Resilience in Survivors of Child Sexual Abuse

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Resilience in Survivors of Child Sexual Abuse: A Systematic Review of the Literature

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Abstract

Objective. This review article summarizes empirical research on resilience in survivors of child sexual abuse (CSA) and discusses protective factors that are associated with adaptive functioning in spite of sexual victimization. Methods. A literature search to identify studies published up to November 2013 was performed within the databases PsycINFO, MEDLINE/PubMed, Web of Science, and PSYNDEXplus. Additional relevant studies were retrieved using a snowball technique. A total of 37 articles met the inclusion criteria and were included in the final sample. Results. In the studies included in this review, the percentage of CSA survivors who were found to have a normal level of functioning despite a history of sexual abuse ranged from 10% to 53%. The protective factors that had the best empirical support were found to be education, interpersonal and emotional competence, control beliefs, active coping, optimism, social attachment, external attribution of blame, and most importantly, support from the family and the wider social environment. Conclusions. Preventive and clinical interventions for survivors of CSA should utilize psychoeducation and cognitive strategies that are adapted to the developmental level of the victim and that seek to enhance social support from significant others. Future research should focus on longitudinal research designs considering resilience rather as a dynamic process with multiple dimensions in a social and developmental context.

Keywords

child sexual abuse, protective factors, resilience, review

The adverse consequences of child sexual abuse (CSA) on the psychosocial adjustment and health of victims have been extensively documented. Short- and long-term sequelae after CSA are evidenced as a wide range of mental disorders, including posttraumatic stress disorder, depression, anxiety, aggression, and substance abuse (e.g., Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Beitchman et al., 1992; Kendall-Tackett, Williams, & Finkelhor, 1993; Maniglio, 2009; Paolucci, Genuis, & Violato, 2001; Putnam, 2003; Spataro, Mullen, Burgess, Wells, & Moss, 2004). Nonetheless, despite the increase in risk for psychiatric disorders, research indicates that some sexually abused individuals retain normal levels of functioning (Dufour, Nadeau, & Bertrand, 2000; Kendall-Tackett et al., 1993). The phenomenon of a dynamic developmental process encompassing the attainment of positive adaptation within the context of significant adversity is referred to as resilience (Cicchetti, 2010; Davydov, Stewart, Ritchie, & Chaudieu, 2010; Luthar, Cicchetti, & Becker, 2000).

Although the concept of resilience has been scientifically studied for over four decades and has had various definitions and conceptualizations applied to it (Cicchetti, 2010; Luthar et al., 2000), there is still no consensus on an operational definition of it to date. For example, discrepancies exist in conceptualizations of resilience as a personal trait versus a dynamic process. There is a growing consensus to consider resilience as a two-dimensional construct that encompasses both aspects of victims' life circumstances *and* evidence of positive adaptation (Luthar et al., 2000). A critical issue that is so far unresolved is the level of competence that is needed to define positive adaptation and whether competence must be demonstrated in only one or in more than one domain. For example, some researchers believe that resilience must include positive adaptation in several areas of life ("true" or "overall" resilience; e.g., Kaufman, Cook, Arny, Jones, & Pittinsky, 1994; Spaccarelli & Kim, 1995), whereas others believe that positive adaptation in only one domain that is theoretically or empirically linked to the adversity under consideration is sufficient ("relative" resilience; e.g. Daigneault, Hebert, & Tourigny, 2007; Daigneault, Tourigny, & Cyr, 2004; Luthar et al.,

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2000). The majority of studies included in this review define resilience or adaptive functioning merely as the absence of psychopathological symptoms, thereby focusing on relative resilience. Consequently, this review is guided by the conceptualization of relative resilience as suggested by several authors (Daigneault et al., 2007; Daigneault et al., 2004; Luthar et al., 2000).

Protective factors associated with resilience refer to characteristics of the individual and the environment that modify, ameliorate, or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome (Rutter, 1985). More distinct definitions of protective factors, such as the concepts of protective-stabilizing, protective-enhancing, and protective-reactive factors expounded by Luthar et al. (2000), unfortunately have not been adopted in empirical studies, and hence this review relies on the broader concept of Rutter (1985).

To our knowledge, only one literature review in French language has been published that looked specifically at protective factors following CSA (Dufour et al., 2000), but there are several on resilience following child maltreatment in general (Afifi & MacMillan, 2011; Haskett, Nears, Sabourin Ward, & McPherson, 2006; Heller, Larrieu, D'Imperio, & Boris, 1999; Walsh, Dawson, & Mattingly, 2010). Research on child maltreatment in general has found empirical evidence for both individual and environmental protective factors. Individual factors include personal characteristics such as personality traits (openness, extraversion, and agreeableness), internal locus of control, mastery, self-efficacy, self-esteem, cognitive appraisal (i.e., positive interpretation of events and cohesive integration of adversity into self-narrative), and optimism (Herrman et al., 2011). There are also indications that intellectual functioning, cognitive flexibility, social attachment, positive self-concept, emotional regulation, positive emotions, spirituality, active coping, hardiness, hope, resourcefulness, and adaptability are associated with resilience (Afifi & MacMillan, 2011; Haskett et al., 2006; Heller et al., 1999; Herrman et al., 2011). Environmental protective factors that are correlated with resilience and that have broad empirical support to date include social support from family, peers, teachers, or other significant adults (Herrman et al., 2011). In addition, family coherence, good parenting skills, stable caregiving, good parental relationships, spousal support, and absence of maternal depression or substance abuse are associated with fewer behavioral problems and better psychological well-being in maltreated children (Afifi & MacMillan, 2011; Haskett et al., 2006; Heller et al., 1999; Herrman et al., 2011).

Several authors have highlighted the importance of separately considering specific subtypes of child maltreatment (Afifi & MacMillan, 2011; Heller et al., 1999), since the association between exposure to maltreatment and psychosocial outcomes may vary according to the nature of the maltreatment. In fact, different types of maltreatment predict different types of outcomes (e.g., English et al., 2005); thus, aggregating types of maltreatment likely confuses the conclusions that can be made about resilience following different stressors (Heller et al., 1999). This may be especially true for CSA with its specific features such as betrayal, stigmatization, or early traumatic sexualization that distinguish it from other types of maltreatment (Finkelhor & Browne, 1985).

A large number of primary studies of resilience following CSA have been published in recent years; and therefore, an update of the review by Dufour, Nadeau, and Bertrand (2000) is needed. This systematic review of the literature has four aims. First, we provide an overview of protective factors associated with resilience specifically following CSA. Second, we compare the outcomes and protective factors at different developmental stages (children, adolescents, and adults) and take the issue of age specificity of resilience into account. Third, we aim to extract the resilience rates of survivors of CSA found in these studies. Fourth, we rate the quality of the incorporated studies according to a quality assessment checklist and review methodological issues in the discussion section.

