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IDENTIFICATION AND CONCEPTUALIZATION OF SEXUAL ABUSE RESILIENCY
FACTORS:
A REVIEW OF THE LITERATURE

by

Heidi J. Moss

Thesis submitted in partial fulfillment
of the requirements for the degree

of

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1994

Conceptualizing Factors Associated with Sexual Abuse Resiliency

One discovers that destiny can be directed, that one does not have to remain in bondage to the first wax imprint made on childhood sensibilities. Once the deforming mirror has been smashed, there is a possibility of wholeness. There is a possibility of joy.--Anais Nin

In Partial Fulfillment of the Requirements of

Honors Degree

Heidi Moss

In conjunction with

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Introduction

Resiliency, while historically grounded and defined, lacks important conceptual clarity when considering the area of sexual abuse resiliency. Considerable theoretical effort has been dedicated to this phenomena in certain specific areas of human development (e.g., children) with empirical endeavors to validate it's relevance. To date there seems to be consensus with the notion that three specific variables are correlated with resiliency outcomes, namely, biological, psychological and social influences. It is posited that these three primary variables and their substantive variables independently, as well as interactively, buffer the effects of abuse one may experience during the course of a life time. It is the intent of this Honors Thesis to initially examine the realm of abuse in general with focused attention on sexual abuse. Secondly, biological, psychological and social variables which may be associated with resiliency will be examined. Finally, a methodology for further examination of the impact of these three variables will be posited.

Definition of Terms

Basic terms which will be used in this Honors Thesis are defined below. They are organized in alphabetical order for ease of reading and reference.

Abuse. Abuse is a generic term referring to the maltreatment of children including, though not necessarily limited to: physical abuse, sexual abuse, emotional abuse and neglect. Geiser (1979) states that "abuse implies an exclusive relationship between abuser and victim.... [with] the consequences of [abuse] will showing up somewhere in this system as

physical and/or behavioral symptoms in the child or as psychic distress in other family members."

Child sexual abuse. Child abuse, and more specifically child sexual abuse, was defined in the 1974 Child Abuse Prevention and Treatment Act. In 1984, the U.S. Congress amended the previous act to read, "The term sexual abuse includes: (I) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in any sexually explicit conduct (or any simulation of such conduct) for the purpose of producing any visual depiction of such conduct; or (ii) the rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children, under circumstances which indicate the child's health or welfare is harmed or threatened thereby" (Child Abuse Prevention and Treatment Act 42 as Amended by Public Law 98-457, 98th Congress, 9 October 1984).

Child sexual abuse, "a non-normative event" (Hetherington & Parke, 1986), is "the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles" (Kempe and Kempe, 1978). The National Center on Child Abuse and Neglect (1985) has noted child sexual abuse is "any childhood sexual experience that interferes with or has the potential for interfering with a child's healthy development."

Gilgun (1988) elaborated on the legal definition of child sexual abuse, indicating that it consists of:

non-consensual genital contact between a child who is 17 years old or younger and a person who manipulates, tricks, or forces the child into sexual behaviors.

Non-consent is presumed when the child is 15 or younger and the other person is 19 or older, or when there is a 5-years or more age gap between the older person and the child victim. When there is less than a 5-year gap in age, non-consent is determined by the victim stating that the genital contact was not wanted. Types of genital contact include penetration, attempted penetration or stimulation of the vaginal or rectal area by a penis, finger, tongue, or any other part of the perpetrator's body, or by an object used by the perpetrator; and also includes and type of genital or anal contact of the perpetrator by the victim, such as fellatio, masturbation, and intromission of any kind. Unwanted touching of breasts is included in this definition. No-contact sexualized behavior. The definition of child sexual abuse in this research also encompassed no-contact sexual behavior. This was operationalized as an adult sleeping in same bed with a child when either the child or the adult or both experiences sexual stimulation; seductive looks and talk to a child age 17 and younger by parents of other persons who have power over the child and such talk violates generation and/or personal boundaries; allowing or forcing others to witness sexual behavior such as intercourse, masturbation, and fellatio; allowing or forcing a child to observe pornographic pictures or films; inducing the child to pose for sexually explicit photographs; or inducing the child to perform sex on others. For the purposes of this research, a one-or two-time incidence of being a victim of exhibitionism and voyeurism by acts of a stranger

is not included; but being victimized through exhibitionism or voyeurism within a family or intimate setting over time is included.

Perpetrator. A perpetrator is an individual, male or female, who employs aggression or threat of aggression (real or perceived) to coerce or manipulate another to participate in some manner of sexual conduct they do not fully understand, approve of, or are in a position which inhibits or prohibits informed choice.

