol abuse, childhood sexual abuse was associated with alcohol abuse in both lesbians and heterosexual women (Hughes et al., 2001). Of note is that an additional study showed that lesbians with a history of childhood sexual abuse had a higher rate of family history of alcoholism and drug abuse (Roberts & Sorensen, 1999). It is a confounding factor such as this one that suggests caution when generalizing results.

Roberts and Sorensen (1999) studied childhood sexual abuse and related sequelae in a lesbian population. Findings from this study showed an increase in incidents of eating disorders, panic and anxiety attacks, suicidal thoughts, and suicide attempts. Lesbians with a history of childhood sexual abuse also were more likely to be in therapy, and have family issues. Of note is that 52.1% of the lesbians in this study who had a history of childhood sexual abuse had never told anyone of the abuse. This number is far less than Lundqvist et al. (2004) (who did not assess for sexual orientation) who reported that 78% of women never told anyone.

Physical effects

Lesbians who have been sexually abused also showed significantly more sexual, health, and family problems than those without childhood sexual abuse histories. The survivors of childhood sexual abuse reported significantly higher rates of gynecological problems and hospitalizations. In addition, fewer survivors of childhood sexual abuse reported getting regular dental checkups (Roberts and Sorensen, 1999). Lesbians with a history of childhood sexual abuse may struggle with

obesity as well. Aaron and Hughes (2007) found that a history of childhood sexual abuse was related to higher Body Mass Index scores and higher rates of obesity in lesbians. This information confirms the research conducted with primarily heterosexual women suggesting more physical problems in women with a history of childhood sexual abuse (Golding, 1994; Leserman, 2005; Thakkar & McCanne, 2000).

Sexual effects

Hall (1999) also discusses the concept of a "double secret" related to lesbians and childhood sexual abuse. Hall completed a phenomenological study on a non-clinical group of lesbian women survivors of male perpetrated childhood sexual abuse where the abuse happened between the age of eight and fifteen. Eight women participated in the study. These women were recruited through professional contacts and by advertising in gay and lesbian press.

Results showed that all but one woman had problems related to their adult sexual relationships. More specifically was the inability to acknowledge and express their sexual needs (Hall, 1999). This type of shame is not uncommon in women who are survivors of childhood sexual abuse (Bass & Davis, 1994). In addition to this sexual shame came a lack or arousal or anorgasmia (Hall).

Hall (1999) also showed that participants had a general fear of initiating sexual encounters. With this fear came the fear of replicating the abuse. The women interviewed did not want to become "the abuser" therefore would initiate sex less. In addition to this cognition, some were afraid that they would abuse their own children. With these damaging faulty cognitions, it was difficult to have a healthy sex life. It

was also difficult for the women interviewed to differentiate sex, intimacy, and love. This led some women to oversexualize their relationships.

Several women described dissociation during sex. All but one had flashbacks during sex therefore leading to more disruption in their lives. These complications led to more restriction of motivation and avoidance of further sexual activity. Feelings of vulnerability resulted when memories of childhood sexual abuse came flooding back to them during sex leaving them with confused emotions. Three of the participants stated that they were prone to periods of depression or low moods. Three of the women had difficulty tolerating touch (Hall, 1999).

However, not all consequences were negative. A theme universally expressed was a sense of normality of their lesbian identity. One woman suggested that she may have not known she was lesbian had it not been for the abuse. Another suggested that lesbians still experience greater sexual freedom and willingness to experiment sexually (Hall, 1999).

Greater sexual freedom has been found in the literature as well. Runtz and Brier (1986) conducted a study on "acting out" after sexual abuse. Their study showed that sexually abused adolescents were more likely to have homosexual contact as a result of being sexually abused. The fact that there is an increase in homosexual activity could be a factor in the increase in numbers of survivors of childhood sexual abuse describing themselves as homosexual or bisexual.

Baker (2003) interviewed self-identified lesbians whom have been sexually abused as children. Her interview questions included the impact of the abuse and how they came to terms with it. An open-ended qualitative analysis was used for this

study. Participants were recruited using flyers in the gay, lesbian, bisexual, transgendered community of a large central Canadian community representing various age groups. The flyer invited lesbian survivors who "have worked through the issues and are willing to share [their] stories of healing." (Baker, p. 34).

The results of this analysis of childhood sexual abuse on lesbians were consistent with the previous literature regarding the effects on sexuality (Hall, 1999). Individuals discussed coping strategies that later impeded their exploration and desire for sex. In addition, their self-confidence was low, making it difficult to act on their attractions. Lesbians with a history of childhood sexual abuse struggled to value and respect their own desires. They also struggled with an internalized homophobia reportedly based on messages given to them by their perpetrator. In addition to this internal struggle, lesbian survivors of childhood sexual abuse struggled with spiritual issues, which resulted in feeling unsafe in the religious community (Baker, 2003).

Relationships

Relationship problems have been found in women with a history of childhood sexual abuse (Fleming et al., 1999; Griffin et al., 2005). However, there is little research on the quality of lesbian relationships with a history of childhood sexual abuse (Weingourt, 1998). In comparing a group of women who were in a live-in relationship with other women for at least 6 months to heterosexual women who met the same criteria, Weingourt found the level of sexual satisfaction in the current relationship was significantly lower in the group of women who reported a history of childhood sexual abuse than those who did not. However, comparing the heterosexual women to lesbians showed no difference in the level of satisfaction when controlling

for childhood sexual abuse. This shows that the variable of childhood sexual abuse was more important than the variable of sexuality (Weingourt).

As women have a higher rate of childhood sexual abuse (Dube et al., 2005), lesbian relationships have a greater chance of being affected by childhood sexual abuse than do many heterosexual relationships. Robinson (2002) evaluated the relationship between childhood sexual abuse and trust in 190 lesbians. The findings suggested that participants who had a history of childhood sexual abuse felt less able to predict their partner's actions than the participants without an abuse history. In other words, there was a lower level of trust with individuals with a history of childhood sexual abuse than those without a history.

There was no relationship found between trust and relationship or sexual satisfaction among participants with a history of childhood sexual abuse. However, there was a higher relational satisfaction of individuals without a history of childhood sexual abuse who were in relationships with people who also didn't have an abuse history. This is in contrast to a lower level of satisfaction that individuals without a history of childhood sexual abuse had with individuals with a history of childhood sexual abuse (Robinson, 2002). A potential reason for this is the individual without a history of sexual abuse may not have confidence in dealing with issues of a person who has a history of childhood sexual abuse. Individuals with a history of childhood sexual abuse may present as more complex in relationships as well.

This research highlights trust being a salient factor in dealing with women with a history of childhood sexual abuse. In assessing couples for treatment, this notes the importance of assessing for childhood sexual abuse as 63.3% of the

participants had at one time been involved in a relationship where one person had a history of childhood sexual abuse. In this study, there was a 36.3% rate of childhood sexual abuse in a sample of women ages 19-75 recruited from several large gay and lesbian social functions in Southern California. Over 70% felt that their relationship was affected by the abuse yet only 24.4% attended couples therapy (Robinson, 2002).

Guyer (2000) reviewed the relationships between childhood sexual abuse and personal perceptions and self-esteem. A total of 50 participants were recruited from South Florida and the San Francisco Bay Area. Although this study was conducted with gay men and women, it illustrates the effects childhood sexual abuse may have on an individual. Of note is that there was no control group in this study therefore these repercussions may not be able to be distinguished from issues of sexual orientation.

A total of 84% of the respondents said that the abuse affected their lives today. Data indicated that most respondents had not resolved their negative feelings about their abusers. Individuals with a history of childhood sexual abuse had mixed feelings about themselves. In addition, they had negative feelings about the abuse and ongoing difficulties believed to be related to the childhood sexual abuse. Nearly all participants expressed feelings of anger, fear, and mistrust. There were problems noted in relationships and with intimacy. A third of the respondents blamed themselves with the overwhelming majority stating they felt some form of guilt, shame, or blame. Implications of this research suggest that when assessing gay and lesbian clients for childhood sexual abuse issues, it is important to address unresolved issues with the abuser. This is not to be mistaken with confronting the abuser which

was often found to be negative. It is also important to address areas of shame and guilt. As found in Robinson's (2002) study, it is also important to assess interpersonal levels of trust and intimate relationships.

Economic consequences

Economic consequences have also been addressed for lesbians with histories of childhood sexual abuse. Data were obtained from individuals who were considered old enough to have completed college and entered the workforce and completed the National Lesbian Health Care Survey. A total of 1,889 lesbians were surveyed (Hyman, 2000). There were numerous consequences associated with childhood sexual abuse. Not only was childhood sexual abuse a significant predictor of numerous physical and mental health problems, but survivors of childhood sexual abuse were less likely to have earned a college degree than other women. Women who experienced certain types of childhood sexual abuse such as extrafamilial abuse by a stranger or incest also experience a substantial reduction in earnings.

Help seeking behaviors

Help seeking behaviors have also been addressed in the literature related to lesbians and childhood sexual abuse. Bradford et al. (1994) conducted the National Lesbian Health Care Survey with a total of 1,925 lesbians reporting. The results of this survey indicated that 41% of the sample reported being raped or sexually attacked at least one time in their life. A total of 21% reported being sexually abused as a child. Although 794 reported being sexually assaulted or raped, only 35% of these ever sought assistance afterwards. Friends were sought 19% of the time followed by police (12%) and counselors (10%) for assistance. Highest rates of

satisfaction were reported by those who sought help from special groups organized to help women (women's healing circles, women's health centers, and rape crisis centers). The most dissatisfaction came from seeking help from members of the clergy, private doctors, emergency rooms and the police (Bradford et al.). External homophobia is an issue specific to lesbians and one they struggle with when considering assistance for their childhood sexual abuse. A lesbian may want to research and find out if a place is safe for homosexuals before pursuing it as an option for assistance.

Summary

Research related to childhood sexual abuse and the lesbian community has added to the literature by identifying the specific effects of childhood sexual abuse on the lesbian population. In doing so, the needs of this population can be better served. Childhood sexual abuse has been shown to affect lesbians in similar ways to women who participated in studies geared toward the heterosexual community. One way in particular was the effect it has on sexuality (Browne & Finkelhor, 1986; Hall, 1999). Lesbians with a history or childhood sexual abuse were susceptible to increased sex risking behaviors (Rohbohm et al., 2003). This confirms research on community samples of women with a history of childhood sexual abuse that suggests that they too suffer from misguided sexual practices (meaning risk taking behaviors, not their sexual orientation) (Meston et al., 1999; Noll et al., 2003).

Like their heterosexual counterparts, lesbians with a history of childhood sexual abuse also struggled initiating sex (Hall, 1999). Having a history of abuse may also increase their sexual risk taking behaviors such as higher rate of practicing

unsafe sex, or participating in dangerous sex. Lesbians with an abuse history also reported more pain with sex (Rohbohm et al., 2003). They may also struggle with flashbacks or dissociation during sex (Hall). This research would confirm Finkelhor and Browne's (1986) dynamic of traumatic sexualization geared toward women without the mention of sexual orientation.

Health problems were also affected by childhood sexual abuse in a sample of community women (Finestone et al., 2000). This was also true for lesbians. Lesbian survivors of childhood sexual abuse reported significantly more gynecological problems and hospitalizations. In addition, they were less likely to get regular dental check-ups (Roberts & Sorenson, 1999). Lesbians with a history of childhood sexual abuse were also at risk for obesity (Aaron & Hughes, 2007).

Emotional and behavioral consequences were also found to be related to childhood sexual abuse in lesbians. Lesbians reported difficulties with suicidality, self-injury, depression, anxiety, self-injury, compulsive exercise, substance abuse problems, dangerous activity, and illicit activity (Rohbohm et al., 2003). Suicidality has also been found in a community sample of women with a history of childhood sexual abuse (Gladstone et al., 2004). Depression and anxiety has also been noted in the literature (Glastone et al., 2004). Women with a history of childhood sexual abuse have been found to have a higher rate of comorbid disorders than those without a history of childhood sexual abuse (Katerndahl et al., 2005a). Additional psychological problems have been noted as well (Neumann et al., 1996).

The literature on lesbians with a history of childhood sexual abuse also revealed economic consequences. Lesbians with a history of childhood sexual abuse

were less likely to earn a college degree than those without a history of childhood sexual abuse. They also had a substantial reduction in earnings (Hyman, 2000).

The research on lesbian relationships and childhood sexual abuse revealed they had significantly lower level of satisfaction in relationships than those without a history of childhood sexual abuse. When comparing heterosexual women to homosexual women, there were no statistical differences. This indicates sexual orientation was not a factor (Weingourt, 1998).

Issues specific to being a lesbian with a history of childhood sexual abuse include the coming out process. Rohbohm et al. (2003) suggested that a history of childhood sexual abuse may make coming out easier. Remarks on a qualitative section suggested that having history of childhood sexual abuse made individuals more open to their sexuality making it easier to accept. Other comments suggested that it inhibited their coming out process as they did not want to fall into the myth of becoming a lesbian because they were abused (Rohbohm et al.). Childhood sexual abuse may also bring along internalized homophobia that lesbians may have to struggle with (Hall, 1999). This may affect the coming out process as well.

Lesbians are affected like many other women by childhood sexual abuse but in many ways they serve as a unique population. The effects of childhood sexual abuse on lesbians are broad. They impact this population range from behavioral and emotional (Rohbohm et al., 2003) to economic realms (Hyman, 2000). In addition to their sexuality (Hall, 1999), childhood sexual abuse may impact a lesbian's coming out process (Rohbohm et al., 2003).

The above mentioned effects of childhood sexual abuse appear to be broad and all inclusive. The repercussions of childhood sexual abuse in lesbians seem to be as complex as the results in samples of presumably heterosexual women. However, many women find the strength to persevere despite their trauma.

Resiliency and Childhood Sexual Abuse in Women

Resilience is an important factor in helping children overcome trauma (Feinauer et al., 2003). It also allows individuals the ability to lead satisfying and productive lives (Bogar & Hulse-Killacky, 2006). It has been used to describe sustained competence during stress (Werner, 1995) and an individual's capacity for successfully adapting to traumatic or adverse events (Wilcox et al., 2004). Although there are different definitions in the literature, for the purpose of this study, resiliency has been conceptualized as a combination of personality traits and environmental influences that serve to protect an individual from harmful psychological effects of severe stress or traumatic events.

Resilience has a positive, protective effect in the face of childhood sexual abuse. Childhood trauma may interfere with the development of resilience (Feinauer et al., 2003; Werner, 1995). Trauma, such as childhood sexual abuse, interferes with a sense of adequacy, impeding the opportunity to learn positive methods of coping. Without resiliency factors such as positive role models or mentors, these innate skills can lay dormant (Feinauer et al.).

Reviewed here will be themes associated with resiliency. Specific relations to childhood sexual abuse will be examined and factors related to hardiness, another term for resilience, will be uncovered. As with most of the studies on the long term

effects of childhood sexual abuse on women, none of these studies mentioned sexual minorities. There seems to be little research on resiliency and lesbian women who have been sexually abused; therefore resiliency and women in the general population will be included.

In working with a longitudinal study with individuals born in Kauai, Hawaii, Werner and Smith (2001) defined successful coping by using numerous criteria. The first criterion was that the individual was employed or enrolled in school and was satisfied with his or her achievement. The next area of successful coping was an individual's relationship with his or her mate or partner. If the individual was married or in a long-term committed relationship, was satisfied with that relationship, and had no record of desertion, divorce, or spousal abuse, he or she was considered to be in the resilient category. The same went with individual's relationship with his or her children. Relationships with parents and siblings were also important when considering resilience as was relationships with peers. To be considered in the resilient category, an individual must report little conflict with his or her parents or siblings and have several close friends who provide emotional support. The final assessment of resilience was a self-assessment. This indicated that the individual was happy or mostly satisfied with their present state of life, had no dependency on drugs or alcohol, no psychosomatic illnesses, and no psychiatric disturbances. Findings from this study suggest that resilience was found in many ways and took many forms. Among high risk individuals, it was important that they felt that they could overcome the odds and have a positive outlook on life. An internal locus of control, the idea that one has power over their environment, was also important. Protective factors included

autonomy, social maturity, scholastic competence and high self-efficacy (Werner & Smith, 2001).

Childhood sexual abuse disrupts the environment in which the child lives. Werner and Smith (2001) found several latent variables, including childhood sexual abuse correlated with the environment that influenced adaptation at age forty. The first was maternal competence. Maternal competence includes the proportion of positive interactions between a mother and her child during the developmental years. The second influence was sources of emotional support. This was true from the toddler years to age forty. High rating of social support was an important factor in resilience. The final variable was the number of stressful life events. Stressful life events such as childhood sexual abuse may have a pronounced effect on individual's resilience.

However, adaptive coping with childhood sexual abuse is possible (Binder et al., 1996). Binder et al. describes the adaptation strategies for 30 women who have a history of childhood sexual abuse. In describing coping strategies, of paramount importance was that there was a supportive person in the environment. Another important factor was that there was motivation to escape the abuse situation. This hope and expectation assisted women in dealing with their childhood sexual abuse. Special talents were also noted as a factor in their recovery. These special talents included artistic ability, musical ability or the ability to excel in school. Finally, resilience was tied into women believing that they were not responsible for the abuse.

Bogar and Hulse-Killacky (2006) conducted a phenomenological, qualitative study with survivors of childhood sexual abuse. The participants included ten women,

30 years or older, who had been sexual abused during childhood by someone they knew. To determine their level of resiliency, they endorsed a satisfactory current life situation characterized by the ability to maintain stable a relationship; pursue and maintain a career; volunteer; pursue leisure interests; be relatively content with themselves and their current life circumstances; and believe that their lives had meaning. A total of 10 women were interviewed and characteristics of resiliency were identified. The five clusters of resiliency determinants found were (a) interpersonally skilled, (b) competent, (c) high self-regard, (d) spiritual and (e) helpful life circumstances. The four clusters of resiliency processes identified were (a) coping strategies, (b) refocusing and moving on, (c) active healing, and (d) achieving closure.

The first characteristic of *interpersonally skilled* described the participant's innate or learned ability to interact positively and effectively with others. Skills included verbal ability, capacity for emotional intimacy, independent-minded / assertiveness, and an optimistic or enthusiastic outlook on life and relationships. These interpersonal skills were believed to assist them in leading happier and more fulfilled lives (Bogar & Hulse-Killacky, 2006)

These skills were consistent with other findings which suggest the ability to find supportive relationships outside the family as being crucial in helping women overcome the experience of childhood sexual abuse (Valentine & Feinauer, 1993). Participants from this study suggested that external support was significant for their recovery. It was also vital to have someone believe them when they disclosed their childhood sexual abuse. Research indicated that this support, often coming from

schools or churches, produced good marriages as a result of giving them good role models (Valentine & Feinauer).

Self-identified talents or skills such as excelling in school or being creative also enhanced one's resilience later in life. These skills were known as having *competence.* With these skills also came an enhancement of *high self-regard* (Bogar & Hulse-Killacky, 2006). Although feelings of shame and low self-esteem are prevalent in women with a history of childhood sexual abuse (Finkelhor & Browne, 1986), all 10 women possessed high self-regard at some point in the interview. Some participants discussed specific moments in their lives when they made a conscious decision to change their negative self-view and accept positive feedback from others. Negative messages that were internalized were replaced with positive, more supportive ones. This positive self-talk was used in the development of high self-regard (Bogar & Hulse-Killacky; Valentive & Feinauer, 1993).

Most participants also identified *spiritual* or religious convictions as contributing to their resiliency. Several commented that they always embraced God whereas others developed a spiritual connection later in life (Bogar & Hulse-Killacky, 2006). This confirms earlier research suggesting that religion assisted women in overcoming early childhood sexual abuse (Valentine & Feinauer, 1993). Women in this study stated that their religion or church was important in providing a network of people with whom to interact. Religion also assisted them in making sense of the experience in a manner that gave them faith to find meaning and purpose in their lives.

The final resiliency determinant identified was *helpful life circumstances*. All 10 participants identified life circumstances that helped foster resiliency in their childhood and their adulthood. Not all of these circumstances were positive. Participants identified difficult times in their lives that contributed to them becoming stronger women. These challenging times were seen as events or circumstances that gave way to them becoming more resourceful or compassionate women (Bogar & Hulse-Killacky, 2006).

There were also resiliency processes that participants experienced. *Coping strategies* were important to help emotionally self-soothe, or self-protect in various ways. Although unhealthy coping strategies were identified, many utilized healthy ones such as writing, self-talk, athletics, and setting limits or boundaries. *Refocusing* and *moving on* was important to many participants. Maintaining the ability to refocus their energy was important in the participants moving on with their lives. This assisted them in functioning effectively and gave them the ability to respond to opportunities and responsibilities in their lives, develop a meaningful purpose, and minimize or eliminate the influence of their childhood sexual abuse (Bogar & Hulse-Killacky, 2006).

Taking a role in *active healing* was also important in fostering resilience. It was important to all participants to directly confront their childhood sexual abuse issues and pursue an active, conscious process of healing. It was important that they take responsibility for their own recovery and reject the role of the "victim." Included in this was talking about the childhood sexual abuse to other people. This contributed to *achieving closure*. Closing the door on the childhood sexual abuse was an essential

component of the resiliency process. Achieving closure did not mean participants forgot about the abuse, it was a means of integrating that aspect of their lives into their life stories without the emotional pain attached. Closure implied that the participant's childhood sexual abuse no longer controlled her decisions or behaviors. Ways of achieving closure were making sense of the meaning of the childhood sexual abuse, directly or symbolically confronting the perpetrator, and forgiving themselves and others (Bogar & Hulse-Killack, 2006).

External attributions of blame have been shown to positively affect resiliency in women with a history of childhood sexual abuse (Valentine & Feinauer, 1993). Over time, possibly with an active role of healing (Bogar & Hulse-Killack, 2006), individuals with high resilience were able to recognize that the abuse was not their fault. Most of the women interviewed said they figured out that their perpetrator was "sick," a "manipulator," or a "pedophile." They were also able to look at the situation and believe that it was not always going to be the way it was and were able to perceive a future free from the abuse (Valentine & Feinauer).

Some children believe instantly that it is not their fault (Feinauer et al., 2003). For others, it may take more of an active role in their healing (Bogar & Hulse-Killack, 2006). Some children believe that the blame and shame exist outside of themselves, therefore adapting to the trauma of childhood sexual abuse with less damage to their personality. These individuals are known as being resilient, invulnerable, or "hardy." This concept of hardiness is a coping style that empowers individuals to remain "whole" even when they encounter stressful life circumstances or repeated stressful events (Feinauer et al.).

Hardiness has been examined in its relation to severity of sexual abuse and internalized shame on intimacy. Of note is that this was conducted on individuals in heterosexual relationships. Results indicated that as shame increased, hardiness decreased. The same relationship was seen in severity of abuse. As the severity of the abuse increased, hardiness decreased. With respect to intimacy in a relationship, as internalized shame increased, intimacy decreased. Hardiness was shown to reduce the negative effects of shame on marital or a relationship's intimacy through providing the skills necessary to negate some of the negative effects of the abuse. Hardiness also provides the ability to negotiate intimate interpersonal relationships (Feinauer et al., 2003).

An internal locus of control and recognition of personal power has also been seen in individuals with high resiliency (Himelein & McElrath, 1996; Valentine & Feinauer, 1993). Women rated high in resilience noted that they recognized their power early on in life. Others came to this later in life as they took steps toward personal power such as leaving home and setting boundaries with others. The importance of taking risks and have an outside purpose was noted. It was also important to have a positive philosophy in life (Valentine & Feinauer).

Cognitive coping skills have also received attention in the literature on resiliency (Himelein & McElrath, 1996). Participants in this study were 180 females entering their first year of college at a small southeastern public university. Using a mixed method design, Himelein and McElrath examined cognitive coping strategies associated with resilience in a non-clinical sample of women with a history of childhood sexual abuse. Resilience was defined as healthy adjustment following a

history of trauma. Healthy adjustment was defined globally, rather than simply the absence of pathology using three measures of overall functioning instead of abuse-specific symptomatology. Women were divided into two groups, high adjustment and low adjustment.

Results from this study confirmed earlier research that greater perceptions of internal control and optimism were strongly related to healthy adjustment later in life (Bogar & Hulse-Killacky, 2006; Valentine & Feinauer, 1993). Believing in one's own ability to control future events and believing that the events will unfold in a more positive manner proved to be highly adaptive irrespective of abuse history (Himelein & McElrath, 1996). Cognitive reframing such as ascribing a different meaning to the event has also been found to be important in healing from abuse (Davis, 2000).

Hinelein & McElrath (1996) revealed that women with higher adjustment disclosed a greater quantity of information about both their experiences with childhood sexual abuse and their attempts to cope with it. Interviewers observed that the individuals in the well-adjusted group of women appeared more comfortable and confident when discussing the topic of childhood sexual abuse. They also required less encouragement and fewer follow up questions in telling their stories.

Positive coping processes were also seen in this analysis by more resilient women. A high percentage of the well-adjusted group (85%) had disclosed their childhood sexual abuse to someone. Most reported that talking to others had been helpful in their attempts to cope with their childhood sexual abuse. This is reflected in Bogar and Hulse-Killack's (2006) work where the participants discussed taking an active role in healing. It appears that talking about the abuse is important in resilience

(Himelein & McElrath, 1996). Fewer women on the low adjustment group ever talked about the abuse. The most frequent advice offered by participants to other women who have experienced childhood sexual abuse was to talk about it.

Minimization was another coping skill used by women in the high level of resiliency group. Several women described the impact of their childhood sexual abuse as having low impact on their lives. Fewer than half named their childhood sexual abuse as one of the top three stressors in their lives. Even when it was viewed as a significant stressor, it was downplayed as to the aspect it had on their lives. Women in the low adjustment group named childhood sexual abuse as a significant stressor in their lives (Himelein & McElrath, 1996). Perhaps this is related to the positive reframing that was also found in the women with high resiliency. Well adjusted women described at least some positive or self-enhancing perception of the childhood sexual abuse. There was a commonality of hope and optimism. Many well adjusted women believed that the childhood sexual abuse contributed to a beneficial life change. Again it was noted that finding meaning in adversity was important.

Finally, a refusal to dwell on the childhood sexual abuse was seen in women with high resiliency. Both groups discussed attempts not to think about their experience of childhood sexual abuse. However, women in the high adjusted group were more likely to report thinking about their childhood sexual abuse in the past but consciously refusing to dwell on it in the present. This is in contrast to the low adjusted group who reported efforts to "forget" it but had the inability to escape thoughts about their childhood sexual abuse (Himelein & McElrath, 1996).

More recently, Barnyard and Williams (2007) explored the patterns of stability and change in resiliency functioning in women with a history of childhood sexual abuse. Resilience was measured as positive functioning across several domains. This longitudinal study revealed that higher resilience scores were related to fewer symptoms of psychological distress. Higher scores were also a protective factor against less trauma exposure as an adult. In addition, resilience scores were positively related to later adaptive coping skills.

