Protective factors promoting resilience in the relation between child sexual victimization and internalizing and externalizing symptoms

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A B S T R A C T

Sexual victimization has been one of the most frequently studied forms of child victimization. Its effects are common and diverse; however, not all children and youth exposed to sexual victi- mization eventually develop adjustment problems. A total of 1105 children and youth (590 male and 515 female) aged between 12 and 17 from northeastern Spain were assessed regarding their experiences of sexual victimization, symptoms of psychopathology, and protective factors. The results showed that all forms of sexual victimization were associated with higher levels of emotional and behavioral problems. However, the presence of a low Negative Cognition, high Social Skills and high Confidence seem to act buffering internalizing problems. Additionally, a significant interaction between Sexual Victimization and low Negative Cognition was observed ($p < 0.5$), so that, low Negative Cognition was related to a lower risk of being in the clinical range for internalizing problems. Likewise, high scores on Empathy/Tolerance, Connectedness to School, Connectedness to Family and low Negative Cognition acted as promotive factors in re- lation to externalizing symptoms, in this case without any interaction effect. The strong re- lationship found with emotional and behavioral problems highlights the importance of con- tinuing the research on the protective factors underlying resilience in the relationship between sexual victimization and psychopathological symptoms. The findings also support the multi-di- mensional and specific nature of resilience and identify some of the protective factors that should be regarded as key intervention targets in adolescents with a history of sexual victimization.

1. Introduction

Over the past years, sexual victimization has been one of the most studied forms of child victimization and has emerged as one of the most serious problems affecting children and adolescents in our societies (Finkelhor, 2007). The effects of sexual victimization are common and diverse. In most cases, it negatively affects children's development and it can cause emotional, cognitive, social and/or sexual problems (see, for example, the review by Maniglio, 2009). Some studies have focused on assessing the adjustment problems associated with sexual victimization in children, youth and adults, but others have found that some survivors of sexual abuse do not exhibit these negative outcomes (Collishaw et al., 2007; Marriott, Hamilton-Giachritsis, & Harrop, 2014; McGloin & Widom, 2001).

These results have encouraged researchers to try to identify the protective factors that

determine these differences in the outcome of victimization and, above all, to describe the underlying mechanisms by which these factors can contribute to positive results (Luthar, Cicchetti, & Becker, 2000).

1.1. Sexual victimization and its effects on psychological adjustment

The concept of sexual victimization covers a range of sexual behaviors towards children and youth conducted under coercion, manipulation or use of violence, among them child sexual abuse (Finkelhor, 2007). Over a number of years, the extent of the problem has been confirmed through studies of prevalence and especially through meta-analyses, which have reported rates of sexual vic- timization ranging from 7.6% to 8.0% for boys and from 15% to 19.7% for girls (Barth, Bermetz, Heim, Trelle, & Tonia, 2012; Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, Van IJzendoorn, Euser & Bakermans-Kranenburg, 2011).

A wide range of empirical research indicates that sexual victimization has significant effects in both the short and the long term. It has been shown that sexual victimization may be associated with problems in different dimensions of the person during childhood and adolescence, and may also affect functioning in adulthood (Chen et al., 2010; Hillberg, Hamilton-Giachritsis, & Dixon, 2011; Maniglio, 2009). More specifically, research has found that sexual victimization can be related with a great variety of internalizing symptoms and disorders such as depression (Maniglio, 2010), anxiety and posttraumatic stress disorder (Lindert et al., 2014; Paolucci, Genuis, & Violato, 2001), obsessive-compulsive symptoms (Caspi et al., 2008), somatization (Paras et al., 2009), suicidal and self-injurious ideation and behavior (Klonsky & Moyer, 2008; Maniglio, 2011a) and interpersonal problems (including feelings of inadequacy, inferiority, or discomfort when interacting with others; Fergusson, Boden, & Horwood, 2008; Maniglio, 2009). Sexual victimization has also been associated with an increased risk of externalizing symptoms and disorders including substance abuse (Maniglio, 2011b), engagement in high risk sexual behavior (Arriola, Louden, Doldren, & Fortenberry, 2005), psychosocial impair- ment (Schaefer, Mundt, & Ahlers, 2012), aggressive behaviors and conduct disorder (Maniglio, 2014), negative beliefs and attitudes towards others (Maniglio, 2009) and other interpersonal problems (i.e., relationship difficulties and social dysfunction; Kendall- Tackett, 2002). It has also been associated with a higher risk of psychotic disorders, borderline personality and increased rates of revictimization (Bendall, Jackson, Hulbert, & McGorry, 2011; Fossati, Madeddu, & Maffei, 1999; Roodman, & Clum, 2001).

