Chapter Nine:
Fostering Resilience In Children and Youth

I. Lesson Plan

A. Purpose:
   1. Define and describe resilience.
   2. Identify strategies necessary to foster resiliency in children and youth.

B. Objectives:
   1. Understand risk, protective factors, and developmental assets, and their relationship to resilience.
   2. Identify and apply four basic steps to fostering resilience in children and youth.

C. Time: 45–60 minutes

D. Preparation/Materials Needed:
   ✪ Bounce Back Activity Materials

II. Training Session Content

A. PowerPoint Slides
   Slide 9-1: Chapter 9 Introduction Slide
   Slide 9-2: Resilience: Shifting Paradigms
   Slide 9-3: Understanding Risk Factors
   Slide 9-4: Definitions of Resilience
   Slide 9-5: The Grandmothers of Resilience: Emmy Werner and Ruth Smith
   Slide 9-6: Profile of Resilient Individual
   Slide 9-7: Profile of Resilient Individual (cont.)
   Slide 9-8: Protective Factors
   Slide 9-9: The 40 Developmental Assets
   Slide 9-10: Working Together: Protective Factors and Developmental Assets
   Slide 9-11: Four Steps to Fostering Resilience
   Slide 9-12: Step One in Fostering Resilience
   Slide 9-13: Step Two in Fostering Resilience
   Slide 9-14: Step Three in Fostering Resilience
   Slide 9-15: Step Four in Fostering Resilience
   Slide 9-16: Discussion Questions
B. Activity & Directions
   1. Bounce Back Activity
      • Trainer Tip: Be sure to thoroughly review activity instructions and prepare all materials prior to facilitating this activity.
      • Share instructions with group and facilitate activity as directed.
      • Process questions provided with large group at conclusion of activity.

III. Must-Read Background Material
   A. Fostering Resiliency in Children and Youth: Four Basic Steps for Families, Educators, and Other Caring Adults—Nan Henderson, MSW
   B. Resiliency Requires Changing Hearts and Minds—Bonnie Benard
   C. Fostering Resiliency in Kids: Protective Factors in the Family, School, and Community—Bonnie Benard
   D. The Children of Kauai: Resiliency and Recovery in Adolescence and Adulthood—Emmy Werner, Ph.D.
   E. 40 Developmental Assets—Search Institute
   F. Risk and Protective Factor Framework
   G. Fostering Resilience in Time of War—American Psychological Association
   H. Building Resilience in Children in the Face of Fear and Tragedy—Richard Gallagher, Ph.D., and Anna Chase
   I. Promoting Resilience in Military Children and Adolescents—Michael Faran, Mark Weist, Diane Faran, and Stephen Morris
   J. Bounce Back—Tom Jackson

IV. Evaluation
   A. Reflection Questions
      1. What did you learn in this discussion about fostering resilience with children and youth?
      2. How do children and youth deal with the deployment of a parent or loved one potentially at risk?
      3. What protective factors or developmental assets can provide support for dealing with the stress associated with the deployment of a parent or loved one?
   B. Application Questions
      1. How can we work together as a team to foster resilience in the lives of children and youth who are dealing with the deployment of a parent or loved one?
      2. How can we...
         • Communicate the resiliency attitude?
         • Focus on strengths?
         • Work toward building a wheel/web of support?
         • Demonstrate a never-give-up attitude?
      3. How can we foster our own resilience as a team to stay enthusiastic and motivated?
Chapter 9: Fostering Resiliency In Children and Youth

Operation: Military Kids
Ready, Set, Go! Training

Slide 9-1: Introduction Slide

Content of this slide adapted from: N/A

Materials Needed: N/A

Trainer Tips: See Must-Read Materials in this chapter for additional information to support slide content and group discussions.

What to Do, What to Say:

Do:  
• Review slide content with participants.
• Share purpose and objectives of this chapter.

Say:  The purpose of this chapter is to define and describe resilience and the strategies necessary to foster resilience in children and youth.

The objectives include: understanding risk, protective factors, and developmental assets, and their relationship to resilience. We will then identify and apply four basic steps to fostering resilience in children and youth.
Resilience: Shifting Paradigms

- From
  - Risk
  - Problem Solving
  - Pathology
  - Reactive
  - Deficiency
  - Competition
  - People as Problems
  - Authoritarian
  - Remedial

- To
  - Resiliency
  - Positive Development
  - Wellness
  - Proactive
  - Competency
  - Collaboration
  - People as Resources
  - Democratic
  - Empowerment

Content of this slide adapted from: N/A

Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:

Do:  
  • Review slide content with participants.
  • Emphasize the key point of discussion as described below.

Say:  Resilience is about building on an individual’s strengths rather than focusing on deficits.
Understanding Risk Factors

- Those conditions, attitudes, and behaviors that occur around and within communities, families, schools, teens, and their friends that increase the likelihood that individuals will have difficulty with school/work, the law, alcohol, and other drugs, violence, and abuse.

  From: Together We Can by Gibbs and Bennett

- What risk factors are present in the lives of children or youth dealing with the deployment of a parent or loved one?

Slide 9-3: Understanding Risk Factors

Content of this slide adapted from: Together We Can by Gibbs & Bennett. Bounce Back Activity adapted from More Activities That Teach by Tom Jackson, www.active-learning-site.com

Materials Needed: Instructions for Bounce Back Activity
One inflatable beach ball

Trainer Tips:
Simultaneously demonstrate and integrate the Bounce Back Activity into discussion of Chapter 9, slides 9-3 through 9-6. See Chapter 9 Must-Read Material for Bounce Back Activity details and instructions.

What to Do, What to Say:
Do:  • Review slide content with participants.
     • Encourage participants to respond to the following question.

Say:  What risk factors are present in the lives of children or youth dealing with the deployment or reintegration of a parent or loved one?

Do:  • Facilitate group brainstorming and record responses on flip chart paper.
Definitions of Resilience

• The capacity to spring back, rebound, successfully adapt in the face of adversity, and develop social, academic, and vocational competence despite exposure to severe stress or simply the stress that is inherent in today’s world.

  Nan Henderson, MSW

• The capacity to rise above adversity and to forge lasting strengths in the struggle. It is the means by which children/adults can rebound from hardship and emerge as strong, healthy individuals, able to lead gratifying lives, albeit with some scars to show for their experiences.

  Stephen and Sybil Wolin

• How do you think children and youth dealing with the deployment of a parent or loved one demonstrate their resilience?

Ready, Set, Go!

Slide 9-4: Definitions of Resilience


The Resilient Self by Steven and Sybil Wolin

Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:

Do: • Review slide content with participants.
  • Continue demonstration of Bounce Back Activity.
  • Encourage participants to respond to the questions below.

Say: What components of these definitions resonate with you and why?
Do:  • Facilitate group brainstorming and record responses on flip chart paper.

Say:  How do you think children and youth dealing with the deployment or reintegration of a parent or loved one demonstrate their resilience?
Slide 9-5: The Grandmothers of Resilience: Emmy Werner and Ruth Smith

Content of this slide adapted from: N/A

Materials Needed: N/A

Trainer Tips: Resilience is a research-based theory—see Chapter 9 Must-Read Materials for more information.

What to Do, What to Say:

Do:
• Review slide content with participants.
• Emphasize key points of discussion as described below.

Say: This is the first of many studies, and it is the one with the most longitude. It has taught us about this important perspective of resiliency and building on strengths. The results from Werner and Smith’s 30-plus year follow-up study indicate that 25% of those initially determined as being at-risk during adolescence and young adulthood were later labeled as resilient in their 30’s.
Slide 9-6: Profile of Resilient Individual: Social Competence and Problem Solving

Content of this slide adapted from: Fostering Resiliency in Kids: Protective Factors in the Family, School, and Community by Bonnie Benard. Portland, OR: Northwest Regional Educational Laboratory, 1991.

Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:

Do:  
- Review slide content with participants.
- Finish demonstration of Bounce Back Activity.
- Encourage participants to respond to the following question.

Say:  Have you witnessed any examples of the resilient characteristics identified on this slide being demonstrated by children and youth you encounter in your work?
Profile of Resilient Individual

- **Autonomy**
  - Strong sense of independence
  - Internal locus of control
  - Sense of personal power, self-esteem, and self-efficacy
  - Self-discipline
  - Impulse control
  - Ability to separate self from environment

- **Sense of Purpose**
  - Healthy expectancies
  - Goal-directedness
  - Success/achievement orientation
  - Persistence
  - Hopefulness
  - Hardiness
  - Sense of anticipation and compelling future

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**Slide 9-7: Profile of Resilient Individual: Autonomy and Sense of Purpose**

*Content of this slide adapted from:* Fostering Resiliency in Kids: Protective Factors in the Family, School, and Community by Bonnie Benard. Portland, OR: Northwest Regional Educational Laboratory, 1991.