This study recognized resiliency as being stable over time. Resiliency does not seem to be a linear process, but is an ongoing process. Earlier resilience scores were associated with more active and positive coping and greater life and role satisfaction. Change of resilience was possible, however, and women attributed positive growth and change to "turning points" in their life. Most of these turning points happened in adulthood. Noted subthemes surrounding these turning points included the relationships with their children and wanting to better their lives for their children (Barnyard and Williams, 2007).

The above mentioned studies are predominantly made up of non-minority women and assume heterosexuality. Although there has been little research on the lesbian community, childhood sexual abuse, and resilience, there has been research conducted on other minorities (Banyard, Williams, Siegel, & West, 2002). Results of over a 25 year study with predominantly African American women indicated that survivors who were highly resilient were less likely to have experienced incest or severe childhood physical abuse. In addition, they were more likely to be reared in stable homes with fewer moves, less foster care placements, and less parental drug

use. Graduation from high school was also a predictor of resilience. This indicates the role of the environment in fostering resilience (Banyard et al.). Environments providing genuine, positive, and affirming relationships where positive coping skills are supported, identified, and then modeled foster resilience (Feinauer et al., 2003).

Social support has also been noted as important in fostering resiliency. This protective factor suggests that the individual with a history of childhood sexual abuse needs a positive role model. This may take the form of stabilizing the family of a child who has a history of childhood sexual abuse or strengthening support networks (Banyard et al., 2002). For many women, distrust is a repercussion of childhood sexual abuse and psychotherapy may be a place where they may deal with their fears and distrust. This protective shelter allows them to experiment with trust and reach out to others in an attempt to become involved in genuine relationships (Feinauer et al., 2003).

Summary

Resiliency refers to a combination of personality traits and environmental influences that serve to protect an individual from harmful psychological effects of severe stress or traumatic events (Boagar & Hulse-Killack, 2006). The determination of "resilient" is defined in many ways. For some it is the absence of pathology, for others, it is based on a variety of measures (Himelein & McElrath, 1996). Resilient children are seen as engaging to other people, having good communication and problem solving skills, having the ability to recruit substitute caregivers, possessing talents or hobbies that are valued by their peers, and having faith that their own actions can make a positive difference in their lives (Werner, 1995). Much research

has been conducted on resiliency, women, and childhood sexual abuse (Bogar & Hulse-Killack, 2006; Feinauer et al., 2003; Himelein & McElrath, 1996; Valentine & Feinauer, 1993). Many have had qualitative components that capture the lived experience of these women (Banyard & Williams, 2007; Bogar-Hulse-Killack; Himelein & McElrath; Valentine & Feinauer).

Cognitive skills

The resiliency skills of adults fall into numerous categories. The first category of resiliency skills was seen in the realm of cognitive skills. Women who were seen as resilient had a positive outlooks on life with greater optimism and positive or self-enhancing perceptions (Himelein & McElrath, 1996; Werner & Smith, 2001). An internal locus of control was also paramount in their recovery and resilience. Refocusing and moving on was helpful to achieve closure (Bogar & Hulse-Killacky, 2006). Cognitive reframing such as external attributions of blame and recognition of power in a situation assisted in resilience (Valentine & Feinauer, 1993). Talking about the abuse was beneficial and may have enhanced these positive self-perceptions. Finally, refusing to dwell on the past and minimizing the impact of the events were substantial in forming resilience (Himelein & McElrath).

Characteristics of an individual

Characteristics within an individual were also beneficial to resiliency. More social maturity, a higher sense of self-efficacy, and a better health status appeared to assist individuals in coping (Werner & Smith, 2001). A feeling of high self-regard was an important resiliency skill in recovering from the trauma of childhood sexual abuse. Taking an active role in one's own healing was also paramount in women's recovery

(Bogar & Hulse-Killacky, 2006). Perhaps it is this active stance that enhances one's feeling of self-efficacy.

Supportive relationships

Supportive relationships are of great importance with reference to resiliency skills (Bogar & Hulse-Killacky, 2006; Valentine & Feinauer, 1993, Werner & Smith, 2001). It was important that individuals with a history of childhood sexual abuse were interpersonally skilled. This included skills such as verbal ability, capacity for emotional intimacy, independence, assertiveness, and optimism in relationships (Bogar & Hulse-Killacky). Relationships with others also supported resiliency. This includes parents, siblings, and children. These skills may be impeded by childhood sexual abuse as many individuals are abused by family members (Anderson, Martin, Mullin, Romans, & Herbinson, 1993).

School / employment

School and employment positively influenced resilience through facilitating relationships and enhancing scholastic competence and special talents and abilities (Werner & Smith, 2001). This may assist with positive life circumstances to enhance resiliency (Bogar & Hulse-Killacky, 2006). It may also produce the social support one needs to enhance their innate skills of self preservation and hardiness.

Spirituality

Spirituality was important to many individuals recovering from childhood sexual abuse (Bogar & Hulse-Killacky, 2006). Perhaps it is due to the structure and social support that churches and spiritual organizations provide. It also has been found to assist individuals with dealing with the meaning of abuse (Baker, 2003).

Resilience can be found in many ways. Although it has been found to be relatively consistent over time, it can be a constantly evolving process full of many turning points (Barnyard & Williams, 2007). Women who have a history of childhood sexual abuse have been found to be adaptive in many ways giving way to resilience at every step. It is important to foster this resilience when working with women with a history of childhood sexual abuse. It is of equal importance in the gay and lesbian community where most members have likely been victim to multiple traumas including oppression and minority stress (Meyer, 2003). Therefore, research needs to be expanded to this area (Bogar and Hulse-Killack, 2006).

Resiliency and Gays and Lesbians

Although there is literature related to homosexuality and resiliency (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Connolly, 2005; Iwasaki, Bartlett, MacKay, Mactavish, & Ristock, 2005; Rabin & Slater, 2005; Russel & Richards, 2003; Sanders, 2000), little exists on the resiliency in lesbians with childhood sexual abuse. Much of the literature shows similar resiliency skills in the time of stress as with reports from women with a history of childhood sexual abuse. To illustrate, Bowleg et al. conducted a qualitative study to explore minority stress and resilience among Black lesbians. These minority lesbians experienced stressors of racism, sexism, heterosexism, and the intersection of the three. To overcome these issues, participants explained internal self-characteristics similar to women with a history of childhood sexual abuse such as the use of spirituality (Bogar & Hulse-Killacky, 2006), self-esteem (Werner & Smith, 2001), happiness, and optimism (Himelein & McElrath, 1996). Another resiliency process described was to actively and directly

confront oppression. This is similar to taking an active role in healing (Bogar & Hulse-Killacky). Assessing their power to change situations was also important. This mirrors abused women's expression of the need to recognize their own personal power (Himelein & McElrath). Finally, social support was important in overcoming oppression. This was also noted in studies of women with a history of childhood sexual abuse (Feinauer et al., 2003; Valentine & Feinauer, 1993).

Coping skills resulting from social exclusion has also been addressed with gays and lesbians (Iwasaki et al., 2005). Research related to non-dominant groups suggested that gays and lesbians utilize some of the same coping skills as do women who have a history of childhood sexual abuse. Social exclusion resulted from heterosexism and lack of acceptance of their homosexuality. Gays and lesbians discussed having a solid support system as a coping resource. Other resources include a safe environment where they felt like they belonged, spirituality, meditation or prayer, maintaining positive thinking and having a positive outlook in dealing with stress.

Resiliency, Childhood Sexual Abuse, and Lesbians

Research on resiliency in the lesbian population with a history of childhood sexual abuse is lacking (Balsam, 2003a). Studies conducted on samples of women will benefit lesbians with a history of childhood sexual abuse. However, lesbians serve as a unique population with unique needs. To benefit this group of individuals, already invisible in most studies, research needs to be conducted specifically targeting the resiliency factors of lesbians. In doing so, lesbians will no longer be the invisible minority in resiliency studies.

In looking directly at lesbians, Baker (2003) utilized a qualitative method to understand resilience in women who have a history of childhood sexual abuse. Resilience was conceptualized as a transactional parcel involving dynamic interactions between the respondent and her environment over time. To be a part of the study, self-identified lesbians had to indicate they had "worked through the issues and are willing to share [their] stories of healing" (Baker, p. 34). Respondents were asked how they came to terms with the abuse, about skills used in healing, and any issues related to the resilience process they wished to discuss.

For most respondents, being a lesbian brought confusion to their complex resilience process by complicating coming out issues. However, for some, being a lesbian tended to facilitate the resiliency process. In contradiction to this, the development of a lesbian identity negatively impacted the resiliency process by interfering with their social relationships, particularly during their healing work. Yet, there were respondents who met other lesbian survivors that assisted them with their optimism and efforts to heal from their childhood sexual abuse. Some mentioned that being in a lesbian community assisted them with their self-esteem and self-confidence. In some cases, older lesbians served as role models (Baker, 2003).

Spirituality

Spirituality can be a struggle for many gays and lesbians due to homophobia and oppression within many religions (Buchanan, Dzelme, Harris, & Hecker, 2001). However, spirituality emerged as an important part of the resiliency process by offering ways to deal with the meaning of the abuse, assisting them with gathering a sense of faith and security, and meeting like minded people who also struggled with

trauma. This spirituality was used for some to rebuild a positive concept of womanhood and femininity. This form of spirituality they developed was different from the religion or spirituality from their past (Baker, 2003).

Resources

The respondents made use of available professional resources. This use of professional resources may be similar to taking an active role in healing (Bogar & Hulse-Killacky, 2006). Support groups were used as well as professional and paraprofessional resources. Childhood sexual abuse support groups were important in the resilience process in addition to other self help groups such as 12-step groups. Several women, however, noted that they had professional experiences that were not helpful or were ineffective and significantly impeded their healing process. One reason for this could be the inexperience or incompetence of the worker. Another reason could be that the worker behaved in an unethical manner. Finally, geographic or economic restraints could significantly impede the resolution process (Baker, 2003).

Coming out

In contrast to conventional wisdom that suggests coming out to be a time of stress, respondents suggested that coming out furthered their resiliency process. It was seen as a break from the pain of healing. They were able to find personal strengths when they came out which they applied to their healing (Baker, 2003).

Conclusion

Although Baker (2003) conducted research that was paramount for lesbians surviving childhood sexual abuse, her focus was not on counseling related to these

resiliency skills. Her work did illuminate the resiliency skills used by lesbians in their coming out process. Therefore, there still needs to be research conducted on the counseling implications of resiliency in lesbians with childhood sexual abuse..

Resiliency is found in many ways and takes many forms. Commonalities have been revealed among ways that minorities address stressful situations and women who have a history of childhood sexual abuse address the same. Crucial to the delivery of services for lesbians who have been sexually abused as children is the need to understand their experiences of healing (Baker, 2003). It appears that more research needs to be conducted in this area (Bogar & Hulse-Killack, 2006). Through qualitative research, an individual's experiences of resilience can be revealed and the understanding of these variables can occur. In understanding this phenomenon, lesbians, identified as a unique population, can be better served.

Chapter 3

Methodology

This is a collective case study in which multiple cases will be examined. A case study allows a participant to translate personal experiences into narratives (Creswell, 1998) and allow me to identify themes in resiliency. A case study will allow me considerable amount of time to analyze the participant's data looking for themes that may not have transpired had this been a survey or other predetermined measurement. Another strength of a case study, I believe, is the amount of information generated will produce an understanding of resiliency and clinical implications. A limitation of a case study is that it involves a smaller number of participants and does not generate information from a larger participant pool. I felt that a case study would be the best research design for this study as I am looking to specify categories *a posteriori.* Although there are specific questions I will ask, I prefer a case study design because it allows for the multiplicity of perspectives.

The participants will be a group of adult self-identified lesbians who have been sexually abused as children who meet Bogar and Hulse-Killacky's (2006) criteria for resilience and who have had a counseling experience. This is an intrinsic case study because the primary focus of the study is to better understand particular cases (Stake, 1995). This collective case study will investigate the psychological,

emotional, and / or behavioral strategies lesbians use when trying to overcome or work through childhood sexual abuse. In addition, it will explore the impact of their counseling experiences on their resiliency. This will be done through detailed description of thoughts, feelings, behaviors, and other issues related to resiliency and counseling experiences subsequent to childhood sexual abuse.

Description of Sample

The sample for this study will be adult women at least 30 years of age who identify themselves as lesbian and who meet the criteria for being survivors of sexual abuse as children. The term lesbian is defined as "a woman who experiences the human need for warmth, affection, and love from other women; sometimes this includes sexual contact" (Child Welfare, 2006, p. 112). Whether a participant is lesbian will be determined by the participant. The participants will be asked what being a lesbian means to them in the phone interview. Any definitions or answers that are not relatively consistent with the above definition will be disqualified from the study. Self identified heterosexual and bisexual women and lesbians who are mentally or psychologically incapacitated (i.e., exhibiting extreme signs of mental illness or active drug addiction) will be excluded from the study. The term childhood sexual abuse means unwanted or otherwise inappropriate sexualized behavior with an individual who is at least five years older than the survivor when the survivor was under the age of 14 years or completed or attempted rape from 14 to 17 years old (Balsam et al., 2005; Russell, 1983). Russell's criterion will be used because it is grounded in the literature and has been referenced in recent studies (Amodeo, Griffin,

& Fassler, 2006; Hebert, Parent, Daignault, 2006; Leserman, 2005). Balsam et al. will be used to differentiate sexual abuse from child-on-child molestation.

The selection-eligibility characteristics for childhood sexual abuse are as followed:

1. The participant must have had an unwanted sexual experience with someone before the age of 14 years (Russell, 1983) or
2. Completed or attempted rape from the age of 14 to 17 years (Russell, 1983) with someone 5 or more years older than the participant (Balsam et al., 2005). Note that "sexual experiences" range from touching or attempts at touching of breasts or genitals to rape on at least one occasion (Russell).

The age of 30 years will be used as this is a study about adults (Keyes, 2004). There is no upper age limit on this study as resiliency has been found in older adults (Blieszner & Ramsey, 2002). An advanced age is also being used to ensure that the participant has achieved sufficient psychological and emotional distance from the event.

The individual must answer 5 or above on the following question; "on a scale of 1 to 10, one meaning "I haven't worked through my childhood sexual abuse at all" and 10 meaning "I have completely worked through my childhood sexual abuse," where would you place yourself on this scale?" The term "worked through" will be defined by the participant. The participant must also have a history of attending a self-described history of counseling and / or psychotherapy by a licensed

psychotherapist. There is no predetermination on how many session they have to have attended.

The participant must meet criteria for resilience. To determine resiliency, affirmative criteria must be met in four different domains (Bogar & Hulse-Killacky, 2006). These domains have been adopted from previous literature on resiliency and childhood sexual abuse. To be deemed "resilient," the participant must endorse (say, "I agree" to) the following statements;

1. I have the ability to maintain stable relationships.
2. I have the ability to pursue and maintain career, volunteer, or leisure interests.
3. I feel relatively content with myself and my current life situation.
4. I believe that my life has meaning.

Finally, the participant must be free from alcohol and drug addiction using a modified version of the CAGE assessment for alcohol problems (Bush et al., 1987).

Eligibility criteria can be found in Appendix A.

Sampling Scheme

The sample will consist of 8 lesbians with self-reported childhood sexual abuse prior to the age of 18 years. These women will be recruited from flyers placed at coffee shops, and gay and lesbian social events, from an internet source for lesbians, and through social networking (See Appendix B for the flyer). They will be screened via phone screening interview (See Appendix C for a complete list of phone screening questions).

Participants will sign a consent form in order to participate in the study (See Appendix D for the consent form). Permission to tape record will be included in the consent form. Purposeful, criterion based sampling (Stake, 2005) will be used to collect participants for this study. Purposeful, criterion based sampling is necessary because the study requires that the participants are lesbians with a history of childhood sexual abuse

Instruments

Initial phone screening

There will be some brief questions asked via phone to determine whether the participants are appropriate for the study. The phone screening instrument can also be found in Appendix C. The interview script is as followed;

"I appreciate you taking the time to contact me and for your interest in the study.

How did you hear about the study?

There are a few things I want to tell you before we begin. This is a study for my doctoral dissertation in Counselor Education at the University of South Florida. I became interested in this type of research because I am a lesbian. I am in the community and believe that there needs to be more research and services for our population. I have also worked with many women who have been survivors of childhood sexual abuse.

To ensure confidentiality, please think of a pseudonym to use for the study. Although I will need your signature for a consent form

prior to the study, your real name will not be used.

You would need to travel to my south Tampa office for this study. This is to ensure that the interview conditions for all participants will be consistent.

You may experience some discomfort during the interview because we will be talking about childhood sexual abuse. This would be a normal reaction.

Now I would like to ask you some basic questions about yourself if that is OK?

1. Could you tell me your age, your occupation, and your level of education?

2. What is your ethnicity?

I realize that this may be difficult, but I need to ask a few questions to see if you meet the inclusion criteria for the study. I would like to ask you some questions about your sexuality and your sexual abuse history if that is OK?

1. Are you lesbian or bisexual?

2. For how long have you considered yourself to be a lesbian, and for how long have you been out?

3. What does being a lesbian mean to you?

These next questions are specifically about childhood sexual abuse.

1. Did you experience any unwanted touching or attempts at touching your breasts or genitals before you were 14?

2. Did you experience any forced sexual relations before you were 14?

3. Did you have this experience between the ages of 14 and 17?

4. Was the person or persons who did this 5 or more years older than you?

5. As an adult, have you had any other sexual assault experiences?

6. On a scale of 1 to 10, one meaning "I haven't worked through my childhood sexual abuse at all" and 10 meaning "I have completely worked through my childhood sexual abuse," where would you place yourself on this scale? I understand that "working through" means different things to different people. For the purpose of this question, use your own definition.

7. What does that number mean to you?

8. Have you had counseling with a licensed clinician to address your childhood sexual abuse or issues related to this?

9. Did you find counseling helpful, unhelpful, or both?

10. How helpful or unhelpful did you find counseling in dealing with your abuse issues either directly or indirectly?

I would now like to ask you four questions about your life right now. Please say whether you agree with the following statements or disagree with them.

a. I have the ability to maintain stable relationships.
b. I have the ability to pursue and maintain career, volunteer, or leisure interests.

c. I feel relatively content with myself and my current life situation.

d. I believe that my life has meaning.

This is to determine your level of alcohol and drug usage. Please say whether you have or have not experienced the following within the last 6 months.

a. Do you feel you should cut down on your drinking or drug use?

b. Have people annoyed you by criticizing your drinking or drug use?

c. Do you feel bad or guilty about your drinking or drug use?

d. Have you ever had a drink or drug first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover?

I have just a few more questions.

1. Do you feel you would be able to discuss the effects of these experiences with me for research purposes?

2. Would you be willing to meet with me for about 1-2 hours to discuss how you worked through your childhood sexual abuse and then be contacted at a later date to review a transcription of your interview to make sure it is accurate?

3. This discussion will be taped and transcribed for research purposes. Would it be acceptable to you to have your transcripts read by others provided you remained anonymous?

4. What questions do you have about the study at this time?

5. Is there a phone number where I can reach you or a confidential e-mail where I may contact you?

6. May I leave messages there?"

Notes from the phone interview will be recorded and included in the dissertation.

Interview script

If the participant meets the criteria for the study, I will ask her to make an appointment to complete the interview. In the interview, I will ask demographic and rapport building questions followed by the major questions for the study. The script for the interview is as followed (See Appendix E);

Thank you again for participating in this study. This session will be recorded and transcribed. This transcription will be read by my committee members and an outside auditor. Quotes from this interview will be used in the dissertation, but I want to remind you that your true identity will remain anonymous. I will respect and protect your confidentiality.

Please let me know if at any time the interview becomes too uncomfortable. We can either take a break or terminate the interview if necessary. I would like to give you a moment to read a consent form

that you will need to sign in order for me to continue with the interview. If you have difficulty reading it, please let me know, I can read it to you. [I will then give them the consent form, review it and have them sign it.]

1. Do you have any questions about the consent form?
2. Having read the consent form, do you still agree to be a part of the study?
3. I would now like to start taping, is that ok with you?

I would like to start with some basic questions if you are ready to begin [I will then attend to any needs they have prior to starting the study]

4. Are you currently in a relationship and if yes, for how long?
5. On a scale of 1 to 10 with 10 being the most satisfied, how satisfied are you in your current relationship?
6. What does that number mean to you?
7. Do you have any children? If so, what are the ages?
8. On the same scale, how satisfied are you with your relationship with your children?
9. What does that number mean to you?
10. You mentioned during the phone interview that you were had been in therapy at one point with a licensed clinician, are you currently in therapy?
11. If so, for how long [Probing question]

12. What is your current occupation?
13. How long have you been_____?
14. Same scale 1-10, how satisfied are you in your current profession or school?
15. What does that number mean to you?
16. 1-10, how satisfied are you currently in regard to your friendships?
17. What does that number mean to you?
18. 1-10, how satisfied are you with yourself?
19. What does that number mean to you?
20. 1-10, how satisfied are you with your current life overall?
21. What does that number mean to you?
22. During the phone interview you stated that you had experienced childhood sexual abuse. I would like to ask a few questions about that. Can you tell me what happened?
23. What was your relationship to the person who committed this act? [Probing question]
24. How often did this happen to you? [Probing question]
25. Who did you ever tell about this experience?
26. Who have you spoken with about the abuse since then?
27. How are you feeling right now? [At this time I would attend to any needs that they would have]
28. When you think about your life now, what specifically has helped you work through your abuse?

29. In what ways did ____ help you work through this? [Probing question]
30. You mentioned that you were in counseling, what about counseling was helpful in you working through your abuse?
31. Were there any aspects of counseling that were not helpful?
32. What about _____ was not helpful? [Probing question]
33. Were there any barriers to getting counseling and if so, what were they?
34. What things do you do currently to cope with problems?
35. What advice would you give to someone who is working through their childhood sexual abuse issues?
36. How are you feeling right now?

That's all the questions I have for you at this time. Here is my email address, if within one week you decide that you would like to add anything to the interview, please do not hesitate to email me additional information [Card with email address will be handed to the participant]

What questions do you have for me?

I will have to send you the transcripts of this interview. What is the best way to get them to you?

From here, someone will contact you to follow up on this interview. She will be a Licensed Mental Health Counselor. Here is her number, as well as the crisis line and a local emergency room. This

Licensed Mental Health Counselor too will protect your confidentiality. I want you to know that there are resources available to you if you need further assistance. I appreciate your time. Thank you for contributing to this research. May I have a number where she may contact you?

Phone debriefing

As the discussion of anything related to childhood sexual abuse may produce discomfort for the individual, I plan to have them debriefed after the interview. This will be done by a Licensed Mental Health Counselor to determine whether or not the participant needs a referral to someone for additional assistance. I plan to use the following script for the phone debriefing (See Appendix F).

"It's not unusual after discussing such topics to have a resurgence of symptoms, and you may have experienced some discomfort during the interview. This is normal. In the event that you have extreme levels of discomfort, please go to your doctor, counselor, the emergency room or the nearest hospital and then call me. Otherwise, please consider a referral to a therapist. I can help you with that.

1. How are you feeling after the interview?
2. To what extent did you experience any significant discomfort?
3. Do you think you have an adequate support network that you can reach out to if needed?
4. Do you currently have a therapist?

5. Is there any way I can be of assistance to you right now?

In the event that you need any further assistance, please do not hesitate to call."

Interview

The type of interview will be semi-structured. It will begin with some general rapport building questions (Creswell, 1998; Fontana and Frey, 2005). After the initial rapport building questions, the interview will remain collaborative using active listening and probing questions as needed. The interview process then will continue with several predetermined questions followed by clarification questions depending on the answers of the participant. Several questions post-interview will be used to debrief the participant. I will also use descriptive observation (Creswell) to describe nonverbal aspects of the interview.

I expect the interview to last approximately 1-2 hours. Any breaks during the interview will be determined by the participant. The time estimate is based on the length it may take me to establish rapport, answer demographic questions, and give an explanation of what was helpful in working through childhood sexual abuse and what aspects of counseling were helpful or not helpful. Additional questions can be found in the interview script (Appendix E). I anticipate that data collection will occur over a two-month period. This will allow adequate time for prolonged engagement with the transcribed interviews and for providing detailed descriptions of resiliency as well as clinical implications. This should also allow enough time for me to engage in member checks, external auditing, and examination of emergent themes.

I will use the interview to review questions that determine the psychological and behavioral strategies lesbians use in successfully working through childhood sexual abuse issues. I will then contact the participants via email, phone, or in person for descriptive validity purposes. This should take a maximum of approximately one more hour of their time. At this time, I will review transcripts with the participants and ask if they would like to add anything to the interview. Participants will be invited to email any additional feedback to me within one week of their initial interview.

Eight individuals will be the participants for this research. In the event that more than eight people respond to the flyers, the first eight participants who meet the criteria will be the study participants. Four individuals will be used for the interviews and their data will be analyzed. Two individuals have been used in the pilot study. Their data was not be analyzed. Two individuals will be used as back up in the event that the first four individuals are unable to follow through. The first two individuals who respond and meet criteria were used for the pilot. The next four who meet criteria will be used for the interview with their data analyzed. The final two will be used only if the prior four do not follow through.

I will interview the participants in an office in a building which houses various psychotherapy offices in the south end of Tampa, Florida. The office is furnished with two chairs, a couch, a desk, art fixtures, and lamps. The participants will have the option of sitting wherever they are most comfortable. A tape recorder as well as a digital recorder will remain on a small table in between the interviewer and the participant.

Data collection procedures

Pilot testing

The interview protocols for this study were pilot-tested by two lesbian participants who have been sexually abused as children in order to increase credibility for this research. They were informed that their data would not be used for analysis. However, they were recorded to review the dialogue between me and the participant. Participants were selected using the same criteria via solicitation through the flyer and phone screening.

Participants were asked to evaluate the questions and study procedures to determine whether they are appropriate for this research. The participants answered the questions briefly and gave their opinions about the interview. During this time, I evaluated the questions as well. Pilot testing occurred prior to the initiation of any interviews with participants to ensure that the questions were adequately screened and piloted. After the pilot test, the questions were revised. The script for the pilot test is was follows (See Appendix G);

> "Thank you for participating in the research project 'Resiliency in Lesbians with a History of Childhood Sexual Abuse: Implications for Clinical Practice.' I appreciate your willingness to be a part of this important project. I will be asking you a series of questions to be used as a pilot study. I am interested in your feedback on these questions. If you do not understand any of these questions or think that any of these questions could be asked in a better way, please stop me and give me that feedback. Do not hesitate to stop me if there is something that you

do not understand. Please answer the questions from your own experience. Do you have any questions at this time?"

I read the script to the pilot test participants prior to beginning the demographic questions in the face to face interview. They were asked in the phone interview if they would be willing to be a part of the pilot study. The first two participants who responded to the study were used for the pilot study.

Procedures

Authorization for the study will be obtained from the Institutional Review Board at the University of South Florida prior to engaging in the study. Informed consent will be obtained from all participants informing them of the nature of the study and potential distress to the participant by virtue of the topic being discussed. No deception will be used in this study.

