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**Factors Promoting Resilience Following Childhood Sexual Abuse: A Structured, Narrative
Review of the Literature**

Clare Marriott ^a, Catherine Hamilton-Giachritsis^b, and Chris Harrop ^c

^aNorthants NHS Trust; ^bUniversity of Birmingham, Edgbaston, Birmingham, UK; ^c West London Mental Health Trust.

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^{a1} Corresponding Author:

Dr. Clare Marriott
Senior Clinical Psychologist
Learning Disability Psychology Service
Floor 2 Newland House
Campbell Square
Northampton
NN1 3EB

Tel: 01604 657748

Fax: 01604 638991

E-mail: Clare.Marriott@nht.northants.nhs.uk

Abstract

The aim of this paper was to review research investigating resilient outcomes for people with a history of childhood sexual abuse (CSA) and implications for practice, as well as to consider issues for clearer definitions. Fifty English language peer-reviewed studies (1991–2010) met the inclusion criteria. The reviewed papers identified a number of factors that were repeatedly associated with individuals showing resilient outcomes to CSA. These included inner resources (e.g. coping skills, interpretation of experiences and self-esteem), family relationships, friendships, community resources (e.g. church or school), as well as some abuse-related factors (e.g. older age at onset). A large number of methodological concerns within these studies were also noted, including the way in which resilience, CSA and protective factors were defined. However, despite this, many papers identified similar factors that could be utilised to develop both effective prevention programmes and resilience interventions for the survivors of CSA.

Keywords: resilience; child sexual abuse; protective factors; outcome

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Introduction

Until relatively recently, psychological research and interventions for people who have experienced childhood sexual abuse (CSA) focused upon the deleterious effect of this form of maltreatment. This is understandable as CSA has repeatedly been shown to have the potential to have a devastating impact upon the individual, such as an increased risk of developing psychopathology (Hillberg et al., 2011; Kendall-Tackett et al., 1993), revictimisation (Hamilton and Browne, 1999; Olafson and Boat, 2004), dissociation (Hanks and Stratton, 1995), interpersonal/sexual difficulties (Ahmad, 2006), suicidal behaviour (Tonge and King, 2004) and addiction (Lee et al., 2008). As a result, CSA survivors may make increased use of medical and psychiatric services (Hall and Lloyd, 1995; Waller and Smith, 1994).

However, research has also identified that maladaptation and mental ill-health are not the only possible outcomes following abuse or adversity. Instead, a considerable number of people exposed to a variety of risks demonstrate positive outcomes or show few long-term negative outcomes as a result of early adverse experiences (e.g. Collishaw et al., 2007; Luthar, 2003). These individuals are usually referred to as 'resilient', but considerable debate remains about the definition and assessment of this concept (Goldstein and Brooks, 2005).

Rather than arising out of academic theory, this field of research developed from researchers' observations (Richardson, 2002). For example, Werner and Smith (1971, cited in Werner and Smith, 1992) conducted a 30-year study of 200 children in Hawaii who were

Resilience Following CSA

considered to be at high risk for poor long-term outcomes due to parental stress, poverty, daily instability and serious parental mental health problems. Surprisingly, over one-third (36%) continued to do well. These children tended to be female, robust, socially responsible, adaptable, tolerant, achievement-oriented, good communicators and high in self-esteem. Further, they were more likely to be receiving support from caregivers, both within and outside of their immediate family.

Similar phenomenological studies were conducted by both Garmezy (1971–82, cited by Garmezy and Tellegen, 1984) and Rutter et al. (1976). In the Minnesota Risk Research Project, Garmezy and Tellegen (1984) found that many children of parents with schizophrenia did not develop similar psychopathology, emphasising the role of a triad of factors in this, including the individual's disposition, familial support and their external support system. In Rutter et al.'s (1976) research in the Isle of Wight, one-quarter of a sample of children exposed to multiple risks (such as low socioeconomic status (SES), maternal psychopathology and family conflict) demonstrated resilience. Again, resilient individuals were predominantly female, had a positive school experience, high levels of self-mastery and self-efficacy, good planning skills and a warm, close relationship with an adult.

However, while intuitively resilience appears to be a relatively simple concept, it is in fact very difficult to operationalise. Resilience is not directly measured, but is inferred from two component constructs: risk and positive adaptation (Luthar and Zelazo, 2003). In terms of risk factors, Goldstein and Brooks (2005) highlight that it is very difficult to

differentiate between a factor that places someone at risk (e.g. maternal depression) and one that has no causal influence (e.g. where the child experiences a high quality of caregiving, maternal depression may have little or no impact). Therefore, the effect that different experiences have upon an individual can vary considerably based on the interaction of a myriad of other factors, including individual characteristics, the severity of the experience and whether it co-occurs with other risk factors (Glantz and Johnson, 1999). As a result, there is a high possibility of confounding variables (Luthar and Cushing, 1999).

Similarly, Wright and Masten (2005) argue that a protective factor is a quality of a person, context, or the interaction of the two that predicts better outcomes in situations of risk or adversity. They cite airbags, emergency services and health insurance as everyday examples of protective factors for physical health. However, although factors such as good cognitive skills, effective parents and good schools are often cited as protective factors for mental health, Wright and Masten (2005) argue that these are assets or compensatory factors since they are helpful to the individual regardless of exposure to risk or adversity. Furthermore, protection can come from a process (e.g. the process of overcoming stress) or a buffer that mitigates the risk impact (such as secure attachment). Therefore, while there is a consensus that protective factors moderate the risk-outcome relationship, the term is used in a number of different ways.