**Materials Needed:** N/A

**Trainer Tips:** N/A

**What to Do, What to Say:**

**Do:**
- Review slide content with participants.
- Encourage participants to respond to the following question.

**Say:** Have you witnessed any examples of the resilient characteristics identified on this slide being demonstrated by children and youth you encounter in your work?
**Protective Factors**

- **Definition:** Conditions that buffer people from the negative consequences of exposure to risks by either reducing the impact of risks or changing the way a person responds to the risk by promoting positive behavior, health, well-being, and personal success.
  
  David Hawkins and Richard Catalano

- What protective factors can be made available to children and youth to help them cope with stress related to dealing with the deployment of a parent or loved one?

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**Slide 9-8: Protective Factors**

**Content of this slide adapted from:** Fostering Resiliency in Kids: Protective Factors in the Family, School, and Community by Bonnie Benard. Portland, OR: Northwest Regional Educational Laboratory, 1991.

**Materials Needed:** N/A

**Trainer Tips:** N/A

**What to Do, What to Say:**

**Do:**
- Review slide content with participants.
- Encourage participants to respond to the following question.

**Say:** What protective factors can be made available to children and youth to help them cope with stress related to dealing with the deployment or reintegration of a parent or loved one?
Slide 9-9: The 40 Developmental Assets

Content of this slide adapted from: The 40 Developmental Assets by Search Institute, www.search-institute.org

Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:

Do: • Review slide content with participants.
   • Encourage participants to respond to the following question.

Say: How can OMK state, regional, and local teams build on The 40 Developmental Assets in the work that they do?
Working Together: Protective Factors and Developmental Assets

Building Protective Factors
The Social Development Strategy: Framing Youth Assets

Healthy Behaviors

Healthy Beliefs & Clear Standards

Community
- Caring Neighborhood
- Religious Community
- Adult Role Models
- Safety

Family
- Family Support
- Positive Family Communication

School
- Bonding to School
- School Engagement
- Achievement Motivation

Individual/Peer
- Positive Peer Influence

Opportunities
- Other Adult Relationships
- Community Services
- Music, Art, Drama
- Sports, Clubs, Organizations
- Prosocial: Helping Others
- Youth Given Useful Roles
- Time at Home
- Parental Involvement
- Reading for Pleasure
- Homework

Recognize
- Community Values Youth
- Youths Given Useful Roles
- Caring School Climate
- High Expectations

Skills
- Personal Control
- Cultural Competence
- Family Boundaries
- Interpersonal Competence
- Non-Violent Conflict Resolution
- Planning and Decision-Making
- Resistance Skills

Individual Characteristics
- Personal Control
- Behavioral Restraint
- Self-Esteem

Adapted from (c) 2000 Developmental Research and Programs, Inc.

Slide 9-10: Working Together: Protective Factors and Developmental Assets

Content of this slide adapted from: Developmental Research Programs (2000)

Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:

Do:
- Review slide content with participants.
- Emphasize the key point of discussion as described below.

Say: It is important to remember that these two strategies can work together very effectively to support children and youth impacted by the deployment or reintegration of a parent or loved one.
Slide 9-11: Four Steps to Fostering Resilience


Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:

Do: • Review slide content with participants.
   • Emphasize key point of discussion as follows.

Say: The following slides will describe in more detail the four steps to fostering resilience.

Four Steps to Fostering Resilience

• Step One—Always communicate the “resiliency attitude.”
• Step Two—Focus on strengths with same or even greater meticulousness than used in characterizing weaknesses.
• Step Three—Build “Resiliency Wheel/Web” around each child/youth.
• Step Four—A Never Give Up! attitude.
Step One in Fostering Resilience:
Always Communicate the “Resiliency Attitude”

- Expressed verbally and nonverbally.
- “I see what is right with you no matter what has happened in the past, no matter what challenges/problems you face right now.”
- How can we communicate the “resiliency attitude” to children and youth we encounter who may be struggling with the deployment of a parent or loved one?


Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:

Do:  • Review slide content with participants.
     • Encourage participants to respond to the following question.

Say:  How can we communicate the “resiliency attitude” effectively to children and youth we encounter who may be struggling with the deployment or reintegration of a parent or loved one?
Step Two in Fostering Resilience:
Focus on strengths with same or even greater meticulousness than used in characterizing weaknesses.

- Honestly acknowledging problems/challenges.
- And…focus more prominently on individual strengths and positive supports! (Reframing)
- How can we build on strengths of children and youth dealing with deployment of parent or loved one?

Slide 9-13: Step Two in Fostering Resilience: Focus on Strengths


Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:
Do: • Review slide content with participants.
    • Encourage participants to respond to the following question.

Say: How can we build on the strengths of children and youth dealing with the deployment or reintegration of a parent or loved one?
Slide 9-14: Step Three in Fostering Resilience: The Resiliency Wheel


Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:

Do:  • Review slide content with participants.
     • Emphasize key point of discussion as follows.

Say:  In a few minutes you will have the opportunity to brainstorm and then share specific examples of how your team can build a resiliency wheel or web around children and youth in your own states, regions, local areas.
Step Four in Fostering Resilience: Never Give Up! attitude

- Resiliency is a lifespan process that ebbs and flows.
- Resiliency doesn’t happen by putting a kid through a program.
- Connection(s) with caring adults with high expectations and who offer opportunities for involvement create resilient children.
- How can we present a “Never Give Up!” attitude to children and youth dealing with the deployment of a parent or loved one?

Slide 9-15: Step Four in Fostering Resilience: Never Give Up!


Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:

Do:  • Review slide content with participants.
     • Emphasize key point of discussion as follows.

Say:  Developing just one connection with a caring adult is one of the most critical components to effectively fostering resilience with children and youth.

Do:  • Encourage participants to respond to the following question.

Say:  How can we present a ‘Never Give Up!’ attitude to children and youth dealing with the deployment of a parent or loved one?
Discussion Questions

• How can we work together as a team to foster resilience in the lives of children and youth who are dealing with the deployment of a parent or loved one?
  How can we...
  - Communicate the resiliency attitude?
  - Focus on strengths?
  - Work toward building a wheel/web of support?
  - Demonstrate a never-give-up attitude?

• How can we foster our own resilience as a team to stay enthusiastic and motivated?

Ready, Set, Go!

Slide 9-16: Discussion Questions

Content of this slide adapted from: N/A

Materials Needed: N/A

Trainer Tips: N/A

What to Do, What to Say:

Do: • Review slide content with participants.
    • Divide into small groups and have each identify a facilitator to support all participating in conversation.
    • Allow 15–20 minutes (minimum) to discuss questions on slide.
    • Upon completion, process general responses to questions with large group.

Say: What responses did your group have to the questions presented on the slide?

Do: • Check for group understanding.

Say: Are there any final comments or questions on this chapter?
“Where do I start in fostering resiliency in my children?” “What are the most important things to do?” “How long does it take?” “What if I only see them once a week (or once a month)?”

Parents and other family members, and educators and other helping professionals, all pose similar questions about resiliency. No one doubts that it is important, even crucial. Almost everyone agrees with my premise that resiliency—the capacity to spring back, rebound, successfully adapt in the face of adversity, and develop social, academic, and vocational competence despite exposure to severe stress or simply to the stress that is inherent in today’s world (Henderson & Milstein, 1996, p.7)—is needed by every child alive. Yet often feeling too stretched as it is, family members and helping professionals alike can’t imagine fitting one more thing into their already time-pressured interactions with children.

After reading dozens of resiliency-focused studies and books, and after talking with hundreds of kids about their resiliency, I have identified four basic steps to fostering resiliency in children and youth—steps that can be used by every adult, whatever their role in children’s lives.

The good news is this: To a large degree, fostering resiliency occurs by integrating certain attitudes and behaviors with kids into the interactions we already have with them. This is because fostering resiliency is a process that occurs first and foremost in relationships.

When I ask young people who and what contributed to their resiliency (as defined above), they always name individual people first...then go on to mention activities, opportunities, classes, or—occasionally—programs. Their relationships with the individuals they name are characterized by the following recommendation:

1. Always communicate “the resiliency attitude.” Fostering resiliency begins with an attitude, expressed verbally and nonverbally, that communicates, “I see what is right with you, no matter what you have done in the past, no matter what problems you currently face. Your strengths are more powerful than your ‘risks.’ And whatever risks, problems, and adversity you are facing are steps on the road to bouncing back—they are not the end of the road!”