Method

Inclusion Criteria

In accordance with the guidelines for systematic reviews (Centre for Reviews and Dissemination, 2009; Higgins & Green, 2011), the following criteria for study inclusion were applied: (1) The study had to have been published in English, German, or French in a journal that complies with the peer review policy. (2) The study investigated resilience after CSA. All definitions of CSA (e.g., contact or noncontact and different legal ages) were accepted. If child maltreatment in general was examined, then part of the data analyses must have been specific to CSA. (3) Resilience was conceptualized as adaptive functioning and/or the absence of psychological disorders. (4) Main outcomes had been assessed using standardized instruments, that is, prior psychometric evaluation and publication of the main outcome instrument. (5) Only quantitative studies were included. (6) Sample sizes had to be at least 20 participants. (7) Studies investigating short-term resilience during childhood and adolescence as well as long-term resilience into adulthood were included. (8) Studies with different sample characteristics (e.g., representative, community, clinical, child protective services, at-risk people, and others) were included.

Search Strategy for the Identification of Relevant Articles

To ensure a thorough and systematic review of the literature, two methods were used to retrieve relevant studies. First, we conducted a search of the computerized bibliographic databases PsycINFO, PubMed, Web of Science, and PSYNDEXplus, using the following combinations of search terms for title and abstract: "child" AND "sexual" AND "abuse" AND "resilience" OR "resilient" OR "resiliency" OR "protective factor." No constraints were placed on the publication date; thus, the only limiting factor was the starting points of the databases themselves. The literature search comprised articles from 1995 to November 2013. Second, a snowball technique was applied whereby the reference lists of all relevant studies were

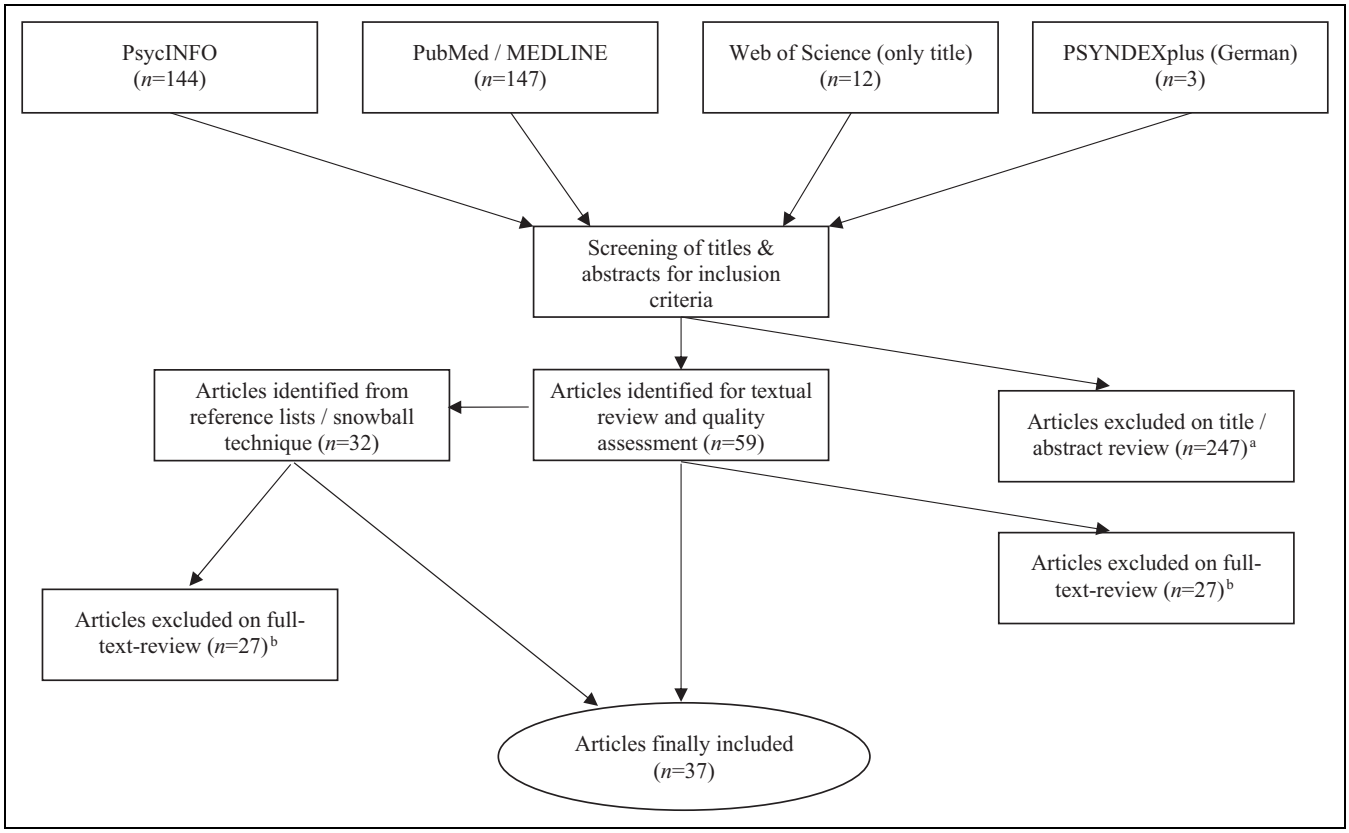

Figure 1. Summary of study selection process. [a]The most frequent reasons for study exclusion based on title/abstract review are publication as book or dissertation, no original research article, and study focuses on other topic. [b]The most frequent reasons for study exclusion based on full-text review are no separate analysis for distinct maltreatment types, qualitative research design, and resilience conceptualized as non-offending.

scanned in order to identify further studies. For an overview of the study selection process, see Figure 1.

Quality Assessment

Quality criteria. In line with the recommendations for systematic reviews (Centre for Reviews and Dissemination, 2009; Higgins & Green, 2011), a checklist for the quality assessments specific to the needs for this review was developed. Study quality was assessed on the basis of the following 10 criteria: (1) "Sample characteristics" refers to the participants recruited in each study. Population-based or representative samples were rated higher in quality than specific samples such as clinical or child welfare samples, as they generally enable a broader generalization of the findings. Specific samples were rated lower in quality, as they increase the selectivity of results. (2) "Study design" refers to the type of research design implemented in each study. Prospective designs with multiple assessments were rated higher than longitudinal or cross-sectional designs, as the conclusion to causality is more robust. (3) "Total sample size" refers to the number of study participants in each study. Studies with sample sizes of more than 300 participants were rated higher in quality than studies relying on smaller sample sizes ($N = 60$–300; $N = 20$–60), as they have a broader empirical base and generally enable the possibility of detecting small effects. (4) "Sample size resilient group" refers to the number of participants found to be resilient ($n > 50$; $n = 20$–50; and $n < 20$). Higher numbers indicate higher quality, as they constitute a broader empirical base and generally enable the detection of small effects. (5) "Control group" refers to the availability of a group of non-resilient survivors of CSA, that is, victims of sexual abuse who do display clinically relevant psychopathology. Control group designs are rated higher in quality, as they allow the comparison between resilient and non-resilient victims of CSA. (6) "Multi-method assessment for outcome" refers to the methodologies used in each study in order to detect the outcome. Relying on multiple methods (e.g., questionnaires, interviews, records, medical examination, etc.) was rated higher in quality than relying on single methods, as this minimizes possible bias due to measurement issues. (7) "Number of different informants" was applied for child and adolescent samples only and refers to the number of sources consulted in each study. Studies that relied not only on self-reports but also on reports from other sources (e.g., parent, teacher, or social worker) were rated higher in quality, as they minimize possible bias related to informants. (8) "Explicit definition of CSA." and (9) "Explicit definition of resilience" refer to the availability of a specification of the type of CSA and the specification of resilient functioning in the publication. Studies that stated explicit definitions of CSA and resilience were rated higher in quality than

