



V E I L L E

Approaches Based on Resilience  
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V E I L L E



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## Introduction

The interest shown in children's mental and physical health has evolved considerably over the course of our history. Children, characterised by a state of dependence on adults, have seen their physical and psychological integrity increasingly protected over the course of history. In three centuries, we have gone from the simple physiological protection of children (17<sup>th</sup> century, for economic and survival reasons) to their psychological protection (20<sup>th</sup> century, for ideological and moral reasons). This new conception of the child led, in 1989, to the establishment of the first international convention on the rights of the child.

The concept of resilience, in the way it is used in psychology, has come from studies developed in the United States from 1954, by the psychologist Emmy Werner. She studied the children of a highly disadvantaged Hawaiian island over the course of thirty years. Aged between 10 and 18 years at the beginning of the study, these subjects demonstrated, as adults, an improvement in or a recovery from the majority of the physical, psychological and social impairments they had suffered in their childhood. Of 200 children considered to have a high risk of psychological disorder, 70 (35%) had developed favourably (Werner 1989: 47). On the other hand, around two thirds of the subjects who were not resilient in childhood had become so in adulthood, which brings the total of individuals who developed favourably to 78%. This demonstration of an aptitude to develop in a non-pathological manner, despite the unfavourable living conditions at the start, brought up the concept of resilience. This concept was then clarified by Michaël Rutter in the context of studies on the variation in resilience in the face of adversity within the individual and the family unit (Rutter 1985: 39; Rutter 1979: 38).

Norman Garnezy, Michaël Rutter and Dante Cicchetti, among others, have concentrated on developmental psychopathology in the field of child psychiatry, and emphasise the role of socialisation – in particular within the family - in the development of psychological disorders. They studied the questions raised by the surprising proportion of children who developed in a highly satisfactory manner (between 20 and 40%, according to the studies), after having been confronted with very serious difficulties in their childhood. The challenge then became that of identifying the factors that had contributed to this constructive development in the face of adversity, in order to be able to take early action in the case of serious childhood psychological traumas.

Sexual abuse and sexual exploitation belong to these traumas. They are at the root of psychiatric disturbances that appear in adulthood, in particular greater psychological distress and a more significant depressive and anxious symptomatology (Greenwald, Leitenberg *et al.* 1990: 22).

In 1997, Lynskey and Fergusson highlighted a number of protective factors against the appearance of psychiatric disturbances in subjects who had suffered sexual abuse in childhood. The quality of their interpersonal relations (family relations, relations amongst their peers) was particularly emphasised (Lynskey and Fergusson 1997: 33).

While the concept of resilience has undeniably come from Anglo-Saxon research, nonetheless studies and programmes based on resilience have developed in French-speaking countries and in certain developing countries.

In order to increase our present understanding of resistance, it is necessary to bear in mind that a human person, for all that it is completely biological, is constructed through interaction. Friedrich Lösel of Germany makes it clear: "Genetic heritage determines the extreme limits of the possible, but within these limits we have an enormous range of possibilities, some of which will be realised thanks to social interaction, which helps us to construct a life for ourselves." Thus resilience "is never absolute, total, established once and for all". It is "variable according to circumstances, the nature of the traumas, the contexts and the stages of life; it can be expressed in very different ways according to the different cultures" (Manciaux, Vanistendael *et al.* 2001: 3).

# 1 The concept of resilience

## 1.1 Definition and history

The term resilience is originally used in metallurgy to indicate the capacity of materials to resist impact or continuous pressure and to then return to their initial state.

In computing, the term indicates the system quality that allows it to continue to function correctly despite defects in the constituent elements.

In ecology, the term refers to the recovery capacity of an organism or a population, or to the ability of an ecosystem to recover from a disturbance.

In medicine and in psychology, resilience indicates physical resistance, spontaneous-recovery phenomena and the ability to re-establish an emotional equilibrium in stressful situations.

The concept was defined by N. Garmezy in the United States in 1984 as the manifestation of a competence developed by children despite exposure to stressful events. In 1985, M. Rutter defined resilience as facing up to a stressful event in a way that favours an increase in personal and social competencies by means of a responsibility rendered accessible by the circumstances. In 1995, Gordon spoke of resilience as an ability to develop in a satisfactory manner and to develop one's competencies despite adversity.

The concept of resilience refers to an evolutionary process. It no longer involves a return to an original state, as in the original sense of the term. We speak of 'adjustment', of 'positive adaptation', of 'adaptive functioning', of 'post-traumatic growth' or of 'post-traumatic recovery'. After an event, consisting of a trauma or a potentially pathogenic psychosocial context, a process occurs that takes place over time and consists of the psychic organisation of the initial event.

In France, more than elsewhere, resilience has been approached by paediatricians and psychoanalysts, by people such as Serban Ionescu, professor of psychopathology, Michel Manciaux, professor of social paediatrics and public health, and Boris Cyrulnik, ethologist, neuropsychiatrist and psychoanalyst. The latter was first to popularise the concept by giving it media coverage, in particular in television transmissions. According to the psychoanalyst Simone Korff-Sausse, the term 'resilience' covers phenomena that had already been studied in psychoanalysis by S. Freud, S. Ferenczi and W.R. Bion, but given different names. At that time, terms were used such as defence mechanism and the 'psychic processing' of a trauma (Korff-Sausse 2002: 30). For psychoanalysis, therefore, resilience is a "dynamic, intrapsychic **process** that includes the capacity to maintain connections between the inner and the outer world" (Houssier 2002: 24).