The Resiliency Attitude is also one in which caring and support is expressed in as many ways as possible—in word and in deed. Listening with compassion, validating the pain of a child’s problems while conveying his or her ability to overcome, and providing thoughtful and nurturing gestures—great or small—are all part of this attitude. “She talks to me. She encourages me. She helps me a lot [with my baby]. She lends me money when I need it. She praises me. She tells me she is proud of me,” is how Loretta Dejolie (see “Faces of Resiliency” on page 175) described her mother—the embodiment of the resiliency attitude.

L.W. Schmick, now finishing his freshman year in college, described the attitude of the teacher he credits most with his resiliency in this way:

In my sophomore year, I had an English class with Brian Flynn...A lot of teachers when they see an “at risk” student, they automatically distrust and they don’t give them some of the responsibilities they would give other students. But Brian Flynn showed me respect and trust. He gave me a lot of power to take responsibility. He said, “If you want an inch, take an inch. If you want a mile, take a mile.” I wasn’t set apart as different. He saw me as just another person, not as an “at risk” student (Henderson, 1996a, p.30).

2. Focus on strengths with the same or an even greater meticulousness than you use in cataloging weaknesses. Steve Wolin (see interview with Benard on page 145) believes that focusing on strengths goes against human nature. I believe it would be easier to do if we lived in a strength-reinforcing culture (that is possible to create), which viewed discussing one’s capabilities and talents, goals, and achievements as positive. A part of this culture would be a good news-reporting media focused equally on all the ways people help, support, sacrifice for, and care for one another. Whether it is because of “nature or nurture”—that old debate!—all adults interacting with young people need training in focusing on strengths, in “cataloguing...capabilities with the exquisite concern we normally reserve for weaknesses” (Higgins, 1994, p. 320). I have used a process called the Resiliency Chart outlined in Figure 1 to train myself and others in identifying, reinforcing, nurturing, and using strengths in personal and professional interactions with children and youth.

The way The Resiliency Chart might look at two different points in one child’s life is diagrammed in Table 2 and Table 3. Last fall, I wrote about Juanita Corriz, a 15-year-old ninth grader in Santa Fe, New Mexico, who—after a two-year wait—was matched with a Big Sister, Sharyn Obsatz, when she was 14 (Henderson, 1996b). When I talked with Juanita, it became clear that her life has changed significantly for the better in the two years since she met Sharyn—that her strengths evident at age 12 have been nurtured, that others have emerged, and that many of the “risks” in her life have been mitigated by this growing list of positive personal and environmental characteristics.
Figure 1. The Resiliency Chart

For each particular child, draw a t-chart as shown below. On the left-hand side of the chart, list all the concerns—internal, in terms of the attitudes and behaviors of this child, and external, in terms of environmental risks and stressors—that you have about the child. Try to limit your list to a handful of the most pressing problems. On the right-hand side of the chart, list every positive you can think of both within this child and within his or her environment. Think in terms of attitudes, behaviors, personality characteristics, talents and potential talents, capabilities, and positive interests. Think also in terms of the child’s environment: List every person, place, organization, or structure that provides positive interaction and support for this child. Referring to Table 1, lists of individual and environment characteristics that facilitate resiliency, can help with this strength-identification process. Don’t limit you thinking, however, to these lists. Include anything you think of as a strength or positive support.

Child’s Name

<table>
<thead>
<tr>
<th>Problems/Challenges</th>
<th>Strengths/ Positive Supports</th>
</tr>
</thead>
</table>

Table 1. Individual and Environmental Characteristics that Facilitate Resiliency

<table>
<thead>
<tr>
<th>Individual Characteristics</th>
<th>Environmental Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Gives of self in service to others and/or a cause</td>
<td>1. Promotes close bonds</td>
</tr>
<tr>
<td>2. Uses life skills, including good decision-making, assertiveness, impulse control, and problem-solving</td>
<td>2. Values and encourages education</td>
</tr>
<tr>
<td>3. Sociability/ability to be a friend/ability to form positive relationships</td>
<td>3. Uses high warmth/low criticism style of interaction</td>
</tr>
<tr>
<td>4. Sense of humor</td>
<td>4. Sets and enforces clear boundaries (rules, norms, and laws)</td>
</tr>
<tr>
<td>5. Internal focus of control</td>
<td>5. Encourages supportive relationships with many caring others</td>
</tr>
<tr>
<td>6. Perceptiveness</td>
<td>6. Promotes sharing of responsibilities, service to others, “required helpfulness”</td>
</tr>
<tr>
<td>7. Autonomy/independence</td>
<td>7. Provides access to resources for meeting basic needs of housing, employment, health care, and recreation</td>
</tr>
<tr>
<td>8. Positive view of personal future</td>
<td>8. Expresses high, and realistic, expectations for success</td>
</tr>
<tr>
<td>9. Flexibility</td>
<td>9. Encourages goal-setting and mastery</td>
</tr>
<tr>
<td>10. Capacity for and connection to learning</td>
<td>10. Encourages prosocial development of values (such as altruism) and life skills (such as cooperation)</td>
</tr>
<tr>
<td>11. Self-motivation/initiative</td>
<td>11. Provides leadership, decision-making, and other opportunities for meaningful participation</td>
</tr>
<tr>
<td>12. Is “good at something”/personal competence</td>
<td>12. Appreciates the unique talents of each individual</td>
</tr>
<tr>
<td>13. Feelings of self-worth and self-confidence</td>
<td></td>
</tr>
<tr>
<td>14. Personal faith in something greater; spirituality</td>
<td></td>
</tr>
</tbody>
</table>

It is important to note that families often simultaneously contribute risks and strengths in a child’s life—a point almost entirely overlooked in the dysfunctional family model. In Juanita’s case, her mother is a high-school drop-out, who got pregnant as a teenager, and who survived for many years on welfare—and now works nights as a custodian to support her family. But this same mother communicates to her children by example and by word, “Make a better life for yourself.” Recognizing her own time limitations, she made the call to Big Brothers/Big Sisters that provided both Juanita and one of her younger brothers with mentors.

Two years later, as a result of weekly interactions with her Big Sister Sharyn whom Juanita describes as “a best friend...I’ve grown to love, who gave me the belief, ‘I’m going to try to do good because I know I can do good’” (p. 19). I would modify Juanita’s chart as shown in Table 3.

It is not possible, nor even desirable in preparing a child to successfully cope with life, to eliminate 100% of the risks, stresses, challenges in his or her life.

### Table 2. Juanita, age 12

<table>
<thead>
<tr>
<th>Problems/Challenges</th>
<th>Strengths/Positive Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Single-parent mom who must work every night, and who has several children to care for</td>
<td>1. Mom who gives message, “Become something better for yourself” and, recognizing her children’s need for more quality adult time, contacted Big Brothers/Big Sisters</td>
</tr>
<tr>
<td>2. No father in her life—has never know her dad</td>
<td>2. Example set by mom of getting off of welfare</td>
</tr>
<tr>
<td>3. Lots of unsupervised time on her hands</td>
<td>3. Oldest of four children, recognition that “I am a role model for the others”</td>
</tr>
<tr>
<td>4. Family history of many people—“including about 20 cousins”—not graduating from high school</td>
<td>4. “Required helpfulness” role (see Warner, 1996) in helping with younger children</td>
</tr>
<tr>
<td>5. Family history of poverty</td>
<td>5. Desire to do well in school</td>
</tr>
<tr>
<td>6. Struggling with some of her schoolwork</td>
<td>6. Very giving of self to mom and younger siblings</td>
</tr>
<tr>
<td></td>
<td>7. Sociability—outgoing, friendly, enthusiastic</td>
</tr>
<tr>
<td></td>
<td>8. Interest and ability in foreign languages</td>
</tr>
<tr>
<td></td>
<td>9. Insight about what she needs to do well</td>
</tr>
</tbody>
</table>

### Table 3. Juanita, age 15

<table>
<thead>
<tr>
<th>Problems/Challenges</th>
<th>Strengths/Positive Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delete #3 above</td>
<td>Add the following:</td>
</tr>
<tr>
<td>Delete #6 above</td>
<td>10. Weekly interaction for several hours with a Big Sister who conveys The Resiliency Attitude</td>
</tr>
<tr>
<td></td>
<td>11. A certain belief by Juanita that she will go to college</td>
</tr>
<tr>
<td></td>
<td>12. Over a 1.5 raise in G.P.A.</td>
</tr>
<tr>
<td></td>
<td>13. Increased time reading, due to Big Sister’s influence</td>
</tr>
<tr>
<td></td>
<td>14. Expansion of altruism to include goal of one day being a Big Sister herself.</td>
</tr>
</tbody>
</table>
What can be done, through interactions with family members and other caring adults, is to increase “the right-hand side of the chart” by focusing on and adding to strengths and environmental supports, which mitigate the impact of risk factors and stress. The balance is thereby shifted: The power of the risks and problems are reduced and the strengths—including talents, competencies, resiliency characteristics, and environmental supports—grow.