Because childhood sexual abuse is a very personal and emotionally laden subject, there will be a debriefing after each interview. Debriefing questions can be found in Appendix F. Participants will be given referrals to resources for sexual abuse survivors in the event that they need additional therapy or support after the interview.

About the Researcher

I am a doctoral student in Counselor Education at the University of South Florida and have studied Qualitative Research Methods and Design at the doctoral level. I am also a Licensed Mental Health Counselor and Certified Addictions Professional with about 10 years in the field of mental health counseling working with women whom have struggled with childhood sexual abuse. I will be the researcher and primary investigator.

I am also a lesbian. I became involved in the lesbian community over 12 years ago. I became interested in the lesbian community after realizing that there was a lack of research with this marginalized population.

Research Design and Verification Procedures

Researcher bias may occur because I, being a licensed mental health counselor with a history of treating sexual abuse survivors, may have *a priori* knowledge that may lead me to interpret in a certain direction. This bias may influence the participants and me and could affect the study procedures or even contaminate the data. Researcher bias does not occur only at the data collection stage but it can also contaminate the analysis and interpretation stage (Onwuegbuzie & Leech, in press), therefore an external auditor will be used throughout the study. The role of the external auditor will be to respond to any ethical concerns I have regarding the study or any participants. The outside auditor will also review the themes that emerge and ensure that they are consistent with the data provided by the participants. The role of the outside auditor will also be used to clarify researcher bias through conducting necessary interviews pre and post interviews with the participants.

Clarification of researcher bias

To guard against threats of legitimation, clarification of researcher bias will take place prior to the collection of data (Creswell, 1998). In this instance, the researcher will speak with the external auditor, who is also the peer debriefer with a similar background in qualitative research, about prejudices or biases that may alter the interpretation of the results of the study. The outcome of this will be documented under the heading "potential researcher bias" in the final documentation of the study.

As a means of understanding and clarifying my researcher bias, the following transcript will be used prior to the start of the interviews (See Appendix H);

1. What biases do you think that you have in going in to this dissertation?

2. Do you think that you have any prejudices against any of the parties involved in this research?

3. What is your experience with this population?

4. Why did you choose this dissertation topic?

These questions are to provide an understanding for both me and my external auditor any bias I have prior to engaging in the study. Related to these questions, I believe the following will be disclosed. A potential issue involving the researcher is that I am a lesbian. This may affect the way that the participants perceive the study. It may be that the participants feel more comfortable talking to a lesbian. However, this may hinder them from speaking of experiences with childhood sexual abuse. The sexual orientation of the researcher will be disclosed.

Peer debriefing

To maintain perspective, the researcher will be debriefed using a peer debriefing session (Creswell, 1998) after each of the interviews. The following questions will be used for the session. (See Appendix I);

1. How do you feel after the interview?
2. What are some thoughts that you have on the interview?
3. Did you notice anything unusual about the interview?

4. Did you feel you lost any objectivity during the interview?
5. Is there anything else you want to say about this interview?

This peer debriefing will allow me to understand the process of my research better and to relieve any stress from the interview. This individual will be a peer who has a Ph.D. in Counselor Education, has had a doctoral level class in Qualitative Research Method and Design, and knowledge of qualitative research. She is also the external auditor. She will inquire about meanings explored and interpretations made after the meeting with the participant (Lincoln & Guba, 1985).

External auditing

To maintain dependability, the analysis of the data will go through an inquiry audit to be completed by an individual who has had a doctoral level class in Qualitative Research Methods and Design. This inquiry audit will review the product of the analysis for accuracy of themes. The auditor will also review how the analysis has been conducted and the results of the study (Lincoln & Guba, 1985).

Email feedback

There is the potential that the presence of the researcher will disrupt the information being offered by the participant. The individual may be unduly influenced by the researcher as she may want to offer more information to "better" the study or offer less as she may feel embarrassed because of the details. To ensure that the participant has different forums to provide feedback, the participant may email more feedback on any of the questions within one week of her interview. This will ensure that the participant is given various methods of telling her story. The email account used will be password protected by me. I am the only one who will have

access to the email account. This email feedback will be facilitated by providing the participant with my email address and telling them that they may email me as many times as they wish within one week.

Member checking

Data will be verified using "member checking" (Lincoln & Guba, 1985; Stake, 1995). The participants will be contacted after the interviews have been transcribed and will be asked to review their transcripts. They will be contacted either in person, via email (if they have provided me with a confidential email address) or the U.S. Postal Service. Participants will be asked if they need to make any changes, or if they want to add anything to the transcripts. Any additional information provided will be included in the analysis. The participants will also be allowed to email me any more information they would like to include in the analysis. To remind the clients of this, a follow up email will be sent to the participants. The email will state the following (See Appendix J)

> "Dear Pseudonym,
>
> Thank you for participating in my research project. I appreciated the time you took to answer my questions and provide detailed information as to your resilience surrounding your childhood sexual abuse. I wanted to remind you that you may email me within one week if you feel you need to add anything to your interview. You may email me as many times as you would like.
>
> From here, your audio tape will be transcribed and I will review it. I will email [or send it, or hand deliver it] to you per our

agreement so that you can review it for accuracy. This should be done within one month.

Thank you again for your participation. Please do not hesitate to contact me with any questions you have.

Sincerely,

Amy Menna"

Data Analysis

Data to be collected are spoken materials in addition to affect, change in mood, and other non-verbal communication (Atkinson & Delmont, 2005). Data will be collected via audio tapes and field notes taken by me. Data will be transcribed by a transcription service. This transcription service adheres to confidentiality and will transcribe data based on digital files given to them. Software to be used is Microsoft Word and Microsoft Excel.

Themes within the case will be analyzed using within case analysis (Creswell, 1998). Data will be transcribed into Microsoft Word. Data will then be chunked into meaningful sections. Meaningful sections will be determined by me by taking out words and sentences that do not have to deal directly with resiliency skills such as "and" and "well, let me think." After meaningful segments have been reviewed, sections will be chunked into themes. A complex color coding system will be used where meaningful sections will be highlighted according to what question they fall under. They will then be placed on a spread sheet and organized within the questions into categories. A color coded system will be used to identify themes using another

spread sheet. Categories will be specified *a posteriori*. Themes categorized will be resiliency skills lesbians use to overcome childhood sexual abuse; helpful, unhelpful, and barriers to receiving counseling; current resiliency skills; and advice given to others. Reviewed separately will be the clinical implications of the knowledge gained through this research and how counselors can assist this population.

Chapter four will reveal the results of this study. Each participant will be reviewed individually and emergent themes will be evaluated and discussed. Chapter five will focus a review of the themes emerged in the individual categories as well as clinical implications, limitations, recommendations for use of the present findings, and recommendations for future research.

Chapter 4

Results

In this chapter, the results of this study will be presented by addressing the participants' responses to the interview questions regarding their resiliency after childhood sexual abuse. Resiliency was defined as a combination of personality traits and environmental influences that serve to protect an individual from the harmful psychological effects of stress or traumatic events (Bogar & Hulse-Killaky, 2006). For the purpose of this study, resiliency also includes skills and adaptive thought processes. Since the term "resiliency" is not often recognized by those outside the academic community, the term "coping" was used in this study with the participants in place of resiliency. Hence, for the purpose of this study, coping and resiliency are synonymous.

Throughout the interviews, some participants used the word "counselor" while others used the word "therapist." For the purpose of this research, they are synonymous. The terms "therapy" and "counseling" are also used synonymously.

Based on the recommendations of Miles and Huberman (1984), I chose to include my thoughts and reactions to the participant's data. These thoughts and interpretations are interspersed throughout the document in addition to the discussion at the end of each participant's write-up.

I used a color coded system to identify resiliency themes within cases after

reviewing the transcripts and field notes of the interviews. I developed the resiliency themes out of clusters of common behaviors or thoughts. At times, I used the exact wording of the participant to capture the true voice of the participant. The themes are disclosed throughout the document through "I" statements such as "I identified" or "I recognized." They are also disclosed by "this theme emerged" or "the theme identified." Resiliency skills are adaptive coping mechanisms used by the participants. However, they are at times interchangeable with a theme (i.e. the skill of "self-care" may also be a theme by the same name). A final discussion of these emergent themes will be presented in the 5th chapter.

This chapter will begin with a section on potential researcher bias followed by the results of each participant's data. Field notes from the preliminary phone interview may be found in Appendix L and field notes from the interview may be found in Appendix M. The exact transcripts are not included in this study by agreement with the participants.

Potential Researcher Bias

I had an interview involving clarification of researcher bias with the external auditor prior to beginning this study. A complete transcript of the interview can be found in Appendix K. During the interview, I disclosed my thought that my primary bias during this research was my belief that lesbians are particularly resilient as a result of having to overcome oppression related to their sexual identity. Another bias was my focus on individuals' strengths versus their weaknesses. These biases developed through my involvement in the gay community for 12 years and my work with trauma survivors for almost 10 years.

The dissertation topic resulted from my focus on trauma resolution and particularly on sexual abuse. It seemed a natural choice as I have always focused on resiliency in my clients. I chose the population of lesbians because they are an under researched population.

Anna – Participant #1

Telephone screening

Anna is currently a 31-year-old Caucasian female who is a real estate broker with a Bachelors degree in Business Administration. She met criteria for the study via telephone screening. She called me after seeing an advertisement on an Internet website that facilitates networking of lesbians. Anna answered "I agree" to all four resiliency criteria questions. She does not have a drinking or drug problem as evidenced by answering "No" to all four questions about drinking and drug use. She was willing to discuss the effects of childhood sexual abuse with me for research purposes and agreed to all conditions. Phone screening field notes can be found in Appendix L.

During the telephone screening, she reported experiencing unwanted touching or attempts at touching of her breasts or genitals before she was 14 years old. She also reported experiencing "forced sexual relations" before the age of 17 years old. She has not had any other sexual assault experiences as an adult.

Anna had no questions about the study. She stated she just wanted to see the results and help others. She ended the phone interview without any questions.

First impression

Anna was neatly dressed in casual, although professional, clothing. When I greeted her at the door, she shook my hand immediately and smiled. During the interview she made very good eye contact, appeared to be free with her discussion, and did not appear to be nervous. Anna was personable and talkative during the interview. She did not ask any questions about the study. Instead, she seemed to be more concerned about helping others and getting the information out to other lesbians who may have had similar experiences.

Sexuality

Anna stated that she has been a lesbian since she "admitted it" to herself 11 years ago. Thus, she has considered herself to be "out" for 11 years. When asked what being a lesbian meant to her, she stated that she found more "intimate and emotional comfort" with women than with men.

Levels of satisfaction

Anna seemed to have an overall high level of satisfaction with her life. She has been in a relationship for 5 years and described it as a 10 (with 10 being the most satisfied). She stated her partner was her "soul mate" and she "compliments my weaknesses" and "I compliment hers." Anna also said that she, "unfortunately," has no children.

Currently she reports being "very satisfied" with her career. She rated it as a 10 on the same 1-10 scale. When asked what that meant to her, she stated that she finds "joy in [her] job."

Anna also rated herself as a 10 with regard to her satisfaction with her friendships. She commented that she can "trust and count on all of them." She also stated that she could count them on less than one hand. There is "no gossiping," and they do everything in the "highest truth." She later commented on doing everything with the "highest integrity and ethics." This is what I assumed to be the highest truth.

Anna rated her satisfaction with herself as a 10 as well. She commented this number meant she was "proud of who I am despite any difficulties that life may bring." She believes that "there's always a way to get past [difficulties]," and she finds "the good in every situation." She rated her current life situation overall as a 9 because "finances can always be better." She stated that she was on track with all the personal goals she has set and does "everything with the highest integrity and ethics."

History of childhood sexual abuse

Anna commented on three separate incidences when asked about her childhood sexual abuse. The first incident of sexual abuse was by her biological father. She stated that she did "research" and believes it started between the ages of 2 and 5 years old. It stopped between the ages of 12 and 13 years. In the 5th grade, the second incident occurred when she was molested by her father's best friend who was in the military. This was a one time incident. The third incident she reported was when she was 17, and her virginity was "taken from her" by her ex-fiancee.

When she was 12 years old, Anna told her best friend about the molestation by her father. Her best friend then told a "school therapist." The school therapist insisted this friend provide her with Anna's name or she would call the friend's parents. When Anna found out about what had happened with her friend, Anna went to the therapist

and stated that her only "stipulation" was to know what her "options" were before anyone called her mother. Unbeknownst to Anna, the school therapist had already called her mother. As a result of this, Anna's mother took her and her brother out of the house, and Anna was mandated to counseling.

One day, Anna's father picked her up from school for what she thought was a mutual therapy appointment. When commenting on this incident with her father, she stated that "he knew my weakness was my mother, and for her to get back to [her home country], which is her dream, he said he needed to be around because he made all the money." Anna agreed she would say she made it all up and that it wasn't true, provided she was allowed to lock her door. She commented also that "if he ever touched me again, he knew that I would cut his dick off." Anna said she slept with a knife under her bed from this point forward.

Anna reported she eventually told her mother the details of her abuse. The only people she told during the time of the abuse were the school therapist and her friend. Since then, she has talked to many of her friends and family members about it. Anna has also revealed her abuse to a therapist during her time in counseling.

After describing the abuse in detail to me, Anna stated that she felt "cold." When asked if she was physically cold, she stated, "No, just my fingers are cold." She then changed the subject saying that she was just trying to remember everything. I thought at this point she may be a little nervous, although she did not outwardly appear so.

Level of resilience related to childhood sexual abuse

When asked on a scale of 1-10 where she felt she rated herself with regard to working through the abuse (10 representing she had completely worked through her childhood sexual abuse), she stated that she would be "cocky" and give herself a 10 although she commented her therapist might not agree with that. She chuckled when saying this. When asked what that number meant to her, she stated she had coped on her own to the point of forgiveness. She likes to help others now to "regain power." Anna said she was not disgusted by men anymore. Her childhood sexual abuse was just a part of her life now. When she said this, I thought of the resiliency skill of gaining cognitive distance from the event.

Anna stated that she received counseling to address her childhood sexual abuse. During the phone interview she stated that the counseling was unhelpful. This was the result of what I interpreted to be her therapist having poor boundaries. Later in the interview, she described the helpful aspects of counseling. Currently, she is not actively involved in counseling.

Resiliency skills and childhood sexual abuse

There were many resiliency skills that Anna used in working through her abuse issues. First, I recognized the theme of *taking on an active role in healing* when Anna reported that "looking everything up on sexual abuse" and reading and learning about people overcoming their abuse was helpful. She read books about stages of recovery (nonfiction), survivor's workbooks, literature about survivors coping mechanisms, and other fiction books about abuse survivors.

Another active role Anna took in creating resiliency was to remove herself from stressful situations. I interpreted this as the second theme, *establishing boundaries.* When discussing her family of origin, she commented that "they're still living in a very sad past and they don't even want to work through it…I go [to] the family requirements." I assumed these family requirements to be infrequent social gatherings.

I recognized a third theme known as *cognitive reframing*, often used in cognitive behavioral therapy, when Anna described how her reading and research assisted her in deciding that she did not want to be a "victim" or become a "statistic." My thought was that many other individuals who experienced sexual abuse used the term "survivor." Anna did not explicitly use the term "survivor" when talking about not being a victim. However, when discussing her resiliency skills and how she overcame her abuse, I often thought of this word. I was surprised that Anna did not explicitly use the term survivor to describe herself at anytime in the interview.

A skill related to the theme of cognitive reframing was gaining distance from her anger. Anna commented that she had to stop being angry because it wasn't healthy for her. She stated that she "took it (her power) back" and "no longer gave that power to somebody who didn't even live in my life anymore." In addition to this, she noted that she had to stop looking for "excuses." She told me that her brother had died of a drug overdose because he wasn't strong enough to cope with their family of origin's weaknesses and problems. I interpreted this to mean that he never took back his power and was unable to cope with the circumstances of his childhood. This supported the fourth theme of *gaining a sense of power*.

Fifth, I recognized the theme of *artistic expression* when Anna spoke of writing poetry and drawing as a child. She believed that these tools helped her to express her feelings and build resiliency. She reported that this assisted her in working through the anger she felt. She believes it is helpful to look back and read some of her poetry now.

The sixth skill used by Anna and a theme recognized was *gaining an understanding of the history of the abuser*. Anna built resiliency by discovering her father's (the abuser) personal history. She commented, "I wanted to understand passing on the legacy. I figured from my reading that something may have happened to him when he was a child." She reflected that "women want to stop the legacy, and men don't know how to cope with it." Anna said that understanding that her father was physically and sexually abused by his stepfather and step-uncle was helpful in her recovery. She commented that her understanding of the legacy made it easier to accept and understand her abuse.

Helpful aspects of counseling

During the phone interview, Anna stated that counseling was "unhelpful." However, she later stated that she did have a very positive experience with a counselor to whom she now refers clients on a regular basis. I recognized the first two themes of *providing a sounding board* (listening) and *establishing trust* when Anna stated that "it reiterated to me that I was taking the right steps" and that it was a "sounding board when I didn't feel like I could trust people." She implied that trusting a therapist was difficult initially as the first school therapist she came in contact with "betray[ed]" her.

The third theme of *receiving guidance* emerged when Anna stated she needed someone with whom to check her reality. This counselor was also the person who gave her a survivor's workbook. Anna commented that the workbook was not something she would have found on her own. She also stated she was not ready to "read" or "hear things" at certain times. Anna said the counselor provided a safe place to hear these things and work through the book. I interpreted this as having a need to have someone guide her through the process.

The final theme of *receiving support* emerged when Anna said the counselor gave her the support she needed by providing a different and objective prospective. Anna reported this therapist was instrumental in assisting her in learning how to trust. Thus, I interpreted that regaining trust was important in her development of resiliency.

Unhelpful aspects of counseling

In addition to having a positive counseling experience, Anna had a negative experience with another counselor. This other counselor's feelings went "beyond the professional line." I immediately interpreted the theme of *boundary violations* when Anna stated that the counselor told her about having romantic feelings for Anna. Anna was angry that she had learned to trust someone, and because "they could not keep their professionalism intact," she had to start over. Anna reported not going back to therapy for a "long time" after this incident. At this point in the interview, I found it difficult to maintain my role as interviewer and not process this violation of boundaries. I thought about how difficult it must have been to trust another therapist after this violation.

Another theme I interpreted from speaking with Anna was a *counselor-influenced agenda.* It seemed that the therapist had a preconceived belief that Anna had to become angry with her mother. However, Anna stated she never experienced angry feelings toward her mother. Anna stated, "no matter how often she tried to tell me that and tried to go down that avenue…that would upset me." At this point, I thought about how difficult it may have been to have a counselor that you have trusted tell you something that was incongruent to what you believe.

Barriers to counseling

The dominant theme which was a barrier to receiving counseling was *inadequate mental health insurance*. In addition to this, Anna stated when she did have mental health insurance she worked for "corporate America." She commented that she paid for her therapy out of pocket because she didn't want "big brother" to know that she was going to therapy. I interpreted this as a perceived *lack of confidentiality*.

Current resiliency skills

Current resiliency skills refers to the skills the participant engages in to address current difficulties. The resiliency skills noted are in response to a question surrounding what the participant does to currently cope with problems. Although they may overlap with resiliency skills used to cope with childhood sexual abuse, they are not specific to childhood sexual abuse.

The first theme of Anna's current resiliency skills I noticed was *gaining distance and perspective.* When coping with a current problem, Anna stated she does not like to handle it impulsively. She reported that she seeks to gain perspective and

tries to think about situations as a "person looking in." Anna said she doesn't react to situations emotionally. According to Anna, emotional reactions are what tend to cause problems. By listening and not interrupting, Anna is able to hear the whole story. She stated "if you interrupt, you might be missing the point that they're actually trying to make." She said this helps her remain reletively "laid back."

In addition to listening and gaining distance from situations, Anna stated she has only high expectations for herself. Having *realistic expectations* was the second theme in her current resiliency skills. Anna commented she has "realistic" expectations of others and expects the truth from everyone. She stated earlier that her friends hold true to this "highest truth." I interpreted this as a resiliency skill because it allowed her to continue to have a positive outlook on life. I believe that the theme of *having a positive outlook on life*, in addition to her realistic expectations of others, produces a greater sense of peace and satisfaction.

Confronting taboos was the final theme I noticed. I was surprised to hear Anna describe being a nudist in her home with her girlfriend as being part of her resiliency. She stated this contributes to her resilience as it "releases" taboos. She commented, "when you put taboos on things, that's when they get more and more difficult." She claims she talks about sex with everyone because it is taboo. She stated that by releasing taboos, people become more comfortable with topics. Therefore, topics that were closeted before are easier to talk about. I thought that this may be how she handles the taboo of childhood sexual abuse. I thought about how easy it was for her to talk about it in this interview. Perhaps it is this practice that has allowed her to be more open with others.

Advice to others

Anna reiterated the importance of looking at "the historical outlook of it" and trying to "understand the history of the abuser." I immediately noticed the theme of *understanding the history of the abuser* when she said, "if you can understand it, it's easier to cope with it." In reference to this, she commented on looking at the difference in timeframes stating, "I remember in my day and age, we didn't have the gay and straight alliance in school." I believe she was referring to how open individuals can be in today's society with their sexuality as opposed to many generations ago. I thought about how this is true for childhood sexual abuse as well. This disparity in generations might contribute to the secrecy of childhood sexual abuse. For instance, older generations may not be willing to confront childhood sexual abuse whereas younger generations have been taught to discuss it because is no longer a taboo. With regard to the timeframes, I believe she was referring to the fact that she grew up in a more secretive generation, which may affect survivors of childhood sexual abuse.

The theme of *having realistic expectations* was supported when Anna commented that many abused women want to hear "I'm sorry" from their abuser. She then stated that one shouldn't hope for an apology to achieve closure. She commented that this was not a realistic goal and that closure should come from within each individual. This comment was interesting to me, as it seems it is more realistic to be able to achieve closure within oneself than receive an apology from an abuser.

I interpreted the themes of *letting go* and *taking back control* when Anna commented that her biggest advice to others is to let go of their anger, depression, and

the guilt associated with the abuse. She commented that when she was "hanging onto anger, the depression, the guilt…[she] was totally giving up control of [her] life and [her] emotions to another entity without them even being a part of [her] life." Anna said she tries to show people that these other individuals (the abusers) who live many states away no longer have control over her life. Anna commented, "Once you can release that and say 'I take it back, this is my life, I will not allow you to rule my emotions anymore,' then that's when you take away that control that was once taken, and regain control of your own life. In turn, this makes you a stronger person" A final comment she made was to "learn that if you've gone through that (the abuse) and coped with that and you're able to look at yourself in the mirror and not feel inferior at your own image, then you can pretty much handle any situation thrown to you, 'cause surviving that is huge."

Post-interview thoughts

After the interview, Anna stated that her fingers were still cold, so she may be "nervous." She said she was concerned mostly about remembering everything. She stated that she felt childhood sexual abuse was very detrimental to people and she just wanted to be helpful. I interpreted her non-verbal behavior to be relaxed and engaging.

Telephone debriefing

Anna did not report any significant stress or anxiety related to the interview. She stated she was "a little nervous". However, she felt she has an adequate support system in place in the event that she needs further assistance noting that she has a

very supportive partner. She was not currently in therapy yet she has a therapist she can contact if needed. She commented on the benefit of the follow-up phone call.

Peer debriefing

After meeting with the peer debriefer, I thought that the interview went well with Anna and that it was a positive (meaning without any negative associations attached to it) experience for both of us. I thought it was a good start and was excited to continue with this study. I also thought the interview was difficult for me as it was hard not to function as a therapist. It was my job to listen and analyze, not to process. This was particularly challenging when Anna told me about boundary violations with a therapist.

Summary of themes

On the scale of 1 to 10 with 10 representing having completely "worked through" her childhood sexual abuse, Anna was the only individual who rated herself as a 10. The other women I interviewed, even those who didn't meet criteria, said they rated themselves at around an 8 or 9 many stating "no one ever gets to a ten." However, after having interviewed Anna and seeing her resiliency skills, I thought that a 10 was probably accurate for her situation.

I recognized several resiliency themes Anna had used as she worked through her childhood sexual abuse. The first theme I recognized was taking back control (power). I construed her ability to read and learn about childhood sexual abuse as giving her a greater sense of power. She commented numerous times on getting the power back that was taken from her during the abuse. In addition, I thought by cognitively shifting her outlook on power, she was able to develop resiliency. Another

skill she employed was gaining distance from her anger. This, as described by Anna, was important in working through her abuse. I also noticed a theme of Anna taking an active role in healing by researching information on childhood sexual abuse and removing herself from the family situation. In addition, she engaged in artistic self-expression.

The theme of understanding the history of the abuser emerged as Anna discussed the personal history of her father. A resiliency skill used by Anna that I had not anticipated was to research the abuser's personal history. I postulated that this was how Anna made meaning of her experience. She commented on understanding the "legacy" of abuse. I thought this ability (to make meaning of the event) may have also assisted Anna in developing resiliency through the technique of gaining distance from her anger.

Finally, I interpreted Anna's ability to establish boundaries with her family as a theme related to her working through her childhood sexual abuse. In establishing boundaries with her family, I thought she was able to insulate herself from their ongoing problems. I interpreted her attending only family requirements as a resiliency skill.

Anna had both helpful and unhelpful experiences while in counseling. Themes that emerged involving the helpful counseling experiences included receiving guidance, trust, and support. Anna discussed how helpful it was to have someone with whom to check her reality. I interpreted trust as being important in this counseling relationship. In addition, the guidance and support from the counselor assisted her in

talking through her issues and by processing through cognitive behavioral assignments (e.g. workbooks.)

Themes involving unhelpful counseling experiences were associated with boundary violations and the existence of a counselor-influenced agenda for the counseling session. I observed a boundary violation when Anna stated her therapist had romantic feelings for her and crossed a "professional line." I also interpreted that the therapist appeared to have had her own agenda for the session when Anna stated the therapist tried to convince her she was angry at her mother when Anna did not feel so.

I observed an unhelpful theme of financial constraints as a barrier to receiving counseling. In addition to this, I noticed a lack of confidentiality as a barrier to getting counseling. This was supported by Anna's comment related to her not wanting "big brother" to know she was attending counseling.

Current resiliency themes include gaining distance and perspective from problems, having realistic expectations, having a positive outlook on life, and confronting taboos. Anna stated she likes to gain distance from problems to garner perspective. In addition to this, she commented on having high expectations of herself and realistic expectations of others. I believe these skills contribute to a more positive outlook on life.

The final current resiliency theme illustrated by Anna was confronting taboos. Initially, I did not understand how being a nudist in her home was a resiliency skill. However, Anna later explained to me that by releasing "taboos" she is able to talk openly about difficult topics which most people are ashamed. This made sense when I

thought of childhood sexual abuse and how many women stated they needed to talk about the abuse to heal (Heimlein & McElrath, 1996).

Advice Anna said she would give to others was to gain an understanding of the history of the abuser; have realistic expectations; let go of anger, depression, and guilt; and take the control back. In these themes I noticed taking an active role in healing. I also interpreted that her shifting her cognitive outlook helped to resolve her feelings about negative situations.

