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Women's voices on recovery: A multi-method study of the complexity of recovery from child sexual abuse☆,☆☆

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Abstract

Objective: The current study was exploratory and used multiple methods to examine patterns of stability and change in resilient functioning across 7 years of early adulthood. Second, qualitative data were used to examine in greater detail survivors' own narratives about correlates of healing.
Method: This study was longitudinal and used both structured and open-ended interviews. Eighty women with documented hospital records of child sexual abuse were interviewed at two time points 7 years apart in early adulthood. Structured interviews including investigator-based questions and standardized measures of trauma exposure and functioning were conducted. A subset of 21 survivors participated in in-depth, open-ended interviews about coping with sexual abuse.
Results: Quantitative findings showed patterns of both stability and change on an index of resilient functioning across multiple domains in the 7 years between interviews with 76% of participants showing less than a one standard deviation change in scores. Lower resilience was associated with exposure to additional trauma between the two interviews ($r = -.44$) while positive functioning was related to social role satisfaction and positive sense of community. Qualitative data permitted examination of the dynamic quality of recovery over time including the role of "turning points" across the lifespan.

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Conclusions: The findings extend previous studies of resilience in the examination of how it changes over the course of one segment of the life cycle. This study supports recent work that described resilience as a non-linear process and further highlights factors including the role of re-traumatization, social supports, and opportunities for making new choices that may be important correlates of recovery processes among sexual abuse survivors over time.

Keywords: Child sexual abuse; Resilience; Recovery

Introduction

Merrill, Thomsen, Sinclair, Gold, and Milner (2001) describe "third generation" studies in the field of child maltreatment that go beyond documenting prevalence and direct links between abuse and negative outcomes to a more complex analysis of intervening mediating and moderating processes. One part of this developing area of research focuses on notions of resilience and recovery to understand variability within groups of survivors. While a growing volume of research on this topic has examined samples of children, less attention has focused on adult survivors (Luthar, Cicchetti, & Becker, 2000). This paper uses longitudinal data from a sample of female survivors of child sexual abuse to examine in an exploratory manner aspects of resilience and well-being across the early adult portion of the lifespan.

Defining terms

A central question in this work has to do with definitions and terminology (e.g., Glantz & Sloboda, 1999). Masten, Best, and Garmezy (1990) described three types of resilience, including individuals who exhibit exemplary outcomes after adversity, those who while not exceptional in their functioning show positive development in the context of adversity, and finally those who may initially show negative consequences of trauma but over time recover adaptive functioning. Some researchers have applied these findings to an understanding of adult survivors of trauma (e.g., Bonanno, 2004; Carver, 1998; Harvey, 1996; Poorman, 2002). Palmer (1997, 1999) challenged models of resilience that reflect a more linear pattern of increasing growth across time. Harvey described a model of resilience composed of several stages or types of resilience and using qualitative data showed how individuals may move back and forth between these levels over time. Her work fits with that of Barringer (1992) who described survivors' healing process from child sexual abuse not as linear but "as spiral, as a repeated traversing of the issues, layer by layer, piece by piece, sorting and resorting, until the toxicity of the abusive experiences has been released (p. 15)." Luthar et al. (2000) provided a definition to span such complexity. They stated, "resilience refers to a dynamic process encompassing positive adaptation within the context of significant adversity (Luthar et al., 2000, p. 543)." They further note "that positive adaptation despite exposure to adversity involves a developmental progression, such that new vulnerabilities and/or strengths often emerge with changing life circumstances (p. 544)." An important implication of this is that all elements of resilience are not necessarily captured in childhood but should be examined across the lifespan (Grossman, Cook, Kepkep, & Koenen, 1999; Luthar et al., 2000; Palmer, 1997; Stein, Fonagy, Ferguson, & Wisman, 2000). The current study is grounded in this broad definition while focusing on a sample that exemplifies Masten et al.'s third "recovery" category.

Key findings and remaining questions from resilience research

Studies of resilience examine factors within the individual and at varying levels of context beyond the individual to both measure and explain resilience (e.g., Waller, 2001). For example, Rutter's (1987) classic discussion of resilient children identified four processes that contribute to resilience including those at the intrapersonal level (e.g., self-esteem and cognitive appraisal) and those that involve interactions with the environment such as how opportunities are presented at life turning points (e.g., support to complete high school or resources to reduce other negative events associated with the trauma or adversity). Kaplan (1999) and Waller (2001) review work on children by Garmezy and others that finds resilience promoted by individual factors like cognitive skills as well as interpersonal relationships including the presence of a supportive adult in a child's life and broader community factors such as sense of community and opportunities for involvement in positive and supportive environments and activities. Extending such discussions to work with adult survivors of abuse, Harvey (1996) described the need for more research on survivors who recover outside of traditional psychotherapy to understand their strengths. Grossman, Cook, Kepkep, and Koenen's work (1999) revealed the powerful roles of psychotherapy, spirituality, connections to others, altruism, and employment in resilient functioning among adult survivors of child sexual abuse. Carver (1998) highlighted the need for further study of how variables such as optimism, coping skills, and social support may be related to growth following traumatic events. Other studies show the impact of variables such as coping, social support, and community ties on mental health (e.g., Hobfoll, Jackson, Hobfoll, Pierce, & Young, 2002; Merrill et al., 2001). The purpose of the current study was to continue to examine such ecological protective factors among adults recovering from childhood trauma.

