Research Review: Resilience in Child Maltreatment and Abuse

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Research Review: Resilience in Child Maltreatment and Abuse

Abstract

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Objective: Child maltreatment (physical, sexual, emotional or neglect) is a major concern in today’s society, yet the prevalence continues. Despite the continuation of abuse, there are certain children who thrive and lead resilient, well-balanced lives. It is clear these children possess qualities that cause them to be resilient despite adversity. This discussion will examine the current peer-reviewed literature in relation to child abuse or maltreatment and the protective factors that help promote resilience.

Study Design: The databases CINAHL, PubMed, and Google Scholar were utilized to search for relevant research articles, ranging from 1998 to 2011, related to the topic of resilience, child maltreatment/abuse, and protective factors.

Results: As research continues to examine the definitive qualities of resilient children following abuse, current findings suggest protective factors at an individual-, familial- and community-level act as a buffer against negative outcomes. Factors that contribute to
Healthy adapted lifestyles include characteristics within the child (i.e. easy-going temperament, flexibility, resourcefulness), and external to the child (i.e. a supportive, available family member, peer relationships, and community organizations).

**Conclusion:** After review of the current literature regarding child maltreatment and its relationship with resilience, it was found that resilient children possess individual characteristics (i.e. easy temperament, outgoing, resourceful and strong problem-solving and planning skills), along with having strong family support and community resources available to them versus non-resilient children.

*Key Words: child maltreatment, child abuse, protective factors, resilience, well-being*
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Research Review: Resilience in Child Maltreatment and Abuse

Child maltreatment (physical, sexual, emotional abuse and neglect) continues to be a world-wide concern in the field of healthcare. It impacts the physical and psychological health in patients, creating long-term consequences in well-being. The CDC reports that “in 2008, U.S. state and local child protective services (CPS) received 3.3 million reports of children being abused or neglected” (2010). It is estimated that approximately 772,000 children were subjected to abuse, mainly by their parents, rather than other relatives or caregivers; 71% being victims of neglect, 16% as victims of physical abuse, 16% were victims of sexual abuse and 7% as victims of emotional abuse (Child Maltreatment, Center for Disease Control and Prevention, 2010). According to the World Health Organization (2010), each year, it’s determined that approximately 31,000 children under the age of 15 years die from child maltreatment; however, this is an underestimation as “a significant proportion of deaths due to child maltreatment are incorrectly attributed to falls, burns, drowning and other causes” (World Health Organization, 2010).

Many characteristics that contribute to the risk factors which predispose children to maltreatment can include individual vulnerabilities (i.e. prematurity, physical or intellectual abnormalities), parental circumstances (i.e. single parent, mood disorders, substance abuse, etc.), and environmental resources (i.e. available programs, education, peer relationships, etc.). The consequences of child maltreatment can vary from person to person, ranging from mood disorders to delinquency, criminal activities and homicide/suicide. It can affect “lifelong physical and mental health and the social and
occupational outcomes can ultimately slow a country’s economic and social
development” (World Health Organization, 2010).

Despite the many repercussions of child maltreatment, certain children adapt and
develop healthy lifestyles as adults. This leads to the questions, “Why and how?” What
characteristics do resilient children possess and does the type of abuse have an effect?
Recent research studies have found a number of elements that contribute to the child’s
development of a healthy, well-balanced lifestyle, labeled ‘protective factors.’ These
protective factors are broken down into 3 different levels with several subcategories:
individual, family and community. In order to gain a better understanding, this paper will
serve as a resource, through the examination of literature, the analyzation of resilience as
a concept, the various forms of child maltreatment and the examination of protective
factors that lead to a well adapted life.

Literature Review

Methods

Several electronic search databases were used to locate relevant articles dating from 1998
to 2011 including: CINAHL, PubMed and Google Scholar. Terms used to search the
databases include: resilience, child abuse, child maltreatment, physical abuse, sexual
abuse, neglect, and emotional abuse with a variety of combinations of stated keywords.
From the three databases’ results, 31 articles were chosen for review and 16 articles were
selected as they correlated with the topic to be discussed.