Betsy – Participant #2

Telephone screening

Betsy is currently a 55-year-old Caucasian female with a medical degree. She is a "semi-retired" Board Certified Emergency Medicine Specialist. She has been a physician for 25 years and has worked in emergency medicine for 19 years. Criteria for the study were met via telephone screening. She called me after seeing an advertisement on an Internet website which facilitates networking of lesbians. Betsy answered "I agree" to all four resiliency criteria questions. She does not have a drinking or drug problem as evidenced by answering "No" to all four questions about drinking or drug use. She was willing to discuss the effects of childhood sexual abuse with me for research purposes and agreed to all conditions. Phone screening field notes can be found in Appendix L.

During the telephone screening, Betsy disclosed that she had experienced unwanted touching or attempts at touching of her breasts or genitals before the age of 14 years. She also reported experiencing "forced sexual relations" before 14 years old. She experienced no other sexual assault experiences as an adult.

Shortly after the telephone interview started, Betsy began discussing how medication helped her in her recovery. I interpreted this as a "warm-up" discussion for her so that she would feel more comfortable talking to me. I noticed in previous interviews that individuals often needed to talk about "safe" topics before delving into my questions. After a few minutes of her talking about the specifics of how medication helped her deal with her "visceral reactions," I interpreted her as being able to relax and focus on my questions. Throughout the remainder of the telephone screening, she was forthcoming and seemed eager to participate.

First impression

Betsy was casually dressed when she presented for the interview. She shook my hand and greeted me confidently. However, she seemed to need some discussion before the interview to relax her. Prior to beginning the formal interview and taping, we discussed the research protocols and issues related to finding participants. She appeared to be interested in the research process and what I would be doing with the results. An important note is that this participant traveled from another state to Florida for a week to visit family. She was in Florida only one week and yet made it a priority to attend this interview and participate in this research. I thought this commitment showed a high level of interest in the study.

Sexuality

Betsy has considered herself to be a lesbian for 30 years. When asked how long she had been "out," she said that she told her mother within four to five years of her realization. I interpret this to mean she considered herself "out" when she told her mother. She commented she was in the Navy, which made it hard to determine when

and where she could be out. I interpreted this as meaning she had hidden her sexuality at different times with different individuals. When asked about what being a lesbian meant to her, she stated "I emotionally bond with women in terms of long term and pairing better than I do with men."

Levels of satisfaction

Betsy appeared to be satisfied in many areas of her life. She has been in a 19 year relationship and rated her satisfaction as a 9 on a scale of 1 to 10 (with 10 representing the most satisfied). She stated this number meant "there's always room for improvement, but it's pretty darn good." When asked if she had any children, she commented with a chuckle "no human children."

Betsy had currently been a physician for 25 years and worked in emergency medicine. She was currently "semi-retired." She stated she was doing a couple of jobs part time and laughed when she said she is "trying to figure out what I want to do when I grow up." She commented she was "really happy doing that."

With regard to her friendships, Betsy rated them as a 9 commenting "the ones I have are great." She said that this number meant "I wouldn't mind a few more good, close friends, but the ones I have are good, real good." She stated she has had some friends since she was a "kid."

Her lowest number of satisfaction was a "seven…eight" with regard to how satisfied she is with herself. She commented "I'm waffling around life right now, and will feel more content once I seem to gain some direction." However, with her current life overall she rated herself as a 9 stating she is "just damn lucky."

History of childhood sexual abuse

I was not surprised when Betsy gave me limited information about her childhood sexual abuse because of how nervous she appeared in the beginning of the interview. She reported only that she was "intimately abused by [her] stepfather" from about 10 to 14 years of age. However, as the interview progressed, more details were revealed about the course of her childhood sexual abuse.

Betsy stated that her childhood sexual abuse was "real sporadic" depending on the employment of her mother. According to Betsy, her mother would work at "restaurants or night clubs" until "late night" after her day job. Betsy stated the frequency of her abuse increased when her mother was at her late night jobs. She commented "she wouldn't get home until two, three, four in the morning. And that was the vulnerable time for me." She stated, "It never happened when she was there, it was always when she wasn't around." Betsy commented that it took her a few years to figure out "how to avoid being vulnerable."

Betsy started having body sensations related to memories of her childhood sexual abuse after being exposed in medical school to women who were also sexually abused as children. She later had "visceral symptoms" related to her history of childhood sexual abuse. At the same time, she was having nightmares and avoidance symptoms such as leaving the room after viewing a movie with a rape scene.

Betsy never told anyone about the abuse until she was 26 years old. However, she said "people knew something was wrong because I was having night terrors at times." As a result of having "bad night terrors" in medical school, she was falling asleep in class. Betsy said that she was "so tired [she] was…almost nonfunctional at

times." Because of these difficulties, Betsy talked to her "faculty advisor." This faculty advisor who Betsy stated "was probably single handedly responsible for getting me not only through medical school, but through that whole period in my life," insisted she see a counselor. Betsy later told this counselor about the abuse. At the same time, Betsy also became part of a women's group where she started talking about the abuse in "very vague terms." Since then, she has continued counseling "off and on" to discuss her abuse.

After describing some specifics of the abuse, Betsy said she felt "fine." She appeared a little more relaxed as evidenced by her body language and the way she spoke more freely about the abuse. I was reminded of the importance of spending time with the participants before starting the interview process.

Level of resilience related to childhood sexual abuse

When asked on a scale of 1 to 10 where she felt she was in regard to working through her abuse (with 10 representing completely worked through her childhood sexual abuse), she stated that she was at a nine. When I asked her what that number meant to her she stated, "I still see myself as a victim but I've moved on."

Betsy has had counseling to address her childhood sexual abuse and related issues. When asked about counseling, she commented that some "helped" and "some didn't." She stated in the phone interview that counseling "just got me to where I could talk about it." She then briefly revealed details of the course of her discovery. She stated that she "never thought about it" until she was 26 years old because it "didn't even come into conscious mind." Betsy then told me briefly about getting triggered (having symptoms related to the abuse such as memories or feelings) at a

family wedding and how this episode brought her to counseling. She is not currently in counseling.

Resiliency skills and childhood sexual abuse

The first resiliency theme I interpreted from Betsy was the theme of *receiving guidance*. I noted this when Betsy commented that being "pushed into" and "confronted" about dealing with her abuse helped build her resiliency. Since she stated previously that her faculty advisor assisted her in this process, I interpreted it as her mentor guiding her in the process of resolving her childhood sexual abuse.

The second resiliency theme was *supportive relationships*. Betsy commented specifically on the importance of supportive partners. It was critical that her partners "dealt with it (her childhood sexual abuse) very matter of factly." She also noted the importance of her partners not making her "feel sick."

I noticed the third theme of *having acceptance* when Betsy said "they (her partners) didn't make me feel like I had something wrong with me. It was just…you know...sort of like, yeah I have brown eyes and I was abused." Betsy said this was essential to the development of her resiliency because she "frequently before that kept feeling like a freak." She commented how she was "afraid to spend the night with people and stuff because how do you explain you're waking up screaming, especially if you don't want to talk about it?" The theme of acceptance was further supported by Betsy's comment that, with her supportive partners, she "just felt accepted and it wasn't a big problem." This reminded me of the need to release the "taboos" of childhood sexual abuse therefore normalizing the discussion of it.

Finally, obtaining medication was also a resiliency skill used by Betsy. This would be noted under the theme of *self-care*. She discussed this first during the initial phone interview giving specifics about a particular drug and how it worked on an individual's system. In the interview she commented "that [the medication] was just an inadvertent gift."

Helpful aspects of counseling

During the phone interview, Betsy mentioned that there were beneficial aspects of counseling. I identified the theme of *catharsis* as helpful when she described talking about the abuse as "desensitizing." I interpreted the term of catharsis as talking about something producing an emotional release. According to Betsy, after repeated discussions on the topic, it gradually became easier to discuss. She commented, "I think just as I talked about it more and more, I became able to talk about it because in the beginning, I couldn't talk about it." I considered the fact that counselors are often the first individuals to hear the details about sexual abuse and how difficult it may be for survivors to initially disclose details about their abuse. This was confirmed when Betsy said, "In the beginning, if I even consciously thought about it…I'd feel really hot, I'd get really diaphoretic, I'd get kinda shaky, and so counseling helped me to be able to talk in spite of those visceral symptoms." I interpreted this to mean she was now able to talk about the abuse without physical symptoms. A final quote I thought captured the process of counseling for Betsy was "…it was like having a big huge pie and you nibble on the edges a little, and then you just nibble and nibble and nibble and nibble, and you eventually can get to the center

of the problem, but it took a lot of nibbling around those edges to be able to get into there."

Unhelpful aspects of counseling

Betsy did not focus much on unhelpful aspects of counseling. I interpreted the theme of *personal ambivalence* when Betsy commented the only unhelpful aspect was that "it stirred things up." I interpreted the term personal ambivalence as wanting to go to therapy at times and at other times not wanting to go. She stated "if I was kind of having a good week, and then I'd go to counseling, you know I was like aah (small scream), you know, that kind of thing." I interpreted this as a dread of counseling as the result of the feelings associated with discussing the past. This was evident by her next comment, "I never looked forward to going to counseling." She noted a different situation when she looked forward to her couples counseling sessions. The theme of personal ambivalence was further supported when she commented, "I never anticipated counseling. I just sort of went because I thought you know, be a big girl, you gotta go." I interpreted this last statement as having personal ambivalence between the knowledge of how counseling can be helpful and the fact that it may be uncomfortable. The hesitation she experienced before counseling made me appreciate the strength it took to go to therapy. It also made me appreciate how difficult it must have been to complete the interview process.

Betsy initially mentioned that telling her mother was helpful. However, she later recanted saying "in retrospect, I'm not really so sure that it was important. If I had it all to do again, I wouldn't have told her." She said "everyone kept telling me I needed to do that (tell her mother)... Counselors and people kept saying 'you should

do that, you should tell her, it's important, part of the healing process." When she said this, I thought of the theme of a *counselor-influenced agenda*. Betsy commented, "In retrospect, I might have kept not wanting to do it because I didn't see any point in hurting her. I mean, it wouldn't do anything good for her, it would only hurt her." My belief is that it is a personal choice of the survivor of to tell whomever they want to tell of the abuse. What concerned me more was others having their own agenda.

Barriers to counseling

Betsy initially stated that there were no barriers to getting counseling. However, she then said "I was the biggest barrier." *Personal ambivalence* was a theme I noted in this discussion. She commented on her "reluctance to deal with it (the abuse)." She reported attending counseling "off and on" for the last 10 years. It occurred to me that it was normal for trauma survivors to go in and out of therapy and for it to be a cyclical process.

Current resiliency skills

I noticed the theme of *altruism* and development of *good communication skills* as current resiliency themes. Betsy commented how "the baby boomer children" are having to resolve issues with their aging parents at this point in time and how she is trying to help her parents from a distance. Betsy believes helping others, including both her and her partner's parents, is a form of resilience.

In addition to helping others, good communication skills assist in her resiliency. Betsy said she has a "partner…who excels in communication….we don't even have arguments any more because things don't ever get to that point because we can just talk." I though it was interesting how she identified resiliency skills in the

context of her relationship. A final comment she made was, “I don’t feel that I have a lot of problems right now.”

Advice to others

I immediately noted the theme of *seeking counseling* as important when Betsy stated “counseling is a necessary evil.” The theme of *supportive relationships* also arose when she commented that a “really supportive partner or supportive friends” are important. After a pause, she added that medication (the theme of *self-care*) would be helpful as well but commented that her advice may not be in “that order.”

Post-interview thoughts

After completing the interview questions, I asked Betsy how she was feeling and she responded, “ok…I’m fine.” She had a smile on her face and did not appear nervous. However, after the recording stopped, Betsy continued to discuss details about the abuse. It was evident that once the formal interview was complete, especially the portion which was recorded, Betsy became more comfortable.

Telephone debriefing

Betsy stated she felt “fine” after the interview. She reported she felt no discomfort during the interview and that she had an adequate support system. She was not currently in therapy, but she had a therapist that she could reach out to if needed. She appreciated the follow-up call.

Peer debriefing

After meeting with the peer debriefer, I thought that this interview went very well for me and for Betsy. I was again struck by how the participants became more

comfortable the more they talked. I thought about how important it was to discuss the implications of the research with them because it helped them to relax.

Betsy went in to detail about her abuse once the recording stopped and the interview was over. This reminded me of a previous comment made by a pilot participant surrounding the need to "discharge energy" after the interview to feel she has gone "full circle." Betsy talked about details related to her abuse after the interview. I interpreted this as necessary for closure.

Summary of themes

Betsy displayed several resiliency themes both in working through her childhood sexual abuse and in how she currently copes. Resiliency skills used to work through her childhood sexual abuse included: receiving guidance, supportive relationships, acceptance, and self-care. The first theme, receiving guidance through the process, was evident when she mentioned she had a mentor who guided her toward counseling when in medical school. This woman was an integral part of the second theme of supportive relationships which Betsy utilized while working through her abuse. In addition, supportive partners were also important to Betsy in building resiliency.

The third theme, acceptance, was evident when Betsy commented how important it was for her partners to validate her feelings and not make her "feel sick." It was important for Betsy to be able to facilitate discussions of childhood sexual abuse. It appeared that by being in an accepting environment, Betsy was able to engage in discussions about a subject that Anna (participant #1) referred to as "taboo." Betsy described it as needing to be "desensitized" to the topic of childhood

sexual abuse. Medication also assisted with this process. I interpreted taking medication to support the fourth theme of self-care.

Betsy attended counseling to address her childhood sexual abuse issues and found talking to be helpful. This supported the theme of catharsis. She commented that counseling helped to desensitize her and that even though it was initially difficult, it became easier with time. She described this by commenting on how the more you talk about it, the easier it gets.

Themes noted with respect to unhelpful aspects of counseling included personal ambivalence, and a counselor-influenced agenda. The theme of personal ambivalence was identified when Betsy commented she never "looked forward to going to counseling." I interpreted this to mean there was a part of her which knew she needed to go; however there was a part of her that feared attending. This was supported when she later stated that counseling was a "necessary evil." I thought about how difficult counseling can be for some individuals. This difficulty may reflect personal ambivalence.

Another theme noted in unhelpful aspects of counseling was the theme of the counselor-influenced agenda. This was supported by Betsy telling me how the counselor and "people" advised her to tell her mother about the childhood sexual abuse. Betsy told her mother, but she later regretted. I interpreted this to be the agenda not only from a counselor, but from other individuals. Having one's own agenda regarding what is right or wrong for a client with respect to disclosing abuse did not appear to be helpful for this participant.

I also noticed the theme of personal ambivalence when Betsy was asked about possible barriers to counseling. She commented, "I was the biggest barrier." Betsy has been in counseling "off and on" for the last 10 years. This is not uncommon for abuse survivors.

Betsy's current resiliency themes include altruism and good communication. The theme of altruism was supported as Betsy told me about how she supports her aging parents. The theme of good communication was attributed more to her partner than to her. She felt that her partner "excels in communication." This theme was supported when Betsy told me about how fights are avoided because they "can just talk."

Advice to others included the themes of seeking counseling, supportive relationships, and self-care (medication). Betsy said, "Maybe not in that order." This was not surprising as these three themes were what Betsy reported to cope with her problems.

Emily – Participant #3

Telephone screening

Emily is currently a 38-year-old Caucasian female. She is a dental assistant, and she has completed "some college." Criteria for the study were met via a telephone screening. She called me after seeing an advertisement on an Internet website which facilitates networking with lesbians. Emily answered "I agree" to all four resiliency criteria questions. She answered "No" to all four questions about drinking and drug use indicating she does not have a drinking or drug problem. She was willing to discuss the effects of her childhood sexual abuse with me for research

purposes and agreed to all of the conditions. Phone screening field notes can be found in Appendix L.

During the telephone interview, she disclosed that she had experienced unwanted touching or attempts at touching of her breasts or genitals before she was 14 years old. She also disclosed that she had experienced "forced sexual relations" before she was 17 years old. She reported no other sexual assault experiences as an adult.

Emily stated that she did not have any questions about the interview. She appeared to be more interested in telling me about her "need to give" back to people. She commented that she really wanted to "help someone else." She believes she is a "success story" and told me she still had plenty to learn but now she had the tools necessary to continue the process. During the telephone interview, I interpreted her as being eager to participate.

First impression

Emily was casually dressed and appeared eager to participate greeting me with a friendly and welcoming smile. During the interview she appeared to be confident and relaxed. She spoke freely, and gave detailed information for each question. Prior to the interview, she did not ask any questions about the study. She appeared more interested in discussing how she was a "success story" and how she wanted to "give back."

Sexuality

Emily stated she acknowledged that she was a lesbian at the age of 12 years. However, she reported being "out" for the last 10 years. When asked what being a

lesbian meant to her, she stated “I like the same sex.” She also commented that she enjoys a woman’s company whether it is “intimacy or platonic.”

Levels of satisfaction

Emily reported to be satisfied overall in many aspects of her life including her 16 years as a dental assistant. She rated her satisfaction with her career as a 10 on a scale of 1 to 10 with 10 representing the most satisfaction. According to Emily, this number meant “I love my job, I always have.”

Emily is not in an intimate relationship and has no children. However, she does have “some really good friends.” She rated her satisfaction with her friends as a 9 on the same scale. She rated her satisfaction as a 10 with regard to herself. According to Emily, this means “that I’m okay.” When asked about her satisfaction with her current life overall, she stated “we’ll be realistic” and thus her answer was a 9 overall. This meant she has a “pretty good life.” She commented “it’s not much, but I have a good life.”

History of childhood sexual abuse

Emily was sexually abused by her biological father and paternal grandfather. She stated her grandmother and mother told her the abuse started from about 6 months old. Emily said it lasted until she was 20 years old. Her paternal grandfather was also sexually abusive when she was a child, but Emily commented “it was mainly my father.” When asked how often this happened, Emily stated “I just know it was a lot.”

Emily began having “flashbacks” when she entered a drug and alcohol treatment facility as an adult. While in treatment for about three months, she was

encouraged to go to a "sexual trauma unit." She declined this referral at the time. After treatment, she was diagnosed with Dissociative Identity Disorder (DID), formally known as multiple personality disorder, and "hooked up with a therapist who was a specialist." She commented that the therapist was someone who "believed" in the diagnosis of DID. During her treatment for DID, details of the abuse were disclosed, and she was treated for her history of childhood sexual abuse.

Emily never told anyone of the abuse when she was a child. When she "got sober" as an adult, she told her therapist. Since then, she reported having spoken to "a lot of people" including her therapists, grandmother, and aunt. She commented "they gave me a lot of validation. 'Cause sometimes it wasn't so, it didn't seem real, you know, that that could have happened." Emily now talks about the abuse when she has questions or if she feels she can help someone else. She said "I haven't hidden it since I've spewed." She was referring to being in therapy and discussing the details of the abuse.

I was not surprised that Emily deemphasized the details of her abuse choosing instead to focus more on resiliency and her desire to help others. After discussing the story of her past, she stated she felt "fine." Her affect indicated no anxiety. She was open to answering all questions throughout the interview. She didn't seem to dwell on the details of the abuse but appeared eager to answer more questions.

Level of resilience related to childhood sexual abuse

She reported being an "8.5 to a 9" on a scale of 1 to 10 describing where she felt she rated herself regarding having worked through her childhood sexual abuse (with 10 representing completely worked through her childhood sexual abuse). She

did not expand very much on the details of the number. Emily stated she found counseling to be "extremely" helpful in addressing her childhood sexual abuse issues. She was not in counseling at the time of the interview.

Resiliency skills and childhood sexual abuse

When asked what she did to work through her childhood sexual abuse, Emily stated, "Therapy. Just good old talk therapy." This revealed the first theme of *seeking counseling*. "Play therapy" was a certain type of therapy used with Emily. Play therapy is a type of therapy that utilizes the symbolic function of play (Landreth, 2002). She began play therapy as an adult where she acted out the abuse through the use of play. Although it was not "talking" about the abuse, I noticed the theme *catharsis* when Emily stated play therapy was a way of "getting out my stories…or the abuse." She commented "that's the way I started healing." Through play therapy, she came to know her "insiders." She was referring to the different identities associated with DID. Emily stated play therapy "consisted of being in a play therapy room and allowing any of my insiders who wanted to come out and play." She commented she wasn't allowed to play much as a child. During her time in therapy, she played with toys, colored, watched movies, and "relived [her] childhood." At times, she said she would destroy the play therapy room because she "didn't believe in it." Through the process of play therapy she "learned how to work with the different aspects and parts" of herself. She commented on the integration of the selves when she stated now she takes "care of us."

I noticed the second theme of *artistic expression* through Emily's use of different types of art. She also described expressing herself creatively through play

therapy. I believe play therapy gave her a creative way of expressing herself during this integration process.

The third theme of *building a more positive self-concept* was supported when Emily discussed how she engaged in "a lot of self-talk" in the form of "positive affirmations." I interpreted doing positive affirmations as taking on an active role in healing. Through the use of these affirmations, I believe Emily was able to enhance her view of herself.

The skill of needing to find others with similar issues, also noted as the fourth theme of *universality*, was revealed when Emily discussed using the Internet to find people "like" her. Universality is when individuals find they share something in common with others (Yalom, 2005). She commented that a "chat room" had been helpful stating "I actually found people all over the United Stated and other countries who were diagnosed the same as me and who understood what it was like to be me… it helped me discover who I was." This theme was further supported when Emily later suggested it was important to find someone who had gone through a similar situation.

Helpful aspects of counseling

During the phone interview, Emily stated counseling was "extremely" helpful. She stated counseling provided an environment where she could "spew out all kinds of stuff that, in my head that was not making sense." I interpreted this as the theme of *catharsis*. I also interpreted the theme of a *providing a safe place* when Emily said counseling was the "only safe place to be." The themes of *acquiring tools* and *listening* were supported when Emily commented she could talk to her therapist and he or she would "listen" and then offer "tools" or "suggestions." Emily thought this

had been helpful in fostering resiliency.

The themes of *consistency* and *support* were supported when Emily commented on a specific therapist who went "above and beyond what therapists are supposed to do to help." According to Emily, the therapist would "stay in contact… just if I needed it." These themes were further supported when Emily continued her discussion about extended length of time she saw her therapist. I interpreted her to be benefiting from a consistent relationship in her life. Perhaps this is where trust can again be established.

I again reflected on the theme of *catharsis* when Emily initially commented that the actual "dredging up memories" was unhelpful. However, she later stated "it's necessary." It was here that I noticed some personal ambivalence. She commented she needed to "feel the fear and do it anyways." This is her "motto." I was curious of the necessity of "dredging up memories" considering how unpleasant it can be. However, according to Emily, this was necessary.

The theme of *supportive relationships* was supported when Emily noted that her therapist involving her husband (Emily was married to a man for a short period of time) was a "big part" of building resiliency. This family involvement was seen as valuable to Emily. I thought this treatment was comprehensive, involving all sources of potential resiliency.

According to Emily, helpful qualities evident in the therapist revealed the themes of *acceptance* and *encouragement*. "Just knowing there was a place that I could go," was helpful to Emily. She stated "it was also a place where I could go and dump and leave and not have to worry about it…I didn't have to carry [it] with me." I

assumed the she was referring to the childhood sexual abuse. I was struck again by the importance of catharsis.

Unhelpful aspects of counseling

The reported "push" from therapists suggesting the theme of a *counselor-influenced agenda* was supported when Emily stated she was "always told to write" by her therapists. However, she was too intimidated and fearful to write and therefore never did. At this point in the interview, she was animated about the frustration with therapists telling her what to do. I thought of how harmful it may be to a client to push them into doing something they are not ready to do. This may be particularly damaging to someone with a history of childhood sexual abuse where there has already been abuse of power. However, I am not sure that Emily told them that she did not want to write. Writing is a tool often used in trauma therapy (Pennybaker, 1990), so this would only be counselor-influenced agenda if Emily told them she did not want to and they persisted. However, as evidenced by her passion about them continuously telling her to do so, I assumed she had let her thoughts be known.

I interpreted the theme of *boundary violations* after a discussion with Emily about "finding a bad therapist." She expanded on the definition of what constituted a "bad" therapist was by saying, "I don't believe that therapists should tell me anything about their personal life." Apparently, Emily had seen a therapist who had also been diagnosed with DID. Emily's opinion of this therapist was that she was not "very healed." Emily's feelings were prompted by what I and Emily interpreted to be too much therapist self-disclosure. Emily reported feeling that it was inappropriate and said, "Because I just don't want to hear about your personal life…This is about me.

I'm paying you for me, and I don't want to hear about you."

I interpreted the theme of *finding a compatible therapist*, after a discussion related to an unhelpful experience. Emily commented "If you don't like the therapist you find, move on and find another." She then said with an elevated, passionate voice, "malingering. Oh my God, get rid of that word." Malingering is a term used for individuals who exaggerate or falsely produce symptoms of a disorder (APA, 2000). I thought this comment, coupled with an earlier comment about finding someone who "believed" in the diagnosis of DID, underscored the need to find someone trained in dealing with survivors of childhood sexual abuse and DID.

The theme of *unethical behavior* was supported through further discussion related to the behavior of this counselor. In addition to what I interpreted as poor boundaries, Emily commented that the therapist "kept raising her prices." Apparently, she was supposed to be seeing Emily on a sliding fee scale, however "every time was more and more expensive." Emily was on disability at the time so it was difficult for her to continue to afford therapy on her fixed income.

Barriers to counseling

The theme of *financial constraints* was supported when Emily said "money" was a barrier for getting counseling. She stated "it's always about money." After this short answer, Emily discussed how grateful she was to have found a therapist who saw her for "nothing." Emily stated, "my whole therapy has been free. I'm not saying that's the way to go…but I was given a break."

Current resiliency skills

Emily's interview provided evidence of a variety of resiliency skills revealing numerous themes. I interpreted the theme of *gaining distance and perspective* when she discussed having a "three day rule." This was reflected by the comment that she gives herself "three days to think about it, entertain it, and then find a solution to it." She stated she uses "three day rule" to wait and not argue with someone. I interpret her ability to not "make a decision for three days" as a way of gaining psychological and emotional distance from her problems. She later commented on the need to "let go of anger." Perhaps it is this anger that gets in the way of gaining emotional distance from a situation.

The theme of *supportive relationships* was identified through Emily's comment about talking to her friends and to her mother. I interpreted reaching out to others as a form of resiliency. This was seen in other participants as well.

The theme of a *developing a positive self-concept* was revealed when Emily discussed her use of "self-talk." I noted the skill of self-reflection when she commented, "I go deep and I find what the solution is for me." The theme of *self-care* was revealed when Emily discussed the importance of taking time for herself. She stated she tries to be "kind" to herself. She takes "hot baths, hot showers," and "drink[s] tea." She commented she can be with people, but she is "comfortable in [her] own skin." One of Emily's comments which encapsulated her ability for self-care was, "I know how to take care of me, 'cause nobody else can."