Such ecological models also inform the definition and measurement of recovery and resilience. These models lead to the conceptualization of resilient outcomes in terms of components at the intrapersonal, interpersonal, and broader community levels (e.g., Harvey, 1996; Harvey et al., 2003; Luthar & Cushing, 1999). What follows from this is the need to conceptualize a resilient outcome as a multi-method measure that examines functioning in a number of different domains (e.g., Harvey, 1996; Harvey et al., 2003; Luthar & Cushing, 1999). Luthar and Cushing (1999), for example, review research using composite measures of functioning across several domains.

Future research to examine these questions should also use a multi-method approach in terms of blending qualitative and quantitative tools. For example, discussions of qualitative research have highlighted its utility as a tool for rich descriptions of phenomena. Such detail and texture are useful both for understanding "the 'why' of human behavior" (Banyard & Miller, 1998, p. 498) and for laying the foundation for further quantitative study. Banyard and Miller discuss how qualitative research can complement quantitative findings, helping explore and make sense of more quantitative findings. Given that the majority of research on concepts of resilient functioning has focused on children the rich description offered by qualitative methods and narrative inquiry seemed appropriate for an exploratory understanding of resilience and recovery processes in early adulthood (e.g., Harvey, Mishler, Koenen, & Harney, 2000). Indeed, several qualitative studies of this issue have been recently published and make this point (e.g., DiPalma, 1994; Grossman et al., 1999; Harvey et al., 2000; Morrow & Smith, 1995; Poorman, 2002; Valentine & Feinauer, 1993). Grossman et al. (1999) discuss the limitations of an exclusive reliance on questionnaires and statistics that hide the unique texture of individual lives. They state, "We wanted to give voice to survivors, who have too often been silenced and who have important knowledge to impart to those of us in mental health professions. For these and other reasons, we decided to learn through

interviews (p. 23)." The current study sought to build on this earlier work by combining both quantitative and qualitative findings.

Current study

The current analyses are exploratory and primarily descriptive. Multiple methods are used to examine aspects of resilience and recovery in the lives of female survivors of child sexual abuse (CSA) across 7 years of early adulthood. First, quantitative changes in measures of resilience over time were examined. To what extent did women stay the same, increase, or decrease in functioning in a variety of spheres across 7 years during early adulthood? Next, the role of re-traumatization as an impediment to ongoing resilience and correlates of growth or increased well-being over time were examined. Finally, because resilient processes in adulthood have not been the focus of much research and require further description, qualitative data from a subset of participants was used to examine survivors' own narratives about recovery and healing to learn about key aspects of resilience in women's own words.

Methods

Participants in the quantitative structured interview (longitudinal data)

The participants in the study were women who were interviewed at three time points as part of a longitudinal study (details of the sample including methods of re-contact and retention have been published in detail elsewhere, Banyard, Williams, & Siegel, 2001; Williams, 1994). For the current analyses, data on the child sexual abuse experience come from the wave 1 interview and documented hospital records. These interviews were conduced in 1973–1975 with girls (aged 10 months to 12 years) and their caregivers who had been seen at a large city hospital because of child sexual abuse. The total number of girls interviewed was 206 (56% of victims in this age group treated at the hospital). In 1990, a second wave of the study followed up 136 of these girls (66% of original sample) who were now young women ranging in age from 18 to 31. At wave 2, the mean age of participants was 25.49 (S.D. = .33). Thirty three percent had graduated high school or had an equivalent degree while 15% were employed full time.

In 1997 (wave 3 of the study and 23 years after the initial report of the abuse), 87 of the original 206 girls from the 1970's study were contacted and interviewed. Of these women, 80 had also been interviewed at wave 2 in 1990. These 80 women constituted one sample for the current analyses (i.e., the 80 victims of child sexual abuse who participated in the study in waves 1, 2, and 3). Overall, there were few significant patterns of differences between interviewed and non-interviewed women throughout the study on demographic variables and characteristics of the documented incident of sexual abuse (Banyard et al., 2001).