Theoretical Framework

Many health professionals or clinical psychologists would agree that child
maltreatment can produce many negative consequences in a victim’s physiological and
psychological health. However, the theory that resilient children possess qualities, as well as having resources available in the family and community, is still a new concept that is currently being tested and reviewed.

Over the past decade, researchers have studied resilient versus non-resilient children. Each investigation developed explanations of why certain children are able to lead well-balanced and resilient lives in adulthood, while others develop physical and mental health illnesses. Many professionals believe that it is the individual’s internal characteristics and coping styles that make a child resilient. Others theorize that it is a combination of both internal, individual factors and available external resources (i.e. family and community). In more recent studies, it has become clearer that the latter theory is more accurate, with the acknowledgement that these qualities are protective factors. Similarly, research has examined more closely the specific factors that aid in the process of resilience, how to predict how a child will respond to adversity based on the proposed protective factors, and how to prevent the negative consequences of maltreatment for those at risk youth.

It is essential to pinpoint the protective factors that make a child resilient; specifically so healthcare providers can create effective interventions before serious consequences occur. Afifi and MacMillan (2011) state that “focusing on [the] protective factors can provide insight into how to promote resilience and overall health and well-being among maltreated children;...it can inform the development of interventions aimed at reducing impairment following exposure to child maltreatment” (p. 267). If primary care professionals can assess the available protective factors in families and children seen
in clinic, they can target those who are at risk for maltreatment and intervene where necessary.

Resilience and Child Maltreatment

Resilience is a broad and complex concept to define. It has been a recurring topic of discussion in various fields of study, especially in healthcare. In all professional forums, it is presumed that the idea of resilience has a concise definition; however, it is clear that each field has its own learned definition. Gillespie, Chaboyer and Wallis (2007) states that developing “a better conceptual understanding of resilience may lead to recognition of its utility in explaining why some individuals are able to overcome adversity while others are not, and therefore inform strategies that may build resilience” (p. 125). One reason it is a difficult term to define is because “resilience cannot be directly measured; rather, it is inferred from [the] process of examining positive adaptation in conjunction with adversity” (Edmond, T., Auslander, W., Elze, D., Bowland, S., 2006).

The concept of resilience first originated in healthcare as an association to a child’s ability to overcome stressors and adversity – while maintaining the capacity to develop a healthy, functioning life as an adult. Yi-Frazier, Smith, Vitaliano, Yi, Mai, Hillman and Weinger (2009) describe resilience as an individual’s ability to maintain a state of well-being with the help of personal characteristics that enhance their capacity to adapt to adversity. Quale and Schanke’s (2010) article adds to the definition by stating that resilience is “a broad conceptual umbrella, and the construct refers to important psychological skills and to the individual’s ability to use family, social, and external
support to cope better with stressful events...Resilience reflects the ability to maintain a stable equilibrium” (p. 13, 14).

There have been large amounts of research about why some children are able to endure significant stressors at a young age and still have the capacity to flourish, while others cannot. Svanberg’s (1998) article, which discussed the role of attachment in resilience, states that:

...secure attachment, which can be established in the very early years of the child’s life, will provide the necessary resilience for the child to cope with many adverse life events as an adult without developing psychological or psychiatric symptomatology (p. 543).

He describes how attachment can help provide the child useful tools to self-comfort in the face of danger or distress. The degree of the development of attachment as an infant can determine whether or not a child will be resilient in traumatic and stressful events, such as abuse (Svanberg, 1998). Attachment is the bond of trust that a caregiver will be ever-present when danger or threats occur. It can help provide the child useful tools to self-comfort in the face of adversity. Ultimately, developing a secure attachment is a survival strategy for a child. Maltreatment can alter this connection, particularly if abuse occurs after a secure attachment has developed; moreover, this causes the child to see the parent or caregiver as both loving and harmful. Eventually, this can break down attachment, driving the child to develop a sense of mistrust in others.