In summary, resilience is variously defined as the presence of a positive outcome and the absence of a negative outcome. A variety of different criteria have been used to

judge positive adaptation, including the absence of pathology, successes in age-salient developmental tasks and self-reports of wellbeing (Wright and Masten, 2005). As a result, the same individual may be classified as resilient using one criterion, but not resilient using another (Glantz and Johnson, 1999). Furthermore, it is possible that levels of resilience vary over time. Consequently, an individual who is resilient at one point in their life can be less resilient at another (Hjemdal, 2007). So, should resilience be defined over a long period or short?

Thus, the key terms in resilience research need to be defined. Resilience research has the potential to identify ways in which the detrimental impact of risk can be reduced and highlight the protective factors that are beneficial to people in overcoming their experiences. The aim of this paper is therefore to assess resilience research that investigates the outcomes for people with a history of CSA and identify potential definitional approaches, as well as clinical implications.

Methodology

In order to identify relevant studies for a narrative review, the databases AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS and ELITE were searched, using the terms 'child maltreatment', 'child abuse', 'sexual abuse' 'abuse' and 'resilience, hardiness, invulnerability, 'positive outcomes' and 'protective factors' in the article title. No limits were set regarding date or the age of the participants involved in the study. Reference sections of the identified papers were also scrutinised for additional studies.

Resilience Following CSA

A total of 123 papers were found; only 50 papers (dates 1991-2010) met the criteria:

- Participants had a history of CSA (up to the age of 18 years).
- The paper attempted to measure or investigate the presence of resilience, hardiness, positive outcomes, invulnerability or protective factors in people who have experienced CSA, rather than risk.
- It was an English language paper.
- It was published in a peer-reviewed journal.

Although a systematic search was undertaken, the papers identified were reviewed narratively. This was to maintain a broad approach to the literature because a systematic review approach often significantly reduces the number of studies included and is sometimes criticised for taking a narrow approach. In contrast, a narrative review maintains a broader base of research but provides less information about the quality of those studies. Hence, it is not an exhaustive cataloguing of the quality of each paper; more a mapping of current findings, the identification of which techniques are most appropriate and an attempt to ascertain ideas for useful future research, as well as any cross-over from research to clinical practice. However, in this narrative review, the additional information available from longitudinal studies has been emphasised given that this is a more robust methodological approach and shows a clearer causality than cross-sectional designs.

Results

Methodological Considerations

Given the issues highlighted regarding methodology, the varying definitions and approaches will first be considered, followed by a review of the findings. Regarding methodology, the key areas of comparison are listed in Table 1, but studies included are exemplars only as space precludes every study being included. Where appropriate, attention has been paid to the longitudinal studies given that this is considered to be the 'gold standard' approach to research, although more difficult and resource-intensive to undertake and therefore less common. However, this is not to say that there is no value in other approaches and the purpose of this review was to maintain a broad focus. Indeed, qualitative studies (e.g. Bogar and Hulse-Killacky, 2006) add a depth that can be lacking in wider studies.

[Table 1 here]

Studies design. Since resilience is a dynamic concept subject to change over time, it is important to have longitudinal studies. However, longitudinal studies focusing upon resilience following CSA are rare. Of the studies reviewed, only eight used a longitudinal design, most of which have been published since 2007. Instead, most of the studies reviewed used cross-sectional designs. While this reflects common difficulties in researching this field, this does prevent conclusions about causality being made, as well as the durability of resilience over time.

Defining resilience. Within the studies there were noticeable variations in the way that resilience was defined, varying from proven competence in at least one field to the absence of negatives such as psychopathology (see Table 1). In three of the longitudinal studies, resilience was conceptualised positively measuring competence in at least one domain, yet the majority of studies across this review (including two of the longitudinal studies) defined resilience as the absence of negative outcomes such as psychopathology and delinquency. Yet, it should be queried whether a clinical level of psychological distress at one point in an individual's life means that they are not 'resilient' if this state is only transitory and/or they function well in every other domain. Notably, many studies took a variety of approaches to get a broad perspective, and this was not only relevant to the definition but also to the method of collection and assessment.

Defining childhood sexual abuse. Similar variety in assessing CSA was also found, ranging from reasonably rigorous (empirical measures of CSA; see Table 1) to more problematic (single question at interview). This latter approach does not permit any deeper analysis into the type and severity of abuse and links with outcome. In terms of self-report, it can be argued that it is subjective and influenced by participants' characteristics and that some level of objective assessment is needed to permit comparisons with confidence that they are 'comparing like-with-like'. However, particularly if combined it with a more objective measure (e.g. official records), self-report may have specific relevance in determining resilience in that perception of events may be

one of the most crucial aspects. As a consequence, however, the abusive experiences for participants in these studies might have varied considerably.