In Latin America, (Argentina, Brazil, Chile), a specific line of thought is developing around the notion of community resilience. In the same way that the individual is capable of a certain resilience in the face of uncertainty and adversity, a community is equally capable. We have seen social groups operating rapid changes in order in order to adapt to a crisis. While the Western model is very individualistic, management of a crisis on a community level exists in collectivist societies, where belonging to a group is culturally important.

A critical review of national and international literature on resilience, carried out by Brazilian authors, shows that there is no consensus regarding its definition (Junqueira and Deslandes 2003: 27). The literature also demonstrates substantial variations in the operationalisation and measurement of key concepts concerning resilience (Luthar, Cicchetti *et al.* 2000: 31). For example, there is a difference between conceptualising resilience as a personality trait or as a dynamic process. The expression 'ego resiliency' refers to a characteristic of a person's personality and does not necessarily involve exposure to traumatic existential events. On the other hand, 'resilience' refers to a dynamic developmental process and the maintenance of positive coping in the face of adverse living conditions.

## 1.2 The different factors contributing to the capacity for resilience

## 1.2.1 Individual factors

### 1.2.1.1 Personality factors

A review of the available literature shows that personality traits such as self-organisation, self-esteem, personal effectiveness and hardiness are marked in resilient subjects and that their behaviour stems from an internal locus of control.

- **Self-organisation** is an individual's capacity to utilise his or her personal tendencies to recover when (s)he is confronted, either suddenly or chronically, by stressful or traumatising experiences (Cicchetti and Rogosch 1997: 10).
- **Self-esteem** is an emotional state resulting from a self-perception constructed from the recognition of others of one's personal competencies.
- **Personal effectiveness** is an individual's belief (true or false) that (s)he is capable of achieving a given objective.
- **Internal-external control**, or locus of control: people's behaviour varies according to whether they attribute the cause of their successes and failures to themselves (internal control) or to an external cause, such as chance, luck or another person (external control).
- **Psychological endurance** or hardiness: this concept is used to differentiate between individuals on the basis of their capacity to resist the negative effects of stress. J. Kaddour has studied the validity of the scales used to measure hardiness (Kaddour 2004: 28).
- **Drawing on positive emotions**: in numerous studies, having a sense of humour is indicated as favouring resilience.
- The model of the Big Five personality factors is a descriptive model that defines five dimensions of personality. Neuroticism is the tendency to easily experience negative emotions such as anger, anxiety, depression or vulnerability. Extraversion is the tendency to seek stimulation and the company of others. Conscientiousness is the tendency to demonstrate self-discipline, to act within the rules and to prefer a planned behaviour to spontaneity. Openness to experience is an attraction to art, emotion, adventure, original ideas, imagination and curiosity. Agreeableness is the tendency to favour compassion and cooperation above suspicion and antagonism in one's relations with others. A study of the correlation between resilience and this model shows that:
  - **neuroticism** correlates negatively with resilience
  - **extraversion** and **conscientiousness** have a strong positive correlation with resilience,
  - **openness to experience** has a positive correlation – weak, but nonetheless statistically significant – with resilience,
  - **agreeableness** has a non-significant correlation with resilience (Campbell-Sills, Cohan *et al.* 2006: 7).

### 1.2.1.2 Cognitive factors

- **Coping strategies:**

Numerous studies have shown that resilient children put active coping strategies into operation:

- **seeking emotional support** and **disclosure** towards a third person (adult or sibling) are active strategies that can have a protective effect depending on the quality of the support and attention,
- **cognitive restructuring** (or cognitive reframing) is a strategy that leads to a change in the understanding of the traumatic event and its implications. It involves progressively handling memories of the traumatic event and the painful affects associated with it in order to arrive at an awareness of the problematic significations that have been assigned to the traumatic event in the past (Spaccarelli 1994: 41).

Furthermore, the deployment of a passive coping strategy has been observed in non-resilient children:

- **avoidance coping**: this is a conscious denial of what has really happened. The empirical research conducted by Johnson and Kenkel (1991) demonstrated that this strategy increased the risk of psychological symptoms in adolescents and adults who had been sexually abused in their childhood. According to Tremblay *et al.*, children who use avoidance-coping strategies present more types of aggressive and delinquent behaviour (Tremblay, Hebert *et al.* 1999: 44)

- **Cognitive aptitude:** resilient children often demonstrate a greater capacity for understanding and analysing situations and a greater capacity for attention and concentration.
- **Dispositional optimism:** this is a stable, generalised set of expectations of positive things that will come to us in different areas of life and at different times in our existence. Tusaie and Patterson demonstrated that this is an important factor in resilience and that it is one of the most important cognitive factors in moderating the effect of stress. However, there are other forms of optimism: **situational optimism** corresponds to expectations of positive things in specific situations; **comparative optimism**, on the other hand, corresponds to comparing the probability that an event will occur to oneself in relation to comparable others. They also demonstrated that boys have a tendency to be more optimistic than girls (Tusaie and Patterson 2006: 45). An evidence-based programme, developed with an aim to improving resilience, would need to measure the different aspects of optimism and develop strategies specific to each sex.