At wave 3, the mean age of the 80 women was 31.14 (S.D. = 3.34). Mean income from the last month was US$ 1176.91 (S.D. = US$ 916.50). Just over a third (37.5%) reported that they were working at the time of the interview. Eighty-five percent identified their race/ethnicity as African-American. These women reported a mean of 2.82 children (S.D. = 2.63). Fifteen percent also reported having an additional child for whom they were responsible.

For a number of analyses reported in the current paper, 19 women had missing data and thus were unable to be scored on the longitudinal measure of resilience. Therefore, for a section of data analyses

reported here a sub-sample of 61 women were used. Their mean age was 31.07 (S.D. = 3.41), with 36% employed, 84% African-American, and a mean of 3.26 children (S.D. = 2.80).

Qualitative interview participants

Within 2 years of the wave 3 interviews, an additional subset of 21 survivors were re-contacted and participated in more in-depth, open-ended qualitative interviews about life events, coping, recovery, and resilience. Women invited to participate in this qualitative phase of the study included only those who at the time of the wave 3 interview recalled the documented child sexual abuse. Three women who evidenced very severe and long-standing psychological distress at the time of the wave 3 interview were excluded from re-interview at this stage because of concerns that the narrative nature of the study would be overly distressing for these individuals. Interviews were conducted by the authors and co-investigators. The average age for this sub-sample was 31.52 (S.D. = 3.66), 29% graduated high school, 33% were working at the time of the wave 3 interview, the mean income from past month at the wave 3 interview was US$ 1119.57 (S.D. = 622.28) and the mean total number of children was 3.05 (S.D. = 3.69).

Measures

Resilience. In keeping with discussions of resilience as positive functioning across several domains that have been identified in previous literature (e.g., Luthar et al., 2000; Luthar & Cushing, 1999), a "summative" (Luthar & Cushing, p. 144) approach was used to create a measure of resilience. A 13 item resilience scale was created for analyses of life-course correlates of competent functioning at wave 2 of the data collection (Hyman & Williams, 2001) for which a Cronbach's alpha of .65 was reported. Participants were given a score of "0" or "1" for each of the following dimensions: (1) a low total score on the Trauma Symptom Checklist (TSC-40) (Briere & Runtz, 1989) with low scores assigned "1" for resilience (i.e., TSC-40 scores below the sample median at wave 2); (2) a score above the sample median on the self-esteem scale of the Middlesex Hospital questionnaire would be scored "1" (Cronbach's alpha = .84) (Bagley, 1980); (3) no reported history of severe illness or surgery after age 17 would receive a score of "1"; (4) no reported current drug or alcohol use across a series of questions including the MAST scored "1" (Selzer, 1971) and the CAGE (Ewing, 1984; Mayfield, McLeod, & Hall, 1974); (5) a report of friendships with males and few problems with relationships with men (all women identified as heterosexual at wave 2); (6) a score above the sample median on an adapted measure of sexual functioning (e.g., feel awkward in sexual situations, satisfied with sexual partner, have satisfying orgasms, Cronbach's alpha = .74) (Greenwald, Leitenberg, Cado, & Tarren, 1990); (7) a report that all biological children lived with participant; (8) no prior reports to authorities for abuse of her own children; (9) a report of friendships with women; (10) a report of at least a moderate level of social activity (belongs to organization or does social activities at least a few times per year); (11) no self-reported arrests as an adult; (12) income above the sample median; and (13) working full time. Scores ranged from 1 (few areas of resilience) to 11 (resilient across a number of domains), $M = 6.26$, S.D. = 2.15. It should be noted that wave 2 resilience scores for these 61 participants was comparable to the full sample of 80 ($M = 6.33$).

Using wave 3 data, the same resilience index was computed. Due to extensive missing comparable data on questions about relationships with men at wave 3, only 12 items of the original 13-item index could be created at wave 3. Thus, for the current paper, a revised, 12-item index was created for both waves 2 and 3. This index omits the one resilience item about having male friends and reporting no problems in

relationships with men. For this sample 61 women had complete data with scores ranging from 2 to 10, $M = 6.66$, S.D. = 2.15.

Mental health symptoms. Outcomes measured at wave 3 were based on the 100-item Trauma Symptom Inventory (Briere, 1995). This measure has been shown to have good reliability and validity in a representative sample of adults and African-Americans (Briere, 1995) including for this sample of survivors (Banyard et al., 2001). The current study used nine sub-scales: anxious arousal ($M = 11.50$, S.D. = 8.31), depression ($M = 12.11$, S.D. = 9.73), anger ($M = 12.15$, S.D. = 8.90), dissociation ($M = 9.03$, S.D. = 8.22), sexual concerns (dissatisfaction with sexuality, negative thoughts or feelings about sex, shame or problems in sexual relationships) ($M = 8.35$, S.D. = 8.55), dysfunctional sexual behavior (behaviors of a sexual nature that may be problematic including getting into trouble because of sexual behavior, using sex to deal with loneliness, sexual attraction to dangerous persons) ($M = 6.93$, S.D. = 7.77), intrusions ($M = 10.69$, S.D. = 8.80), defensive avoidance ($M = 13.59$, S.D. = 9.08), impaired self reference ($M = 10.30$, S.D. = 8.76). Higher scores indicated a greater number of symptoms. For current analyses, outliers were brought to within 3 standard deviations of the mean.

