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Fostering Resiliency and Preventing Re-Victimization: A Proposed Social Learning Theory Intervention for Adult Survivors of Childhood Sexual Abuse

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Abstract. *Adverse childhood experiences (ACE) are traumatic and/or negative events during childhood, including childhood maltreatment. Multiple studies have documented the sequelae resulting from ACEs, which include health risk behaviors, chronic illness, and early death (Felitti et al., 1998). Childhood sexual abuse (CSA) is an area of childhood maltreatment with a lifetime prevalence of 28% (Finkelhor, 2010). Research has documented individuals with exposure to CSA can experience longterm consequences from this subset of abuse, specifically, re-victimization. Both the prevalence and unique implications of CSA for survivors suggests the need for an intervention that fosters resiliency in this group. A social learning theory and intervention is proposed in efforts to help foster resiliency for this population, and may offer utility in the understanding of issues related to this subset.*

Keywords: *re-victimization, intervention, resiliency, childhood sexual abuse, adverse childhood experiences*

Adverse childhood experiences (ACEs) are characterized by traumatic and/or negative events related to three domains: childhood maltreatment, family dysfunction, and social disadvantage. A mass survey conducted by the Center for Disease Control and Prevention (CDC) revealed that 63.9% of children had experienced 1 or more ACEs (n= 17,337) (Center for Disease Control and Prevention (CDC), 2018). Two decades of research has documented the sequelae resulting from ACEs, which include health risk behaviors, chronic illness, and early death (Felitti et al., 1998). A breakdown of the children with exposure to $\geq$ 1 ACE reveals a Ushaped curve when examining prevalence across increasing exposures. This is noteworthy given that research has consistently documented a doseresponse relationship between the number of ACEs and adult mental health (Felitti et al., 1998). Concerning the foremost domain, childhood maltreatment, four areas categorize child abuse and neglect: physical abuse, emotional abuse, sexual abuse, and neglect. In 2016, Child Protective Services (CPS) received 676,000 reports of childhood abuse and neglect, of which 1,750 resulted in death (CDC, 2018). The current proposal focuses on the area of sexual abuse.

In the previously mentioned study conducted by the CDC, 20.7% of all children experienced sexual abuse, and 24.7% of girls had experienced sexual abuse (n= 17,337; female= 9,367) (CDC, 2018). Prior work has documented the lasting impact of childhood sexual abuse (CSA) on adult survivors. Specifically, research has shown implications of CSA to include an increased risk for substance use disorders, eating disorders, suicide attempts, teenage pregnancy, $\geq$ 50 sexual partners, and sexual assault after sixteen (16) years of age (Ferguson et al., 1997). The last implication will be the primary focus of this proposal and henceforth referred to using the term "re-victimization."

The implications of exposure to childhood sexual abuse for adulthood have been well documented (The Attorney General of the United States, 2012). Childhood sexual abuse can be devastating and can negatively alter the course of one's life even into adulthood. As such, literature is compelling regarding the importance for caregivers and teachers, or other adults in authority, to teach young children how to recognize potential abusive situations and people, and strive for prevention of these experiences. However, despite such attempts, sexual abuse of children still happens, and at sobering rates. According to the National Center for Victims of Crime, 1 in 5 girls and 1 in 20 boys per year are victims of childhood sexual abuse, with an overall lifetime incidence rate of 28% (Finkelhor, D., 2010). If prevention attempts are not employed, or are ineffective, and exposure occurs, the focus shifts to accurately identifying earliest possible signs a child has been, or is being, sexually abused, and delivering treatment after exposure. While prevention and treatment are crucial to increasing

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the odds for optimal well being following exposure, an important step in the intervention continuum appears to be missing: fostering reactive resilience in adult survivors of childhood sexual abuse using a programmed social learning theory approach (Kaminsky et al., 2007). Shifting the focus to reactive resilience interventions targeting less extant psychological symptoms and focusing more upon the prevention of re-victimization, may be a potentially helpful endeavor, and in the nature of resiliency, may result in outcomes more positive than originally anticipated, perhaps fostering posttraumatic growth. What follows will be a discussion of only female adult survivors, as literature on male adult survivors is scarce and is non-existent regarding their re-victimization. The topics of adult re-victimization and the need for an intervention, the mechanism of action for employing the selected intervention, a review of the literature, and finally, parting remarks, will follow.