## 1.2.2 Familial factors

The family is the first social group to which the child belongs. Emotional attachment and familial cohesion come into play in the development of resilience.

Emotional security provided by parents who exercise their parental role in an effective manner in the first years of life (0 to 6 years) contributes to the development of a good resistance to stress.

An emotionally positive educational climate, and emotional and social support provided by one of the two parents, or by a sibling, are important factors in the resilience of a child who has to face adversity.

A meta-analysis has highlighted a positive association between protective factors such as parental behaviour and the development of resilience in adolescents of different ethnic backgrounds. In this study, the characteristics of the resilient adolescent are the absence of psychiatric symptoms, social competence, behavioural adaptation and a good scholastic performance (Cuaranti-Burgio 2001: 12).

The observation of 310 boys between the ages of 1.5 and 12 years demonstrated that the quality of the relationship between the parents and the child, as well as the quality of the conjugal relationship, which creates a warm emotional climate within the family, are important factors in the development of resilience in children growing up in an at-risk neighbourhood (economically disadvantaged urban environment) Vanderbilt-Adriance and Shaw 2006: 46).

In a sample of adolescents with a history of maltreatment (13% of whom had suffered sexual abuse), a structural equation model highlights the importance of the bond between the adolescent and one of the parents in the construction of the resilience to face up to the constant source of stress represented by maltreatment (Rajendran and Videka 2006: 37).

The family therefore constitutes a non-negligible protection factor against adverse conditions. It needs to be targeted when drawing up action and prevention programmes aimed at improving resilience in abused children.

## 1.2.3 Sociological factors

### 1.2.3.1 Social identity

- **Membership of social micro-systems:** one's family, neighbourhood and community are membership groups where the child can find a support that allows him or her to develop resilience in the face of adversity. Outside the family, adults who provide a support for the child can counterbalance the negative effects of a disturbed and pathogenic family life. Membership of a social group, the feeling of providing each other mutual support, and adherence to a group's moral rules are elements that favour resilience in young people exposed to difficult conditions. The mechanisms of this collective support were observed by J.K. Felsman in 1989 in children between 7 and 12 years of age living in the street in Colombia (Tousignant 1999: 43).
- **Membership of social macro-systems:** the cultural environment and the socio-political system also constitute membership groups that influence, through their values and their attitudes, what resilience might be. For example, the Western cultural values of resistance would be autonomy, and the ability to confront adversity and resolve one's problems without the support of others. Asiatic cultures, on the other hand, would favour the individual's capacity to live in harmony with the collectivity.

### 1.2.3.2 Social influence, peer relations

Adolescence is a period in which peer relations take on a new significance. Identification with the membership group leads to a greater emotional support if the identification is strong and to a more marginal status if the identification is weak. Positive peer relations are a significant factor in healthy development in adolescence, and favour resilience.

But although the positive effects of identification with the peer group have been highlighted in numerous studies, there are also some negative effects in certain identification contexts. This is the case, for example, when the identification is with a delinquent group. On the other hand, being rejected by one's peers or experiencing difficulties in maintaining friendly relations are situations that are often associated with the appearance of psychological disturbances during the course of development (Jackson, Born *et al.* 1997: 25)

### 1.2.3.3 Socio-demographic factors

- **Age:** the younger the child is at the time of the abuse, the higher the risk appears to be of developing psychological disturbances (Lynskey and Fergusson 1997: 33).
- **Gender:** girls are more resilient than boys in adolescence and early adulthood (Dumont, Widom *et al.* 2007: 15). Girls, more often than boys, use resilience factors associated with seeking social support (Somchit and Sriyaporn 2004: 40).
- **Socio-economic status:** poverty is a condition that increases the risk of experiencing stressful events and of experiencing psychological distress at a younger age, and it reduces the resources available for facing adversity. The literature suggests that the abused child who grows up in an economically advantaged neighbourhood has more possibility of appearing resilient than a child who grows up in a disadvantaged neighbourhood (Dumont, Widom *et al.* 2007: 15)

### 1.2.3.4 Spirituality and religious belief

Active participation in the practices of a religious community and membership of a religious belief associated with seeking God's support to rid oneself of a negative emotion are attitudes that correlate to a reduction in the depressive mood of adults who have suffered sexual abuse in childhood (Gall 2006: 19).

A study carried out in Colombia on female victims of domestic violence highlights the importance of spirituality in the development of resilience in subjects living in a context with a high level of distress and violence. In this study, spirituality is measured using the Pamela G. Reed's *Escala de Perspectiva Espirituale* (1986) and refers to self-understanding, to a feeling of connection with a superior being or to the existence of a supreme goal (Jaramillo-Vélez, Ospina-Muñoz *et al.* 2005: 26).