Additional trauma exposure. Seven questions about traumatic life experiences were adapted from the National Women's Study (Resnick, 1996). Participants were asked if they ever had a serious accident, were attacked with a weapon, were attacked without a weapon, were seriously injured in some other way, saw someone seriously injured or violently killed, had a close friend or family member deliberately killed. Participants were also given space in a final open question to indicate whether they had experienced any other extraordinarily stressful event not listed. Participants received a score of "1" for each yes response. Otherwise, participants received a score of "0" indicating that they did not report this type of trauma. Participants were asked to give the ages at which these experiences had taken place. Using age at time of interviews, calculations were made of trauma exposure between interviews at waves 2 and 3 and a summation of trauma exposure calculated ($M = 1.44$, S.D. = 1.50, range = 0–7) for the total sub-sample of 80 women.

Correlates of resilience and growth over time

A series of questions from the wave 3 interview were used as measures of correlates of resilient functioning.

Optimism and life satisfaction. Participants were asked two questions. The first was a dichotomous question about whether or not they felt hopeful about their future. They were also asked on a four point scale from "very dissatisfied" to "very satisfied" how "in summary, satisfied they are with the quality of their life right now."

Coping. Participants were asked to think about the most important stress they had faced in the past year and to describe what they did to cope with the problem using an open-ended response. Using Holahan and Moos' (1987) typology of coping strategies as a model for context coding, their responses were categorized as yes or no responses to a series of types of coping including, talked to others, let feelings out, tried to do something to deal with the problem, used alcohol or drugs, helped others.

Social connections. Participants were asked a number of questions about their thoughts about current social relationships and asked to rate on four point scales their happiness or satisfaction with these relationships: "how much satisfaction do you get from your current or most recent marriage/living together relationship?" "how satisfied are you with yourself as a parent?" "how satisfied are you with your relationship with your children?" "how satisfied are you with your family life?" "do you feel part of a community?" "do you belong to a religious organization or group?"

Data analysis

Quantitative data were analyzed at both the bivariate and multivariate levels using Pearson correlations and multiple regression analyses.

Qualitative interviews

The sub-set of 21 participants who participated in the more in-depth qualitative interviews were asked a number of open-ended questions about their experiences with CSA, how they coped, and their views of recovery. These interviews were tape recorded with participants' permission and transcribed verbatim.

Methods for approaching the qualitative data followed recommendations by many writers on qualitative analysis (e.g., Creswell, 1998; Maxwell, 1996; Straus & Corbin, 1990; Tutty, Rothery, & Grinnell, 1996). Analysis began with a general review of interview transcripts and the writing of memos about ideas and potential themes by the researchers (Creswell, 1998). Responses to open-ended questions were then open coded by the authors using principles of grounded theory (Straus & Corbin, 1990) to generate coding categories from the sentence and phrase by phrase analysis of words of participants. As outlined by Tutty et al. (1996) first level coding was performed by reading over transcripts and "identifying meaning units (p. 101)" or small chunks of information from the women's own words that seemed related to coping, recovery, and growth. We worked to preserve the language of participants in the naming of codes (e.g., Morrow & Smith, 1995). Using this list, a set of higher order categories of information and themes were identified by comparing and contrasting the codes, a rebuilding of the data described as axial coding by Straus and Corbin (1990). A continuous process of code refinement occurred, what Creswell (1998) describes as "the data analysis spiral (p. 142)." The computer program Atlas Ti was used to facilitate assignment of codes and to assist with sorting sections of each interview assigned a particular code. This also facilitated comparison of different examples of the same code to refine the category and to aid in describing various elements of that particular phenomenon. Maxwell (1996), discusses issues of validity in qualitative research and recommends the use of strategies such as searching for negative cases and disconfirming evidence, done in the current study both individually by the researchers and through discussions together, and triangulation through the use of multiple informants and multiple data sources. He also recommends the use of "rich data (p. 95)" meaning verbatim transcripts of interviews rather than notes taken by researchers and "quasi statistics" to summarize data and examine the relative salience of certain themes or categories. These were done in the current study. Discussion with research team members, documentation of coding processes and triangulation by comparing results to quantitative data from the current study and to findings from other qualitative studies of child abuse survivors also helped to ensure "trustworthiness" of results (Tutty et al., 1996, p. 112).