Therefore, the research findings confirm that sexual victimization has consequences for all areas of the victim's life and argue against the existence of a specific syndrome of sexual abuse (Browne & Finkelhor, 1986) encompassing all the emotional, cognitive and social problems related to the experience (Kendall-Tackett, Williams, & Finkelhor, 1993). They also suggest that sexual victi- mization should be considered as a general and non-specific risk factor in the development of psychopathological symptoms (Maniglio, 2009). In this regard, it is not possible to determine a characteristic group of symptoms or to establish a causal relation between sexual victimization and subsequent psychopathological symptoms; there are many variables related to the specific char- acteristics of the victimization in addition to the individual and psychosocial factors that may influence the development of psy- chopathology in victims (Luthar et al., 2000; Marriott et al., 2014).

1.2. Factors related to resilience

This heterogeneity in the outcome of child victimization (Rutter, 2007) suggests that not all children and young people eventually develop problems of social and individual adjustment. Indeed, one third or more of those who are sexually victimized in childhood are resilient and successfully overcome the experience without developing psychopathological symptoms (Collishaw et al., 2007; McGloin & Widom, 2001).

Resilience is defined as the phenomenon or mechanism through which some individuals present relatively good adaptation despite suffering risk experiences that would be expected to have serious sequelae (Rutter, 2007). This situation has promoted the research into possible protective factors that act by inhibiting the impact of other risk or vulnerability factors and enable the person to function adequately. Therefore, the characteristics of adversity, the person's resources, and their behavior or response are all relevant (Grych, Hamby, & Banyard, 2015).

In this respect, the ecological-transactional model is based on Bronfenbrenner's (1977) ecological theory to provide a conceptual framework for integrating the individual and environmental factors underlying resilience (Gartland, Bond, Olsson, Buzwell, & Sawyer, 2011; Luthar et al., 2000). In this model, the individual's context is conceptualized as multiple nested levels in which each level influences and is influenced by the others and in turn influences the children's development, so that each level of the environment contains risk and protection factors for the individual (Cicchetti & Lynch, 1993). In this sense, the current research suggests that three sets of factors are implicated in the development of resilience: (1) the attributes of children themselves, (2) aspects of their families, and (3) characteristics of their wider social environments (Luthar et al., 2000). In this regard, protective factors such as positive self-esteem, determination, sense of control or self-efficacy, processing of experiences, emotion regulation and control of thoughts and behavior (Afifi & MacMillan, 2011; Bogar & Hulse-Killacky, 2006; Cicchetti, 2013; Marriot et al., 2014; Wright, Crawford, & Sebastian, 2007), as well as internal locus of control, achievement orientation, empathy, optimism and autonomy (Afifi & MacMillan, 2011; Cicchetti, 2013; Theron & Theron, 2010) have all been identified to be relevant as protective factors of the individual domain. Regarding the family level, care and acceptance from the family, good family relationships and parental support are the prominent protective factors among survivors of sexual victimization (Bogar & Hulse-Killacky, 2006; Marriott et al., 2014). In the case of wider social environments, examples of protective factors include social support, commitment to school, positive peer relationships, safe neighborhoods and a stable situation with regard to housing and education (Afifi & MacMillan, 2011; Marriot et al., 2014).

In view of the above, the study of specific protective factors involved and the role that resilience can play in the relationship between sexual victimization and psychological consequences may determine the differences in the responses of individuals exposed to the same type of adverse experience.

1.3. Purpose of the present study

The purpose of the present study is to assess the role of individual, family, and social protective factors in the relationship between sexual victimization experiences and

internalizing and externalizing symptoms in adolescents. To do so, we directly assessed adolescents aged between 12 and 17 regarding their experiences of sexual victimization, symptoms of psychopathology and protective factors. Our research purposes were: (1) to determine the extent to which children and youth victims of sexual victimization present higher levels of psychological problems, both internalizing and externalizing, compared to non-victims of this experience; (2) to analyze what factors may be related to specific internalizing and externalizing symptoms; and (3) to explore the protective factors that may interact with sexual victimization in its relationship with maladjustment.

2. Method

2.1. *Participants*

The study sample comprised children and adolescents recruited from seven secondary schools in northeastern Spain. Participants in the study were aged between 12 and 17 years of age and were selected on the basis of their current educational grade. All the schools invited agreed to participate in the study. The participating schools were medium sized, with an average of 2000 students and located in neighborhoods from low, medium and high socioeconomic status, mainly in urban areas. The different classroom groups within each school were selected randomly. Students with cognitive and/or language difficulties were excluded (less than 1%), considering that this condition might undermine the validity of their responses to the assessment protocols. The final sample consisted of 1105 children and youth, 590 males and 515 females ($M = 14.52$, $SD = 1.76$). The main socio-demographic characteristics of the sample are shown in Table 1.