## 1.2.4 Biological factor

**Cerebral plasticity:** The basic processes behind neuron plasticity have their origin in two mechanisms that affect the modulating effects of neurotransmitters: protein phosphorylation and gene-expression regulation. The first of these two mechanisms regulates the pre- and post-synaptic neurotransmitter receptors, and also plays a central role in cell growth and differentiation. The second mechanism, with which neurotransmitters induce long-term changes in target-neuron function by regulating their gene expression, makes it possible to best adapt their functional state to respond to the numerous synaptic inputs (Cicchetti and Blender 2006: 9). Current research in neurosciences and in molecular genetics opens new perspectives in the understanding of the genotype-environment interaction in resilient or pathological coping. Thus one study has demonstrated that a functional polymorphism in the serotonin transporter gene promoter (5HHT) moderates the influence of stressful events on depressive conditions (Caspi, Sugden *et al.* 2003: 8). It therefore appears necessary today to study the interrelations between the psychological and biological processes in research into resilience and psychopathology.

According to Cicchetti and Blender, it becomes indispensable at the present time to integrate a neurobiological framework into the design of action and prevention programmes. If one considers that experience alters the nervous system, research has to offer the opportunity to conduct experiments where experience and environment are altered in such a way as to promote a resilient behaviour in subjects exposed to traumatic conditions (Cicchetti and Blender 2006: 9).

### 1.3 Methods of measuring resilience

Defining resilience in an operational way in order to be able to assess it raises methodological difficulties (Kinard 1998: 29). There is no real consensus in the literature on a definition of resilience that allows the theoretical concepts to be put to the test, as certain authors distinguish between the factors that define resilience and those that are associated with resilience.

Resilience is assessed through the variability that appears in different domains: the absence of psychiatric symptoms (in particular depression and anxiety disorders) and behavioural disorders, the state of physical health, perceived parental competence, and marital satisfaction.

Different psychometric tests are used to measure this variability:

- The *Composite International Diagnostic Interview* (CIDI; World Health Organisation, 1993), assesses mood disorders, anxiety disorders and substance abuse,
- The *Self-Report Delinquency Instrument* (SRDI; Elliott & Huizinga, 1989) assesses behavioural disorders,
- The *Trauma Symptom Checklist* (TSC-33; Briere & Runtz, 1989) assesses the posttraumatic symptoms of sexual abuse,
- The *Parental Bonding Instrument* (PBI; Parker, Tupling & Brown, 1979) and the *Parental Attachment Scale* (PAS; Armsden & Greenberg, 1987), assess the quality of parent-child relations (Lynskey and Fergusson 1997: 33),
- The *Parenting Stress Index* (PSI; Abidin, 1995) assesses the parent's personality, his or her attachment to the child, the factors that influence parental behaviour, the perception of the parental role and the child's qualities that interfere with the implementation of this parental role,
- The *Coping Strategy Indicator* (CSI; Amirkhan, 1990) assesses three coping strategies: problem resolution, the search for social support, and avoidance,
- The *Dyadic Adjustment Scale* (DAS; Spanier, 1976) assesses the quality of the marital relationship,
- The *Center for Epidemiologic Studies – Depression Scale* (CES-D; Radloff, 1977) assesses depressive symptomatology (Wright, Fopma-Loy *et al.* 2005: 49),
- The *Teacher Report Form of the Child Behavior Checklist* (TRF; Achenbach, 1991) is a questionnaire for teachers, to assess children's behavioural problems (Flores, Cicchetti *et al.* 2005: 17),
- The *Children Depression Inventory* (CDI; Kovacs, 1982) is a self-administered questionnaire that assesses depressive symptomatology in children of school age,
- The *Self-Esteem Inventory* (SEI; Coopersmith, 1981) is a questionnaire through which children indicate their general perception of themselves (Cicchetti and Rogosch 1997: 10),
- The *Questionnaire d'Evaluation Familiale* (QEF; Terrisse, 2002) assesses the familial resilience competencies (with regard to risk factors) in order to use them in the context of family support,
- The *Sexual Victimization Questionnaire* (SVQ; Finkelhor, 1979) assesses the characteristics of experiences of abuse at different ages. The experiences assessed include forms of contact abuse (caresses, vaginal penetration and anal penetration) and non-contact abuse (invitation to actions that have a relationship with sex, or exhibition).
- The *Multidimensional Trauma Recovery and Resilience* (MTRR) is a multidimensional measure of trauma recovery and resilience. One study offers an adaptation into Spanish for a Chilean sample (Haz, Castillo *et al.* 2003: 23),
- The *Self-Reporting Coping Scale* (SRCS; Causez & Dubow, 1992) assesses coping mechanisms,
- The *Perceived Competence Scale for Children* (PCSC; Harter, 1985) is a questionnaire that measures self-perception in six areas: scholastic aptitude, peer acceptance, sporting aptitude, physical appearance, behaviour/conduct and personal value,
- The *Traumatic Sexualization Survey* (TSS; Matorin & Lynn, 1998) assesses the cognitive behavioural factors associated with a case history of sexual abuse in childhood (Matorin and Lynn 1998: 35).

## 2 Long-term health risks from sexual abuse suffered in childhood

Abused children, compared over three years with non-abused children, present more psychopathological symptoms, less prosocial behaviour and more difficulties with adaptation to school (Cicchetti and Rogosch 1997: 10).

Finkelhor's traumatogenic dynamics model (1988) shows that sexual abuse includes four types of experience:

- 1. traumatic sexualisation or exposure to inappropriate sexual behaviour,
- 2. a feeling of powerlessness to prevent the abuse,
- 3. the stigmatisation or negative connotations perceived by the child,
- 4. the realisation that a person whom the child trusted has failed in their role of protector.