studies that did not provide this crucial information, as the results of each study are reliant on the conceptualization of CSA and resilience applied. (10) ''The number of domains of resilient functioning assessed'' refers to the number of outcome domains considered in each study. Studies that assessed more than one domain of resilient functioning were rated higher in quality than those investigating only one, as they allow comparisons between different areas of resilient functioning.

Finally, the overall risk of bias of the included studies was rated independently by each reviewer as either ''low,'' ''moderate,'' or ''high'' based on the aforementioned quality criteria recorded in the checklist and the reviewer's personal comprehensive evaluation of the study. Bias was defined in line with several authors as ''a systematic deviation from the truth that distorts the result of research'' (Centre for Reviews and Dissemination, 2009; Miettinen, 1985; Rothman, 1986; Sitthi-amorn & Poshyachinda, 1993). A special focus was placed on bias related to the possible sources—namely, selection, confounding, intervention, measurement or information, analysis, and interpretation bias (Sitthi-amorn & Poshyachinda, 1993).

Procedure of quality assessment. The quality of the incorporated studies was rated by three independent reviewers using a quality assessment checklist. The first author rated all the included studies and the second and last author rated half of the studies. If there was nonagreement regarding the risk of bias, discrepancies were discussed and a final congruent evaluation was reached. Interrater reliability was assessed with Cohen's κ. According to the classification of Fleiss, Levin, and Paik (2003), interrater reliability over all the quality criteria was excellent ($\kappa = .755$).

Categorization of Protective Factors

In accordance with several authors (Luthar & Zigler, 1991; Masten & Garmezy, 1985; Werner, 1989; Werner & Smith, 1992), the emerging protective factors from the literature are classified within three broad categories, referring to Bronfenbrenner's ecological model of human development (1979): (1) Internal factors related to the victim; (2) external factors related to the family of the victim; and (3) external factors related to the wider social environment of the victim. The findings are further divided by three different age-groups/developmental phases (Steinberg, 1993), based on the average age and standard deviation in each study. Study participants aged 10 years or younger were classified as children; those aged between 11 and 17 years were categorized as adolescents; and those aged 18 years or older were categorized as adults.

Results

The search of the electronic databases yielded 306 articles, and a further 32 articles were identified by manually searching the reference lists of included articles. Ultimately, 37 primary studies were found to meet the inclusion criteria (see Figure 1). Studies relying on the same data sets were aggregated. Six of the studies were secondary data analysis of studies conducted on research questions other than resilience after CSA and/or associated protective factors (Aspelmeier, Elliott, & Smith, 2007; Chaffin, Wherry, & Dykman, 1997; Daignault & Hebert, 2009; Goldstein, Faulkner, & Wekerle, 2013; Tarakeshwar, Hansen, Kochman, Fox, & Sikkema, 2006; Vural, Hafızoğlu, Türkmen, Eren, & Büyükuysal, 2012). Table 1 presents an overview of all the included studies, significant protective factors, resilient rates, and the risk of bias.

Rates of Resilient Victims Among CSA Survivors

Altogether, 10 studies explicitly described resilience rates among their samples of CSA survivors. Among samples involving children and adolescents, the proportion of resilient victims ranged from 10% to 53%, while in those involving adults it ranged from 15% to 47%.

Protective Factors Associated With Resilience Following CSA

Internal factors

Optimism and hope

Adolescents. Williams and Nelson-Gardell (2012) found in a sample of adolescents that hope and expectancy both predicted resilient outcome, defined as an absence of psychopathology. Similarly, Edmond, Auslander, Elze, and Bowland (2006) found that resilient adolescent victims (again, defined as no psychopathology) who were currently living in foster care were more optimistic about their future.

Adults. A protective role of optimism and hope/expectancy was also found in a study with HIV-infected adults who had been sexually abused in childhood (Tarakeshwar et al., 2006).

Control beliefs and internal locus of control

Adolescents. In a longitudinal study of sexually abused adolescents (Daigneault et al., 2007), a greater sense of empowerment was associated with resilient profiles (defined as no psychopathology).

Adults. In adult samples, an internal locus of control (Liem, James, O'Toole, & Boudewyn, 1997) was identified as a protective factor for mental health and self-esteem, whereas an external locus of control was a risk factor for drug addiction (Dufour & Nadeau, 2001). In a longitudinal study with women, self-efficacy had a protective function against interpersonal problems and HIV/sexual risk-taking behaviors (Lamoureux, Palmieri, Jackson, & Hobfoll, 2012).

Active coping

Children. In a study with mother–daughter dyads (Daignault & Hebert, 2009), mothers rated their

Table 1. Summary of Study Characteristics and Protective Factors.

Study	Design and sample	*N*	Age *M* (*SD*); age range	Males included	Assessment and definition of CSA	Outcome	Protective factors	% of Resilient victims	Risk of bias
Aspelmeier, Elliott, and Smith (2007)	Cross-sectional; student	324 (122 with CSA)	18.26 (.62); 18–21	No	Self-report; any sexual act before age 16	Trauma symptoms	Attachment security in peer and parent relationships	—	Moderate
Banyard and Williams (2007)[a] and Banyard, Williams, and Siegel (2002)[a]	Prospective longitudinal; clinical	80	31.1 (3.34); 18–31	No	Self-report and document; no definition of CSA	Trauma symptoms; reexposure to trauma	Satisfaction with social support (from family and community) Satisfaction with relationship Positive sense of community Satisfaction with social role	—	Moderate
Breno and Galupo (2007)[a]	Cross-sectional; clinical	84 (55 with CSA)	20.56 (1.58); 18–25	No	Self-report; no precise information on type of CSA and age	Connor–Davidson Resilience Scale → self-report of resilience	Feeling powerful (i.e., no powerlessness)	—	Moderate
Cha and Nock (2009)[a]	Cross-sectional; clinical/community	54 (11 with CSA)	17.30 (1.92); 12–19	Yes	Self-report; any sexual act before age 18	Suicidal ideation and attempts	Strategic emotional intelligence	—	Moderate
Chaffin, Wherry, and Dykman (1997)	Cross-sectional; clinical	84	7–12	Yes	Self-report and one additional confirmation criteria; any sexual act	Psychopathology	Avoidant coping (related to fewer behavioral problems but also associated with greater sexual anxieties)	—	Moderate
Chandy, Blum, and Resnick (1996a)[a,b] and Chandy, Blum, and Resnick (1996b)[a,b]	Cross-sectional; student	3,051	Males: 15.26 (1.7); females: 15.37 (1.7)	Yes	Self-report; any sexual act	School performance; suicidal behavior and ideation; disordered eating; sexual behaviors and pregnancy risk; substance use; delinquency	Females: Higher emotional attachment to family Perception of overall health Nurse or clinic at school Being religious or spiritual Presence of both parents at home Caring from adults Younger age For males: Maternal education Parental concern	10.5% of males and 9.6% of females	Low