Resiliency. Murphy (1987) defined resilience as recovery from adversity. "Children who experience adversity are vulnerable to developing adverse outcomes. Growing up in poverty, living in institutional settings, and being a child of a mentally ill parent are examples of situations that are associated with vulnerability to negative developmental outcomes. When children overcome difficult childhoods and develop good peer relationships, respectable academic records, and success in their work, they are considered resilient."

For purposes of this paper, resiliency will imply the ability, consciously or subconsciously, to employ biological, psychological or social coping strategies and skills to buffer the overall impact of traumatic stressors (Openshaw, personal communication, 1994).

Statement of the Problem

Janus and Janus (1993) noted that "only recently has American society begun to recognize the enormous problem of sexual child abuse...". Sexual abuse poses a social problem that warrants immediate attention and research. Unfortunately there has been only modest focus on the remediation of the effects of child sexual abuse with both child and adult survivors of sexual abuse, there has been almost no dedication to the area of prevention.

Prevention, it is posited, refers to the: a) the identification of high risk factors, as well as, b) the facilitation of biological, psychological and social influences which may serve as buffering elements which thereby mediate the overall outcome of the experience.

The prevalence of abuse, in specific child sexual abuse, makes a case for itself for the necessity of acquiring a better understanding of factors associated with sexual abuse resiliency. This paper will examine first the various elements of abuse and then focus on some of the more prominent biological, psychological and social variables purported as resiliency factors.

Victims of Sexual Abuse

The effects of child sex abuse have been, and continues to be, well documented (Beitchman, Zucker, Hood, DaCosta & Akman, 1991). Victims of sexual abuse have shown an spectrum of perceived effects. While some victims have noted effected areas such as "personality, health, work, parenting, spirituality, intimacy and sexuality" (Westerlund, 1992), there are certain predominant, repetitive characteristics that have been identified. For example, Roundy (1993) summarizes the damaging consequences of incest in Table 1. Other studies (Kinzl & Biebl, 1992; Towers, 1993) have listed childhood sexual abuse victims as having higher rates of depression, substance abuse, eating disorders, premenstrual syndrome and sexual disorders as shown in Table 2. While some effects of sexual abuse may show continuity throughout the life cycle, other effects may be developmental-specific (Beitman, Zucker, et al., 1991; Towers, 1993).

Most frequent factors associated with the outcome of child sexual abuse include intenseness of the overall impact on the child and the longevity of the impact. include though

not limited to, age of onset, sex of child, relationship to offender, frequency and duration, type of sexual act , and use of force. One factor, not well researched, is that of resiliency.

E. James Anthony was noted as making an analogy that effectively demonstrates various levels of resiliency. "There are three dolls, one made of glass, the second of plastic, the third of steel. Struck with a hammer, the glass doll shatters, the plastic doll is scarred. But the steel doll proves invulnerable, reacting only with a metallic ping" (Gelman, 1991). This analogy parallels the potential range of outcomes of sexual abuse which lie on a continuum ranging from most severe, psychopathological perpetrators to psychopathological outcomes other than perpetration (mild to severe in nature) to resiliency.

The Range of Sexual Abuse Outcomes

Sexual perpetrators. Numerous studies have attempted to ascertain the extent of child sexual abuse worldwide (Tower, 1993; Finkelhor, 1979; Kinsey, 1953; Russell 1984). Recent research (Grave, 1993), suggests that approximately 37% of those abused become perpetrators. Research (Groth, 1979) has found that between 50 and 70 percent of those who become perpetrators were victims of sexual abuse as children. Knopp (1985), raises that percentage to 82.

Psychopathology. According to Ferenczi (1932), sexual trauma has a pathogenic nature meaning that victims may have a tendency to develop mental and emotional deficits. Today, conceptualized as merely potentiality, these concepts are encompassed in what is known in the DSM IV as Axis I and Axis II disorders.

Axis I disorders include clinical syndromes relevant to the trauma experienced by the victims. Some victims are not able to resolve the issues related to sexual abuse. They have not yet fully ego developed or utilized resiliency factors. Consequently, Axis I symptoms and disorders emerge. These clinical syndromes include, but are not limited to, the following disorders: eating disorders, conduct disorders, identity disorders, paranoia, affective disorders, anxiety, somatoform disorders, dissociative and psychosexual disorders. Kinzl and Biebl (1992) report that abused women in contrast to non abused women scored higher on dissociation, physical disturbance, anxiety, depression, and sexual dysfunction in most of the studies they reviewed (Bagley & Ramsay, 1986; Briere & Runtz, 1988; Chu & Dill, 1990; Gold, 1986; Murphy et al., 1988; Russell, 1986). Kinzl and Biebl report that "knowledge about the frequency of incestuous experiences among patients with mental and psychosomatic disorders increasing. Glyngdal, Friis, and Malver (1989) found that in a clinic for neurotic patients, 25% of the women had been victims of incest or sexual abuse. Other studies have demonstrated higher rates of childhood sexual abuse experiences in patients with depression, substance abuse, eating disorders, premenstrual syndrome, sexual disorders, multiple personality disorders, adjustment disorders, somatoform disorder, borderline personality disorders, and post traumatic stress disorders (Bryer, Nelson, Miller & Krol, 1987; Bulik, Sullivan, & Rorty, 1989; Coons, 1986; Damlouji & Ferguson, 1985; Finkelhor & Browne, 1985; Friedman, Hurt, Clarkin, Corn & Aronoff, 1982; Gold, 1986; Greenwald, Leitenberg, Cado, & Tarran, 1990; Herman, Russell, & Trocki, 1986; Lindberg & Distad, 1985; Morrison, 1989; Ogata et al., 1990; Sloan & Leichner, 1986).