2.2. *Procedure*

This multicenter cross-sectional study was guided by the basic ethical principles of the Declaration of Helsinki in Seoul (World Medical Association, 2008) and by the Code of Ethics of the Catalan Psychological Association (COPC, 1989). It was also approved by the Institutional Review Board of the University of Barcelona (IRB00003099). The research complied with Article 13.1 of the 1996 Protection of Minors Act, which establishes the obligation to report any cases of children at risk detected during the study. The first step involved contacting the school principals in order to inform them of the purpose of the research and to request permission to carry out the study. Participants' parents or guardians were then informed and using the passive consent procedure, which facilitates

Table 1
Socio-demographic characteristics.

	Male		Female		Total	
	n	% %	*n*	%	*n*	
Age						
12–14	283	48.0	266	51.7	549	49.7
15–17	307	52.0	249	48.3	556	50.3
Marital status of parents						
Single/haven't lived together	1	0.2	5	1	6	0.5
Married or living together	482	81.7	398	77.3	880	79.6
Separated/divorced	92	15.6	95	18.4	187	16.9
Widower/widow	14	2.4	16	3.1	30	2.7
Parents' education						
No education or unfinished primary	2	0.3	0	0.0	2	0.2
Primary school	5	0.8	4	0.8	9	0.8
Secondary school	27	4.6	31	6.0	58	5.2
High school	65	11.0	60	11.7	125	11.3
Above high school	429	72.7	369	71.7	798	72.2
Do not know/refused to answer	62	10.5	51	9.9	113	10.2
Socio-economic status						
Low	7	1.3	9	1.9	16	1.6
Medium-low	38	7.2	30	6.4	68	6.2
Medium	70	13.3	65	13.9	135	13.6
Medium-high	180	34.1	171	36.7	351	31.8
High	233	44.1	191	41.0	424	42.7

the right of children to report their experiences of violence (Carroll-Lind, Chapman, & Raskauskas, 2011), they had the opportunity to withhold consent for their children to participate in the research. The adolescents themselves also gave their assent to participate. Fewer than 3% of the children did not have parental permission to participate or declined to take part. In early 2012, the instruments were applied in a classroom session through a paper/pencil assessment by two researchers trained in the bases of developmental victimology and in collecting data on violence against children (UNICEF, 2012). Participant's privacy when they completed the questionnaire was ensure at all times. Likewise, all researchers signed a confidentiality agreement.

2.3. Measures

2.3.1. Socio-demographics

For the purpose of this study, an ad hoc demographic information sheet was administered. Information was collected on age, gender, grade, and parents' marital status, occupation and educational level. An adaptation of the Hollingshead Index of socio- economic status (SES) (Hollingshead, 1975) was calculated based on these data. The information was collected because of the significant associations that have previously been reported between these variables and victimization experiences (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009).

2.3.2. Interpersonal victimization

The Juvenile Victimization Questionnaire (JVQ; Finkelhor, Hamby, Ormrod, & Turner, 2005) is a comprehensive questionnaire originally designed to measure different types of victimization among children and youth. The questionnaire was translated into Spanish and Catalan by the Research Group on Child and Adolescent Victimization (GReVIA) at the University of Barcelona. The Spanish version included 36 forms of victimization against children and youth across six general areas: Conventional Crime (9 items), Caregiver Victimization (4 items), Victimization by Peers and Siblings (6 items), Sexual Victimization (6 items), Witnessing and
Indirect Victimization (9 items), and Electronic Victimization (2 items) (Hamby & Finkelhor, 2001; Finkelhor et al., 2005). The good psychometric properties of the JVQ have been demonstrated in previous research ($\alpha = 0.80$ in Finkelhor et al., 2005). The Spanish adaptation has also shown its suitability for assessing child victimization (Pereda, Gallardo-Pujol, & Guilera, 2016). For the purpose of this study, we analyzed only those items referring to sexual victimization with physical contact (sexual abuse or assault by known adult [S1], sexual abuse or assault by unknown adult [S2] or by peer or sibling [S3], and forced sex, including attempts [S4]), and
without physical contact (flashing or sexual exposure [S5] and verbal sexual harassment [S6]). Participants were considered to have suffered sexual victimization when they answered *yes* to any of these six questions.

2.3.3. Psychopathology

The Youth Self-Report (YSR; Achenbach & Rescorla, 2001, translated by the Unit of Epidemiology and Diagnosis in Developmental Psychology of the Autonomous University of Barcelona) is a 119-item scale used to measure symptoms of psychopathology in the form of behavioral and emotional problems experienced during the last six months. It was designed as a self-report instrument for youth between 11 and 18 years of age. The YSR provides

information about two broadband scales of internalizing and externalizing symptoms and can also be organized into eight narrowband subscales (Anxious/Depressed, Withdrawn/Depressed, Somatic Com- plaints, Social Problems, Thought Problems, Attention Problems, Rule-breaking Behavior, and Aggressive Behavior). The YSR is a widely used measure that has demonstrated good test-retest reliability ($r = 0.82$) and internal consistency ($\alpha = 0.71–0.95$; Achenbach & Rescorla, 2001). In the present study, Cronbach's alpha coefficients were 0.86 for internalizing and 0.84 for externalizing problems. The dimensional structure of the YSR has also been confirmed cross-culturally in different countries (Ivanova et al., 2007).