At the end of the interview, Emily wished to add a few more of her current resiliency skills. Emily stated helping others adds to her resiliency thus supporting the

theme of *altruism*. A theme of *artistic expression* was revealed as she spoke of using positive imagery and visualization. She disclosed about how she imagines herself putting her troubles into the waves of an ocean and having them wash away from the shore. She believes that this skill is extremely helpful.

Advice to others

When asked what advice she would give to others, Emily stated with a smile, "you don't have enough tape." I noticed the theme of *understanding the history of the abuser* when Emily said "believe in yourself. No one is to blame….There are people that cause this and yes, they are to blame, if you want to say blame. But I have discovered in the past couple years that people give you only what they have…If my parents weren't given the tools necessary to go through life in normal capacity and not hurt and abuse…that's all they knew." She clarified this by saying, "You can't give someone five dollars if you don't have it…My parents didn't have what it took to be the kind of parents that I needed. Yes, they're to blame. But not really." I did not see her as giving her abusers absolution but rather an attempt at placing situations in a more positive context. This also reminded me of the previously reported resiliency skills of making meaning of the abuse.

Emily also looked at how she could change things by commenting "what can I change about me?" The theme of *placing situations in a more positive context* was revealed when Emily commented she would advise others, "You have choices. You're not locked back there anymore…Whatever was done to you in your past, you can change it today." I noticed the theme of *self-affirmation* when Emily commented "believe in yourself, believe that you are worth it. You're so worth it." She put

emphasis on this and appeared to be passionate about what she was saying to me. She was enthusiastic as evidenced by her free speech and animation. It appeared that a belief in oneself and the ability to place situations in a more positive context, may help survivors gain resiliency skills.

The theme of *seeking counseling* emerged when Emily said, "Get a therapist." She was referring to the need to talk to someone. "If it's the Dalai Lama you need to talk to…to me it's finding someone who's not involved in your life." She commented on the importance of having someone "who doesn't know you on a daily basis." Emily also noted the importance of talking to someone who you can "get things out to." This reminded me of her earlier comment about "dredging up memories." I was reminded of the resiliency skill of talking about the abuse and the theme of catharsis.

Supportive relationships were important to Emily. This theme in addition to *universality* was supported when she commented it was helpful to find "someone who has gone through or is going through a situation that you're going through, or have been through." The theme of universality was supported when Emily stated it was important to "find common ground."

The theme of *taking an active role in healing* was supported when Emily noted that she had filed for and received disability. She had also found free counseling services. Emily reiterated her gratitude by saying "I just got lucky" when it came to having a good therapist. Taking an active role in healing was further supported when Emily later added she read books about childhood sexual abuse.

Post-interview thoughts

Emily was enthusiastic about the interview. After the formal questions, she said she was feeling "fine." When I stopped recording, Emily continued to discuss the positive aspects of her life and how she walks through fear. She commented on "living" being "positive" and dwelling on the past being "negative." Emily stated she has "walked through a great deal of fear" to get to where she is today. She stated she has learned a lot from the experience of dealing with childhood sexual abuse. I experienced her as an extremely resilient woman.

Telephone debriefing

Emily stated she was feeling "great" after the interview. She experienced "no discomfort" and had an adequate support system in the event that she needed further assistance. She was not currently in therapy yet had someone she could contact if she needed further assistance.

Peer debriefing

After meeting with the peer debriefer, I thought this interview went very well as Emily was very positive. She was the most "warmed up" participant I had seen up to that moment. She did not spend a lot of time on the specifics of the abuse. She focused more on her strengths and how she was able to survive.

Summary of themes

Emily described a variety of themes when addressing her childhood sexual abuse. First, she described seeking counseling as being "extremely" helpful. She stated, "play therapy," a specific type of counseling involving the elements of play, was helpful to her. The theme of catharsis emerged when Emily commented she was

able to “address memories” in therapy. She commented about it being “necessary” to discuss “memories.” Although she may not have been verbalizing the memories, Emily stated she was able to “act” out the abuse. I noticed the theme of artistic expression when Emily had been able to use artistic mediums in play therapy.

The theme of taking an active role in healing was revealed when Emily described the use of self-talk through the use of “positive affirmations.” Through this, I interpreted Emily was able to transform her cognitions into more positive terms. In doing so, she was able to have a more positive outlook on herself and life.

The themes of universality and supportive relationships were evident when Emily discussed the need to reach out to people who were “like” her. She initiated relationships on the Internet by finding other individuals who had been abused or diagnosed with DID. She commented on the importance of finding “common ground” and how it had been paramount to find someone who had been through a similar situation. I interpreted this interaction with similar individuals to reduce isolation. The effects of childhood sexual abuse may be less pathologized if a survivor of abuse is able to relate to other individuals who have the same symptoms.

There were several themes in the counseling experience that were helpful. The theme of providing a “safe place” to address her memories of childhood sexual abuse was supported when Emily commented about a safe place being an environment where she could discuss her thoughts and make sense of them with another individual. The theme of acquiring tools was supported when Emily stated that her counselors would often offer her tools. In addition to this, the themes of consistency

and support were substantiated when Emily commented it was helpful when the therapist stayed in contact with her "just if [she] needed it."

It was in counseling that Emily was able to address her memories. I reflected on the theme of catharsis when Emily discussed the necessity of "dredging up" memories. I was again reminded of the resiliency skill of talking about the abuse.

The theme of finding a competent therapist was revealed when Emily made a comment about having someone "believe" in her diagnosis. I construed this as the need to have someone knowledgeable in trauma, trauma related diagnosis (especially DID), and specifically in treating survivors of childhood sexual abuse. Many individuals with a history of childhood sexual abuse have a dual diagnosis (Fleming et al., 1999). I interpret finding a competent therapist to be important as a result of Emily's comments surrounding the need to be treated for her DID and childhood sexual abuse. I interpret Emily believing a therapist should be accepting, encouraging, and supportive as she mentioned these three qualities to be helpful.

Unhelpful themes in counseling included boundary violations, a counselor-influenced agenda, finding an incompatible counselor, and unethical behavior. Emily described an unhelpful counseling experience with a therapist who disclosed too much of her personal life. I construed this experienced as boundary violations. This was supported by Emily's comment, "This is about me…I don't want to hear about you."

The theme of a counselor-influenced agenda was revealed as Emily discussed being "push[ed]" by therapists to write. This was something Emily reported being repeatedly told to do, however, Emily was not comfortable doing so although it is not

evident whether she explained this to her therapists or not. Either way, after discussing this with Emily, I interpreted Emily felt pressured to do so. I thought it was important to include the theme of a counselor-influenced agenda as she was quite passionate about her discomfort with counselors telling her what to do.

The theme of finding an incompatible therapist was supported after Emily stated that if you do not find a counselor that you like, find another. She then commented about someone being non-judgmental as being more compatible for a survivor of childhood sexual abuse. Finally, the theme of unethical behavior was revealed when Emily commented her therapist continued to keep raising her prices.

Financial constraints were identified as a theme related to barriers to counseling. When asked about the barriers to counseling, Emily stated, "money," then focused immediately on how grateful she was. I took this as an indication of the resiliency skill of having a more positive outlook in life. Emily appeared to be more focused on the positives versus the negative aspects of her life.

Current resiliency themes included gaining distance and perspective, supportive relationships, development of a positive self-concept, self-care, altruism, and artistic creativity. Emily has a "three day rule" when addressing problems. She gives herself three days to think about her problems before making a decision. This revealed the theme of gaining distance and perspective. It also assists her in letting go of her anger.

Supportive relationships were also important to Emily as was the development of a positive self-concept. To develop a positive self-concept, Emily used positive self-talk and self-reflection. Emily appeared to balance taking care of herself and

taking care of others. The theme of self-care was revealed when Emily discussed her numerous self-care behaviors and assurance she has time alone. In addition to focusing on herself, Emily commented that helping others assists with building resiliency thus revealing the theme of altruism.

The theme of artistic expression was supported when Emily described using positive imagery and visualization. I believe this creativity may have been cultivated by her experience with play therapy. Emily commented that, through play therapy, she was able to play whereas she was never able to play as a child.

When asked about what advice Emily would give to others, themes of understanding the history of the abuser, placing situations into a more positive context, self-affirmation, seeking counseling, supportive relationships, universality, and taking an active role in healing were revealed. Emily commented on her parents' history and how they were abused as children. I thought of the theme of understanding the history of the abuser and how it may have assisted Emily in making meaning of the abuse. She was able to understand that her parents didn't have the necessary tools to adequately parent her. I interpreted this as placing situations in a positive context. It may be a better resiliency skill to understand than to blame.

The theme of having self-affirmation was supported when Emily commented numerous times about believing it is possible to overcome childhood sexual abuse. I interpreted her references to mean she felt powerful. In addition, she stated she felt individuals have choices. I interpreted this internal locus of control as a resiliency skill. It was evident that Emily thought she had the power to change her thoughts and her life. I never sensed that she felt she was a victim of any circumstances.

The theme of seeking counseling was supported when Emily bluntly stated, "Get a therapist!" She was referring to the need to talk to an individual who was not involved in her daily life. In doing so, Emily was able to "get things out." This supported the theme of seeking counseling as well as catharsis.

According to Emily, having supportive relationships was important advice in fostering resiliency. This was supported by her need to find someone who had been through a similar situation. She stated this in terms of "common ground," which I interpreted as individuals being able to foster relationships with others with similar background thus supporting the theme of universality.

Emily reported being on disability at one point when she was addressing her childhood sexual abuse issues. Her ability to find free services clearly demonstrated the importance of taking an active role in healing. Her final piece of advice was an exclamation of excitement when she told me that services were "out there." I interpreted her enthusiasm at this point as having a true belief that one can get past her childhood sexual abuse and become resilient.

Lila – Participant #4

Telephone screening

Lila is currently a 38-year-old Caucasian female who has her General Education Degree (GED). She is an office administrator manager for a construction company. Criteria for the study were met via telephone screening. She initiated a phone call to me after a friend had forwarded her an ad from an Internet website that facilitates networking for lesbians. Lila answered "I agree" to all four resiliency criteria questions. She does not have a drinking problem or drug problem as

evidenced by answering "No" to all four questions about drinking and drug use. She was willing to discuss the effects of childhood sexual abuse with me for research purposes and agreed to all conditions. Phone screening field notes can be found in Appendix L.

During the interview, she disclosed she had experienced unwanted touching or attempts at touching of her breasts or genitals before she was 14 years old. She also stated she had experienced "forced sexual relations" before 17 years old. She denied any other sexual assault experiences as an adult.

I was surprised that Lila met criteria. I had noticed a trend in women I had interviewed over the phone that the more reserved they were, the less likely they were to meet criteria for the study. I postulated that women who had worked through their abuse might be more willing to talk about it. Lila was very quiet during the phone interview, never deviating from the answers to the questions. However, she did talk minimally at the end of the interview telling me her boss had encouraged her to do the study. I thought how this must be a supportive and open work environment.

First impression

Lila was casually dressed in jeans waiting outside of the office building when I greeted her. She brought a friend with her for "support." Lila was the only participant who brought someone with her. I interpreted her ability to obtain support when going into a situation that may produce anxiety as being resilient. I came to this conclusion because I recognized it as her having the ability to ask for help in stressful situations. I was not surprised she arrived with a friend considering her reticence

during the phone interview. She introduced her friend to me and explained that she would wait outside during the interview.

Lila was quiet when she entered the room, and she appeared hesitant. As a way of establishing rapport, we discussed what I would like to do with the results of the study. In addition, we also discussed the sensitive nature of such a personal interview with a stranger. She grew more relaxed as the discussion progressed, but she kept a pillow on her lap throughout the first half of the interview.

Sexuality

Lila stated she has been a lesbian since she "came out" with her partner 9 years ago. She was married twice before to men. When asked what being a lesbian meant to her, she stated that "I love to be with women." She commented that she loved the "sensitivity and involvement with women" and stated she likes the "emotional connection better."

Levels of satisfaction

Lila was not currently in a relationship although she did have two children, ages 12 and 19 years. On a scale of 1 to 10 with 10 representing the most satisfied with her relationship with her children, she rated herself as "five…probably" According to Lila, this number is "kinda in between 'cause…my oldest one, it'd be probably more like a 4 and my youngest one it's probably be more like a nine." The disparities in numbers were due to the different types of relationships Lila has with her children. Lila commented that she had been having some difficulties with her oldest child as he was being "spoiled" by his grandparents.

Lila had currently been an office manager for 8 years and rated her satisfaction with her career as an 8 on the same scale. According to Lila, "Eight means for the most part I'm very satisfied…I love my job." She was also an 8 in regard to her satisfaction with friendships although she commented "I don't have a lot of friends." However, she stated that she was "pretty satisfied all in all with the few friends" she does have.

Lila rated herself as a 7 with regard to her satisfaction with herself. When asked what this meant to her, she commented, "for the most part I am satisfied, but I think there's a lot of things that I'm still missing in life." She reported that she was "probably an 8" regarding her satisfaction with her current life overall commenting "for the most part I'm pretty satisfied."

History of childhood sexual abuse

Lila was sexually abused by her biological father. She stated she is unaware of when the abuse started because she "blocked out most of it." Her mother committed suicide when she was a year old and the abuse started when her father would take her to visit the burial site. Lila stated "He'd pull over on the interstate and he would try to mess with me and stuff." In addition, the abuse also happened in her bed at home.

Lila's stepmother discovered the abuse after walking in on an incident. Lila stated, it "just kinda got worse from there." After this incident, Lila's stepmother asked her to tell her about the abuse "all the time." Lila stated, "She just asked me to describe it all the time." I interpreted this to be retraumatizing.

When asked about how often the abuse occurred, Lila stated, "quite a bit." At this time in the interview, Lila asked me how detailed I wanted her to be. I informed

her it was at her discretion. I didn't require further details; however, I didn't want to keep her from talking if she wanted to continue discussing the abuse. Lila further described how she avoided her father providing an example that she "never wanted to miss the bus" or school. Lila eventually left home at 15 years old to stop the abuse and to protect herself.

Lila did not tell her stepmother about the abuse until it had been occurring for a while. Her stepmother found out after walking in on her father "beating" her with the "vacuum cleaner cord" telling her she had to "do something." I assumed this was sexual, but as a result of how nervous Lila had been in the beginning, I did not ask her. Lila has excused her stepmother's inability to intervene by saying she was "scared" of her husband. She commented that it was "living in hell" stating, "I had one person messing with me and it seemed like another person just wanted me to describe it all the time."

Lila eventually told a bus driver who then told the police. As a result, Lila was taken to a hospital only after she had to "describe everything to a tee." The abuse started "coming out" after this incident. Her two brothers found out about the abuse when the story was reported on the news. She said "I had to tell them (her brothers)."

Lila stated, "My dad was well known in the area where I'm from." She commented that everyone knew her father, which made it more difficult for her to accuse him. Yet, after the incident with the bus driver and the hospital, Lila was still willing to go to court to prosecute her father. However, she stated the "County Courthouse doesn't do background checks to find out what school the kid's attending at the time they're going to court." Thus, anyone studying "law or something" from

her school was in the courthouse. Lila described having her peers in the courthouse when she was supposed to testify as particularly difficult. It appeared that the court experience was retraumatizing for Lila. As a result of this, she dropped the charges. She stated, "I just told them I didn't want to talk and I walked out of court and I dropped everything." She was visibly frustrated when she said, "I just remember to this day looking at the judge and saying 'how could you do this to me.'…I can't believe y'all did this…I'm trying to supposedly start my life over, and I said 'and you sit here and you bring people from my school.'"

Lila had a court appointed counselor whom she told about the abuse. Since then, she has also spoken to "friends." She commented she talks "openly about it now." After describing her abuse, Lila stated she was "all right" commenting "It's a lot easier." She was referring to how much easier it was to speak about the abuse since her father's death. She stated, "I feel like he can never hurt me again."

Level of resilience related to childhood sexual abuse

When asked on a scale of 1 to 10 where she felt she was with regard to working through her childhood sexual abuse (with 10 representing completely worked through her childhood sexual abuse), she stated she was between an 8 and a 9. When asked what this number meant to her, she stated "I've made it through." She commented that she thinks she deals with it pretty well. Lila then made a comment that other participants have made which is, "I don't think anyone's every totally worked through this."

Lila has been in counseling to deal with her childhood sexual abuse. She stated that it was "both" unhelpful and helpful "depending on what time" she went. She was not currently in therapy.

Resiliency skills and childhood sexual abuse

When asked what specifically helped her work through her abuse, Lila highlighted the skill of "talking about (the abuse)." This supports the theme of *catharsis*. She then discussed the importance of "accepting it." I interpreted the theme of *appropriate attributions of blame* when Lila commented it was important to accept she "didn't deserve it." As a result of this, Lila stated she was focusing on being a "better parent" to her children.

Helpful aspects of counseling

Lila thought talking about the abuse was helpful in counseling for her childhood sexual abuse. The theme of *catharsis* was supported when she stated that "just being able to open up" was helpful. She said "just being heard" was useful and commented "sometimes knowing it's not inside you anymore" was beneficial. The helpful theme of *distancing the abuse* was supported when Lila said, it's "just not in your head. I mean it was a part of your life." I reflected on the resiliency skill of minimization of the importance of the abuse. I thought of how counseling can facilitate discussions about the abuse therefore possibly assisting with this cognitive reframing.

Unhelpful aspects of counseling

Lila stated the only thing that was not helpful about counseling was when the counselor said, "if you didn't remember things in your past, you [should] just make it

up." Narrative therapy is a type of intervention where the client can reauthor her life and reauthor meanings attached to her life. It is a collaborative approach where the counselor facilitates therapeutic conversations (Archer & McCarthy, 2007). This is different than asking a client to make up their story. Thus, I interpreted her experience to support the theme of a *counselor-influenced agenda*. Lila commented about how this counselor repeatedly tried to impress upon her what she should do. She stated, "Reality is reality in my life" saying she has deficits in her memory that are there possibly as a means for protection. Lila commented, "I shut it down just so it doesn't hurt me." She discussed how angry it made her for this counselor to tell her to make up her past.

Lila also said the counselor had very poor boundaries and in the last session she had "cussed him out." From this I interpreted the theme of *boundary violations*. Lila never returned to him for further counseling.

Barriers to counseling

When Lila commented she didn't want to go to a counselor that made her "constantly live in [her] past," I assumed the barrier to counseling was seeing a counselor who wanted to constantly talk about the abuse. I thought of another participant who talked about the necessity of "dredging up memories" and the apparent contradictions between participants. I interpreted the barrier of having someone who was judgmental when Lila commented (about this same counselor), "I didn't want to go to a counselor and have them judge me." I interpret this as having a *lack of information about an appropriate counselor* to be a barrier to treatment.

Current resiliency skills

I interpreted *employment* as a resiliency theme when Lila said "Work. I work a lot." I interpret her gaining support from her coworkers from her comment on the phone interview about her boss suggesting she complete the study. I also interpret gainful employment as adding stability.

The theme of *self-care* was revealed when Lila said "going for a walk" was one way she helped herself deal with problems. However, she also commented that she likes to be alone. I was concerned about her being alone in a time of crisis. She commented "it just helps me, I know I'm not bringing other people down with me." I was concerned with this comment and did not see it as being very resilient as it contradicts gaining social support. I had asked what was helpful about it and she stated, "Well, it might not be." I gathered she saw this as being unhelpful. I have concerns about categorizing this as a resiliency skill as she stated "I'll quit picking up the phone" and described isolating herself. Although the theme of self-care was identified, isolation was ruled out as being a resiliency skill.

Advice to others

The theme of *catharsis* was supported when Lila stated, "just talk through it." The theme of *seeking counseling* was supported as Lila suggested that other survivors "go to counseling." Lila also commented, "know that it wasn't your fault." She stated, "There's nothing you could have done probably to change it." This highlighted the theme of the *appropriate attributions of blame*.

I though her advice was concise and to the point. She said very little yet apparently knew exactly what she wanted to say. However, I was not sure if it was also because she was getting tired during the interview.

Post-interview thoughts

After the interview, Lila stated she felt "pretty good." She appeared to be more relaxed and spoke openly towards the end of the interview. After the tape was turned off and the formal interview ended, much like the other participants, she continued to discuss certain circumstances of her abuse. Lila discussed not wanting to fall into the "myth" that women become lesbians because they were sexually abused. She talked about a girlfriend who believed the myth was true and how offended she had been.

Lila talked about her father's death and the circumstances surrounding the court procedures when he was arrested for the childhood sexual abuse. She stated she did not want to be a "Jerry Springer" story. I interpreted this to mean she didn't want to have a dramatic and feuding family life. She said that she chose not to go to court when her stepmother wanted to divorce her father. I interpreted this as her attempt to disengage from the family problems by gaining distance from the situation. I specifically interpreted this as a resiliency skill since she was able to protect and insulate herself from further harm.

Telephone debriefing

Lila commented that she was "feeling good" after the interview. She stated she did not have any discomfort throughout the interview as she has little feelings left after her father died. She stated she has her friend who came with her for support in

the event that she needed further assistance. She was not currently in therapy but stated she has an Employee Assistance Plan that would afford her to see a therapist if needed.

Peer debriefing

After meeting with the peer debriefer, I thought this interview was "wonderful." I thought about how anxious Lila must have felt initially while she leaned forward with a pillow on her lap. She was definitely the most nervous participant, and she was the only one to bring a friend with her. I felt I was objective during the interview, and I enjoyed the process.

Summary of themes

Lila appeared to be the most reserved of the four participants. She became more relaxed as the interview progressed and was able to highlight a number of themes with respect to resiliency, counseling experiences, and advice to others. Like others, she noted that talking about the abuse was a resiliency skill used to work through her abuse. Perhaps this catharsis allowed her to place blame in the appropriate context which Lila reported as being important. By "being heard," Lila commented the abuse was "not inside [her] anymore." I believe this influenced her ability to cognitively reframe her abuse.

It was again noted that a helpful aspect of counseling was having the ability to talk about the abuse thus highlighting the theme of catharsis. Lila commented she was able to "open up" and how important it was to "just be heard." I wanted to highlight the importance of this theme as it has been repeatedly revealed in the results. It appears that talking about the abuse is paramount for a helpful counseling experience.

The theme of a counselor-influenced agenda was noted as being unhelpful in the counseling experience. When speaking about this counseling experience, Lila also commented her counselor had "poor boundaries." These two themes have surfaced repeatedly in my research. Therefore, I would like to highlight the two themes of boundary violations and counselor-influenced agendas as being unhelpful aspects of a counseling experience.

Catharsis has been revealed numerous times as an important theme in building resiliency. However, when discussing barriers to treatment, Lila commented she didn't want someone who made her "constantly live in [her] past." I found this confusing as it was obvious there was a need to talk about the abuse, but at the participant's pace. I interpreted Lila to be saying she did not want a counselor who was going to control the session. I was inclined to interpret this as a counselor-influenced agenda if the counselor ignored the needs of the survivor to set her own pace. However, as Lila noted various aspects of this counselor that did not work for her, I interpreted the theme of lacking information about an appropriate counselor.

Current resiliency themes reported included employment and self-care. I interpreted Lila's work environment to be supportive as evidenced by her boss stating she should participate in the study. I believe her stable work environment also provided consistency and support. Self-care was noted when Lila commented on walking as a current resiliency skill.

Three themes were noted when Lila discussed advice she would give to other survivors. They were catharsis, seeking counseling, and appropriate attributions of blame. Again, talking about the abuse was noted. I interpreted that an appropriate

venue for doing so would be in a counseling environment. With respect to appropriate attributions of blame, she commented, “know it wasn’t your fault.” I find this a common theme among the participants.

Conclusion

The results of this study indicate numerous resiliency themes concluded from four women. These themes will be discussed in the final chapter where they will be categorized within the individual inquiries of (a) the resiliency themes associated with working with childhood sexual abuse; (b) helpful and unhelpful experiences in counseling; (c) barriers to counseling; (d) current resiliency skills; and (e) advice given to other survivors. Clinical implications will be reviewed in the form of recommendations to counselors working with lesbian survivors of childhood sexual abuse. Limitations, recommendations for use of the present findings, and recommendations for future research will also be addressed.

Chapter 5

Summary and Conclusions

In this chapter, I will review and discuss the themes revealed in the results of the previous chapter. They will be reviewed within the context of the current literature on resiliency and childhood sexual abuse. The themes that will be reviewed were identified by a complex color categorization coding system. I organized themes into categories using a spread sheet. Some of the named themes were taken verbatim from the skill such as understanding the history of the abuser. As noted earlier, I have found the term theme and skill to be synonymous at times. In addition, some of the themes overlap. To highlight specific aspects, I differentiate the themes by different names. I used some verbatim quotes as to not lose the voice of the participant. Limited quotes will be used in this section to avoid repetition. However, individual participants will be referenced throughout the chapter in regard to themes. Clinical implications will be reviewed along with limitations, recommendations for use of the present findings, and recommendations for future research.

Resiliency

Resiliency has been conceptualized as a combination of personality traits and environmental influences that serve to protect an individual from harmful psychological effects of severe stress or traumatic events (Bogar & Hulse-Killacky,

2006). It allows individuals to lead satisfying lives. Resiliency has a protective effect in the face of childhood sexual abuse and was reflected in these four participants.

Resilience was demonstrated in this study as these participants had clearly overcome difficult circumstances and had a generally positive outlook on life. These participants illustrated that coping with childhood sexual abuse was possible. All four participants interacted positively and effectively with me during the interview and for the most part, all were comfortable talking to me about their childhood sexual abuse. They required little encouragement, and responded to the questions without hesitation. Finally, I also witnessed a commonality of hope and optimism (Himelein & McElrath, 1996) in all four participants.

This study was a collective case study. Four individuals were interviewed, and numerous themes were revealed regarding resiliency and childhood sexual abuse; helpful and unhelpful experiences in counseling; barriers to counseling; current resiliency skills; and advice to other lesbian survivors of childhood sexual abuse. All criteria of the study were met without difficulty. There were no breaks in the protocol and no unusual happenings.

Resiliency Themes and Childhood Sexual Abuse

A number of resiliency themes were revealed throughout my interviews with the participants involving how they worked through their childhood sexual abuse. The themes are categorized as environmental, cognitive, and active. “Environmental” themes are influences outside of the survivors that helped them cope or themes related to some external force. The classification of “cognitive” means internal

thoughts or mental representations of events that lead to resilience. “Action” themes are those that lead to coping that cause the survivor to take action. The three categories, in addition to the themes noted, are depicted in the Table 1.

Table 1

Resiliency Themes and Childhood Sexual Abuse

Environmental	Cognitive	Action
1. Receiving guidance	1. Regaining personal	1. Catharsis
2. Acceptance from	Power	2. Seeking counseling
Others	2. Cognitive reframing	3. Taking an active
3. Supportive	3. Making meaning of the	role in healing
relationships	Abuse	4. Establishing
4. Universality	4. Understanding the	boundaries
	history of the abuser	5. Artistic expression
	5. Appropriate	6. Self-care
	attributions of blame	
	6. Build a more positive	
	self-concept	

Environmental themes

Environmental themes included *receiving guidance* through the participants’ process of resolving their childhood sexual abuse. The theme of receiving guidance was derived from Betsy commenting that it was beneficial when her faculty advisor “pushed” her into or “confronted” her about having to deal with her childhood sexual abuse. Betsy stated her faculty advisor “insisted” she see a counselor at one point.

