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FOSTERING RESILIENCE IN SURVIVORS OF CHILD SEXUAL ABUSE TO DECREASE VULNERABILITY TO SEXUAL REVICTIMIZATION

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Abstract: *Child Sexual Abuse (CSA) is an enormous public health issue worldwide, affecting health outcomes in millions, and the United States is not immune. One significant sequela of CSA is increased vulnerability for sexual revictimization. Each CSA survivor has varying factors that affect their own risks for revictimization, and significant attempts to lower such risks must take into account their complexity. This author seeks to foster resilience in survivors of CSA, utilizing strengths and positive factors which are already part of the survivor as well as those who surround them, and by enhancing or teaching factors of resilience, to decrease sexual revictimization.*

Keywords: *resilience, child sexual abuse, revictimization*

Introduction

The World Health Organization in 1999 defined child sexual abuse as:

> *the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust, or power, the activity being intended to gratify or satisfy the needs of the other person.* (p. 15-16)

Child sexual abuse (CSA) is not a new problem, nor is it likely to disappear any time soon. It occurs in all countries and cultures, and the true prevalence of CSA is likely underrepresented because of the secrecy in which it is enshrouded (Hinton 2019; Lalor & McElvaney, 2010). How have we, as a society, progressed in identification of children individuals who are susceptible and victimized, and how do we care for them? CSA is an enormous public health problem as it affects a significant portion of our children, who often suffer short and long-term emotional, psychological, and physical health issues.

In the United States, it is estimated that the lifetime prevalence of sexual abuse or assault through the age of 17 years old is 26.6% for girls and 5.1% for boys (Finkelhor et al., 2014). The CDC further estimates that the cost of CSA in the United States in 2015 was $9.3 billion (CDC, 2021). The United States' National Child Abuse and Neglect Data System (NCANDS) reveals that in 2019, 650,000 victims of child abuse and neglect were reported in the U.S., with 9.3% reported to have experienced CSA. Data was also

collected on child sex trafficking victims (up to age 24 years old), and the results revealed of the children who experienced more than one maltreatment type (physical abuse, sexual abuse, neglect, or sex trafficking), 30.7% of female children and 28% of male children who experienced sex trafficking also had a history of CSA (Child Maltreatment, 2019).

Sequelae of Child Sexual Abuse

The literature reveals a host of negative outcomes for victims and survivors of CSA, including increased risk for severe mental, physical, and behavioral health problems (Letourneau and Shields, 2016). There is a wealth of data outlining the multiple short- and long-term sequelae of CSA, including anxiety, depression, post-traumatic stress disorder (PTSD), substance use, and suicide attempts (Brier and Elliot, 2003; Hinton, 2019; Lalor & McElvaney, 2010; Letourneau & Shields, 2016). In addition, CSA and physical abuse often result in low self-esteem, anger and aggression, and elevated risk-taking behavior (Briere & Elliott 2003; Letourneau & Shields, 2016). Survivors of CSA are also documented as suffering guilt, shame, fear, helplessness, and grief. They may suffer from feelings of isolation, stigmatization, and negative self-image (Hinton, 2019). Some of these effects may be short-term, but many extend into or worsen in adulthood, often inducing difficulties with relationships, parenting, and sexual functioning (Hinton, 2019; Lalor & McElvaney, 2010). Survivors of CSA are more likely to experience drug and alcohol misuse and participate in self-harm or self-destructive behavior (Lalor & McElvaney, 2010).

An effect of CSA that is unique, compared to other experiences of childhood trauma, is sexualized behavior that is inappropriate for a child's developmental age (Cole et al., 2016; Finkelhor & Berliner, 1995). CSA may also lead to high-risk sexual behaviors, such as multiple partners, earlier onset consensual sex, casual sex, changing partners frequently, and group sex (Lalor & McElvaney, 2010). These high-risk sexual behaviors may lead to sexual exploitation and prostitution, multiple STI, teen pregnancy, and increased vulnerability to sexual assault later in life (Lalor & McElvaney, 2010, Cole et al., 2016; Hyman & Williams, 2001). It is because of these specific sequelae of CSA that survivors have a high risk of sexual revictimization.