Resilience, however, is not a single-component characteristic; in fact, it is composed of a number of elements. It is a complex concept that is used to explain a process or event of positive adaptation when faced with trauma or hardship (Edmond, T.,
Auslander, W., Elze, D., Bowland, S., 2006). McGuinness (2010) states that “many factors contribute to resilience; including an easygoing temperament, the ability to form supportive relationships with other adults, and emotional intelligence (i.e., the capacity to delay gratification and understand other people’s signals)” (p. 16). Resilience can also be defined as “well-being, rather than simply the absence of pathology, and considered self-acceptance, positive relations to others, and environmental mastery as important concepts of [the term]” (McClure, F.H., Chavez, D.V., Agars, M.D., Peacock, M.J., Matoasian, A., 2007, p. 86). Werner (2000) mentions that resilience is an “end product of buffering processes that do not eliminate risks and stress, but that allow the individual to deal with them effectively” (p. 116). In this research article review, resilience will be defined as the ability to use internal and external resources to cope with adversity, in order to achieve or maintain a state of physical, psychological and emotional well-being. Furthermore, this paper will review the literature that examines the components of resilience in persons who experienced maltreatment in childhood.

**Risks and Consequences of Child Maltreatment**

**Types of abuse**

Physical and sexual abuses are most commonly associated by the general population, because it is frequently reported in the news. However, it is emotional abuse and neglect, which are usually combined, that occur most often largely due to the fact that they are easily undetected.

Emotional abuse is classified as actions that belittle or humiliate a child, which, in turn, causes the child to develop negative views of self-worth and self-esteem. The
caregiver can purposefully choose to maltreat or they can also be unaware that they are emotionally abusing the child. Iwaniec, Larkin and Higgins (2006) explain that:

Emotional abuse may be passive, due to a failure to act [attributed to an inability, unwillingness or indifference to support, anticipate or respond to the child’s needs]. Emotional abuse may also constitute active, deliberate, sadistic and cruel carer behaviours, such as terrorizing, humiliating, tormenting, exploiting, ignoring and criticizing, which lead to the ultimate rejection and denigration of the child. While motivation to harm the child may not be the intention of the carers, their behaviour communicates to the child that he or she is ‘worthless, unloved or inadequate”’ (p. 74).

Emotional abuse and neglect are found to have a greater impact on a child’s social and cognitive development than other types of maltreatment, as the effects are on-going in nature. It affects both the maturation of the psyche and the physiological process (Iwaniec, D., Larkin, E., & Higgins, S., 2006). “[It] is particularly damaging as this is almost designed to undermine the person’s confidence and self-esteem, wounds that are difficult to heal outside a therapy situation” (Svanberg, P.O.G., 1998, p. 555-556).

Iwaniec, Larkin and Higgins (2006) identified 6 parts to emotional abuse and neglect, where 1 or more can be present:

Persistent hostility; persistent failure to respond to the child’s physical, emotional, intellectual and social needs; seriously unrealistic expectations; inappropriate stimulation of a child’s aggression and/or sexuality; exploitation of a child for the gratification of another’s needs; and grossly inconsistent care which can include
harsh discipline, conditional parenting, insecure attachment, denigration and emotional unavailability (p. 73).

Chambers (2005) goes on to describe behaviors consistent with emotional abuse, which include: rejection of the child, isolation from important social experiences, ignoring the child’s emotional and physical needs, terrorizing with hostile words and tone of voice and corruption by positively reinforcing socially unacceptable behavior. Examples of damaging parental behaviors include: “threats of assault, irritable scolding, disparaging remarks, comparisons with another child or sibling, withholding love and affection, threats of or actual abandonment, and character assassination such as name calling” (Chambers, J. 2005). Furthermore, emotional abuse does not need to be directed specifically to the child. Witnessing family violence or intimate partner violence can negatively impact a child’s emotional and psychological health (Iwaniec, D., Larkin, E., & Higgins, S., 2006; World Health Organization, 2010).