Although there is some agreement, published figures are more speculative than verified. Proceeding from the hypothesis defined by Ferenczi in 1949, traumatic experiences of childhood sexual abuse may lead to specific deficits in ego development and to specific sequelae of objectual relationships. Investigation into the importance of threats of abandonment and the child's failure to form affectional bonds with mother form the basis of Bowlby's attachment theory (1973, 1980). This theory suggests because of early acquired psychological vulnerability, life events affecting objecting relationships gain in significance for disorders."

Finkelhor and Browne (1986) noted Briere (1984) as "reporting that 54% of the sexually abused patients suffered from anxiety attacks, 54% had nightmares, and 72% had trouble sleeping. "Young (1992) notes that "59% of those women who had been sexually abused had symptoms of nervousness and anxiety, 41% had symptoms of severe tension, and 51% had trouble sleeping. "Sixty-seven percent of a group of sexually abused children evidenced somatic and behavioral symptoms (Rimsza & Berg, 1988, as cited by Young, 1992).

In a study done by Westerlund (1992), a majority (77%) of women who had been victims of incest reported a psychic "numbing", a sign of depersonalization, a dissociative reaction. Up to 51% noted a feeling of leaving their bodies and 40% mentioned they observed themselves from nearby. A life-time pattern may emerge as a result of these encounters and corresponding body estrangement's. One woman stated, "I was out of my body most of the time for many years. Later I didn't know how not to be" (Janus and Janus, 1993).

Multiple Personality Disorder - a dissociative disorder- is reported (Young, 1992) as being "increasingly linked to severe and often physically sadistic sexual abuse" (Baldwin, 1984; Braun, 1984; Kluft, 1984, 1985; Putnam, 1984).

Cicchetti (1986), noted that the linking of childhood sexual abuse to subsequent problems is not a new idea. On one hand, a review of literature illustrates psychiatry's early identification of the psychodynamic impact of child sexual abuse; on the other hand, the lack of follow-up response by clinicians illustrates their difficulty in believing the abuse actually occurred. The magnitude of psychodynamic impact from childhood sexual trauma was presented by Freud in 1895. He stated that hysterical symptoms could be understood when traced to an early traumatic experience and the trauma was always related to the patient's sexual life. The trauma manifested itself when revived later-usually after puberty-as a memory.

Included among the Axis I disorders are those disorders involving relationship maintenance such a marital discord. Marital dissatisfaction, more specifically, lack of emotional and sexual intimacy in relationships of sexually abused victims, is common and contributes to the degree of relationship displeasure (Westerlund, 1992). Westerlund continued by reporting that sexual abuse victims are more likely to show a pattern of involvement with abusive (physically, emotionally and/or sexually) men. Because of the subconscious and conscious anger still present, which is a stronger emotion than pleasure and satisfaction derived from sexual encounters, sexual satisfaction was minimized. Some women opt for alternative sexual lifestyles such as celibacy and homosexuality. Westerlund (1992) captures the nature and extent of the impact sexual abuse has on sexuality noting that 63%

were predominated by inhibition, 49% had periods of celibacy, 47% participated in promiscuous activities, 21% alternated between celibacy and promiscuity, 23% noted sexual compulsions, 14% were plagued with sexual aversion, 12% had periods of prostitution, and 7% had adopted a masochistic orientation.

Axis II disorders are classified into two areas, developmental and personality. The more common of the two seen in the literature is personality disorders, i.e. paranoid, antisocial, borderline, dependent, compulsive, passive-aggressive, histrionic, etc. Abusive situations which have prevailed early on in life and have been maintained across time have disruptive effects on one's personality development and can result in distorted personality development as noted by the development of personality disorders.