(continued)

Table 1. (continued)

Study	Design and sample	*N*	Age *M* (*SD*); age range	Males included	Assessment and definition of CSA	Outcome	Protective factors	% of Resilient victims	Risk of bias
Daignault and Hebert (2009)	Cross-sectional; clinical	100 mother–daughter dyads	8.64; 7–12	No	Document; any sexual act	Academic performance; social functioning; externalized behaviors	More approach coping strategies Paternal support	47%	Moderate
Daigneault, Hebert, and Tourigny (2007)[a,b]	Longitudinal; clinical	86	14.6 (1.4); 11–17	No	Confirmed; only contact CSA	Psychopathology (anxiety, withdrawal, social problems, attention problems, and aggressive behavior)	Empowerment Interpersonal trust	34% (Resilient both at first and second measurement); 23% (resilient only at second measurement); and 5% (resilient only at first measurement)	Low
Daigneault, Tourigny, and Cyr (2004)[a]	Cross-sectional; clinical	30	15.5 (1.4); 13–17	No	Confirmed; only contact CSA	Psychopathology; self-esteem; Global Resilience Scale	Disclosure to a greater number of people	10–53%	Moderate
Dufour and Nadeau (2001)[a]	Cross-sectional; clinical	40	30 (resilient group); 35 (addicted group); 22–48	No	Self-report; unwanted sexual experience before age 16	Addiction; mental health status; trauma symptoms; self-perception if the person has overcome the trauma	External attribution of blame	—	High
Edmond, Auslander, Elze, and Bowland (2006)[a,b]	Cross-sectional; clinical	99	16 (.95); 15–18	No	Self-report; only contact CSA	Psychopathology	Overall positive future orientation More certain about their educational plans Positive peer influence	50%	Low
Eisenberg, Ackard, and Resnick (2007)[a]	Longitudinal; community	8,592	Adolescents	Yes	Self-report; contact CSA	Suicidal ideation and attempts	Family connectedness Teacher caring Other adult caring School safety	—	Moderate
Feinauer and Stuart (1996)[a]	Cross-sectional; clinical	276	37; 18–65	Yes	Self-report; no definition of CSA	Current level of functioning; trauma symptoms	External attribution of blame	—	High
Feiring, Taska, and Lewis (1998)[a] and Feiring, Taska and Lewis (2002)[a]	Longitudinal; clinical	147–154	8–15	Yes	Confirmed; any sexual act	Psychopathology	Parental support	—	Moderate

(continued)

Table 1. (continued)

Study	Design and sample	*N*	Age *M* (*SD*); age range	Males included	Assessment and definition of CSA	Outcome	Protective factors	% of Resilient victims	Risk of bias
Goldstein, Faulkner, and Wekerle (2013)	Cross-sectional; clinical	93	19.46 (1.27); 18–25	Yes	Self-reported; contact and non-contact CSA (CTQ)	Behavioral outcomes (tobacco use and dependence, and depression symptoms); religious and community involvement; parental/ caregiver monitoring	Internal resilience (Because of a composite index of self-reported protective factors, no distinct protective factors are listed in the table)	—	Moderate
Hyman and Williams (2001)[a]	Longitudinal; clinical	136	18–31	No	Self-reported and documented; contact CSA	Psychopathology; physical health; mental health; interpersonal relationships; adherence to community standards; and economic well-being	Graduating from high school Growing up in a stable family	18% Excellent resilience and 29% good resilience	High
Jonzon and Lindblad (2006)[a]	Cross-sectional; clinical	152	41 (9.4); 20–60	No	Self-report; contact and non-contact CSA	Psychopathology; psychosomatic symptoms; health care utilization	Self-esteem Social support (not specified to which resources)	—	Moderate
Katerndahl, Burge, and Kellogg (2005)[a]	Cross-sectional; clinical	90	18–40	No	Self-report; contact CSA	Psychopathology	High individual SES Stable family environment Maternal caring	—	Moderate
Lam and Grossman (1997)[a]	Cross-sectional; student	264 (44 with CSA)	18.8 (2.3); 17–25	No	Self-report; any sexual act before age 15	Psychopathology; social adjustment	Because of a composite index of self-reported protective factors, no distinct protective factors are listed in the table	—	Moderate
Lamoureux, Palmieri, Jackson, and Hobfoll (2012)[a]	Longitudinal; clinical	693 (271 with CSA)	21; 16–29	No	Self-reported; contact and non-contact CSA before age 16	Interpersonal problems and HIV/sexual risk taking behaviors	Self-esteem and self-efficacy	—	Moderate
Leon, Ragsdale, Miller, and Spacarelli (2008)[a]	Longitudinal; clinical	142	13.2 (1.9); 10.4–17.9	Yes	Self-report; any sexual act	Trauma symptoms; sexually ruminative thoughts, nonsexual rumination	Positive parenting practices Caseworker agency support Interpersonal and emotional competence Male gender Club involvement (only for low CSA severity)	—	Moderate

(continued)

Table 1. (continued)

Study	Design and sample	*N*	Age *M* (*SD*); age range	Males included	Assessment and definition of CSA	Outcome	Protective factors	% of Resilient victims	Risk of bias
Liem, James, O'Toole, and Boudewyn (1997)[a]	Cross-sectional; community	687 (145 with CSA)	24.87; 16–65	Yes	Self-report; unwanted sexual contact before age 14	Psychopathology; self-esteem	Internal locus of control External attribution of blame Larger family with more siblings More time since abuse Male gender Older age	28%	Moderate
Lynskey and Fergusson (1997)[a,b]	Prospective longitudinal; community	1,025 (107 with CSA)	All participants studied at age 18	Yes	Self-report; any unwanted sexual act before age 16	Psychopathology; delinquency	Paternal care in childhood	24.3%	Low
Pharris, Resnick, and Blum (1997)[a]	Cross-sectional; student	13,923 (1,157 with CSA)	Adolescents	Yes	Self-report; any unwanted sexual act	Physical and mental health; risk behaviors; health service utilization; delinquency; relationships with family and friends; hopelessness; suicidality	*Girls*: Family attention Positive feelings toward school Parental expectations Caring exhibited by family, adults, and tribal leaders *Boys*: Enjoyment of school Involvement in traditional activities Strong academic performance Caring exhibited by family, adults, school people, and tribal leaders	—	Moderate
Reyes, (2008)[a]	Cross-sectional; clinical	61	10.8 (2.5); 7.3–16.6	Yes	Self-report; contact and noncontact	Trauma symptoms	High self-concept	—	Moderate
Romans, Martin, Anderson, O'Shea, and Mullen (1995)[a]	Cross-sectional; random community	138	18–64	No	Self-report; only genital contact CSA before age 13	Psychiatric disorder; self-esteem	Good quality of her adolescent relationship with father Get along well with boys Like high school Academic achievement Sport Quality of relationship High individual SES, current paid employment	—	Moderate