2.3.4. *Counseling*

A further two questions regarding previous psychological treatment or counseling received by the adolescent were also included (i.e., 'Are you currently seeing a psychologist?' and 'Have you previously seen a psychologist?') in order to assess the relationship of this variable with maladjustment. Adolescents who responded *yes* to either of these questions were then asked for further information (i.e., the chief complaint and the age at which they began to see a psychologist).

2.3.5. *Resilience*

The Adolescent Resilience Questionnaire (ARQ; Gartland et al., 2011) is a questionnaire based on the ecological-transactional model of development and comprises 88 items and 12 scales measuring resilience in five domains: Self, which comprises the scales of Confidence ($\alpha = 0.82$), Emotional Insight ($\alpha = 0.60$), Negative Cognition ($\alpha = 0.73$), Social Skills ($\alpha = 0.70$), and Empathy/Tolerance ($\alpha = 0.38$); Family, which includes Connectedness ($\alpha = 0.84$) and Availability ($\alpha = 0.80$); Peers, including the scales of Connectedness ($\alpha = 0.76$) and Availability ($\alpha = 0.73$); School, comprising Supportive Environment ($\alpha = 0.78$) and Connectedness ($\alpha = 0.71$); and Community which includes Connectedness ($\alpha = 0.82$). The ARQ can identify adolescents who show deficits or poor engagement in all or some of these areas, and who may be vulnerable in the face of adversity. Items comprise statements answered on a five-point Likert response scale that ranges from 'Almost never' (1) to 'Almost always' (5). Higher scores indicate greater resilience. It should be noted that the Negative Cognition scale measures low tendency for worry, rumination, or pessimism, so that this variable has been dichotomized taking into account that 0 = High Negative Cognition, 1 = Low Negative Cognition. The ARQ was translated into Spanish and adapted by the Research Group on Child and Adolescent Victimization (GReVIA) at the University of Barcelona and it has shown acceptable psychometric properties in terms of reliability and validity (Guilera, Pereda, Paños, & Abad, 2015).

2.4. *Data analysis*

The association between lifetime sexual victimization with individual (gender, age) and family characteristics (siblings, marital status, SES) was assessed by the odds ratio (OR) and the corresponding 95% confidence interval. In this sense, age variable was dichotomized to fit the data provided by previous prevalence studies (including some general victimization surveys) and therefore to be able the compare the results with those formerly obtained (Cyr et al., 2013; Finkelhor, Shattuck, Turner, & Hamby, 2014). Since children and adolescents were clustered within schools, intraclass correlation coefficients were

computed for internalizing and ex- ternalizing YSR scores. In both cases, they reached values under 0.03, suggesting that the assumption of independence of observations for applying ordinary least squares method was met. Linear regression analyses were performed separately for internalizing and externalizing symptoms to determine whether they were associated a) with sexual victimization and b) with any particular protective factors. Individual and family characteristics were controlled for in these analyses, and the interaction effect between resilience and sexual victimization experiences in both types of symptoms was also explored. To this end, variables in the regression analyses were entered in three different blocks. In block 1, sexual victimization was entered into the model after first including the individual and family characteristics. In block 2, and in order to identify which factors that promote resilience contributed independently to YSR scores, counseling and all ARQ subscales were added to the model using the stepwise method. Each ARQ subscales were dichotomized using the 70th percentile as the cut-off for low and high scores. The 70th percentile was used instead of the top 15%, because it has been estimated that between 22% and 30% of people who were abused during childhood are resilient in adulthood (DuMont, Widom, & Czaja, 2007; McGloin & Widom, 2001). In this way, the cut-off has been established based on evidence from previous studies directly related to the construct assessed as well as taking into consideration that the ARQ questionnaire evaluates compe- tence and not risk, it has been considered more appropriate to establish a more flexible cut-off that may include a further number of subjects, with respect to a more restrictive one that can leave out subjects that in themselves present good scores on the factor related to resilience. Finally, in block 3, we entered the interaction terms between the experience of sexual victimization and the protective factors that were statistically significant in block 2. Potential problems related to multicollinearity between variables were examined by obtaining tolerance values for each predictor, all being larger than 0.10. Standardized coefficients, the associated statistical significance level, and adjusted R^2 are reported.