Table 1
Pearson correlations of resilience scores at wave 2 with wave 3 mental health symptoms ($N = 80$)

Wave 3 outcome	Resilience index wave 2
Re-exposure to trauma	−.29**
Anxiety	−.50***
Depression	−.46***
Dissociation	−.52***
Intrusive experiences	−.52***
Dysfunctional sexual behavior	−.41***
Avoidance	−.40***
Impaired self reference	−.47***
Anger and irritability	−.46***
Sexual concerns	−.48***

** $p < .01$.
*** $p < .001$.

Results

Quantitative findings from prospective study

Resilience as a predictor of functioning. Pearson correlations were used to examine the relationship between resilience scores measured at wave 2 and mental health symptoms self-reported at wave 3 (approximately 7 years later) and reports of re-exposure to trauma between waves 2 and 3 (Table 1). Not surprisingly, higher resilience scores at wave 2 were related to fewer symptoms of a variety of forms of psychological distress and were also a protective factor for less trauma exposure between waves 2 and 3. It should be noted that correlations between wave 2 resilience scores and wave 3 TSI scores were also computed using a revised version of wave 2 scores that did not include the variable reflecting TSC scores. The pattern of results was the same.

To take these analyses a step further, correlations were also computed between wave 2 resilience scores and coping, support, and optimism variables at wave 3 (Table 2). Resilience at wave 2 was related to more adaptive types of coping with stress in the year preceding the wave 3 interview.

Stability of resilience. The next question of interest was to examine the stability of scores on the resilience or well-being index over time from wave 2 to wave 3 of the study. Wave 2 resilience scores were subtracted from wave 3 resilience scores ($M = .33$, S.D. = 2.02). Due to missing data on items on the resilience scale at wave 3 the number of women for these longitudinal analyses is 61. As a more conservative measure of change in resilience scores an examination of the proportion of women who increased or decreased their resilience score by more than one standard deviation (using the S.D. of 2.26 from the wave 2 resilience index) was also performed. One standard deviation was used because 84% of scores fall below it. We felt that using a marker of change that represents the top 16% of change scores would be significantly enough above average to be instructive. Five participants (8.1%) showed a decrease of over one standard deviation. Ten participants (16.3%) showed an increase of more than one standard deviation. Using this measure stability rather than change was the more common pattern among this group of participants (75.6% of the sample). Given that the mean resilience scores for the sample as a whole was between 6

Table 2
Correlations between resilience scores at waves 2 and 3 positive adaptation outcomes ($N = 80$)

Wave 3 outcome	Resilience index wave 2
Coping	
Try to change problem	−.06
Get more information	.28**
Help others	−.03
Rely on family/friends	.24
Acceptance of situation	−.26*
Use alcohol or drugs	−.13
Optimism and satisfaction	
Hopeful about life	−.18
Satisfaction with life	.26*
Social support	
Feel part of community	.15
Belong to religious organization	.29**
Satisfied with self as parent	.33**
Satisfied with rel with children	.24*
Satisfied with family life	.12
Disatisfied with marriage	.06

* $p < .05$.
** $p < .01$.

and 7, most women were functioning somewhere in a middle ground—with positive functioning in about half of the areas measured.

Predictors and correlates of change. We next examined the role of re-traumatization as a factor in resilient functioning. For example, a Pearson correlation of the re-trauma variable with the competent functioning or resilience index at wave 3 was −.44, $p < .001$. A hierarchical regression was also computed. Resilience scores at wave 2 were entered on the first step and re-trauma scores were entered on the second step (Table 3). Even after controlling for wave 2 scores, variance in resilience at wave 3 was significantly explained by exposure to traumatic events between waves 2 and 3.

There were 10 participants whose resilience scores increased by a least one standard deviation between interviews, displaying what might be termed resilient growth. The small sample size of this study prohibits

Table 3
Hierarchical regression of resilient functioning at wave 3 as explained by re-traumatization controlling for resilience at wave 2 ($N = 61$)

	Independent variable			
	B	SEB	Beta	*p*
Step 1: $R^2 = .30$, $p < .001$				
Wave 2 resilience	.56	.11	.54	.001
Step 2: $R^2 = .37$, $p < .001$				
Re-trauma	−.44	.17	−.29	.01

further quantitative analysis of this group. However, case examples in the qualitative data of two women in this group who also participated in the qualitative section of the study reveal interesting details about those who seemed particularly able to improve their functioning over time. Though results of the qualitative data more generally are presented later in this paper, a review of these two women's lives is presented here. Both were mothers of young children who described a number of important recent changes in their lives. A few remarks from their interviews provide more texture to these quantitative findings.