Marital dissatisfaction and dysfunction. Marital dissatisfaction, more specifically, lack of emotional and sexual intimacy in relationships of sexually abused victims, is common and contributes to the degree of relationship displeasure (Westerlund, 1992). Westerlund continued by reporting that sexual abuse victims are more likely to show a pattern of involvement with abusive (physically, emotionally and/or sexually) men. Because of the subconscious and conscious anger still present, which is a stronger emotion than pleasure and satisfaction derived from sexual encounters, sexual satisfaction was minimized. Some women opt for alternative sexual lifestyles such as celibacy and homosexuality. Westerlund (1992) captures the nature and extent of the impact sexual abuse has on sexuality noting that 63% were predominated by inhibition, 49% had periods of celibacy, 47% participated in promiscuous activities, 21% alternated between celibacy and promiscuity, 23% noted sexual

compulsions, 14% were plagued with sexual aversion, 12% had periods of prostitution, and 7% had adopted a masochistic orientation.

Resiliency

Previous and current life experiences are factors that effect a person's perception of reality. An example of this type of variation is the common witness statements taken by police. Each person witnessing a crime or accident will report widely varying aspects and details of the incident. Rutter (1990) offers the following explanation of this theory in relation to resiliency:

"resiliency is concerned with individual variations in response to risk factors. For the concept to have any meaning it must apply to differences in responses to a given dose of the risk factor, that is, it is not just a dose effect by which the children who have the better outcome have been exposed to a lesser degree of risk" (p. 183).

This illustration holds true in the area of child resiliency as well. Child-health specialists report that there are

"sharp differences in the way children bear up under stress.

In the aftermath of divorce or physical abuse, for instance, some are apt to become nervous and withdrawn; some may be illness-prone and slow to develop. But there are also so-called resilient children who shrug off the hammer blows and go on to highly productive lives" (Gelman, 1991: p.79).

Further, Boyce (as quoted in Gelman, 1991) noted that "there are kids in families from very adverse situations who really do beautifully, and seem to rise to the top of their potential, even with everything working against them....nothing touches them; they thrive no matter what" (p.79). The question and the quest to discover what those characteristics are that enable people to "bounce-back" from traumatic experiences in their lives is enticing and exciting.

It is postulated that there are certain characteristics that distinguish the resilient from the less or non-resilient. Reports listing resiliency factors observed in diverse environments are few and non-conclusive. One study (Blom, Cheney and Snoddy, 1986) did, however, report behaviors as empathy, helping others, and problem solving. Honig (1986) noted, "other behaviors seem to be more complex and global and do not easily lend themselves to an instructional or training approach. These include the ability to detach from the dysfunctional behaviors of others, being personable and well liked, creative thinking, optimism, having a sense of humor, being aware of personal power, having a future orientation, and having a well developed value system" (p. 51).

The research also indicates that these protective factors are not mutually exclusive but rather interactively interwoven (Honig, 1986). Other examples of resiliency factors include, but are not limited to: affection from at least one parent; harmonious relationships between parents; persons inside or outside of the family who encourage and facilitate the child's ability to cope and who foster positive values; and the personal qualities of the child, such as the ability to express internal states and to empathize with the internal states of others (Cicchetti, 1987; Garmezy, 1987; Rutter, 1987; Werner & Smith, 1982). On the other hand, there have been several studies done in regards to children and stress-management. In 1978, Segal and Yahraes spoke of "children who will not break." They identified a group of children they defined as "the invulnerables", who, despite disadvantages, had managed to obtain high levels of competence and emotional health. This group did not become victims of despair, degradation, and deficit. They not only appear to remain unscarred, but are able to function remarkably well. Segal and Yahraes continued by stating that:

"the study of so-called invulnerability may be among the most important research projects underway in child development today. If we can discover what the factors are that make the difference between prevailing over and

succumbing to adversity, we can hope to learn how to impart these capacities to the children who need them" (p.288).

As research in resiliency continues, new heights will be reached. As Anthony (1987) put it, we can "incorporate those ingredients, whatever they turn out to be, into every childhood" (p. 41).

Biopsychosocial Factors of Resiliency

Within the literature of resiliency, three main categories emerge. These areas are biological, psychological, and social. Factors contributing to resiliency fall into one of these three areas. Each of these areas are developmentally based, or rather, mediated by the stage of development (Openshaw, personal communication, 1994).

Biological Influences

Every person is born with a certain set of biologically determined factors. These factors are innate or genetic. Unfortunately, few have been identified so far (Openshaw & Moss, 1994). Two of these factors are intelligence and temperament. The influence of development will be discussed as well. These factors appear to be intertwined in a manner that does not make complete segregation of each element feasible.

Temperament

Biological predispositions may lead to vulnerability or less resilience (Gilgun, 1991). Temperament, the "constitutional predisposition to react in a particular way to stimuli"

(Openshaw & Moss, 1994), has been noted as being a factor of resiliency in children (Hetherington, 1990; Rutter, 1980). Hetherington, Stanley-Hagan, and Anderson (1989) stated "temperamentally difficult children have been found to be less adaptable to change and more vulnerable to adversity than are temperamentally easy children" (p. 304).