3. Results

3.1. *Demographic variables associated with sexual victimization*

From the total sample, 8.8% reported some form of sexual victimization during their lifetime (4.1% males and 14.2% females). Specifically, 3.3% report experiences of sexual victimization with physical contact (among which 36.36% gave from peers) and 6.2% of sexual victimization without physical contact (of which in 58.26% of cases the perpetrator was a peer). Sexual victims were compared to other adolescents with no sexual victimization experiences with respect to individual and family characteristics. Prevalence of sexual victimization was more common among females (*OR* = 3.90; 95% CI [2.42–6.28]) and more prevalent in children and youth in the age range of 15–17 years old (*OR* = 1.60; 95% CI [1.04–2.44]). Instead, analyses revealed no association between sexual victimization and family characteristics (i.e., siblings, marital status, SES). Sample characteristics comparing sexual victimization and no sexual victimization experiences are shown in Table 2.

3.2. *Protective factors related to internalizing and externalizing problems*

Children and youth victims of any sexual victimization showed a higher risk of being in the

clinical range for emotional and behavioral symptoms than those without these experiences of victimization. Specifically, of all adolescents with any sexual victi- mization, 33.3% were within the clinical range for internalizing symptoms and 24.2% for externalizing symptoms; the corresponding figures for adolescents without sexual victimization experiences were 13.2% and 10.9% respectively.

The regression analyses showed several main effects for internalizing problems (Table 3, model 1). Children and youth who experienced some form of sexual victimization, female, whose parents lived together, and those in psychological treatment or counseling showed higher levels of internalizing problems. Furthermore, factors such as Negative Cognition, Social Skills, Con- fidence, Empathy/Tolerance and Availability to Peers seem to act as promotive factors against internalizing problems. Additionally, the interaction between Sexual Victimization and Negative Cognition was statistically significant (Table 3, model 2). As can be seen in Fig. 1, the risk of being in the clinical range ($T \geq 64$) for internalizing problems was twice as high in children and youth with experience of sexual victimization than in those without. However, a low Negative Cognition was related to a lower risk of being in the clinical range for internalizing problems, both for children and youth who had not been victims of any sexual victimization (from 11.86% to 0.90%) and, to a greater extent, for those who reported some form of sexual victimization (from 29.89% to 1.15%).

Regarding externalizing problems, main effects were obtained for sexual victimization and age (Table 4, model 1): adolescents who experienced this type of abuse and older adolescents (i.e., 15–17 years old) presented higher levels of symptomatology. Ad- ditionally, regression analyses revealed several main effects related to resilience. High scores on the factors Empathy/Tolerance, Connectedness to School, Connectedness to Family and Negative Cognition were related to lower levels of externalizing symptoms. However, some statistically significant main effects were observed in the opposite direction, i.e., factors such as counseling and high scores on the Connectedness to Peers domain seem to act as risk factors. In model 2, no statistically significant interaction terms were found between sexual victimization and protective factors (Table 4).

Table 2
Sample characteristics for any form of sexual victimization and for no experience of sexual victimization.

	Sexual victimization (any form of victimization) ($n = 97$)		No experience of sexual victimization ($n = 1008$)		Association measures
	n	%	*n*	%	
Gender					
Male	24	4.1	566	95.9	χ^2 (1) = 35.08 ($p < 0.01$)
Female	73	14.2	442	85.8	OR = 3.90 95% CI [2.42–6.28]
Age					
12–14	38	6.9	511	93.1	χ^2 (1) = 4.70 ($p < 0.05$)
15–17	59	10.6	497	89.4	OR = 1.60 95% CI [1.04–2.44]
Siblings					
Yes	79	8.5	850	91.5	χ^2 (1) = 0.27 ($p = 0.60$)
No	18	10.2	158	89.8	OR = 1.16 95% CI [0.67–2.01]
Marital status of parents [a]					
Parents living together	71	8.1	809	91.9	χ^2 (1) = 2.86 ($p = 0.09$)
Parents not living together	26	11.6	199	88.4	OR = 1.50 95% CI [0.94–2.42]
Socio-economic status [a]					
Low	24	11.0	195	89.0	χ^2 (1) = 0.97 ($p = 0.33$)
High	68	8.8	707	91.2	OR = 0.78 95% CI [0.48–1.28]

Note. OR = odds ratio; CI = confidence interval.
[a] Marital status of parents and socio-economic status were dichotomized due to small sample sizes in some categories.

Table 3
Regression analyses between socio-demographics, sexual victimization and factors underlying resilience with the level of internalizing problems.

Variables	Model 1 Block 1: $R^2 = 0.076$ Block 2: Change $R^2 = 0.299$; $R^2 = 0.357$ *Beta*	Model 2 Block 3: Change $R^2 = 0.010$; $R^2 = 0.360$ *Beta*
Female	.149***	.156***
Siblings	−0.031	−0.027
Parents not living together	−0.079*	−0.089**
High Socio-economic status	−0.030	−0.034
15–17 age	0.005	0.006
Sexual Victimization (SV)	.116***	−0.190**
Low Negative Cognition	−0.252***	−0.232***
High Social Skills	−0.166***	−0.172***
Counseling	.172***	.173***
High Confidence	−0.126***	−0.132***
High Empathy/Tolerance	−0.105**	−0.098**
High Availability to Peers	−0.099**	−0.091**
SV x Gender		−0.073
SV x Marital status		0.050
SV x Negative Cognition		−0.104**
SV x Social Skills		0.049
SV x Counseling		0.017
SV x Confidence		0.025
SV x Empathy/Tolerance		−0.023
SV x Availability to Peers		−0.048

Note. SV = sexual victimization.
* $p < 0.05$.
** $p < 0.01$.
*** $p < 0.001$.

