



Resilience among adult survivors of childhood neglect: A missing piece in the resilience literature



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ABSTRACT

Despite the established long-term effect of childhood maltreatment, some proportion of adult individuals, who suffered childhood maltreatment, appear more resilient than others and continue to function well in life. We searched the databases of MEDLINE, PsycINFO and ERIC in order to identify relevant studies on resilience among adult survivors of child neglect, which constitutes the most common form of child maltreatment. We found that the vast majority of quantitative ($n = 41$) and qualitative ($n = 45$) studies on resilience among adult survivors focused on survivors of sexual and physical abuse rather than neglect. Only few studies examined neglect often along with other forms of child maltreatment. We reviewed the studies, identified gaps in the existing literature, and suggested directions for future research.

1. Introduction

Research has demonstrated a connection between a childhood history of maltreatment (CM) and a wide array of long-term health-related consequences as well as negative social outcomes in adulthood (e.g., Herrenkohl & Herrenkohl, 2007; Jonson-Reid, Chung, Way, & Jolley, 2010; Jonson-Reid, Kohl, & Drake, 2012; Widom, DuMont, & Czaja, 2007; Widom, Czaja, & Dutton, 2008). The economic toll of child maltreatment on society is also high (e.g., (Fang, Brown, Florence, & Mercy, 2012; Wang & Holton, 2007). These consequences have been found regardless of whether a child has suffered abuse or neglect (Gilbert et al., 2009). Child neglect, however, is the most common form of CM (USDHHS, 2016) and therefore drives much of the personal and social costs. Not all children with histories of neglect, however, experience negative outcomes. These children are often called resilient. Understanding the factors and processes that significantly contribute to positive adaptation and successful functioning can inform intervention designed for victims.

While studies of resilience among children with adverse experiences exist, few studies have examined resilience in adult survivors of neglect. This paper reviews the literature on resilience among adult survivors of child neglect, identifying the gaps in the existing literature, and suggesting directions for future research.

We organized the introduction in four parts. In the first part we reviewed the concept of resilience in the specific context of child maltreatment, since the focus of the paper is on resilience of adult victims of child neglect. In the second part we explained the focus on

childhood experience of neglect rather than other forms of child maltreatment. We conclude in the third part with explanation on why it is important to study resilience of adult survivors separately from resilience of children and adolescents.

1.1. Resilience in the context of child maltreatment

Resilience is generally defined as successful adaptation in spite of high risk for poor outcomes (Luthar, Cicchetti, & Becker, 2000; McGloin & Widom, 2001; Rutter, 2006) or competence in face of adversity (Hyman & Williams, 2001). In other words, resilience reflects the capacity to recover from significant challenges (Masten, 2011, 2014a, 2014b). Despite the established long-term effect of CM, some proportion of adult individuals, who suffered CM, appear more resilient than others and continue to function well across several life domains (Collishaw et al., 2007; McGloin & Widom, 2001; Pitzer & Fingerman, 2010; Topitzes, Mersky, Dezen, & Reynolds, 2013).

Scholars argue about whether resilience can be measured according to objective functioning across several domains in life or through the absence of negative behaviors or conditions (Afifi & MacMillan, 2011; Bonanno & Diminich, 2013; Collishaw et al., 2007; McGloin & Widom, 2001; Nasvytiene, Lazdauskas, & Leonavičiene, 2012). Resilience is viewed as a multidimensional or multi-determined process (Walsh, Dawson, & Mattingly, 2010), that is more accurately captured using multiple rather than single indicators. The way an individual responds to and interacts with various social-ecological systems is assumed to impact on adaptive and non-adaptive adjustments, thus attesting to the

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interactive nature of resilience (Masten, 2011; Rutter, 2006; Ungar, Ghazinour, & Richter, 2013).

There are also somewhat differing views regarding the underlying mechanism that produces resilient results. Resilience is considered a dynamic process. The relationship between resilience at a particular point in time and a later outcome is not fixed or deterministic and may vary over time and across developmental phases (Klika & Herrenkohl, 2013; Rutter, 1987, 2006, 2012). While a great deal of focus is placed on children, evidence suggests that adult experiences may mediate the relationship between CM and adult psychopathology (Coid et al., 2003; Horwitz, Widom, McLaughlin, & White, 2001). Such experiences may provide important turning points for at-risk individuals (Rutter, 2006).

1.2. Why study resilience in neglect survivors?

Understanding resilience in *neglect* survivors is of particular importance. Neglect comprises the largest percentage of official reports and estimates of incidence of child maltreatment (Sedlak et al., 2010; USDHHS, 2016) and is heavily associated with recurrence (Jonson-Reid et al., 2010). This means that most of the negative outcomes of child maltreatment are experienced by neglect survivors. Studies suggest that the consequences of neglect are enduring and may result in profound developmental deficits, which are at least as serious as or surpass those resulting from physical abuse (Berry, Charlson, & Dawson, 2003; DeBellis, 2009; Gilbert et al., 2009; Herrenkohl & Herrenkohl, 2007; Hildyard & Wolfe, 2002; Jonson-Reid et al., 2012; Widom, Czaja, Wilson, Allwood, & Chauhan, 2013). Studies on resilience among neglect survivors can inform interventions designed for this particular high-risk subgroup.

Neglect differs in nature from abuse since it reflects the omission rather than commission of a particular behavior: neglect occurs when there is a deficiency in appropriate parenting behavior, rather than when there is an occurrence of inappropriate parenting behavior (English, Thompson, Graham, & Briggs, 2005; Schumacher, Slep, & Heyman, 2001). Neglect is more frequently chronic in nature (Jonson-Reid, Drake, Chung, & Way, 2003). According to Masten (2001) resilience reflects ordinary rather than extraordinary processes, and usually arises from the normative function of human adaptation systems. Chronic exposure to trauma may compromise the normative protective, adaptation systems and make the individual more vulnerable to maladaptive adjustment. Indeed, in the general resilience literature, the nature of resilience following chronic adversity, as in the case of neglect, is assumed to differ from the nature of resilience following a single-incident trauma (Bonanno & Diminich, 2013). One can, therefore, conclude that the literature on resilience in sexual and physical abuse victims may not apply to neglect survivors.