Factors relating to the abuse. Related to the variation in assessment of abuse was the clear finding that a large number of studies did not investigate abuse factors; many studies either did not report or did not collect data about when the abuse occurred in the person's life (young childhood or older), the severity, sub-type and chronicity. This is a clear gap in the literature and further information on the effects of types of abuse would be needed in future research. Thus, although in some cases these studies demonstrated that the frequency/severity of CSA experiences is unrelated to outcome (e.g. Dufour and Nadeau, 2001; Lambie et al., 2002), as a result, it is hard to ascertain the importance of abuse characteristics in likelihood of resilience. This seems to be a fundamental aspect of research in CSA and it is curious to find it so often absent in research.

Recruitment strategies. Recruitment strategies demonstrated the ingenuity of researchers in tackling the difficult problem of accessing people who had adverse experiences. The larger samples that emerged because the study was part of a larger research programme probably provide the best-quality data (see Table 1), especially if these data were carefully planned to be more representative of the general public; a downside was that some of these studies relied on single questions to establish some variables. Advertising in newspapers can also produce larger sample, but clearly brings about a response bias in that people responding are choosing to come forward with their experiences, excluding people who are resilient but less forthcoming. In addition, it seems

likely the wording of the advert or article and the type of publication can affect the results substantially. Quite a lot of studies employed court- or records-based recruitment, which could be seen as more robust regarding the assessment of CSA, but could potentially bias the sample towards more serious cases, or those with more overtly negative outcomes, thus limiting the generalisability of findings to those whose disclosure of CSA resulted in a legal or medical response. Where participants had been recruited from prisons and therapeutic settings, it calls into question whether these studies correctly operationalised resilience.

Protective vs compensatory factors. Within the studies examined, none make a clear distinction between factors that promote positive functioning in situations of adversity and those that promote it regardless of the individual's previous experiences. Instead, variables such as good cognitive skills, effective parents and good schools, which Wright and Masten (2005) argue should correctly be labelled as assets or compensatory factors, are typically referred to as protective. While for some, this could be considered to be a serious methodological flaw, it could also call into question whether a distinction between compensatory and protective factors is required.

Factors Promoting Resilience

In the studies identified (denoted with a dagger symbol in the References), between six per cent (Chandy et al., 1996a) and 48 per cent (DuMont et al., 2007) of the people studied were found to demonstrate some form of resilience, with a wide range of factors associated with a positive outcome for people who have experienced

Resilience Following CSA

CSA. This was typically related to the presence of inner resources, good family relationships, friendships, community supports and additional demographic/abuse characteristics (Table 2).

[Table 2 here]

Demographic/abuse characteristics. No obvious consensus was found for some demographic characteristics, even within the longitudinal studies. For example, males or females were more resilient in different studies. Similar variations were found in ethnicity, with some studies noting that non-white adolescents (DuMont et al., 2007) or being African American were positively related to resiliency (with an odds ratio of 1.18; Chandy et al., 1996a), but another longitudinal study found no difference between African Americans and the rest of the sample (Hyman and Williams, 2001). DuMont et al. (2007) describe their finding as an 'important contribution' and draw upon ethnographic research to suggest that it may be associated with African American adolescents or their parents using different strategies to promote resilience. They also stress that additional research needs to be conducted that investigates whether similar racial differences are found across different types of adversities, and to determine what increases resilience amongst the 'subgroups' that are more successful. However, while, if correct, this is an important finding, the variability across the three papers raises questions. One possible explanation for this lack of consensus may be the samples utilised by the studies. DuMont

et al. (2007) had a sample of 676 participants who they interviewed in adolescence and early adulthood. In their paper, they report that 61.5 per cent of participants were white. However, they fail to report how many of their participants came from other ethnic backgrounds represented in the study. Further, in the results section of the paper they refer only to 'non-whites' being found to be more resilient, but in the discussion draw upon ethnographic research exclusively focused upon African Americans. Hyman and Williams' (2001) sample consisted of 136 women, 86 per cent of whom were from an African American background. Chandy et al.'s (1996a) study consisted of 1959 adolescents (1121 of whom reported some form of sexual maltreatment), but only eight per cent of the sample were African American, three per cent were Asian or from the Pacific Islands and two per cent were Hispanic or Native American. This therefore causes us to question whether the methodologies that these papers used to recruit participants (court reports, hospital records and a large-scale health questionnaire) inadvertently recruited small numbers of resilient individuals from the non-dominant ethnic background, rather than a representative sample.

There was more consensus regarding SES background and cognitive capacity, with higher SES (Wright et al., 2005) and at least average or higher intelligence (DuMont et al., 2007; Herrenkohl et al., 1994) both found to be associated with resilience. Indeed, Herrenkohl et al. (1994) noted that intellectual capacity appears to be a necessary condition for successful outcome, although is not sufficient in isolation (although this conclusion is based on only 14 adolescents identified as resilient).

Resilience Following CSA

Younger age at onset was found to be associated with more negative outcomes and older children were more likely to be resilient (Table 2). For example, Moran and Eckenrode (1992) found that neglect or abuse that began before an individual was 11-years old was associated with lower self-esteem, increased depression and a more external locus of control for good events. Feinauer et al. (2003) posit that this reflects early abuse, severe abuse (typically accompanied by extreme physical punishment) and the lack of a supportive parent being indicative of greater family dysfunction, likely to be more chronic and, as a result, more likely to interfere with development. These factors would all, indeed, be expected to increase the likelihood of a less resilient outcome, but younger age may also reflect the fact that developmentally younger children are less equipped to 'make sense' of the abuse, both cognitively and in terms of being less likely to have the freedom and independence to spend time in the company of more positive influences, be they peers, friends' families or at some social group.