4. Discussion

Three main conclusions arise from the results of this study. First, children and youth who had reported experiences of sexual victimization present higher levels of psychological adjustment problems, both internalizing and externalizing. Second, the

results

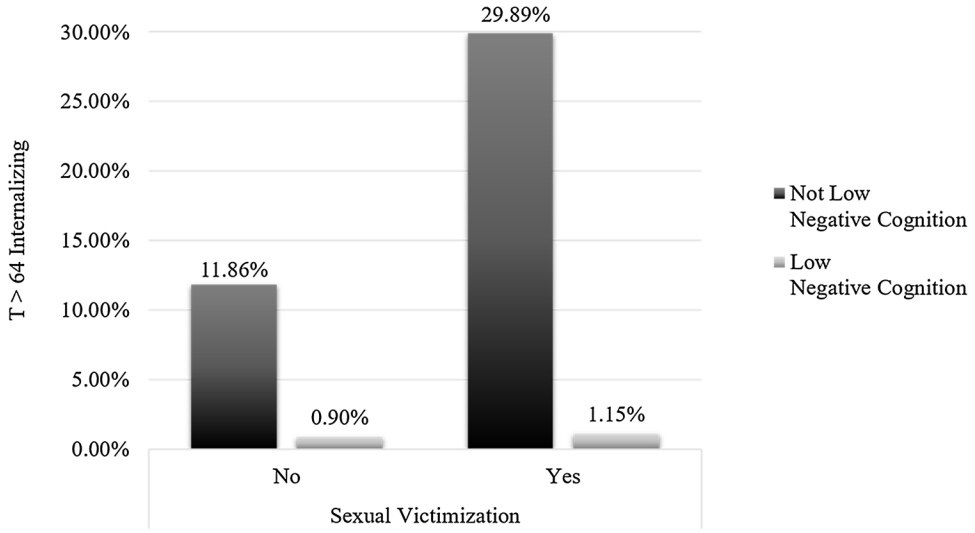

Fig. 1. Internalizing problems, taking into account sexual victimization and low Negative Cognition.

Table 4
Regression analyses between socio-demographics, sexual victimization and factors underlying resilience with the level of externalizing problems.

Variables	Model 1 Block 1: $R^2 = 0.061$ Block 2: Change $R^2 = 0.160$; $R^2 = 0.221$ *Beta*	Model 2 Block 3: Change $R^2 = 0.009$; $R^2 = 0.222$ *Beta*
Female	−0.040	−0.039
Siblings	−0.007	−0.008
Parents not living together	−0.005	−0.006
High Socio-economic status	0.004	0.003
Age 15–17	.093**	.113**
Sexual Victimization (SV)	.167***	.290***
High Empathy/Tolerance	−0.211***	−0.224***
Counseling	.177***	.178***
High Connectedness to School	−0.164***	−0.152***
High Connectedness to Family	−0.117**	−0.102**
Low Negative Cognition	−0.097**	−0.101**
Connectedness to Peers	.073*	.084*
SV x Age		−0.091
SV x Empathy/Tolerance		0.038
SV x Counseling		−0.018
SV x Connectedness to School		−0.056
SV x Connectedness to Family		−0.057
SV x Negative Cognition		0.014
SV x Connectedness to Peers		−0.031

Note. SV = sexual victimization.
* $p < 0.05$.
** $p < 0.01$.
*** $p < 0.001$.

identify different protective factors in different domains and for particular symptoms of psychopathology, supporting the multi- dimensional and specific nature of resilience. Third, the findings also suggest that low Negative Cognition is more protective against emotional and behavioral problems in victims of sexual victimization than in children and youth without these experiences of victimization.

4.1. Prevalence and characteristics of sexual victimization

Sexual victimization was a prevalent phenomenon in the sample, and seemed to be more frequent in females and in older youth. These findings are in agreement with previous studies from other countries using the same instrument, which have found higher rates of sexual

victimization in girls than in boys (Cyr et al., 2013; Finkelhor, Vanderminden et al., 2014; Radford, Corral, Bradley, & Fisher, 2013), as well as in adolescents in the older age group (Finkelhor, 2008). The same gender pattern has also been obtained in studies with young adults from the same country and geographical area (Pereda & Forns, 2007). Regarding the higher rate of sexual victimization in older adolescents, and considering the lifetime perspective applied in the present study, it is not surprising that the older participants are more likely to have experienced victimization due simply to their longer lives. It may also be the case that many child victims may not recognize themselves as such, due to cognitive and emotional processes (London, Bruck, Ceci, & Shuman, 2005).