Physical and sexual abuses are the more commonly known forms of child maltreatment in the general public. “Childhood sexual abuse (CSA) and childhood physical abuse (CPA) are reported by as many as one in four individuals. The rate of child abuse are even higher among inner-city women, many of whom experience both physical and sexual abuse” (Walter, K.H., Horsey, K.J., Palmieri, P.A., Hobfoll, S.E., 2010, p. 264). The World Health Organization (2010) states that “approximately 20% of women and 5-10% of men report being sexually abused as children, while 25-50% of all children report being physically abused.” Physical abuse is described by the Center of Disease Control and Prevention as “the use of physical force such as hitting, kicking, shaking, burning or other show of force against a child” (Understanding Child
Maltreatment, 2010), where a child can suffer physical injuries from bruising to broken bones. Some examples of physical abuse include grabbing roughly, jerking of arms, shaking infants, hitting with objects or punching. “Sexual abuse involves engaging a child in [any] sexual acts. It includes fondling, rape, and exposing a child to other sexual activities” (Understanding Child Maltreatment, *Center of Disease Prevention*, 2010). Sexual abuse involves inappropriate touching of the child by the abuser, the child being forced to touch the abuser, and sexual exploitation.

**Risk factors**

Edmond, Auslander, Elze and Bowland (2006) note that “risk factors refer to characteristics of a group that increase the statistical probabilities of experiencing negative outcomes” (p. 4). They are components of vulnerabilities which makes a relationships more susceptible to abuse and mistreatment. But what factors potentiate the risk for abuse? It can be broken down to two categories: parental and child characteristics.

Abuse can be a learned behavior often originating within the context of the family. Pollack (2004) states that:

Families are the primary context in which young children learn what kinds of social behaviours to expect from others as well as how to interpret and send emotional signals to others. In abusive families, children are exposed to maladaptive forms of emotional communication and behaviour and receive poor models of adaptive self-regulation (p. 1).

Parental factors that increase the risk for abuse include: poverty, substance abuse, single parenthood, low self-esteem, mood disorders, learning disabilities and parental isolation.
from peer relationships (Iwaniec, D., Larkin, E., & Higgins, S., 2006; Svanberg, P.O.G., 1998). It has been found that abusive parents not only had their own histories of abuse in childhood, but also were “more likely to yell at their own children and to be more susceptible to employing emotionally abusive and neglectful behaviour…” (Iwaniec, D., Larkin, E., & Higgins, S., 2006).

Child factors, though not as extensive as parents, can contribute to the potential for abuse. Children under the age of 4 years are at a higher risk for maltreatment. In 2008, CPS reported approximately “21.7 per 1,000 infants under the age of 1 year were victims of maltreatment” (Child Maltreatment, Center for Disease Control and Prevention, 2010). Cases where the child has a higher instance of vulnerability, such as prematurity, intra-uterine growth restriction (IUGR), congenital/physical abnormalities and learning disabilities, increase the chance for maltreatment by their parents (Svanberg, P.O.G., 1998; Iwaniec, D., Larkin, E., & Higgins, S., 2006). Physical or intellectual abnormalities/defects make a child “up to three times more likely to experience emotional abuse and neglect than children without any registered impairments” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 75). It is believed that this is largely due to interruptions in the parent-infant bonding process; moreover, since prematurity or congenital abnormalities require more care and attention than the average newborn, the parental stress is increased (Iwaniec, D., Larkin, E., & Higgins, S., 2006).

Consequences

Current research has found that the victim can suffer from many consequences of child maltreatment, ranging from depression and anxiety to death and suicide. According to the Center of Disease Control and Prevention (Child Maltreatment, 2010), “in 2008,
an estimated 1,740 children ages 0 to 17 died from abuse and neglect (rate of 2.3 per 100,000 children)...[with] 80 percent of deaths [occurring] among children younger than age 4.”

**Emotional abuse**

Iwaniec, Larkin, and Higgins (2006) explain that there are 5 broad classes that impact the consequence of abuse. The nature of abuse, frequency, intensity and duration, individual characteristics of the child, relationship between the child and abuser and response of others to the abuse can all influence the severity of consequences. Through their research involving emotional abuse, maltreatment has been found to affect the cognitive, educational, social, physical and mental-health in a child’s development. Children have been observed to experience difficulties in basic skills such as reading, language and math. Abused adolescents are more likely to skip school and have lower educational and career aspirations. In social situations, maltreated children display emotional extremes “such as engaging behaviours that can be described as overly adaptive, overly compliant or overly demanding” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 76). The problem behaviors were maladaptive coping, but ultimately they were self-abusive and the internalization of the critical voice of the abuser lay “the foundation for low self-esteem and mood disorders in adulthood” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 76). Moylan, Herrenkohl, Sousa, Tajima, Herrenkohl, and Russo (2010) discussed that “exposure to domestic violence [which is a component of emotional abuse] in childhood has been linked to...low self-esteem, social withdrawal, depression, and anxiety; and aggression, violence, and delinquency” (p. 54). Abused children tend to be physically smaller in stature, weigh less than the average norm for their age group.
They often “fail to meet expected developmental milestones... [present with] hyperactivity, sleep disturbance, anxiety, and learning and memory problems” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 76).