This is supported by the research finding that family maltreatment is less associated with resilient outcomes, perhaps because it increases the time spent in an adverse environment and reduces the likelihood of positive role models. For example, Hyman and Williams (2001) reported that although 54 per cent ($n = 73$) of their participants overall were abused by family members, in the highly resilient group this rate was lower at only 32 per cent (8 of the 25 highly resilient group). Furthermore, rates of concurrent severe physical abuse were 58 per cent ($n = 79$) for the overall sample, but only 28 per cent ($n = 7$) in the highly resilient group, with physical force alongside CSA also

found to be significant. However, the limitation of this study is that it is not entirely clear whether the 'severe physical abuse' is perpetrated by parents or caregivers, nor is a definition of severe provided other than that data were collected on whether the women had experienced 'pushing, shoving, slapping, beating, or choking'. On the other hand, it does demonstrate the effect of the multiplicity of abuse, where it appears to be a combination of factors that become overwhelming.

This may explain the contrast with other studies which indicated that the severity of abuse was not linked to later adaptation (e.g. Dufour and Nadeau, 2001; Lambie et al., 2002). For example, in a study of offending and non-offending males who had been childhood victims of CSA, Briggs and Hawkins (1996) found that, perhaps counter-intuitively, the participants they considered to be resilient actually reported a greater frequency of CSA experiences, while some with a lower frequency of abuse had become perpetrators of abuse themselves. This was true in every age category (i.e. 0–5, 6–10, 11–15 years), with the non-offender group reporting a greater frequency of sexual abuse than the offenders. However, offenders who had been abused against by a greater number of people were less likely to have seen it as abusive if the perpetrator was known to them or was female, while the most resilient participants were those who had been abused by a stranger and who felt able to externalise responsibility.

Overall, therefore, contradictory findings in many aspects reviewed suggest that resilience is linked to a combination of factors, not just that quality in isolation, and consideration should be paid to possible confounding by other variables (such as social

support and community factors, discussed later). However, the research also suggests that a multiplicity of events may be an important factor in outcome, in particular, the impact of family abuse in terms of reducing support and positive experiences. Thus, resilience can be viewed at an individual level, but also in terms of the wider factors of family, community and society.

Inner resources. The use of adaptive coping skills and hardiness is regularly cited as being associated with resilience (Table 2), with the emphasis in these papers appearing to be upon the term 'adaptive' because the positive outcomes clearly stem from specific coping strategies. For example, Feiring et al. (1998) reported that positive strategies to actively deal with past experiences, such as expressing emotion and actively seeking change, were associated with positive psychological functioning compared to more self-destructive behaviours and/or avoidant behaviours that were more likely to be associated with impaired functioning.

Many of the papers also identified that the individual's interpretation of their abuse experiences was important, such as the individual's attributional style (i.e. the extent to which individuals assess events as being personal, permanent or pervasive). Typically, resilient outcomes were associated with individuals perceiving negative events in their lives to be external to them, changeable and restricted to one aspect of their life, with resulting higher optimism (Liem et al., 1997; Moran and Eckenrode, 1992; Valentine and Feinauer, 1993).

Resilience Following CSA

How the individual understands their abuse experiences was also important.

Dufour and Nadeau (2001) identified that the 20 women in their study whom they defined as demonstrating positive functioning blamed themselves less for the abuse they experienced and felt less stigmatised than the 20 women who reported problems with addiction. Finally, Bogar and Hulse-Killacky (2006) stated that the ten resilient women in their qualitative study had achieved this through integrating the abuse experiences into their personal life stories without a high level of emotional pain. They had done this in a variety of ways that allowed them to make sense of, or construct meaning for, the abuse. For six of the ten this had included some form of psychotherapy, but they also talked about other methods such as being creative (e.g. writing, drawing) and for nine out of ten it included the concept of forgiving their abuser. Consequently, these studies demonstrate that the meaning that people attach to their abuse experiences is related to their later functioning, but also show the complexity of factors that were associated.

For example, Bogar and Hulse-Killacky (2006, p. 322) state that

‘although most of the participants struggled with feelings of shame and low self-esteem during some point in their lives, all possessed high self-regard at the time of the interviews. Some participants recalled a point in their lives when they made a conscious decision to change their negative self-view’.

However, some studies utilised self-esteem as an outcome measure, indicating resilience (Feiring et al., 1999; Runtz and Schallow, 1997). Thus, as Jonzon and Lindblad

(2006) question, it is unclear whether self-esteem should be viewed as a precursor of resilience or an outcome, or both.

Other inner resources repeatedly investigated by Cicchetti et al. (1993), Cicchetti and Rogosch (1997) and Flores et al. (2005) are ego resilience and ego control. They found that children aged six to 11 years with a history of maltreatment (according to the Department of Social Services' records) tended to be more likely to overcome their traumatic experiences when they demonstrated these personality constructs. In particular, being more reserved, controlled and rational in their interpersonal interactions was associated with more adaptive functioning. The authors therefore proposed that interventions should focus on autonomy, mastery and self-determination. Perhaps linked, Leon et al. (2008) found that those high in interpersonal or emotional competence tended to be more likely to demonstrate resilience. This refers to the individual's ability to make mature social relationships and to demonstrate appropriate coping skills.

