

**A systematic review of the psychological factors associated with resilience among
survivors of sexual abuse**

**A mini-thesis submitted in partial fulfilment of the requirements for the degree of
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Declaration

I declare that *a systematic review of the psychological factors associated with resilience among survivors of sexual abuse* is my own work, and that it has not been submitted before for any degree or examination at any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Is-haaq Lekganya



Date:

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ABSTRACT

This study aimed to synthesise the debates on factors associated with promoting resilience among women survivors of sexual abuse. Using systematic review methodology, six electronic databases (EBSCO, PsychINFO, SAGE, Science Direct, Springerlink and JSTOR) were used. Several keywords related to resilience and sexual abuse were utilised to search for articles published between January 2000 and December 2013 for inclusion. These primary studies were collocated, systematically assessed, synthesised and interpreted. Using two reviewers, data extraction was conducted in three stages, namely: the title reading, the abstract reading and the full text reading of articles. For the quality assessment, four instruments were employed, two of which were self-constructed tools. Thirty articles acquired an acceptable threshold score during the analysis and were used to compose this systematic review. Findings of this review highlighted that resilience is multidimensional; that is, it is made up of intrinsic and extrinsic resources/factors and is also a complex gradual dynamic process with specific indicators. These indicators include demonstration of competence and excellent functioning in important areas of life such as work, relationships, self-management, psychological well-being, and good health. Ten interacting factors were identified as promoting resilience including, 1) availability of social support from family and friends; 2) ego resources; 3) temperament/personality factors; 4) biographic characteristics; 5) ability to regulate emotions; 6) cultural factors; 7) positive life opportunities; 8) religion and spirituality; 9) abuse related factors; and 10) coping skills/strategies. These factors interact together, leading the survivor to be resilient. Major findings of the study as well as the implications for practice and further research are discussed.

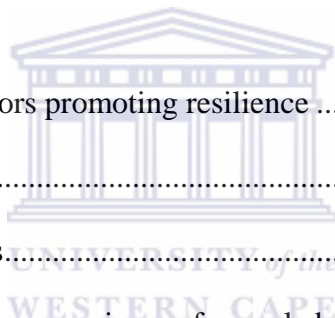
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CHAPTER ONE: Introduction

Background of the study

This study is a systematic review of the literature reporting on psychological factors associated with resilience among women survivors of sexual abuse. Primary studies vary on identifying specific factors that are associated with promoting resilience among survivors of sexual abuse (Ryan & Caltabiano, 2009). For example, Bonanno (2004) reported that resilience is promoted through: hardiness, self-enhancement, positive emotion and laughter. Whilst other studies (e.g. Cowen, 1994) argued that resilience is promoted by ecological factors; meaning that individuals are embedded in their social context and a variety of contextual forces interact to promote their resilience. These ecological factors include (a) forming wholesome early attachments, (b) acquiring age and ability-appropriate competencies, (c) exposure to settings that favour wellness outcomes, (d) having an empowering sense of being in control of one's fate, and (e) coping effectively with the abuse (Cowen, 1994). Wright, Fopma-Loy and, Fischer, (2005) emphasised that personal characteristics (e.g. internal locus of control and low self-destructiveness), family characteristics (low stress in the family environment), and abuse-related characteristics (e.g. relationship to perpetrator and extent of physical violence) all significantly contribute to the likelihood of a resilient outcome among survivors of sexual abuse. Banyard and Williams (2007) reiterated that four processes contribute to resilience including those at an 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).

Tedeschi and Calhoun (2004) contended that resilience develops through having a sense of appreciation for life, meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life. McClure, Chavez, Agars, Peacock and Matosian (2008) added that high levels of well-being and the demonstration of positive functioning among those at risk of negative outcomes constitute resilience. Philippe, Laventure, Beaulieu-Pelletier, Lecours and Lokes, (2011) concurred that competent functioning or robust recovery following trauma or substantial life stress are constituents of resilience. In advocating this approach, academic, interpersonal competence and other positive characteristics have been put forward as indicators of resilience (Luthar, Cicchetti, & Becker, 2000).

As it is apparent that studies lack consensus on what promotes resilience, the unified common factor among studies of resilience is that they generally highlight that a working understanding or definition should consider two critical points: (1) exposure to significant threat or severe adversity, (i.e., sexual abuse) and (2) the achievement or presence of positive adaptation (Collishaw, Pickles, Messer, Rutter, Shearer & Maughan, 2007; Luthar, Cicchetti & Becker, 2000; Philippe et al. 2011; Rutter, 1993). Positive adaptation refers to the absence of psychopathology (Almedom & Glandon 2007; Bonanno, 2004; Rutter, 1993). Operational definitions of resilience devoid of the two mentioned critical points increase complication on summing up vital components of resilience (Collishaw et al. 2011; Rutter, 1993). This review adopted this understanding as a working definition, namely that resilience is the achievement of positive adaptation following exposure to significant threat or severe adversity.

This study focuses on resilience following sexual abuse. Sexual abuse has far reaching negative effects. Maniglio (2009) reviewed the impact of sexual abuse on health, indicating that adults with a history of sexual abuse tend to show evidence for sexual dysfunctions, anxiety,

post-traumatic stress disorder, depression, and suicidal ideation. Other frequently reported problems in this population include interpersonal discord, low self-esteem, parenting difficulties, and substance abuse (Menna, 2008; Painter & Howell, 1999). A greater vulnerability to later victimization for individuals with a history of sexual abuse has been reported (Davydov, Stewart, Ritchie & Chaudieu, 2010). Whitelock, Lamb and Rentfrow, (2013) emphasise that variables such as duration of abuse, presence of penetration, and perpetrator identity (e.g., the victim's father or stepfather) increase likelihood of long-term consequences for sexual abuse survivors.

While most studies have evaluated children, adolescents, and adults with adjustment problems associated with sexual abuse, many studies have found that some survivors of sexual abuse do not exhibit these negative outcomes (Singh, 2006; Wright, Crawford & Sebastian, 2007; Phillips & Daniluk 1994). Such survivors are described as being resilient (McClure et al. 2008; Phanichrat & Townshend, 2010; Ryan & Caltabiano 2009). Filtering through the existing literature, there is a considerable discrepancy on what really promotes resilience among survivors of sexual abuse. Thus, this review study aims to provide consolidation of such discrepancy and therefore offer clarity around factors promoting resilience.

Rationale of the study

Existing systematic reviews have focused on the impact of sexual abuse on psychological health (Davydov et al. 2010; Maniglio, 2009) and psychotherapy outcomes for adult survivors of sexual abuse (Price, Hilsenroth, Petretic-Jackson & Bonge, 2001). There is an absence of a systematic review study exclusively focusing on synthesising the findings around the factors that promote resilience among women survivors of sexual abuse. This review study is aimed at addressing this research gap.

In the existing literature, research studies lack consensus on what promotes resilience among women survivors of sexual abuse (Singh, 2006). In addition to that, most studies on resilience among survivors of sexual abuse have diverse areas of focus. Some studies focused on exploring the particular characteristics of survivors including (a) where they live i.e., urban, suburban, and rural areas (Phasha 2010); (b) their socioeconomic status (Theron, Theron & Malindi, 2013); (c) sexual/gender orientation (Chandy, Blum, & Resnick, 1996); (d) personality traits (Bogar & Hulse-Killacky, 2006); (e) self-enhancement/positive life opportunities (seeking opportunities for improving oneself e.g. education) and management skills (Singh, 2006); (e) family dynamics (McClure et al. 2008); (f) and community resources (Theron & Theron, 2010). Other studies focused on abuse characteristics such as (a) type of abuse (i.e., penetration or fondling) (Whitelock et al. 2013; McClure et al. 2008); (b) age of the abuse (i.e., early or late abuse) (Singh, 2006); (c) extent and duration of the abuse (Ligi'ero, Fassinger, McCauley, Moore & Lyytinen, 2009); (d) the relationship to the perpetrator (i.e., family member or stranger) (Phillips & Daniluk, 1994).

This study is an attempt to assess and synthesise these primary studies with the purpose of providing an empirical base of literature reporting on factors that promote resilience amongst adult women survivors of sexual abuse. Syntheses of the findings make knowledge on resilience among survivors of sexual abuse to be easily accessible to stakeholders and mental health professionals working with such survivors. This provides directions for improving treatment and health policy (Higgins & Green, 2006; Cook, Mulrow & Haynes, 1997). Furthermore, it is important to note that primary studies may present with methodological and design limitations. Conducting this systematic review will allow for the evaluation of the methodological rigour of selected articles for the purpose of providing reproducible and consistent scientific findings

against varying limiting factors of such individual/primary studies (Khad, Kunz, Kleijnen, Antes & 2003). In doing so, clinical practitioners are kept abreast of current literature, while offering a basis whereby practice guidelines can be efficiently developed. (Higgins & Green, 2006).

The review questions

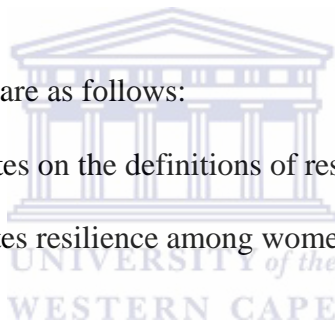
The current study attempted to answer the following review questions:

- 1) What is the definition of resilience?
- 2) What promotes resilience among women survivors of sexual abuse?

Objectives of the study

The objectives of this study are as follows:

- 1) To synthesise the debates on the definitions of resilience.
- 2) To clarify what promotes resilience among women survivors of sexual abuse.



Significance of the study

Existing research has demonstrated that resilience can be enhanced through psychological interventions and that there are wide range of behaviours associated with resilience, which can be learned by almost everyone (Ryan & Caltabiano, 2009). Bonanno (2004) stated that people can learn ways to become more resilient, for example, by practising techniques that help them stay in the present, work on the problem at hand, and keep things in perspective. Therefore findings of this study will comprehensively identify factors promoting resilience among women survivors of sexual abuse which can be used to guide intervention programs to assist survivors of sexual abuse to achieve effective coping. Identifying such factors will inform our understanding of pathways leading to psychological, academic, social, and physically recovery from the abuse.

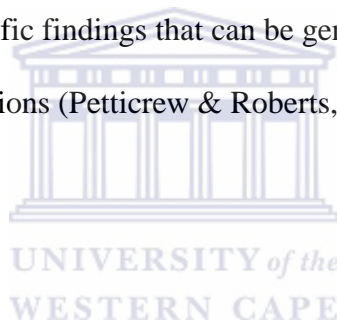
These factors can also be used to help the survivors avoid negative trajectories from the abuse to later develop symptomology (Bogar & Hulse-Killacky, 2006).

Knowing which factors promote resilience can benefit mental health practitioners such as counsellors and psychologists by informing them about processes that lead women survivors of sexual abuse to achieve resilience (McClure et al. 2008). This allows psychotherapists to develop and integrate efficient psychotherapeutic interventions and treatment plans for survivors (Singh, 2006). For this reason, it is hoped that the findings of this study will provide more clinical utility and ways to provide effective psychotherapy for the survivors of sexual abuse at large. Such factors and effective coping skills are useful in helping those struggling to recover from the abuse (Bouvier, 2003; Phillips & Daniluk, 1994). Moreover, studies on resilience such as this current study are thought to be superior because the findings will not only help those at risk to adjust and recover, but will also guide the survivors to be resilient (Bogar & Hulse-Killacky, 2006).

Another major significance of this study is addressing the difficulty faced by healthcare providers, consumers, researchers, and policy makers of being confronted by unmanageable/unorganised amounts of information (Higgins & Green, 2006). Findings from previous studies addressing resilience among survivors of sexual abuse vary considerably with no consensus as to what really promotes resilience among the survivors of sexual abuse (Ryan & Caltabiano, 2009). Therefore, this study, through endeavouring to identify, appraise and synthesise primary studies on the matter will provide a comprehensive consolidated answer to the question: what leads to or promotes resilience among survivors of sexual abuse. This is called a systematic review approach; it limits bias (systematic errors) and reduces chance effects (Petticrew & Roberts, 2006) thus providing valid information and conclusive findings (Higgins

& Green, 2006). Systematic reviews, when used accordingly, add value to research, clinical decision making and positively influence health policy (Khad, Kunz, Kleijnen & Antes, 2003).

Additionally, primary studies examining resilience among survivors of sexual abuse usually have specific focus areas with different population characteristics and limitations (Ligi'ero, Fassinger, McCauley, Moore & Lyytinen 2009). Some conceptualised resilience differently (Whitelock et al. 2013; McClure et al. 2008). Combining them in this review will provide conclusive insight about factors promoting resilience among survivors of sexual abuse. Ultimately, this systematic review then becomes a significant means to amalgamate, assess and analyse a wide range of publications (Higgins & Green, 2006) on resilience among survivors of sexual abuse. This produces scientific findings that can be generalised across different types of interventions, settings, and populations (Petticrew & Roberts, 2006).



CHAPTER TWO: Review of literature

Introduction

This chapter presents the literature review regarding previous research findings about survivors of sexual abuse in general and their ways of achieving resilience. The review will begin by presenting discussions on the definitions of resilience followed by highlights of the prevalence of sexual abuse and its consequences. The literature review will also cover discussions on factors promoting resilience which include family and social factors, effective coping skills, intrinsic and personality factors, positive cognitions and appraisal, multiple interacting factors, and religion and cultural values. Chapter summary will be presented at the end of the chapter.



What is resilience?

Resilience is a complex term that defies simple definitions and measurements (Almedom & Glandon 2007; Bonanno, 2004; Singh, 2006). It has been broadly defined as the capacity to positively adapt to, or regain levels of functioning after difficult life experiences (Luthar et al. 2000). As Bonanno (2004) elaborated, resilience is the ability of adults who are exposed to a highly disruptive event or life-threatening situation, thereafter experience mild distress but nevertheless maintain reasonably stable levels of psychological and physical functioning. Bogar and Hulse-Killacky (2006) stated that resilience is the ability of the survivor to return to the level of functioning present before the trauma occurred. McClure et al. (2008) defined resilience as self-acceptance, ability to engage in positive relationships with others, adjustment to life challenges and environmental adaptation. The essence of resilience is the ability to bounce back

from adversity, and is indicated by the absence of psychopathology (Theron & Theron, 2010; Rutter, 1993; Ryan & Caltabiano, 2009).

Resilient individuals adapt well in the face of adversity, trauma, tragedy and threats. They maintain exceptional performance in family relations, overcome relationship problems, report no serious health problems and are productive at workplace and academic spheres (Abraham, Greeff, & Loubser, 2008; American Psychological Association, 2008). Thus, it has been proposed that resilience constitutes not just recovery, but growth and strengthening from adversity (Rutter, 1993). These positive traits are encompassed in survivors' hardiness, self-efficacy, self-acceptance, tolerance, determination, happiness, commitment, self-reliance, and optimism (Janas, 2002; Chandy et al. 1996).

As it can be observed from above, researchers lack consensus on what constitutes resilience and this outcome can be attributed to the following factors. Firstly, lack of consensus on the definitions of the resilience construct (Luthar et al. 2000; Ryan & Caltabiano, 2009). Secondly, definitions of the successful outcomes indicative of a resilient person vary according to gender, age and culture of participants (Ligi'ero et al. 2009; Singh, 2006). Thirdly, diversity in defining environmental risks and protective factors (Bogar & Hulse-Killacky, 2006; McLean, Maxwell, Platt, Harris, & Jepson, 2008), and fourthly, the primary personal characteristics of a resilient person (Phillips & Daniluk, 1994; Smucker, Dancu, Foa & Niederee, 1995). Finally, the methodology employed has an influence on the definitions of resilience used in a particular study (Bogar & Hulse-Killacky, 2006; McClure et al. 2008; Phillips & Daniluk, 1994; Singh, 2006). For those reasons, there is a need to synthesise the definitions of resilience among studies particularly focusing on resilient survivors of sexual abuse.