Children who are emotionally abused or neglected develop a paradoxical view of adults. The parents are seen as both harmer and protector, which cause the child to see them and other adults as rejecting and untrustworthy. Paradoxical and unpredictable parenting “renders the child less confident, inhibits capacity for emotional expression and undermines children’s capacity to manage their emotions, address stressful situations, and understand their environment” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 76). Children are likely to be insecurely attached to the abusers and develop feelings of mistrust and rejection, which projects directly to future relationships. As a result, when the child becomes an adult, they display a limited ability to have compassion for others, struggle with interpersonal relationships and often develop poor parenting skills.

Powers, Ressler, and Bradley (2009) explore the relationship between child abuse, the development of depression and the perceived social support from peers and family. Through a sample of 378 men and women chosen from a public urban hospital in a primary care and OB/GYN setting, each participant answered questions related to their “developmental history, traumatic experiences, currently relationship support, and depressive symptoms” (Powers, A., Ressler, K.J., & Bradley, R.G., 2009, p. 46). The conclusion of the study found that “childhood emotional abuse and neglect proved more predictive of adult depression than childhood sexual or physical abuse” (Powers, A., Ressler, K.J., Bradley, R.G., 2009, p. 46). In addition, higher levels of depression were reported in females who were abused in childhood.
A study by Simon, Herlands, Marks, Mancini, Letamendi, Li, Pollack, Van Ameringen & Stein (2009) targeted the development of generalized subtype of social anxiety disorder (GSAD) with past experiences of childhood maltreatment or neglect. They took a sample of 103 participants with a primary diagnosis of generalized subtype of SAD and requested the men and women to complete the Childhood Trauma Questionnaire. Of those classified with GSAD, 70% met the criteria of at least one type of childhood maltreatment or neglect. Their results concluded that those who reported histories of childhood maltreatment, particularly emotional abuse and neglect, were “associated with greater severity and poorer function, resilience, and quality of life” (p. 1029).

**Physical and sexual abuse**

Physical and sexual abuse can be psychologically damaging to children. Recent studies have found that children who have histories of physical or sexual abuse develop internal outcomes (depression, anxiety, and other mood disorders) and external outcomes (violence abuse, substance abuse, etc.). A study by Moylan, Herrenkohl, Sousa, Tajima, Herrenkhol and Russo (2010) reviewed single exposure (physical or sexual abuse) versus dual exposure and the development of internalizing and externalizing behaviors. Moylan, et al (2010) extracted data from the Lehigh Longitudinal Study, which analyzed children and families from the 1970’s and evaluated them at “key developmental points for children (preschool, school age, and adolescence)” (p. 55), and, a fourth evaluation during adulthood is currently underway. The total sample number consisted of 416 children from various socio-economical and racial backgrounds. The children who were
abused both physical and sexually were found to have a higher risk for internalizing and 
externalizing outcomes than those who were exposed to just one form of abuse.

association between childhood maltreatment and later risky lifestyle choices and health 
disorders in adulthood. Over 9,000 participants responded to a questionnaire sent out to 
patients had fulfilled a medical evaluation. The questionnaire assessed 7 subjects of 
childhood maltreatment: “psychological, physical, or sexual abuse; violence against 
mother; or living with household members who were substance abusers, mentally ill or 
suicidal, or ever imprisoned” (Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, 
D.F., Spitz, A.M., Edwards, V. et al, 1998, p. 245) and were evaluated to see relationships 
with risky lifestyle behaviors. It was found that those who experience 4 or more 