However, it has been argued that much of the research on resilience generally, and on inner resources specifically, is based on Western literature and concepts (Ungar, 2008; Ungar and Liebenberg, 2011). This is an important distinction in terms of defining and assessing resiliency, but also in terms of the implications for interventions at individual, family and societal levels, not least because differing resources may mean that different opportunities are available. Thus, it has been argued that an emphasis should be placed on an individual's ability to 'navigate' towards the sources of support in the surrounding community, but that these need to be 'negotiated' to be meaningful to the child (e.g.

education that is culturally and personally appropriate rather than just any education) (Ungar, 2008).

Family relationships and environment. One of the most consistent findings among the longitudinal and other studies was that of stability, in terms of a connected and supportive family environment (Table 2). The definition used by the studies' authors usually relates to one or more caregivers who are present throughout the child's life and who remain there without frequent changes of caregiver (e.g. new partners coming into the home) and/or a stable situation with regard to housing (i.e. without frequent house moves) and education (e.g. disruptions to schooling or frequent changes of schools). This association was particularly found in the presence of stable caretaking by at least one parental figure, chiefly the mother. For example, in their longitudinal study of resilience in children from maltreating homes, Herrenkohl et al. (1994) found that all 14 participants who were considered to be resilient in adolescence (drawn from an initial sample of 23 considered resilient in early childhood) came from homes where there was the stable presence of at least one caretaker throughout childhood. DuMont et al. (2007) also found, in their study of 676 abused adolescents, that the likelihood of resilience increased if they had grown up in a stable household that had two consistent caregivers and few moves.

In these studies, resilience was associated with the individual feeling supported and understood by their parents (Table 2). Perhaps as part of the development of this feeling of being supported, positive parenting practices (such as the use of appropriate discipline and praise) were also found to be protective both in the families of

origin (Romans et al., 1995) and in foster homes (Leon et al., 2008), suggesting that positive caregiving at any point is beneficial. Further, both DuMont et al. (2007) and Liem et al. (1997) found that resilience was more likely when the survivor of CSA lived in a family where other stressful life events were minimised (e.g. lower divorce rates, death, family illness), suggesting that in this context CSA may be viewed as an aberration. These studies indicate that the family environment plays a key role in ameliorating the effects of sexual maltreatment upon the individual and again emphasises the role of multiplicity – or rather that the absence of multiple negative events increases the likelihood of resilience.

Friendships. Just as a positive family environment can be supportive, Chandy et al. (1996a) found that discussing problems with family or friends and the perception that this helped, increased the probability of an individual being classified in the study as resilient (by a factor of 1.29). Ten of the studies, including five of the eight longitudinal studies, found that a confiding relationship enabled individuals to resolve some of the emotional pain they had experienced as a result of their maltreatment experiences. It also enabled them to develop interpersonal trust (Daigneault et al., 2007; Kia-Keating et al., 2010), which is important in the context of a history of abusive relationships and lack of trust.

Adulthood relationships. Similarly, DuMont et al. (2007), Little and Hamby (1999) and Wright et al. (2005) found that perceived support from a spouse, or having children, was associated with positive outcomes in adults with a history of CSA. In a longitudinal study of 676 individuals, participants involved in a highly supportive relationship in adulthood (partner/spousal) were more likely to be resilient (DuMont et al., 2007). In

contrast, for 79 women (mean age 38.2 years) with at least one child, spousal/partner support did *not* act as a buffer against the effects of CSA severity on later outcome, but did contribute directly to positive outcomes in parenting competence and depressive symptoms (Wright et al., 2005). This latter finding is important in the prevention of the intergenerational cycle of maltreatment and whilst apparently not buffering for the individual concerned, it does have implications for buffering children from the effects of those outcomes.

However, some of the studies reviewed indicate that social support is only helpful at certain times in people's lives, such as immediately post-disclosure (Dufour and Nadeau, 2001). Feiring et al. (1998) found that social support was helpful among children, but in adolescence was associated with hyper-arousal and a belief that others perceive the individual negatively.

Education. Several studies (including both longitudinal and qualitative) identified that positive school or educational experiences were associated with resilience (Table 2). These include good relationships with teachers, high academic achievement and the completion of education, as well as the development of a positive future orientation that enables respondents to make realistic plans. For example, Edmond et al. (2006) found that girls who did not demonstrate mental health or behaviour problems as a result of their CSA experiences (49 of 99 girls, average age 16 years) demonstrated higher scores in measures of future orientation and were significantly more likely to be sure of their educational plans. One possible explanation is that academic success during childhood

Resilience Following CSA

provides a respite from the reality of CSA experiences and any other hardships in their lives (Bogar and Hulse-Killacky, 2006).

However, academic achievement is not a pre-requisite for positive adaptation. Jonzon and Lindblad (2006) found that among the women who they considered to be resilient in their study there were low proportions of highly educated individuals. Therefore, while academic success may be associated with resilience, it is not essential for positive outcomes.