1.3. Why study resilience among adult survivors of neglect?

Young adulthood and adulthood are recognized as distinct developmental life phases, separate from childhood and adolescence (Arnett, 2006; Bynner, 2005; Masten et al., 2004). A review of the literature on resilience following CM indicates that our understanding of resilience among *adult* survivors is limited (e.g., McGloin & Widom, 2001; Topitzes et al., 2013) because most of the research on resilience following CM was conducted on children and adolescents (e.g., Alford & Grados, 2005; Conte & Schuerman, 1988; Klika & Herrenkohl, 2013; Masten, 2007, 2011, 2014a, 2014b). Given the hypothesis that resilient processes may develop or be enhanced during adulthood, this gap is concerning. Further, given the unique attributes of the experience of neglect, what is known about resilient survivors of sexual or physical abuse may not be applicable to survivors of child neglect.

Another argument justifying the focus on adult survivors rather than children is that the negative outcomes associated with child maltreatment are different in childhood and adulthood (Jonson-Reid et al., 2012; Widom et al., 2013). There is thus a need to study resilience of

adult survivors separately from resilience of children.

This review of the literature was conducted to summarize what is known in this area and identify gaps to inform future research.

2. Search strategy and selection criteria

Due to the interest in summarizing rather than comparing variables explored or effect sizes, a search and critical review was conducted rather than a formal systematic review (Afifi & MacMillan, 2011). Given the scant literature on resilience in adult survivors specific to neglect, we decided to expand our search to include studies on resilience in *adult* survivors of child maltreatment generally and consider the possible relevance. The search focused on MEDLINE, PsycINFO and ERIC databases aimed at identifying relevant studies up to April 2017. We used these three major databases that were used in previous studies (e.g., Afifi & MacMillan, 2011) and added an additional comprehensive search of Google Scholar. References from retrieved articles were also reviewed for additional relevant citations. Terms used in the search included resilience, resilient, adult survivors of neglect, child abuse, and child maltreatment. We included in our examination studies and doctoral dissertations. Both quantitative and qualitative studies were included. Studies were included in the sample if resilience and child maltreatment were the focus of the examination.

3. Results for resilience in adult survivors of childhood maltreatment

The review process resulted in a total of 86 studies. The vast majority of quantitative ($n = 41$) and qualitative ($n = 45$) studies on resilience among adult survivors focused on survivors of sexual and physical abuse rather than neglect (e.g., Anderson & Hiersteiner, 2008; Banyard & Williams, 2007; Banyard, Williams, Siegel, & West, 2002; Bogar & Hulse-Killacky, 2006; Collins, O'Neill-Arana, Fontes, & Ossege, 2014). Forty seven studies (55%) focused on women, ranging in age from 18 (e.g., Howell & Miller-Graff, 2014) to 72 (e.g., Morrow & Smith, 1995). Of the 41 quantitative studies, 25 studies (60%) included men and women participants and fourteen studies included only women (35%). With regard to qualitative studies, 33 studies (73%) focused exclusively on women; 7 studies included men and women (15%). Five studies (11%) were conducted on male survivors: two studies focused on sexual abuse (Crete & Singh, 2015; Kia-Keating, Grossman, Sorsoli, & Epstein, 2005) and sexual and/or physical abuse (Buckhout, 2001), and another study included a sample of three participants survivors of neglect (Eshed Bar-Sade, 2008). Another study was a case study of one male who was followed from early childhood to adulthood (Stein, Fonagy, Ferguson, & Wisman, 2000). Resilience among adult survivors of neglect was not the focus of any published study located.

Resilience was conceptualized in various ways. In some studies resilience was conceptualized as successful functioning in several life domains such as employment, education attainment, absent of criminal behavior or psychiatric problem (e.g., six out of eight in the study of McGloin & Widom, 2001; or five out of seven in the study of Topitzes et al., 2013); others measured resilience as the absence of negative symptoms or events such as absence of mental health problems in adult life (e.g., Afifi & MacMillan, 2011; Collishaw et al., 2007; Liem, James, O'Toole, & Boudewyn, 1997) and still others focused on a lack of sexual revictimization (Jankowski, Leitenberg, Henning, & Coffey, 2002). The summary of quantitative and qualitative studies is presented in Tables 1 and 2, respectively. The Tables summarize studies by name of author/s, year of publication, sample size and participants' gender, type of childhood maltreatment, resilience definition and measures used to assess child maltreatment for quantitative studies only (Table 1).

Table 1
Quantitative studies on resilience to childhood maltreatment.