Had 4- to 12-fold increased health risks for alcohol, drug abuse, depression, and 
suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, > or = 
50 sexual intercourse partners, and sexually transmitted disease; and 1.4- to 1.6- 
fold increase in physical inactivity and severe obesity. The number of categories 
of adverse childhood exposures showed a grade relationship to the presence of 
adult disease including ischemic heart disease, cancer, chronic lung disease, 
skeletal fractures, and liver disease (Felitti, V.J., Anda, R.F., Nordenberg, D., 

A related study by McGuinness (2010) reviewed the effect of stress and trauma on the 
hypothalamic-pituitary-adrenal (HPA) axis. The study explained how the “body’s stress 
reaction is orchestrated by the HPA axis and [how the] neuroendocrine response 
contribute to the regulation of the immune system, emotions, and metabolism” (p. 17).
The study showed that chronic stress or trauma, such as child abuse, stimulated the HPA axis “to release corticotropin-releasing factor and leading to chronically elevated systemic levels of corticosteroids. These disruptions in HPA signaling cause sustained inflammatory processes, which may have a role in developing cancers, heart disease, and immune disorders” (McGuinness, T.M., 2010, p. 17).

**Protective factors**

Despite the numerous consequences of child maltreatment, there are traits and resources that resilient children possess called protective factors. Protective factors are “moderators of risk and adversity that enhance good, that is, developmentally appropriate outcomes” (Werner, E.E., 2000, p. 116). The term encompasses many components, classified into 3 categories: individual, familial and community characteristics. “A protective factor may influence, modify, ameliorate, or alter how a person responds to the adversity that places them at risk for maladaptive outcomes” (Afifi, T.O., MacMillan, H., 2011, p. 268). These components help endure hardship, such as abuse, and help promote resilience.

**Individual characteristics**

There have been various studies that have examined what personality characteristics resilient children possess. Results of such studies have concluded that there are specific attributes that can be considered a protective factor. Afifi and MacMillan (2011) determined, through review of longitudinal studies, that at the individual level there is evidence for “personality traits (ego resilience and ego overcontrol), positive self-esteem, easy child temperament, and daily living skills (personal domestic, and community adaptive functioning skills) as protective factors.
related to resilience following maltreatment” (p. 269). Ego ‘overcontrol’ and ego resilience are essentially a person’s ability to be “resourceful and flexible, which may help maltreated children become adaptive and highly functioning” (Afifi, T.O., MacMillan, H., 2011, p. 269).

Iwaniec, Larkin and Higgins (2006) recognize that a child’s disposition can impact their response to abuse. Those with the ability to problem solve, plan for the future, were outgoing and capable of utilizing external support, were found to be more likely to develop solid and positive relationships. Werner (2000) supports this finding by describing how resilient children tend to be flexible in employing a range of coping strategies. Moreover, in infancy, resilient children were more apt to attracting positive attention to them and were quicker to recover from discomfort. By the time children are in school, they have developed a strong sense of independence and are also capable of asking for help when they need it (Werner, E.E., 2000). In contrast, “children who [were] more withdrawn, irritable, present poor social and interpersonal skills and are less engaging may be more vulnerable” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 78) to abuse. In addition to the effect of a child’s disposition, children who recognize external causes of abuse, rather than believing it to be their own fault, fair better than those who self-blame.

A study by Pitzer and Fingerman (2010) consider whether the variability of a child’s internal and external resources determine their well-being as an adult. After interviewing over 2,700 men and women, aged 25 to 74 years of age, they found that high levels of personal control were associated with better physical and psychological functioning among adults who were physically abused as children.
Thus, personal control may be a key factor to health and well-being and thus resilient functioning following childhood abuse (Pitzer, L.M., Fingerman, K.L., 2010, p. 425).

Furthermore, if an abused child strongly believed that they can achieve the goals set before them, it was found to be a source of strength. “The long-term maintenance of health and well-being after childhood abuse is facilitated by the perception that one can overcome obstacles and barriers to goals, which may include a healthier lifestyle” (Pitzer, L.M., Fingerman, K.L., 2010, p. 431). Edmond, Auslander, Elze and Bowland's study (2006) contributed to this finding, after interviewing almost 100 girls who were sexually abused. Ninety-nine sexually abused girls, with the average age of 16 years, in the Foster Care System were questioned regarding their past experience of sexual abuse. As a result, the girls who seemed well-adjusted and displayed resilience had a higher positive future orientation that those who suffered from mental-health and behavioral problems.