The prevalence of sexual abuse

WHO (2013) highlighted that global prevalence figures of sexual abuse indicate that 35% of women worldwide have experienced either intimate partner or non-partner sexual abuse in their lifetime. International studies reveal that approximately 7-36% women and 5–10% of male children have experienced sexual abuse worldwide (Callender & Dartnall, 2010; Finkelhor, 1994; Jewkes, Penn-Kekana & Rose-Junius, 2005). In a systematic review examining studies conducted between 1981 and 2008, Stoltenborgh, van IJzendoorn, Euser and Bakermans-Kranenburg (2011) estimate sexual abuse prevalence to be 127/1000 in self-report studies and 4/1000 in informant studies. Self-reported sexual abuse was more common among female (180/1000) than among male participants (76/1000).

Barth, Bernmetz, Heim, Trelle and Tonia (2013) conducted a systematic review of studies from 24 countries published between 2002 and 2009 that reported sexual abuse in children below 18 years. Prevalence estimates ranged from 8 to 31 % for girls and 3 to 17 % for boys. Nine girls and 3 boys out of 100 were victims of forced sexual intercourse.

In South Africa, the South African Police Service (SAPS) recorded a total of over 50 000 crimes against children for the years 2010/11. More than half (52%) of all reported crimes against children were sexual in nature, while sexual crimes accounted for “only” 19% of crimes against adult women. Establishing the true extent of sexual abuse in South Africa and elsewhere is difficult because police statistics are the main source of data; however, the under-reporting of rape suggests that prevalence estimates are grossly underestimated (Jewkes, Levin, Mbananga & Bradshaw, 2002; Jewkes et al. 2005). These studies confirm that sexual abuse is a global problem of a considerable extent (Stoltenborgh, van IJzendoorn, Euser & Bakermans-Kranenburg, 2011). This necessitates the establishment of an empirical base of filtered

information on what facilitates resilience so as to inform policy development, psychosocial and therapeutic interventions.

The impact of sexual abuse

Survivors of sexual abuse are significantly at risk of developing a wide range of health problems. Briere and Elliott (1994) described three stages of victim response that can be associated with sexual abuse: (1) initial posttraumatic stress disorder, painful emotions, and cognitive distortions; (2) development of coping behaviours; and (3) long-term consequences. Studies have documented both short and longer term psychological, social, and physiological sequel associated with sexual abuse (Davydov et al. 2010; Maniglio, 2009). Physical effects such as pain and tissue injury from sexual abuse can heal in time, however psychological and interpersonal difficulties might persist throughout survivors' life (McClure et al. 2008).

Beitchman, Zucker, Hood, DaCosta, and Ackman (1991) reviewed the short-term effects of sexual abuse using 42 studies of clinical and nonclinical populations. They described several symptoms commonly reported by samples of sexually abused children which are sexualized behaviour, conduct problems, academic problems, depression and low self-esteem. They are also susceptible to self-destructive behaviours such as suicide attempts, substance abuse, self-mutilation, bingeing and purging (Asberg, 2008; Jenny & Roesler, 2003; Wright et al. 2007). McClure et al. (2008) reported evidence supporting the role of abuse-specific characteristics as mediators of symptomatology (e.g., age of onset, frequency, duration, severity, and type of sexual abuse). Impaired academic or occupational functioning are among the immediate outcomes observed in children, adolescents, and adults with histories of sexual abuse (McClure et al. 2008).

Beitchman et al. (1992) reviewed the long-term effects of sexual abuse using 32 studies of clinical and nonclinical samples. They indicated that adults who were sexually abused as children tended to show evidence for sexual dysfunctions, anxiety, depression, and suicidal ideation. In the review by Jumper (1995), sexual abuse was significantly related to depression, self-esteem impairment, and other psychological problems (i.e. suicidal ideation or behaviour, anxiety, personality, psychotic, somatoform, and dissociative disorders). Other frequently reported long term psychological effects include post-traumatic stress disorder, low self-esteem, interpersonal problems, social alienation, and suicidal behaviours (Menna, 2008; Painter & Howell, 1999). Klonsky and Moyer (2008) found a small, significant association between sexual abuse and self-injurious behaviour (i.e. intentional, direct damage to body tissue without suicidal intent). In their review of female samples, Neumann, Houskamp, Pollock and Briere (1996) found that sexual abuse was significantly related to anxiety, anger, depression, self-mutilation, sexual problems, substance abuse, suicidal ideation or behaviour, self-concept impairment, interpersonal problems, dissociation, obsessions or compulsions, somatization, traumatic stress responses, general symptomatology. In the review by Paolucci et al. (2001), sexual abuse was significantly related to posttraumatic stress disorder, depression, suicidal/self-injurious ideation/behaviour, early involvement in sexual activity or prostitution, sexual perpetration, and intelligence/learning impairment. In their review of student samples, Rind and Tromovitch (1998) found that sexual abuse was significantly related to alcohol problems, anxiety, depression, dissociation, eating disorders, hostility or anger, interpersonal sensitivity (i.e. feelings of inadequacy, inferiority, or discomfort when interacting with others), obsessions or compulsions, paranoid ideation, phobia, psychotic symptoms, self-esteem impairment, sexual dysfunction and social maladjustment.

Phillips and Daniluk (1994) reported that variables such as duration of abuse, presence of penetration, and perpetrator identity (e.g., the victim's father or stepfather) increase likelihood of long-term consequences for childhood sexual abuse survivors. Some studies report that a history of sexual abuse also has an impact on survivors' personality and spirituality (Ganje-Fling & McCarthy, 1996). Fossati, Madeddu and Maffei (1999) found a moderate, significant association between sexual abuse and borderline personality disorder.

Factors promoting resilience

While previous studies have evaluated children, adolescents, and adults with adjustment problems associated with sexual abuse, many studies have found that some survivors of sexual abuse do not exhibit these negative outcomes (McClure et al. 2008; Phillips & Daniluk 1994; Ryan & Caltabiano 2009; Singh, 2006). There are diverse findings on factors that lead to or promote resilience among survivors of sexual abuse. In this section I will discuss such factors which include family and social factors, effective coping skills, intrinsic and personality factors, positive cognitions and appraisal, multiple interacting factors, and religion and cultural values.

Family and Social Factors

Family and social networks have been identified as playing an important role in building greater resilience (McClure et al. 2008). That is because resilient individual have the unique ability to utilise family, social and external support systems to cope better with the trauma (Chandy et al. 1996). In addition, Cowen (1994) affirmed that families are the most important protective factor. These supportive networks are known as extrinsic protective factors and are specifically identified as supportive adults (i.e., parents, friends and family connectedness) (Ryan & Caltabiano, 2009). Survivors of sexual abuse who experience care and acceptance from their

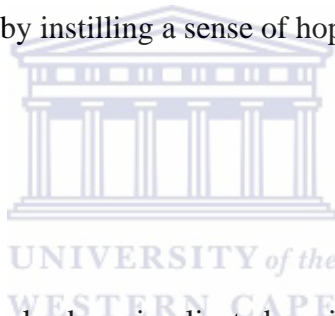
own families regain adequate psychological stability after the abuse incident (Bogar & Hulse-Killacky, 2006). Thus Chandy et al. (1996), reiterated that good family relationships and parental support are the prominent factors promoting resilience among survivors of sexual abuse. Such secure interpersonal relationships provide an important source of emotional support. In the study of McLean et al. (2008), resilient survivors pointed out that protective figures in the family such as parents or adults who are positive role models, all play a strong educational role fostering and protecting survivors from encountering negative consequences related to the abuse.

McClure et al. (2008) explored factors that contribute to resilience among 177 university women who had experienced sexual abuse. Outcomes of the study revealed that family characteristics (i.e., family conflict and cohesion) accounted for 13–22% of the variance in the well-being outcome. In contrast, other characteristics (i.e., age at which the abuse occurred, abuse severity, and relationship to perpetrator) accounted for 3% or less in the variance of the well-being outcome. Results of the study emphasised that family functioning facilitates resilience among survivors of sexual abuse. Similarly, Bogar and Hulse-Killacky (2006) asserted that family and social networks generate resilience among survivors of sexual abuse. Likewise, participants in Ligi'ero et al. (2009) study echoed the importance of having secure interpersonal relationships as an important source of emotional and social support in coping with sexual abuse trauma. Also Chandy et al. (1997) reported that good family relationships and parental support were the most prevalent protective factors among resilient survivors in the study.

Social support from the wider community can also serve as a building block for resilience (Theron & Theron, 2010). Singh (2006) emphasises that community plays a protective role; a community that stigmatizes survivors of sexual abuse contributes to the survivors' psychological adjustment problems and difficulties. Contrary, a community displaying greater acceptance of

the survivors contribute to their quick recovery and psychological well-being. That is because survivors of sexual abuse who feel accepted by their own family and community are less involved in risk behaviours (Bogar & Hulse-Killacky, 2006; McClure et al. 2008). The feeling of being accepted enabled them to develop a good sense of self-esteem which led them to cope with the trauma of sexual abuse. It made them feel confident. As a result, they were able to continue achieving personal success and self contentment.

In other studies, social support leading to resilience was gained through romantic partners, religious gatherings and helping professionals (Theron & Theron, 2010). Thus, religious or spiritual activities have been implicated as another external component that can aid social support leading to resilience by instilling a sense of hope in the survivors (Pargament et al. 2004)



Effective Coping Skills

Effective coping skills have also been implicated as aiding resilience. These skills can be grouped into avoidant, emotion-focused and problem focused coping skills (Phanichrat & Townshend, 2010; Wright et al. 2007). Wright et al. (2007) elaborated that emotion-focused coping refers to efforts of attempting to regulate one's emotions in dealing with the stressor. In addition, problem-focused coping involves managing stressful situations through active problem solving, seeking social support, and confrontation. Avoidant coping skills are denial, distancing, disengagement and self-isolation (Wright et al. 2007). Phanichrat and Townshend (2010) argued that resilient survivors of sexual abuse become resilient through adopting positive coping styles such as problem solving and positive cognitive appraisal. It has been noted that resilient

survivors mostly employ problem focused coping skills while the most challenged employ avoidant coping strategy (Phanichrat and Townshend, 2010).

Avoidant coping skills have been viewed as less adaptive coping responses. They were found to be the most frequently used by vulnerable survivors with more psychological distress (Phanichrat & Townshend, 2010; Sigmon, Greene, Rohan, & Nichols, 1996). This finding was also reported in a cross-sectional survey of a nationally representative sample of 3,615 Hungarians, in which 30.7% (n = 1, 141) experienced sexual abuse. In the study, avoidant coping behavior was strongly connected to the sexual abuse experience and was significantly more common among the abused women than the non-abused group (Csoboth, Birkas & Purebl, 2003). Survivors' reliance on avoidant coping skills reflects a strong desire to escape painful feelings and memories. Such strategies only provide short-term relief from distress and may temporarily regulate negative effect of the abuse (Wright et al. 2007).

Nagel (1997) examined coping styles and psychological adjustment of 42 sexually abused and 42 non-abused adolescent females. A self-report measure was administered to assess coping skills of avoidance, problem focused, social support, and turning to religion among the participants. The findings of the study revealed that the avoidant coping strategy negatively correlates to psychological adjustment for both sexually abused and non-sexually abused adolescents. On the other side, action/planned or problem focused coping strategy was positively correlated to psychological adjustment for both sexually abused and non-sexually abused adolescents. Contrary to the control group, sexually abused adolescents had high reliance on social support and this coping strategy was positively correlated to their psychological adjustment. Turning to religion was not a significant outcome of psychological adjustment for

either group. The findings of the study highlighted the importance of problem focused coping and social support in the psychological adjustment for survivors of sexual abuse.

Overall, studies exploring coping behaviours among the survivors of sexual abuse are unanimously in agreement that problem-focused coping skills are the most efficient. They should be promoted as part of therapeutic interventions for survivors of sexual abuse. These studies also draw attention to the fact that emotion focused and avoidant coping skills are less adaptive.

Intrinsic and Personality Factors

Theron and Theron (2010) identified specific personal traits to resilience namely: goal and/or achievement orientation, empathy, optimism, autonomy, conservatism, conscientiousness and the ability to self-regulate, extroversion, enthusiasm, and assertiveness. Similar findings were reported by McLean et al. (2008) indicating that such factors are referred to as intrinsic protective factors. Additionally, Bogar and Hulse-Killacky (2006) highlighted additional personal traits that develop resilience as positive self-image, high self-esteem, determination, positive functioning, self-acceptance, high self-esteem, affirmative psychological adjustment and control of thoughts and behaviour.

Furthermore, other studies noted the importance of intrinsic protective factors in enabling resilience. For example, Singh (2006) concurred that resilient women with a history of sexual abuse have a strong sense of self-efficacy. Meaning they trust their ability in mobilising motivation, cognitive resources and action in order to exert control over their traumatic experiences. Personal talents and life achievements among the survivors of sexual abuse are the indicators of high self-efficacy (Philippe et al. 2011). Some resilient survivors of sexual abuse have displayed a strong sense of perseverance and self-discipline (Bogar & Hulse-Killacky,

2006). They show determination in the struggle of overcoming painful experiences from the abuse incident and have internal locus of control (Ligi´ero et al. 2009).

Subsequently, current theories view resilience as a construct that incorporates both internal and external protective factors (Luthar et al. 2000). Although many factors have been proposed, thus far, common findings reveal that the internal characteristics associated with resilience include self-efficacy, perseverance and internal locus of control. Elaborating on this, Ryan and Caltabiano (2009) highlighted the following.

- 1) Resilient women with a history of sexual abuse have a strong sense of self-efficacy. They are confident in their ability to recover and continue to remain motivated and self-assured of being in control over their traumatic experiences. They possess high self-esteem and tend to persist during the countenance of their trauma.
- 2) Resilient survivors of sexual abuse have perseverance. Perseverance entails persistence, self-discipline and a willingness to continue the struggle to rebalance one's life after adversity. Survivors with such traits remain optimistic, enthusiastic and determined to continue the struggle of overcoming painful experiences from the abuse incident.
- 3) They have internal locus of control. Meaning they are in control of their thoughts and behaviours. They direct their focus and abilities towards creating positive outcomes for themselves.
- 4) Survivors of sexual abuse employ effective coping skills and adjustment strategies that include a set of cognitive and behavioural reinforcements. They feel confident about coping successfully with their trauma. They often employ a wide range of problem-solving and emotion-focused skills. Religious or spiritual beliefs have been implicated as

another coping strategy which they use to develop resilience. They use such beliefs to re-instil their sense of hope.

- 5) Resilient survivors have secure interpersonal relationships which work as an important source of their emotional and social support. They utilize family and other social external support systems to cope with the trauma of being sexually abused.

Positive Cognitions and Appraisal

Sexual abuse may lead to cognitive distortions which impair the ability to trust others, and can lead to ambivalence about interpersonal closeness, heightened fear of abandonment and feelings of hopelessness (Lamoureux, Palmieri, Jackson, & Hobfoll, 2012). As a consequence, one of the most common mechanisms of coping amongst survivors of sexual abuse is the mechanism of positive cognitions and construing benefits from the experience of the abuse. Wright et al. (2007) reiterated the importance of making something good out of something bad as a way for survivors of sexual abuse to know that their suffering was/is not in vain. Positive cognitions and appraisals are coping strategies which focus on changing one's perspective regarding a traumatic event (Wright et al. 2007). Thus, some survivors of sexual abuse are reported to employ cognitive and behavioural reinforcements as strategies to achieve resilience, i.e., problem-solving and emotion-focused skills (Phanichrat & Townshend, 2010).

Researchers (i.e. Briere and Elliott, 1994) identified cognitive coping responses to the situation of sexual abuse into two categories: (1) strategies aimed at preventing the person from being overwhelmed by intense feelings (e.g., avoidance) and; (2) strategies aimed at managing feelings of helplessness and a lack of control (e.g., reframing). Thus, Whitelock et al. (2013) and McClure et al. (2008) suggested that the impact of sexual abuse on adult well-being could be

mediated by these processes of cognitive appraisal and coping behaviour. As mediating variables, these processes can operate as either risk or resilience factors in relation to the long-term effects of the abuse. These interventions strengthen one's purpose and meaning during hard times of the abuse (Wright et al. 2007)

Phillips and Daniluk (1994, p. 10) assert that the following is the unifying statement among resilient survivors of sexual abuse which shows that they positively view and appreciate challenges brought by the abuse incident.