Author(s)/Year of Publication	Sample Size Gender	Malt. Type	CM Measure/Definition	Resilience Definition/Measure
1. Beutel et al., 2017	n = 2486 women and men	Emotional, physical, and sexual abuse; emotional and physical neglect	The Childhood Trauma Screener	Brief Resilience Coping Scale (BRCS)
2. Bellis et al., 2017	n = 7, 047 women and men	Physical, verbal and sexual abuse; parental separation; exposure to domestic violence and growing up in a household with mental illness, alcohol abuse, drug abuse or with an individual who had been incarcerated	Adverse childhood experiences (ACE) questions taken from the Centers for Disease Control and Prevention short ACE tool	Mental well-being; measured by the Short Warwick-Edinburgh Mental Well-being Scale
3. Graves, Borders, & Ackerman, 2017	n = 55 men	Sexual abuse	Physical contact of a sexual nature that (a) occurred between a child under 18 years of age and a person 5 or more years older regardless of the minor's consent or (b) occurred to a child under 18 years of age without his consent (i.e., entailed use of force or coercion) by a perpetrator of any age and regardless of age discrepancy	The Resilience Scale
4. Kaye-Tzadok & Davidson-Arad, 2016	n = 100 women	Sexual abuse	Katerndahl, Burge, and Kellogg's screening tool (2005)	Four scales that assessed overall functioning and psychological health: Social Functioning, depression, satisfaction with life, and positive affect
5. Rohlehr, 2014	n = 166 women and men	Physical abuse	The Childhood Trauma Questionnaire	Personal Mastery Scale, the Sense of Coherence Scale, the Ego Resilience Scale
6. Howell & Miller-Graff, 2014	n = 321 men and women	Type not indicated ^b /sample included other types of childhood violence	Juvenile Victimization Questionnaire – Adult Retrospective – Short Form (JVQR2)	Connor-Davidson Resilience Scale (2003)
7. Topitzes et al., 2013	n = 1182 men and women	Not indicated ^b	Official maltreatment records	Positive score of 5 or above on the following domains: educational attainment, employment, criminality, behavioral health, and mental health (several domains included two measures yielding a total possible score of 7)
8. Shilling, 2012	n = 143 women	Sexual abuse	Self-report of being victim	College adjustment, measured by College Adjustment Questionnaire
9. Shirley, 2012	n = 301 women and men	Child abuse and neglect	Childhood Maltreatment Questionnaire (CMQ) Abuse and Neglect	Low-child-abuse potential quantified on the Child Abuse Potential Inventory
10. Traina, 2008	n = 80 women	Physical abuse	Conflict Tactics Scale	Resilience was measured by physical health status and negative/non-negative affect
11. Pitzer & Fingerman, 2010	n = 2711 men and women	Physical abuse	Conflict Tactics Scale	Positive score of 5 or above on the following domains: educational attainment, employment, criminality, behavioral health, and mental health (several domains included two measures yielding a total possible score of 7)
12. Mersky & Topitzes, 2010	n = 1411 men and women	Abuse and neglect	Official abuse and neglect records	Resilience was measured with the Connor-Davidson Resilience Scale (2003)
13. Wingo et al., 2010	n = 792 men and women	Child abuse	Childhood Trauma Questionnaire (CTQ)	Brief COPE
14. Sutherland, 2009	n = 103 men	Sexual abuse	Self-report	Having high levels of well-being: Self-acceptance, ability to engage in positive relationships with others, and environmental mastery
15. McClure, Chavez, Agars, Peacock, & Matosian, 2008	n = 177 women	Sexual abuse	Modified version of Finkelhor's (1979) "Childhood Experiences" Survey	A composite score composed of seven indicators of resilience (college and employment participation, scholastic achievement, self-esteem, postponing childbearing, avoiding early drug and alcohol use, avoiding post-traumatic stress disorder, and avoiding depression).
16. Hisle-Gorman, 2008	Unavailable ^a women and men	Abuse and neglect		Successful functioning in at least six of the eight domains assessed: graduating from high school, psychiatric disorder, substance abuse or dependence, arrests, self-reported violence, employment, homelessness, and social activity
17. Dumont et al., 2007	n = 676 men and women	Physical and sexual abuse and neglect	Substantiated court cases of CM	

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Table 1 (continued)

Author(s)/Year of Publication	Sample Size Gender	Malt. Type	CM Measure/Definition	Resilience Definition/Measure
18. Collishaw et al., 2007	n = 364 men and women	Physical sexual and physical Abuse	Childhood Experience of Care and Abuse Interview	Absence of mental health problems in adult life
19. Gall et al., 2007	n = 101 men and women	Sexual abuse	Self-identified adult survivors of CSA	Current adjustment (mood, personal growth, resolution of the abuse)
20. Breno & Galupo, 2007	n = 84 women	Sexual abuse	Participants answered a series of questions in order to establish a history of sexual abuse	The Connor-Davidson Resilience Scale
21. Williams-Munroe, 2007	n = 50 women	Sexual abuse	Questions about any physical abuse and sexual before the age of 18	Emotional, physical, and social functioning
22. Jonzon & Lindblad, 2006	n = 152 women	Sexual abuse	Child Maltreatment History Self-Report Questionnaire	Health outcomes: psychological and psychosomatic symptoms
23. Williams, MacMillan, & Jamieson, 2006	n = 6681 women and men	Physical and sexual abuse	The Parent-Child Conflict Tactics Scale	Mental health adjustment which was defined as low rates of externalizing and internalizing psychiatric disorders.
24. Pepin & Banyard, 2006	n = 200 women and men	Abuse and neglect	Self-identification as a survivor of CSA	Trust, intimacy, and full-scale adjustment in adulthood.
25. Wright et al., 2005	n = 79 women	Sexual abuse		Resilience was assessed across intrapersonal, interpersonal, and intrafamilial domains using four outcomes measures: Depression Scale, Parenting Stress Index [PSI] Health Scale, PSI Parenting Competence Scale, and a measure of marital satisfaction
26. Parvizian, 2004	n = 96 women and men	Child abuse		Negative ratings on the following: abuse by a partner, abuse of a partner, insecure attachment, depression, substance abuse, criminal history, job instability, self-reported eating disorder, underweight or overweight status, PTSD, posttraumatic impairment, and dissociation.
27. Simpson, 2005	n = 114 women	Sexual abuse	Genital contact and/or penetration by a family member	Lack of depressive symptomatology, social competence and academic ability.
28. Kurtz, 2003	n = 162 women	Sexual abuse	Measure of Cumulative adversity in childhood (name not indicated)	Lack of depressive symptoms
29. Turner & Butler, 2003	n = 649 women and men	Childhood adversity	CSA was measured as a dichotomous variable by asking respondents the following question: "Now taking your whole childhood into account, did you ever receive physical injuries from the discipline used by your parents (that is, bruises, welts, cuts, lacerations, burns, broken bones, dental injuries, head injuries, etc.) before age 16"	Lack of sexual revictimization, which was define as sexual assault in older adolescence/adulthood
30. Jankowski et al., 2002	n = 974 women	Sexual abuse	NI	
31. Aberle, 2002	n = 161 men and women	Sexual abuse	Cases of child abuse and neglect that had been validated and substantiated by the court	Lack of revictimization by sexual assault.
32. McGloin & Widom, 2001	n = 676 abused and neglected individuals n = 520 controls men and women	Abuse and neglect		success across six of eight domains of functioning: employment, homelessness, education, social activity, psychiatric disorder, substance abuse, and two domains assessing criminal behavior (official arrest and self-reports of violence)
33. Hyman & Williams, 2001	n = 136 women	Sexual abuse	CSA was defined as sexual contact that was against the child's wishes, involved force or coercion, and was perpetrated by a male who was 5 or more years older than the victim	Competent functioning in several interrelated spheres despite adversity, and was operationalized as well-being in five essential spheres: physical health, mental health, interpersonal relationships, adherence to community standards, and economic well-being.
34. Muller & Lemieux, 2000	n = 66 men and women	Child physical and/or sexual abuse	Record of Maltreatment Experiences (ROME) self-report	Adult attachment style and posttraumatic stress symptomatology
35. Visalli, 1999	n = 246 men and women	Sexual and emotional abuse	The Psychological Maltreatment Experience Scale, The Sexual Abuse Experience Questionnaire, A revised version of the Childhood Experiences Questionnaire	The Trauma Symptom Inventory
36. Chambers & Belicki, 1998	n = 97 women and men	Child physical sexual and emotional abuse, neglect (10 women)	Childhood Experiences Questionnaire	Having a good quality of sleep
37. Bachop, 1997	n = 100 men and women	Sexual and/or physical abuse		resilience to the stress of abuse and psychopathology; assessed by the the Symptom Check List 90-Revised
38. Himelein & McElrath, 1996	n = 180 women	Sexual abuse	A history of CSA was measured by questions about sexual experiences before 15 years old with anyone at least 5 years older than the participant	Better adjustment as measured by optimism, sense of control and cognitive style