(continued)

Table 1. (continued)

Study	Design and sample	*N*	Age *M* (*SD*); age range	Males included	Assessment and definition of CSA	Outcome	Protective factors	% of Resilient victims	Risk of bias
Rosenthal, Feiring, and Taska (2003)[a,b]	Longitudinal; clinical	147	8–15	Yes	Confirmed; primarily contact CSA	Adjustment in multiple domains (psychopathology, self-esteem, and school functioning)	(Early emotional) support from caregivers	—	Low
Simpson (2010)[a]	Cross-sectional; clinical	134	30.1 (8.7); 18–57	No	Self-report; contact and non-contact prior the age of 16	Connor–Davidson Resilience Scale (adaptation and ability to cope)	High control against deviant behavior Interpersonal competence (ability to work with others) Sense of acceptance and belonging to a family	—	High
Spaccarelli and Kim (1995)[a]	Cross-sectional; clinical	43	10–17	No	Self-report; primarily contact CSA	Psychopathology; social competence	Parental support	12% (Both domains) and 25% (one domain)	Moderate
Tarakeshwar, Hansen, Kochman, Fox, and Sikkema (2006)	Cross-sectional; clinical	266	Males: 41.49 (6.70); females: 43.14 (6.98)	Yes	Self-report; contact CSA	Perspectives on addressing trauma; HIV-related stress	Optimism Social support (resources not defined) Religiosity Finding growth and meaning	—	Moderate
Tremblay, Hebert, and Piche (1999)[a]	Cross-sectional; clinical	50	9.2; 7–12	Yes	Document; contact and noncontact	Psychopathology, self-worth	Social support from parents	—	Moderate
Vural, Hafızoğlu, Türkmen, Eren, and Büyükuysal (2012)	Cross-sectional; clinical	28	13.9 (3.2); 8–18	Yes	Confirmed, referral by court; any sexual act	Psychopathology (depression); psychological adjustment	Perceived maternal acceptance (positive parenting and emotional bond between child and mother)	—	High
Williams and Nelson-Gardell (2012)[a]	Cross-sectional; representative sample of children "in home" placements	237	11–16	Yes	Self-report; contact	Psychopathology	School engagement Caregiver social support Caregiver perception of social support (from community) Hope and expectancy Caregiver education Family high SES	—	Moderate
Wright, Fopma-Loy, and Fischer 2005[a]	Cross-sectional; clinical	79	38.2 (8.02)	No	Self-report; only contact CSA	Psychopathology; perceptions of physical health; marital satisfactions; perceived parenting competence	Partner/spousal support High SES for partner	20.5% (All four domains), 25.6% (three domains), 20.5% (two domains), and 15.3% (one domain)	Moderate

Note. CSA = child sexual abuse; CTQ = Childhood Trauma Questionnaire; SES = socioeconomic status. — = Data were not obtained or reported. Because the studies of Banyard et al. (Banyard & Williams, 2007; Banyard et al., 2002), Chandy et al. (1996a, 1996b), and Feiring et al. (1998, 2002) reported findings from same data sets, the corresponding publications were combined in order to avoid an overestimation. [a]Main research question on resilience after CSA and/or associated protective factors. [b]These five studies are considered as high standard → top five studies according to the quality assessment protocol.

children's problem-focused coping approach, as conceptualized by Roth and Cohen (1986). The children's problem-focused coping approach was found to be associated with adaptive functioning on academic, behavioral, and social levels. However, Chaffin, Wherry, and Dykman (1997) found mixed results in sexually abused school-aged children for avoidant coping (e.g., distraction or wishful thinking) and no effect for active coping (i.e., seeking social support and problem-focused coping). Avoidant coping was on one hand related to fewer behavioral problems, but on the other hand was associated with greater sexual anxieties, whereas active coping was unrelated to outcomes.

Adolescents. The use of avoidant coping was found to be a risk factor for negative outcomes in an adolescent sample (Tremblay, Hebert, & Piche, 1999).

Adults. Avoidant coping was associated with nonresilience in one study with adults (Wright, Fopma-Loy, & Fischer, 2005).

Externalizing blame, trauma-related beliefs, and cognitions

Adults. In three studies with adult samples, external attribution of blame (i.e., blaming others rather than oneself) was associated with resilient outcome (Dufour & Nadeau, 2001; Feinauer & Stuart, 1996; Liem et al., 1997). In their study of women who had been raised in the child welfare system, Breno and Galupo (2007) found that feeling powerful, as assessed with the Trauma-Related Beliefs Questionnaire (Hazzard, 1993), was associated with self-reported resilience. Among HIV-infected adults who had a history of CSA, finding personal growth and meaning was part of a resiliency score, which was supported in a structural equation modeling approach (Tarakeshwar et al., 2006).

Education and schooling

Adolescents. Being more certain about one's educational plans (Edmond, Auslander, Elze, & Bowland, 2006), achieving a stronger academic performance, and having positive feelings toward school (Pharris, Resnick, & Blum, 1997), as well as showing more school engagement (Williams & Nelson-Gardell, 2012), were all associated with resilient outcomes in adolescent samples.

Adults. Academic performance was found to be a protective factor for self-esteem in one study with adults (Romans, Martin, Anderson, O'Shea, & Mullen, 1995). In the same study, enjoyment of school was also associated with higher self-esteem and absence of psychiatric disorders (Romans et al., 1995). Finally, in a study of women who had been sexually abused as children, graduation from high school was significantly correlated with resilience (Hyman & Williams, 2001).

Emotional intelligence, interpersonal competence, and trust

Adolescents. Strategic emotional intelligence in terms of understanding and managing emotions (e.g., understanding which feelings are expected to emerge in response to different events and knowing how to regulate emotions to help attain one's goals) was found to be protective against suicidal ideation and suicide attempts in a sample of adolescents (Cha & Nock, 2009). In another adolescent sample (Leon, Ragsdale, Miller, & Spacarelli, 2008), interpersonal and emotional competence, as assessed with the Socialization Domain of the Vineland Adaptive Behavior Scales (Sparrow, Balla, & Cicchetti, 1984), were associated with lower levels of nonsexual rumination. In the longitudinal study of Daigneault et al. (2007), interpersonal trust, as assessed with a subscale of the Children's Attributions and Perceptions Scale (Mannarino, Cohen, & Berman, 1994), was found to be protective against psychopathology.