“I wouldn't wish the pain of sexual abuse on anybody, but I realise that if I hadn't been abused or been through hell like that, I might never have known how unlimited the human spirit is around finding its way through impossible odds. I wouldn't afford to miss such a learning experience for the world”.

Similarly, in the study of Asian adult women survivors of sexual abuse, Singh (2006) found several areas of perceived benefits in participant's responses. Wright et al. (2007) reported that resilient survivors engage in one or more forms of cognitive restructuring, with benefit-finding and meaning-making; this process facilitates recovery and long term adjustment which potentially limits sexual abuse negative consequences. Thus, both meaning-making and benefit-finding appear to be methods used by survivors of sexual abuse to rebuild shattered assumptions about themselves, the world, and their place in the world (Pargament, Koenig, Tarakeshwar, & Hahn 2004). By focusing on the positives within themselves and their lives, and by searching for and finding meaning in the abuse, the survivor can begin to adapt to the post-trauma life with new meaning and new perspective (Phillips & Daniluk, 1994).

Multiple Interacting Factors

Recognition of multiple factors that develop resilience permeated in most studies. Such studies attempted to highlight that resilience is not promoted by one factor, rather person–environment multiple factors interact and complement each other to develop resilience (Cowen, 1994). For instance, Phillips and Daniluk (1994) explored how seven adult women survivors of sexual abuse emerged and experienced resilience in dealing with their traumatic experiences of sexual abuse. They highlighted that through (1) increasing sense of determination and integrity, (2) emerging sense of self-definition and self-acceptance, (3) shifting towards a positive worldview and, (4) overcoming regrets over what had been lost, aided development of resilience. Participants emphasised that a combination of restructuring their cognitive distortions and seeing the abuse positively was an important factor to resilience.

Similarly, in a phenomenological study of Bogar and Hulse-Killacky (2006) revealed that a combination of interpersonal skills, competency, self-regard, spirituality and environmental agencies were the determinants and processes that facilitated resilience. In addition participants reported to have refocused their attention towards constant positive thinking about the abuse as a coping skill. In the same vein Baker (2007) identified an integration of personality characteristics, attachment styles with social support, and spirituality or religion as multiple complementing factors contributing to resilience among a sample of Canadian women survivors of sexual abuse. Participants further indicated that internal resources such as problem-solving skills, persistency, competency and external resources such as social support network and accessibility to professional health services all provided them with a framework of coping with the trauma of being sexually abused.

Singh (2006) also conducted a qualitative study with the purpose of describing resilience strategies of 13 south Asian female survivors of sexual abuse. Semi-structured interviews were employed to collect the data and phenomenological data analysis was used. The findings of the study revealed that resilience strategies among south Asian female survivors of sexual abuse included a blend of positive use of silence, maintaining hope, seeking social support, self-efficacy and self-care.

Religion and Cultural Values

Abraham, Greeff, and Loubser, (2008) proposed that religious and traditional factors aid resilience. These researchers hold that religious leaders, engaging in prayers, the power to forgive, faith, belief and surrendering to God are important in developing resilience. As with general coping, spiritual or religious coping has demonstrated both positive and negative aspects in relation to well-being (Pargament et al. 2004).

Gall (2006) elaborated that negative forms of spiritual coping invoke a sense of personal discontent, anger and detachment in an individual's relationship with a higher power. In contrast, positive forms of spiritual coping reveal a greater sense of attachment and reliance on a higher power for comfort and security coupled with active seeking of support from this higher power under times of stress. Negative spiritual coping has been related to poorer emotional and psychological outcomes, while positive spiritual coping has been related to better well-being for individuals confronted with significant life stress (Bryant-Davis, Ullman, Tsong, Gobin, ,2011).

Pargament et al. (2004), conducted a review of literature on the effects of Judeo-Christian religious beliefs on coping with traumatic events such as sexual abuse. The review concluded that religious coping provides people with several cognitive aspects that help them to recover

from traumatic life experiences. According to the authors, these positive religious coping skills can be summarized as follows:

- 1) Benevolent reappraisal (i.e. seeking a lesson from God in the event).
- 2) Seeking spiritual support (i.e. searching for comfort and reassurance through God's love and care).
- 3) Active religious surrender (i.e. doing what one can and then putting the rest in God's hands).
- 4) Seeking spiritual connection (i.e. thinking that challenges in life are part of spiritual trials meant to guide mankind to be close to God).
- 5) Seeking religious direction (i.e. praying to find a new reason to live).

In addition, the study also concluded that participating in church activities generally leads to psychological stability among the survivors of sexual abuse.

McLean et al. (2008) reviewed four studies examining religious participation as a protective factor against vulnerabilities and negative behaviours associated with sexual abuse. In the study, girls who had been sexually abused reported that participating in religious activities was among factors which contributed to their well being and resilience. The review concluded that participants with high levels of religiosity and spiritual well-being are less likely to suffer from traumatic experiences associated with sexual abuse compared to those with lower levels of spiritual well-being.

The literature on using religion as a way of coping reveals that interventions such as beliefs and spiritual practices provide survivors of sexual abuse with coping skills that reduce suffering (Pargament et al. 2004). These interventions strengthen one's purpose and meaning during hard times of the abuse (Wright et al. 2007).

With regards to traditional factors, Theron and Theron (2010) identified the values of 'Ubuntu' among South Africans as a contributor to resilience. In the same vein Singh (2006) highlighted that silence might serve as a traditionally effective coping strategy among the South-East Asians.

Chapter summary

The literature review revealed that the prevalence of sexual abuse is broader than it is actually recorded and that survivors of such a trauma endure severe short and long term health difficulties. However, resilient survivors of sexual abuse are able to regain adequate psychological stability after the abuse incident through employing different aiding factors leading them to achieve resilience. These supportive factors that promoted survivors' resilience were identified as self-efficacy, perseverance, internal locus of control, social and family support. In addition, resilient survivors of sexual abuse are noticed to have high determination, positive functioning, self-acceptance, high self-esteem, affirmative psychological adjustment and well-being. Regarding coping skills, the literature review has shown that individuals with histories of sexual abuse employed avoidant, emotion focused and problem focused coping skills. Resilient survivors mostly employ problem focused coping skills while those who continued to endure abuse repercussions mostly employ avoidant coping strategy.

The literature revealed two kinds of protective factors employed by the survivors of sexual abuse namely intrinsic and extrinsic protective factors. The intrinsic protective factors include positive self image, high self-efficacy, high self-esteem, and control of thoughts and behaviour. Meanwhile, extrinsic protective factors are identified as supportive adults i.e., parents, family connectedness, supportive communities and goals achievement. Family support emerged to be the most superior protective factor. Religious beliefs and practices were also

identified as important factors aiding survivors of sexual abuse to effectively cope with the repercussions of sexual abuse.



CHAPTER THREE: Methodology

Introduction

This study aims to employ a systematic review methodology to synthesise the debates on factors associated with promoting resilience among women survivors of sexual abuse. This chapter will therefore present details on the research method and design used to accomplish the aim of this study. Furthermore, this chapter will report on the study procedures, followed by elaborating on inclusion criteria, data retrieval strategies and instruments used. The assessment of validity and reliability as well as ethical considerations of the study will also be covered.

Research Methodology: A systematic review

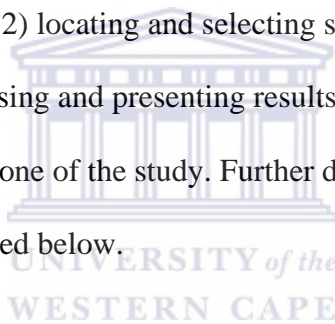
A systematic review is an exhaustive review of the literature addressing a clearly defined question, which uses a systematic and explicit methodology to identify, select and critically evaluate all the relevant studies, and collect and analyse the data emerging from the studies included in it. (Petticrew & Roberts, 2006). This approach adheres to a set of scientific methods that consolidates findings from previous studies through attempting to identify, appraise and synthesise all relevant studies in order to answer a particular question (Higgins & Green, 2006). A systematic review collocates, critically evaluates and synthesises all studies that deal with a specific clinical question in a manner that limits bias (Khad, Kunz, Kleijnen, Antes & 2003). Cook, Mulrow & Haynes, (1997) assert that systematic review is a scientific investigation. It has a pre-planned methodology, and uses primary studies as its 'subjects'. The basic steps that are followed in a systematic review involve strategies to limit bias and random error (Petticrew & Roberts, 2006). These steps include the collection of information by searching for all potentially relevant articles. The articles are then subjected to a series of rigorous criteria before being

selected for inclusion in the review. The methodology research design, study and participant characteristics of the primary studies are critically evaluated (Higgins & Green, 2006).

Accordingly, the current study employed a systematic review as a research methodology in attempting to answer the review questions of the study; 1) what is the definition of resilience? 2) what promotes resilience among women survivors of sexual abuse?

The study procedures

The current study followed the five logical sequences or procedures of conducting a systematic review. These procedures are outlined by Khad, Kunz, Kleijnen and Antes, (2003) as: 1) framing the focus of the review; 2) locating and selecting studies; 3) assessment of study quality; 4) collecting data; 5) analysing and presenting results. The first step of framing the focus of the review is detailed in chapter one of the study. Further details on the other four logical sequences or procedures are provided below.



Inclusion criteria

For the purpose of this study, research articles were considered on the basis of the following criteria:

1). Types of studies:

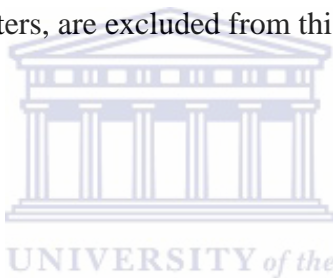
- a) Research articles that appear in peer-reviewed journals;
- b) Full text articles;
- c) English journal articles;
- d) Articles published between January 2000 and December 2013;
- e) Studies utilizing either qualitative or quantitative or both methods

2). Type of participants:

- a) Studies focusing on resilient adult women survivors of childhood/adult sexual abuse;
- b) Females aged 18 years and older;
- c) Have been exposed to sexual abuse and positively adapted with the repercussions, marked by the absence of psychopathology;
- d) Offended by male perpetrators.

Exclusion criteria

Unpublished studies, dissertation papers, systematic reviews, editorials, letters, conference proceedings, books, and book chapters, are excluded from this review. Only primary studies are considered.



Retrieval strategy

Articles were retrieved in two ways. Firstly, keywords were identified by means of a limited search in one or two databases in order to identify text words contained in titles and abstracts and the index terms used to describe the articles. Secondly using the identified keywords, a comprehensive search was initiated in the six databases available at the University of the Western Cape library. These databases were selected through scanning and examining A-Z available databases of the library; the ones hosting and consisting of social and psychological journals were considered. Further databases were identified through expert opinion and through the electronic search results of the University's library online services. As the search progressed more keywords were identified culminating in the following keywords: resilience, effective coping, protective factors, self-efficacy, hardiness, positive adjustment, locus of control, sexual abuse, rape, sexual assault and sexual trauma. The databases that were included were:

- a) EBSCO
- b) PsychINFO
- c) SAGE
- d) Science Direct
- e) Springerlink
- f) JSTOR

Method of review

Total number of reviewers: 2

Data extraction was conducted in three stages, namely: the title reading, the abstract reading and the full text reading of articles. At each stage a pair of reviewers worked independently of each other and assessed and recorded articles. After assessing articles at each stage, the two reviewers met to discuss outcomes. Any disagreements that arose between reviewers were resolved through discussion to reach an agreement. In the event that reviewers failed to agree, the supervisor would mediate and make a final decision.

Assessment strategy

This review made use of a three step assessment strategy; title reading, abstract reading and full text reading.

Title reading: Articles were assessed firstly at the title stage to evaluate if they met the inclusion criteria. Reviewers worked in pairs in selecting articles based on relevancy. Titles identified as appropriate and an outcome of decision for inclusion was recorded in the title reading and extraction tool (see Appendix A). This was conducted at the University of The Western Cape.

Abstract reading: The articles included in the title reading stage were subjected to an assessment of their respective abstracts based on the inclusion criteria. Reviewers worked in pairs reading the abstract independently and decided on their relevancy.

Full text reading: The articles whose abstracts met the inclusion criteria were assessed at the full text reading level. At this level, the selected articles were assessed by the two reviewers independently using two quality assessment tools namely, qualitative evaluation tool (see Appendix C) and quantitative evaluation tool (Appendix D) to determine the methodological quality and coherence of respective studies. We made use of verification by working in pairs and groups and the supervisor acted as a control to verify all decisions made at all stages of the review process.

Instruments

Four instruments were employed in this study, two of which were self-constructed tools.

Title reading and extraction tool – A self-constructed sheet that was used to record information of all titles suggested for inclusion in the study (see Appendix A). Working in pairs reviewers recorded this information.

Abstract reading and extraction tool – Articles that passed the abstract assessment phase were recorded in this summary sheet (see Appendix B). Decision to include or exclude was recorded. The completed sheets were discussed and verified by the two reviewers for accuracy and compiled a final composite list.

Critical appraisal tool – Qualitative and quantitative evaluation tools were utilized at the full text reading to assess articles. Both tools were tested by the reviewers to assess ease of administration, logical coherence, content relevance and scoring mechanism. Afterwards the tools were modified by removing irrelevant sections, namely sections that assessed for

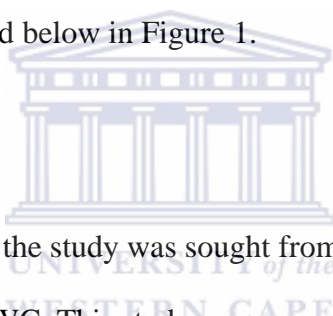
interventions. For purposes of this study, a dichotomous rating scale (Yes/No) was added for both scales to attain a composite score for each article. Reviewers worked independently and then discussed the findings and reached a consensus regarding the final scores for inclusion.

All full text articles were assessed using the following tools. Firstly a qualitative evaluation tool (see Appendix C) which was adopted and modified from Long, Godfrey, Randall, Brettle and Grant (2002). The tool assessed the uniqueness of qualitative research, in particular, its concerns with meaning, context and depth. Various aspects (study evaluative overview; phenomenon studied and context issues; ethics; data collection, analysis and researcher bias) were assessed. The tool sought to provide an extensive informative series of questions both to evaluate the core content of the retrieved studies and to assess the quality of the designs in relation to their aims and outcomes. It ensures that the criteria employed to evaluate qualitative studies accorded due significance to the epistemology and practice of qualitative research approaches.

Secondly a quantitative evaluation tool (see Appendix D) was adopted from Long, Godfrey, Randall, Brettle and Grant (2002). This tool was developed to assess quantitative research studies on various aspects of methodological quality. In both the qualitative and quantitative tools, each full text obtained a composite score that was used to determine the overall quality of the article reviewed. The first section of the tool was designed to be applicable across all study types. It provides a summary overview of the study, in the form of an evaluative abstract. Its purpose was to enable any reader of a review, and the reviewer subsequently, to access essential details of a study and its potential value. The overview indicates the purpose of the study, key findings, an evaluative summary of its strengths and weaknesses and possible

theory, policy and practice implications, in addition to bibliographic details. The other sections of the tool provide the descriptive and analytical details.

Threshold scores: Scores were classified as weak (0-40%), moderate (41-60%), strong (61-80%), or excellent (81-100%). The lowest threshold score necessary for inclusion was 50% and above. The tools quantify an overall quality score of the article, which emphasised the equal importance of each of the indicated criteria; ensuring that the methodological rigour of each study was assessed by considering the mean score. Should a score above the mean was attained, the highest level of methodological rigour can be assumed. Conversely, should a score below the mean was achieved, an indication of the lowest level of methodological rigour can be assumed. A flowchart of the process is presented below in Figure 1.