3. **Build a Resiliency Wheel around each child.** After communicating a resiliency attitude, after assessing and figuring out how to reinforce, nurture, and expand on strengths, the next step—which can happen simultaneously with the first two—is to build a web of resiliency-fostering environmental conditions around each child. This web is diagrammed in the The Resiliency Wheel shown in Figure 2. This wheel is in actuality a web of protection, support, and nurture of each child’s “self-righting tendency” (Werner & Smith, 1992) and capacity for resiliency. No child can have too many strands in his or her web and most today have far too few.

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**Figure 2. The Resiliency Wheel**

- **Provide Opportunities for Meaningful Participation**
- **Set and Communicate High Expectations**
- **Set Clear, Consistent Boundaries**
- **Teach “Life Skills”**
- **Increase Prosocial Bonding**
- **Provide Caring and Support**

Risk factor research, which encompasses hundreds of studies over several decades, (Hawkins, Catalona, & Miller, 1992) suggests three main strategies—elements one, two, and three of The Resiliency Wheel—for mitigating the impact of risk in the lives of children and youth, in effect moving them towards resiliency (Hawkins & Catalona, 1990). These are:

**Increase Bonding**—This involves increasing the connections between young people and resiliency-fostering peers and adults and between young people and any prosocial activity (such as sports, art, music, drama, community and/or school service, and reading and other learning).

**Set clear and consistent boundaries**—This involves the development and consistent implementation of family rules and norms, school policies and procedures, and community laws and norms. These expectations should be developed with input from young people, clearly communicated (in writing is ideal), and coupled with appropriate consequences that are consistently enforced. My experience as a clinical social worker working with families has shown me that often parents believe that their children know the family rules and what consequences to expect if they are broken, when in the children's minds there is no clarity or consistency about them. Recent experiences with groups of young people in schools has emphasized that here, too, kids often experience inconsistency and a laxness—which they complain to me about in our meetings!

**Teach “life skills”**—These include cooperation, healthy conflict resolution, resistance and assertiveness skills, communication skill, problem solving and decision making, and healthy stress management. When these skills are adequately taught and reinforced they help young people successfully navigate the perils of adolescence including resisting the use of cigarettes, alcohol, and other drugs (Botvin & Botvin, 1992), and successfully dealing with hurtful peer or adult behaviors.

The lifespan-focused resiliency research yields three additional steps (synthesized by Benard, 1991)—elements four, five, and six of The Resiliency Wheel—that are consistently shown to help young people “bounce back” from risk, stress, and adversity. These are

- **Provide caring and support**—This includes providing unconditional positive regard and encouragement. Because it is the most critical of all the elements that promote resiliency, it is shaded on The Resiliency Wheel. In fact, it seems almost impossible to successfully “overcome” adversity without the presence of caring. This caring does not necessarily have to come from biological family members—though that is ideal. Optimally, every child should have several adults he or she can turn to for help (Benson, Galbraith, & Espeland, 1994). Educational reformers are recognizing the criticalness of a caring environment as the foundation for academic success. Noddings (1988) notes, “It is obvious that children
will work harder and do things—even odd things like adding fractions—for people they love and trust” (p. 32).

- **Set and communicate high expectation**—This strategy means providing opportunities for problem solving, decision making, planning, goal setting, and helping others, and involves adults sharing power in real ways with children. This resiliency builder is also increasingly showing up in school change literature with expectations that teaching become more “hands-on,” curriculum more “relevant” and “real world,” and decision making site-based, actively involving all members of the school community (Cooper & Henderson, 1995).

One way that a family member or other concerned adult can use The Resiliency Wheel is by filling in the grid shown in Figure 3, The Resiliency Web, for each child. Again, the goal is to weave as many “strands” in each area, recognizing that due to an individual’s circumstances, most of the strands in one or several of the six elements of the Wheel may come from the family, or the school, or the community—rather than being equally distributed across each of these environments.

**Figure 3. The Resiliency Web**

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Prosocial Bonding</th>
<th>Clear, Consistent Boundaries</th>
<th>Life Skills Taught/Practiced</th>
<th>Caring and Support Provided</th>
<th>High Expectations Communicated</th>
<th>Opportunities for Meaningful Participation/Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the Family</td>
<td>By whom/what?</td>
<td>How?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In School</td>
<td>By whom/what?</td>
<td>How?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the Neighborhood</td>
<td>By whom/what?</td>
<td>How?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In the Community</td>
<td>By whom/what?</td>
<td>How?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Once this grid is complete, where should a parent or other adult start in making use of this information? Start where you see the greatest need and/or start wherever you can. Often, as in the case of teacher Brian Flynn, who guided L.W. Schmick and his peers through a community service project, one action will embody many of the elements of The Resiliency Wheel. It is important to recognize that there is no way to know just how much of this web is needed by any one individual to assure “shifting the balance” to a resilient outcome. Most resilient kids who have been studied didn’t have a strong web in their family, school, and community environments. Some have only a few strands in just a few places. So, start wherever you can, based on your assessment of what would help an individual child the most and based on available resources.

Children do need both quantity and quality of resiliency-fostering interactions. Yet, feeling they don’t have enough time to give, parents and other adults often underestimate the power of what they can do. As Higgins (1994) notes:

Several subjects in [my] study [of the resilient] strongly recommended that those of you who Touch the life of a child constructively, even briefly, should never underestimate your possible Corrective impact on that child...In fact, one of the strongest leitmotifs rippling through the interviews [I conducted with resilient survivors] was the reparative power of simple, open availability...Remember, too, that the surrogates [caring adults outside the immediate family] of the resilient were generally available for only small amounts of clock time, and some faded after a limited developmental exposure. Yet their positive impact persisted for life (pp. 324–325).

4. **Never Give Up!** Resiliency is a life-span process and it ebbs and flows throughout an individual’s life. Many resilient survivors of difficult childhood circumstances share how crucial persistence by caring people around them was to their ability to both become resilient and to maintain their resiliency. Leslie Krug, now 17 and nearing high school graduation from an alternative school, went through ninth grade in a traditional high school three times before succeeding on the fourth try in her alternative school. She, too, credits her mother as a major source of resiliency. “She just kept making me go to school. She wouldn’t let me drop out,” Leslie said in an interview last year. She reported that during years of skipping school and “hanging out” her mom got mad at her for her behavior but she never gave up on her. No matter what, her mom was “just always there” (Henderson, 1996c, p.13).

Phil Canamar’s story (Henderson, 1996d) shows how each of the four steps discussed in this article helped him change from a gang and drug-involved 16-year-old school dropout to a 19-year-old nearing high school graduation, and currently soliciting grants from companies such as Honeywell to help “multicultural youth.” Phil, too, had a single-parent mother who worked overtime to support her three children. He began getting into trouble in middle school when he experienced a void of caring, supportive adult interaction.
This void, he said, contributed to his gang involvement, which he initiated at a time when he said to himself, “No one is here for me. I’m sick of it.” He said “I turned toward the gang to find support” (p.14). Eventually, he dropped out of school and he ran away from home.

His life began turning around when he reconnected with Joe, a former male friend of his mother’s who had told him if he ever needed help to contact him. He eventually moved in with Joe and Joe's parents, all three of whom he considers his family. He reports that they give him love and care, support, and encouragement. Phil also contacted an alternative school he had heard about years before. On the day of his initial contact, the principal encouraged Phil to attend, telling him, “I know you are a good kid.”

“The structure of the school”—which is built around adult and student cooperative teams, experiential activities, identifying and nurturing strengths, finding real-world work placements as part of learning—“the environment here, and last—but not least—my teacher Kathryn who always [for several years] gave me encouragement to take it one day at a time,” (p.14) are the reasons Phil says he is still in school and working in a community agency writing grants to help other kids. His goal after graduation is to own his own video production company.

“Facilitating resiliency is more a matter of orientation than specific intervention,” writes Higgins (1994, p. 319), based on her study of resilient survivors of childhood trauma. It is clear that fostering resiliency doesn’t happen as a result of putting kids through a program, though many programs such as Big Brothers/Big Sisters, as well as families, provide the caring adults that provide this crucial “resiliency orientation.” A “resiliency orientation” something all caring adults, however and wherever they interact with children, can convey—through an attitude of optimism and encouragement, a focus on strengths, a commitment to weaving strands from The Resiliency Wheel into children’s lives, and persistence, for decades if necessary, in these approaches.