According to the CDC (2021), survivors of CSA are two to three times more likely to experience sexual revictimization in adulthood, and two times more likely to experience sexual interpersonal partner violence. Sexual revictimization may include interpersonal violence, sexual assault, pornography, and commercial sexual exploitation. Lalor and McElvaney (2010) found that sexual revictimization in adolescence is associated with being 13.7 times more likely to experience sexual assault as an adult, and those with a history of CSA are 3.5 times more likely to report sexual violence by a non-partner in their lifetime. The more severe the CSA, and with the addition of physical abuse, the higher the risk for sexual revictimization (Hyman & Williams, 2001; Lalor & McElvaney, 2010).

Ogloff, et al. (2012), also noted an increased risk for subsequent sexual and non-sexual victimization and perpetration among victims of CSA. It is estimated that greater than 90% of children who experience sex trafficking have a history of sexual abuse (Darkness to Light, n.d.). Studies show that a majority of females who are sexually exploited have a history of CSA, especially experiences with more severe abuse, longer duration of abuse, and having experienced CSA at an earlier age (Cole et al., 2016; Lalor & McElvaney, 2010). Lalor & McElvaney (2010), state that 63% of women who had

experienced CSA before the age of 14 also experienced rape or attempted rape after 14 years of age, compared with 35% of women with no history of CSA. Breaking the cycle of revictimization is a necessary goal in our treatment of victims of CSA.

Resilience and Child Sexual Abuse

However, not all individuals who experience CSA are destined to a lifetime of difficulty. Hinton (2019) states that 40% of those who experience CSA have pathology enough to require therapy in adulthood; but many continue with their lives without significant pathology and live successful lives. It is estimated that 21% to 49% of children who experienced CSA have no short-term effects (Hyman & Williams, 2001; Lalor & McElvaney, 2010). What makes these children different? What makes them able to bounce back, be resilient, resist negative outcomes, and even thrive?

Several studies have been conducted on resilience and survivors of CSA. Definitions regarding resilience in children who have experienced CSA vary somewhat in the literature, but overall concentrate on strengths-based, positive coping skills in the face of adversity, which is often chronic (Berry-Fletcher, 2013; Gilligan et al., 2014; Hinton, 2019). It is seen as a dynamic process which can be taught, learned, and nurtured (Hinton, 2019; Hyman & Williams 2001). Some definitions of resilience range from being able to competently function in society and lack psychopathology (Domhardt et al., 2015; Hyman & Williams, 2001), while others are more expansive, positing that resilience in such children reflect not only the ability to cope within adversity, but an ability to respond more positively in future stresses, or even thrive despite adversity (Gilligan, et al., 2014; Hinton, 2019). Domhardt et al., (2015) summarize in their review that the 10%-53% of adolescent and adult survivors of CSA show signs of resilience.

One area that requires more data is resilience in those who experience CSA and seem to have no short-term sequelae, but are triggered in later years, resulting in negative health outcomes. In reviewing the literature, resilience factors can be divided into individual factors, family factors, and community factors (Domhardt et al., 2015; Berry-Fletcher, 2013; Hinton, 2019; Wilcox et al., 2004).

Individual Factors

In regard to personal or individual factors, Berry-Fletcher (2013) emphasizes the importance of the developmental stage of the child when the abuse begins and occurs; the more immature a child is in terms of emotional, social, and physical development, the more susceptible the child is to negative impacts from the abuse. While maturity can correlate to chronologic age, it also takes into account individual variability as well as children with disabilities. Berry-Fletcher (2013) states that "children who have had more opportunities to accomplish as many normative developmental tasks as possible are better equipped to manage stress or trauma" (p. 7). Individual or internal factors promoting resilience may include optimism and hope, a sense of self-efficacy, problem-focused coping skills, the ability to externalize the blame of the abuse on the perpetrator, a sense of self-empowerment, higher educational ability, higher emotional intelligence and ability to connect with others, a more secure attachment with one's family, and spiritual or religious beliefs (Domhardt et al., 2015; Gilligan et al., 2014; Hinton, 2019; Wilcox et al., 2004).