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Table 1 (continued)

Author(s)/Year of Publication	Sample Size Gender	Malt. Type	CM Measure/Definition	Resilience Definition/Measure
39. Liem et al., 1997	n = 687 men and women	Sexual abuse	Unavailable ^a	Not being depressed in combination with having good levels of self-esteem
40. Runtz & Schallow, 1997	n = 302 men and women	Sexual and physical abuse	Modified version of Finkelhor's (1979) Sexual Victimization of Children Survey	Psychological adjustment measured by psychological distress and self-esteem.
41. Lam & Grossman, 1997	n = 264 women	Sexual abuse	Child Abuse and Trauma Questionnaire (CAT)	A composite index of protective factors consisting of a combination of 16 self-report variables in the individual, familial, and social domains

^a Unavailable = could not be found in the abstract of the paper which could not be accessed.

^b Not indicated = not indicated in the study.

3.1. Quantitative studies on resilience

3.1.1. Longitudinal studies

Only four published papers, involving three separate longitudinal studies of adult resilience were located (see Table 1). A study following a cohort of children with court substantiated maltreatment prior to age 12, found that 22% of the subjects were resilient and functioned well in life in young adulthood across a broad range of adult psychosocial domains (McGloin & Widom, 2001). More women (26.6%) than men (17.6%) were found to be resilient. Although the study did include neglect survivors along with abuse survivors in the sample, results were not examined according to the type of maltreatment. In a subsequent study, based on the same sample, Dumont, Widom, and Czaja (2007) examined the continuity of resilience and non-resilience from adolescence to adulthood, and found that approximately 50% of maltreated children were resilient in adolescence and nearly 33% were resilient in adulthood. Of the nearly 50% of abused and neglected individuals who were resilient in adolescence most remained resilient in young adulthood (50.4%), while the majority of those who were not resilient in adolescence remained not resilient in adulthood (89%). Factors associated with resilience in adolescence related to gender (girls) and having a stable living situation, while resilience in adulthood related to gender (women) and a supportive partner relationship (DuMont, Widom, & Czaja, 2007). The second study did not include non-maltreated individuals.

A separate study examined young adult outcomes for low-income children with or without a history of maltreatment reports ($n = 1182$). Resilience was defined as a positive score of 5 or above on the following domains: educational attainment, employment, criminality, behavioral health, and mental health (several domains included two measures yielding a total possible score of 7). Several factors were associated with young adult adjustment: fewer moves between schools, fewer out-of-home placements, reading ability, fewer acting-out behaviors, better social skills, less juvenile delinquency, commitment to school, and the expectation of attending college (Topitzes et al., 2013). The article did not elaborate on the types of childhood maltreatment experienced. In this study, 20.9% of previously maltreated adults met the criteria for resilience. In contrast, a significantly higher proportion of adults who were not maltreated in childhood met the criteria for resilience (45.6%).

In a longitudinal study of female survivors of child sexual abuse, resilience was defined as a composite score of functioning in 13 dimensions: lack of trauma, self-esteem, no reported history of severe illness or surgery after age 17, no reported current drug or alcohol use, friendships with males, sexual functioning, living with own biological children, no prior reports to authorities for abuse, friendships with women, social activity, no arrests as an adult, income above the sample median and working full time. Scores ranged from 1 (few areas of resilience) to 11 (resilient across a number of domains). Resilience was stable across a seven year period of young adulthood and associated with reduced risk for re-exposure to trauma ($r = -0.44$). Earlier resilience was associated with positive later coping and greater life and role satisfaction (Banyard & Williams, 2007).