Re-Victimization

While there are many caregivers and teachers who employ prevention strategies, there are far more who do not. And for each child who experiences abuse and has the abuse recognized or discloses it, and receives care in the aftermath of it, there are far more whose abuse goes undetected, or worse, is known and continued. As previously mentioned, exposure to sexual abuse in childhood has been shown to have numerous implications in adulthood. Re-victimization may be the most severe as it can be malignant and even "contagious," as it may breed trans-generational abuse. Re-victimization is a difficult concept to understand. It goes without saying that experiencing sexual abuse is harrowing and traumatizing. An investigation into understanding re-victimization proposed an ecological approach, linking personal, interpersonal, and sociocultural factors and processes (Grauerholz, L., 2000). This investigation communicated a staggering statistic: 66%-82% of survivors are revictimized as adults. In concordance with Bronfenbrenner's (1979) original ecological model, this investigation identified various factors and processes at each level that increase the likelihood of re-victimization in adulthood.

A Developmental Model

At the first or innermost level, the genesis of re-victimization includes the initial victimization experience. Traumatic sexualization, dissociative disorders, low self- esteem, social isolation, learned helplessness, learned expectancy of victimization, and feelings of powerlessness and self-loathing are a portion of contributing factors and processes identified that increase the risk of re-victimization at the personal level. Moving to the microsystem, exposure risk (interpersonal and environmental) was identified as a core factor, one in which the presence of the factors and processes identified in the first level increases. The adult survivor may find herself in situations that increase the risk of revictimization. The risk of a potential abuser acting aggressively toward a survivor of sexual abuse was discovered to be primarily due to perception of the victim as an "easy target." This perception is fueled by the stigmatization andlack of support identified in level one. Additionally, a victim's display of resistance to sexual advances may be perceived as insincere. Adding to this is the presence of a victim's decreased ability to respond assertively and to be effective in resisting advances.

For the third level, the exosystem, lack of resources in the form of tangible provisions, and social support increase the likelihood of revictimization. The availability of interpersonal support has been identified as a key factor in promoting resilience. Its absence increases risk of a continuing cycle of abuse (Ozer et al., 2003; Werner, E., 2005).

Finally, at the fourth level, the macrosystem, the cultural tendency to place blame on victims and perceptions of the female, contribute to revictimization. When observing re-victimization mechanisms from another angle, a study by McClure and associates (2007) examined cognitions of risk in female college students with histories of childhood sexual abuse (McClure, et al., 2007). Results of this study indicated those who were victims reported greater perceived benefits and lower perceived risks associated with illicit drug use, heavy drinking, and risky sexual behaviors. Additionally, victims reported greater expected involvement in risky behavior, which was mediated by cognitions about the risks and benefits of risky behavior, even when controlling for post-traumatic symptomatology (Smith et al., 2004).

The question now is, how do we decrease the likelihood of re-victimization or prevent its occurrence entirely for adult survivors of childhood sexual abuse? One prescriptive answer may reside in offering the adult survivor a continuum of care (Kaminsky et al., 2007). Such a prescription for an effective intervention strategy may include three core components: resistance, resilience, and recovery (Everly, G. S., 2012). The heuristic is the Johns

Hopkins resilience continuum (Kaminsky et al., 2007; Nucifora et al., 2007) wherein resistance represents primary prevention, resilience represents rebound fostered through psychological crisis intervention such as psychological first aid, and recovery represents treatment and rehabilitation.

Focusing upon the reactive resilience phase of the Hopkins continuum, the optimal outcome is to reactively build a sense of competency in this population's ability to manage their lives, including trusting themselves to make good decisions, form and maintain healthy relationships, and engage in roles that are productive, successful, and fulfilling. Essentially, our aim is to build reactive, resiliencyfocused self-efficacy. Self-efficacy as described by Bandura's (1997) social learning theory approach may be thought of as a sense of personal competence and agency. It can be fostered through four processes which act can independently, but may act synergistically as well: performance (enactive attainment), vicarious successful experience, verbal encouragement and interpersonal support, and management of physiological/affective arousal.

Overview of the Intervention

Goal: Apply features of efficacious resiliency interventions based upon the Johns Hopkins Resistance, Resilience, Recovery prescription.

Population: Adult female survivors of childhood sexual abuse currently experiencing psychological distress from untreated or inadequately treated impairment (including posttraumatic symptomatology, and dissociation) from childhood sexual abuse, engaging in revictimization, and/or at risk for re-victimization through participation in risky behaviors and highrisk relationships.

Administration: Two co-facilitators per approximately 10 women who are specially trained and will administer the proposed intervention below, and not only provide referral information for individual psychotherapy with a trauma-informed clinician, but will actively encourage initiation of and adherence to individual therapy.