Each of these experiences is connected to certain psychological effects and specific behavioural traits:

- 1. traumatic sexualisation can lead to a confusion in sexual norms and identity; it can also be at the root of precocious sexuality, compulsive sexuality or sexual dysfunctions (particularly sexual aversion).
- 2. a feeling of powerlessness can be at the root of anxiety disorders or an identification with the aggressor, as well as different psychiatric symptoms (somatoform disorders, depression, dissociation),
- 3. stigmatisation is a source of guilt and shame as well as of a drop in self-esteem; it can lead to social isolation, substance abuse, behavioural problems and suicidal behaviour,
- 4. the conviction of having been betrayed can be the cause of a feeling of anger, a lack of trust in others, a vulnerability to other abuse, and behavioural problems (Spaccarelli 1994: 41).

In the field of psychoanalysis, Sandor Ferenczi developed a model for phenomena of seduction and incestuous abuse: play between the child and the adult can take an erotic form, but for the child it always remains at the level of tenderness. The same does not hold true for some adults, who confuse children's play with the desires of a mature person. The child's first movements of resistance are inhibited by an intense fear and a feeling of absolute powerlessness. When this fear reaches its culmination, it obliges the child to submit to the will of the aggressor, to become the least of the child's own desires, to forget him- or herself totally by identifying with the aggressor. At the same time, the child introjects the adult's feeling of guilt. Split in two, at the same time both innocent and guilty, the child's faith in the testimony of his or her own senses is broken. The child's personality, still barely developed, reacts to the aggression, not by defending him- or herself, but by an anxious identification with, and the introjection of, the person menacing or aggressing him or her (Ferenczi 1982: 1).

With regard to the long-term effects listed in the literature on childhood sexual abuse (Greenwald, Leitenberg *et al.* 1990: 22) (Beitchman, Zucker *et al.* 1992: 6), the following psychiatric pathologies are recorded in adult subjects:

- mood disorders, in particular depression,
- anxiety disorders: compulsive and obsessional disorders, phobias and post-traumatic stress,
- substance abuse: drug addiction and alcoholism,
- suicide attempts,
- delinquency,
- somatoform disturbances,
- a new victimisation,
- sexual dysfunctions: absence of sexual desire, sexual aversion, pain, lack of satisfaction,
- at-risk sexual behaviour that makes the person more vulnerable to sexually transmitted diseases. Studies have revealed a connection between sexual abuse in childhood and an increased risk of HIV contamination in adulthood. Between 15% and 76% of seropositive men and women were sexually abused in childhood (Tarakeshwar, Hansen *et al.* 2006: 16).

## **3 The contribution of approaches based on resilience and evidence-based practice**

### **3.1 Approaches based on resilience**

In 1987, the American psychiatrist Elwin James Anthony spoke of the 'invulnerable child' to indicate the child that develops normally in a pathogenic environment (alcoholic parents, abuse etc.). Cohort studies, such as the one by Emmy Werner, led researchers to ask themselves what the processes involved in this 'invulnerability' were, and that is how the concept of resilience was formed.

Werner pointed out that all the resilient subjects she had observed reported having known, at some time in their life, an adult who had had a determining influence on them for the simple fact that (s)he had been recognised by these subjects as a benevolent, supportive adult.

Postulating resilience as a concept, rather than 'invulnerability', means giving priority to the fact that the individual can overcome the trauma and come out of it stronger than before. By conceptualising resilience as a process, the idea is introduced that it is possible to intervene in the development of individuals in order to improve them or favour their development.

The concept of resilience focuses on the individual variation in the responses given to comparable traumatic experiences and the processes of causality brought into play (Fossion and Linkowski 2007: 18). It approaches individuals by placing importance on their abilities, not their faults. "It allows us to detach ourselves from a too-linear and pessimistic view of the trauma as something that, like an inescapable destiny, unavoidably brings with it indisputable damage" (Korff-Sausse 2002: 30).

It also makes it possible to relativise deterministic models, according to which the experiences of early childhood condition the whole of one's existence, and biological models, according to which individuals are defined by their genes.

The development of knowledge about resilience leads health-service and social-services professionals to change the way they view the child victim. It is no longer a matter of indicating what is wrong; now it is necessary to systematically look for positive aspects, to highlight the child's abilities and make him or her feel more valuable in order to increase his or her self-esteem. It is also important to look for positive aspects in the groups to which the child belongs (family, community) (Manciaux 2001: 34).

### **3.2 Evidence-based practice**

#### **3.2.1 In medicine**

In medicine, three dimensions are found at the origin of evidence-based medicine (EBM):

- 'clinical' expertise,
- application of the 'most scientifically proven' practices,
- data resulting from the patient's 'desires, acceptations and preferences'.

Furthermore, more and more interest is shown in the practitioner's personal experience and in his or her influence on the clinical decision-making as if, at the end of the day, a too-theoretical view of EBM dehumanised the practices. Thus, this concept (like that of resilience) is evolving, according to the research on the subject.

However, the search for evidence for interventions and results must not detract from the importance of assessment processes. Double-blind randomised clinical trials are the reference for examining the effectiveness of interventions. Descriptive studies in medicine, which focus on the basis of the diagnosis and the prognosis, are sidelined, when they have an essential role.