The temperament factor influences the resiliency level of a person, that is, persons with certain temperaments have longer reaction time and seem to absorb and observe before rejecting and reacting (Wolin & Wolin, 1993). Persons with shorter reaction times are reportedly more emotional and thus may internalize environmental factors deeper than the afore mentioned group (Wolin & Wolin, 1993; Tower, 1993; Kaufman & Zigler, 1990). Heatherington & Parke (1986) reported children with difficult temperaments as having an increased vulnerability to stress as well as becoming more likely to "elicit different or adverse experiences" (pg. 86). In other words, they seem to attract irritability and negative responses from others.

Intelligence

Intelligence, or the capacity to acquire and apply knowledge, is another factor which has been identified with resiliency (Garmezy, 1983; Hetherington, 1990; Hetherington, Stanley-Hagen & Anderson, 1991; Masten, 1986; Werner, 1987; Hetherington, Law and O'Conner, 1993). Intelligence has been linked to children's adaptability in the face of stressful life experiences (Hetherington, Stanley-Hagan & Anderson; Garmezy, 1983; Hetherington, 1990; Masten, 1986; Werner, 1987).

Hetherington, Law and O'Conner (1993) included intelligence as a factor of resiliency in their study of children's response to divorce. They noted that:

"the role of intelligence and temperament may be of special interest since behavior genetics studies of identical and fraternal twins and adopted children find a substantial contribution of heritability to these characteristics and considerable stability in these attributes beyond age 3" (pg.).

Garmezy (1991) adds to this contention by reporting that "30% of the individual differences in children's adaptation to stressful life events are attributable to intelligence."

Developmental Considerations

Biological factors of resilience are mediated by age, developmental stage, etc. For example, older children develop effective coping skills because of their increased ability to rationally solve problems (Hetherington & Parke, 1986). In preadolescents, intellectual ability has been noted to be a protective factor against stress in predicting various indices of competence (Luthar, 1991; Masten et al, 1988; Pellegrini, 1980). Another example is that of two-year-olds who are at a transition stage of security and insecurity. They can talk a little, but not enough to express feelings adequately. They can walk and desire to be independent, but are still insecure in many motor skills. Four to five-year-olds are in a stage of growth in pride of mastery. This is a propitious stage for resilience, in contrast to the earlier stage, in which resilience is threatened. For example, thresholds for distress, pain and disintegrative reactions to stress are lower during the time a child is cutting teeth, has a cold, or colicky. This makes it more difficult to comfort a baby, increasing the discomfort, and decreasing the resiliency of the baby. Pre-puberty is another stage of complex biological changes. These biological factors remain interdependent and connected in a manner that perhaps man may

never understand completely. Regardless of the understanding, they are clearly a part of resiliency.

Psychological Influences

Psychological factors impacting resiliency appear to be founded on genetic factors which provide a springboard for the development of identifiable factors. Included within this area are the following: attachment (i.e., object constancy and permanence), locus of control, ego defense mechanisms, empathy, and coping mechanisms.

Attachment. Personal attributes are theorized to develop from secure attachments to parents and parental figures during infancy, early childhood, and/or across the life span (Bowlby, 1973; Cicchetti, 1987; Egeland et al., 1988). Neighbors, Forehand and McVicar (1993) noted that "the resiliency literature has consistently pointed to the child or adolescent's relationship with parents as an important family factor that can differentiate between resilient and nonresilient children" (pg. 463).

In long-term studies of British youths, Rutter (1979) found that a good relationship with one parent provides considerable protection against stress accompanying severe family discord. Werner (1984) identified a close bond with at least one caregiver as a recurring feature of children who are able to cope effectively with stress. Neighbors (1991) agrees indicating that a positive relationship with at least one parent reduces "the effects of some specific stressors, including marital conflict and parental divorce" (p. 469).

Locus of control. Research has shown the importance of an individual's self view in regulating the negative effects of stress. Among the self phenomena is self-esteem, or perception of control, which ranks high in mediating one's ability to cope with stress. Self-esteem is a variable that differentiates adolescents who cope successfully with child abuse and those who do not.

In a recent review of resilience and vulnerability, Luthar and Zigler (1991) suggested, "it is possible that so-called resilient children's reactions to their stressful experiences are primarily of an internalizing nature, expressed in more covert symptoms such as depression or anxiety" (p. 9). Data in support of this argument indicates high stress/high competence groups obtained higher scores identifying depression and anxiety than that of low stress/high competence groups. Luthar's analyses indicates adolescents who are resilient do not internalize the effects of stress greater than those nonresilient adolescents.