References


Resiliency Requires Changing Hearts and Minds

By: Bonnie Benard

Western Regional Center for Drug-Free Schools and Communities
Far West Laboratory for Educational R&D
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Judging from the positive response I’ve had to my document on resiliency published a year and a half ago, as well as from the growing number of recent books and articles incorporating this concept, I feel the need to address what I see as the fundamental issue of the “resiliency approach”—the shifting of our personal perspective, our paradigms, from a focus on risks and deficits to a focus on protection and strengths. My concern is that the movement toward resiliency—toward creating family, school, and community environments rich in the protective factors of caring, high expectations, and opportunities for meaningful participation—not dissolve into more add-on, quick-fix programs and strategies.

Systemic Change

The building of resilient kids is a long-term developmental process that involves systemic change—the fundamental altering of our human systems, including the family, the school, the neighborhood, community-based organizations, and the workplace to make each of these arenas supportive, caring, participatory climates for all involved persons. Fostering resiliency isn’t something we do to kids; it isn’t about teaching them “resiliency skills,” per se. Rather, protective-factor research has clearly shown us that the development of resiliency is the process of healthy human development that is based on and grows out of nurturing, participatory relationships grounded in trust and respect. If we as adults and preventionists are truly concerned with preventing problems like alcohol and other drug abuse, then it is imperative that we make our central vision and mission the creation of supportive relationships with youth and their families. Only then will we be helping to create what Garmezy calls a “protective shield” that helps children “withstand the multiple vicissitudes that they can expect of a stressful world” (1991).

Years of educational community research have documented that long-lasting, systemic change—change that is infused throughout the daily life of the school and community and not just a tacked-on program—begins with our beliefs, feelings, and attitudes. If we have the attitudes, we can easily learn skills and strategies; if we try to learn skills and strategies that don’t match our attitudes and values, we’ll drop them by the wayside. Consider this example from education: It is futile for a teacher to learn the logistics of creating cooperative learning groups in her classroom when she believes that kids need a competitive environment to be motivated or that only she has the expertise and right answers.
On the other hand, the belief that each child has talents and skills to share with others will encourage her to use a pedagogy like cooperative learning.

It is only when we change our paradigms—that is, our world view or the lens through which we see our work—that we will change our feelings, beliefs, and attitudes, and ultimately our behaviors and practices. To make the systemic changes in our schools, community-based organizations, and prevention programs that will foster resiliency in kids and families depends ultimately, then, on changing the hearts and minds of all those who work with them.

Paradigm Shifting

“Paradigm-shifting” is a concept appearing in the dialogue of several fields, especially organizational development. Probably 100 different terms describe paradigm-shifting. We can best summarize the resiliency perspective this way: Seeing people as resources, as experts in their own lives, as possessing innate mental health and well-being, instead of identifying and labeling them as problems. As Bill Lofquist so eloquently puts it: “If we were to use as a beginning point a new commitment to viewing and respecting young people as resources in all that we do—which incidentally would mean that we would also begin viewing and respecting all people as resources—we would create a new basis for shaping a shared vision and clear mission for youth opportunity systems” (1992).

If we are to shift our prevention paradigm to a resiliency focus, we have to let go of our preoccupation with risk and risk factors as the research base guiding our planning and evaluation efforts. Solutions do not come from looking at what is missing; solutions will come by building on strengths. While several approaches to prevention programming try to combine a risk- and protective-factor approach, I believe that these are two incompatible paradigms for change. Individuals cannot simultaneously hold on to two competing paradigms; we cannot simultaneously see the proverbial glass as both half-empty and half-full. Thomas Kuhn, who coined the paradigm-shift concept 30 years ago in his book *The Structure of Scientific Resolutions*, discusses it as requiring a “transformation of vision” that “cannot be made a step at a time, forced by logic and neutral experience. Like a gestalt switch, it must occur all at once or not at all” (1962, p. 149). The shift is born out of “flashes of intuition” or like “scales falling from one’s eyes.”

As change agents, we have to focus on what works, on what we’ve learned from longitudinal research about what protects kids living in high-risk environments, on what we’ve learned from programs that have successfully reduced problems such as alcohol and other drug abuse, teen pregnancy, and school failure. As Werner and Smith state in their recent book *Overcoming the Odds: High Risk Children from Birth to Adulthood*: “Our findings and those by other American and European investigators with a life-span perspective suggest that these buffers make a more profound impact on the life course of children who grow up under adverse conditions than do specific risk factors or stressful life events. They appear to transcend ethnic, social class, geographical, and historical boundaries.
Most of all, they offer us a more optimistic outlook than the perspective that can be gleaned from the literature on the negative consequences of perinatal trauma, caregiving deficits, and chronic poverty. They provide us with a corrective lens—an awareness of the self-righting tendencies that move children toward normal adult development under all but the most persistent adverse circumstance" (1992, p. 202).

This quote provides two critical rationales for the resiliency paradigm. First, we know that the protective factors of caring relationships, high expectations, and opportunities for meaningful participation are more powerful than risk factors and serve to protect kids across ethnic, social class, geographical, and historical boundaries. Second, a resiliency paradigm offers us, as change agents, hope and optimism, which can also prevent burn-out. We know, all too well, the power of negative expectancies to become negative outcomes. We also know how negative expectancies result in high levels of burn-out among teachers and other human service workers. In a discussion of paradigm-shifting in *The Seven Habits of Highly Effective People: Powerful Lessons in Personal Change*, Stephen Covey sees positive expectancies toward others as a “self-renewing” process: “What do we reflect to others about themselves? And how much does that reflection influence their lives? We have so much we can invest in the emotional bank accounts of other people. The more we can see people in terms of their unseen potential, the more we can use our imagination rather our memory, with our spouse, our children, our co-workers or employees. We can refuse to label them—we can ‘see’ them in new fresh ways each time we’re with them. We can help them become independent, fulfilled people capable of deeply satisfying, enriching, and productive relationships with others” (1989, p. 301).

Moreover, as researcher Martin Seligman explains in his recent book focused on his paradigm shift from studying learned helplessness to learned optimism (*Learned Optimism: How to Change your Mind and Your Life*), optimistic people “do better in school, win more elections, and succeed more at work than pessimists do. They even seem to lead longer and healthier lives!” (1990, p. 96–97).

A third related rationale I will propose is that a risk-factor approach itself can become a risk factor. While labeling is noticeably absent from most lists of risk factors, an enormous body of research has documented the deleterious effects of programs that label and track kids. (See the related article on children of alcoholics and resiliency, Page 6.) Yes, we try to talk about high-risk environments, but we still end up with programs for high-risk kids, families, schools, and communities. We end up with programs that perhaps further “blame the victim” and further stigmatize disenfranchised populations.

Furthermore, the labeling process is clearly a demotivator to change. For change to happen, people have to have a sense of self-efficacy. They have to believe and have hope that they have the strengths and the abilities to make positive changes. A risk-factor approach that sees the “half-emptiness” of kids, families, schools, and communities can only further entrench feelings of “internalized oppression”
that disenfranchised groups in our country already face. As community development specialist John McKnight explains: “Our greatest assets are our people. But people in low-income neighborhoods are seldom regarded as ‘assets.’ Instead, they are usually seen as needy and deficient, suited best for life as clients and recipients of services. Therefore, they are often subjected to systematic and repeated inventories of their deficiencies with a device called a ‘needs survey.’ The starting point for any serious development effort is the opposite of an accounting of deficiencies. Instead there must be an opportunity for individuals to use their own abilities to produce. Identifying the variety and richness of skills, talents, knowledge, and experience of people in low-income neighborhoods provides a base upon which to build new approaches and enterprises” (1992, p. 10).

**Beyond Therapy**

Educator and writer Herb Kohl also provides us with a clear challenge to move from a risk to a resiliency paradigm: “Although I’ve taught in East Harlem, in Berkeley, and in rural California, I have never taught an at-risk student in my life. The term is racist. It defines a child as pathological, based on what he or she might do rather than on anything he or she has actually done. It is a projection of the fears of educators who have failed to educate poor children. Rather than define children as ‘at risk’ it would be educationally and socially more effective to join with community members and fight to eliminate poverty. Standing with the community is one strong way of showing children that their teachers care and are willing to take risks for them, instead of dubbing them ‘at risk’” (Nathan, 1991, p. 679).

Similarly, in her latest book, Anne Wilson Schaef argues for moving from a mechanistic scientific paradigm to an empowering participatory paradigm. Beyond Therapy, Beyond Science: A New Model for Healing the Whole Person challenges all helping professionals to examine their underlying paradigm: “Are psychologists and others in the helping professions open to ask, ‘Is the unspoken world view that underlies the assumptions in the way I practice my profession perhaps, unwittingly, contributing to the very problems that I am committed to help solve’? If we are not open to struggling with this question and articulating our assumptions, we are, indeed, part of the problem” (1992, p. 227).