Certainly it is necessary to intervene effectively, but it is also necessary to find systems that make it possible to develop the information that helps the practitioner to understand the other and to recognize interactions between the subjects and their environment (in the social sense).

On the other hand, it is important to point out that the subjects' word is not sufficiently taken into consideration when examining 'evidence-based' practices.

We can conclude by saying that no research methodology should be attributed a dominant role in relation to the others. Everything depends on what one hopes to learn from the studies carried out.

### 3.2.2 In social psychology

The perspective of evidence-based practices is increasingly becoming a working condition in the context of social work. However, in this context, the debate is still young and requires that attention be given to the epistemological foundations of the discipline. It is still only a perspective that is still forming as an emerging condition of practice (Couturier and Carrier 2003: 11).

Jane Gilgun invites us to consider the centrality of assessment in practical application with regard to studies in social psychology. Gilgun is referring to assessment according to the RSGB (Resilience-Schema-Gender Brain) theory (Gilgun 2005:20). This research can be applied to practice with children and adolescents who have been confronted with adversity and who adapt badly.

Gilgun, as a practitioner, gives us her definition of what is evidence. There is an evidence continuum in the information that appears in different stages of the practical process. This includes research and theory, experience, target public, and the subjects' responses to the interventions. Evidence is therefore interactivity – the ideal would be to continually update assessments and action plans while the evidence unfolds. One can also say that practice is a process. Professionals engage in the dialectics of conjecture: the initial action plan is refuted if new, more probative information emerges and/or the subjects' behaviour or preferences are at variance with the plan, etc.

Descriptive research, such as surveys, non-experimental case studies, narratives and ethnographies, is the observation of naturally occurring phenomena. It can sensitise practitioners to the subjects' needs and concerns.

If we consider the following four fields of research – resilience theory, schema theory, gender study and brain function – we discover connections that can unite them, an observable reciprocity and a constant interactivity. For example, considerations of ethnicity, culture and values can be placed within the category of 'resilience'. The different ecosystems in which individuals live out their lives are important, and knowledge of the four sectors of an assessment according to RSGB theory can help to understand them. Practice will be more individualised and more sensitive as a result.

It is our duty to gather together the best of what we know and examine how theories function in practice, and to remain ready to challenge concepts and ideas as new evidence presents itself.

Randomised clinical trials are certainly part of the research mechanism: it is hypothesis and its refutation.

More than 70 years ago, Edith Abbott warned practitioners that, in her opinion, they were at risk of becoming 'headless machines', unless they constantly fed the practice of a deep understanding of people and social-connection systems.

## **4 Applications and perspectives in prevention programmes and therapeutic interventions**

Sexual violence has been the subject of sensitisation and prevention campaigns since the 1990s. But the challenge of the 21<sup>st</sup> century is effective, continuous and long-term intervention.

Resilience research has to develop approaches that integrate different spheres (biological, psychological, environmental etc.) in order to put in place prevention programmes and therapeutic interventions (Cicchetti and Blender 2006: 9).

The objectives of these programmes would need to be to allow children, sometimes child victims, to make their individual history their own and, to a certain extent, compare it to prevention, support and rehabilitation practices. In fact, acting on the spheres of influence surrounding a child plays a determining role in his or her development:

- the microsystems of neighbourhood, school and family relations,
- the mesosystem of the interactions between these microsystems,
- the exosystem of what society offers in the way of social protection, family model and instruction,
- the macrosystem of the social relations specific to a given culture etc.
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### **4.1 Programmes targeting the general population**

The impact of programmes aimed at all children without distinction is undeniable, because they do not create any stigmatisation: no subject is identified as presenting psychological disorders in comparison with his or her peers.

These programmes can be developed in the school environment. They can prevent violence, develop social, emotional and cognitive skills in children, act on the environment – particularly that of school, enriching the adaptation to school – and they can sometime act on different factors (family, school, society).

### **4.2 Programmes targeting at-risk populations**

Actions centred on at-risk populations focus on observable disruptive behaviour. In this case, the developmental model that researchers have in mind is that of a vicious circle of disorder reinforcement in children who have poorer social skills. The neurobiological origins of certain disorders still need to be studied. In this case, children who already suffer from certain symptoms (pre-clinical stage) could benefit from programmes:

- centred on them (allowing them to manage conflicts, reduce aggressiveness, form social relations),
- centred on the adult tutor (Big Brother, Big Sister programme),
- not centred on a specific target (taking into consideration help for parenthood, children).

### 4.3 Programmes centred on internalised symptoms

Anxiety and mood disorders, and 'internalised' symptoms, do not have any certain theoretical pathogenic bases to justify interventions. Their connection (comorbidity) with externalised symptoms is frequently described. Little known and uncategorised, these 'bases' need more in-depth research. Predisposing events (genetic, familial) are of course described. The scientific evidence is that stressful and tragic events such as sexual abuse more often lead a child victim first of all to depression, then to anxiety disorders, then to substance abuse and suicide attempts and finally to behavioural disorders (Manciaux, Vanistendael *et al.* 2003: 5).