It appears that the resilient group has some sort of protective mechanism working for them in the area of internalizing problems. "Perceiving yourself in control of your life and having self-esteem are factors that help you cope adequately with external stressors" reports Honig (1986, p. 51). High internal verses external locus of control scores reflect a sovereignty over life's adverse circumstances. Higher levels of psychological health, less physical illnesses, lower sleeping/eating disorders, and less sadness were linked to an "intact" locus of control (Lee, 1986).

Coping strategies. Resilience capacities of children are often related to the child's own coping strategies. This involves coping with threat and dealing with tension at an early stage. Anthony (1987) observed that not all children have the same capabilities to cope. He stated that children's "ways of coping and their types of competence may be very different" (p. 231). Slaikeu (1990) notes that "when an individual is no longer able to cope, and everything held dear seems to have disintegrated, it is almost as if there is nothing left to defend" (p. 20). This reduced state allows an "opportunity for change", that is, for resilient strengths to shine through.

Resilient individuals have developed the capacity to effectively solve problems as well as prioritize, or as Lazarus (1980) states, "what to do". Caplan (1964) lists seven characteristics of effective coping behavior (see Table 3 in Appendix). Murphy (1987) also offers a summary of a child's coping strategies in regards to threat (see Table 4 in Appendix). Age is an element of the coping mechanism due to maturation and frame of reference.

Empathy. Another area in the psychological influences of resiliency capacities includes that of empathy, which is the ability to identify with or relate to the feelings or thoughts of another person (Stein, 1980). Block and Block (1980) stated that, "the construct of ego resiliency assesses flexible, adaptive behavior across broad social and behavioral domains" (p. 343). Strayer and Roberts (1989) concur, noting that "such adaptive behavior is facilitated by understanding other's feelings and points of view" (p. 229). Further, ego-resilient children, whose own emotional needs are met, have shown empathetic traits such as consideration of others' thoughts and feelings. Strayer and Roberts' study concludes by referencing empathy and role taking (which is interpreted as a self phenomena involving coping and self) being positively related to resiliency.

As research continues to be done in this area, greater understanding will be obtained as to the extent of empathy's role as a resiliency factor.

Social Influences

Social influences that facilitate resiliency appear to develop and progress parallel to the maturation of the child. The first circle of social influence is the child's own family environment, with an expansion of peers and school personnel as the child develops. Another social influence is that of the religion/culture the child grows up in.

Family Environment. Parents influence their children in many aspects. Depending upon the parents outlook on life, a child may tend to view themselves as capable or incapable of properly resolving and making decisions. Anthony (1987) explains this factor in detail. His examples paint a clear and understandable picture that relays the influence of this factor on resilience. He notes:

"There are many inequalities into which children are born in this unfairly constituted world-inequalities of rank, or riches, or opportunities, of basic endowment-all of which have been with us for so long a time that they are more or less taken for granted. One of the most significant inequalities for the future well-being of the individual is the inequality of risk, that is, the uneven distribution of stress through the population of children. This means that for some the world is secure, stable, and predictable; they are born into acceptance, concern, and care; they are planned for, hoped for, and welcomed. For others, the reverse is true. Life for them is short, sharp and brutish. They have parents who hate them from conception, reject them from birth, batter them as infants, neglect them as toddlers, and institutionalize them or have them fostered at the drop of a hat. Nevertheless, two children from the same stock, the same womb, the same propitious or unpropitious environment may end it quite differently with one falling psychologically ill and the other apparently blossoming. A super child may come out of the ghetto and a sad and sorry child from the well-to-do suburbs. Why and how? By what mysterious process of psychological selection is the one destroyed and the other preserved? Admittedly, the two worlds may not be so different beneath the surface, a seemingly indulgent household in a superior neighborhood may camouflage as many cruelties and crudities as an overcrowded tenement apartment. Exposure is clearly not the whole story; vulnerability and mastery also play integral roles in determining the response to stress" (p. 533).

As Anthony suggests, the location of socialization has significant impact on abilities to overcome adverse life situations and experiences. In addition, they tend to rely on informal networks of neighbors, peers and elders for counsel and advice in times of crises and life transitions. This then alludes to an even deeper and more influential impact on the resilience capacities of a child.

School. When a child leaves the home and enters the world of education, they are introduced to a variety of new elements. These elements have either a positive or negative effect on the child. Rutter studied adult women who had grown up in institutions because of parental abuse or abandonment. He found about a third of the women possessed qualities of

resilience despite having lower levels of competence. Rutter found that the girls had positive experiences in school, finding "success in sports, achievement in music, getting positions of responsibility in the school or developing a good relationship with a teacher" (p. 57 in Honig, 1986). He also found that the most important protective factor was the women's secure attachments with their husbands later on in life. Honig (1986) commented about Rutter's findings, stating "good school experiences gave the girls a feeling that they were able to succeed at something and that they were more in control of their own lives, so maybe they could succeed at other things" (p. 57). Werner (1984) noted that:

"resilient children are apt to like school and to do well there, not solely in academics, but also in sports, drama, or music. Often they make school a home away from home, a refuge from a disordered household. A favorite teacher can become an important model of identification for a resilient child whose own home is beset by family conflict or dissolution" (Wallerstein & Kelly, 1980).