Religion. Being part of a religious group or a sense of being spiritual was also found to be associated with resilience. This may be partly due to the meaning that it gives to people, but also to the social support that it provides by feeling part of a larger social group or community (Hobfoll et al., 2002; Valentine and Feinauer, 1993) and the reduction of social isolation (Kia-Keating et al., 2010). This is corroborated by research showing that support from clubs or a formal care agency is also beneficial (Leon et al., 2008).

Discussion

The aim of this paper is to provide a preliminary assessment of resilience research investigating outcomes for people with a history of CSA. As outlined earlier, this is a broad-canvas approach with the aim of maximising inclusiveness. This does mean that studies have been included that might not have been if more exacting scientific criteria had been applied, yet the emphasis has been on gathering ideas rather than rejecting that which is not yet proven.

It appears the field is looking healthy – resilient – in the variety of ideas and techniques used, but that it might be beneficial for researchers to develop a common definition. That is not to say it should be a narrow definition (e.g. absence of psychopathology) and, indeed, we would argue that resilience should adopt a wide approach, for example, considering a variety of domains (as many researchers have done) but also across time, such that individuals who maintain successful functioning in day-to-day life are ‘resilient’ even if they have periods where they are less adaptive (e.g. periods of depression). In addition, we would argue that there is little to be gained from an academic debate about whether a factor is ‘protective’ (a quality that predicts better outcomes in situations of risk or adversity) or ‘compensatory’ (helpful to the individual regardless of exposure to risk or adversity) – if a factor is known to benefit an individual irrespective of other experiences (e.g. good education, positive family environment), is it not appropriate to highlight those features for all children in all cultures?

It appears that simple steps like using more robust measures of both abuse and resilience could offer quick wins to progress the field (Heller et al., 1999; Kaplan, 2004; Luthar et al., 2000). This would enable better knowledge of how, for example, different types of abuse affect people. Using more standardised constructs would enable better comparisons between studies to be made; certainly, the many methodological differences between the different studies potentially made the generalisation of findings difficult. We are currently preparing a paper considering whether the same individuals are classed as resilient using the different definitions and measurement tools as a first step towards

achieving this aim. In the meantime, we suggest it is important to go beyond the absence of psychopathology in a definition of resilience and to start to consider resilience across the life-span and across several domains, perhaps allowing for transient periods of difficulty within an overall picture of resiliency.

However, it is striking that despite these differences and the different samples, many papers presented similar findings. A number of key factors have been repeatedly highlighted across the studies and a preliminary consensus reached with the same factors repeatedly identified as associated with resilience following CSA (including in the eight longitudinal studies reviewed). It could be argued that this actually makes the evidence more compelling.

In particular, interpersonal features (i.e. adaptive coping strategies, attributional style, an adaptive reaction to the abuse and self-esteem) were repeatedly identified as associated with resilience in the studies examined; but importantly so were familial support and stability, peer friendships, appropriately timed social support, academic success, spirituality and a sense of community. Indeed, the majority of longitudinal studies reviewed here agreed on the importance of a stable family environment, with one or two parents who remain stable over time, fewer moves and feeling both supported and understood by parents. These factors fit neatly into the triad of factors identified by Garmezy and Tellegen (1984) as the individual's disposition, the support received from their family and their external support system. In addition, they are similar to the factors

Resilience Following CSA

identified by researchers using phenomenological methodologies (e.g. Werner and Smith, 1971; Werner & Smith, 1992).

While many, if not most, clinical interventions are likely to focus on the domain of 'inner resources', there seems to be quite strong evidence that friends, family, schools and other community groups can inculcate resilience. Systemic interventions can help bolster all these areas. It also seems likely that health promotion initiatives and social policies and programmes can improve resilient outcomes for people with a history of CSA, and this is surely a topic worthy of increased research effort.

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Table 1. Key methodological aspects in which studies varied (longitudinal studies indicated in bold)

Domain	Approach (in order of rigour)	Studies
Study design	Longitudinal	Eight longitudinal studies: Banyard et al. (2002); Banyard & Williams (2007); Collishaw et al. (2007); Daigneault et al. (2007); DuMont et al. (2007); Herrenkohl et al. (1994); Hyman & Williams (2001); Leon et al. (2008).
	Cross-sectional/qualitative	Remainder of studies cross-sectional or qualitative
Definition of resilience	Competence in at least one domain	For example: Banyard & Williams (2007); Breno & Galupo (2007); Daigneault et al. (2007); DuMont et al. (2007); McGoin and Widom (2001); Spaccarelli & Kim (1995); Wright et al. (2005)
	Measured by psychometric instruments (e.g. Dispositional Resilience Scale, Bartone et al., 1989)	Kia-Keating et al. (2010)

	Absence of negatives – psychopathology and delinquency	For example: Gilgun (1991); Fiering et al. (1998); Himelein & McElrath (1996); Hobfoll et al. (2002); Collishaw et al. (2007); Daigneault et al. (2007); Leon et al. (2008)
	Measured by self-report	Anderson & Hiersteiner (2008); Baker (2003); Bogar & Hulse-Killacky (2006); Kia-Keating et al. (2005); Valentine & Feineuer (1993)
Definition of Childhood Sexual Abuse (CSA)	Psychometric tools	Child Abuse and Trauma Scale (Lam & Grossman, 1997); Childhood Experiences Questionnaire (Chambers & Belicki, 1998); Child Sexual Abuse Severity Rating (Wright & Masten, 2005); Population Characteristics Scale (Rew et al., 2001); Childhood Trauma Questionnaire (Hobfoll et al., 2002).
	Interview questions	Dufour & Nadeau (2001); Jonzon & Lindblad (2006); Lambie et al. (2002); Baker (2003); Briggs & Hawkins (1996); Kia-Keating et al. (2005); Little & Hambie (1999); Pharris et al. (1997)
	Attendance at CSA support group	Anderson & Hiersteiner (2008); Daigneault et al. (2007)