The challenge to us as preventionists, then, is to look within ourselves, examine our personal lenses, reflect on our practices, discuss our beliefs, values, and feelings with others, and listen to the kids and families we work with. Finally, we have to let go of prior negative beliefs and assumptions.

“Change—real change—comes from the inside out. It doesn’t come from hacking at the leaves of attitude and behavior with quick-fix personality ethic techniques. It comes from striking at the root—the fabric of our thought, the fundamental, essential paradigms, which give definition to our character and create the lens through which we see the world” (Covey, 1989, p. 317). Moving
to a resiliency approach requires a personal transformation of vision. Creating positive changes in ourselves requires a context characterized by caring relationships, mutual respect, and active participation.

Inside-out change means that we take care of ourselves, that we love and accept ourselves. This message resounds through the anthology Healers on Healing: “The best thing therapists, whether medical or psychological practitioners, can do to help their clients the most is to love themselves. When therapists really love who they are, it’s easy for them to teach that love to their clients...When we’re willing to love and accept ourselves, we can make changes” (Hay, 1989, p. 23).

References

Fostering Resiliency in Kids: 
Protective Factors in the Family, School, and Community

By: Bonnie Benard

Western Regional Center Drug-Free Schools and Communities

The field of prevention, both research and practice, came a long way in the 1980s: from short-term, even one-shot, individual-focused interventions in the school classroom to a growing awareness and beginning implementation of long-term, comprehensive, environmental-focused interventions expanding beyond the school to include the community. Furthermore, in the mid-1980s we finally started to hear preventionists talking about prevention strategies and programs based on research identifying the underlying risk factors for problems such as alcohol and other drug abuse, teen pregnancy, delinquency and gangs, and dropping out (Hawkins, Lishner, and Catalona, 1985). While certainly a giant step in the right direction, the identification of risks does not necessarily provide us with a clear sense of just what strategies we need to implement to reduce the risks. More recently, we are hearing preventionists talk about “protective factors,” about building “resiliency” in youth, about basing our strategies on what research has told us about the environmental factors that facilitate the development of youth who do not get involved in life-compromising problems (Benard, March 1987). What clearly becomes the challenge for the 1990s is the implementation of prevention strategies that strengthen protective factors in our families, schools, and communities. As Gibbs and Bennett (1990) conceptualize the process, we must “turn the situation around...by translating negative risk factors into positive action strategies” which are, in essence, protective factors. After a brief overview of the protective factor research phenomenon, this paper will discuss the major protective factors that research had identified as contributing to the development of resiliency in youth and the implications of this for building effective prevention programs.

Protective Factors: A Research Base for the Prevention Field

Historically, the social and behavioral sciences have followed a problem-focused approach to studying human and social development. This “pathology” model of research traditionally examines problems, disease, illness, maladaptation, incompetence, deviance, etc. The emphasis has been placed on identifying the risk factors of various disorders like alcoholism, schizophrenia and other mental illnesses, criminality, delinquency, etc. These studies have been retrospective in design, that is, they do a one-time historical assessment of adults with these existing identified problems, a research design that can only perpetuate a problem perspective and implicate an inevitability of negative outcomes. Furthermore, the data yielded from such research studies have ultimately been of only limited value to the prevention field, concerned as it is with building health-promoting,
not health-compromising, behaviors and with facilitating the development of social competence in children and youth. According to Garmezy, this pathology model of research has “provided us with a false sense of security in erecting prevention models that are founded more on values than facts” (in Werner and Smith, 1982).

This retrospective research approach even became problematic for investigators focused on studying risks for the development of “problem behaviors,” for they were stymied by the issue of whether abnormalities in people already diagnosed as schizophrenic, criminal, or alcoholic were the causes or consequences of schizophrenia or alcoholism (for example, is the lack of problem-solving skills usually found in adult alcoholics a cause or a result of drinking?) Consequently, with the exception of a couple of earlier studies, beginning in the late 1950s and on into the 1960s and 1970s, a few researchers decided to circumvent this dilemma by studying individuals postulated to be at high risk for developing certain disorders—children growing up under conditions of great stress and adversity such as neonatal stress, poverty, neglect, abuse, physical handicaps, war, and parental schizophrenia, depression, alcoholism, and criminality. This risk research, therefore, used a prospective research design which is developmental and longitudinal, assessing children at various times during the course of their development in order to better understand the nature of the risk factors that result in the development of a disorder.

As the children studied in these various longitudinal projects grew into adolescence and adulthood, a consistent—and amazing—finding emerged: While a certain percentage of these high-risk children developed various problems (a percentage higher than in the normal population), a greater percentage of the children became healthy, competent young adults. For example, Manfred Bleuler found that only 9 percent of children of schizophrenic parents became schizophrenic, while 75 percent developed into healthy adults. He found “remarkable evidence of strength, courage, and health in the midst of disaster and adversity” (in Watt, 1984). Similarly, Michael Rutter’s research on children growing up in poverty found “that half of the children living under conditions of disadvantage do not repeat that pattern in their own adult lives” (Garmezy, 1991). And, according to the often quoted statistic, while one out of four children of alcoholic parents develops alcohol problems, three out of four do not. And in the 1980s, researchers in the collaborative, international, interdisciplinary Risk Reduction Consortium reported the same phenomenon in their ongoing prospective, longitudinal research—children who somehow are “invulnerable,” “stress-resistant,” “hardy,” “ego-resilient,” “invincible,” and, the most current popularly used term, “resilient,” in spite of severe stress and adversity.

The above finding, along with the increasing theoretical acceptance in the child development field of the transactional-ecological model of human development in which the human personality is viewed as a self-righting mechanism that is engaged in active, ongoing adaptation to its environment (see Bronfenbrenner, 1974), has resulted in a growing research interest in moving beyond the
identification of risk factors for the development of a problem behavior to an examination of the “protective” factors, those “traits, conditions, situation, and episodes, that appear to alter—or even reverse—predictions of [negative outcome] and enable individuals to circumvent life stressors” (Segal, 1986; Garmezy, 1991). The importance of this research to the prevention field is obvious: If we can determine the personal and environmental sources of social competence and wellness, we can better plan preventive interventions focused on creating and enhancing the personal and environmental attributes that serve as the key to healthy development. “Ultimately, the potential for prevention surely lies in increasing our knowledge and understanding of reasons why some children are not damaged by deprivation” (Garmezy and Rutter, 1983).

While researchers have commonly categorized protective factors falling within the domains of individual personality attributes or dispositions, family characteristics, and environmental influences (i.e., peers, school, and community), the discussion here will begin with a profile of the resilient child (as opposed to the “protective factors within the personality system”) and then will examine the protective factors consistently found in the family, the school, and the community arenas. In order to avoid falling into the pathology paradigm and “blaming the victim” syndrome with its concomitant focus on “fixing kids,” our perspective is that personality and individual outcomes are the result of a transactional process with one’s environmental contexts—families, schools, and communities that, in turn, reinforce positive behaviors.

Profile of the Resilient Child

A phrase occurring often in the literature sums up the resilient child as one who “works well, plans well, loves well, and expects well” (Gamezy, 1974; Werner and Smith, 1982). Since this is a little too abstract for most researchers, the following more specific attributes have been consistently identified as describing the resilient child.

Social Competence

This commonly identified attribute of resilient children usually includes the qualities of responsiveness, flexibility, empathy and caring, communication skills, a sense of humor, and any other prosocial behavior. Resilient children are considerably more responsive (and can elicit more positive responses from others), more active, and more flexible and adaptable even in infancy (Werner and Smith, 1982; Demos, 1989). Furthermore, a great number of resilient children have a sense of humor, that is, they have the ability to generate comic relief and find alternative ways of looking at things as well as the ability to laugh at themselves and ridiculous situations (Masten, 1986). As a result, resilient children—from early childhood on—tend to establish more positive relationships with others, including friendships with their peers (Berndt and Ladd, 1989; Werner and Smith, 1982).

Not only do most studies on resiliency document these attributes, but studies done on individuals already experiencing problems with crime, delinquency, alcohol and other drug abuse, and mental illness consistently identify the lack
of these qualities. According to Trower, “One of the few facts that emerges clearly in the beleaguered field of mental health is the extent of poor social skills in psychiatric patients. The studies and surveys show skills problems to be a major component in schizophrenia, mental handicap, depression, social anxiety, addiction disorders, psychopathology, childhood and adolescent problems... There is evidence, too, that individuals with the poorest social competence have the worst prognoses and highest relapse rate, and childhood competence level is predictive of severity of adult psychiatric problems” (1984; also see Kellam, 1982; Hawkins et al., 1985; Austin, 1991; Lerner, 1984).