In other reports, it was found that they tend to be well-liked by their classmates and have at least one, and usually several close friends and confidants (Garmezy, 1983; Wallerstein & Kelly, 1980; Werner & Smith, 1982).

The influence of school as a resiliency factor is another area that warrants more research and will most likely yield greater knowledge as to possible buffering agents fostered therein.

Religion/Culture. One aspect that has received attention in recent publications is that of religious and/or cultural influence upon values and traditions of a people. This carries true in the area of resiliency (Murphy and Moriarty, 1976). Werner (1984) concluded that people "manage to believe that life makes sense, that they have some control over their fate, and that God helps those who help themselves" (p. 76). Further, in a study done by Carter and Parker

(1991), they found that spirituality was a resource of healing and balance for victims of sexual abuse.

A person's theoretical beliefs do effect their personal outlook and attitude upon life events and circumstances. Interpretation of stressors may serve as a buffering factor, creating greater and stronger resilience.

Conclusion of Primary Biopsychosocial Factors

The areas of biological, psychological, and social factors contributing to resiliency appear to be intertwined in such a manner that does not allow for complete segregation of each element. These areas are developmentally based and are mediated by a variety of influences.

Biologically determined factors, such as intelligence and temperament, are influenced by psychological factors. The psychological factors, however, appear to be founded on genetic factors. Included in the psychological area are attachment (i.e., object constancy and permanence), locus of control, ego defense mechanisms, empathy, and coping mechanisms. These areas appear to be swayed by social influences that develop and progress parallel to the maturation of the child. Family environment, peers and school personnel, and religion/culture are categories within the social realm. Some of these elements are biologically determined, to a degree. (See Hypothetical Model for illustration, p. 32.)

Factors Influenced by the Nature of the Sexual Abuse

Frequency, duration, intensity (including type of abuse as well as relationship of victim to the perpetrator) are elements of the abuse that have effect on the resiliency of the victim.

The extent of each element will effect the ease and ability of the victim to overcome the

adverse consequences that may occur. Research also points in the direction of needing to recognize the time frame in which the abuse or neglect occurred, that is, as a part of one's childhood history (Towers, 1993). Of course, these elements are in conjunction with the previously listed resiliency factors, as will be illustrated later in a hypothetical model.

Frequency

The first of the factors associated directly with the sexual abuse is that of frequency, meaning how often the abuse took place. Beitchman, Zucker, Hood, daCosta and Akman (1991) stated that "sexual abuse that occurs more frequently might have a greater impact on the victim" (p. 549). It was found that there is an overall lack of research in the child sexual abuse studies (Beitchman, et.al., 1991; Towers, 1993; Kinzl & Biebl, 1992).

The data available has thus far supported the notion that the more frequent the abuse, the deeper and longer lasting the outcome (Towers, 1993; Beitchman, et.al., 1991). Burgess et.al. (1984) and Johnston's (1979) studies also support this contention. In their studies, they investigated and reported longer lasting effects on the children who were exposed to more frequent abuse, whether in sex rings or other sexual abuse. Sexual behavior was also linked to duration of abuse in a study conducted by Freidrich et.al. in 1986. Thus, it appears that frequency is a factor in the child's probability of recovery and effects the resilience level.

Duration

Another factor effected is that of duration. Kinzl and Biebl (1992) observed that abuse in incestuous families can take years before being disclosed. Long, extended abuse creates more trauma, the exception being a one-time incident of involved violence or sadism. Burgess

et al. (1984) studied children and adolescents involved in sex rings. They found that those who were abused for more than one year were more likely to remain symptomatic or to identify with the perpetrator (i.e., through exploiting others or engaging in antisocial behavior). Sirles et al. (1989) conducted a study of similar nature and discovered duration as a factor of variance from victim to victim.

Intensity

Intensity, or the type of abuse, is on a continuum from touching to intercourse to ritualistic abuse as well as the identity and/or relation of the perpetrator to the victim. Towers (1993) observed that "some victims of family incest appear to be more deeply affected than those who were abused by someone outside of the family" (p. 146). She continues by noting that "any type of misuse can cause traumas for children, a perpetrator who takes a child further along the progression, or does more physical damage to the child, creates more residual effects" (p. 146). Victims are affected more by family abusers than someone abused by a non-relative. Yet, if the abusers have a significant relationships to the victim, the affect appears to be as profound.