**Family characteristics**

Family characteristics have the greatest impact on how a child is affected by maltreatment. Afifi and MacMillan (2011) noted that “family-level protective factors include resources and supportive relationships, such as family coherence, stable caregiving, parental relationships, and spousal support” (p. 268). When a child is exposed to discord within the family, it can provide them with a view that disapproval or depreciation is common occurrences in life. McClure, Chavez, Agars, Peacock, Matosian (2007) took a sample of 177 women who reported that they had experienced childhood sexual abuse. It was requested that the women fill out a questionnaire pertaining to a description of the family’s living conditions, nature of abuse and a self-evaluation of their
degree of resilience. The results concluded that the family’s living conditions “accounted for 13-22% of the variance in the well-being outcomes [and] in contrast, abuse characteristics accounted for 3% or less of the variance in the well-being outcomes” (McClure, H.F., Chavez, D.V., Agars, M.D., Peacock, M.J., Matosian, A., 2007, p. 81).

In addition, they discuss that

Family environments rife with contention, criticism, and dissension are highly unlikely to provide healthy problem-solving strategies. Lacking a constructive or helpful model of how to approach life’s challenges, it is not surprising that children who grow up in families characterized by high conflict feel deficient in their ability to manage life’s daily challenges (p. 86).

However, when there is family cohesion and affectionate ties with alternative caregivers, abused children can thrive. Family members who can provide supplemental parenting include grandparents and siblings. Despite adversities, those children who are identified as resilient “have had the [opportunities] to establish a close bond with at least one person who provided them with stable care and from whom they received adequate and appropriate attention during the first year of life” (Werner, E.E., 2000, p. 123).

Grandparents are able to provide emotional and financial support. They can also serve as a valuable role model to children. Siblings are a major source of emotional support and act as buffers from crisis; furthermore, they are effective at becoming supplemental parents (Werner, E.E., 2000).

Afifi and MacMillan (2011) reviewed longitudinal and cross-sectional studies and determined that one single supportive family member aided in creating a stable environment for maltreated children. The collective findings from the longitudinal
studies indicate that if a child feels supported by a stable family environment, it may contribute to the promotion of resilience following abuse. Cross-sectional studies found that “supportive family relationships and family environments were identified consistently as protective factors for resilience...More specifically, a warm and supporting relationship with a nonoffending parent, better parent performance, and family coherence were linked with resilient following such exposure” (Afifi, T.O., MacMillan, H., 2011, p. 269).

**Community characteristics**

There are several community-level factors that affect a child’s resilience. The presence or absence of school, peer-relationships, and organizational groups can aid in a child’s response to abuse. School is one component to the community where a child’s self-worth can be supported or rejected. “Skills and interests established in specific subject areas and extracurricular activities can enhance self-efficacy and self-esteem. Academic attainments and achievements may provide a means of escape, autonomy and independence” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 79). Abused children view school as a form of respite and distraction from being maltreated and it can provide a chance to create and develop positive relationships. However, if a child does not develop positive peer relationships or does poorly in school, it “may perpetuate any negative self-perceptions and render some children particularly vulnerable” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 79). Mentors, such as teachers or counselors, are important protective buffers for children. They can be used as confidants and positive role models outside their dysfunctional household (Werner, E.E., 2000).
Solid social and peer resources are important to a child’s resilience. In the study by Edmond, Auslander, Elze and Bowland (2006), the girls who displayed resilient actions scored higher on the positive peer behavior scale and surrounded themselves with friends who were not subject to abusive situations. Iwaniec, Larkin and Higgins (2006) notes that peer relationships and organizational groups were life-lines for abused children. Children who were isolated from the opportunity to establish relationships with same-aged children, or to attend functions that promoted socialization, were more vulnerable to develop negative behaviors due to abuse. As with school, community organizations and relationships can be a safe haven for abused children. These organizations provide a stable and predictable environment where the children can feel safe and secure. “Belonging to different organizations, sports clubs or interest groups may provide such children with a sense of being wanted and appreciated” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 79).