This could also be interpreted as challenging the survivor. However, I interpreted it as receiving guidance through our discussion of her faculty advisor leading Betsy into counseling and a women's group where she addressed her childhood sexual abuse. Having guidance through this process may be similar to the resiliency skill of having positive role models or mentors (Feinhauer et al., 2003).

The environmental theme of receiving guidance through a survivor's process is mirrored in Baker's (2003) discussion of the need for professional resources. In Baker's work, childhood sexual abuse support groups were important in building resilience. Although they were not mentioned in my results, I believe these groups would fall under the theme of receiving guidance and support through the resolution process.

Acceptance from others was evident when counseling was described to provide a non-judgmental environment where the survivor's abuse is met with acceptance and symptoms are less pathologized. This acceptance from others ultimately leads to the cognitive process of depathologizing the symptoms. I believe this influence is environmental as it relates to reducing stigmatization (Finkelhor & Browne, 1986). I interpreted acceptance from others to mean that the environment needs to facilitate discussions of the symptoms of the abuse while providing a place of acceptance.

Supportive relationships are important in building resiliency (Feinhauer et al., 2003; Valentine & Feinauer, 1993, Werner & Smith, 2001). Betsy commented on the significance of supportive relationships by stating how important it was to have supportive partners. This provided evidence for the theme of supportive relationships.

Emily's comment on the importance of finding people with similar backgrounds also supported this theme in addition to the theme of *universality*. The theme of supportive relationships is validated by Werner and Smith who use relationships with partners as measure of resiliency. Valentine and Feinauer (1993) discussed supportive relationships in the context of having the ability to find relationships outside of the family.

Cognitive themes

Numerous researchers have noted cognitive skills as building resilience (Bogar & Hulse-Killacky, 2006; Himelein & McElrath, 1996; Werner & Smith, 2001). While discussing the abuse, Anna stated she wanted to take back her power. This recognition of personal power has been noted in women with high resiliency (Himelein & McElrath). I interpreted the theme of *regaining personal power* when Anna commented on rejecting the notion of being a "victim" of childhood sexual abuse, which is a resiliency skill noted in Bogar and Hulse-Killacky's research. I also interpreted this theme as *cognitive reframing*. Cognitive reframing is when an individual transforms a maladaptive thought into a more adaptive, also seen as positive, thought (Dyrden & Ellis, 2001).

Anna discussed gaining distance from her anger and making meaning of the abuse. The theme of *making meaning of the abuse* has been noted as a resiliency skill categorized as spiritual (Baker, 2003). One interpretation of making meaning under the category of spirituality is the notion that there is some spiritual reason the abuse took place, or the individual can gain spirituality as a result of the abuse. However, this was not what to which Anna was referring. Anna was able to make meaning of

the abuse through gaining an *understanding of the history of the abuser*. In understanding the abuser's personal history, I interpreted Anna as having the ability, much like Lila, to be able use the resiliency skill of *appropriate attributions of blame* (Binder et al., 1996; Valentine & Feinauer, 1993). This cognitive reframing of abuse has been noted to enhance resiliency (Davis, 2000). Specific cognitive reframing to the self was the theme of *building a more positive self-concept*. This was supported by Emily who used self-talk and positive affirmations.

A cognitive shift of perspective was seen in all participants. Anna was able to get back her power. Betsy insisted she find people who did not pathologize the symptoms related to the abuse, therefore cognitively reframing it to where she didn't feel like a "freak." Emily tried to have a more positive outlook on herself, and Lila commented on how she refocuses on her children and more positive things. These cognitive shifts have been noted to enhance self-perception (Himelein & McElrath, 1996), gain a more positive outlook on life (Werner & Smith, 2001), and assist with refocusing and moving forward (Bogar & Hulse-Killacky, 2006).

Action themes

Bogar and Hulse-Killacky (2006) noted the importance of taking an active role in healing. This was stressed in action steps such as acting out the abuse during play therapy or talking about the abuse. Talking about the abuse was stressed specifically by three of the four participants thus supporting the theme of *catharsis*. Bogar and Hulse-Killacky's active role in healing suggests a survivor directly confront the childhood sexual abuse. Talking about the abuse may assist in this process. It has also been shown to assist with achieving closure (Bogar & Hulse-

Killacky). Emily and Lila suggested talking about the abuse was helpful in counseling. Each participant stated she had spoken to counselors about her abuse indicating each had engaged in catharsis (James, 2008) at one point in her life.

Emily commented "therapy" was important in building resiliency thus supporting the theme of *seeking counseling*. Each participant had been in therapy and suggested that it was helpful. As each participant had engaged in therapy at one point in her life and could describe helpful aspects, I interpreted seeking therapy to be *taking an active role in healing* to build resiliency.

Play therapy and acting out abuse were reported by Emily as helpful in resolving her childhood sexual abuse. I believe the acting out of the abuse further supported the theme of catharsis. Play therapy is a therapeutic method based on the idea that through play, children express themselves (Griffith, 1997). It has been noted as an important clinical technique to use with children (White & Allers, 1994) and has been recognized to be effective in working with DID (Klein, 1993). It was used with Emily because of her DID. Through play therapy, her "insiders" were allowed to come out and play. In doing so, they were allowed to become more integrated.

In addition to therapy, Anna took on an active role in her own recovery. She stated she read books, both fiction and non-fiction, about sexual abuse and researched the topic of childhood sexual abuse. In researching this topic, she was able to learn about people who had overcome childhood sexual abuse. I recognized this as similar to Emily who wanted to meet people who were similar to her.

Taking an active role in healing was also seen in Anna as she described only going to family requirements. I interpret this as *establishing boundaries*. Anna places

distance between her and her family. This would minimize her distress.

Emily exhibited an active way of healing through the use of positive affirmations. Although this is recognized as a cognitive tool, this was an active way of establishing resiliency. Emily and Anna also expressed themselves creatively by drawing and writing poetry. This supported the theme of *artistic expression*. I believe this enhanced their self-esteem, thereby increasing their resiliency (Valentine & Feinauer, 1993).

A final theme was *self-care*. From the beginning of the phone interview, Betsy commented on a specific medication that assisted her in the resolution of her childhood sexual abuse. There is evidence that certain medications have mitigating effects on symptoms related to trauma (Padala et al., 2006; van der Kolk, 1987). Medication, along with psychosocial treatments, has also been shown to enhance resiliency (Davidson et al., 2005).

Helpful Themes of Counseling

Helpful themes of counseling were organized into three categories; the characteristics of the counselor, the actions of the counselor, and tasks completed within counseling. All four participants found counseling to be beneficial. The various themes of counseling that were helpful are depicted in Table 2.

Table 2

Helpful Themes of Counseling

Characteristics of Counselor	Actions of the Counselor	Tasks Completed Within Counseling
1. Accepting	1. Foster supportive	1. Catharsis
2. Encouraging	relationships	2. Distancing the abuse
3. Supportive	2. Offer guidance and	
4. Trusting	tools.	
	3. Collaborative treatment	
	Planning	
	4. Listen	
	5. Be consistent	
	6. Provide a safe place	

Characteristics of the counselor

The first category of themes involved characteristics of the counselor. Anna commented that the counselor needed to be *accepting* and *encouraging.* I interpreted the term accepting from Roger's perspective of unconditional positive regard. Unconditional positive regard is the ability to see the client's inherent worth and enabling the client to feel that whatever she says will not cause her to be rejected (Archer & McCarthy, 2007). I interpreted the theme of encouragement from an Adlerian perspective where it is suggested for the counselor to promote courage (Capuzzi & Gross, 2007). The theme of the counselor being *supportive* was noted when Emily commented about needing a "safe place." It was further noted when she stated that counseling reinforced her feeling that she was taking the right steps.

Trust was an important theme in counseling. Anna stated she needed someone with whom she could check her "reality." In addition, she was looking for a "sounding board." Her counselor also provided a different and objective perspective. It was important for Anna to learn how to trust again after the abuse. Trust is a basic element tainted by childhood sexual abuse (Finkelhor & Browne 1986), therefore it is important to establish trust within the counseling relationship.

Actions of the counselor

Certain actions of counselor were also important. Emily found it important to include her family. I interpreted this theme as *fostering supportive relationships*. Malley and Tasker (2007) found that gays and lesbians have a "family of choice" that can be supportive in their treatment. These are individuals who may not be blood relatives, but other people which the individual bonds with. Although Emily found her husband to be a great support system, involving the survivor's family of choice may be beneficial.

Having a counselor who understood childhood sexual abuse and DID was important to Emily. I interpreted this as the theme of *providing competent treatment*. It is important that any therapist who works with survivors of childhood sexual abuse have specific training both in trauma and trauma related disorders. Without such training, misdiagnosis can occur and poor outcomes may result.

Offering guidance was again supported when Emily discussed the therapist providing her with "tools." This supports Malley and Tasker's (2007) research that indicated it was helpful for gay and lesbian clients to receive information and advocacy from their counselors. Perhaps it was the counselor taking a more active

role in therapy that assisted Emily in building resiliency. I interpreted this as a theme *offering guidance and tools*. This is not to be confused with a counselor-influenced agenda. To differentiate the two, I believe it may be beneficial for a counselor to give practical tools (i.e. to overcome anxiety) yet not "push" the issue if the client is not ready to use these tools. Burkell and Goldfried (2006) reviewed therapist qualities preferred by sexual minorities. Their findings indicate sexual minority clients prefer to have a therapist that is working on mutually agreed upon goals. Perhaps this is the litmus test for a counselor-influenced agenda. Hence, the theme of *collaborative treatment planning* was revealed as essential for the lesbian survivor of childhood sexual abuse.

Lila mentioned that she just wanted to be heard. It has been recognized that some gay and lesbian clients found it helpful for the counselor to just listen (Malley & Tasker, 2007). I believe this allowed Lila to foster the resiliency skill of distancing the abuse (Himelein & McElrath, 1996). I believe it is important to hear the client's story without interruption or personal agenda. I interpreted hearing the client as the theme of *listening*. As I found throughout this interview process, participants will disclose what they need to disclose about the abuse. Therefore, it may be beneficial for counselors to listen to their client's story of abuse before providing interpretation.

The theme of *being consistent* appears to be an important factor as well. This may also be reflected in availability. Emily commented that her therapist was available in the event she needed anything. I believe it is important for counselors to maintain good boundaries while providing a consistent atmosphere. Boundary violations were noted several times as being unhelpful. In providing care with good

boundaries, survivors can get the consistency they need for trauma resolution. Perhaps this is what Emily meant when she commented on counseling being a "safe" place to be. This comment illustrated the need for counselors to *provide a safe place*. I believe without this safety, the catharsis spoken of so often in this research, will not be met.

Tasks completed within counseling

Action steps on behalf of the survivor were also helpful. Two actions were addressed specifically: *catharsis* and *distancing the abuse*. Three out of the four participants stated that talking about the abuse, which I interpreted as bringing relief (indicating a catharsis) was helpful in counseling. This has been recognized as specifically helpful in building resiliency (Himelein & McElrath, 1996). Talking about the abuse thereby narrating one's trauma within the context of a supportive counselor may be the element that minimizes the effects thus distancing the abuse. This minimization of the effects was important to Lila who commented that the abuse was just part of her life.

Unhelpful Themes of Counseling

An unhelpful therapy experience can lead to early termination (Liddle, 1996). All four of the participants provided feedback on unhelpful experiences in counseling. The two categories of themes that emerged within unhelpful aspects of counseling with respect to the counselor were characteristics of the counselor and actions of the counselor. No tasks completed within counseling were noted. Another category that emerged was issues inherent to the individual. They are depicted in Table 3.

Table 3

Unhelpful Themes of Counseling

Characteristics of Counselor	Actions of the Counselor	Tasks Completed Within Counseling	Issues Inherent to the Survivor
1. Incompetent	1. Counselor-influenced agenda 2. Boundary violations 3. Unethical behavior	None noted	1. Personal ambivalence 2. Fear

Characteristics of the counselor

Emily commented finding a "bad therapist" was unhelpful. It has been recognized that a therapist who is uneducated about the concerns of lesbians can lead to early termination (Liddle, 1996). Further discussion with Emily revealed the potential damaging effects of a counselor who is not trained in trauma. I interpreted this as the theme of *incompetence*.

Actions of the counselor

An unhelpful characteristic noted by all four participants was a *counselor-influenced agenda*. This is mirrored in Malley and Tasker's (2007) work who reported that gay and lesbian clients found it unhelpful for counselors to make "assumptions" or be too directive. Although each participant described it in her unique way, this illustrated the importance of allowing survivors to progress at their own pace. The following examples illustrate a common thread of a counselor influenced agenda. Lila commented that her therapist told her to make up her past; Emily was pushed to do things she was not comfortable doing; Betsy had outsiders telling her she had to

confront her mother; and Anna was told repeatedly that she was angry with her mother. I believe it is important for counselors to avoid taking an overly controlling approach to the treatment of lesbian survivors of childhood sexual abuse. I realize this may contradict the theme of guidance. However, mutually agreed upon goals may be the most helpful to the survivor (Burkell & Goldfried, 2006). Treatment planning in which the survivor takes on a collaborative role with the counselor may not only produce better results but is standard for ethical practice.

The theme of *boundary violations* was noted by three of the four participants. This highlights the need for ethical treatment of survivors, and of any client for that matter. Avoidance of dual relationships and professional delineation of roles is a contract that cannot be breached for any client, much less a lesbian survivor of childhood sexual abuse who may already struggle with issues of trust.

Emily discussed her frustrations with a counselor who was untrained in issues related to trauma which led me to interpret a possible breach in ethical issues. This breach could be a matter of practicing beyond the scope of one's profession thereby revealing the theme of *unethical behavior*. In practicing outside of the scope, it becomes easier to misunderstand and misdiagnose a client. Finally, in speaking of unhelpful experiences, Emily also commented on a counselor who kept raising her prices. This too supports the theme of unethical behavior.

Issues inherent to the survivor

The themes of *personal ambivalence* and *fear* were noted when Betsy commented on her hesitancy to continue with counseling for these reasons. There was personal ambivalence surrounding the knowledge that counseling was helpful and how it may be uncomfortable. Issues inherent to the survivor may be outside of the control of the counselor. However, by recognizing these themes, counselors are better prepared to treat lesbian survivors of childhood sexual abuse.

Barriers to Counseling

There were three categories of themes regarding barriers to counseling: financial, internal struggles, and difficulty with the content of the session. They are depicted in Table 4.

Table 4

Barriers to Receiving Counseling

Financial	Internal Struggles	Difficulties with Content
1. Financial constraints	1. Fear	1. Counselor-influenced
2. Inadequate mental	2. Ambivalence	Agenda
health insurance	3. Perceived privacy	2. Having had a
	issues	judgmental counselor

Financial

Two of the participants revealed the theme of *financial constraints* as being a barrier for treatment. Emily commented that "money" was a constraint to her finding treatment. Anna commented that she didn't have mental health insurance. I

interpreted her as having the inability to attend services as a result thereby revealing the theme of *inadequate mental health insurance*.

Internal struggles

A second barrier to counseling was the internal struggles of one woman. I believe it is normal to have a sense of fear concerning attending a counseling session that may produce discomfort. The ambivalence presented itself when Betsy knew she had to do it for her own good. I believe these themes of *fear* and *ambivalence*, again, out of the control of the counselor, need to be addressed to create the safe and trusting environment of which Emily spoke.

Anna self-paid for her treatment because, at the time, she was working for a large corporation. She didn't want "big brother" to know that she was attending treatment. I interpreted this as the theme of *perceived privacy issues* being a barrier to receiving counseling services.

Difficulties with content

Final barriers were having difficulty with aspects of the counseling session itself. Lila stated that one of her barriers to getting treatment was to that she would constantly have to talk about the abuse. This was interpreted as the inability to control the session and go at her own pace. I also interpreted this as a *counselor-influenced agenda*. Lila also commented that she had a counselor judge her and she never returned to him. I interpreted this as *having a judgmental counselor*. Having a judgmental counselor was deemed to be less desirable to gay and lesbian clients (Malley & Tasker, 2007). This highlights the need for adequate training in cultural diversity in mental health programs.

Current Resiliency Themes

Current resiliency themes were classified into three different categories: cognitive, actions involving the self, and actions involving others. They are depicted in Table 5.

Table 5

Current Resiliency Themes

Cognitive	Actions Involving the Self	Actions Involving Others
1. Gaining distance and perspective 2. Realistic expectations 3. Confronting taboos 4. Positive outlook on life 5. Developing a positive self-concept	1. Self-care 2. Employment 3. Artistic expression	1. Supportive relationships 2. Good communication 3. Altruism

Cognitive

Many cognitive themes were revealed by the participants as they described their resiliency skills in working through their childhood sexual abuse. Perhaps many of the skills learned early on in dealing with the abuse have now been generalized into other areas of their lives. This would be consistent with the research denoting that resiliency is consistent throughout the lifespan (Barnyard & Williams, 2007). Anna commented on gaining distance and perspective on her problems. Emily noted this as

the "three day rule." I interpret this as the theme of *gaining of distance and perspective* as she was able to place psychological and emotional distance between her and her problems. I believe this assisted Emily in not reacting emotionally, thus revealing this resiliency skill. Emily commented on the need to let go of her anger and having realistic expectations of others and high expectations of herself. I interpreted this as the theme of having *realistic expectations*. In addition to Emily, Anna also commented on the need to release taboos of forbidden topics such as childhood sexual abuse thus revealing the theme of *confronting taboos*. I believe this cognitive distancing of problems, realistic expectations, and ability to confront "taboos" leads to a more *positive outlook on life* thus revealing this theme.

Emily commented on the use of positive self-talk and visualization. Although I also recognize these as action steps, the intent is to lead to a more positive view of one's self. I interpreted this theme as *developing a positive self-concept*. This cognitive skill may mirror the resiliency theme of having a more positive or self-enhancing perception (Himelein & McElrath, 1996).

Actions involving the self

The theme of *self-care* was noted by two participants. It was evident that taking care of oneself is a strong foundation for resilience. Lila did this through taking walks while Emily would focus on herself through drinking tea and taking hot bathes. Positive self-care coping skills have been revealed to assist with resiliency (Bogar & Hulse-Killacky, 2006).

Although many individuals may be employed in a solitary environment, Lila suggested that working assisted in her current resiliency. Perhaps it is the benefit of

peers or the support of coworkers that enhances resiliency (Werner & Smith, 2001). *Employment* has been noted as a resiliency skill and I believe this theme has many benefits. I believe that having a stable work environment also provides consistency and support, two themes noted as being important in the counseling relationship.

Artistic expression is an important means of expression for a child who has been abused (Clements, 1996). The theme of *artistic expression* was revealed in Emily through her use of positive imagery and visualization. This theme was also noticed in working through childhood sexual abuse.

Actions involving others

Actions involving others were equally important. Both Betsy and Emily commented that helping others assisted with their current resiliency. Emily also stated that reaching out to others was important in her current resiliency thus revealing the theme of *supportive relationships*. This suggests that resiliency is built not only within the self, but with others as well.

Betsy revealed the theme of *good communication* as being important in relieving her daily stress. I believe this is what bridges the actions within the self and others. Betsy commented that her partner excels in communication. Perhaps it is having partners around the survivor who also excel in communication which enhances resiliency. This also supports the theme of supportive relationships (Werner & Smith, 2001).

Both Emily and Betsy commented on helping others therefore supporting the theme of *altruism*. Betsy commented specifically on assisting her aging parents. In helping others, I believe that survivors are also using the skill of refocusing and

moving on (Bogar & Hulse-Killacky, 2006). Altruism has also been noted as activism which has been recognized as a resiliency skill (Southwisk, Vythilingam, & Chaney, 2005). This has also been associated with positive mental health benefits (Scwartz, Meisenhelder, Yunsheng, & Reed, 2003) thus enhancing resiliency.

Advice to Others

Each participant was afforded the opportunity to state what advice she would give to other lesbian survivors of childhood sexual abuse. The responses were classified into three categories: cognitive, environmental, and action. The responses are depicted in Table 6.

Table 6

Advice to Other Survivors

Cognitive	Environmental	Active
1. Understanding the history of the abuser 2. Making meaning of the abuse 3. Take control back 4. Place situations in a more positive context 5. Appropriate attributions of blame 6. Let go of anger, Depression, and guilt 7. Realistic expectations 8. Self-affirmations	1. Supportive Relationships 2. Universality	1. Seeking counseling 2. Taking an active role in healing 3. Catharsis 4. Self-care

Cognitive

The most recommended themes were cognitive in nature. Both Anna and Emily commented on the theme of *understanding the history of the abuser*. Anna commented that understanding her father's history assisted her in coping with the abuse. Emily commented about understanding how her parents did not have the

necessary tools needed to parent a child and how knowledge of this assisted with coping with the abuse. This understanding may have assisted Anna and Emily in achieving closure. I believe it also allows one to *take back control* of her life which was recommended by Anna. In this, I recognized the theme of *making meaning of their abuse* (Baker, 2003). Furthermore, I believe this was Emily's way of *placing the situation in a more positive context* thus revealing this theme. I believe this reflects Himelein and McElrath's (1996) work suggesting a positive philosophy on life enhances resiliency. Emily stated that she really did not blame her parents. This further supports the advice that Lila gave, which was to appropriately assign blame to someone other than oneself. This supports the theme of *appropriate attributions of blame* (Valentine & Feinauer, 1993).

Anna strongly recommended *letting go of anger, depression, and guilt* thereby leading to resolution of feelings surrounding the abuse. She advised individuals to take back control. I recognized this as the resiliency skill of having an internal locus of control (Himelein & McElrath, 1996). I noticed a similar skill when Emily commented about looking at what one can change about oneself. I believe the advice to take back the power and to look at what can be controlled encourages resolution of trauma. However, achieving closure may be difficult. Anna commented that one should not hope to achieve closure with her abuser or look for an apology. She said this because she felt that closure came from within the individual. This supported the skill of finding closure within oneself and the theme of having *realistic expectations*. Having the control within oneself was important to Anna. Believing in oneself was important advice given by Emily thus supporting the theme of *self-affirmation*. Both

of these, I believe, enhance the resiliency theme of self-efficacy (Werner & Smith, 2001).

Environmental

Participants also advised others to draw from the environment. *Supportive relationships* have long been recognized as enhancing resiliency (Feinauer et al., 2003; Valentine & Feinauer, 1993; Werner & Smith, 2001) and was recommended by Betsy as she commented on "really" supportive friends and a supportive partner. Emily recommended that lesbian survivors of childhood sexual abuse find someone similar to them. This also supports the theme of supportive relationships but more specifically, the theme of *universality*. I believe this may have implications on two levels; finding someone who may share the same background of childhood sexual abuse and finding someone who is a lesbian. In finding common ground, survivors can gain the companionship and possible mentorship needed to address their childhood sexual abuse issues.

Active

Action steps on behalf of the survivor are important in the resolution of childhood sexual abuse. Three out of four of the participants recommended *seeking counseling*. This is consistent with the theme of *taking an active role in healing*. In doing so, it has been recognized that the resiliency is enhanced (Bogar & Hulse-Killacky, 2006). Counseling was noted by Betsy as a "necessary evil." Emily commented that it was important to find someone to talk to, even if it's the "Dalai Lama."

Lila also recommended talking through the abuse. This supports the theme of *catharsis* which has surfaced in numerous categories throughout my research. The theme of catharsis may also assist in taking an active role in healing. Both Lila and Emily recommended talking about the abuse because for them it was paramount in the resolution of childhood sexual abuse. Again, this is consistent with the literature stating that talking about the abuse enhanced resiliency (Himelein & McElrath, 1996).

To further support the advice of taking an active role in healing, survivors may be even more invested in their treatment. For example, Emily commented that she found counseling services available to survivors of childhood sexual abuse. In taking an active role to find therapy, Emily further elaborated on taking an active role by stating that it may be helpful to read books about childhood sexual abuse.

Finally, Betsy commented on the use of medication to alleviate some of her symptoms related to childhood sexual abuse. I interpreted this as a theme of *self-care*. Although prescribing medication is out of the scope of practice for counselors, I believe it is important to be knowledgeable in the field of pharmacology and have information on the medication a client is taking including the side effects. Issues specific to medication may be the side effects, compliance, and availability due to insurance or other financial constraints.

Revisiting Feminist Theory

Inherent in childhood sexual abuse is an imbalance of power. Through creating a voice for those who had none in the past, power has been re-established. This study gave voice to an oppressed population. In giving voice to a minority

group, their subjective realities are acknowledged and validated (Negy & McKinney, 2006). Resiliency and strength were found in the face of adversity thereby bypassing the silencing often accompanied by childhood sexual abuse. In doing so, social justice has been served.

Clinical Implications

The clinical implications of this research are woven throughout this manuscript. However, I would like to highlight some recommendations resulting from this research based on the results. There were several themes noted throughout this research that surfaced more than once. I interpreted them to be extremely important, therefore will include them in clinical implications. I assembled the clinical implications from information regarding what was helpful, what was not helpful, and the barriers to getting counseling.

The clinical implications are as followed;

1. It is important to create an accepting, encouraging, and supportive environment for survivors where they can begin a journey of self-exploration for a broad range of issues; not solely childhood sexual abuse. Counseling the lesbian community presents unique issues (McDougall, 1993; Pachankis & Goldfriend, 2004). Recalling that trust is an important factor in the counseling relationship, it is paramount that the relationship is built with a foundation of consistency, support, and with good boundaries.
2. Specific training in trauma, especially in childhood sexual abuse, is recommended when working with this population. Training individuals in

graduate programs or seeking training beyond graduate programs to work with childhood sexual abuse and minorities is recommended.

3. Comprehensive treatment which includes the family of choice is recommended. It is important to recall that family to lesbians may not include their biological relatives. As supportive relationships are important, including those in the survivor's support system is paramount to comprehensive treatment.
4. It is important to do more reflective listening versus interpretation when the survivor first tells her story. The theme of catharsis was revealed on many separate occasions through three separate survivors. Lila commented that she just wanted to be heard. I believe that hearing the story of the survivor is an essential portion of treatment. Although all the details may not be recalled, I believe it is the responsibility of the counselor to allow the story to unfold at the client's pace.
5. As with any client, boundaries are important to survivors. It is of the utmost importance that counselors have consistent boundaries with clients. In addition to the basic elements of dual relationships, and fee disclosure, I would also address self-disclosure in this recommendation. It appears that limited self-disclosure would enhance the professional relationships between the counselor and the survivor. In following ethical guidelines, counselors can provide a "safe place" for survivors.
6. It was discussed on separate occasions that a counselor-influenced agenda was unhelpful. Therefore, I believe that it is important to let the client lead

the session as much as possible. This is not to say that cognitive behavioral skills or analytic tools cannot be used. It simply suggests that, recalling the fear and personal ambivalence as barriers, pushing these survivors may be contraindicated. I believe it is important to have a collaborative relationship with the client and implement treatment planning with mutually agreed upon goals.