On the other hand, it has been demonstrated that two protective factors can modify mood disorders: social support and learning adaptation strategies.

There are specific prevention programmes:

- for mood disorders (Coping with Stress Program, Penn Prevention Program),
- for anxiety (only the Queensland Early Intervention and Prevention of Anxiety Project, which involves progressive exposure to the risk, is considered to be of interest),
- for suicide (C-Care, CAST),
- for stress (CODIP for children of divorcés).

To our knowledge, the literature does not contain any resilience-based prevention programme aimed specifically at children who have been sexually abused. On the other hand, other programmes for different populations exist and could serve as a basis for the design of future programmes aimed at children who are victims of sexual abuse or of sexual exploitation.

### 4.4 The BICE programme

In Latin America (Brazil, Colombia, Chile, Guatemala and Peru), BICE (Bureau International Catholique de l'Enfance) has developed a programme of care and support for children and adolescents experiencing particularly difficult situations and who present an elevated risk of developing psychopathological and behavioural disorders. The project integrated a study on the concept of resilience in order to construct an intervention model based on this concept. Certain factors were highlighted as being able to reinforce resilience and its applicability in social programmes:

- a revision of the power exercised by adults on the younger generations in order to promote the role of children and adolescents in the community,
- the fundamental role played by educators in creating a bond with the child in which empathy is privileged,
- team work in which strategies are devised for identifying available abilities and developing positive approaches in which resilience figures as a central resource,
- the integration of the concept of resilience into the individual realities of each country with an aim to overcoming the communication problems between the different generations and facilitating the potentialities of each one in everyday life (Rodriguez-Pena and Maria-Aguilar 2001: 4).

### 4.5 The AI's Pals: Kids Making Healthy Choices programme

A resilience-based prevention programme was put in place in the United States between 1993 and 1997. It was applied in nursery schools, childcare centres, the first classes of primary school and in extra-curricular activity programmes. It was aimed at children living in disadvantaged socioeconomic conditions and exposed on a daily basis to violence and substance abuse. The programme focused on a number of points:

- training for the teachers responsible for these children,
- construction of a special school programme spanning a year and providing teachers with clear information on how to conduct the courses,
- a set of instructions given to the parents so that they could continue at home the learning begun at school.

A study assessing the effectiveness of this programme shows that the children's abilities associated with resilience development improved (positive coping, prosocial behaviour and cooperative interaction) and that aggressive and antisocial behaviour disappeared (Lynch, Geller *et al.* 2004: 32).

### 4.6 The I CAN DO programme

A team of researchers and educators devised a school-based prevention programme for young children, designed to promote the acquisition of coping skills as well as the development of self-efficacy.

Learning through problem solving is the basis of this programme for children, which consists of thirteen sessions of 45 minutes each. The child learns general coping strategies, which are then put into practice in difficult situations.

The programme was assessed over a period of time, and demonstrated encouraging and positive results with regard to helping children confronted with stressful situations. A test after five months showed that the improvement in finding solutions for stressful situations persisted.

Only a self-assessment had been carried out, which is an important limitation. Other assessments, by parents and teachers, need to be programmed to test the evolution of the children's problem-solving capacity (Manciaux, Vanistendael *et al.* 2003:5).

#### **4.7 Public-health action research on the assessment of self-esteem**

A prevention project, in the form of action research<sup>1</sup>, demonstrated that it is possible to work on self-esteem and social skills from as young as five years.

A multi-disciplinary team intervened in French schools over a period of three years in the framework of an experiment in preventing at-risk behaviour. This team was made up of a teacher and two health professionals, one from 'school health' and the other from 'external health'. This work developed along four axes:

- meeting people,
- knowing oneself and knowing others,
- experiencing and identifying feelings,
- solving relational problems.

A questionnaire-based assessment showed that this intervention had brought changes in the quality of life and behaviour of the children who had benefited from the intervention (Manciaux, Vanistendael *et al.* 2003: 5).

#### **4.8 The PATHS programme**

Greenberg has developed a number of studies aimed at producing a prevention programme for psychiatric disorders in children and adolescents. The programme is intended for application in schools. It integrates prevention, developmental psychopathology and neurosciences in order to promote resilience by improving children's executive function, their ability to resolve problems, their emotional regulation and their capacity for attention.

Executive function refers to the psychological processes implicated in conscious thought control. Complex cognitive processes, and abilities in coping and emotional regulation develop with the maturation of the frontal lobes, a process that takes place from early childhood through to the end of adolescence. Executive-function deficiencies are associated with disorders of emotional control, social behaviour, attention and mood.

Greenberg's PATHS (Promoting Alternative Thinking Strategies) programme contributes to reducing internalised and externalised symptoms and increasing social and emotional competence. The programme's logic model is based on the idea that any intervention must firstly lead children to be less impulsive in their social interactions, and secondly help them to reinforce their vocabulary for controlling their behaviour and communicating better with others.

A randomised control study, carried out on 318 children in primary school, reveals an improvement in behaviour and provides empirical arguments in favour of the theory of conceptual action which forms the basis of the PATHS model and according to which, firstly, children's neurocognitive functioning plays a fundamental role in their social and emotional adaptation and, secondly, the executive function is directly linked to a reduction in behavioural disorders (Greenberg 2006: 21).