3.1.2. Cross-sectional

Other studies included exclusively physical or sexual abuse survivors and were cross-sectional explorations of the association of various factors with resilience (see Table 1). Social relationships were consistently found to be associated with resilience in these studies. Collishaw et al. (2007) found that positive relationships across childhood, adolescence and adulthood were associated with the psychological well-being of survivors of sexual and physical abuse. In a study of sexually abused girls, social connections, life satisfaction, and adaptive coping were correlated to resilience during a 1-year period in adulthood (Hyman & Williams, 2001). In contrast, the findings related to social support were mixed and approaches to measurement varied. Spousal

Table 2
Qualitative studies on resilience to child maltreatment.

Author(s)/Year of Publication	Sample Size Gender	Malt. Type	Resilience Definition
1. Curilla, 2015	<i>n</i> = 6 women	Sexual abuse	Self-report of healing and resiliency from experience
2. Crete & Singh, 2015	<i>n</i> = 5 men	Sexual abuse	Self-report of being resilient to CSA
3. Collins et al., 2014	<i>n</i> = 9 women	Sexual abuse	Healing from abuse
4. Newsom, 2014	<i>n</i> = 6 women	Sexual abuse	Self-identification as resilient
5. Singh, Garnett, & Williams, 2013	<i>n</i> = 10 women	Sexual abuse	Healing from child sexual abuse
6. (Mixed-method) Chandler, 2010	<i>n</i> = 10 women	Sexual abuse	A nonstandardized psychological and medical history, the Hardiness Scale and the Purpose in Life Test
7. Luck, 2010	<i>n</i> = 8 women	Sexual abuse	The ability to cope with difficulties and alleviate psychopathological responses
8. Baker, 2007	<i>n</i> = 12 women	Sexual abuse	Subsequent adaptation and shifts from reactive coping to positive transformation of abuse sequelae, and ultimately to overall improved functioning and well-being
9. Ligiéro et al., 2009	<i>n</i> = 9 women	Sexual abuse	The ability to overcome adversity. Surviving the abuse—being strong and not give up
10. Vogel & Gschaider-Kassahun, 2009	<i>n</i> = 11 6 women 5 men	Child abuse	The individual's ability to cope with contextual issues (poverty and war related trauma) later in life.
11. (Mixed method) Cirillo, 2008	<i>n</i> = 32 women and men	Physical abuse	Adult life functioning
12. Anderson & Hiersteiner, 2008	<i>n</i> = 27 25 women and 2 men	Sexual abuse	Staying on course in life and maintaining a coherent life story despite the abuse
13. Knapik et al., 2008	<i>n</i> = 50 27 women and 23 men	Sexual abuse	Being delivered: being rescued, saved, or set free from the effects of sexual violence
14. Thomas & Hall, 2008	<i>n</i> = 44 women	Sexual abuse (74%) combined with other forms of child malt.	Surviving and thriving after CM
15. Suzuki et al., 2008	<i>n</i> = 10 8 women and 2 men	IPV	Normative mental health
16. Eshed Bar-Sade, 2008	<i>n</i> = 3 men	Neglect	Not maltreating own children
17. (Mixed-method) Gegenheimer, 2008	<i>n</i> = 10 women and men	Neglect, physical, emotional, and sexual abuse	Adaptive functioning, and satisfaction with social support.
18. (Mixed method) Banyard & Williams, 2007	<i>n</i> = 80 women participated in the 1st quan. study. In the 2nd qual. Study: <i>n</i> = 21 women	Sexual abuse	A composite score of functioning in 13 dimensions: lack of trauma, self-esteem, no reported history of severe illness or surgery after age 17, no Reported current drug or alcohol use, friendships with males, sexual functioning, living with own biological children, no prior reports to authorities for abuse, friendships with women, social activity, no arrests as an adult, income above the sample median and working full time
19. Wright et al., 2007	<i>n</i> = 60 women	Sexual abuse	Positive adjustment (marital satisfaction, better physical health, less isolation)
20. Singh, 2006	<i>n</i> = 13 women	Sexual abuse	Use of silence, hope social support, social advocacy, self-care
21. Bogar & Hulse-Killacky, 2006	<i>n</i> = 10 women	Sexual abuse	Determinants of resiliency were interpersonal skills, competence, high self-regard, spirituality, and helpful life circumstances. Processes that facilitated resiliency were coping strategies, refocusing and moving on, active healing, and achieving closure
22. Anderson, 2006	<i>n</i> = 26 women	Sexual abuse	Not provided
23. Kia-Keating et al., 2005	<i>n</i> = 16 men	Sexual abuse	Never been sexually abusive to anyone and functioning well in at least one area of life (e.g., employment, having ad at least one stable relationship).
24. Baker, 2004	<i>n</i> = 5 women	Sexual abuse	Health and life satisfaction
25. Oaksford & Frude, 2003	<i>n</i> = 11 women	Sexual abuse	Adaptive adjustment by using adaptive coping strategies with the abuse experience
26. Feinauer, 2003	<i>n</i> = 195 women	Sexual abuse	Hardiness—positively adapt to stressful events
27. Flynn, 2003	<i>n</i> = 21 women	Sexual abuse	Posttraumatic growth and creation of a resilient self
28. Navarro, 2003	<i>n</i> = 15 men and women	Not indicated ^a	Academic success
29. Banyard et al., 2002	<i>n</i> = 136 women	Sexual abuse	Physical health, mental health, interpersonal relationships, adherence to community standards, and economic well being
30. Banyard et al., 2001	<i>n</i> = 136 women	Sexual abuse	Social connections, life satisfaction, and adaptive coping
31. Buckhout, 2001	<i>n</i> = 8 women	Sexual, physical/or psychological abuse	A transformative process that proceeds in a non-linear progression back and forth between external and internal life experiences
32. Glaister & Abel, 2001	<i>n</i> = 14 women	Sexual abuse	Achieving a measure of healing

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Table 2 (continued)