Adults. Interpersonal competence was predictive of resilient status in adults, applying a definition of resilience as "the ability to work with others" (Simpson, 2010).

Social attachment

Adolescents. A cross-sectional study found that higher emotional attachment to one's family was protective in female students but not in male students (Chandy, Blum, & Resnick, 1996a).

Adults. In a sample of young women, secure attachment in peer and parent relationships was found to be protective against negative effects of CSA (Aspelmeier et al., 2007). In a sample of women sexually abused in childhood (Simpson, 2010), a sense of acceptance and of belonging to a family was positively correlated to the Connor/Davidson Resilience Scale (adaptation and ability to cope).

Self-esteem

Children. In a child sample, self-concept, as measured with a global self-worth scale, was related to posttraumatic stress symptoms and explained a significant proportion of outcome variance (Reyes, 2008).

Adults. In a study of women, self-esteem, defined as the ability to think well of oneself, significantly predicted subjective health among adult female victims of CSA (Jonzon & Lindblad, 2006) and was found to be protective against interpersonal problems and sexual risk-taking behaviors (Lamoureux et al., 2012).

Religiosity and spirituality

Adolescents. In a cross-sectional study, a higher degree of religiosity/spirituality was found to be protective in female adolescents after CSA (Chandy et al., 1996a; Chandy, Blum, & Resnick, 1996b).

Adults. Religiosity was also part of an empirically tested model of resiliency in a sample of adults with HIV who had been sexually abused as children (Tarakeshwar et al., 2006).

Law-abiding behavior

Adults. In one study with women (Simpson, 2010), which relied on a self-report measure of resilience, high control against deviant behavior was found to be protective against the adverse impact of CSA. Another study (Hyman & Williams, 2001), which referred to several domains of resilience (psychopathology, physical health, interpersonal relationships, adherence to community standards, and economic well-being), not being arrested was found to be protective.

Leisure and cultural activities

Adults. Leisure activities such as sports emerged as a protective factor enhancing self-esteem and preventing psychopathology in a sample of women (Romans et al., 1995).

Adolescents. Involvement in traditional activities was found to be protective against the higher risk for psychopathology after CSA in American Indian male adolescents (Pharris et al., 1997).

Individual employment and socioeconomic status (SES)

Adults. Personal high SES was found to be protective against psychopathology in two studies with women who had been sexually abused as children (Katerndahl, Burge, & Kellogg, 2005; Romans et al., 1995). In the latter of these studies, current paid employment was positively associated with self-esteem but not with psychopathology.

Perception of health

Adolescents. Overall health perception was found to be protective against negative behavioral and educational outcomes for girls (Chandy et al., 1996a); however, the study did not specify the relationship of health perception to different outcome domains.

Family factors

Family social support—Altogether, 14 studies across different developmental periods found that social support from the family acted to buffer various adverse impacts of CSA. Three of these studies had mixed samples of children and adolescents

Children. Five studies with child samples found that support from the father (Daignault & Hebert, 2009), support from both parents (Feiring, Taska, & Lewis, 1998; Spaccarelli & Kim, 1995; Tremblay et al., 1999), and early emotional support from caregivers (Rosenthal, Feiring, & Taska, 2003) served as a protective factor.

Adolescents. Six studies with adolescent samples described positive family factors such as caring from adults/parental concern (Chandy et al., 1996a, 1996b), family connectedness (Eisenberg, Ackard, & Resnick, 2007), parental support (Feiring et al., 1998; Spaccarelli & Kim, 1995), caregiver support (Williams & Nelson-Gardell, 2012), and early emotional support from caregivers (Rosenthal et al., 2003).

Adults. In adults, five studies found a protective impact of the following components of perceived family support: social support satisfaction (Banyard & Williams, 2007; Banyard, Williams, & Siegel, 2002), maternal caring (Katerndahl et al., 2005), nature and quality of family relationships (Lynskey & Fergusson, 1997), paternal support in childhood (Lynskey & Fergusson, 1997; Romans et al., 1995), and spousal/partner support (Wright et al., 2005). In two other studies (Jonzon & Lindblad, 2006; Tarakeshwar et al., 2006), the sources of social support were not specified; thus, it was not clear whether social support relates to family or to community sources.

Stable family

Adolescents. Living with both biological parents was associated with positive outcomes among female adolescent CSA survivors (Chandy et al., 1996a).

Adults. Three studies with adults found that growing up in a stable family, that is, stability of parents and household, was associated with resilience (Hyman & Williams, 2001; Katerndahl et al., 2005; Romans et al., 1995).

Relationship satisfaction and quality

Adults. Relationship satisfaction protected against the risk of retraumatization in women who had been sexually abused as children (Banyard et al., 2002). Romans et al. (1995) found that the quality of partner relationship was associated with self-esteem in women. Additionally, the ability to get along well with boys (i.e., women who reported having had a comfortable social adolescent relationship with members of the opposite sex) was correlated with self-esteem.

Social role satisfaction and positive sense of community

Adults. In one study with young female adult survivors of CSA, social role satisfaction, that is, being satisfied with oneself as a parent, prevented retraumatization and posttraumatic stress symptoms (Banyard & Williams, 2007). In the same study, a positive sense of community, for example, belonging to a religious community, was associated with resilience.

Positive parenting

Adolescents. Pharris et al. (1997) found in a subsample of the National American Indian Adolescent Health

Survey that parental expectations and family attention prevented suicidality and hopelessness in sexually abused adolescent girls. At the second measurement of a longitudinal study of adolescents, positive parenting was found to prevent negative affect (Leon et al., 2008). Perceived maternal acceptance (positive parenting and emotional bond between child and mother) served as a protective factor against depression in a study of Turkish adolescents (Vural et al., 2012).

Caregiver level of education

Adolescents. Chandy et al. (1996b) found in a study with adolescents that a high maternal level of education was protective for boys. In another study with sexually abused minors, caregiver level of education predicted resilience (Williams & Nelson-Gardell, 2012).

SES of family or partner

Adolescents. In a sample of adolescents, high family SES predicted resilient outcome, defined as absence of psychological symptoms (Williams & Nelson-Gardell, 2012).

Adults. Wright, Fopma-Loy, and Fischer (2005) found in a study with adult female CSA victims that high SES of the partner was associated with resilience.

Community factors

Community social support

Adolescents. In six adolescent studies, several forms of social support at the community level were associated with resilience: caring from other adults and nurses at school (for females only; Chandy et al., 1996a), positive peer influence (Edmond et al., 2006), caring from a teacher or other adults (Eisenberg et al., 2007), support from a child welfare caseworker (Leon et al., 2008), caring exhibited by adults, "school people" (for boys only), tribal leaders (Pharris et al., 1997), and the caregiver perception of social support from community (Williams & Nelson-Gardell, 2012).