	Single question	Eisenberg et al. (2007); Heckman & Clay (2005)
Abuse Factors	Frequency/severity of CSA experiences	Dufour & Nadeau (2001); Lambie et al. (2002)
	Abuse characteristics frequently not assessed or missing (e.g. timing, severity, sub-type and chronicity)	Bogar & Hulse-Killacky (2006); Chambers & Belicki (1998); Heckman & Clay (2005); Little & Hamby (1999); Keiley et al. (2004); Manly et al. (1994, 2004); Fergusson & Lynskey (1997)
Recruitment Strategy	Subgroup of larger study	Chandy et al. (1996a, 1996b); Eisenberg et al. (2007); McKnight & Loper (2002); Pharris et al. (1997)
	Advertising in newspapers	Dufour & Nadeau (2001); Jonzon & Lindblad (2006); Wright et al. (2005)
	Student populations	Briggs & Hawkins (1996); Himelein & McElrath (1996); Lam & Grossman (1997); Runtz & Schallow (1997).
	Therapeutic settings	Baker (2003); Breno & Galupo (2007); Daigneault et al. (2007) ; Lambie et al. (2002); Little & Hamby (1999); Kia-Keating et al. (2005, 2010); Spaccarelli & Kim (1995);

Resilience Following CSA

		Henry (1999, 2001); Heckman & Clay (2005)
	Prisons	Briggs & Hawkins (1996); Gilgun (1991)
	Homelessness shelters	Rew et al. (2001)
	Child protection agencies, court or hospital records	Banyard & Williams (2007) ; Cicchetti & Rogosch (1997); Cicchetti et al. (1993); Fiering et al. (1999); Flores et al. (2005); Hyman & Williams (2001) ; Leifer et al. (2004); McGloin & Widom (2001); Moran & Eckenrode (1992); Rosenthal et al. (2003)

Table 2. Factors associated with resilience following CSA (longitudinal studies are indicated in bold)

Domain	Finding linked to higher resilience		
	Factors	Supported by longitudinal study?*	
Demographic	Female	Mixed	Protective to be female (DuMont et al., 2007 ; Flores et al., 2005; Liem et al., 1997; McGloin & Widom, 2001; Pharris et al., 1997) Protective to be male (Leon et al., 2008 ; Little & Hamby, 1999)
	Non-white	Yes	African American protective (Chandy et al., 1996a) Non-white adolescents more likely to demonstrate resilience (DuMont et al., 2007).
	Higher SES	No	Higher SES background linked to resilience in a correlational study (Wright et al., 2005)
	Higher cognitive functioning (not too	Yes	Higher intelligence (DuMont et al., 2007) or at least average functioning

Resilience Following CSA

	high)		(Herrenkohl et al., 1994) linked to resilience
Factors related to the abuse	Older age at onset	No	Younger age at onset associated with more negative outcomes; older children more likely to be resilient (Feinauer et al., 2003; Moran & Eckenrode, 1992)
	Non-family perpetrator	Yes	Fewer women resilient when maltreated by a family member (Hyman & Williams, 2001)
	Severity of abuse	Mixed	Severe abuse less resilient (Hyman & Williams, 2001) Severe abuse more resilient (Briggs & Hawkins, 1996) Severity of abuse not linked (Dufour & Nadeau, 2001; Lambie et al., 2002)

Childhood family relationships and environment	Connected, supportive family	Yes	Stable, connected and supportive family environment repeatedly associated with resilience (Banyard et al., 2002 ; Chandy et al., 1996b; Eisenberg et al., 2007; Herrenkohl et al., 1994)
	Stable caregiving at least one parent, usually the mother	Yes	Resilience linked to the presence of stable caretaking by at least one parental figure, chiefly mother (Banyard et al., 2002 ; Daigneault et al., 2007 ; Dufour & Nadeau, 2001; DuMont et al., 2007 ; Leifer et al., 2004)
	Fewer moves	Yes	Resilience more likely when other stressful life events were minimised (e.g. lower divorce rates, death, family illness; DuMont et al., 2007 ; Liem et al., 1997)
	Fewer other stressful life events	Yes	
Feeling supported and understood	Yes	Resilience associated with individual feeling supported and understood by parents (Collishaw et al., 2007 ; Feiring et al., 1998; Lambie et al., 2002; McKnight & Loper, 2002; Pharris et al.,	