Author(s)/Year of Publication	Sample Size Gender	Malt. Type	Resilience Definition
33. Buckhout, 2001	<i>n</i> = 8 men	Sexual, physical or and/or psychological abuse	Transformative process of healing
34. Dabney, 2000	<i>n</i> = 16 women	Sexual abuse	Sources of counseling support including individual, group, and spiritual counseling.
35. Davis, 2001	<i>n</i> = 20 women	Sexual abuse	Self-identification as resilient
36. Harvey et al., 2000	<i>n</i> = 3 women	Sexual abuse	Process of recovery
37. Stein et al., 2000	<i>n</i> = 1 man	Physical abuse and neglect	Capacity for successful adaptation in circumstances usually associated with psychological dysfunction
38. Perrott et al., 1998	<i>n</i> = 40 women	Sexual abuse	psychological well-being
39. Herringshaw, 1997	<i>n</i> = 8 women	Sexual abuse	Lack of depression, satisfaction with life Scale and self-efficacy.
40. (Mixed method) Himelein & McElrath, 1996	First quant. Study <i>n</i> = 120 women Second qual. <i>n</i> = 20 women from 1st study <i>n</i> = 10 women	Sexual abuse	Psychological well-being as measured by three components: positive affect, Life satisfaction and absence of psychological distress
41. Godbey & Hutchinson, 1996	<i>n</i> = 11 women	Sexual abuse	Healing from childhood sexual abuse and positive feelings about the self and the world Survival and coping strategies
42. Morrow & Smith, 1995	<i>n</i> = 15 women	Sexual abuse	Self-identification as high-functioning individuals
43. DiPalma, 1994	<i>n</i> = 22 women	Sexual abuse	Functioning well in life: employed and/or living in the community without needing state or welfare assistance, not have been institutionalized in hospitals, prisons or shelters for the homeless or battered.
44. Valentine & Feinauer, 1993	<i>n</i> = 14 women	Physical and sexual abuse	Surviving child abuse
45. Crockett, 1984			

^a Not indicated = not indicated in the study.

support was related to resilience among sexual abuse survivors (Jonzon & Lindblad, 2006; Runtz & Schallow, 1997; Wright, Fopma-Loy, & Fischer, 2005) but in another study of physical abuse survivors, emotional and instrumental support from others were not found to be related to resilience (Muller & Lemieux, 2000; Pitzer & Fingerman, 2010). Recently, one study found that having access to a trusted adult as a child may impart resilience against developing poor health and mental well-being in adulthood (Bellis et al., 2017).

A number of other factors were mentioned in various studies. Optimism about the future, high self-esteem (e.g., Jonzon & Lindblad, 2006; Muller & Lemieux, 2000), and internal locus of control or perceived control (e.g., Liem et al., 1997; Pitzer & Fingerman, 2010), were prominent among resilient survivors. Other studies identified that the absence of negative factors like low neuroticism and adolescent mental health disorders as associated with resilience (Collishaw et al., 2007). Another study found low self-blame and low trauma-related beliefs (Afifi & MacMillan, 2011) characterized resilient survivors. In one study, spirituality was associated with positive adaptation in adulthood of adult survivors of childhood sexual abuse and, in particular, with a greater sense of personal growth, self-acceptance and hope (Gall, Basque, Damasceno-Scott, & Vardy, 2007).

Some studies focused on accumulation of stressors or traumas as compared to singular events in childhood. One study found that less family stress and fewer stressful life events was associated with resilience (Liem et al., 1997). Conversely, cumulative trauma over the life course was related to higher levels of psychological distress (e.g., Banyard, Williams, & Siegel, 2001; Jankowski et al., 2002; Turner & Butler, 2003; Turner & Lloyd, 1995).

As evident, the majority of the studies focused on quantitative assessments of resilience *outcomes*, usually defined as successful functioning across several domains or the absence of negative events. Unfortunately, these studies shed little light on the *process* of becoming resilient that is a process medicating the response to childhood maltreatment. It is also unclear how the identified protective factors

contribute to resilience directly or how they assist in developing resilient adaptation among survivors. Further the variation in measures, types of maltreatment included and sample compositions make comparisons across studies difficult. Finally, none focus on survivors of child neglect.

3.2. Qualitative studies on resilience

Qualitative studies on resilience following CM among adult survivors incorporate the victims' "voice" (Banyard & Williams, 2007) but are also limited in several respects. No qualitative study to our knowledge has focused on survivors with a childhood history of neglect (with or without abuse). The vast majority of qualitative studies focused on adult survivors of childhood sexual abuse (*n* = 25), nearly exclusively women (see Table 2). A few exceptions included a small number of male participants, for example, a study by Vogel and Gschaider-Kassahun (2009), which consisted of 6 women and 5 men, a study by Anderson and Hiersteiner (2008) included 25 women and two men, a study by Suzuki, Geffner, and Bucky (2008) with two men and 10 women, and a study by Knapik, Martsof, and Draucker (2008) which included 27 women and 23 men. One study by Kia-Keating et al. (2005) including solely men (*n* = 16). Six studies focused on survivors of physical abuse and sexual abuse (*n* = 3), physical abuse only (*n* = 1), physical abuse and neglect (*n* = 1), and exposure to IPV (*n* = 1), a form of abuse which can be reported as child maltreatment in certain U.S. states. Finally, one study did not specify the type of abuse experienced by the participants (Vogel & Gschaider-Kassahun, 2009).

The fact that qualitative studies tend to be small makes heterogeneity a problem in comparing findings. The age range in studies varied widely. For example, two studies on survivors ranging from college to retirement age (e.g., 29–51 years in Vogel & Gschaider-Kassahun, 2009; and 21–79 years in Hall et al., 2009). This raises issues related to differences in external factors as well as recall.