Length: 3 Months (1 month per phase)

Hypothesized Outcome: Increased reactive self-efficacy, increased positivity and adaptive cognitive appraisals, increase in healthy support system, decrease/terminate unhealthy relationships, decrease participation in risky behaviors, decrease in re-victimization experiences, and increase in overall life satisfaction.

Outline for Implementation Phase One—Assessment

1. Assess current distress, personal safety, and acute symptomatology warranting immediate higher levels of care. Facilitation of access to such care as appropriate.
2. Provide psycho-education of the long-term effects of childhood sexual abuse

a. This will help normalize, and hopefully redirect possible internalization, of experiences.

3. Assess/Explore:
    a. Number and nature of exposure to trauma following childhood,
    b. Current appraisal of abuse history and evolution of appraisal,
    c. Prior treatment(s), if applicable,
    d. Survivor interpretation of their experience(s)' impact on their life, and
    e. Survivor perception regarding current life satisfaction.

    This is designed to gauge motivation, cognitive style, and predict adherence to intervention strategy. The intervention format will utilize small group dynamics, where connectedness is a core component of success. Thus, dropout occurrences, poor/resistant adherence, and/or lack of motivation to actively engage in components of the intervention will undermine the success of the entire intervention.
4. Provide psycho-education of potential current symptoms such as dissociation, hyper-arousal, healthy and unhealthy interpersonal relationships, as well as understanding re-victimization.

    This will help validate experiences and potentially begin to mobilize interpersonal support.

Phase Two—Increase Psychosocial Success

Increase survivor confidence and competence in the ability to effectively manage their lives.

1. Identify personal goals and plan for success
    a. Preferable, readily attainable and relatively short-term
    b. Break into manageable units and plan execution of goals
2. Monitor progress and celebrate victories through genuine praise each time progress is made. Temper failures with plan modification, exploration of where failure occurred and offer encouragement.

Phase Three—Increase Vicarious Success and Interpersonal Support

Increase survivor connectedness, increase healthy social supports, and promote healthy boundaries (both within and outside the group)

1. Collectively engage in activities that foster trust and group cohesion
2. Enlist a fellow survivor regarded as resilient to engage with the group (buddy system concept)

Phase Four—Improving SelfRegulation

Increase ability to cope effectively with stress and manage symptoms through ways that are healthy and adaptive

1. Teach coping skills to combat hyperarousal
   a. Mindfulness meditation
   b. Yoga
2. Reframe cognitive distortions, if applicable

Rationale for Intervention

1. **Performance:** Successes increase self-efficacy; repeated failures decrease self-efficacy. Goals that are easily identifiable and tangible should be identified and broken down into manageable units for successful performance.
2. **Vicarious experience:** Unfortunately, there is a heavy stigma around being a survivor of childhood sexual abuse, leaving it a taboo topic. This is due to a sense of shame often felt by survivors, and the discomfort many others feel in hearing about the experience. This population needs to see others with similar histories lead successful, fulfilling lives through achievements and healthy relationships. Although direction here is unclear, it is worthy of consideration and would involve a reduction of stigma and greater transparency of the topic.
3. **Verbal encouragement and support:** This relies on a support system, that many survivors do not have, or have unhealthy ones. There needs to be an educational component implemented here for how to create and maintain healthy boundaries, how to recognize relationships that need to end, and how to appropriately maintain and accept comfort from beneficial ones. Support: seek support from healthy, safe people within support systems, and allow oneself to receive what they are offering.
4. **Physiological/affective arousal:** A book by Jasmin Lee Cori, *Healing from Trauma*, identified an antidote for hyper-arousal. This antidote operates through her three S's: Stop, Soothe, and Support (Cori, J. L., 2008; p. 164). Stop: Stop what you're doing and accept that an alternative is needed. Seek: Seek support. Soothe: Do something that makes you feel safe and comfortable (this will be different for every survivor). Additionally, positive cognitions and optimism need to be fostered (Everly, G.S., 2012). This population often experiences irrational thoughts and internalizes negative events/interactions. We can begin to approach these issues by increasing survivors' objectivity (Cori, J. L., 2008). We can increase objectivity by having survivors begin to ask themselves, *Is this true?* look for evidence in their environment to confirm or disconfirm the thought or whether internalization is appropriate, and/or take an alternate point of view. This will also assist in recovery, as childhood sexual abuse is often internalized.