Problem-Solving Skills
These skills include the ability to think abstractly, reflectively, and flexibly and to be able to attempt alternate solutions for both cognitive and social problems. As with social competence, studies on adults experiencing psychosocial problems have also consistently identified their lack of problem-solving skills (Shure and Spivack, 1982). And conversely, studies on resilient children repeatedly find the presence of problem-solving skills. For example, Rutter found especially prevalent in the population of abused and neglected girls who later became healthy adults the presence of planning skills that resulted in their planning marriages to nondeviant men (1984). The literature on “street” children growing up in the slums of the United States and other countries provides an extreme example of the role these skills play in the development of resiliency since these children must continually successfully negotiate the demands of their environment or not survive (Felsman, 1989).

Furthermore, as with social competence, research on resilient children has discovered that these problem-solving skills are identifiable in early childhood. According to Halverson and Waldrup’s research on pre-schoolers, “A child who can demonstrate at an early age that he or she is an agent capable of producing change in a frustrating situation tends to be active and competent in grade school as well” (1974).

Autonomy
Different researchers have used different terms to refer to autonomy. For example, Anthony refers to a “strong sense of independence” (1987); Garmezy and Werner and Smith to an “internal locus of control” and “sense of power” (1974 and 1991; 1982); Rutter and Garmezy to “self-esteem” and “self-efficacy” (1984; 1983); and others to “self-discipline” and “impulse control.” Essentially, the protective factor researchers are talking about is a sense of one’s own identity and an ability to act independently and exert some control over one’s environment.

Several researchers have also identified the ability to separate oneself from a dysfunctional family environment—“to stand away psychologically from the sick parent”—as the major characteristic of resilient children growing up in families with alcoholism and mental illness (Anthony, 1974). According to Berlin and Davis, “In our work with children and families of alcoholics we have begun to view the crucial task that they must master, if they are to cope...
successfully with the dilemmas of alcoholism, as the task of adaptive distancing,”
the process of breaking away from the family focus on the dysfunctional behavior
(1989; also see Chess, 1989). Similarly, Beardslee and Podorefsky found that
the resilient children they studied “were able to distinguish clearly between
themselves and their own experiences and their parents’ illness” and, thus,
realized they were not the cause and that their future would be different (1988).

The task of adaptive distancing, according to Wallerstein’s study of children
successfully dealing with their parents’ conflict and divorce, involves two
challenges: (1) to disengage enough from the centrifugal pull of parental
distress to maintain pursuits and satisfactions in the outside world of peers,
school, and community and (2) to “remove the family crisis from its commanding
position in [the child’s] inner world” (1983). Chess states: “Such distancing
provided buffer that was protective of developmental course, of self-esteem,
and of ability to acquire constructive goals” (1989).

Sense of Purpose Future
Related to a sense of autonomy and self-efficacy and the belief that one can have
some degree of control over one’s environment is another characteristic of
resilient children—a sense of purpose and future. Within this category fall
several related attributes invariably identified in the protective factor literature:
healthy expectancies, goal-directedness, success orientation, achievement
motivation, educational aspirations, persistence, hopefulness, hardiness, belief in
a bright future, a sense of anticipation, a sense of a compelling future, and a sense
of coherence. This factor appears to be a most powerful predictor of positive
outcome.

According to Brook et al.’s research on risk and protective factors for adolescent
alcohol and drug use, high achievement orientation appeared to have a protective
influence which even offset the effects of alcohol consumption by peers, the
most commonly identified influential risk factor (1989). Furthermore, Newcomb
and Bentler found that “educational aspirations” were an even more powerful
predictor of high school graduation than actual academic achievement (1986).

Cameron-Bandler’s research into why some children of alcoholics developed
into healthy, successful adults identifies the critical variable as their “sense of a
compelling future.” As she explains, “When a compelling future is generated,
we are easily persuaded to subordinate immediate gratification for a more
fulfilling later gratification, or to save ourselves from some intensely unpleasant
future experience” (1986). Similarly, Marian Wright Edelman concludes, from
the Children’s Defense Fund’s ongoing adolescent pregnancy prevention
initiative, that “a bright future is the best contraceptive!”

Werner and Smith also validate the power of this attribute in summarizing their
35-year study of resiliency in childhood: “The central component of effective
coping with the multiplicity of inevitable life stresses appears to be a sense of
coherence, a feeling of confidence that one’s internal and external environment is
predictable and that things will probably work out as well as can be reasonably expected” (1982). According to these researchers, this sense of coherence, of purpose and meaning and hopefulness, lies in direct contrast to the “learned helpfulness” that Seligman and others have consistently found present in individuals experiencing mental and social problems (1982). Furthermore, a Club of Rome study of several years ago identified that a sense of anticipation, the taking “responsibility for our ability to influence—and in some cases, determine—the future” is one of the traits that not only is essential to individual success but will be a trait essential for human survival in the increasingly complex world of the future (Botkin et al., 1979).

While research also ascribes a few other characteristics to resilient children (i.e., good health or being female), theabove attributes of social competence, problem-solving skills, autonomy, and sense of purpose appear to be the common threads running through the personalities of resilient children, those who “work well, play well, love well, and expect well”—no matter their health or sex status. Now let’s look at the environments of resilient children, at the protective characteristics within the family, the school, and the community systems that appear to facilitate the development of resiliency in youth.

What must be kept in mind in this discussion is that resiliency or protective factor research, by definition, is studying children and youth that experience major stress, adversity, and risk in one or more of these environmental systems. Therefore, if a child’s major risks lie in the family system, such as growing up in an alcoholic, abusive, or schizophrenic home, many of the factors identified as protective will derive from the school or community environments. Likewise, when a child’s major risks come from the community system—usually the condition of living in poverty as over one-fourth of the children in the United States now do—protective factor research has usually examined the role that the family and school systems play in the development of resiliency. Of course, given the self-righting nature of human systems, researchers have also identified strengths and protective attributes even within environments characterized overall by great risks. Unfortunately, according to Werner, “Most studies of vulnerable children have defined risk at only one level of organization [i.e., system]. Data analyses that explore the interplay among multiple risks and protective factors at all three levels—the individual organism, the immediate family, and the larger social context—are still rare” (1990).

**Protective Factors Within the Family**

What clearly emerges as a powerful predictor of the outcome for children and youth is the quality of the immediate caregiving environment, which is determined by the following characteristics.

**Caring and Support**

What is evident from nearly all the research into the family environments of resilient children is that, “despite the burden of parental psychopathology,
family discord, or chronic poverty, most children identified as resilient have had the opportunity to establish a close bond with at least one person [not necessarily the mother or father] who provided them with stable care and from whom they received adequate and appropriate attention during the first year of life” (quote from Werner, 1990; Watt, 1984; Anthony, 1974 and 1987; Garnezy, 1983; Demos, 1989; Werner and Smith, 1982). While Werner and Smith identified caregiving during the first year of a child’s life as the most powerful predictor of resiliency in children, other researchers have also found that a caring and supportive relationship remains the most critical variable throughout childhood and adolescence (Rutter, 1979; Demos, 1989; Feldman, Stiffman, and Jung, 1987). A just-published longitudinal study that looked at parents’ child-rearing practices when the child was five, at other childhood experiences, and at social accomplishment at age 41, found that “having a warm and affectionate father or mother was significantly associated with adult social accomplishment” and contentment (Franz, McClelland, and Weinberger, 1991).

According to Feldman, Stiffman, and Jung, “The social relationships among family members are by far the best predictors of children’s behavioral outcomes” (1987). Furthermore, Rutter’s research found that even in cases of an extremely troubled home environment, “a good relationship with one parent” (defined in terms of the presence of “high warmth and absence of severe criticism”) provides a substantial protective effect (also see Baumrind, 1985). Only one-fourth of the children in the troubled families studied by Rutter showed signs of conduct disorder if they had a single good relationship with a parent, compared to three-fourths of the children who lacked such a relationship (1979). Similarly, Berlin and Davis’s study of children growing up in alcoholic families found that the supportiveness of the nonalcoholic spouse was the most crucial variable in the degree of impact of alcoholism on the family (1989). And, recently, the research of Brook et al. has clearly identified that “a nonconflictual and affectionate parent-adolescent relationship insulates the adolescent from drug use…and [results] in less alcohol use” (1989).

The incredible power of this attribute of caring, support, and affection to protect children is clear. As Werner and Smith explain this dynamic, “Constant feedback from a few adults early in life—not necessarily a parent—gave the resilient infants a basic trust and sense of coherence” (1982). This “sense of basic trust,” identified long ago by Erik Erickson (1963), appears to be the critical foundation for human development and bonding, and, thus, human resiliency. As philosopher-psychologist Sam Keen explains this phenomenon: “To the degree that we are not held and bonded, we will have to find something to hold on to some substitute for that holding we didn’t get. The nature of addiction is all in the way that we hold on, that we grasp, in order to make up for the way in which we were not held,” and therefore, did not develop this basic trust in the world (Keen, 1990).