Adults. Satisfaction with social support from the community appeared to be protective in women who had been sexually abused in childhood (Banyard et al., 2002). Lynskey and Fergusson (1997) found that the nature and quality of peer relations in adolescence (low affiliations with substance-using peers and strong peer attachment) was associated with resilient outcome at age 18.

Club involvement

Adolescents. In one longitudinal study, participation in club activities was associated with less sexually ruminative thoughts for adolescents with low levels of abuse severity but not for those with higher abuse severity (Leon et al., 2008).

School safety

Adolescents. In two studies with adolescent samples, safe schools (Eisenberg et al., 2007) and less stressful school environments due to perceived low levels of substance use in and around school were associated with resilient outcome (only for females; Chandy et al., 1996a, 1996b).

Quality Assessment of the Included Studies

According to our quality assessment of the studies under review, the criteria that were most consistently met were total sample size and explicit definition of CSA. Of the 37 studies, 31 (83.7%) had total sample sizes of at least 60 participants, while the remaining 6 had between 20 and 60; and 34 studies (91.8%) used an explicit definition of CSA, generally enabling to determine the association of certain protective factors to certain types of CSA. The criteria that were least met were sample characteristics, with 28 studies (75.6%) relying on specific samples such as clinical or child welfare samples, thereby increasing the risk for selectivity effects; "design," with 26 (70.2%) studies implementing a cross-sectional research design; and the number of domains of resilient functioning, with 21 (56.7%) studies examining only one resilience domain.

Discussion

This systematic review of the literature, which looked at 37 studies employing different methodologies, samples, and conceptualizations of resilience, found a wide range in the percentage of survivors of CSA who displayed adaptive functioning. The findings suggest that a range of individual and environmental factors moderate or mediate the well-established adverse impact of CSA (e.g., Maniglio, 2009) across different developmental periods.

In child and adolescent samples, the rates of resilience ranged from 10% to 53%, and in adult samples, it ranged from 15% to 47%. The earlier review of Dufour et al. (2000), which found an overall resilience rate from 20% to 44%, did not distinguish between short- and long-term resilience. In comparison, the resilience rates in mixed child maltreatment samples ranged from 0% to 20% for global indices of resilient functioning, with higher resilience rates for specific domains of functioning (Haskett et al., 2006). In the review of Walsh, Dawson, and Mattingly (2010), restricted to studies assessing resilience within several domains, approximately 10–25% of maltreated children achieve resilience.

The wide variation in resilience rates of victims of CSA, as well as in the rates seen following other types of child maltreatment, is considerably influenced by a number of factors related to conceptual and methodological issues. The most important factor is probably the number of resilience domains used in order for a survivor to be considered resilient (Chandy et al., 1996b; Daignault & Hebert, 2009; Hyman & Williams, 2001; Liem et al., 1997; Spaccarelli & Kim, 1995; Wright et al., 2005). Obviously, the higher the number of domains

considered, the smaller the percentage of victims who will be deemed to have adaptive functioning. Other factors that impact the rate are the selection of the cutoff criterion for resilience (Daigneault et al., 2004; Hyman & Williams, 2001) and the specificity of the outcome domains (Chandy et al., 1996b) and outcome instruments (Edmond et al., 2006). The time lag between the occurrence of abuse and outcome evaluation most probably has an effect on resilience rates as well (Daigneault et al., 2007). In the same vein, different measurement points in longitudinal studies also influence resilience rates (Daigneault et al., 2007). Finally, sample characteristics such as the recruitment of clinical or community samples (Edmond et al., 2006; Lynskey & Fergusson, 1997), as well as the scarcity of data on male victims, have a large impact on resilience rates (Daigneault & Hebert, 2009; Daigneault et al., 2007; Daignault et al., 2004; Edmond et al., 2006; Hyman & Williams, 2001; Spaccarelli & Kim, 1995; Wright et al., 2005). Nonetheless, the conjunction of resilience rates over different studies may give important clues for the actual proportions of resilience following CSA at different developmental stages.

Research on resilience in the aftermath of sexual abuse can be valuable, as it can inform clinical practice and guide research in the development of a theoretical basis for interventions aiming at positive mental health following CSA. That is, empirical knowledge about protective factors may provide valuable information for designing treatment and prevention programs against the adverse effects of CSA. For example, the importance of actively confronting trauma-related issues is on one hand documented as a protective factor after child maltreatment (Herrman et al., 2011) and on the other hand as one important therapeutic agent in the trauma-focused cognitive behavioral therapy for sexually abused children (Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, & Knudsen, 2005).

Our review found the best established protective factor on an individual level to be education. Educational engagement, plans, performance, and positive feelings toward school all contributed to resilience in both adolescent and adult samples. Although education is not amenable to change in a therapeutic context, the attitude toward it, motivation, and illustration of its importance can be a target for therapy as well as being used to foster academic skills. Additionally, the findings suggest an important role of psychoeducation in the treatment of sexually abused clients, which should be delivered in a developmentally appropriate manner.

A conceptual impediment exists because education can be considered not only as a protective factor but also as an indicator or domain for resilient outcome (Daignault & Hebert, 2009). Other variables that are conceptualized from both these perspectives are self-esteem and law-abiding behavior. This illustrates the intertwined nature between resilience domains and resilience factors, which often bidirectionally influence each other. For those examples, it is hard to determine causality, and it is more appropriate to acknowledge the interdependence/circular relationship between factors and domains.

Good evidence was also found for the protective function of emotional and interpersonal competence as well as interpersonal trust in adolescent and adult samples. Sexual abuse is a traumatic event in which interpersonal trust is shattered (Finkelhor & Browne, 1985), and reestablishing or maintaining interpersonal and emotional competence afterward seems to prevent adverse effects of CSA. This may be because resilient victims possess a higher ability to cope and manage social and emotional risk factors that are inherent to sexual abuse, such as stigmatization, shame, shattered interpersonal trust, or feelings of guilt. Therefore, fostering emotional and interpersonal competences should be a key target in therapeutic work with CSA survivors. As the protective factor of interpersonal trust has not been identified in previous reviews, this is the first indication that it might be rather specific for CSA. Further studies should try to clarify the specificity of the protective function of interpersonal trust against the deleterious effects of CSA.

The established protective factors of optimism, hope, and control beliefs all illustrate the significance of strengthening CSA survivors' belief in their own future and their ability to cope in therapy with the adverse event. Positive effects of external attribution of blame point to the importance of challenging the perception of guilt, which is an established risk factor for psychopathology, and to reinforce blaming the perpetrator. The protective value of externalizing blame might be especially important for CSA compared to other types of child maltreatment.