7. It is recommended that there be more services available, specifically to the lesbian community, on a sliding fee scale. Lack of financial means and managed care were reasons why someone women did not get assistance for treatment of their childhood sexual abuse. By broadening the availability of services, survivors not only have a better chance to be treated, but have a better selection of counselors in the event that they find one that does not fit.
8. As clients typically prefer therapists who have knowledge of sexual minority issues (Burkell & Goldfried, 2006), it is important that the services available are competent on issues specific to the lesbian survivor or childhood sexual abuse. Training should be provided to counselors working with this population.
9. Resiliency must be cultivated in lesbians with a history of childhood sexual abuse on all levels. Guidance and mentorship may be an avenue to assist them. This can be done through counselor led support groups geared toward lesbians with a history of childhood sexual abuse. Networking within their family of choice also fosters resilience (Oswald, 2002).

Through building a community, lesbian survivors can find the common ground described in this research and depathologize their symptoms of abuse. In addition to support groups, this can be done through the Internet, self-help groups, or other forums created to bring lesbian survivors of childhood sexual abuse together.

10. Cognitive procedures should be offered to the lesbian survivor of childhood sexual abuse. Specific cognitive skills that may be helpful are regaining personal power, cognitive reframing, making meaning of the abuse (Himelein & McElrath), understanding the history of the abuser, appropriate attributions of blame (Valentine & Feinauer, 1993), and assisting them with building a more positive self-concept (Himelein & McElrath).

Support for Evidence Based Practice

Trauma focused cognitive behavioral therapy has been supported as treatment for childhood sexual abuse (Hoch-Espada, Ryan, & Deblinger, 2006). Trauma focused cognitive behavior therapy recommends addressing the trauma directly in a supportive environment while providing psychoeducation and enhancing the individual's ability to self-care. This study supported several aspects of trauma focused cognitive behavioral therapy as it noted the necessity to directly confront the trauma, cognitive reframing techniques, and methods of self-care. The theme of catharsis was indicative that the participant's counseling was focused in part on the trauma. The themes of appropriate attributions of blame, making meaning of the abuse, understanding the history of the abuser, and building a more positive concept,

are also cognitive shifts supporting cognitive behavioral treatment. Cognitive behavioral treatment stresses a collaborative relationship between the client and the counselor which was reflected in the theme of collaborative treatment planning.

Similarities and Differences between Lesbians and Heterosexual Women

This was a qualitative study where sexuality was a defining factor in participation. In other studies conducted related to resiliency, sexual orientation was not assessed (Bogar & Hulse-Killacky, 2006; Feinauer et al., 2003; Himelein & McElrath, 1996; Valentine & Feinauer, 1993), therefore it is assumed they are made up of the majority of women who are heterosexual. I found my results to be similar to the results found in the population of women who are presumed to be heterosexual. I found many similarities that are referenced throughout chapter five such as cognitive reframing, making meanings of the abuse, self-care, and taking an active role in healing. There were, however, some resiliency skills that were unique to the lesbian survivor of childhood sexual abuse such as understanding the history of the abuser and altruism. As there appears to be more similarities than differences, I would recommend further research with the lesbian population with more direct questions related to resiliency and how it relates to their sexuality.

Limitations of the Study

This study met its intended goals. However, it did have limitations. First, although there were a wide variety of educational backgrounds, there was little in diversity. All four participants were Caucasian suggesting these results may only reflect the resiliency strategies of Caucasian lesbian survivors of childhood sexual abuse. Only one African American and one Latina responded to the ad out of nine

individuals who were screened and did not meet the criteria. Perhaps a different recruitment strategy may have been more effective in recruiting women of color.

Second, all four participants were from the same source. I had placed flyers at gay and lesbian events, sent out emails to colleagues and friends, posted the flyer at a large University, and spread my study by word of mouth. However, my largest response was from an ad on "Prosuzy," a website geared toward networking lesbians. Although I did have a large response, I also had numerous individuals call and not follow through with the appointment for the phone interview.

Third, there was only one interview with each person. I believe that more than one interview would have possibly revealed more resiliency skills. A stronger rapport could have been established and perhaps the participants would have produced more disclosure. Perhaps a second or third interview would have revealed more skills and more information.

Another limitation was the projection of my own interpretation. There were several occasions during the interviews when I chose to interpret a particular word or phrase rather than ask for clarification. In this way, the fourth limitation is that I may have projected my own perception of the interview.

Each of these individuals was sexually abused by her biological father or step-father, indicating incest. The lack of variability of the trauma experienced was the fifth limitation. Perhaps there are other resiliency skills lesbian survivors use when they have been abused by individuals external to their family.

Finally, this was a study conducted on lesbians who are "out." This indicates that they are willing to disclose their sexuality to others and discuss it with me in an

interview. This is not the case for many lesbians. There is much that is unknown regarding this group of lesbians.

Recommendations for use of Present Findings

I believe there are three groups this research needs to reach. The first one is the counselor educator. Research indicated that graduate programs in counseling may be heterosexist and mental health counselors may be ill prepared to serve the lesbian community (Lidderdale, 2002). I believe we need to continue to educate on diversity and teach future counselors best practices in treating lesbians who have been sexually abused as children. In doing so, counselors will be able to identify what is helpful and unhelpful in counseling this special population.

Next, this research needs to reach the practicing counselor. I believe the counselor who is actively treating lesbian survivors needs to have the information necessary to cultivate resiliency. In doing so, the counselor can produce the "safe environment" required for a lesbian survivor to resolve her childhood sexual abuse. In addition, they would also have access to the knowledge of how to foster resiliency in the lesbian survivor of childhood sexual abuse.

The final population this information needs to reach is other lesbians who have been sexually abused as children. I believe this information is important to the lesbian community and could assist lesbian survivors in cultivating their own resilience. In presenting these findings to the community, lesbian survivors can learn the benefits of counseling as well as identifying what they can do to work through their own childhood sexual abuse. This research supports the idea of counseling and

offers suggestion as to how to resolve childhood sexual abuse. I believe it is imperative that it reaches the lesbian community.

Recommendations for Future Research

This study explored research on the resiliency of lesbians with a history of childhood sexual abuse. It covered various topics from helpful aspects of counseling to advice they would give to other survivors. Future studies could include other variables. For example, I am curious how the work or school environment could assist in the fostering of resilience. Although I investigated how counselors have been helpful, it would be interesting to do more research on how family members or friends were helpful or unhelpful.

In addition to covering other areas, I believe other sexual minorities should be studied to reveal themes of resiliency in resolving childhood sexual abuse. Bisexuality and male homosexuality were excluded from this study. However, male homosexuals suffer childhood sexual abuse at a significant rate (Tomeo et al., 2001). Therefore, I propose this research to be replicated with other sexual minority populations. In addition to this, I recommend this research to extend itself to African Americans, Latinos, and other minorities who also suffer from childhood sexual abuse as well as oppression. In doing so, the voice of many other minorities can be heard.

I would also be curious as to whether or not there is specific training in minority issues related to trauma in graduate programs and post graduate trainings. A research project denoting what training is available and what the needs of the students

are would be beneficial. This would assist in integrating the specific training needed for this population.

Conclusion

The lesbian population has been affected by childhood sexual abuse at an alarming rate (Hughes, 2003; Hughes et al., 2001). However, successful coping is possible. Through this research, themes have been revealed indicating the various methods used by lesbians to cope with childhood sexual abuse. The themes identified were broad and the coping skills were many suggesting each survivor has her unique story and resilience takes on many forms.

There is little research about resiliency and the lesbian survivor of childhood sexual abuse. This indicates there are many more stories that have not been heard. I believe it is the responsibility of the educators and counselors to examine how to foster resiliency and provide a "safe place" where lesbian survivors can cope with abuse. In doing so, foundations can be laid for resiliency to be cultivated.

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Appendices

Appendix A: Selection Criteria for Study

1. The participant must be at least 30 years old
2. The participant must describe herself as a lesbian consistent with the following definition: "a woman who experiences the human need for warmth, affection, and love from other women. Sometimes this includes sexual contact" (Child Welfare, 2006, p. 112).
3. The participant must meet criteria for abuse per the following selection criteria:
    a. The participant must have had an unwanted sexual experience with someone before the age of 14 years (Russell, 1983) or
    b. Completed or attempted rape from the age of 14 to 17 years (Russell, 1983) with someone 5 or more years older than the participant (Balsam et al., 2005). Note that "sexual experiences" range from touching or attempts at touching of breasts or genitals to rape on at least one occasion (Russell).
4. The participant must answer 5 or above on the following question; "on a scale of 1 to 10, one meaning "I haven't worked through my childhood sexual abuse at all" and 10 meaning "I have completely worked through my childhood sexual abuse," where would you place yourself on this scale?" Note: the term "worked through" will be defined by the participant.
5. The participant must have a history of attending a self-described history of counseling and / or psychotherapy by a licensed psychotherapist.

6. The participant must answer “I agree” to the following statements.
    a. I have the ability to maintain stable relationships.
    b. I have the ability to pursue and maintain career, volunteer, or leisure interests.
    c. I feel relatively content with myself and my current life situation.
    d. I believe that my life has meaning.
7. The participant must answer negative to the following questions within the last 6 months.
    a. Do you feel you should cut down on your drinking or drug use?
    b. Have people annoyed you by criticizing your drinking or drug use?
    c. Do you feel bad or guilty about your drinking or drug use?
    d. Have you ever had a drink or drug first thing in the morning (as an “eyeopener”) to steady your nerves or get rid of a handover?
8. The participant must be willing to travel to my South Tampa office to be interviewed.
9. The participant must be willing to and discuss the abuse and how she overcame it with a researcher while it is recorded and later transcribed.
10. The participant must be willing to be contacted at a later date for member checks.

Appendix B: Flyer to Solicit Participants for Study

We are conducting research on

LESBIAN SEXUAL ABUSE

AND THE EFFECTS ON ADULTHOOD

and we need your help.

We are looking for lesbian volunteers to be interviewed on the effects sexual abuse has had on their lives. This will be confidential and may benefit others who have suffered in the same way. By producing research on the effects of abuse, lesbians' needs can be recognized and met.

Please help.

If you are not a survivor of abuse, please give this to a friend.

All information is confidential. You will be screened over the phone.

Benefits of participation include furthering research in the area of lesbian sexual abuse therefore helping other survivors.

Note: This research is being conducted through the University of South Florida and has been approved through the Institutional Review Board #106307

Contact

Amy Menna

Licensed Mental Health Counselor / Researcher

813-766-8510

Appendix C: Phone Screening Interview

"I appreciate you taking the time to contact me and for your interest in the study.

How did you hear about the study?

There are a few things I want to tell you before we begin. This is a study for my doctoral dissertation in Counselor Education at the University of South Florida. I became interested in this type of research because I am a lesbian. I am in the community and believe that there needs to be more research and services for our population. I have also worked with many women who have been survivors of childhood sexual abuse.

To ensure confidentiality, please think of a pseudonym to use for the study. Although I will need your signature for a consent form prior to the study, your real name will not be used.

You would need to travel to my south Tampa office for this study. This is to ensure that the interview conditions for all participants will be consistent.

You may experience some discomfort during the interview because we will be talking about childhood sexual abuse. This would be a normal reaction.

Now I would like to ask you some basic questions about yourself if that is OK?

1. Could you tell me your age, your occupation, and your level of education?

2. What is your ethnicity?

I realize that this may be difficult, but I need to ask a few questions to see if you meet the inclusion criteria for the study. I would like to ask you some questions about your sexuality and your sexual abuse history if that is OK?

1. Are you lesbian or bisexual?

4. For how long have you considered yourself to be a lesbian, and for how long have you been out?

5. What does being a lesbian mean to you?

These next questions are specifically about childhood sexual abuse.

1. Did you experience any unwanted touching or attempts at touching your breasts or genitals before you were 14?

2. Did you experience any forced sexual relations before you were 14?

3. Did you have this experience between the ages of 14 and 17?

4. Was the person or persons who did this 5 or more years older than you?

5. As an adult, have you had any other sexual assault experiences?

6. On a scale of 1 to 10, one meaning "I haven't worked through my childhood sexual abuse at all" and 10 meaning "I have completely worked through my childhood sexual abuse," where would you place yourself on this scale? I understand that "working through" means

different things to different people. For the purpose of this question, use your own definition.

7. What does that number mean to you?

8. Have you had counseling with a licensed clinician to address your childhood sexual abuse or issues related to this?

9. Did you find counseling helpful, unhelpful, or both?

10. How helpful or unhelpful did you find counseling in dealing with your abuse issues either directly or indirectly?

I would now like to ask you four questions about your life right now. Please say whether you agree with the following statements or disagree with them.

a. I have the ability to maintain stable relationships.
b. I have the ability to pursue and maintain career, volunteer, or leisure interests.
c. I feel relatively content with myself and my current life situation.
d. I believe that my life has meaning.

This is to determine your level of alcohol and drug usage. Please say whether you have or have not experienced the following within the last 6 months.

a. Do you feel you should cut down on your drinking or drug use?

b. Have people annoyed you by criticizing your drinking or drug use?

c. Do you feel bad or guilty about your drinking or drug use?

d. Have you ever had a drink or drug first thing in the morning (as an "eye opener") to steady your nerves or get rid of a hangover?

I have just a few more questions.

1. Do you feel you would be able to discuss the effects of these experiences with me for research purposes?

2. Would you be willing to meet with me for about 1-2 hours to discuss how you worked through your childhood sexual abuse and then be contacted at a later date to review a transcription of your interview to make sure it is accurate?

3. This discussion will be taped and transcribed for research purposes. Would it be acceptable to you to have your transcripts read by others provided you remained anonymous?

4. What questions do you have about the study at this time?

5. Is there a phone number where I can reach you or a confidential e-mail where I may contact you?

6. May I leave messages there?"

Appendix D: Consent Form

Informed Consent to Participate in Research

Information to Consider Before Taking Part in this Research Study

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Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. This form tells you about this research study.

We are asking you to take part in a research study that is called
"Resiliency in Adult Lesbians with a History of Childhood Sexual Abuse: Implications for Clinical Practice"
The person who is in charge of this research study is Amy Menna**.**
The research will be done at 2504 W Azeele Street, Tampa, Fl 33609.

Purpose of the study

The purpose of this study is to explore resiliency in lesbians who have a history of childhood sexual abuse. You are being asked to discuss what you did to work through your childhood sexual abuse and what was helpful about your counseling experience.

Study Procedures

If you take part in this study, you will be asked to complete an interview which will take up to two hours. In addition, you are being asked to meet with the interviewer again or complete via telephone or email a review of your transcripts and the themes that have emerged from your description. This will take approximately one half hour. Audio taping will occur at all points. The research will be conducted at your convenience, on your schedule.

Alternatives

You have the alternative to choose not to participate in this research study.

Benefits

We don't know if you will get any benefits by taking part in this study.

Risks or Discomfort

Speaking about childhood sexual abuse may provide some psychological discomfort. If you would like to talk more with a professional about past CSA or any discomfort resulting from this interview, Ms. Menna can assist you in finding someone who can help.

Compensation

We will not pay you for the time you volunteer while being in this study.

Confidentiality

We must keep your study records confidential. All data will be protected on a computer that is password protected. Audio recording files will be kept for 3 years then permanently deleted from the hard drive. They will be given to a transcription service who will also maintain confidentiality.

However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

The research team, including the Principal Investigator.

Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.) These include the University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.

Any agency of the federal, state, or local government that regulates this research. This includes the Department of Health and Human Services.

We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are.

Voluntary Participation / Withdrawal

You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study, to please the investigator or the research staff. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.

Questions, concerns, or complaints

If you have any questions, concerns or complaints about this study, call Amy Menna at 813-766-8510.

If you have questions about your rights, general questions, complaints, or issues as a person taking part in this study, call the Division of Research Integrity and Compliance of the University of South Florida at (813) 974-9343.

If you experience an adverse event or unanticipated problem call Amy Menna at 813-766-8510.

Consent to Take Part in this Research Study

It is up to you to decide whether you want to take part in this study. If you want to take part, please sign the form, if the following statements are true.

I freely give my consent to take part in this study. I understand that by signing this form I am agreeing to take part in research. I have received a copy of this form to take with me.

_____ _____

Signature of Person Taking Part in Study Date

_____

Printed Name of Person Taking Part in Study

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect.

I hereby certify that when this person signs this form, to the best of my knowledge, he or she understands:

- What the study is about.
- What procedures/interventions/investigational drugs or devices will be used.
- What the potential benefits might be.
- What the known risks might be.

I also certify that he or she does not have any problems that could make it hard to understand what it means to take part in this research. This person speaks the language that was used to explain this research.

This person reads well enough to understand this form or, if not, this person is able to hear and understand when the form is read to him or her.

This person does not have a medical/psychological problem that would compromise comprehension and therefore makes it hard to understand what is being explained and can, therefore, give informed consent.

This person is not taking drugs that may cloud their judgment or make it hard to understand what is being explained and can, therefore, give informed consent.

Signature of Person Obtaining Informed Consent	Date
Printed Name of Person Obtaining Informed Consent	Date

Appendix E: Interview Script

Thank you again for participating in this study. This session will be recorded and transcribed. This transcription will be read by my committee members and an outside auditor. Quotes from this interview will be used in the dissertation, but I want to remind you that your true identity will remain anonymous. I will respect and protect your confidentiality.

Please let me know if at any time the interview becomes too uncomfortable. We can either take a break or terminate the interview if necessary. I would like to give you a moment to read a consent form that you will need to sign in order for me to continue with the interview. If you have difficulty reading it, please let me know, I can read it to you. [I will then give them the consent form, review it and have them sign it.]

37. Do you have any questions about the consent form?
38. Having read the consent form, do you still agree to be a part of the study?
39. I would now like to start taping, is that ok with you?

I would like to start with some basic questions if you are ready to begin [I will then attend to any needs they have prior to starting the study]

40. Are you currently in a relationship and if yes, for how long?

41. On a scale of 1 to 10 with 10 being the most satisfied, how satisfied are you in your current relationship?
42. What does that number mean to you?
43. Do you have any children? If so, what are the ages?
44. On the same scale, how satisfied are you with your relationship with your children?
45. What does that number mean to you?
46. You mentioned during the phone interview that you were had been in therapy at one point with a licensed clinician, are you currently in therapy?
47. If so, for how long [Probing question]
48. What is your current occupation?
49. How long have you been_____?
50. Same scale 1-10, how satisfied are you in your current profession or school?
51. What does that number mean to you?
52. 1-10, how satisfied are you currently in regard to your friendships?
53. What does that number mean to you?
54. 1-10, how satisfied are you with yourself?
55. What does that number mean to you?
56. 1-10, how satisfied are you with your current life overall?
57. What does that number mean to you?

58. During the phone interview you stated that you had experienced childhood sexual abuse. I would like to ask a few questions about that. Can you tell me what happened?
59. What was your relationship to the person who committed this act? [Probing question]
60. How often did this happen to you? [Probing question]
61. Who did you ever tell about this experience?
62. Who have you spoken with about the abuse since then?
63. How are you feeling right now? [At this time I would attend to any needs that they would have]
64. When you think about your life now, what specifically has helped you work through your abuse?
65. In what ways did ____ help you work through this? [Probing question]
66. You mentioned that you were in counseling, what about counseling was helpful in you working through your abuse?
67. Were there any aspects of counseling that were not helpful?
68. What about _____ was not helpful? [Probing question]
69. Were there any barriers to getting counseling and if so, what were they?
70. What things do you do currently to cope with problems?
71. What advice would you give to someone who is working through their childhood sexual abuse issues?

72. How are you feeling right now?

That's all the questions I have for you at this time. Here is my email address, if within one week you decide that you would like to add anything to the interview, please do not hesitate to email me additional information [Card with email address will be handed to the participant]

What questions do you have for me?

I will have to send you the transcripts of this interview. What is the best way to get them to you?

From here, someone will contact you to follow up on this interview. She will be a Licensed Mental Health Counselor. Here is her number, as well as the crisis line and a local emergency room. This Licensed Mental Health Counselor too will protect your confidentiality. I want you to know that there are resources available to you if you need further assistance. I appreciate your time. Thank you for contributing to this research. May I have a number where she may contact you?

Appendix F: Participant Phone Debriefing

"It's not unusual after discussing such topics to have a resurgence of symptoms, and you may have experienced some discomfort during the interview. This is normal. In the event that you have extreme levels of discomfort, please go to your doctor, counselor, the emergency room or the nearest hospital and then call me. Otherwise, please consider a referral to a therapist. I can help you with that.

6. How are you feeling after the interview?
7. To what extent did you experience any significant discomfort?
8. Do you think you have an adequate support network that you can reach out to if needed?
9. Do you currently have a therapist?
10. Is there any way I can be of assistance to you right now?

In the event that you need any further assistance, please do not hesitate to call."

Appendix G: Pilot Test Interview Script

"Thank you for participating in the research project 'Resiliency in Lesbians with a History of Childhood Sexual Abuse: Implications for Clinical Practice.' I appreciate your willingness to be a part of this important project. I will be asking you a series of questions to be used as a pilot study. I am interested in your feedback on these questions. If you do not understand any of these questions or think that any of these questions could be asked in a better way, please stop me and give me that feedback. Do not hesitate to stop me if there is something that you do not understand. Please answer the questions from your own experience. Do you have any questions at this time?"

Appendix H: Clarification of Researcher Bias

1. What biases do you think that you have in going in to this dissertation?

2. Do you think that you have any prejudices against any of the parties involved in this research?

3. What is your experience with this population?

4. Why did you choose this dissertation topic?

Appendix I: Peer Debriefing Questions

1. How do you feel after the interview?
2. What are some thoughts that you have on the interview?
3. Did you notice anything unusual about the interview?
4. Did you feel you lost any objectivity during the interview?
5. Is there anything else you want to say about this interview?

Appendix J: Follow-up Email to participants

"Dear Pseudonym,

Thank you for participating in my research project. I appreciated the time you took to answer my questions and provide detailed information as to your resilience surrounding your childhood sexual abuse. I wanted to remind you that you may email me within one week if you feel you need to add anything to your interview. You may email me as many times as you would like.

From here, your audio tape will be transcribed and I will review it. I will email [or send it, or hand deliver it] to you per our agreement so that you can review it for accuracy. This should be done within one month.

Thank you again for your participation. Please do not hesitate to contact me with any questions you have.

Sincerely,

Amy Menna"

Appendix K: Clarification of Researcher Bias Transcripts

AMY: Clarification of researcher bias.

FEMALE: Okay, Amy. What bias do you think that you have going into this dissertation?

AMY: I think that women are resilient and that lesbians in particular are resilient because they have overcome specific oppression in their identity, with their identity. I think that my biases would be that towards lesbians in particular being resilient women in seeing their strengths instead of their weaknesses.

FEMALE: So you tend to focus on their strengths, not their weaknesses.

AMY: Yes. I just tend to focus on their strengths rather than their weaknesses.

FEMALE: Is there anything else you want to tell me about your biases going into this dissertation?

AMY: Not that I can think of right now.

FEMALE: Okay. Do you think that you have any prejudices against any of the parties involved in this research?

AMY: I don't believe I do.

FEMALE: Okay. What is your experience with this population?

AMY: Well, I am a lesbian. I've been out for 12 years.

FEMALE: And how old are you?

AMY: I am 32 years old, so I've been involved in the community. So I have experience with the lesbian community. I've also worked with sexual abuse survivors as I am a licensed mental health counselor and a certified addictions professional. I worked with women in particular at the Center for Women and worked with a great

deal of women surviving sexual trauma in their childhood. Then I worked in the trauma track at another facility, again, specifically with women, many of which survived sexual trauma.

FEMALE: Okay. You said that you were involved in the community. How are you involved in the community?

AMY: Gosh, I don't know how to answer that. At times, I've been more involved in the community. I've been to specific events that are community-specific, such as the Gay and Lesbian Film Festival. I've been to Human Rights Campaign advocate or the Human Rights Campaign sponsored events. As of right now, I would say I'm less involved in the community simply because of my doctoral program.

FEMALE: Okay. Why did you choose this dissertation topic?

AMY: I chose this dissertation topic because my focus has always been on trauma, and I wanted to specifically do something with sexual abuse. When I decided to do lesbians, it was the result of seeing them as an under researched population. I felt that there needs to be more research specifically in sexual abuse and lesbians. Initially, I was going to look at the long-term effects of lesbians and childhood sexual abuse; however, the literature speaks to that. So I looked at resiliency, because that's what I was really interested in, the strength that people find in overcoming trauma and

sexual abuse. So that's how I chose resiliency. And it just made sense to look at resiliency in these women who are overcoming trauma and sexual abuse.

FEMALE: Okay. Is there anything else you'd like to add?

AMY: I don't think so.

FEMALE: Okay. Thank you.

Appendix L: Phone Screening Field Notes

Date: 11/1/07
Name: Emily

Demographics
How they heard about the study: Prosuzy
Age: 38
Occupation: Dental Assistant
Level of education: Some college
Ethnicity: Caucasian

Sexuality
Lesbian or bisexual: Lesbian
How long they've considered themselves to be lesbian: Acknowledged it at 12
How long they've been out: Out since age 28, 10 years
Being a lesbian mean to you: I like the same sex. Enjoy company whether it's intimacy or platonic. Diverse…(no more notes).

Childhood Sexual Abuse
Unwanted touching or attempts at touching of breasts or genitals before 14: Yes
Forced sexual relations before 14: Yes
Experience forced sex relations between the ages of 14 and 17: Yes
Five year age difference: Yes
Other adult sexual assault experiences: No

Resiliency
Scale of 1 to 10 surrounding working through the abuse: 8.5-9
What number means: No notes
Had counseling: Yes
Counseling helpful, unhelpful, or both: Extremely helpful
How helpful or unhelpful find counseling: Extremely
Ability to maintain stable relationships: Agree
Ability to pursue and maintain career, volunteer, or leisure interests: Agree
Feel relatively content with self and current life situation: Agree
Believe that my life has meaning: Agree

Drinking or Drug Use
Cut down on drinking or drug use: No
Annoyed criticizing drinking or drug use: No
Feel bad or guilty about drinking or drug use: No
Had a drink or drug first thing in the morning: No

Emily
Page 2
Logistics
Discuss the effects of these experiences for research purposes: Yes - absolutely
Meet with me for 1-2 hours: Yes
Contacted at a later date to review a transcription: Yes
Acceptable to have transcriptions read: Yes
Questions about the study: Answered all of them
Feels the need to give to others
Really wants to help someone else
"I believe I'm a success story."
Have plenty more to learn
I have the tools to learn now

Phone Screening Field Notes

Date: 11-15-07
Name: Betsy

Demographics
How they heard about the study: Prosuzy
Age: 55
Occupation: ER Doc, Physician
Level of education: Medical degree
Ethnicity: Caucasian
After this question, participant went on about PTSD and Inderal
Read EKG's – Inderal made it better
Used in veterans
Use for a short period of time for long term effects
"No longer duck effects"

Sexuality
Lesbian or bisexual: Lesbian
How long they've considered themselves to be lesbian: 30 years
How long they've been out: Told mother within 4-5
25 years
Being a lesbian mean to you? I emotionally bond with women in terms of long term relationships. Pairs better with women than with men.