Some describe resilient CSA survivors to have the qualities of being outgoing and social, possessing certain talents, and the ability to engage in supportive resources (Hinton, 2019). Doing well in school and intelligence are also positively correlated with resilience (Hinton, 2019; Wilcox et al.,

2004). In addition, not being arrested, and less deviant or law-breaking activity was found to be associated with resilience in children and adults with a history of CSA. Participation in sports or other activities was shown to be protective (Domhardt et al., 2015). Less aggressive coping skills, less dissociation is also positively correlated with resilience (Lalor & McElvaney, 2010; Spaccarelli & Kim, 1995; Wilcox et al., 2004). Hyman and Williams (2001) also discuss more altruistic behavior in resilient children, such as when they protect their siblings or schoolmates.

Family Factors

Family factors understandably have a large impact on how a child experiences sexual abuse, positively and negatively. The closeness of relationship between victim and perpetrator is important (Spaccarelli & Kim, 1995). Ninety percent of CSA victims know their perpetrators and 30% are abused by a family member (Darkness to Light, n.d.). Early emotional support, caring and concern from parents or caregivers are positively correlated with resilience (Domhardt et al., 2015; Lalor & McElvaney, 2010; Spaccarelli & Kim, 1995).

A stable household with structure, two biological parents and positive parenting, as well as emotional bonds between child and father or mother are protective (Domhardt, et al., 2015). Higher level of caregiver education as well as high expectations from a caring parent have also been predictive of resilience in victims of CSA, and higher SES additionally seems to correlate with more resilience (Domhardt, et al., 2015; Hinton, 2019). On the other hand, disrupted households, instability, frequent moving, substance and alcohol use at home, physical punishment, poor parental attachment, and parental separation can all be negatively correlated with poor outcomes after CSA (Lalor & McElvaney, 2010). A crucial factor is how the parental figures react to the disclosure of abuse; if a child is not believed or listened to regarding CSA, it can cause long term harm (Berry-Fletcher, 2013; Spaccarelli & Kim, 1995; Wilcox et al., 2004). Hyman and Williams (2001) described three characteristics of a family which positively influence resilience: absence of severe physical abuse, stable family, and absence of substance use.

Community Factors

Community and environmental factors that may promote resilience include belonging to organizations, participating in sports, and attending school (Domhardt, et al., 2015; Hinton, 2019; Hyman & Williams, 2001; Spaccarelli & Kim, 1995; Wilcox et al., 2004). These offer a sense of belonging, shared experiences, being a part of something larger than oneself, support, a sense of purpose, responsibility, and emotional and physical expression (Hinton, 2019). Having the ability to contribute skills and talents to one's community fosters resilience and helps one heal. Positive peer relationships and adult relationships outside the family, such as teachers or healthcare professionals, aid in resilience after CSA (Domhardt et al., 2015; Hyman & Wiliams, 2001; Spaccarelli & Kim, 1995; Wilcox, 2004). Hyman and Williams (2001) state that the latter allow the child to believe they are worthy to be loved. These factors may prevent social isolation, thus facilitating the child's healing process and resilience, and lowering the risk for future revictimization.

Summary

The factors found to be most important to outcomes in CSA are severity of abuse, duration of abuse, use of physical force or violence, and not being believed or supported by significant people in the child's life (Domhardt et al., 2015; Berry-Fletcher, 2013; Lalor & McElvaney, 2010; Spaccarelli &

Kim, 1995; Wilcox et al., 2004). Hyman and Williams (2001) present key variables predicting resilience – stable family, no incest, no physical force with the sexual abuse, not being arrested as juvenile, and graduation from high school. Domhardt et al. (2015), state in their review the strongest individual protective factor is education—the ability of the child to engage in and have a positive attitude toward school. Other strong protective factors were the ability to have emotional competence and interpersonal relationships (Domhardt et al., 2015).