Elements of Successful Intervention

Six elements are necessary to providing informed trauma care (Bein, K., 2011). To optimize chances of success, the intervention must be contingent upon the following elements:

1. **Safety:** Consistent, predictable, and nonblaming relationships.
2. **Trust:** Clearly defined boundaries and reciprocal disclosure practices.
3. **Choice and Control:** Opportunities to make choices must be readily available and encouraged; choices should be premeditative and rational.
4. **Collaboration**: Interaction with, and exchange of knowledge and experiences, should be fostered between survivors and co-facilitators.
5. **Empowerment:** Validate and normalize experiences; celebrate victories, no matter how small.
6. **Cultural Relevance:** Co-facilitators are culturally competent and consider the varying sociocultural factors at play in survivors' lives.

The first three elements (safety, trust, and choice and control) are necessary, but not sufficient. In other words, for any chance of fostering resiliency, these elements need to be present; however, their presence alone will not indicate success of the intervention. Thus, a few closing comments on essential dynamic processes will follow.

When reviewing the literature, it appears that re-victimization and difficulties in successful

intervention outcomes could be mediated by neurological changes that childhood sexual abuse has been shown to precipitate. This may complicate the resilience process. A review of brain structure and function by Blanco et al. (2015) identified several changes. There seems to be a decrease in blood flow in the medial and dorsolateral prefrontal cortex, which could impair decision-making ability. This could perhaps explain a portion of this population's frequent inclination towards engaging in risky behaviors and impulsivity. Decreased blood flow also appears to occur in the bilateral anterior frontal region and left inferior front gyrus, which could lead to a deficit in ability to appropriately interpret emotional meaning. It seems likely this could set the stage, so to speak, for maladaptive cognitive appraisals of the abuse and self-perception. Additionally, hyper-secretion of corticotropinreleasing-factor (CRF) from the hypothalamus was identified as a precursor to elevated levels of cortisol seen in survivors. This is likely to exacerbate psychological distress and psychiatric disturbances. Lastly, the hippocampus was noted to be smaller in survivors of childhood sexual abuse, and this was more specifically observable in those survivors with Posttraumatic Stress Disorder and Dissociative Disorders. Thus the practice of physiologic selfregulation is seen to become even more important [1] (Everly & Lating, 2013). In addition, psychotherapy was found to increase hippocampal size (Blanco et al., 2015).

Any successful intervention does not occur outside of interpersonal relationships, and a study by Ports and associates (2016) identified risk and protective factors that contributed to the resiliency of female college students. The authors' construct of resiliency resides on three indicators of well-being: positive relations with others, environmental mastery, and self-acceptance. The role of abuse severity, age at time of abuse, and levels of familial conflict and/or cohesion were the variables measured. What they discovered was primarily unsurprising; abuser-specific characteristics did not account for much of the variation at all (3% of variance), but what did was family conflict/cohesion. High levels of family conflict exacerbated the negative effects and led to greater internalization of negativity. High levels of family cohesion decreased negative effects, and it was found that cohesion had a positive association to sense of competency. One finding was extremely surprising though; they saw a positive relationship between severity-cumulative variables of the trauma and both self-acceptance and environmental mastery. One can conclude that with the right frame of mind, and positive support, trauma does not always have to engulf an individual, and that one's ability to overcome such devastation can result in a greater sense of personal effectiveness in ability to overcome future adversity.

Conclusion

Childhood sexual abuse can leave wounds that, if untreated, may form scars that constrict the ability to actively and effectively participate in life. This can drastically reduce one's well-being, even as far as priming one for the opportunity to experience revictimization. As we've seen, there are neurological factors that occur and can place a survivor at a disadvantage over a non-abused person. These disadvantages include, but are not limited to an increase in psychological distress, the incidence of psychiatric disturbances, and impair cognitive, emotional, and behavioral functioning. Poor social support, lack of resources, maladaptive cognitive appraisal, negative self-perception, and high levels of family conflict further exacerbate difficulties and expand the likelihood of re-victimization. However, the potential benefit from interventions fostering reactive resilience doesn't have an expiration date. This population is in need of an intervention that establishes a sense of belief in one's self and ability to succeed and lead a efficacious life, provides them access to appropriate and healthy supports from their environment, and equips them with the tools needed to reframe their experiences and regulate their emotions and arousal level.

"The world breaks everyone and afterward many are strong at the broken places."
- Ernest Hemingway

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[1] See Everly & Lating (2013) for a step-by-step guide on implementing various interventions designed to reduce over-activation.

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