While cross-study comparison and generalizability are issues with

small qualitative studies, they do provide a window into the process of resilience. The recovery process was described in qualitative studies in various ways such as “becoming resolute” (Thomas & Hall, 2008), act of “resistance” (e.g., Anderson, 2006; Ligiéro, Fassinger, McCauley, Moore, & Lyytinen, 2009), hardiness (Feinauer, 2003; Himelein & McElrath, 1996), “being delivered” (Knapik et al., 2008) and transforming “from victim to survivor” (e.g., Newsom, 2014). Resilient survivors described a decisive agency manifested by fierce determination to surmount their abusive past (Hall et al., 2009; Thomas & Hall, 2008). Some survivors reported refocusing physical and emotional energy on other things such as educational and career pursuits, family involvement, social affiliations, sports, religion and spirituality, which played a significant role in their ability to move on with their lives and function effectively (Bogar & Hulse-Killacky, 2006). Survivors descriptions of resilience were also non-linear in nature (Oaksford & Frude, 2003) and dynamic, responding to additional trauma over time (Banyard & Williams, 2007), or to positive turning points or second chances in the individual's life, which provide opportunity for growth and change (e.g., Banyard & Williams, 2007; Harvey, Mishler, Koenen, & Harney, 2000).

Four main interrelated themes related to protective factors emerged from review of the qualitative studies reflecting the process of becoming resilient: disclosing the abuse, making sense of the trauma, coping strategies to deal with the trauma and building supportive relationships. Confrontation of the abuse through disclosure was an important part of pursuing an active, conscious process of healing (e.g., Anderson & Hiersteiner, 2008; Bogar & Hulse-Killacky, 2006; Himelein & McElrath, 1996). Another related way of confronting the abuse was meaning making (e.g., Anderson & Hiersteiner, 2008; Grossman, Sorsoli, & Kia-Keating, 2006; Harvey et al., 2000; Wright, Crawford, & Sebastian, 2007). Disclosure and making sense of the trauma was associated with reduced feelings of shame and self-blame. Beyond disclosure it was important for survivors to attempt to integrate their experiences into their personal life stories. For example, developing a psychological framework for understanding the abuser or the role of the self in the abuse (Grossman et al., 2006); or survivors retelling or reframing the abuse experience and arriving at new understandings that support the efforts to confront and deal with past traumas and move on with their lives (Harvey et al., 2000). Survivors who were able to attribute blame to the perpetrator were more resilient (e.g., Feinauer & Stuart, 1996).

Disclosure and meaning making were protective coping approaches, along with setting limits and boundaries in order to protect one's self from further abuse (e.g., Ligiéro et al., 2009), prayer and spirituality. In some studies, spirituality helped survivors understand themselves and their interactions with their environment (e.g., Collins et al., 2014; Suzuki et al., 2008). In contrast, avoidant coping was strongly associated with low self-esteem, depressive symptoms and poorer resolution of abuse issues (Perrott, Morris, Martin, & Romans, 1998; Wright et al., 2007).

While the social support findings in cross-sectional studies were mixed, survivors described the significance of receiving support from someone close in their life. Relationships with others were viewed as sources of motivation for creating change and achieving a sense of competence and efficacy (e.g., Suzuki et al., 2008). Supportive relationships were achieved through social connections, friendships, engagement in the community and psychotherapy (e.g., Baker, 2004; Banyard & Williams, 2007). It should be noted that the way in which social support was discussed appeared closer to the discussion of social relationships in the quantitative studies which may indicate that there might be issues of variation in meaning and measurement across studies rather than conflicting findings.

Since most of the subjects in the qualitative studies were survivors of sexual abuse alone or combined with other forms of abuse, it is unknown whether the findings can be applied to neglect. For example, as neglect is often a more chronic experience (cite) it is not clear how

this is similar or different from the discussions of disclosure and meaning making of trauma. Further, most of the studies were limited to women so it remains unclear how well findings apply to male survivors.

4. Discussion

Despite the prevalence of child neglect and the mounting evidence of often equally poor outcomes compared to other forms of maltreatment (Berry et al., 2003; Herrenkohl & Herrenkohl, 2007; Jonson-Reid et al., 2010, 2012; Widom et al., 2013), it was not possible to achieve the initial goal to summarize findings about resilience for adult survivors of child neglect. Only a handful of studies on adult resilience included samples with adults who had experienced neglect and none of these papers discussed possible differences by maltreatment type history. Our discussion is therefore limited to learnings from the existing literature.

From the three longitudinal studies of adult resilience the proportion of resilient survivors across the domains measured was relatively small for those with histories of maltreatment (under 25%). Resilience was measured as successful functioning across various domains in life (e.g., Banyard & Williams, 2007; McGloin & Widom, 2001; Topitzes et al., 2013). While some change in resiliency status from adolescence to adulthood occurred, resiliency prior to age 18 was strongly associated with continued resiliency while relatively few persons with significant problems in adolescence appeared to achieve later resilience. It is not clear, however, if all domains of resilience should be valued equally. It may be that persons who are resilient in some domains would report a greater overall quality of life than persons who are resilient in other areas. Further, ecological model and multi-system framework of resilience posits that individual, family and community factors over time account for successful or pathological development under adversity (e.g., Masten, 2011; Orbke & Smith, 2013; Ungar et al., 2013). This suggests a strong need to encourage further longitudinal work in this area.

Cross-sectional studies also include a measure of resilience as the absence of negative factors (e.g., Afifi & MacMillan, 2011; Collishaw et al., 2007; Jankowski et al., 2002; Liem et al., 1997). Researchers argue that the absence of risk is not the same as the presence of protective factors (Cicchetti, 2013). However, much of the risk and protective factor work has been built from studies of childhood and adolescent development. Additional work is needed to understand if there are practically important differences between these two perspectives related to adult functioning.