Treatment of Child Sexual Abuse

Because child sexual abuse is so pervasive and the effects are far-reaching, it is crucial for interventions to be multidisciplinary to improve the health outcomes of survivors. Interventions to promote resiliency in individuals who have experienced CSA would not only assist healing but prevent revictimization. Interventions must address survivors of CSA at the individual, family, and community levels, and extend to address longer-term sequelae. In addition, societal factors must be considered. Children who are identified as having experienced sexual abuse are referred through their state's child protective services; some receive physical exams from physicians or providers trained in child abuse or forensic exams, which can be a healing experience in the right hands. The most common treatment at this time is various forms of therapy, which have shown varying effectiveness but have been promising. For example, trauma-focused cognitive behavioral therapy (TF-CBT) is a form of therapy often used in survivors of CSA (Letourneau & Shields, 2016; Petersen et al., 2014). When caregiver and child are both included in treatment, TF-CBT has been shown to decrease the symptoms of depression, anxiety, and PTSD, as well as improve social functioning of the child; additionally, it has the benefit of lowering parental stress. (Letourneau & Shields, 2016; Petersen et al., 2014). There can be many barriers to accessing or receiving therapy, such as cost, lack of transportation, negative beliefs about therapy, lack of insurance or incomplete coverage, stigma of therapy, the ability for parents to take time off of work or children to take time out of school; and the quality or availability of services can vary widely. For various reasons parents may decide not to involve their child in therapy, or the child may appear outwardly functional, even while internalizing their suffering. Spaccarelli and Kim (1995) and Hyman and Williams (2001) found that parental reports of their child's well-being post-CSA often differed from the child's self-report. They stated that many girls in their study were able to function well socially, while suffering deeply from depression, anxiety, or aggressive emotions. Some individuals who experience CSA have no short-term sequelae, but may be triggered later in life emotionally, psychologically, physically, and behaviorally (Spaccarelli & Kim, 1995). In these individuals, interventions early after the abuse disclosure may boost resilience that may benefit them years later. Therefore, interventions must be broad-reaching, long-term, accessible, and beginning as early after the disclosure as possible.

Proposed Intervention

I propose an intervention to foster resilience in children who have experienced child sexual abuse to prevent sexual re-victimization, entitled Soar Resilience, in the state of Illinois. Once a child is identified through their local child protective services of having potentially experienced CSA, the child is immediately referred to the Child Advocacy Centers (Children's Advocacy Centers of Illinois, n.d.). It is at this point that the child and non-offending parent(s) or caregiver(s) be enrolled in Soar Resilience. While in the first several weeks, the child and

family may be busy with healthcare visits, advocates, social services, and law enforcement, this busy-ness will eventually resolve. Soar Resilience is designed to carry the family and child through the long-term process of healing, growing, and reclaiming their lives. The ultimate goal is that Soar Resilience be implemented across communities in the United States, to be available to anyone who has experienced CSA at any time in their lives or any location in the U.S. In the initial implementation, however, I propose that the program begin in the state of Illinois, as an extension beyond the Child Advocacy Center (CAC) role.

Upon enrollment, a thorough trauma-informed screening will be done with the child and family to assess demographic characteristics; risk factors, including severity and duration of the sexual abuse, as well as individual, family, and community risk factors unrelated to the abuse; strengths that can be built upon; and goals. This screening can be done in conjunction with other screenings done by the CAC to limit the risk of retraumatization. These will be used not only to create specific plans for the family and child to foster resilience, but as data to inform ongoing evaluation as the program progresses. Follow-up assessments will be repeated after three months, then after a period of six months, and afterwards annually while the child and family are enrolled. After graduation from the program, the program will contact the family at three-year intervals via mail, telephone, or email to further evaluate and track how the family and child are doing, until the child reaches 18 years old. At any point, they are welcome to rejoin the program if there is a need and desire.

As an extension of services to children who experience abuse, I propose Soar Resilience be funded by the state of Illinois. Already, the Crime Victim Compensation Program ensures up to $27,000 in compensation for services rendered in response to a violent crime, including sexual assault or abuse (Crime Victim Compensation Program, n.d.).

Individual Intervention

The Soar Resilience program is not intended to replace individual therapy; however, the program can complement therapy, and in so doing, enhance resilience in survivors and their families. Specific, evidence-based activities to promote resilience will be employed utilizing and highlighting individual strengths and positive qualities.