Ethical considerations

Ethical approval to conduct the study was sought from and was granted by the higher degrees and ethics committee of UWC. This study was non-reactive and required no researcher-participant interaction. As such ethical considerations such as informed consent, confidentiality, privacy and anonymity did not apply since the study is a systematic review and focuses on primary studies (Cook, Mulrow & Haynes, 1997; Higgins & Green, 2006; Petticrew & Roberts, 2006). The research articles used in this review were published in journals and were therefore in the public domain. Thus no additional ethical considerations were necessary in terms of accessing without consent or anonymizing the articles.

Validity and reliability

Systematic reviews are subjected to systematic and random errors which may affect the validity and reliability of the study (Cook, Mulrow & Haynes, 1997). Therefore preventative

measures such as carefully following the study procedures were taken into consideration accordingly. Although the validity and reliability of a systematic review to a large extent depends on the methodological quality of the primary studies (Cook, Mulrow & Haynes, 1997), quality assessment tools were vigorously put in place to qualify each selected study. In essence there are four sources of systematic biases in a review study (Higgins & Green, 2006). They arise from systematic differences in the groups/participants that are compared (selection bias), the care that is provided, or exposure to other factors apart from the intervention of interest (performance bias), withdrawals or exclusions of people entered into the study (attrition bias) or how outcomes are assessed (detection bias). In controlling the four types of biases and ensuring a credible reliability and validity in the review, Higgins and Green (2006) recommend that two independent researchers should conduct the study selection, data extraction, and quality assessment.

Assessment of primary studies by at least two researchers working independently limits biases and increases the validity and reliability of the study (Petticrew & Roberts, 2006). Therefore, two reviewers assessed the primary studies and resolved disagreements about outcomes and inclusion criteria through discussion and the supervisor aided by guiding the process. Studies were only included once consensus was reached. The reviewers further ensured reliability and validity by using quality assessment tools and data extraction tools. The data from each primary study was extracted and recorded without concealing the authors' names, intervention, results, study sites and participant characteristics.

Data process

In the analysis and processing of the data, the initial search yielded 5235 potential articles on resilience in women survivors of sexual abuse. After screening the title for eligibility based on the inclusion and exclusion criteria, 89 articles were obtained. From these, one article was

removed due to duplication remaining with a total of 88 articles. 40 articles were excluded during the abstract search. 48 articles were appropriate and were recorded in the abstract reading and extraction tool. Common reasons for exclusion at this stage included incorrect age group, male participants, and focus of study non-related to resilience. At the full text assessment stage, 18 articles were excluded and common reasons were; incorrect target group, non-relevant to the focus of the current review and failure to meet an acceptable threshold score due to not reporting on core methodological quality aspects. 30 articles acquired an acceptable threshold score during the full text analysis and these articles were used to compose the systematic review. Figure 1 below details the search/screening process.



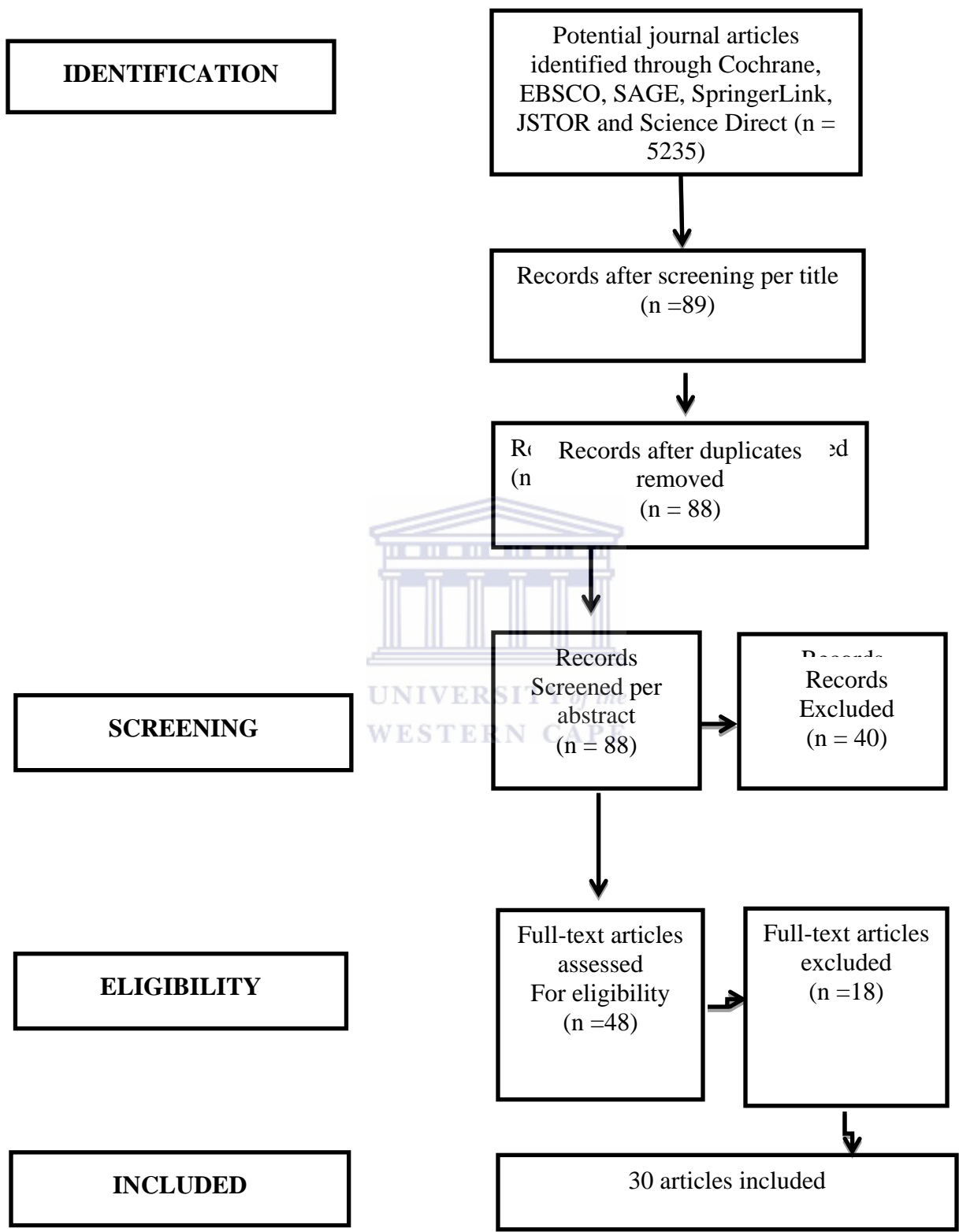
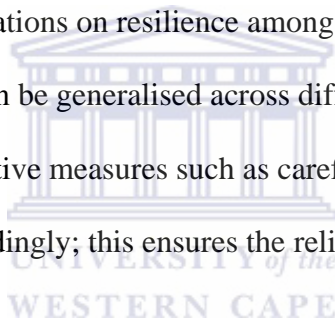


Figure: 1 Evaluation of journal articles flow chart (adopted from Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G., 2009).

Chapter Summary

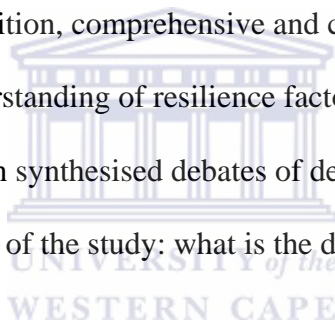
Systematic review approach was identified as the research methodology for this study. It was deemed appropriate hence the aim of this study was to synthesise the debates on factors associated with promoting resilience among women survivors of sexual abuse. Systematic reviews provide guidelines in organising volumes of literature in order to achieve definitive and conclusive answers to clinical questions. The approach consolidates huge bodies of knowledge into accessible summaries of information. This is done through systematic procedures of critically appraising, summarising, and reconciling the evidence which in return inform policy and practice. Thus, this systematic review becomes a significant means to amalgamate, assess and analyse a wide range of publications on resilience among survivors of sexual abuse. This produces scientific findings that can be generalised across different types of interventions, settings, and populations. Preventative measures such as carefully following the study procedures were highlighted accordingly; this ensures the reliability and validity of the study.



CHAPTER FOUR: Findings on definition of resilience

Introduction

While the major aim of this study is to synthesise the debates on factors promoting resilience among survivors of sexual abuse, it was previously noted that researchers also lacked consensus on the definition of resilience. Thus, it became important to initially start by synthesising definitions of resilience using primary studies qualified in this review study. Consolidating definitions clarifies the understanding of resilience as a concept. Furthermore, understanding the concept of resilience creates richer foundation for discussing factors promoting resilience. Hence in addition, comprehensive and conclusive meaning of the concept is necessary in informing our understanding of resilience factors found in this review. Therefore, this chapter will present findings on synthesised debates of definitions of resilience which will be answering the first review question of the study: what is the definition of resilience?



General characteristics of studies

Out of 30 articles that qualified to be included in this review (quality rating above 50%) only 10 studies conceptualized the definition of resilience. Of the 10 studies included, 7 of them were conducted in the United States of America (USA). One study was simultaneously conducted in the United States of America and Canada. As for the remaining 2, one was conducted in Rwanda and the other in the United Kingdom. 5 Studies employed qualitative research methodologies, namely, grounded theory, longitudinal, ethnography and phenomenology. The other 5 which used quantitative approach were cross-sectional studies using multivariate and multiple regression analysis. Studies had an overall strong quality rating falling within 50-80 percent.

The definition of resilience

Primary studies reviewed for methodological quality have revealed varied definitions of resilience. However, these studies had findings with common elements adding to the overall understanding of the concept. In table 5, the synthesised studies indicated that resilience is multidimensional and it has a natural complex gradual dynamic process with indicators. Details of these findings are shown in table 5, which will be followed by further elaboration.



Table 5: Debates on Definitions of Resilience

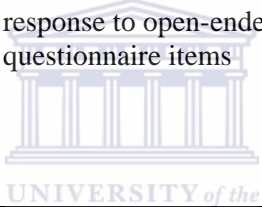
| Author | Study aims | Population/sample | Measuring tools & data collection. | Definitions of resilience |
|-------------------------------|--|---|---|---|
| McClure et al. (2008). | To evaluate influence of family characteristics and abuse characteristics, to resilience (self-acceptance, ability to engage in positive relationships with others, and environmental mastery) | 177 who reported a history of sexual abuse. | 1). Finkelhor's (1979) Childhood Experiences Survey. 2) Ryff (1989) Scales of Psychological Well-Being. 3). Family Environment Scale. 4) Demographic and General Information Questionnaire. | Resilience was defined as well-being, rather than simply the absence of pathology, and was considered to be self-acceptance, positive relations with others, and environmental mastery. |
| Wright et al. (2012) | To address how does the survivor of sexual abuse experience herself as a mother | 94 | Written narrative data in response to open-ended questionnaire items  | Resilience is viewed as multidimensional and contextual variation in functioning across multiple domains. Resilience is influenced not only by the mother's personal ability to cope, but also by the severity and chronicity of the specific challenges she faces and the adequacy of her current resources and support. |
| Banyard et al. (2007). | 1). To explore the functioning in a variety of spheres across 7 years during early adulthood. 2) To explore the role of re-traumatization. 3) To examine survivors' own narratives about recovery and healing to learn about key aspects of resilience in women's own words. | 206 (victims of rape). | 1). Self developed scale (13 item resilience scale for life-course correlates of competent functioning). 2). Trauma Symptom Inventory of Briere (1995). 3). Additional trauma exposure. Seven questions about traumatic life experiences were adapted from the National Women's Study | Three types of resilience, 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. Resilience refers to a dynamic process encompassing positive adaptation within the context of significant adversity. It is positive adaptation despite exposure to adversity, involving a developmental progression. Elements of resilience are not necessarily captured in childhood but should be examined across the lifespan. |

Table 5: Continued

| Author | Study aims | Population/sample | Measuring tools & data collection. | Definitions of resilience |
|--|--|-----------------------------|---|---|
| Hobfoll et al. (2002) | To investigate how sense of mastery and social support might lead to women's greater resiliency. | 160 adult women | The Social Support Questionnaire-6, The seven-item Mastery Scale, Childhood Trauma Questionnaire, The Conservation of Resources Evaluation. Profile of Mood States, State-Trait Anger Expression Inventory, Sexual Risk Behavior. | Resilience is the ability of an individual to control important aspects of life. |
| Bogar et al. (2006) | To identify the underlying processes that facilitated resiliency formation in women survivors of childhood sexual abuse. | 10 women | Interview Protocol—questions | Resiliency is conceptualized as a combination of innate personality traits and environmental influences that serve to protect individuals from the harmful psychological effects of trauma or severe stress, enabling them to lead satisfying and productive lives. |
| Zraly & Nyirazinyoye (2010) | To empirically examine how persons live with and endure the unbearable pain and trauma of genocide-rape and have the capacity to readjust to everyday life in the context of post-genocide Rwanda. | 44 Genocide-rape survivors. | 1). Observation and participant-observation in homes, fields, and workplaces focused attention on emotion, social interaction, and everyday problem management in the daily lives of the study participants. 2). Resilience Narrative Instrument (RNI), a semi-structured interview designed by the first author. | Resilience is a fundamental and ordinary human adaptation system that involves the inextricable domains of self, emotion, and sociality, which are mediated by culture and context. |

Table 5: Continued

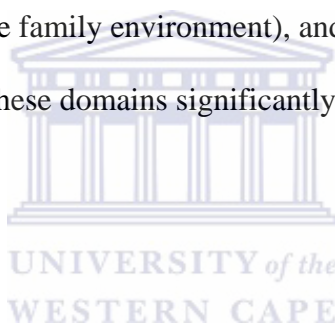
| Author | Study aims | Population/sample | Measuring tools & data collection. | Definitions of resilience |
|------------------------------------|---|---------------------------|---|--|
| Singh et al. (2013) | To explore resilience strategies of African American women who had survived child sexual abuse. | 10 African American women | Semi structured interview protocol | Resilience is capacity to (1) adjust to distressful circumstances in life; (2) achieve successful outcomes despite expectations of negative conclusions; and (3) face difficult situations directly rather than avoiding them. Resilience is an individual's ability over time to face the difficulty of surviving sexual trauma directly and adapt to adverse circumstances with success following sexual trauma. |
| Hyman & Williams (2001) | To investigate resilient outcomes (competence in the face of adversity, and the factors associated with these outcomes) among women who were sexually abused as children. | 136 African American. | 1). Trauma Symptom Checklist-40, and the self-esteem scale of the Middlesex Hospital questionnaire. 2). Health was measured in two ways. One measure was whether the women experienced any severe illness or surgical procedure after age. The other measure of physical health was the use of alcohol or drugs. 3). Resilience in the domain of interpersonal relationships was measured in several spheres: relationships with partners, success as a parent, relationships with female friends, and participation in social activities | Resilience is competence in the face of adversity. Some have defined it as a trait a child exhibits, like hardiness or invincibility following exposure to a known risk factor. Resilience comprises many factors in interaction including functioning in the workplace, psychological well-being, family relationships, and health. |

Table 5: Continued

| Author | Study aims | Population/sample | Measuring tools & data collection. | Definitions of resilience |
|--------------------------------|---|--|---|--|
| Whitelock et al. (2013) | To explore the correlates of negative and positive responses to CSA | 47,869 women who had experienced CSA as a child. | 1). Satisfaction With Life Scale. 2). Childhood Traumatic Events Scale. 3). Big Five Inventory | The term refers to individuals who return to normal levels of functioning rather than deterioration following traumatic events or who show competency in appropriate developmental tasks despite maladaptive circumstances and who do not show the symptomology typically associated with maladaptation. |
| Wright et al. (2005) | This study explored questions about later resilience following CSA within a multidimensional framework by assessing resilience across intrapersonal, interpersonal, and intrafamilial domains | 79 mothers with a history of CSA | Participants completed four outcome measures (Center for Epidemiologic Studies—Depression Scale, Parenting Stress Index [PSI] Health Scale, PSI Parenting Competence Scale, and a measure of marital satisfaction). | 1). Resilience has been defined primarily in terms of intrapersonal functioning, and a combination of positive self-esteem and an absence of clinical symptoms, most notably depression and/or anxiety. Personal characteristics (internal locus of control, low self-destructiveness), family characteristics (low stress in the family environment), and an abuse-related characteristic (absence of physical coercion) all significantly contribute to the likelihood of a resilient outcome. |

Resilience as a multidimensional concept

In their study, Wright et al. (2012) emphasised that resilience is multidimensional and is about functioning across multiple domains. Zraly and Nyirazinyoye (2010) noted that sound self, emotion regulation, and sociality are some of the dimensions of resilience. Wright et al. (2012) added adequacy of current resources and support. Bogar et al. (2006) indicated that these dimensions are a combination of innate personality traits and environmental influences. Wright et al. (2005) elaborated that the multidimensions are intrapersonal functioning, a combination of positive self-esteem, sound health (e.g. absence of clinical symptoms such as depression and anxiety), personal characteristics (e.g. internal locus of control, low self-destructiveness), family characteristics (e.g. low stress in the family environment), and an abuse-related characteristic (absence of physical coercion) all these domains significantly interact and contribute to the likelihood of a resilient outcome.