One woman, who we will call Sarah, was not only a survivor of CSA but described growing up in poverty and having had multiple living situations as a child, including being institutionalized for delinquent behavior as an adolescent. A number of recent changes in her life may have contributed to her growth. She stated that she was getting married soon to a man who had more financial means than she has had. She recently moved with him and her children to a new community outside of the inner city where she felt a more positive sense of community and where she felt there were many positive opportunities. She also described a new found connection to spirituality in adulthood as she worked to pass on more positive coping resources to her young child. She told the interviewer how she took things from day to day—she seemed to describe herself as "in process" and seemed comfortable with this:

> "Hmm . . . Opportunities? I haven't had too many opportunities. [chuckles] Um . . . I got a/a better education, I went back to school . . . Um, I did graduate from high school, but after high school I went to um nursing school . . . And when I became a nurse I didn't like being a nurse . . .. so I'm kinda in a phase where I don't know what I wanna do right now . . . I think I'm just happy at where I'm at, until I find out where I wanna be."

In the context of this, however, she reported positive connections with others. For example, she expressed her connection to children, ". . .one thing, I do love to work with is children."

Another woman who was interviewed for the qualitative component of the study was also identified by the quantitative results as being part of this "growth" group. Her history included not only child sexual abuse but also witnessing violence as a child, intimate partner violence and sexual assault as an adult. She did not obtain a high school degree, was physically bullied by a family member, and described herself as having a childhood where she had to be the adult and care for her mother. She described struggling with substance use problems and a history of difficult relationships with men. In the interview, however, she talked about recent positive changes in her life. At the time of the interview, she was in an intimate relationship with a man who was not violent and who respected her and her children. She described feeling safe and comfortable with him, a new feeling in a relationship. She hoped he would become a positive male role model and father figure for her children. One of her children had serious health problems and yet she described the positive steps she took to problem solve and have positive relationships with her children. She described a network of social supports and involvement in the community that she began building for herself. For example, she discussed the importance of helping others,

> "But due to the fact that you're there. You kinda, give her the inspiration to want to do better. You give her the insight of what she should do next. But every now and then, you have to TELL her that what she doin' wrong. Because I don't think she see . . . what she doin' wrong . . ."

She went on to say:

> "So, you know she has her ups and downs. I help her out with her ups and down. I listen to her problems. She listens to mine. You know she gives me advice. But then sometimes I listen to her

advice an' say to her . . . "You should take heed to your own advice. Do you hear what you just said to me? You need/y'know . . . take heed to your own advice."

She also described playing an active role in making changes in her community, "And then one time we had . . . [a] thrift store. Sold clothes. Umm. Bags of clothes for whoever needed it. A dollar every bag of clothes . . . I donated. You know, I helped out . . .. But I go to the meetin's. They say they have a meetin' I go. An' see what it's about. If I can help I help. If I can't, least I came to the meetin."'

Qualitative findings: women's words on recovery. A number of key themes and responses emerged from open-ended interviews with all 21 survivors. It should be noted that the 21 women interviewed represented the full span of resilience and recovery demonstrated by the larger sample. For these 21 participants, scores on the wave 2 resilience measure ranged from one to nine ($M = 5.57$, S.D. = 2.25) and on wave 3 resilience from two to ten ($M = 5.88$, S.D. = 2.66).

Definitions of recovery. The interviews included a specific question about how women would define the term "recovery" and whether they would apply such a term to their experiences. Fourteen women responded to this question. Most frequently, women indicated that recovery was never fully possible or involved an ongoing process (36%) or indicated that recovery involved change (43%). Narratives also included other ideas: acceptance of what happened; making peace within oneself; connections with others; regrouping; talking about one's experiences and feelings; and making links to substance abuse recovery.

This notion of the process of recovery is captured by several women's words. One woman stated, "You're always in a form of recovery because you're always gaining new knowledge about yourself and who you are . . ." Another noted, "I don't think anyone is actually FULLY recovered . . . I think it's a lifelong process in which you just, you might find other ways of being able to deal with it."

While recovery is a process, several participants did note that one can see progress and change toward more positive or resilient functioning. One woman remarked, "I would like to truly believe that I have recovered from that because when I talk about it I don't cry as much as I used to cry . . . my shame or my guilt or blaming is not as much as it used to be." Another stated, ". . . in a way that I don't have those things, feelings, the thoughts in my mind towards those individuals that, you know, I don't have no hatred, no animosity in my heart. I don't feel fearful . . ." Finally, several participants clearly discussed the challenges they have to face and the effort that must be made to achieve such positive outcomes. One woman described, "With recovery there is change. So you have to change a whole lotta things in your life . . . You have to change old behavior, attitudes . . . and you gotta set in your mind that this is what you wanna do . . . y'know, you cut yourself, you doctor it up an' it heals. Y'know sooner or later it's recovered. We're like open wounds . . . y'know, you just have to keep working on yourself to get better. And then, y'know, you can recover." Still another told researchers, ". . . it's getting' better with yourself . . . I think it goes together [with recovery from substance abuse]. The thing is, drug was just a surface, the chemical, you could stop that. But the thing now is dealin' with you and everything that's inside a' you."