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<sup>1</sup> Action research not only emphasises a better understanding of the problem, but also tries to contribute to the problem's resolution. The research becomes a means of action.

## 5 How can professionals centre their practice around resilience?

Children who have suffered trauma from maltreatment or sexual abuse can regain a harmonious development if their 'emotional confidence' can be restored, if 'resilience tutors' (i.e. those persons who are always there for the children), are put in place and if they are given the opportunity to 'reorganise the emotions provoked by the representation of the ordeal by offering them places to express themselves' (Cyrulnik 2001: 13).

Stefan Vanistendael proposes five factors to consider as a departure point for action aimed at constructing resilience (Vanistendael 2000: 2). These factors are constructed in the person's interaction with the people around him.

- the fundamental acceptance of the child as a human person (therefore not necessarily his or her behaviour) by at least one other person,
- the capacity to discover a meaning to life, which can come from a religious belief, artistic expression, the care and attention given to an animal, or participation in a sports team or a training project etc.
- self-esteem,
- competencies of every type: human, social and professional,
- constructive humour.

Jean Garneau, psychologist, provides a few elements to guide professionals in resilience education (Garneau 2005: 50). He notes three important factors that need to be taken into account when training professionals giving care to children who have suffered a trauma:

- **welcome:** this is the first contact with the child victim. The caregivers' attitude must be benevolent. They must not allow themselves to be discouraged by any manifestations of rejection that child victims sometimes present. Above all, it is important that they show the child that they are ready to listen to him or her. It is necessary to be discreet. There need not be any social recovery. They must be careful that the person who has been exploited is not once again transformed into the subject of a social cause, and used as a symbol for change,
- **expression:** child victims must be allowed to construct an account of their story, in order to symbolise the subjective experience of the trauma suffered. The act of formulating the experience they have gone through allows children to transform the inexpressible, to reclaim this experience and drop the splitting mechanisms that have been put in place to survive. Expression is often difficult. It requires time to formulate itself. Caregivers must give children time to find their own words; they must show patience and demonstrate that they are still listening,
- **reconstruction:** it is a matter of reconstructing the self-esteem and liberty of a person who has been exploited or treated like an object. Caregivers can make use of artistic expression (painting, music, writing etc.) to help the victim transform the experience gone through into an aesthetic expression. It is necessary to provide children with the means to express themselves, leave behind the role of victim and succeed in accepting their responsibilities and finding a balance. Only the children can accomplish these actions. The caretakers are only there to guide the children and help them to develop by providing an environment that does not judge, does not moralise, accepts mistakes and provides benevolent attention.

## Conclusion

"Resilience is more than just resisting; it is learning to live," Boris Cyrulnik tells us.

Research has begun to analyse the protection mechanisms against the negative consequences of trauma. Prevention and reconstruction programmes have already been developed and form the first steps along a path that still needs to be discovered.

To continue along this path, it is essential to have the collaboration of professionals from different backgrounds. Social workers, psychotherapists, doctors, teachers and researchers must work together to come to the aid of traumatised children and give them back the keys to a balanced life.

Rather than trying to act on the risks themselves, it seems to be more fruitful to act directly on the children by helping them to face up to these risks and to overcome the trauma suffered.

A major problem is the absence of consensus with regard to an operational definition of resilience. This leads to considerable difficulties in the construction of research protocols. Dufour et al. (Dufour, Nadeau *et al.* 2000: 14) list the still-to-be-resolved problems under four main themes:

(1) The factors that define resilience are not differentiated from the factors associated with resilience. Some variables are used both as selection criteria and as factors defining resilience. For example, for some self-esteem is a coping factor, while for others it is a protection factor.

(2) The criteria used to assess resilience differ. And the results vary according to the domains assessed. Thus Spaccarelli and Kim (1995) demonstrated that 25% of children are classed as resilient when a single competency domain is assessed, but that the figure drops to 12% if a number of domains are considered at the same time.

(3) Another problem is that of knowing what the person's level of coping was before the traumatic event. Since sexual-abuse studies are always retrospective, resilience is not determined in relation to the individuals themselves, but in relation to criteria chosen by the researcher.

(4) One question connected to retrospection is the stability of resilience across time. Opinions differ as to the fixed or variable nature of resilience. This question directly concerns the connection between the mental health of a subject observed in adulthood and an event that happened numerous years earlier. Is the resilience of a subject who has survived other ordeals during the course of his or her life connected to the sexual abuse suffered in childhood?

Further studies, specifically involving victims of sexual abuse, will need to be carried out in order for answers to be found to these questions and for us to have a better understanding of resilience during the course of an individual's development.

It will also be necessary for research to concern itself with the modern world's new victims of sexual abuse, and that is children on the Internet. Any preventative and educational programmes put together on this subject will have to target both the children who use the Internet and their parents, who, very often, are unaware of the risks involved.

Mitchell, Wolak and Finkelhor (Mitchell, Wolak *et al.* 2007: 36), (Wolak, Mitchell *et al.* 2007: 48) examined the prevalence of 10-to-17-year-old Internet surfers who were victims of sexual solicitations, harassment and exposure to pornographic material. The results vary with the age and the sex of the subjects: 14-17-year-olds receive more unwanted solicitations than 10-13-year-olds, and girls more than boys.