Despite these limitations there were some consistencies across studies that identify factors that should be examined in future studies specific to neglect. These include evidence of positive functioning and stability during adolescence, positive relationships with at least one family member, friends and intimate partners, coping skills, and some form of hope for the future (e.g., Afifi & MacMillan, 2011; Banyard & Williams, 2007; Collishaw et al., 2007; DuMont, Widom, & Czaja, 2007; Hyman & Williams, 2001). Thus far, the quantitative work and much of the qualitative work has identified singular associations between a given skill or resource and resilience. Much work remains to understand how various factors at different ages may accumulate to assist or deter resiliency. Nor are we clear whether this process is similar for individuals who have experienced neglect, particularly neglect without abuse.

A unifying theme across qualitative studies on resilience is that making meaning about traumatic events is a key to the process of recovery and becoming resilient (e.g., Hall et al., 2009; Banyard & Kantor, 2004). Prior studies not specific to maltreatment have found that if an individual perceives a benefit from a negative event he/she is more likely to demonstrate better adaptive functioning in life than individuals who do not perceive such a benefit (McMillen, 1999). This model was tested on sexual abuse survivors and the findings

indicate that perceived benefit was associated with several adult adjustment indicators, such as enhanced self-efficacy or self-confidence and better adult functioning (McMillen, Zuravin, & Rideout, 1995). Perceived benefits fell into four main categories: the ability to protect other children from abuse, self-protection skills, increased knowledge of child sexual abuse, and development of a stronger personality. Similarly, findings from another study on sexually abused women found that resilient women felt that they had become stronger and more complex human beings, at least in part because of their difficult past (Bogar & Hulse-Killacky, 2006). Another study describes this process as “positive framing”, reporting benefits like the development of a stronger personality, increased assertiveness or enhanced feelings of self-protection (Himelein & McElrath, 1996; Oaksford & Frude, 2003). Altogether, it seems that construing childhood maltreatment experience as a vehicle for growth and finding meaning in adversity was an effective coping strategy for survivors. Once again, it is unclear how such processes apply to cases of neglect; some may be more applicable to acute negative events (McMillen, 1999). As neglect tends to be a more chronic condition, it is not clear how well the same processes of reframing may work. Spirituality was also found key to the process of resilience specifically among sexual abuse survivors (e.g., Kaye-Tzadok & Davidson-Arad, 2016). Positive spiritual coping methods, such as religious forgiveness and spiritual support led to less distress (Gall et al., 2007) and better adjustment (e.g., Collins et al., 2014; Suzuki et al., 2008). Given that neglect is less associated by its nature with parental blame compared to sexual or physical abuse it is unclear if spirituality in the form of forgiveness and spiritual support is relevant to positive coping of neglect survivors. Clearly, there is need to study coping skills and strategies among resilient survivors of childhood neglect. Positive coping or maladaptive coping (e.g., avoidance, alcohol and drug use) may contribute to further resilience or negative outcomes, respectively (e.g., Crete & Singh, 2015). A mixed methods approach that combined data on various factors associated with positive functioning with a smaller in-depth qualitative set of interviews could shed light on how these perceptions of events may interact with external resources like friends or doing well in school.

5. Suggestions for future studies

Since there were no studies, quantitative or qualitative, that focused on survivors of child neglect specifically, both approaches would make a significant contribution to the literature. Studies are needed that can explore whether positive adjustment in adulthood is connected to the timeframe (e.g., childhood vs. adolescence, Thornberry, Ireland, & Smith, 2001), severity and duration of maltreatment experience in childhood (Cicchetti, 2013). It is not clear how these characteristics of the maltreatment experience may interact with other protective and risk factors. Nor do we understand how resilient outcomes may be linked to child neglect specifically. Additionally resilient outcomes may vary by the form(s) of child neglect experienced (e.g., basic needs, hygiene, supervisory, emotional and medical) as well as various combinations of neglect and abuse over time. The inclusion of non-maltreated controls is also a necessity as neglect is heavily associated with other risks to development like poverty making it important to distinguish issues that are related to underlying comorbid factors as compared to neglect itself. Understanding the unique effects of neglect is particularly key to knowing if interventions that promote resilience must be targeted to specific maltreatment types.

Studies reviewed fell into either qualitative or quantitative approaches. As aforementioned, mixed methods approaches that can combine the ability to describe larger subgroups with targeted interviews to understand individual perceptions and meanings would be extremely valuable to theory development. There is also much work to be done around how resilience is measured. Another interesting direction for mixed-method research would be to examine whether the subjective perception of positive functioning (the qualitative part)

concur with actual successful functioning in a range of domains (the acceptable definition of resilience in current quantitative literature).

Finally, longitudinal studies are needed to fully articulate the process of resilience over time (DuMont et al., 2007). While developmental phases have long been recognized as a part of child development, recent work has extended this to the investigation of outcomes in adulthood (e.g., Berlin, Furstenberg, & Waters, 2010; Masten et al., 2004; Shanahan, 2000). There are varying forms of milestones from achieving independence in the community, to training or college, to entering the workforce and/or family formation to later adult stages of parenthood (Cohen, Kasen, Chen, Hartmark, & Gordon, 2003; Furstenberg et al., 2010; Masten et al., 2004; Shanahan, 2000). A couple of studies (DuMont et al., 2007; Hyman & Williams, 2001; Topitzes et al., 2013) suggest a relationship between resilient functioning in adolescence and later adulthood but the period of adulthood may also matter. For example it is possible that some individuals do well in early adulthood but find it difficult to develop successful relationships and achieve economically. Others may struggle initially and then become resilient at a later stage. This necessitates longitudinal approaches.

As neglect constitutes the most prevalent form of CM (Sedlak et al., 2010; USDHHS, 2016) and the risk for untoward outcomes can be long lasting, the paucity of research on positive outcomes for this population is a serious limitation to the development of interventions. It is not known whether or not the existing body of literature on resilience relating primarily to sexual and physical abuse can be applied to these survivors. It is hoped that the present review will offer ideas and motivation for future research on adult resilience for survivors of child neglect.

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