The inconsistency found for the effect of active coping across all age-groups might be due to the fact that addressing trauma-related issues is not very easy to accomplish, and avoidant behaviors may be part of a posttraumatic stress disorder. Actively approaching trauma-related information might initially result in emotional turmoil, and the beneficial effect might develop only later. Indeed, the study by Chaffin et al. (1997) was conducted within weeks after the occurrence of the sexual abuse, and thus the majority of participants might have not yet been able to benefit from approach strategies. Methodically, the constructs of active coping and approach strategies are often differently defined and assessed across studies, so direct comparisons are hindered. Referring to well-established conceptualizations of active coping strategies, such as those of Roth and Cohen (1986), would be a significant step forward and would enable better comparisons across studies.

Interestingly, attachment to family or peers was found to be protective only for girls and women. Males were included only in the samples of Chandy et al. (1996a, 1996b), which leaves a gap in the literature with regard to the role of attachment in male victims.

In comparison to the limited evidence for most individual-level protective factors, there is an extensive evidence base for various forms of social support at the family and community levels across all age-groups. However, the intensity of the beneficial effect of social support from family, peers, or partners may be primarily a function of the developmental period of the victims. Findings indicate that children depend on the support

of their non-offending parent or caregiver, adolescents on friends and peers, and adults on their spouse. Rosenthal et al. (2003) found that children derived the most satisfaction with support from caregivers, whereas adolescents reported more satisfaction with support from friends. This pattern is in accordance with normative developmental differences (Furman & Buhrmester, 1992), that is, children rely on the support of their parents, whereas adolescents are expected to increase their reliance on social support from peers.

Altogether, the results of this review clearly indicate that social support from various sources buffers against adverse effects of CSA. In particular, social support from non-offending family members might be a key component in providing effective interventions after disclosure of CSA. In fact, clinical interventions for children and adolescents that integrate parents in the therapy and thus provide support for parents have proven to have beneficial effects in both child and parent outcomes (Deblinger, Stauffer, & Steer, 2001; Elliott & Carnes, 2001) and, most probably, are more effective than interventions that focus solely on the victim.

The reviews of resilience after child maltreatment in general (Afifi & MacMillan, 2011; Haskett et al., 2006; Heller et al., 1999; Herrman et al., 2011) looked at a number of possible protective factors that were not included in the primary studies in our CSA-specific review: personality traits, mastery, cognitive appraisals other than externalizing blame, intellectual functioning, cognitive flexibility, positive emotions, hardiness, resourcefulness, and adaptability. From a clinical perspective, those factors that are amenable to change in therapy are particularly worth studying and await empirical investigation. Differences in these factors with regard to other types of maltreatment may lead to a better understanding of the pathology as well as the healing mechanisms innate to specific experiences of maltreatment.

Only eight of the studies we found were longitudinal, and they cover relatively short periods of time. Studies that monitor the sequelae of CSA into adulthood are very costly to undertake and, consequently, very rare. Thus, little knowledge exists on how resilience develops over time, how possible mechanisms hinder or foster resilience, and how protective factors may interact at different development periods. Future studies should aim to implement longitudinal designs, ideally spanning from childhood into adulthood.

The lack of consensus on an operational definition of resilience (Davydov et al., 2010; Herrman et al., 2011) may be less significant than it appears, as most of the studies used similar domains as evidence of resilience. Most often, it was conceptualized as the absence of psychopathology and adaptive functioning on behavioral, emotional, and social levels. Only a few studies considered multiple distinct domains simultaneously when measuring resilience. However, concurrent measurement of distinct indicators or domains of resilience would be worthwhile, because a CSA survivor may show competence in one domain but not in another. The debate over whether it is sufficient to rely on single indicators of resilience derived from conceptual considerations (e.g., Luthar et al., 2000) or whether it is necessary to consider multiple indicators of resilience (Kinard, 1998; McGloin & Widom, 2001; Walsh et al., 2010) can be best solved when more information on the association between different outcome domains is available. The simultaneous consideration of different domains of functioning would be a challenging but rewarding task for future research.

Six of the included studies (Aspelmeier et al., 2007; Chaffin et al., 1997; Daignault & Hebert, 2009; Goldstein et al., 2013; Tarakeshwar et al., 2006; Vural et al., 2012) had another limitation in that they were secondary analyses of studies conducted for research questions other than the specific purpose of investigating resilience after CSA, and therefore valuable information such as operational definitions of resilience, effect sizes for protective factors, and rates of resilient functioning was not obtainable. What is needed are more studies that are specifically designed to generate these data in order to better understand the stability of adaptive functioning over time and across different developmental periods as well as the distinct effect sizes of protective factors.

Research on resilience following child maltreatment in general has included a focus on biological variables (Cicchetti & Rogosch, 2009), but no study in the current review included such investigations. Cicchetti and Rogosch (2009) present important directions for future research that would tremendously enrich research on resilience after CSA. For example, a longitudinal study by Putnam and Trickett (1997) found indices that sexually abused girls differ from non-abused girls in their levels of stress-related hormones and neurotransmitters as well as in their neuroendocrine responses to stressors. Such biological alterations during adolescence could be a novel target for resilience research after CSA. Research examining biological and genetic protective factors is vital, including the use of twin studies and molecular genetics designs. Knowledge of genetic variation may help to identify which individuals are most vulnerable to adverse experiences. Through investigating Gene $\times$ Environment interactions, protective functions of genes that may facilitate coping with stress may be discovered (Cicchetti & Rogosch, 2009). For example, there are emerging studies that have examined the protective role of the monoamine oxidase A genotype (Nilsson et al., 2011) and H2 haplotype at chromosome 17q21.31 (Nelson et al., 2010) with regard to the CSA-associated risk for alcohol consumption and alcohol dependence.

In conclusion, research into resilience in the aftermath of CSA can be valuable, as it can inform clinical practice and support the development of a theoretical basis for interventions that aim at attaining positive mental health. The findings of this review suggest that a range of individual and environmental factors moderate the adverse impact of CSA across different developmental periods. In particular, strong evidence was found for individual factors such as education and interpersonal and emotional competence, control beliefs, active coping, optimism, social attachment, and external attribution of blame. Furthermore, the empirical evidence for the importance of social support on both the family and the environmental level is substantial. Therefore, preventive and clinical interventions

for victims of CSA should utilize psychoeducation and cognitive interventions adapted to the developmental level of victims and should enhance the social support provided by significant others. Trauma-focused cognitive behavior therapy (Cohen, Mannarino, & Deblinger, 2012) is one example of a therapeutic intervention that successfully integrates several evidence-based protective factors into their treatment approach.

Critical Findings and Implications

- Resilience research can guide the development of treatment and prevention programs;
- The best supported protective factors are education, interpersonal and emotional competence, control beliefs, active coping, optimism, social attachment, external attribution of blame and by far, social support from the family and wider social environment;
- Resilience rates among survivors of CSA range between 10% and 53%;
- Preventive and clinical interventions for survivors of CSA should utilize psychoeducation and cognitive strategies adapted to the developmental level of victims and enhance social support from significant others;
- Future research should focus on mechanisms underlying effective and healthy adaptation to the stressor CSA within longitudinal research designs, considering resilience rather as a dynamic process with multiple dimensions in a social and developmental context.

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