In contrast to previous studies, no differences were found between sexual victims and non-victims with respect to family char- acteristics. Some studies have found that a higher number of children in the family is a risk factor for child victimization (Sedlak et al., 2010; Stith et al., 2009). Similarly, with regard to parents' marital status, nontraditional families have shown higher rates of child sexual victimization than traditional two-parent biological families (Black, Heyman, & Smith Slep, 2001; Finkelhor, 1980). On the other hand, in agreement with previous reports (Sedlak et al., 2010), we did not find an association between socio-economic status and sexual victimization.

4.2. The role of protective factors in relation to psychological maladjustment

Our results show that all forms of sexual victimization were associated with a more than twofold increase in the risk of being in the clinical range for internalizing and externalizing problems. These results are consistent with previous research into the negative effects of sexual victimization on psychological adjustment (Maniglio, 2009; Paolucci et al., 2001).

Our results also highlighted the importance of resilience in relation to emotional and behavioral problems. We observed similar factors to previous studies related to resilience that were most notably associated with the level of emotional problems: a lower tendency to worry, rumination, or pessimism; higher abilities in communication and relationships with others; and positive self- perception and optimism (Muris, Mayer, Reinders & Wesenhagen, 2011; Segrin & Flora, 2000). It should be noted, even so, that other factors like the ability to understand and empathize with others as well as the availability to peers were also relevant in explaining internalizing symptoms (Muris et al., 2011).

In the study of externalizing symptoms, we observed that factors associated with the Self domain, as the ability to empathize with others and a lower tendency to worry or pessimism, but also the Family domain, like the connection with the members of the family and the School domain, as the connection inside the school, were related to lower levels of behavioral problems (de Wied, Goudena, & Matthys, 2005; O'Connell, Boat, & Warner, 2009; Vanderbilt-Adriance et al., 2015). Interestingly, the Peer domain acted as a risk factor rather than as a promotive factor. This finding may be related to the identity of the perpetrator of the victimization, who in half the cases, tends to be a young person of the same age as the victim, most likely a peer. Previous studies suggest that the influence of peers is one of the most important environmental predictors of disobedience, classroom disruptions, behavior problems or substance use (Fortuin, van Geel, & Vedder, 2015; Rubin, Bukowsi, & Parker, 2006); it appears to be more pronounced during early adolescence (before the age of 15) and has a strong influence on the development of externalizing behaviors. Though social support undoubtedly offers advantages, peers may also affect adolescents' externalizing

problems, be it through the choice of friends who are similar to oneself with regard to important characteristics, including behavior problems (Burk, Steglich, & Snijders, 2007), or as deviancy training through mechanisms of socialization (Dishion & Dodge, 2005), or due to antisocial/delinquent peer associations, gang membership and/or peer rejection (Day & Wanklyn, 2012).

Moreover, specifically with regard to sexual victimization, we were able to determine which specific factors related to resilience have a protective character and are related to a lower risk of emotional and behavioural problems. This involved identifying not only the factors that are related to a lower likelihood of internalizing and externalizing symptomatology, but also the ones that are especially significant in cases of sexual victimization — that is, the factors that seem to offer special protection against internalizing or externalizing symptoms in sexually victimized children and youth. Low Negative Cognition in particular was found to be a relevant protective factor related to lower levels of internalizing problems, with a stronger relationship for children and youth with sexual victimization experiences, resulting in a reduction of up to 28 points in the risk of internalizing clinical symptoms. The literature on rumination, pessimism and tendency to worry shows that they are particularly associated with depression and anxiety symptoms, but also with posttraumatic stress symptoms, disturbing thoughts and other emotional problems (Garnefski, Kraaij, & Spinhoven, 2001; Muris et al., 2011). Indeed, according to cognitive theory (Beck, 1976) these thinking styles generally include negative beliefs and assessments about the self, the world, and the future which can be the key factor leading to depression. At the same time, negative beliefs about the self have also been related to anxiety as a behavior that may bias the processing of external stimuli (Beck & Clark, 1997). In the present study, low levels of negative cognition and rumination can be considered a protective factor related to resilience when facing internalizing problems arising from sexual victimization. This is especially important in children with a history of abuse, who are more likely to present negative cognitive styles and self-associations such as negative self-inferential styles, dysfunctional self-attitudes, and low self-worth (Gibb et al., 2001; Van Harmelen et al., 2010), so the interaction effect found seems to be especially relevant. Criminological research claim that violent behavior is very difficult to predict (Grantham, 2013). In fact, violence exists and unfortunately will continue to exist as part of human behavior, so perhaps the important thing is to work on identifying and in- tervening in protective factors to avoid or at least minimize their repercussions at a psychopathological level.