These quotes fit well with calls for a process conceptualization of recovery and highlight the importance of ongoing inquiry into how such dynamics unfold over the full span of the life-cycle.

Turning points and lessons learned. Although women were mainly asked in the open-ended interviews to talk about the story of their life and any significant positive and negative experiences, 16 women (76%) included descriptions of what we termed "turning points" in their narratives. This coding category is

similar to what Stein et al. (2000) talked about in terms of "second chances" that can be observed by following individuals facing adversity over time or what Palmer (1997) might describe as shifts from one level of resilience to another. Many women described more than one. These points were usually described as having occurred fairly recently in adulthood and were related to a variety of factors that map well onto ecological models of risk and protective factors for positive adaptation. Interview transcripts were coded for segments of text in which participants described large shifts or changes in how they were leading their lives, places where they were at some sort of crossroads and made significant changes (e.g., Harvey et al., 2000).

One aspect of the qualitative analysis of these responses was to examine all of the turning points mentioned (some participants had more than one) and when they occurred in the life cycle. The timing was variable though most occurred in adulthood. Seven turning points were described as aspects of childhood or adolescence, three in past adulthood. Six occurred in the last 5 years and three participants noted that they felt they were currently in a turning point in their lives.

In collecting these segments of interviews together, we also sought to explore what women described as precipitants or motivating factors that surrounded these points. Several sub-themes emerged including women's relationships with their children and wanting better lives for their children as well as better relationships with their children. Women also talked about the importance of spirituality. Several women also discussed the need to remember the past so as to not return to where she had been. In talking about this, women noted changes within themselves as a key component of turning points. They seemed to describe realizations and changes as a process that did not happen all at once. They also often recognized the importance of external resources including social support and opportunities in the environment. For example, one woman described how following her abuse she engaged in a great deal of acting out behavior as a teen including stealing from her stepmother. She said her stepmother refused to abandon her or think negatively about her and when this love and caring finally sunk in, the participant said she was able to stop stealing and acting out. She stated, "she's [her stepmother] a beautiful person, and if it had not been for her I probably been dead a long time ago. After that, I didn't steal anymore, I stopped." The following examples from participants further illustrate these points:

> "I'm tryin' to break a lot of behaviors, y'know . . . I just boxed myself into a box but I'm not like that anymore. I wanna let myself out. I have to decide what it is I wanna do an' then I have to stick to it. Y'know, it's like, I have to—I have to be about myself . . . I feel empowered . . .. I feel like I'm in a crossroad. Well, not even a crossroad. It's just a line. An' when this line, the success on this line, I'm right in the line. It's like I don't have to travel that far road that I traveled. I'm right there . . . Y'know, it's like I keep repeatin' it an' repeatin' it instead of just getting' over on the other side. But I'm—I don't know what it's gonna take, but I'm just gon' get over the mark."

> "Well, what helped was that for one I got tired of bein' out there, doin' the drugs. Y'know an' I wanted my old self back, I wanted that person who was independent an' strive to reach higher goals and that was number 1. Second one was believin' in God, that he will help me through this. The third was the support of my family 'cause when I told them I was ready they was like, right there by my side."

> "When she said that to me, you know, that she would take my kids it just, somethin', a light just clicked on inside me, you know, you got to leave all this stuff alone, you just, leave it alone tonight . . ."

"So I call myself getting' high or getting' drunk or something like that, you know, to make the pain go away, you know . . .. an' it don't go nowhere. But I mean, when I finish smokin' crack or either smokin' that marijuana or drinkin' that liquor or that beer, once I'm finished all that and you know I mean, that pain is still there . . .. that's how I realized, you know, I can't do drugs to get away with pain . . ." She later adds "it was just that I didn't want no more, I didn't want no more. It was like, it's enough. Enough is enough. I was sick and tired of being sick and tired."

". . . never forget where I came from. 'Cause I can always fall right back into that trap."

"Well, when I realized that, of all that had happened to me, I love myself and that's what made me actually get myself into a program. To get myself back in life, y'know, on the right track. And there's still so much in life that's worth living, living for . . . these things that have happened to me, they were horrible things, but, that I was not the cause of it, but I can do something about it, as far as how it's going to affect me."

Discussion

The current study used multiple methods to examine women's experiences with resilience as adults following a childhood marked by sexual abuse. Quantitative findings showed that resilience was often stable and was protective, associated with reduced risk for such things as re-exposure to trauma. Earlier resilience was also associated with more active and positive later coping and greater life and role satisfaction. Yet change was also possible, with decreased resilience associated with trauma re-exposure and many women in qualitative interviews discussing positive "turning points" in their adult lives that lead to positive growth and change.