			1997; Romans et al., 1995; Rosenthal et al., 2003; Spaccarelli & Kim, 1995)
	Positive parenting practices	Yes	Positive parenting practices by parents or foster carers linked to resilience (e.g. use of appropriate discipline and praise) protective (Leon et al., 2008 ; Romans et al., 1995), and even a reduction in psychiatric symptoms (Leon et al., 2008)
Inner Resources	Active attempts to deal with the experience via: <ul style="list-style-type: none"> - Therapy - Direct/symbolic confrontation of perpetrator - Forgiveness of self and/or perpetrator 	No No No	Active attempts to cope linked with greater resilience (Daigneault et al., 2007 ; Feineuer et al., 2003; Feiring et al., 1998; Heckman & Clay, 2005; Henry, 1999, 2001; Himelein & McElrath, 1996; Rew et al., 2001; Wright et al., 2005) Attempts to understand/make sense of abuse linked to greater resilience (Bogar & Hulse-Killacky, 2006; Breno & Gallupo, 2007; Briggs & Hawkins, 1996; Kia-Keating et al., 2010; Lambie et al., 2002)
	Attributional style <ul style="list-style-type: none"> - Negative events 	No	Resilience linked with attributions that were external, changeable and

	<p>seen as external, changeable and only one aspect</p> <ul style="list-style-type: none"> - Optimistic - Less self-blame - Feeling less stigmatised <p>Self-esteem</p> <p>Interpersonal/emotional competencies</p> <ul style="list-style-type: none"> - Social relationships - Coping skills 	<p></p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>restricted to one aspect of their life, with resulting higher optimism (Dufour & Nadeau, 2001; Liem et al., 1997; Moran & Echenrode, 1992; Valentine & Feinauer, 1993)</p> <p>Self-esteem linked to resilience (Baker, 2003; Cicchetti & Rogosch, 1997; Cicchetti et al., 1993; Henry, 1999, 2001; Jonzon & Lindblad, 2006; Lam & Grossman, 1997; Moran & Eckenrode, 1992; Valentine & Feinauer, 1993)</p> <p>Argument could be seen as circular, because self-esteem might be considered an intrinsic part of resilience. Thus, as Jonzon and Lindblad (2006) question, it is unclear whether self-esteem should be viewed as a precursor of resilience, or an outcome, or both.</p>
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	<p>Ego resilience / ego control</p> <ul style="list-style-type: none"> - More reserved, controlled and rational in interpersonal interaction 	Yes	<p>Resilience linked to ego resilience and control (Cicchetti & Rogosch, 1997; Cichetti et al., 1993; Flores et al., 2005)</p> <p>For example, being more reserved, controlled and rational in their interpersonal interactions associated with more adaptive functioning</p> <p>Leon et al. (2008) found that those high in interpersonal or emotional competence more likely to be resilient (also circular argument)</p>
	Absence of neuroticism		<p>Low neuroticism associated with resilience (Collishaw et al., 2007; Heckman & Clay, 2005)</p>
<p>Friendships / relationships into adulthood</p>	<p>Confiding relationship</p> <p>Interpersonal trust</p>	<p>Yes</p> <p>Yes</p>	<p>A confiding relationship linked to resilience (10 studies, including 5 of the 8 longitudinal studies; Banyard et al., 2002; Banyard & Williams, 2007; Collishaw et al., 2007; Hyman & Williams, 2001; Leon et al., 2008)</p>

Resilience Following CSA

	Highly supportive relationship in adulthood (leads to parental competence and less depression)	Yes	Perceived support from spouse/partner or having children associated with positive outcomes (DuMont et al., 2007; Little & Hamby, 1999; Wright et al., 2005)
	Timing of support: - Post-disclosure - Not in adolescence	No No	Social support only helpful at certain times, such as immediately post-disclosure (Dufour & Nadeau, 2001). Social support was helpful among children (Fiering et al., 1998) but not in adolescence (associated with hyper-arousal and a belief that others perceive the individual negatively; Fiering et al., 1998)
Community	Positive school and education - Positive relationship with teacher - Academic achievement	Yes	Positive school or educational experiences associated with resilience Including: good relationships with teachers, high academic achievement and the completion of education, as well

	<p>- Development of positive future orientation</p>		<p>as the development of a positive future orientation that enables respondents to make realistic plans (e.g. Banyard et al., 2002; Bogar & Hulse-Killacky, 2006; Chandy et al., 1996b; Dufour & Nadeau, 2001; Edmond et al., 2006; Eisenberg et al., 2007; Hyman & Williams, 2001; Lambie et al., 2002; McKnight & Loper, 2002; Pharris et al., 1997; Romans et al., 1995)</p> <p>Academic achievement is not essential for resilience. Jonzon and Lindblad (2006) found that among resilient women, there were low proportions of highly educated individuals.</p>
	<p>Church/ spirituality</p>	<p>Yes</p>	<p>Interactions with church or a sense of being spiritual associated with resilience (e.g. Baker, 2003; Banyard & Williams, 2007; Chandy et al., 1996a,1996b; Edmond et al., 2006; McKnight & Loper,</p>

Resilience Following CSA

			2002) Effect thought to be due to meaning it gives to people, but also to the social support/group or community membership (Hobfoll et al., 2002; Valentine & Feineuer, 1993) and reducing social isolation (Kia-Keating et al.,2010)
	Support from clubs or care agencies	Yes	Support from clubs or a formal care agency linked to resilience (Leon et al., 2008)

* Banyard et al. (2002); Banyard & Williams (2007); Collishaw et al. (2007); Daigneault et al. (2007); DuMont et al. (2007); Herrenkohl et al. (1994); Hyman & Williams (2001); Leon et al. (2008). CSA = Childhood sexual abuse; SES = socioeconomic status.