The Actuality of Resilience

Zraly and Nyirazinyoye (2010) asserted that resilience is a fundamental and ordinary human adaptation capacity. According to McClure et al. (2007), it is well-being, rather than simply the absence of pathology. Wright et al. (2012) commented it includes overcoming severity and chronicity of the specific challenges. Banyard et al. (2007) stated that it is not only captured in childhood but should be examined across the lifespan. Bogar et al. (2006) concur that resilience protects individuals from the harmful psychological effects of trauma or severe stress. According to Zraly and Nyirazinyoye (2010), it is mediated by culture and context. Wright et al. (2012) also agree that it varies according to context. Whitelock et al. (2013) highlighted that resilient individuals do not show the symptomology following traumatic event.

The Process of Resilience

Findings indicated that researchers such as Banyard et al. (2007), have a consensus that resilience is a process at which initially an individual shows negative consequences of trauma but over time recovers and develops positive adaptive functioning. This means that resilience is a dynamic process of positive adaptation within the context of significant adversity. Banyard et al. (2007) argued that it is a developmental progression to positive adaptation despite exposure to adversity. Singh et al. (2013) also noted it to be the individual's ability to face the difficulty of surviving and adapt to adverse circumstances with success. Whitelock et al. (2013) noted that it is a process of returning to normal levels of functioning.

Indicators of Resilience

There are indicators of resilience and specific instruments have been developed to measure it. Whitelock et al. (2013) inquired about competency in appropriate developmental tasks. For a person to be resilient according to McClure et al. (2007), they must demonstrate self-acceptance, positive relations with others, and environmental mastery. Wright et al. (2012) notes personal ability to cope.

According to Banyard et al. (2007) survivors should exhibit exemplary outcomes after adversity with positive adaptation within the context of significant adversity. Hobfoll et al. (2002) cites that resilient individuals are able to control important aspects of life. According to Bogar et al. (2006), they are able to lead satisfying and productive lives. Singh et al. (2013) reported that the indicators of resilience are the capacity to (1) adjust to distressful circumstances in life (2) achieve successful outcomes despite expectations of negative conclusions and (3) face difficult situations directly rather than avoiding them. In their study, Hyman and Williams (2001)

highlighted functioning in the workplace, psychological well-being, family relationships, and good health as indicators of resilience.

Chapter summary

The above studies qualified to be included in this review due to fulfilling good quality ratings. They conceptualised the concept of resilience among survivors of sexual abuse. It was highlighted that resilience is a multidimensional concept, which is made up of domains that interact to increase functionality. These domains include the sound self, emotional stability, and adequate social support in a form of supportive relationships. Resilience is seen as an ordinary normal human characteristic, emerging from a dynamic process of showing negative consequence of trauma thereafter followed by gradual positive adaptation and functioning. It is exemplified or indicated by survivor's adequate functioning in important areas of life such as work, relationships, self-management, psychological well-being, and good health. Notably, resilience is shaped by survivors' cultural context and value systems.

CHAPTER FIVE: Findings on factors promoting resilience

Introduction

The preceding chapter presented the first set of findings of this review and it consolidated debates on definitions of resilience into facets. This chapter is aimed at addressing the major focus of the review which is to synthesise the debates on factors associated with promoting resilience among women survivors of sexual abuse using a systematic review methodology. A total of 30 articles/studies acquired an acceptable threshold score during the systematic analysis (quality rating above 50%) and therefore qualified for this review.

General characteristics of studies

Most of the 30 studies were predominantly conducted in the United States of America (n=22) with 2 studies in United Kingdom/Britain and 2 genocide rape studies in Rwanda. The remaining studies were conducted from Sweden, Brazil and Canada. Designs employed in most of the qualitative studies included grounded theory, ethnography and archival design. Whilst for quantitative studies, survey design, cross sectional, quasi experimental designs were utilized. Some studies (n=13) did not state their respective designs. Studies had an overall strong quality rating falling within 50-80 percent.

During this review and systematic analysis of the studies, distinct 10 categories of what promotes resilience among women survivors of sexual abuse were identified. These are 1) availability of social support from family and friends, 2) ego resources, 3) temperament/personality factors, 4) biographic characteristics, 5) ability to regulate emotions, 6) cultural factors, 7) positive life opportunities, 8) religion and spirituality, 9) abuse related factors,

and 10) coping skills/strategies. The results of each group are firstly shown in the following table 6 which is followed by detailed elaboration of the findings.



Table 6: Factors associated with resilience

| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | Factors associated with resilience |
|-------------------------------|--|-----------------|--------------------|------------------|---|---|
| Breno et al., (2007) | 1). To describe sexual abuse experiences of a high-functioning girls formerly in foster care. 2). To investigate the psychological correlates of sexual abuse. | Survey design | 84 young women,. | U.S.A. | 1). The TRB Questionnaire of Hazzard (1993). 2) History Taking Questions. 3). Foster care system Questions. 4). Placement Ratio 5). Placement Restrictedness. | Powerlessness emerged as a significant predictor of resilience (accounting for nearly 40% of the variance), over and above foster care variables (i.e., age when entering foster care and placement ratio), abuse demographics (number of abusers for sexual abuse, age at first sexual abuse and number of abusers for physical abuse) and self-blame. Therefore a sense of control or power during recovery leads to less negative effects. |
| McClure et al. (2007). | To evaluate influence of family characteristics and abuse characteristics, to resilience | Not reported | 177 females. | U.S.A | 1). Finkelhor's (1979) Childhood Experiences Survey. 2) Ryff (1989) Scales of Psychological Well-Being. 3). Family Environment Scale. 4) Demographic and General Information Questionnaire. | 1). Abuse-specific characteristics explained 3% or less of the variance in CSA survivor wellbeing. 2). Ability to function exerts significant influence on the long-term adjustment of CSA survivors. 3). Results indicate a strong positive association between family cohesion and environmental mastery. 4). Family conflict was negatively related to self-acceptance in this study. 5). Family conflict was also negatively associated with environmental mastery. |
| Walsh et al. (2007) | To investigate associations between CSA, self-efficacy, (locus of control) LOC, coping styles, and revictimization experiences. | Not stated | 73 females. | U.S.A | 1). The Childhood Trauma Questionnaire. 2) Adult Sexual Experiences. 3). Ways of Coping (Revised). 4) The Internality, Powerful Others, Chance; used to assess LOC. 5). Generalized Self- Efficacy Scale. | Cognitive factors (such as coping styles, LOC, and self-efficacy) were not as strongly linked to forced sexual assault; however, low internal LOC and low positive coping were highly associated with coerced victimization experiences. In other words, coping strategies and feelings of control may be more important in attempting to resist coercive assaults. |
| Wright et al (2012) | To address how does the survivor of sexual abuse experience herself | Grounded theory | 94 | U.S.A. | Written narrative data in response to open-ended questionnaire items | 1) Mothers' processing of their childhood abuse history, 2) Development of a healthy model for mothering, 3) Pain of recovery and the mother's position on the abuse recovery trajectory, and 4) the |

Table 6: Continued

| | as a mother? | | | | | mothers' navigation of specific parenting challenges |
|-------------------------------|--|-------------------------|-----------------------|---------------------|---|---|
| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | Factors associated with resilience |
| Banyard et al. (2007). | 1). Exploring functioning and the role of re-traumatization across 7 years. 2). To examine survivors' own narratives about recovery and healing to learn about key aspects of resilience in women's own words. | Longitudinal study | 206 | U.S.A | 1). Self Developed 13 item resilience scale 2). Trauma Symptom Inventory (Briere, 1995). 3). Seven questions about traumatic life experiences were adapted from the National Women's Study. | 1). 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 associated with more active and positive later coping and greater life and role satisfaction. Decreased resilience was associated with trauma re-exposure. 2). The quantitative findings 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 lifecourse. Re-traumatization is a risk factor for negative changes in competence and resilience. |
| Hobfoll et al (2002) | To investigate how sense of mastery and social support might lead to women's greater resiliency. | Cross sectional design, | 160 adult women | U.S.A | The Social Support Questionnaire-6, The seven-item Mastery Scale, Childhood Trauma Questionnaire, The Conservation of Resources Evaluation. Profile of Mood States, Trait Anger Expression Inventory. | Psychosocial resources are related to better emotional outcomes and lower AIDS risk for women. Greater support satisfaction was significantly related to lower depressive mood. Sexual abuse and mastery did not significantly contribute to depressive mood. Native Americans' communal culture would result in a larger impact of social support over mastery was confirmed. |
| Bogar et al (2006) | To identify the underlying processes that facilitated resiliency formation in women survivors of childhood sexual abuse. | Phenomenological study | 10 women | U.S.A | Interview Protocol—questions | Five resiliency determinants are: (a) interpersonally skilled, (b) competent, (c) high self-regard, (d) spiritual, and (e) helpful life circumstances. Four clusters were identified as resiliency processes: (a) coping strategies (b) refocusing and moving on, (c) active healing, and (d) achieving closure. |

Table 6: Continued


| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | Factors associated with resilience |
|--------------------------------|--|---------------------------------------|----------------------------------|------------------|---|---|
| Wilson et al. (2011) | To examine if a stress management education programme remains effective in improving coping skills as measured by the Ways of Coping. | Quasi experimental intervention study | 32 female adult survivors of CSA | U.S.A | 1). The Ways of Coping Questionnaire. 2). 66-item, self-administered questionnaire, which examines eight scales of coping behaviours. | 1). Seeking Social Support behaviours increased after the intervention. 2). The category of escape avoidance behaviours was significantly reduced after the stress management training. 3). planful problem solving behaviours increased when escape-avoidance behaviours decreased. 4). The increase in positive reappraisal behaviours was significant, suggesting more cognitive processes and more adaptive coping. Reappraisal behaviours refer to growth, actualization and spiritual aspects of the process. |
| Saha et al (2011) | To explore how the sense of self evolves through the recovery process after intensive therapy that focuses on issues pertaining to (CSA) | A retrospective qualitative study. | 4 women | Britain | Narrative Interview and Analysis Design  | 1). Understanding of why these experiences had happened to them resulted in positive consequences. 2). Seeking deserving fair opportunities in life, and being significant and treated fairly. 3) Externalising the abuse experience' by bringing it away from the confines of one's own mind. 3). Emerging positive sense of self and one's ability to cope. |
| Lamoureux et al. (2012) | To examine the impact of CSA impact on resilience on adulthood-interpersonal functioning and sexual risk. | longitudinal study | 693 women | U.S.A | 1). Childhood Trauma Questionnaire (CTQ) 2). Rosenberg (1965) Self-Esteem Scale. 3). Center for Epidemiological Studies Depression Scale (Radloff, 1977). 4). Conservation of Resources Evaluation (Hobfoll & Lilly, 1993). | CSA was significantly linked to fewer personal resiliency resources and greater psychological distress in adulthood. Resiliency resources mediated the impact of CSA on HIV/sexual risk and psychological distress only mediated the impact of CSA on interpersonal problems. |

Table 6: Continued

| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | Factors associated with resilience |
|--------------------------------------|--|-------------------------|--------------------|------------------|---|--|
| Wahab et al (2014) | To explore the association between depression in sexually abused young females, and socio demographic variables and abuse characteristics. | A cross-sectional study | 51 females | Malaysia | 1) Strength and Difficulty Questionnaire (SDQ) 2). Schedule for Affective Disorders and Schizophrenia for School Aged Children (K-SADS) and K-SADS-PL (Present and Lifetime version) and Socio demographic Data. | Abused adolescents who live with others were 23-times more likely to be depressed as compared to those living with their parents. Those who lived with parents appeared to have a better outcome. |
| Jonzon & Lindblad (2005). | To investigate the relationships between risk and protective factors and health outcome in a sample of adult females who had been victims of child sexual abuse. | Not stated | 152 | Sweden, | Measures used in the study assessing 1). Risk factors 2). Protective factors 3). Outcome measures and 4). Confounding factors 5). | Results from both the person-oriented and the variable-oriented methods indicate that it is the presence of resources – especially social support – that seems to be more important for health than the quantity of risk factors. Self-esteem was closely related to health outcome displaying the importance of this concept in clinical practice. |
| Bonanno et al. (2007) | The study examined the expression of positive emotions in relation to social adjustment among females with histories of CSA. | Cross-sectional | 105 | U.S.A | Interview Protocol— questions, Facial Displays of Positive and Negative Emotion, Self-Reported Negative Affect, Repressive Coping and Dissociative Experiences, Social Adjustment and Maladjustment, Caseworker Abuse History Questionnaire | Genuine positive emotional expression was generally associated with better social adjustment. CSA survivors who expressed positive emotion in the context of describing a past CSA experience had poorer long-term social adjustment, whereas CSA survivors who expressed positive emotion while describing a non-abuse experience had improved social adjustment. |

Table 6: Continued

| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | Factors associated with resilience |
|--|---|--------------------|-----------------------|---------------------|---|---|
| Wright et al (2007) | The study explores later resilience across intrapersonal, interpersonal and intrafamilial domains. | Not stated | 79 adult females | U.S.A | 1). Resolution of the CSA experience rating scale. 2). Center for Epidemiologic Studies-Depression Scale (CES-D). 3). Isolation Subscale of the Parenting Stress Index. 4). Physical Health Subscale of the Parenting Stress Index (PSI). 5) Marital satisfaction questions. 6). Children of Alcoholics Screening Test-6 (CAST-6), 7). Coping Strategy Indicator (CSI). 8). Benefit-finding seven-point scale. 9). Meaning-making seven point scale and self narratives written descriptions. | Results indicated that when multiple adaptation domains were assessed, mothers showed discrepancies in how adequately they functioned across domains. While severity of the CSA experience was only weakly associated with outcome, use of avoidant coping emerged as a significant risk factor and was strongly and consistently associated with negative outcome across domains. Spousal/partner support was a strong protective factor and buffered the relationship between depressive symptoms and parenting competence. Difficult child characteristics were significantly associated with mothers' perceptions of physical health and parenting competence. |
| Zraly & Nyirazinyoye (2010) | To examine how persons live with and endure pain and trauma of genocide-rape and have the capacity to readjust to everyday life in the context of post-genocide Rwanda. | Ethnographic study | 57 | Rwanda | 1). Observation and participant-observation . 2). Resilience Narrative Instrument (RNI), a semi-structured interview designed by the first author. | The process of resilience was patterned through Kwihangana - creative process of drawing strength from within the self in order to withstand suffering. Kwongera kubaho – belief that living life is still possible. Gukomeza ubuzima - a sense of moving forward and fighting for survival. These findings reveal emotional ethos of refusing to linger in pain, standing firm in the face of problems, and struggling for survival and health. Social connectedness, to establish meaning and normalcy. Each of the processes are coping strategies, such as “thought control” and “fortifying positive affect”. Collectively “going public” as genocide-rape survivors in a political environment was helpful. |