The findings of the current study are consistent with previous work that emphasizes resilience as a dynamic process (e.g., Luthar et al., 2000) while extending such conclusions to survivors of adversity in early adulthood. Quantitative findings showed how resilient functioning when examined across multiple spheres in early adulthood can be both stable and dynamic over time. Survivor's own narratives support notions of resilience and recovery as an ongoing process that is not necessarily linear (e.g., Barringer, 1992). This process includes experiences of "turning points" or "second chances" (Stein et al., 2000). Stein et al. (2000) use the case study method to make the case that in childhood significant shifts and changes in functioning can be observed. The current study extends these findings and suggests ways in which life course changes may occur even in samples of chronically stressed adults.

The quantitative findings, while exploratory, do suggest that resilient functioning at one point in time does seem related to decreased risk of re-traumatization and mental health problems later in the life-course. Indeed, in the current study re-tramatization is a risk factor for negative changes in competence and resilience. This finding fits with the growing attention in the trauma and maltreatment fields to understanding re-traumatization in more detail (e.g., Banyard et al., 2001), though most of these studies to date focus on the relationship between re-trauma and negative consequences rather than assessing its impact on indices of competent functioning.

The current study supports theoretical discussions and previous empirical findings about correlates of growth and adaptation post-trauma (e.g., Carver, 1998; Grossman et al., 1999) as in the qualitative interviews women often described relationships with others as sources of motivation for creating change in their lives. This finding fits with work by Hobfoll et al. (2002) on the protective role of "communal

mastery," a sense of competence and efficacy achieved through shared connections with others in their community. The words of the women also reveal their active efforts to create change in their lives over time. Women show their attempts to learn from their experiences across the lifespan and thus reveal the many contexts in which women are active learners (Hayes & Flannery, 2000). It is notable that in this sample, many of the turning points reflected women's struggles with substance use issues. The links between trauma and substance use are becoming increasingly well documented (e.g., Newmann & Sallmann, 2004) and may be particularly salient for this sample of women who were dealing with abuse at a time in society when it was largely unrecognized as a problem. This sample of survivors occupied an ecological niche that was less advantaged than other studies of abuse survivors. Many had exposure to multiple traumas across the lifespan along with complicating factors such as poverty (e.g., Banyard et al., 2001). Recovery from abuse and recovery from substance use seemed to co-occur as women moved through the lifecourse and discovered that over time substances could not disguise the pain of abuse or as they made new relationship connections to children and had new sources of motivation to change patterns of behavior.

While women described recovery as ongoing, they were able to articulate how far they have come at least in terms of their self-perception. This fits with Luthar et al.'s (2000) description of "structural-organizational" perspectives on resilience in which, "active individual choice and self-organization are believed to exert critical influences on development (p. 553)." While many of these points have been stressed in prior studies of resilience and recovery, few have investigated these issues in samples of adult survivors of complex trauma. In addition, the confirmation of these findings using multiple methods (both quantitative and qualitative) suggests the utility of combining such approaches in future studies.

A further contribution of the current study is the rich description provided by survivors' own words about the nature of these turning points, which are precipitated by a variety of factors including the intersection of substance abuse and trauma. Cebello's (1999) life narrative analysis introduces the notion of a quilt metaphor. She states, "... the metaphor of African-American women's quilting should help keep us open to the fluid, ever-changing, and complicated nature of life experiences (p. 312)." She then quotes Brown (1989, cited in Cebello, 1999, p. 312), "the essential lessons of the quilt (are) that people and actions do move in multiple directions at once."

There are limitations to the current study. The most important of which is that it used a small sample not demographically representative of all survivors. Given discussions of the need to examine recovery and resilience in an ecological context (e.g., Harvey, 1996) more work in this area is needed. However, given the large number of African-American women and women of limited economic means in the current sample, the study does add the voices of an underrepresented group of survivors to discussions of resilience and recovery. Future research using a variety of more comprehensive measures of resilience at more than two time points will also be important. A strength of the current study is also that it does not rely on self-reports of child sexual abuse but uses official hospital records to identify survivors.

Indeed, perhaps the most important contribution of this study is the additional research questions it suggests. It will be important for future research to examine how social connections work to promote recovery and what role, if any, such connections play in turning points across the lifespan. Further elaboration of the interrelationship of re-traumatization and resilience including exploration of definitions of resilience and factors that promote resilience and recovery in middle and later stages of adult development are needed. Such research also will have important implications for clinical practice with survivors of child maltreatment as it helps build an empirical base of knowledge to identify resources for interventions that are empowering and build on survivor's strengths. Resilience and recovery from trauma indeed appear to be a dynamic and unfolding process across the lifespan. The voices of the current sample of

multiply stressed survivors points to key areas of strength and ongoing development. The current study highlights the need to further examine factors that promote and hinder this positive growth across the full spectrum of adult development.

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