Monthly group meetings will be scheduled according to preschool age with their non-offending parent / caregiver, elementary school-aged children (5-10), middle school-aged children (11-13), and high school-aged children (14-17), the latter three groups without parents or caregivers present. A child will receive a personal, trained mentor, who will interact with the child and the child's family with the goal of a long-term relationship. Effort will be made to find mentors who are CSA survivor-leaders.

Another goal of the mentor is to individualize the child's and family's healing. Each child and family possess their own vulnerabilities, strengths, and histories; there is no one-size-fits-all solution. The groups and mentorship will emphasize safe spaces, confidential areas where they can share and feel support, belonging, and understanding. In this manner, perhaps some decrease in stigma in discussing sexual abuse will occur, and the families and children will feel less alone. This will foster peer support as well as support from someone older (mentor). Much of the literature mentions that children may gain resilience by having an important individual who believes in them (Gilligan et al., 2014; Hinton, 2019; Hyman & Williams, 2001) – ideally, it would be the parent, who will be supported in this program, but if not the parent, then another adult may be able to fill that role. Developmentally appropriate

education about sexual abuse and its consequences will be taught, as well as resilience-building coping mechanisms. Discussing self-care, schooling, building self-sufficiency, and learning to concentrate on what they can control are all examples of possible topics for exchange. As all people have different experiences and react to them individually, there is no time limit on the duration of participation in the program.

Family Intervention

For the families and caregivers, monthly group meetings will be offered specifically for them. Because the program will begin soon after disclosure, Soar Resilience will assist families to navigate the stressful process that occurs in the first several weeks and help them achieve some sense of control and understanding. Soar Resilience will also help support families through the family and social disruptions that may be an outcome of the revelation of the CSA. Education, social support, and enhancing parental confidence are key. Parenting skills will be taught, as often a disrupted household can have contributed to the risk factors for the child and learning parenting skills can help alleviate some of this. As mentioned earlier in the paper, involving caregivers is crucial to full healing for the child (Petersen et al., 2014; Spaccarelli & Kim, 1995). Parenting and communication skills can help address higher risk behaviors that the child might have pre-abuse, as well as new behaviors that develop post-abuse. Interventions have been shown to improve stress in the family (Letourneau & Shields, 2016; Petersen et al., 2014).

Promoting resilience for the family members as well helps in a more holistic way (Wilcox et al., 2004). Parental support for the child is important to help the child interact with their community in a safe way – schools, clubs, activities, peers (Spaccarelli & Kim, 1995). Additionally, Spaccarelli and Kim (1995) found that mothers of incest victims often have emotional and psychological sequelae of their own. Helping parents through their own trauma from the experience, furthers their own resilience, potentially increasing the resilience of their child.

Community Intervention

The Soar Resilience intervention program must also involve community participation. Educating school administrators, teachers, coaches, school nurses, social workers, and volunteers is essential for creating schools that are emotionally safe and equipped to encourage resilience in all children, as well as the adults that work with them. Not only will this strengthen the classroom, but it will also affect after school programs, sports teams, recreation, and student government. Such education will occur at the beginning of each semester. As mentioned previously, CSA survivors who are able to engage in academics are likely to have a more resilient outcome. Similar education will be provided to community centers, park districts, and those who work in these areas. Encouraging children to join groups, sports, arts; somewhere they feel belonging, participation, responsibility, and a sense of contribution—this is important for all children, not only children who excel at a certain field. Building resilience in all children, and the communities they live in may increase resilience in each member. Building a community where less stigma exists around topics such as abuse and trauma can only strengthen its members. Building a community of survivor-leaders of CSA and other trauma can not only be healing but create and foster resilience; survivor-leaders will raise new resilient survivor-leaders, leading to perpetuation of the program.

Conclusion

As all children who suffer from trauma as severe as sexual abuse deserve the resources

to heal and reclaim their lives, our states should enact policies to ensure the health of our children, as children cannot advocate for themselves. Policy makers have a responsibility, as does society, to advocate for the vulnerable. Soar Resilience is one program which has the potential to foster health in our youth, to promote the health of our future adults. The positive impact of Soar Resilience to promote resilience in CSA victims, to prevent sexual revictimization, could last generations, has the potential to impact a multitude of people, be self-sustaining, and cost-effective.

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