Table 6: Continued

| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | Factors associated with resilience |
|-----------------------------|---|-------------------------------------|----------------------------|------------------|---|--|
| Hauck et al. (2007). | To examine the impact of parental bonding as a resilience or a risk factor for psychopathology after rape. | Not stated | 30 women. | Brasil | 1). Bonding quality was measured by the PBI, 2). Davidson Trauma Scale (DTS), 3). Clinical Global Impressions Severity of Illness Scale (CGI-S). 4). Mini International Neuropsychiatry Interview | The perception of having less affective parents was correlated with severity, and acute stress disorder (ASD) was more frequent in participants with less affectionate and more controlling fathers. Perceived lack of support was associated with clinical impairment. |
| Zraly et al. (2013). | To explore the role of motherhood in processes of resilience among survivors of 1994 genocide in Rwanda. | Archival study of ethnographic data | 63 genocide-rape survivors | Rwanda | Primary study utilised participant observation, unstructured interviews, and semi structured resilience-narrative interviews | The study suggests that motherhood bolsters Rwandan genocide-rape survivor's resilience through (1) diminishing the stigma of genocide-rape through its symbolic value, (2) fostering the experience of positive emotion, (3) providing a reason to live, (4) practicing maternal desire-mediated distress tolerance, and (5) making meaning of child related genocide-rape suffering. |
| Singh et al. (2010) | Explores the cultural context and processes of resilience used by South Asian female survivors of child sexual abuse. | Phenomenological study | 13 South Asian adult women | U.S.A | Semi structured interviews and focus group discussions. | 1) Pride in and connection to South Asian identity had a significant impact on experiences of child sexual abuse and resilience This assisted in accessing South Asian modalities of healing (e.g., yoga, meditation) after abuse and buffered them from some of the negative effects of racism. 2). the South Asian context also influenced both the salience and selection of their resilience strategies. |

Table 6: Continued

| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | Factors associated with resilience |
|------------------------------------|---|-------------------------------------|-----------------------|---------------------|---|---|
| Singh et al. (2013) | To explore resilience strategies of African American women who had survived child sexual abuse. | Phenomenological research tradition | 10 women | U.S.A | Semi structured interview protocol | 1) Resilience strategies were infused with a collective and community component—rather than existing as individualistic, internal strategies. 2) Major component of resilience included being able to name the trauma symptoms they were experiencing and overcoming being silenced within their family. 3). The myth of the “strong Black woman,” assisted them in further developing self-esteem, confidence, and self-healing as a survivor of abuse. Informants used intentional and creative ways of resistance—from journaling about how these stereotypes affected them to attending support groups for women of color survivors of abuse and the use of humor, 4). Religion and spirituality played a key role. |
| Leifer et al. (2004) | To assess the continuum of resilience in sexually abused mothers of non-sexually abused children and sexually abused mothers of sexually abused children. | Not stated | 196 mothers | U.S.A | 1). A semistructured, interview. 2). Composite score for continuity of care, adult abuse history and negative outcomes in relationships composite score. 3). Relationship Style Questionnaire (RSQ). 4). Maternal Attachment Questionnaire 5). Trauma Symptom Checklist-40. | Study demonstrate that maternal substance use is an important risk factor contributing to intergenerational transmission of abuse. Abuse discontinuity mothers were significantly less likely to be substance abusers than were abuse continuity mothers. Overall, the findings presented here suggest that maternal resilience acts as a protective factor to reduce the risk of continued intergenerational transmission of CSA. |
| Hyman & Williams (2001) | To investigate resilient outcomes among women who were sexually abused as children. | Not stated | 136 | U.S.A | 1). Trauma Symptom Checklist-40, Middlesex Hospital questionnaire. 2). Two measures of health (severe illness or surgical procedure or the use of alcohol or drugs). 3). A measure of resilience. | Family context played a role in CSA in predicting a resilient outcome. Social support received since the CSA did not appear to explain the women’s resilience. Those who experienced incest or CSA accompanied by physical force and those who were arrested as teenagers were less likely to be resilient. The strongest predictor of resilience was whether a woman graduated from high school, given that. The |

Table 6: Continued

| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | Factors associated with resilience |
|--------------------------------|--|------------------------|-----------------------|---------------------|--|--|
| Whitelock et al. (2013) | To explore the correlates of negative and positive responses to CSA | Cross-sectional design | 49,442 | U.K. | 1). Satisfaction With Life Scale. 2). Childhood Traumatic Events Scale. 3). Big Five Inventory | final predictor of resilience was whether the woman was revictimized as an adult. Women who had been recently raped were less likely to be resilient. Abuse-specific and personality variables were important predictors of life satisfaction for CSA survivors. Positive outcomes were more likely for female, young, white, and employed individuals, who earned more money, were highly educated, were in intimate relationships, and who had suffered fewer additional traumatic experiences in childhood. Satisfied survivors were also more extraverted, agreeable, conscientious, as well as less open and neurotic, than peers with lower life satisfaction. The Big Five personality variables were important predictors of satisfaction: Well-being was associated with greater extraversion, agreeableness, and conscientiousness, as well as lower openness and neuroticism |
| Ligiéro et al., (2009) | To develop a model on how Latinos cope with childhood sexual abuse (CSA) and the ways in which personal and cultural variables influence their coping strategies | Grounded theory | 9 Latino women | U.S.A | In-depth interview. | Results suggested that participants' coping efforts were influenced by a variety of cultural factors and that they engaged in a wide range of coping behaviors, all of which served two main functions: (1) seeking relief from negative emotions and (2) protecting one's self from further abuse. |



Table 6: Continued

| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | Factors associated with resilience |
|--|---|--------------|--------------------|------------------|--|--|
| Bryant-Davis et al. (2011) | The study explores the role of religious coping and social support in the recovery of African American sexual assault survivors. | Not stated | 413 | U.S.A | 1). The Sexual experiences survey (SES). 2). The Social Activities Questionnaire 3). The Brief COPE Scale of Carver (1997). 4). The Center for Epidemiologic Studies–Depression Scale (CES-D) | 1). Women who had more access to and utilization of a social support network reported less depression and PTSD than women with less support. 2). Sexual assault survivors who endorsed greater use of religious coping also reported higher depressive and PTSD symptoms. This may be because the engagement in religious coping exacerbated women’s distress i.e. use of negative religious coping which entails; adoption of belief that God is punishing them, that one should passively wait for God to change the situation, that the individual has failed in their faith and that prayer is a tool for avoidance. |
| Murphy et al. (2009) | To explore the ways in which the current system affected adult survivors of sexual assault and as well as exploring their lived experiences. | Not stated | 12 | U.S.A | Interviews | 1). Making meaning reveals and seeking to climb away from the assault. Understanding why and how the assault happened and coming to terms with the meaning of the assault. 2). Going beyond themselves uncovers the strategies (e.g., spirituality and forgiveness, the pursuit of justice) in an attempt to move from despair to healing. Acknowledging the role of external agencies in helping or hindering that process. The women talked about being depressed and feeling manipulated; they expressed anger and felt wounded. |
| Najdowski & Ullman, (2009). | To examine how traumatic life events, self-blame, perceived control over recovery, and coping strategies were related to PTSD symptoms and self-rated recovery. | Not stated | 969 women | U.S.A | 1). Sexual Experiences Survey & Stressful Life Events Screening Questionnaire, 3). Rape Attribution Questionnaire. 4). Measure of maladaptive coping. 5). Measure of adaptive coping. 6). Posttraumatic Stress Diagnostic Scale. | Maladaptive coping partially mediated the effects of other traumas, self-blame, and perceived control over recovery on both PTSD symptoms and self-rated recovery; greater maladaptive coping was associated with increased PTSD symptoms and lower self-rated recovery |



Table 6: Continued

| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | Factors associated with resilience |
|-----------------------------|--|--------------|-----------------------|---------------------|--|---|
| Wright et al. (2005) | Exploration of resilience following CSA within a multidimensional framework by assessing resilience across intrapersonal, interpersonal, and intrafamilial domains | Not stated | 79 | U.S.A | Participants completed four outcome measures 1), Center for Epidemiologic Studies, 2), Depression Scale, 3), Parenting Stress Index [PSI] Health Scale, 4), PSI Parenting Competence Scale, and a measure of marital satisfaction. | While severity of the CSA experience was only weakly associated with outcome, use of avoidant coping emerged as a significant risk factor and was strongly and consistently associated with negative outcome across domains. Spousal/partner support was a strong protective factor and buffered the relationship between depressive symptoms and parenting competence. Difficult child characteristics were significantly associated with mothers' perceptions of physical health and parenting competence. |
| Gall (2006) | The purpose of this study was to explore the role of spiritual coping in adult survivors' responses to current life stressors. | Not stated | 101 | Canada | 1). Abuse descriptors. 2). The RCOPE. 3). The Cognitive Appraisal Checklist 4). Support satisfaction. 5). Profile of mood states (POMS). | 1). Survivors who responded to their current life stress by being angry with God (i.e., spiritual discontent coping) tended to experience greater levels of depressive mood. Those with positive attitude of spiritual coping (e.g., religious forgiveness, active surrender), experienced lower levels of anger and depressive mood. 2) Those who experienced more severe forms of abuse relied on negative forms of spiritual coping (e.g., anger at God). 3). The timing or onset of abuse, (in childhood or adulthood. 4). Survivors who experienced sense of resolution of their CSA reported using less self-directed coping and God reappraisal (i.e., out of God's control), and more spiritual support, religious forgiveness and active surrender coping. These findings may reflect that survivors utilize more positive forms of spiritual coping (e.g., forgiveness) and rely less on negative forms of coping (e.g., God reappraisal) 5). Finally, those who utilized more self-directed and God reappraisal coping reported greater anger. 6). Summarily there may be two general forms of |

Table 6: Continued

| Author | Study aims | Study design | Population/ Sample | Setting/ Context | Measuring tools and data collection. | spiritual coping: helpful and harmful | Factors associated with resilience |
|----------------------------------|--|--------------|-----------------------|---------------------|--|---|------------------------------------|
| Hyman and Williams (2003) | This study sought to distinguish the specific types of perceived social support that buffer the development of post-traumatic stress disorder (PTSD) in victims of childhood sexual abuse (CSA). | Not stated | 172 | U.S.A | The Interpersonal Support Evaluation List (ISEL) and the Impact of Events Scale (IES). | 1). Results of the study suggest that there is a specific combination of perceived support types that is most useful in preventing the development of PTSD in CSA survivors. The perception that others value the abused individual (self-esteem support), in addition to the perception that she had the ability to obtain advice when coping with problems (appraisal support), were inversely related to PTSD symptom levels. 2). Perceiving that others value the abused individual may counteract the self-blame associated with poor long-term adjustment in this population. Feeling valued may challenge the development of negative core beliefs about self-worth and foster healthier adjustment. 3). In particular, results of this study indicate that perceived appraisal support and self-esteem support contribute beneficially to healthy adjustment in CSA survivors by decreasing the severity of PTSD symptom development. | |



Factors promoting resilience among survivors of sexual abuse

1) Availability of social support from family and friends

Studies demonstrated that social support exerts a significant impact on resilience.

Whitelock et al. (2013) reported that social support in the form of intimate relationships may promote well-being by generating positive affect, a sense of stability, and recognition of self-worth, which are valuable coping resources for survivors just as parents, teachers, and peers often are for young victims. The presence of resources such as social support and self-esteem were found to be important for positive health outcomes after sexual abuse in adults (Jonzon & Lindblad, 2005). Similarly, Bryant-Davis et al. (2011) concur that resilient women who indicated having more access to and utilisation of a social support network reported no depression and PTSD than women with less support. Greater support satisfaction has also been reported by Hobfoll et al. (2002) as significantly related to lower depressive mood among resilient survivors of sexual abuse.

Family support, cohesion and parental support was found to exert a significant influence on survivors' resilience (Hauck et al. 2007; Hyman & Williams, 2001, McClure et al. 2007; Wahab et al. 2014). Leifer et al. (2004) noted that mothers who are resilient survivors of sexual abuse become a protective factor as they continue to reduce the risk of continued intergenerational transmission of sexual abuse. Importantly for Wright et al. (2005) spousal/partner support was a strong protective factor against depressive symptoms. It promoted resilience among mothers who were survivors of sexual abuse and helped them to manage difficult child characteristics (temperamental characteristics that often make parenting stressful i.e., distractibility/hyperactivity, adaptability, demandingness, and mood). In their study, Wright

et al. (2005) noted that such support was significantly associated with mothers' perceptions of improved physical health and parenting competence.

Along the same line, it was indicated earlier that a history of sexual abuse had been linked to poor social adjustment and general relationship problems including negative intimate relationship outcomes, intimate partner violence and decreased satisfaction in romantic relationships. Social support improves interpersonal adjustment (Lamoureux et al. 2012). Interpersonal adjustment becomes a pathway to develop resilience through creating a platform for survivors to receive attention from a mentor or another significant person who encourages and helps them view the future with hope that it will be better than the present or past abusive circumstances (Hyman & Williams, 2001).



2) Ego resources

Ego or intrinsic resources have been demonstrated to exert influence on resilience. A resource such as belief in the sense of control (self efficacy) or power during recovery leads to less negative effects after sexual abuse (Breno et al. 2007). Breno et al. (2007) emphasised that resilience among the participants was related to “recognizing personal power” and to an internal locus of control. Lamoureux et al. (2012) noted that self-esteem and self efficacy are important resiliency resources that limit the negative impact of various stressors. Self-esteem increases self-worth and self-efficacy increase survivors' assertiveness in creating harmonious relationships and protected them in distressful situations. In the same vein, Walsh et al. (2007) reported that coping strategies and feelings of control may be more important in attempting to resist unwanted coercive sexual assaults and somatology. Likewise, Bogar et al. (2006) indicated that interpersonal skills, competency, high self-regard, spiritual and helpful life circumstances (poverty being seen as strengthening one's resilience, being youngest in a family, perpetrator not

living in the same home, influence of both supportive and challenging people) are determinants of resilience. Wright et al. (2007) found that coping strategies, meaning-making, and benefit-finding, strengthens survivors' ego and facilitate robust recovery and long term adjustment.

3) Temperament/Personality Factors

Personality variables are highlighted to be important predictors of resilience and life satisfaction among survivors of sexual abuse. In exploring such personality variables, Whitelock et al. (2013) reported positive associations between extraversion, agreeableness, conscientiousness, and subjective wellbeing/resilience, as well as the negative associations between neuroticism. In their study, resilient survivors were reported to be satisfied, extraverted, agreeable and less neurotic than less satisfied survivors. Elaborating further, Whitelock et al. (2013) indicated that extraversion was thought to predispose survivors' positive affect, while agreeableness predicted greater quantity and quality of social relationships. Conscientiousness was associated with greater achievement; conscientious people set higher goals for themselves, are more highly motivated, and achieve more than less conscientious individuals (Whitelock et al. 2013). Therefore, Whitelock et al. (2013) concluded that resilient survivors are highly conscientious hence they set higher recovery goals: aiming to overcome their trauma fully. Striving for and achieving this goal enhance their life satisfaction/resilience. Hyman and Williams, (2003) concluded that important aspects of the person, the environment, the nature of stressful event, and available supports combine to determine resilience and positive outcomes.

4) Biographic characteristics

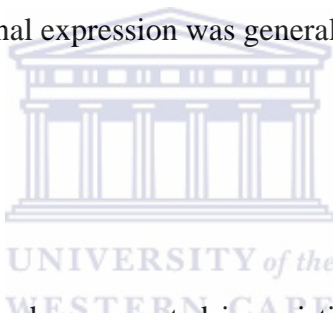
One study reported the role of specific biographical characteristics as emerging resilience. In their study, Whitelock et al. (2013) indicated that demographic variables are

associated with resilience and subjective well-being (current age, gender, ethnicity, employment status, income, and relationship status). Positive outcomes were more likely for female, young, White, and employed individuals, who earned more money, were highly educated, were in intimate relationships, and who had suffered fewer additional traumatic experiences in childhood. In the study, participants who perceived abuse to be less severe managed to recover from it more fully. Education was also noted to be an important resource upon which individuals could draw in the aftermath of trauma. Resilient survivors identified education (e.g. attending school) as a distraction from abuse. Survivors with higher incomes were noted to have better access to counseling and invested on means of recovery and were also less likely to experience additional stresses related to low income that could compound the effects of sexual abuse.