Ultimately, it is the continued support from the community-level that provides protection for those children who are maltreated. Through various internal and external protective factors against abuse, “the most important single survival factor was the presence of at least one person who gave [the child] unconditional, positive regard, who thought well of them and made them feel important” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 79). As within the family-level, if an abused child has just one person who can be available and support them, it can reduce the negative impacts of maltreatment. In addition to support, an encouraging and available person can help a child realize why the abuse occurred, “thus enhancing a sense of control, developing social competence and
strengthening interpersonal skills as a basis for [establishing] relationships with others in the future” (Iwaniec, D., Larkin, E., & Higgins, S., 2006, p. 79).

Discussion

Role of Healthcare Providers

Healthcare providers are among those professionals who see the consequences of abuse firsthand. It is important that family practitioners create and promote tactics that will reduce the incidence of child maltreatment. One such tactic is education, which has been found to be an important key to prevention. A study performed by the Upstate New York Shaken Baby Syndrome Education Program examined the occurrence of shaken baby syndrome (SBS) and hypothesized that educating new parents prior to discharge from the labor and delivery wards would reduce the number of SBS events. Patients were educated by the nurses in the hospital and were required to sign a form stating, “I Will Never, Never, Never, Never, Never Shake a Baby.” The results discovered that “throughout the 66-month study period, the program demonstrated a sustained 50% reduction in the incidence of abusive head injuries in the region” (Smith, K.M., deGuehery, K.A., 2008, p.374).

Although education is an important component in preventing abuse, it is also imperative for healthcare providers to be aware of protective factors that would help them take accurate physical and social histories of both the patient and family. “Knowledge of protective factors...can assist clinicians in taking a history to identify those factors specific to an individual patient that might assist him or her in coping with exposure to maltreatment” (Afifi, T.O., MacMillan, H., 2011, p. 270). With the knowledge of the modifiable external components that promote resilience, such as strong family member
support and community social interactions, healthcare providers can utilize protective factors to enhance resilience. Iwaniec, Larkin and Higgins (2006) add that “in order to enhance resilience, professionals must carefully establish the particular vulnerabilities and protective factors that exist for a child and then decide the best course of action…” (p. 80).

Another implication to provider practice is to recognize key risk situations in clinic. Recognition of the signs of abuse is crucial for intervention, particularly when a child is being emotionally abused or neglected. These signs are not always as evident as physical or sexual abuse. Instances of abuse include: excessive crying, sudden blindness, introversion of a normally outgoing child, performing poorly in school, or sudden anger issues or delinquency.

There are hindrances to the intervention of abuse. Oftentimes, parents view clinicians to be “critical, interfering, rejecting and/or humiliating in the most extreme cases, but perhaps more commonly as thoughtless and inadvertently arrogant” (Svanberg, P.O.G., 1998, p. 556). This feeling is even more exaggerated with teenagers. How a healthcare practitioner is perceived by the parents, regardless of the clinician’s intent, is imperative for education and intervention. If parents believe the provider to be judgmental, barriers within the relationship are built.

Further Research

Despite recent findings that protective factors relate to child abuse, there is still much to examine. Although research is starting to pinpoint what components of a child’s traits and environmental factors promote resilience, it is largely focused on those with past experiences of abuse. In order to reduce the incidence of abuse, developing
screening tools that help focus on those who are at a higher risk can aid in prevention. Until such tools are created, clinicians should continue to educate parents and family members on how to practice healthy parenting behaviors and how to recognize the signs of child maltreatment.

Summary

Abuse, whether it is emotional, physical, sexual or neglect, has a significant impact on today's youth. It causes physical damage, such as ischemic heart disease, bone fractures and immunological disorders, as well as the development of poor psychological health. As the prevalence of child abuse continues, it is clear that interventions will be necessary. Results from recent research, which examines the effects of child maltreatment and protective factors that promote resilience, can provide a guide on how to create interventions.
References