Childhood Sexual Abuse
Unwanted touching or attempts at touching of breasts or genitals before 14: Yes
Forced sexual relations before 14: Yes
Experience forced sex relations between the ages of 14 and 17: No
Five year age difference: Yes
Other adult sexual assault experiences: No

Resiliency
Scale of 1 to 10 surrounding working through the abuse: 9
What number means: I still see myself as a victim but I've moved on.
Had counseling: Yes
Counseling helpful, unhelpful, or both: Some helpful, some unhelpful
How helpful or unhelpful find counseling: Just got me to where I could talk about it. Until she was 26, she never thought about it. Didn't even come into her conscious mind. They 1st year of med school, went to a wedding with her stepfather.
Ability to maintain stable relationships: Agree
Ability to pursue and maintain career, volunteer, or leisure interests: Agree

Feel relatively content with self and current life situation: Agree
Believe that my life has meaning. Agree
Drinking or Drug Use
Cut down on drinking or drug use: No
Annoyed criticizing drinking or drug use: No
Feel bad or guilty about drinking or drug use: No
Had a drink or drug first thing in the morning: No

Logistics
Discuss the effects of these experiences for research purposes: Yes
Meet with me for 1-2 hours: Yes
Contacted at a later date to review a transcription: Yes
Acceptable to have transcriptions read: Yes
Questions about the study: Participant had no questions at this time

Phone Screening Field Notes

Date: 11-15-07
Name: Anna

Demographics
How they heard about the study: Prosuzy
Age: 31
Occupation: Real Estate Broker
Level of education: BA degree
Ethnicity: Caucasian

Sexuality
Lesbian or bisexual: Lesbian
How long they've considered themselves to be lesbian: Admitted to self 11 years ago
How long they've been out: 11 Years
Being a lesbian mean to you: That I find more intimate and emotional comfort with a woman than with a man.

Childhood Sexual Abuse
Unwanted touching or attempts at touching of breasts or genitals before 14: Yes
Forced sexual relations before 14: Yes
Experience forced sex relations between the ages of 14 and 17: Yes
Five year age difference: Yes
Other adult sexual assault experiences: No

Resiliency
Scale of 1 to 10 surrounding working through the abuse: "I'll be cocky and give myself a 10 although my therapist may think [otherwise]."
What number means: On my own, coped to the point of forgiveness.
Help others to regain their power.
Not disgusted by men anymore.
It's just a part of her life now.
Had counseling: Yes
Counseling helpful, unhelpful, or both: Unhelpful
How helpful or unhelpful find counseling: She hit on me, that's how it ended. Participant chuckled when she said this. Mentioned that she had had other counseling experiences. Had a another therapist who she really likes. Refers a lot of clients to her.
Ability to maintain stable relationships: Agree
Ability to pursue and maintain career, volunteer, or leisure interests: Agree
Feel relatively content with self and current life situation: Agree
Believe that my life has meaning: Agree

Drinking or Drug Use
Cut down on drinking or drug use: No
Annoyed criticizing drinking or drug use: No
Feel bad or guilty about drinking or drug use: No
Had a drink or drug first thing in the morning: No

Logistics
Discuss the effects of these experiences for research purposes: Yes
Meet with me for 1-2 hours: Yes
Contacted at a later date to review a transcription: Yes
Acceptable to have transcriptions read: Yes
Questions about the study: Was curious about the results. No other questions.

Phone Screening Field Notes

Date: 11-19-07
Name: Lila

Demographics
How they heard about the study: Prosuzy
Age: 38
Occupation: Office administrative assistant mgr for construction co.
Level of education: GED
Ethnicity: American

Sexuality
Lesbian or bisexual: Lesbian
How long they've considered themselves to be lesbian: Married 2 years. Came out with partner 9 years ago. So 9 years.
How long they've been out: 9 Years
Being a lesbian mean to you: I love to be with women. Love the sensitivity an involvement with a woman. Like the emotional connection. Better.

Childhood Sexual Abuse
Unwanted touching or attempts at touching of breasts or genitals before 14: Yes
Forced sexual relations before 14: Yes
Experience forced sex relations between the ages of 14 and 17: Yes
Five year age difference: Yes
Other adult sexual assault experiences: no

Resiliency
Scale of 1 to 10 surrounding working through the abuse: 8-9
What number means: I've made it through – I think I deal with it pretty well. I don't think anyone's ever totally worked through this.
Had counseling: Yes
Counseling helpful, unhelpful, or both: Both
How helpful or unhelpful find counseling: Depending on when I went. Some experiences were – some counselors wanted me to dwell on my past.
Ability to maintain stable relationships: Agree
Ability to pursue and maintain career, volunteer, or leisure interests: Agree
Feel relatively content with self and current life situation: Agree
Believe that my life has meaning: Agree

Drinking or Drug Use
Cut down on drinking or drug use: No
Annoyed criticizing drinking or drug use: No
Feel bad or guilty about drinking or drug use: No
Had a drink or drug first thing in the morning: No

Logistics
Discuss the effects of these experiences for research purposes: Yes
Meet with me for 1-2 hours: Yes
Contacted at a later date to review a transcription: Yes
Acceptable to have transcriptions read: Yes
Questions about the study: None. There was discussion on how it would be good for her to do this. Her boss is supportive. Discussed logistics of meeting.

Appendix M: Interview Field Notes

Field Notes
Name: Anna
Date: 11/19/07
Page 1

73. Do you have any questions about the consent form?
    a. No
74. Having read the consent form, do you still agree to be a part of the study?
    a. Yes
75. I would now like to start taping, is that ok with you?
    a. Yes
76. Are you currently in a relationship and if yes, for how long?
    a. Yes
    b. 5 Years
77. On a scale of 1 to 10 with 10 being the most satisfied, how satisfied are you in your current relationship?
    a. 10
78. What does that number mean to you?
    a. Found my soul mate
    b. She compliments my weaknesses
    c. Smiling
79. Do you have any children? If so, what are the ages?
    a. Unfortunately no
80. On the same scale, how satisfied are you with your relationship with your children?
    a. N/A
81. What does that number mean to you?
    a. N/A
82. You mentioned during the phone interview that you were had been in therapy at one point with a licensed clinician, are you currently in therapy?
    a. No
83. If so, for how long?
    a. N/A
84. What is your current occupation?
    a. Real estate broker
85. How long have you been a real estate broker?
    a. 7 years
86. Same scale 1-10, how satisfied are you in your current profession or school?
    a. 10

Field Notes
Anna

87. Page 2 What does that number mean to you?
    a. Love my career
    b. Find joy in my job
88. 1-10, how satisfied are you currently in regard to your friendships?
    a. 10
89. What does that number mean to you?
    a. Can trust them
    b. Can count on all of them
    c. Count the…
    d. Highest truth
90. 1-10, how satisfied are you with yourself?
    a. 10
91. What does that number mean to you?
    a. Proud of who I am despite difficulties life may bring me
    b. Find the good in every situation
92. 1-10, how satisfied are you with your current life overall?
    a. 9
93. What does that number mean to you?
    a. On track with goals
    b. Do everything with the highest integrity and ethics
94. During the phone interview you stated that you had experienced childhood sexual abuse. I would like to ask a few questions about that. Can you tell me what happened?
    a. 3 Different instances
    b. Father
        i. Don't know when it started – maybe 2&5
        ii. 17019 did research
        iii. Blocked out memories
        iv. Ended between 12-13
    c. Father's military best friend (3rd grade)
    d. 17- virginity taken by ex fiancé
95. What was your relationship to the person who committed this act?
    a. No notes
96. How often did this happen to you?
    a. No notes
97. Who did you ever tell about this experience?
    a. 12 – Best friend – Asked her to go to the school counselor
    b. Had to give her name up
    c. Wanted options – counselor told mom
    d. Took brother out of the house
    e. Required DCF therapy
    f. Father influenced her to tell them that it was a dream and that she could sleep with a knife under her bed

98. Who have you spoken with about the abuse since then?
    a. Family and friends
    b. Mom
    c. Brother who died
    d. Therapist at 21
    e. Brother died of a drug overdose
99. How are you feeling right now?
    a. Cold fingers
    b. Not physical
    c. Nervous?
100. When you think about your life now, what specifically has helped you work through your abuse?
    a. Reading
    b. True stories
    c. Realizing damage
    d. Didn't want to end up like that
    e. Don't want to be a victim
    f. Typical stages
    g. Cutter
    h. Different people who had been abused
    i. Poetry and drawings had expressed what I was feeling. Helped me see what I had felt like.
    j. Survivor workbook – bored with it.
    k. Thinking everything through
    l. Stop being angry
    m. Stop looking for excuses to be angry
    n. Becoming a stronger person
    o. Fiction / hope
    p. Meeting other people who had been through it
    q. Understand passing on the legacy – dad was abused
    r. Let go of anger – remove self
    s. Got out of the country
101. In what ways did ____ help you work through this?
    a. No notes
102. You mentioned that you were in counseling, what about counseling was helpful in you working through your abuse?
    a. Reiterated that I was taking the right steps
    b. Sounding board
    c. Check transcripts
    d. Learning to trust
    e. Being objective
    f. Once removed kind of relationship

103. Were there any aspects of counseling that were not helpful?
    a. Poor boundaries – wanted to refer her out
    b. "Couldn't keep her professionalism in tact."
    c. Ended up not going back to therapy for a long time.
    d. Kept telling her she was mad at her mother.
104. What about _____ was not helpful?
    a. No notes
105. Were there any barriers to getting counseling and if so, what were they?
    a. Don't have health insurance
    b. Private paid – didn't want big brother to know I was going to therapy
    c. Financial
    d. Finding someone
    e. Don't know how to interview someone
    f. Need to do consultation
    g. BACK TO WHAT HAPPENED
        i. Moved out of house when I was 15
        ii. Found a man in (Country) – was my way out
        iii. Took my virginity
106. What things do you do currently to cope with problems?
    a. Delay reaction
    b. Remove self-Think about different perspectives
    c. No emotional reaction
    d. Now it comes naturally
    e. Listen- don't interrupt
    f. Don't have high expectations – make them realistic
    g. Expect truth from anyone
    h. Girlfriend – nudists in the home
    i. Release taboos
    j. Taboos – that's when they get difficult
    k. Talk about sex with everyone
    l. Talking about things that are taboo
107. What advice would you give to someone who is working through their childhood sexual abuse issues?
    a. Don't hold onto the anger, shame, and d…
    b. Give up control of life and entity to someone else
    c. Release control
    d. Take it back
    e. Make self more powerful
    f. Historical outlook -Understand the history of the abuser

i. Always forget how much we are progressed
ii. Think about their timeframe and gain understanding
iii. F did not admit to it but he said I'm sorry
iv. It's between you and God now
v. Forgiveness

g. Don't hope for…
h. Closure within themselves

108. How are you feeling right now?
   a. Feel like I'm forgetting or missing something
   b. Know that it's detrimental for people
   c. Finger
   d. Nervous
109. What questions do you have for me?
   a. No notes
110. I will have to send you the transcripts of this interview. What is the best way to get them to you?
   a. Email
111. Additional notes:
   a. Discussion off tape about confidentiality and email
   b. Appreciative

112. Do you have any questions about the consent form?
    a. No
113. Having read the consent form, do you still agree to be a part of the study?
    a. yes
114. I would now like to start taping, is that ok with you?
    a. No notes
115. Are you currently in a relationship and if yes, for how long?
    a. Yes, 19 years
116. On a scale of 1 to 10 with 10 being the most satisfied, how satisfied are you in your current relationship?
    a. 9
117. What does that number mean to you?
    a. There's always room for improvement but it's pretty damn good
118. Do you have any children? If so, what are the ages?
    a. No
119. On the same scale, how satisfied are you with your relationship with your children?
    a. N/A
120. What does that number mean to you?
    a. N/A
121. You mentioned during the phone interview that you were had been in therapy at one point with a licensed clinician, are you currently in therapy?
    a. No
122. If so, for how long?
    a. N/A
123. What is your current occupation?
    a. Board certified ER
    b. Since 1982 physician
    c. 1988 ER
124. How long have you been a physician?
    a. See above notes
125. Same scale 1-10, how satisfied are you in your current profession or school?
    a. No notes
126. What does that number mean to you?
    a. No notes

Field Notes
Betsy

127. Page 21-10, how satisfied are you currently in regard to your friendships?
    a. 9
128. What does that number mean to you?
    a. I wouldn't mind a few more
    b. Ones I have are good
129. 1-10, how satisfied are you with yourself?
    a. 7-8
130. What does that number mean to you?
    a. Waffling around in life
    b. Will gain direction
131. 1-10, how satisfied are you with your current life overall?
    a. 9
132. What does that number mean to you?
    a. I'm just damn lucky
133. During the phone interview you stated that you had experienced childhood sexual abuse. I would like to ask a few questions about that. Can you tell me what happened?
    a. M remarried 10-11
    b. From 11-14 intermittedly abused by step father
134. What was your relationship to the person who committed this act?
    a. No notes
135. How often did this happen to you?
    a. Sporadic – depended on what job mom had
        i. Late night jobs
    b. Never happened when she was there
    c. Took me a few years to figure out how not to be vulnerable
136. Who did you ever tell about this experience?
    a. No one until 26-27
137. Who have you spoken with about the abuse since then?
    a. 26-27 Night terrors – falling asleep in class
        i. Told faculty advisor
        ii. Counselor
        iii. Talked about it at school
        iv. Started women's group – vague terms
    b. Visceral responses
    c. Counseling in Navy
    d. Would see rape victims
    e. Would have night terrors
138. How are you feeling right now?
    a. Fine

139. When you think about your life now, what specifically has helped you work through your abuse?
    a. Being pushed in to confronting it
    b. Being in relationships where partners dealt with it very matter of factly
        i. Didn't make me feel sick
        ii. Minimization?
    c. Needed not to feel like a freak
    d. Needed to feel accepted
    e. Inderal – medication
    f. Therapy – helped desensitize me some
    g. Told mother – not helpful
140. In what ways did ____ help you work through this?
    a. No notes
141. You mentioned that you were in counseling, what about counseling was helpful in you working through your abuse?
    a. As I talked about it 0 I became able to talk about it
    b. To talk despite visceral sx
    c. Having big huge pie – nibbling – get to center of problem
    d. Desensitize me
142. Were there any aspects of counseling that were not helpful?
    a. Stirred things up
    b. Have a good week then I'd go into counseling
    c. Never looked forward to counseling
143. What about _____ was not helpful?
    a. No notes
144. Were there any barriers to getting counseling and if so, what were they?
    a. Not really
    b. I was the biggest barrier
        i. Reluctance to deal with it
145. What things do you do currently to cope with problems?
    a. Really am so fortunate now
    b. Spending time helping others – aging problems
    c. Partner who excels in communication
    d. Don't even have argument
146. What advice would you give to someone who is working through their childhood sexual abuse issues?
    a. Counseling is a necessary evil
    b. Supportive partner and friends
    c. Inderal

147. How are you feeling right now?
    a. Fine
148. What questions do you have for me?
    a. No notes
149. I will have to send you the transcripts of this interview. What is the best way to get them to you?
    a. Email
150. Additional notes:
    a. Participant started talking about her abuse at length after the tape stopped
    b. Discussed how difficult a study like this must be yet how helpful the results will be
    c. Just wants to help
    d. Feels comfortable
    e. Relaxed

Field Notes
Name: Emily
Date: 11/30/07

151. Do you have any questions about the consent form?
    a. No
152. Having read the consent form, do you still agree to be a part of the study?
    a. Yes
153. I would now like to start taping, is that ok with you?
    a. Yes
154. Are you currently in a relationship and if yes, for how long?
    a. No
155. On a scale of 1 to 10 with 10 being the most satisfied, how satisfied are you in your current relationship?
    a. N/A
156. What does that number mean to you?
    a. N/A
157. Do you have any children? If so, what are the ages?
    a. N/A
158. On the same scale, how satisfied are you with your relationship with your children?
    a. N/A
159. What does that number mean to you?
    a. N/A
160. You mentioned during the phone interview that you were had been in therapy at one point with a licensed clinician, are you currently in therapy?
    a. No
161. If so, for how long?
    a. N/A
162. What is your current occupation?
    a. Dental assistant
163. How long have you been a dental assistant?
    a. 16 years
164. Same scale 1-10, how satisfied are you in your current profession or school?
    a. 10
165. What does that number mean to you?
    a. I love my job, always have.
166. 1-10, how satisfied are you currently in regard to your friendships?
    a. 9
167. What does that number mean to you?
    a. Some really good friends

168. 1-10, how satisfied are you with yourself?
    a. 10

169. What does that number mean to you?
    a. I'm…

170. 1-10, how satisfied are you with your current life overall?
    a. 9

171. What does that number mean to you?
    a. Pretty good life

172. During the phone interview you stated that you had experienced childhood sexual abuse. I would like to ask a few questions about that. Can you tell me what happened?
    a. Started 6 months old by father
        i. Grandma and mother told her
        ii. Grandfather involved
    b. Lasted until 20
    c. Mainly father

173. What was your relationship to the person who committed this act?
    a. Father and grandfather involved

174. How often did this happen to you?
    a. A lot

175. Who did you ever tell about this experience?
    a. No one until after I got…

176. Who have you spoken with about the abuse since then?
    a. A lot of people
    b. Therapist
    c. Didn't seam real
    d. Grandma and aunt validated it
    e. Talk about it helps someone
    f. Without giving details
    g. Haven't hidden it
    h. Laughing

177. How are you feeling right now?
    a. Fine

178. When you think about your life now, what specifically has helped you work through your abuse?
    a. Therapy – talk
    b. Alcohol and drug treatment – flashbacks
    c. Sexual trauma unit
    d. Anorexic – control
    e. River Oaks

f. DID – therapist who was a specialist
g. Paul- male therapist
h. Insider
i. Don't rely on dissociation
j. Cognitive recall
k. 10 years of therapy
l. Working and believing
m. Art
n. Writing was dangerous – won't do it
o. Self talk
p. Positive Affirmations
q. Internet – find other people like me
r. Healing hopes – chat room
    i. Connection with others
    ii. Understood what it was like to be like me
s. Discovery who I was

179. In what ways did ____ help you work through this?
    a. No notes
180. You mentioned that you were in counseling, what about counseling was helpful in you working through your abuse?
    a. Safe place
    b. Spew out stiff
    c. Not making sense
    d. No judgment
    e. Listening and offer tools or suggestions
    f. Staying in contact when I didn't need it
    g. Included ex husband at the time
    h. Knew what I…
    i. Know – place I could go
    j. Dump and leave and not have to worry about it
    k. No carry with me
181. Were there any aspects of counseling that were not helpful?
    a. Push therapist to tell her to write
    b. Dredging up memories
        i. Necessary but part of it
        ii. Feel the fear and do it anyway
    c. Bad
        i. Boundary issues
        ii. Personal life expressed
        iii. Also been diagnosed with DID
        iv. Not made enough progress about it
        v. Ok about it

vi. Kept raising her prices
vii. Boundaries

182. What about _____ was not helpful?
    a. No notes
183. Were there any barriers to getting counseling and if so, what were they?
    a. Finances – money
    b. Paul went above and beyond
    c. Given a break
184. What things do you do currently to cope with problems?
    a. 3 day rule
    b. 3 days to think, discover, and entertain it, then solution
    c. Talk to friends
    d. Mother
    e. Self
    f. Go deep
    g. Find solution
    h. Be kind to self
    i. Hot showers, baths
    j. Alone
    k. Self-care
    l. Take care of me
    m. Laughing
185. What advice would you give to someone who is working through their childhood sexual abuse issues?
    a. Laugh
    b. Joke
    c. Believe in self
    d. No one is to blame
    e. People cause
    f. People give you what they have
    g. If my parents weren't given…
    h. Their parents abused them
    i. Understand parents
    j. Place blame
    k. No excuses
    l. Don't waste time blaming
    m. You have choices
    n. You're in the present
    o. You can change yourself
    p. People are worth it
    q. Get a therapist

Field Notes

r. Jovial
s. Finding someone who is not involved in your life
t. Common ground
u. Find services – get services – disability
v. You can heal – all comes down to…
w. Got lucky - found a therapist who believed in me
x. Don't stay with a bad therapist

186. How are you feeling right now?
    a. Fine
187. What questions do you have for me?
    a. None
188. I will have to send you the transcripts of this interview. What is the best way to get them to you?
    a. Internet
189. Additional notes:
    a. Learned from relationships
    b. Afraid
    c. Bad and icky inside
    d. Walk through the fear
    e. Not going to let the inside part of me…
    f. Suicide only satisfies the perpetrator
    g. Doesn't want to go to court
    h. Put word out
    i. Don't want to fight about it
    j. That's negative, living is positive
    k. Medication
    l. Fear of regressing
    m. "You can's heal when you're on that much medication."
    n. Rage is in there
    o. Man who tries to hurt me probably won't come out alive
    p. Don't want to kill anyone
    q. TO ADD
        i. Helped others
        ii. Imaging giving trouble going into water
            1. Positive visualization
            2. Imagery
        iii. Letting go of anger
        iv. Books

Field Notes
Name: Lila
Date: 12/1/07

190. Do you have any questions about the consent form?
    a. No
191. Having read the consent form, do you still agree to be a part of the study?
    a. Yes
192. I would now like to start taping, is that ok with you?
    a. Yes
193. Are you currently in a relationship and if yes, for how long?
    a. No
194. On a scale of 1 to 10 with 10 being the most satisfied, how satisfied are you in your current relationship?
    a. N/A
195. What does that number mean to you?
    a. N/A
196. Do you have any children? If so, what are the ages?
    a. Yes
    b. 19
    c. 12
197. On the same scale, how satisfied are you with your relationship with your children?
    a. 5
198. What does that number mean to you?
    a. In between
    b. Oldest 4
    c. Youngest 9
199. You mentioned during the phone interview that you were had been in therapy at one point with a licensed clinician, are you currently in therapy?
    a. No
200. If so, for how long?
    a. N/A
201. What is your current occupation?
    a. Office Manager
202. How long have you been an office manager?
    a. Since 1999
    b. SIDE NOTE - Sitting forward
203. Same scale 1-10, how satisfied are you in your current profession or school?
    a. 8

204. What does that number mean to you?
    a. Very satisfied
    b. Love job
    c. Transitions
205. 1-10, how satisfied are you currently in regard to your friendships?
    a. 8
    b. SIDE NOTE – Pillow on lap
206. What does that number mean to you?
    a. Don't have a lot of friends
    b. Pretty satisfied
207. 1-10, how satisfied are you with yourself?
    a. 7
208. What does that number mean to you?
    a. A lot of things still missing
209. 1-10, how satisfied are you with your current life overall?
    a. 8
210. What does that number mean to you?
    a. Pretty satisfied
211. During the phone interview you stated that you had experienced childhood sexual abuse. I would like to ask a few questions about that. Can you tell me what happened?
    a. Father – don't know how young
    b. Blocked most of it out
    c. Touching on me
    d. Interstate
    e. Mess with me
    f. Come in room
    g. Step mother found out about it
    h. Would tell her to describe it
    i. Turned 15. She said she…
    j. Left home
    k. Dad well known
    l. Passes away in June
    m. Didn't want to be about dad
    n. Any change he got he would do it
    o. Would have to exchange sexual favors for stuff
    p. Court
    q. Different schools
    r. Prosecute father
    s. Dropped charges
    t. People in school were in court

u. Brother and step mom begged her not to do anything
v. Other people in school
w. Youngest of 3

212. What was your relationship to the person who committed this act?
    a. No notes
213. How often did this happen to you?
    a. Quite a bit
214. Who did you ever tell about this experience?
    a. Step mom walked in on it – forgotten something
        i. Beating me with vacuum chord
        ii. Told her
        iii. Scared of dad
        iv. Didn't deserve that
    b. Bus driver
        i. Cops
        ii. Begged them not to take me home
        iii. Went to hospital
        iv. Got checked out
    c. Never told friends or anyone
    d. Bust
    e. Court proceedings
        i. Went bad
        ii. Was in newspaper
        iii. 2 Brothers found out
        iv. Moved in with oldest brother
215. Who have you spoken with about the abuse since then?
    a. Counselors
        i. Chest pain
    b. Seen counselors
    c. Friends – openly
    d. It is what it is
216. How are you feeling right now?
    a. All right
    b. A lot easier now
    c. Sigh of relief
217. When you think about your life now, what specifically has helped you work through your abuse?
    a. Talking about it
    b. Accepting it
    c. Better parent to parent
    d. Don't believe in the statistics

e. Trying to give kids everything I didn't get
f. Counseling

218. In what ways did ____ help you work through this?
    a. No notes
219. You mentioned that you were in counseling, what about counseling was helpful in you working through your abuse?
    a. Talking through it
    b. Never questioned that it was me
    c. Dad preached to her – never "let anyone touch us."
    d. Wasn't raised…
    e. Know it was wrong
    f. Used to pray that things would be different
    g. Not to live in the past
    h. No books were helpful
    i. Book was interesting
    j. Trying to understand
    k. Look at things
    l. Being able to open up
    m. Heard
    n. Knowing it's not inside you
    o. Thoughts in your head
    p. Part of your life
    q. SIDE NOTE – mom killed herself when I was a year old
220. Were there any aspects of counseling that were not helpful?
    a. Make up the past
    b. It'll help with closure
    c. Reality is reality
221. What about _____ was not helpful?
    a. No notes
222. Were there any barriers to getting counseling and if so, what were they?
    a. Started healing – I didn't want to live in the past
    b. Judge me
    c. You could be different if you did this
223. What things do you do currently to cope with problems?
    a. Work a lot
    b. Spend time alone
    c. Friends
    d. Quit answering phone
    e. Not talk to anyone
    f. Not bringing other people down with me
    g. Walks

224. What advice would you give to someone who is working through their childhood sexual abuse issues?
    a. Talk through it
    b. Go to counseling
    c. Know it's not your fault and you couldn't have changed it
225. How are you feeling right now?
    a. Pretty calm
226. What questions do you have for me?
    a. None
227. I will have to send you the transcripts of this interview. What is the best way to get them to you?
    a. Internet
228. Additional notes:
    a. Myth – girlfriend
    b. Planned death but then her dad had a massive heart attack
    c. Bro gay – drugs
    d. Don't do drugs or anything
    e. 19 year old – grandparents spoil – don't want to live by my rules
    f. Brought friend
    g. Step mom wanted her to go back to court against her father

About the Author

Amy Menna received her Bachelor of Arts degree and Master of Arts degree from the University of South Florida. She worked in an outpatient mental health center with children and adolescents affected by abuse and neglect prior to working with low-income, addicted women. She then worked with addicted professionals. Ms. Menna is a writer and active private practitioner in the Tampa Bay community. She has donated time and writing to organizations geared toward helping survivors and has present on the national, state, and local level on counseling related topics. She is committed to the education of counselors and treating the survivor of trauma.