5) Ability to regulate emotions

Emotional regulation was implicated as a requisite constitute of resilience. Bonanno et al. (2007) indicated that emotion regulation involves processes responsible for monitoring, evaluating, and modifying emotional reactions which fosters adaptation to specific environmental threats and opportunities. A display of positive emotion appeared to serve a number of adaptive functions hence they represents sound cognitive and social adjustment. The study concluded that positive emotion is a resilience factor that fosters coping (Bonanno et al. (2007). This reflects the ability to use nonverbal cues to adjust to ones and social needs. The experience and expression of positive emotion contributed to the building of personal and interpersonal resources as well as the cultivation of resilient personality characteristics among the participants. Bonanno et al. (2007) further highlighted that genuine positive emotional signals evoke contagious positive emotional responses in others, helping behaviour and cooperation, promote group cohesiveness, regulate conversation and encourage ongoing social activities, all

of which promotes resilience. In another study by Hyman and Williams, (2001) resilient survivors were able to regulate emotions through their ability to dissociate from intense feelings and not dwell on the abusive events because they are too painful. They acquired much information as possible about the triggers that stimulate unpleasant emotions and in return use altruistic behaviour to develop pleasant emotions; that is, they often try to protect others from abusive experiences and sometimes help other survivors (Hyman & Williams, 2001). Hyman and Williams, (2003) hold that emotional equilibrium enables a positive perception of appraisal support and self-esteem support that contributes beneficially to healthy adjustment in CSA survivors by decreasing the severity of PTSD symptom development. Bonanno et al. (2007) added that genuine positive emotional expression was generally associated with better social adjustment.



6) Cultural factors

Cultural related factors have been reported in assisting healing after sexual abuse. The study of Singh et al. (2010) not only explored how resilience was an important component of healing but also whether resilience was a culturally relevant construct. The study revealed that the cultural context of south Asian women (i.e. strict gender socialization, maintenance of family image, influence of ethnic identity, acculturative stressors) influenced both the salience and selection of their resilience strategies, such as a sense of hope, use of silence, south Asian social support, social advocacy and intentional self-care. Similarly within a sample of African America women, Singh et al. (2013) reiterated the impact of the myth of the “strong Black woman,” (acknowledging the realities of racism and sexism in their lives) assisted further development of self-esteem, confidence, and self-healing among black woman survivors of sexual abuse. Moreover, acceptance and closure were important correlates of resilience.

Ligiéro et al. (2009) reported in their study that values, beliefs, and practices that are specific to a certain cultural group influence how a survivor copes with her experience of sexual abuse. Individuals are influenced by family's culture that stem from the community in which he or she is embedded. The study demonstrated how Latinos' resilience was influenced by all four ecological levels which incorporated culture and values. Some of the cultural characteristics that promoted resilience included the act of reacting to the negativity introduced by the practices of *familismo* (compromising one's well-being for the sake of bonding within the family) *machismo* (the domineering male characteristics that are valued within the cultural context, such as physical strength, power over women, and sexual prowess), and *marianismo* (ideals of feminine passivity and sexual purity, encouraging woman to be docile, compliant, vulnerable, and unassertive). The women's resilience was further promoted by the skills of "*no pensar*" (avoid thinking about the problem), and "*controlarse*" (the ability to withstand stressing times of adversity). Not speaking about the abuse was also described both as a personal characteristic and as one that resulted from contextual factors which promoted their resilience. The sexual abuse these women survived, was not experienced as a gender-neutral trauma, but as intrinsically tied to their culturally embedded sexual self. Their coping efforts were influenced by cultural factors and coping behaviors aimed at relief of negative emotions and protecting oneself from further abuse (religion and church, having close friends, family members, being in a relationship, confiding in an organization and others) (Ligiéro et al. 2009).

In their study, Zraly and Nyirazinyoye (2010) detailed how survivors of rape in Rwanda used their cultural idioms to emerge resilience. They achieved resilience through the processes of 1), "*Kwihangana*" - creative process of drawing strength from within the self in order to withstand suffering, 2), "*Kwongera kubaho*" - belief that living life is still possible, 3),

“*Gukomeza ubuzima*” - a sense of moving forward and fighting for survival. Zraly and Nyirazinyoye’s (2010) findings revealed emotional ethos of refusing to linger in pain, standing firm in the face of problems, and struggling for survival and health. Social connectedness enforced by the Rwandan culture guided the survivors to establish meaning and normalcy.

7) Positive life opportunities

Of importance is the positive life opportunities which according to Hyman and Williams (2001) was the strongest predictor of resilience in their study. They reported that attaining resilience was strongly predicted by whether a woman graduated from high school. Hyman and Williams, (2003) further highlighted that accomplishment of tasks, such as sports, schoolwork, and the attainment of positions of authority promotes resilience. These researchers notified that the opening up of life opportunities or turning points in survivors’ lives may either positively affect resilience (such as completing high school and entering college or the workplace) or have an adverse affect on it (for example, becoming a teenage mother, which may foreclose some options, including the prospect of a successful marriage and the completion of high school) (Hyman & Williams, 2003). Hyman and Williams, (2003) reported that resilient women were significantly more likely than the non-resilient women to have graduated from high school (56% vs. 32%). Furthermore, the highly resilient women were more likely to report that they did well in school and got along well with the teachers (48% vs. 26%).

8) Religion and spirituality

Religion and spirituality has been acknowledged as impacting resilience. Singh et al. (2013) noted that the role of religion and spirituality in informants’ lives was the key in recovery after CSA. Gall (2006) detailed that there are two general forms of coping namely helpful

(positive attitude towards God as a sources of comfort and support; forgiveness and active surrender), and harmful (spiritual discontent, anger with God). Negative forms of spiritual coping invoke a sense of personal discontent, anger and detachment in an individual's relationship with a higher power. In contrast, positive forms of spiritual coping reveal a greater sense of attachment and reliance on a higher power for comfort and security and a concomitant active seeking of support from this higher power under times of stress. Negative spiritual coping was related to poorer emotional and psychological outcomes, while positive spiritual coping was related to better well-being among the survivors. Survivors who responded to their current life stress by being angry and discontent with God and pleaded for a miracle tended to experience greater levels of depressive mood (Gall, 2006). Resilient survivors were observed to use helpful forms of spiritual coping which included spiritual and congregational support, collaborative coping and benevolent religious reframing while the less resilient employed harmful forms of spiritual coping such as spiritual discontent. The study further indicated that spirituality appeared to act as a source of support, to aid in the process of meaning-making and to provide a source of inner strength and belief in self for these women survivors. The greater the perceived impact of the abuse, the more survivors utilized spiritual discontent coping.

Bryant-Davis et al. (2011) noted that engagement in negative religious coping may exacerbate women's distress. In their sample, some women used negative/harmful religious coping which entailed adoption a belief that God is punishing them, passive surrender (that one should passively wait for God to change the situation), spiritual hopelessness (that the individual has failed in their faith), and used a prayer as a tool for avoidance. Furthermore, Bryant-Davis et al. (2011) noted that resilient survivors indicated that positive spirituality and religious activities establish a protective role of social support while religious service attendance served to instil a

sense of purpose in their life that promoted resilient outcomes and contributed significantly to the recovery process. Wright et al. (2007) added religion and spirituality promotes resilience by facilitating cognitive restructuring (i.e. changing one's perspective regarding a traumatic event).

9) Abuse related factors

One study reported on abuse related factors as influencing resilience outcomes. Heckman and Clay (2005) posited that abuse severity (severity, duration, frequency, relationship to perpetrator, etc) moderate the association between hardiness/resilience and health. The study noted that some survivors are observed to be more resilient than others and that abuse characteristic moderate the effects of the abuse. In the study, hardiness (personality characteristics that function as protective resources in the encounter with traumatic life events) was used to refer to resilience. Analysis of survivors' responses revealed that the nature of the abuse and the relationship with the perpetrator and abuse characteristics posed a significant difference between the violently abused and non-violently abused survivors of sexual abuse. Findings of the study indicated non-violently abused women (e.g. absence of hitting, punching) were found to be significantly more physically and emotionally resilient than violently abused women based on their scores on measures of adjustment. The non-violently abused group was significantly healthier than the abused group in terms of both mental and physical health. The non-violently abused sample also possessed more hardiness and less neuroticism. The association was expected to be greater for mental health than physical health because hardiness is a mental construct and is, therefore, theoretically more closely related to adjustment than to physical health (Heckman & Clay, 2005). The association between hardiness and health for the violently abused sample was significantly lower than for the non-violently abused group due to influential abuse-related factors such as severity, duration, frequency and relationship to

perpetrator. Violently abused women may be hardy but have experienced such severe abuse that they become physically or mentally incapacitated.

Similarly, in the study of Gall (2006), individuals who reported more severe abuse (physical and sexual) and who experienced less resolution of their abuse history were noted to be less resilient as they reported greater levels of distress. Survivors who experienced a greater impact of the abuse on their current lives reported experiencing greater anxious and depressive mood. Other abuse characteristics reported in the study such as age of onset, duration, and number of perpetrator categories were not related to distress.

10) Coping skills/strategies

Attainment of resilience is also influenced by the use of effective coping skills. This includes active problem focused coping, social role satisfaction and having a positive sense of community (Banyard et al. 2007). The strategies in which survivors engage to cope with the experience of sexual abuse are important mediators of the relationship between recovery and psychosocial variables. Wright et al. (2007) reported problem-focused coping promotes resilience. This coping refers to the ability to manage stressful situations (i.e. active problem solving, seeking social support, and confrontation). Further, the study revealed that the use of avoidant coping strategies, such as denial, distancing, disengagement and self-isolation, is associated with more psychological distress. Likewise, Wright et al. (2005) argued that use of avoidant coping emerged as a significant risk factor and was strongly and consistently associated with negative outcome across domains. The study also highlighted active problem focused strategies (e.g., seeking social support, active problem solving, and cognitive reframing) are associated with positive outcome leading to resilience (Wright et al. 2005). Najdowski and Ullman, (2009) observed that adaptive coping (i.e. active coping, use of emotional support,

instrumental support, venting, positive reframing, planning, humor, acceptance and religion) mediated the effect of other traumas, self-blame, and perceived control over recovery on PTSD after sexual abuse. Survivors reporting the use of such adaptive coping had better outcomes which promoted their resilience.

Chapter summary

What constitutes resilience to women survivors of sexual abuse is encapsulated in the 10 categories. Family cohesion, an element of social support, permeated most studies as it had a predominant impact on resilience. Cultural related factors, religion and spirituality held both positive and negative outcomes for women depending on the context, culture, use of harmful or positive religious coping. Abuse related factors were demonstrated to have an impact on attaining resilience. Of importance is the role of ego resources, personal/intrinsic factors, ability to regulate emotions, and effective coping skills/strategies. These factors appeared in a number of studies and play a key role in attaining resilience. Interestingly, some studies reported positive life opportunities and another biographical characteristics as a significant predictor of resilience.

CHAPTER SIX: Discussion and Conclusion

Introduction

This study embarked on the process of addressing the identified research gap (i.e. lack of consensus in literature about the definition of and what promotes resilience among survivors of sexual abuse). Chapter 5 presented findings elaborating the synthesised understanding of the concept of resilience while Chapter 6 revealed synthesised findings identifying what promotes resilience among women survivors of sexual abuse. This chapter presents the discussion and conclusion as well as highlighting implications and limitations of the study.

Discussion

What is resilience?

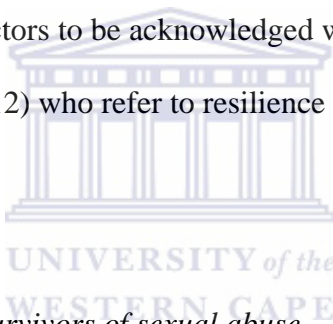
Findings of this review reveal that the concept of resilience is complex and multidimensional. Two major differences were observed among researchers about the concept of resilience. Most studies defined resilience as (1) recovery without showing negative symptoms or (2) gradual recovery whilst showing symptoms and a move towards a positive adjustment.

Researchers such as McClure et al. (2007) and Whitelock et al. (2013) referred to resilience as general well-being or absence of symptomology after exposure to a traumatic event. These findings contradict a previous study conducted by Rutter (1993, p. 628) who argued that resilience is not general well-being, but rather something *"more than the absence of pathology"*. Although Rutter (1993), did not indicate what was meant by *"more than the absence of pathology"*, other studies elaborated on that notion. For example, Tedeschi and Calhoun (2004) expounded that *"more than the absence of pathology"* denoted a sense of appreciation for life,

meaningful interpersonal relationships, and an increased sense of personal strength, changed priorities, and a richer existential and spiritual life. This encapsulates resilience as success and prosperity in the context of adversity. For that reason, researchers (i.e., McClure et al. 2007) see it necessary to measure the indicators of success among the survivors of sexual abuse. This was congruent to the synthesised findings of this review that resilience has indicators. As elaborated by Whitelock et al. (2013) and McClure et al. (2007), these indicators are: competency in appropriate developmental tasks, self-acceptance, positive relations with others, and environmental mastery. Thus far, it can be noted that the concept of resilience refers to extraordinary outcome following the trauma without experiencing remnants of negative symptoms. It can be understood that, the survivor almost has to engage intensively with self-advancement (Hyman & Williams, 2001). This seemed to be a unique factor in understanding the concept of resilience which discards assertions proclaimed by Zraly and Nyirazinyoye (2010) that resilience is simply fundamental and an ordinary capacity.

The second category of studies (i.e. Hobfoll et al. 2002; Hyman & Williams, 2001), advocated that resilience involves robust recovery whilst showing trauma symptoms then gradually attaining an improved adjustment. These studies attempted to demonstrate or emphasise the understanding that to achieve resilience, there must be a complex gradual dynamic process of recovery, where a survivor overcomes trauma symptoms and thereafter attains sustainable or consistent positive outcomes (Philippe et al. 2011). The findings of this review are in line with the findings reported by Luthar et al. (2000), Bonanno (2004), and Theron and Theron (2010) that resilience is the process of bouncing back from adversity. Whitelock et al. (2013) refers to it as returning to normal or even higher levels of functioning. Therefore to attain resilience, it can be expected that a survivor can initially show negative consequences of trauma

but over time, recovers and then develops positive adaptive functioning (Banyard et al. 2007; Whitelock et al. 2013). The unique and significance of highlighting the "*complex dynamic process*", addresses concerns that the absence of trauma symptoms could later lead or develop into negative coping skills, (e.g. repression, dissociation, denial and avoidance) (Wright et al. 2005). In the previous findings, survivors who are not resilient were noted to employ such negative strategies (Phanichrat & Townshend, 2010). The uniqueness of resilient survivors is that they face trauma symptoms through directly engaging in that process leading to positive adaptation. In describing that process in particular, Singh et al. (2013) added that it takes place over time, all along facing the difficulty and adapting with success. These findings attempted to convey the complexity and core factors to be acknowledged when studying resilience contrary to other authors e.g. Wright et al. (2012) who refer to resilience as simply the personal ability to cope.