Sexual abuse by more than one perpetrator has also been associated with more severe outcome. Using multiple regression, Friedrich et al. (1986) examined the relation between a number of abuse-specific variables and parent ratings on the CBCL. Internalizing behavior was significantly associated with being female, having a close relationship to the perpetrator, and with frequency and severity of abuse. Externalizing scores were predicted by being male, less time elapsed since abuse, and abuse of long duration by an emotionally close perpetrator.

Overall, this factor is variable and the long-lasting effect that it will have is dependent upon the individual as well as the level of variability present. Intensity is also relative to the victim's perception of reality. This element is worthy of extensive study to account for or allow for the numerous combinations of components possible.

Presentation of Integrated Developmental Theory of Resiliency

After an exhaustive search of the available research, it was found that researchers have only recently studied the area of resilience in the area of sexual abuse per se, in a broad sense. Research regarding the resiliency of children who have been sexually abused is, unfortunately, lacking and sparse.

It appears that, depending on a person's resiliency, the effect will be more or less visible, however, the abuse will always be a part of the person. Furthermore, like any wound, there are stages that injuries must go through in order to be healed. Farber (1987) noted that "it is highly unlikely that any children remain unscathed" if they are sexually abused. In her study of abused and neglected preschool children, she found that there were "few competent survivors" and that victims will "display maladaptive patterns of development in the early school years if their home situation remains abusive" (p. 451).

Sexual abuse does pose a social problem that warrants immediate attention and research into the possible buffering effects of various biological, psychological and social factors. In order to better visualize this concept, a hypothetical model is suggested (see Hypothetical Model, p. 32).

This hypothetical model is a graphic representation of the child surrounded by the various buffering biopsychosocial factors and the abuse which took place. The second phase depicts the child still surrounded by the biopsychosocial factors, but with the addition of abuse and its varying factors of frequency, duration and intensity enveloping the child for a period of time. The length of each side of the triangle, representing the different factors, is determined by the individual and specific elements. After the abuse has taken place, the child will then enter into one of the three categories or outcomes depending on their personal resiliency level.

Recommendations for Future Research

There are areas which were not fully explored within the realms of this paper. The author suggests that further consideration be given to those elements. For example, Honig (1986) stresses that while it is important to conceptualize stress factors, we must also consider "variables such as age and sex and time of stress, possible potentiation of negative effects years later in life by additional stresses, person-situation interactions, intra-personal vulnerabilities, and how culture contexts lessen or increase the effects of stressors" (p. 36).

Another aspect that deserves more extensive research is that of cognitive therapy, a sort of "mind over mind" therapy. An example of this is the number of survivors who have overcome or become "successful" through their challenges by concentrating on the present and letting go of the past. Further, the victim may need to recognize that they had little control (by virtue of age) over what was happening. Although the victim cannot change the past, they can affect the present and thus the future. By learning to take control of one's own life, one can have a fulfilling life in spite of the residual scars of childhood.

Table 1. Consequences of Incest.

Difficulties with closeness and intimate relationships
 Depression
 Guilt
 Low self-esteem
 Repression or denial of negative emotions
 Anger or rage
 Strong negative feelings about men (or women)
 High need to be in control of the self and others

Table 2. Residual Effects of Familial Sexual Abuse.

Difficulty trusting others
 Low self esteem
 Anxiety and fears
 Shame and guilt
 Physical problems
 Anger
 Self-abusive tendencies
 Depression
 Difficulty touching
 Inability to play
 Distorted view of body
 Difficulty with relationships
 Abuse of alcohol and drugs
 Perception of powerlessness
 Sexual problems

Table 3. Effective Coping Behaviors.

1. Actively exploring reality issues and searching for information
2. Freely expressing both positive and negative feelings and tolerating frustration
3. Actively invoking help from others
4. Breaking problems down into manageable bits and working them through one at a time.
5. Being aware of fatigue and tendencies toward disorganization; while pacing efforts and maintaining control in as many areas of functioning as possible.
6. Mastering feelings where possible (accepting them when necessary), being flexible and willing to change.
7. Trusting in oneself and others and having a basic optimism about the outcome.

Table 4. Coping with Threat.

- I. Means for coping with threat
 - 1. Action in relation to threat.
 - a. Reducing threat: postponing, bypassing, retreating, shifting attention or interest, and so on.
 - b. Controlling threat by changing or transforming limits.
 - c. Balancing threat by changing relation of self to the threat or the environment in which it is contained.
 - d. Eliminating or destroying threat.
 - 2. Dealing with, avoiding tension aroused by threat.
 - a. Discharging tension through action: releasing affect; displacing or projecting via fantasy (dramatics, painting, creative writing, etc.)
 - b. Containing tension via insight, fantasy, defense mechanisms.
- II. Sequence of coping with threat.
 - 1. Preparing steps toward coping.
 - 2. Coping acts.
 - 3. Secondary coping (to deal with consequences of 1 and 2, using more drastic methods or retreating further).