The psychological implications of child victimization have been well documented in the literature, and a significant association has been found between internalizing and externalizing symptoms and the likelihood of post-victimization exposure (Turner, Finkelhor, & Ormrod, 2010). Similarly, the fact that victimization does not affect everyone equally seems to be due to protective factors, which appear to have an impact on the direction or strength of this relationship. Fig. 1, for example, shows how the protective factor Negative Cognition seems to influence the outcome of psychological adjustment by decreasing, though not completely eliminating, the expected correlation between risk (sexual victimization) and outcome (internalizing symptomatology). So the re- lationship between risk and outcome is stronger when the protective factor is absent. These results appear to support the protective-reactive model described by Luthar et al. (2000).

On the other hand, the role of counseling in the results obtained in the present study should also be underlined. Limitations on our ability to measure this factor and the cross-sectional design of the present study mean that we cannot determine the direction of the relationship

between variables or demonstrate its effectiveness in buffering against psychopathological problems. Nonetheless, our study suggests that counseling seems to be associated with higher levels of psychopathology; in other words, children and youth who are in psychological treatment or counseling are the ones with the most emotional and behavioral problems. This apparent inverse association of counseling on young sexual victims it is not so contradictory, and only points out that individuals with more severe symptoms or those that present greater difficulties are those that tend to seek treatment or those to whom treatment is offered. That said, previous studies have suggested that psychological treatment and counseling are effective in reducing symptoms and improving functioning among different age groups and for many psychological and interpersonal problems (APA, 2012), especially in sexual victims (Trask, Walsh, & DiLillo, 2011).

4.3. Limitations

This study has a number of limitations. First, the cross-sectional approach used to obtain information prevents us from estab- lishing causal relationships between variables. However, the present study can be used as a guide to better understand the role of protective factors in the relationship between experiences of sexual victimization and maladjustment. Future longitudinal studies should focus on describing the underlying causal mechanisms by which protective factors can contribute to positive results. Second, the proportion of adolescents from families with high and medium-high socio-economic status was excessively high; this may have affected both the representativeness of the sample and the rates of victimization obtained. Third, the sample only included children who were attending school regularly. Although school attendance is compulsory in Spain until age 16, this feature of the design means that the representativeness of the sample, especially for older youth, is debatable. Likewise, children with cognitive/language difficulties (less than 1%) and those without parental consent or who refused to participate (3%) were not included in the study. Fourth, all the instruments administered were based on self-reports. Although self-reports can be problematic in terms of memory biases, especially considering that some abuses that occur during infancy and early childhood, prior to memory formation, may affect mental health outcomes at a later date and therefore may not be captured in this study (Norman et al., 2012), it is possible that parent or teacher reports may be even less impartial, especially in the case of parents in a study of sexual victimization (Chan, 2012). There is also evidence that parents and teachers may be less aware of the psychological distress of children and adolescents, particularly with regard to internalizing problems (Cantwell, Lewinsohn, Rohde, & Seeley, 1997). Finally, the counseling factor should be assessed in a more comprehensive way: it is necessary to consider other aspects such as the duration and type of treatment and the possibility of early withdrawal, and to include different sources of professional support (e.g., counselors, social workers) and not only ask about psychological support.

4.4. Implications and conclusions

Our results corroborate those of numerous previous studies which have reported a significant relation between sexual victimi- zation and a variety of problems in childhood. However, our findings also add to the evidence of a relationship between sexual

victimization, protective factors and psychopathology. In fact, we found that each type of psychopathology symptoms was more associated with a typical set of factors that promote resilience (Muris et al., 2011). Specifically, we found that resilience to internalizing problems seem to be related to personal factors, mainly low tendency for worry, rumination, or pessimism; whereas for externalizing problems, several factors from different domains were related to lower levels of psychological symptoms (i.e., regarding the self, especially empathy and tolerance capacity, but also with respect to the family and the school domain). So, although it is not possible to intervene on certain variables such as those related to the victimizer and the experience of victimization, results such as those found in the present study highlight that other variables related to the victim and his/her environment can be changed. In this sense, the identification of protective factors that promote resilience among victimized youth is an important topic with interesting implications for both future research and practice, making it necessary to consider some of the protective factors as key intervention targets in children and youth with a history of sexual victimization. In addition, the relationship between victimization characteristics regarding the perpetrator and the sexual abuse experience could be related specifically to different aspects of resilience that should be deeply analyzed in future studies. Nevertheless, we now need to focus on the mechanisms that might explain the role of the protective factors underlying resilience in the relationship between experiences of significant adversity and maladjustment or risk of psycho- pathology. One way of achieving this goal would be to empirically explore the possible role of resilience as a moderating or mediating variable in a causal longitudinal model. A better understanding of underlying mechanisms in the role of resilience related to sexual victimization will allow us to improve the treatment offered to these victims and will help to prevent subsequent psychological problems (Luthar et al., 2000).

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