What promotes resilience among survivors of sexual abuse

From the findings of the review, it was clear that a range of factors can promote resilience, including 1) availability of social support from family and friends, 2) ego resources, 3) temperament/personality factors, 4) biographic characteristics, 5) ability to regulate emotions, 6) cultural factors, 7) positive life opportunities, 8) religion and spirituality, 9) abuse related factors, and 10) coping skills/strategies. These factors interact with one another, leading the survivor to be resilient. The presence of supportive and caring parents was reported to contribute to resilience (Hauck et al. 2007; Hyman & Williams, 2001). Although similar findings were reported by (McClure et al. 2008), these authors emphasised that it is not only the support and care, but rather cohesion and connectedness of the survivor to the family. This is likely to buffer

against poor sense of self (e.g. guilt, self-hatred, isolation and seclusion) by giving the survivor a sense of belonging (Hobfoll et al. 2002). Wright et al. (2005) specified spouse or partner as a significant protective factor which is also part of family support. Either from family or other avenues of social support (e.g. friends, professionals, goal oriented groups) primarily, the survivors of sexual abuse builds resilience through experiencing care and acceptance from such extrinsic elements (Bogar & Hulse-Killacky, 2006). While family and social support can be understood to be extrinsic factors or resources, other studies for example, Whitelock et al. (2013), acknowledged intrinsic factors such as personality and self-resources to be more important. The review identified these resources as self-confidence, feelings of control, self-regard, extraverted, agreeable, and conscientious (Whitelock et al. 2013). These findings are consistent with previous studies (Chandy et al. 1996; Janas, 2002; Theron & Theron, 2010) that report hardiness, self-efficacy, self-acceptance, tolerance, determination, happiness, commitment, self-reliance, and optimism as requisite for resilience.

Biographical factors (i.e. gender, race, educational level, employments status and resident location) were also deemed significant as part of resilience. Survivors seemed to require opportunities that will allow them to emerge resilience (Whitelock et al. 2013). Hyman and Williams (2001) highlighted the importance of employment and education. Similarly Theron and Theron (2010) identified having goals and/or achievements led to resilience among survivors. Interestingly, other authors such as McClure et al. (2007) contend that the presence of opportunities only did not guarantee resilience. Rather in addition to life opportunities, environmental mastery, adequate functioning, control, competence, continuously leading satisfying and productive lives were important. They conclude that opportunities accompanied or complimented with good personal resources in the process may lead to resilience.

Researchers such as Bogar et al. (2006) conveyed that resilient survivors are proactively focused and have a set of skills at their disposal. These skills vary and survivors use them in the process of becoming resilient. Although some researchers i.e. Banyard et al. (2007), ambiguously refer to effective coping skills, Najdowski and Ullman, (2009) were specific in identifying those skills as: the ability to use emotional support, accessing social support, venting, positive reframing, planning, humour and acceptance. Bogar et al. (2006) identified interpersonal skills and Wright et al. (2007) highlighted skills such as meaning-making, and benefit-finding. These findings are consistent with Phanichrat and Townshend's (2010) who argued that survivors become resilient through adopting positive coping styles such as problem solving and positive cognitive appraisal. These researchers also noted that survivors who struggle to achieve resilience mostly employ avoidant coping strategy.

In the process of achieving resilience, religion and culture exerted some influence (Bryant-Davis et al. 2001; Gall, 2006). They afford survivors the opportunity to process the trauma through encouraging meaning-making, and benefit-finding (Wright et al. 2007). Gall (2006) further emphasised religious approaches such as positive attitude towards God as a source of comfort and support, forgiveness and active surrender as contributing to resilience. This is opposed to negative religious coping such as spiritual discontent or anger with God (Bryant-Davis et al. 2011). These findings are in agreement with a study by Abraham et al. (2008), who hold that religious processes of emerging resilience inculcate attaining spiritual support from religious leaders, engaging in prayers, the power to forgive and letting go, having good faith and belief in God as well as surrendering to God. Culture specific practices were also noted to be contributing to resilience (Singh, 2006; Zraly & Nyirazinyoye, 2010).

Summary and major findings of the review

This systematic review synthesised large bodies of information and relevant studies that addressed two research questions, what is resilience? And what promotes resilience among survivors of sexual abuse? While many searches had varied accounts on what resilience is, this study synthesised the debates and noted that resilience is multidimensional (intrinsic and extrinsic resources/factors) and has a natural gradual dynamic process (using skills managing negative symptoms until adjustment is achieved) with indicators (competence and excellent functioning in important areas of life such as work, relationships, self-management, psychological well-being, and good health). Encapsulating the various debates on resilience is a major contribution of this study. Further to that, previous studies conceptualised resilience as composed of two factors which are that the survivor should have exposure to significant threat or severe adversity, (i.e., sexual abuse) and the achievement or presence of positive adaptation. Of importance is that this review study adds one more factor, which is resilience is a complex gradual dynamic process - acknowledging that resilient survivors experience negative consequences without suppression and learn competence in the process.

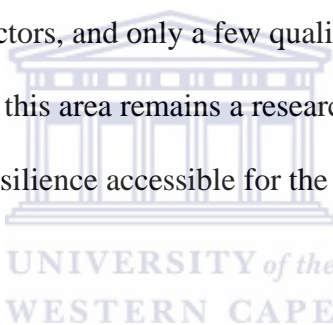
Providing a synthesis of what promotes resilience among survivors of sexual abuse (into 10 categories) is a significant contribution of this study. Overall, the findings from the current review lend credence to previous studies through establishing and reemphasising that resilience incorporates internal characteristics which include self-efficacy, perseverance, internal locus of control, coping and adaptation skills and the external factors that include family and social support networks. In addition, positive life opportunities and biographical characteristics are also significant predictors of resilience which were highlighted by only few studies.

Implication for practice

Sexual abuse is a significant trauma that impacts survivors' emotional, interpersonal, physiological, psychological and behavioural functioning. Such survivors are difficult to treat and they present mental health practitioners with an array of complications. Therefore, mental health professionals dealing with such a population, such as psychiatrist, counsellors and psychologists, can benefit from this study by considering the 10 identified resilience factors to aid treatment outcomes. Thus psychological and clinical interventions may include: 1) family interventions and psycho-education to facilitate support for the survivors' recovery, 2) helping the survivors to develop competent ego/personal/intrinsic resources, 3) guiding/advising survivors to attain improved biographic characteristics when possible (e.g., finding shelter or being in therapeutic programs or environments), 4) training emotion regulation techniques, 5) encouraging them to seek activities or contexts enabling social support, 6) exploring with them their cultural factors/idioms/practices that motivate “*positive thought control*” and “*fortifying positive affect*”, 7) guiding survivors to explore positive life opportunities such as obtaining/furthering education and employment, 8) when relevant, encourage survivors to employ their religion and spiritual interventions in a positive way, 9) use of specific therapeutic techniques dependent on abuse related factors that ameliorate self-blame and guilt, 10) and finally to identify and equip survivors with positive coping skills/strategies as well as eliminating negative ones. Although these interventions are already a focus in most treatment protocols for survivors, the findings of the study confirm and lend support to what already exists in the treatment literature around how to go about helping survivors to heal.

Implication for further research

Although ten factors of resilience have been identified by this systematic review, further research can attempt to study the processes involved in the development of each factor. For instance, this review identified the ability to regulate emotions as contributing to resilience. Future studies can examine the process of attaining emotional regulation. Furthermore, complex terminologies (i.e., locus of control, hardiness, self-efficacy, sound self, high self-regard, positive emotion and laughter, all under personal/intrinsic resources) were identified as leading to resilience. There is a need for further research to examine and demonstrate pathways and processes on how these skills or qualities can be acquired and applied. It was observed that most studies only identified resilience factors, and only a few qualitative studies attempted to explain the process of resilience. Therefore this area remains a research gap. Further elaboration on such resilience factors could make the resilience accessible for the survivors.



Limitations of the Study

The credibility of this systematic review is dependent on the methodological quality of the primary studies that were included. Limitations inherent in the methodology, design and sample size of previous studies might have affected the practical conclusion of this review. The current study was only limited to reviewing studies published between the year 2000 and 2013. Studies that focused on resilience separately and sexual abuse separately were excluded from the study. Therefore, only studies that addressed resilience and sexual abuse simultaneously were included. This study was also limited to published journals investigating resilience among survivors of sexual abuse. Unpublished studies, dissertation papers, systematic reviews,

editorials, letters, conference proceedings, books, and book chapters were excluded in this review.

Conclusion

A survivor of sexual abuse undergoes a life changing experience. While other survivors struggle with overcoming negative consequences of the trauma, there are those amongst them who attain resilience and develop excellence and competence as an outcome. In reaching out to those struggling with overcoming the trauma consequence, studying their resilient counterparts has proven useful. It is hoped that this study served its purpose and that it will be a resource for all survivors of sexual abuse through having identified for them platforms associated with resilience. Resilience can be enhanced by wide range of behaviours which can be learned by almost everyone. Every survivor of sexual abuse can learn ways to become more resilient by practising techniques that help them stay in the present, work on the problem at hand, and keep things in perspective. It is upon the mental health professionals to also take from this study some solutions and ways of helping survivors of sexual abuse. Knowing what promotes resilience is not the end results, but rather a starting point of acknowledging what may help this vulnerable population. It is the responsibility for one and all to work together, ensuring happiness and well-being for the challenged survivors of sexual abuse. More studies explaining processes of attaining the identified resilience factors are needed to continue enriching and informing interventions in order to facilitate the process of resilience for the survivors of sexual abuse.

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Appendix C

Qualitative evaluation tool

| <u>Purpose</u> | Study Yes(1) No(0) | |
|--|-----------------------------------|--|
| 1. Is there evidence that literature has been consulted in providing context or background? | | |
| 2. Is a clear problem statement? | | |
| 3. Is a clear rationale provided for the study? | | |
| 4. Are the aims of the study clearly stated? | | |
| 5. Are the aims explicitly related to the problem statement? | | |
| <u>Key Findings</u> | | |
| 6. Are the key findings of the study indicated? | | |
| <u>Phenomena under Study</u> | | |
| 7. Is the phenomena under study stated? | | |
| 8. Is sufficient detail given of the nature of the phenomena under study? | | |
| <u>Context I: Theoretical Framework</u> | | |
| 9. Is the theoretical orientation of the study reported and described? | | |
| 10. Was the theoretical orientation described in detail? | | |
| 11. Is the theoretical framework reflected in the way the study was done? | | |
| 12. Did the authors locate the study within the existing knowledge base? | | |
| <u>Context II: Setting</u> | | |
| 13. Is the geographical and setting the study was carried out reported? | | |
| 14. Is there a rationale justifying the choice the setting? | | |
| 15. Is the setting appropriate and/or sufficiently specific for examination of the research question? | | |
| 16. Is sufficient detail given about the setting? | | |
| 17. Was the time period of the study stated? | | |
| <u>Context III: Sample (events, persons, times and settings)</u> | | |
| 18. Was the sample selection process described? (events, persons, times and settings) (For example, theoretically informed, purposive, convenience, chosen to explore contrasts) | | |
| 19. Is the sample (informants, settings and events) appropriate to the aims of the study? | | |
| 20. Is the sample appropriate in terms of depth (intensity of data collection - individuals, settings and events) and width across time, settings and events (For example, to capture key persons and events, and to explore the detail of inter-relationships)? | | |

21. Did the authors state the key characteristics of the sample (events, persons, times and settings)?

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Context IV: Outcomes

22. Does the author address the target participant’s perspectives?

23. Is there sufficient breadth (e.g. contrast of two or more perspective) and depth (e.g. insight into a single perspective)?

Ethics

24. Was Ethical Committee approval reported and confirmed?

25. Was informed consent obtained from participants of the study?

26. Have ethical issues been adequately addressed?

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Data Collection

27. Was the method of analysis made explicit?

28. Was the description of the data analysis adequate? (For example, to allow reproduction; steps taken to guard against selectivity)

29. Is adequate evidence provided to support the analysis? (For example, includes original / raw data extracts; evidence of iterative analysis; representative evidence presented; efforts to establish validity - searching for negative evidence, use of multiple sources, data triangulation); reliability / consistency (over researchers, time and settings; checking back with informants over interpretation)

30. Are the findings interpreted within the context of other studies and theory?



Researcher's Potential Bias

31. Are the researcher's own position, assumptions and possible biases outlined? (Indicate how those could affect the study, in particular, the analysis and interpretation of the data)

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Implications

32. Did the authors report the setting where the study findings are generalisable? (For example, is the setting typical or representative of care settings and in what respects? If the setting is atypical, will this present a stronger or weaker test of the hypothesis?)

33. Did the authors report to what population are the study’s findings generalisable?

34. Is the conclusion justified given the conduct of the study (For example, sampling procedure; measures of outcome used and results achieved?)

Total score/Score (%):

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Weak <40%) Moderate (41-60%)
 (61-80%) Excellent (>80)

(Studies will be excluded from the systematic review if the quality of evidence was rated as weak (<50%) and if the combatting of health risk behaviour was not used as an outcome of the intervention.)

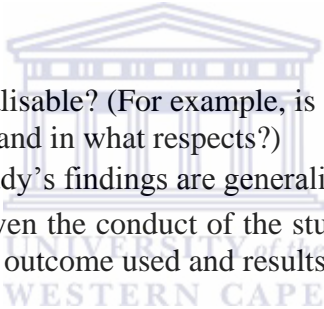
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Appendix D

Quantitative evaluation tool

| | Study | |
|---|------------|-----------|
| | YES (1) | NO (1) |
| <u>1) Study overview</u> | | |
| <u>Purpose</u> | | |
| 1. Is there evidence that literature has been consulted in providing context or background? | | |
| 2. Is a clear problem statement? | | |
| 3. Is a clear rationale provided for the study? | | |
| 4. Are the aims of the study clearly stated? | | |
| 5. Are the aims explicitly related to the problem statement? | | |
| <u>Key Findings</u> | | |
| 6. Are the key findings of the study clearly stated? | | |
| <u>(2) Study, setting, sample and ethics</u> | | |
| 7. Is the design of the study stated? | | |
| 8. Was the study relevant to the area of the topic review? | | |
| 9. Is the theoretical orientation of the study reported and described? | | |
| 10. Was the theoretical orientation described in detail? | | |
| <u>Setting</u> | | |
| 11. Did the authors report on the geographical and setting where the study was carried out? | | |
| <u>Sample</u> | | |
| 12. Was the source population stated? | | |
| 13. Is the inclusion criteria stated? | | |
| 14. Is the exclusion criteria stated? | | |
| 15. Was the sampling choice motivated? | | |
| 16. Was the sampling frame identified? | | |
| 17. Was the sampling method appropriate? | | |
| 18. Is the achieved sample size sufficient for the study aims and to warrant the conclusions drawn? | | |
| 19. Is information provided on the follow up of loss participants? | | |
| 20. Is the sample appropriate to the aims of the study? | | |
| 21. Was the key sample characteristics, in relation to the topic area being reviewed stated? | | |
| <u>(3) Ethics</u> | | |

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| 22. Was Ethical Committee approval obtained? | | |
| 23. Was informed consent obtained from participants of the study? | | |
| 24. Have ethical issues been adequately addressed? | | |
| <u>(4) Group comparability and outcome measurement</u> | | |
| 25. Were the confounding variables controlled (e.g. matching, randomization, in the analysis stage)? | | |
| 26. Was this control adequate to justify the author's conclusions? | | |
| 27. Were there other important confounding variables controlled for in the study design or analyses? | | |
| 28. Did the authors take these into account in their interpretation of the findings? | | |
| <u>Outcome Measurement</u> | | |
| 29. Were the outcome measures stated? | | |
| 30. Are the measures appropriate, given the outcome criteria? | | |
| 31. Are the measures well validated? | | |
| 32. Is there a sufficient breath of perspective? | | |
| <u>Implications</u> | | |
| 33. Are the study findings generalisable? (For example, is the setting typical or representative of care settings and in what respects?) | | |
| 34. Was population where the study's findings are generalisable stated? | | |
| 35. Is the conclusion justified given the conduct of the study (For example, sampling procedure; measures of outcome used and results achieved?) | | |
| Total score/Score (%): | | |
|  | | |
| Weak <40%) <input type="checkbox"/> Moderate (41-60%) <input type="checkbox"/> Strong (61-80%) <input type="checkbox"/> Excellent (>80) <input type="checkbox"/> | | |
| (Studies will be excluded from the systematic review if the quality of evidence was rated as weak (<50%) and if the combatting of health risk behaviour was not used as an outcome of the intervention.) | | |