While we don’t have the time or space here to discuss the issue of family “structure” in terms of family composition (see Benard, January 1989), one point
that must be emphasized is that nowhere in the literature is there support for either divorce as a risk factor or family intactness as a protective factor in the development of later problem behaviors like alcohol and other drug abuse. While divorce is certainly a stressful life event for children and families, research has found that the availability of social support—from family members or from friends, relatives, or others in the community—is the critical factor in the outcome for that child (Werner and Smith, 1982; Werner, 1989; Cowen et al., 1990; Felner et al., 1985; Eggert and Herting, 1991; Wolchik et al., 1989). What is evident is that to mitigate the effects of other risks and stressful life events and to develop healthily, a child needs the “enduring loving involvement of one or more adults in care and joint activity with that child” (Bronfenbrenner, 1983).

High Expectations

Research into why some children growing up in poverty still manage to be successful in school and in young adulthood had consistently identified high parental expectations as the contributing factor (Williams and Kornblum, 1985; Clark, 1983). Similarly, the work of Roger Mills with parents living in an impoverished housing project in Miami demonstrated the power of a parental attitude that “sees clearly the potential for maturity, common sense, for learning and well-being in their children.” According to Mills, an attitude expressed to a youth that, “You have everything you need to be successful—and you can do it!” played a major role in the reduction of several problem behaviors, including substance abuse, in this disadvantaged community (Mills, 1990).

Furthermore, families that establish high expectations for their children’s behavior from an early age play a role in developing resiliency in their children. Norma Haan, whose research on the development of morality in young children clearly challenges prior assumptions of Freud, Piaget, and Kohlberg that young children are morally deficient, i.e., self-serving, writes, “Young children have the same basic moral understandings and concerns as adolescents and young adults” (1989). Moreover, she found that “childhood resiliency and vulnerability have specific relationships to the moral climate of families that build children’s expectancies about the nature of moral interchanges. Resilient children will have reason to be optimistic that moral difficulties can usually be worked out.” Their family environment validates them as worthwhile human beings: “They will be heard; they will usually be able to protect their legitimate self-interests; they will understand that no human is faultless, that even adults morally violate, so they will ‘speak truth to power’ and be able to forgive themselves.”

Concomitant with high expectations are other family characteristics such as structure, discipline, and clear rules and regulations, Bennett, Wolin, and Reiss have found that even in alcoholic families, children tended to have better outcomes if the family was able to maintain some order and clear expectations for behavior (1988). Similarly, Baumrind found that families she labeled “authoritarian” or “permissive,” had low rates of adolescent alcohol and drug use (1985).
Another related aspect of high expectations is that of faith. According to Werner, “A number of studies of resilient children from a wide variety of socioeconomic and ethnic backgrounds have noted that their families have held religious beliefs that provided stability and meaning to their lives, especially in times of hardship and adversity” (1990; also see Anthony, 1987). Werner hypothesizes that, “Such faith appears to give resilient children and their caregivers a sense of rootedness and coherence, a conviction that their lives have meaning, and a belief that things will work out in the end, despite unfavorable odds” (1990). Moskovitz concludes from his study of child survivors of the Nazi Holocaust that this sense of hope and expectation for the future enabled these children to learn to love and to behave compassionately toward others in spite of the atrocities they had experienced (1983).

Encourage Children’s Participation

A natural outgrowth of having high expectations for children is that they are acknowledged as valued participants in the life and work of their family. Research has borne out that the family background of resilient children is usually characterized by many opportunities for the children to participate and contribute in meaningful ways. For example, Werner and Smith found that assigned chores, domestic responsibilities (including care of siblings), and even part-time work to help support the family proved to be sources of strength and competence for resilient children (1982). In her recent review of protective factor research, Werner cites several studies of children growing up in psychotic or alcoholic families, in war-torn countries, and in poverty during the Great Depression, as well as now, that demonstrate “that such productive roles of responsibility, when associated with close family ties, are important protective factors during times of adversity” (1990).

When children are given responsibilities, the message is clearly communicated that they are worthy and capable of being contributing members of the family. Some of the family attributes of resilient children identified by various other researchers, such as “respect for the child’s autonomy” (Hauser et al., 1989; Anthony, 1974) or encouragement of the child’s independence” (Clair and Genest, 1987), are also getting at this sense of family acknowledgment of the child as a valued person in his or her own right. The positive outcomes for children of family environments that value their contributions are supported by a wealth of anthropological studies that find children in other cultures “as young as age three typically assuming duties such as carrying wood and water, cleaning and other household chores, gathering and preparing food, gardening, and caring for younger siblings and animals” (Kurth-Schai, 1988). According to Kurth-Schai, “All of these tasks, even from a child’s perspective, clearly contribute to the welfare of the family” (1988). Thus, to the child, there is no question that he or she is a bonded, integral, contributing member of the family and community.

While various researchers have identified other family factors that appear to be protective of children (for example, small family size, mother over age 17, or children spaced at least two years apart), the factors critical to the positive
development of children are those that provide a caring, supportive family life in which the adult caregivers have high and clear expectations for the child’s behavior and also provide the child with lots of opportunities to participate meaningfully in the life and work of the family. Obviously, family environments with these characteristics provide the fertile soil for the growth and nurturing of that sense of basic trust and coherence essential for human development and, therefore, for the development of the traits of resiliency: social competence, problem-solving skills, autonomy, and a sense of purpose. Yet, as we’ll discuss shortly, the family, like the individual, is a system that also exists in the larger context of the community. For families to create environments characterized by the qualities of caring, high expectations, and opportunities for participation, they, in turn, must exist in communities which also provide support and opportunities.

**Protective Factors Within the School**

In the last decade the literature on the power of the school to influence the outcome for children from high-risk environments has burgeoned (Austin, 1991; Brook et al., 1989; Cauce and Srebnik, 1990; Rutter, 1984; Rutter 1979; Berrueta-Clement et al., 1984; Coleman and Hoffer, 1987; Comer, 1984; Nelson, 1984; Offord, 1991; Felner et al., 1985; Ziegler et al., 1989; Edmonds, 1986—to name a few!). The evidence demonstrating that a school can serve as a “protective shield to help children withstand the multiple vicissitudes that they can expect of a stressful world” abounds, whether it is coming from a family environment devastated by alcoholism or mental illness or from a poverty stricken community environment, or both (Garmezy, 1991). Furthermore, both protective factor research and research on effective schools clearly identifies the characteristics of schools that provide this source of protection for youth. And, lo and behold, they parallel the protective factors found in the family environment of resilient youth!

**Caring and Support**

Just as in the family arena, the level of caring and support within the school is a powerful predictor of positive outcome for youth. While, according to Werner, “Only a few studies have explored the role of teachers as protective buffers in the lives of children who overcome great adversity,” these few do provide moving evidence of this phenomenon (1990). For example, in her own research Werner found that “among the most frequently encountered positive role models in the lives of the children of Kauai, outside of the family circle, was a favorite teacher. For the resilient youngster, a special teacher was not just an instructor for academic skills, but also a confidant and positive model for personal identification” (1990).

Moskovitz’ 30- to 40-year follow-up study of childhood survivors of the Nazi Holocaust who were sent from concentration camps and orphanages to a therapeutic nursery school in England at the end of World War II further documents the power of a caring teacher; all of the resilient survivors “considered
one woman to be among the most potent influences in their lives—the nursery school teacher who provided warmth and caring, and taught them to behave compassionately” (cited by Werner, 1990). Reinforcing these findings, Nel Noddings concludes the following from her research into the power of caring relationships at school to effect positive outcomes for children: “At a time when the traditional structures of caring have deteriorated, schools must become places where teachers and students live together, talk with each other, take delight in each other’s company. My guess is that when schools focus on what really matters in life, the cognitive ends we now pursue so painfully and artificially will be achieved somewhat more naturally...It is obvious that children will work harder and do things—even odd things like adding fractions—for people they love and trust” (1988). Based on his research into effective schools, James Coleman similarly speculates that if we were to “reinstitute the school as an agent of families,” with the primary emphasis on caring for the child—on providing the “attention, personal interest, and intensity of involvement, some persistence and continuity over time, and a certain degree of intimacy—children would develop the necessary attitudes, effort, and conception of self that they need to succeed in school and as adults” (1987).

While the importance of the teacher as caregiver cannot be overemphasized, a factor often overlooked that has definitely emerged from protective factor research is the role of caring peers and friends in the school and community environments. Research into the resiliency of “street gamins” clearly identifies peer support as critical to the survival of these youth (Felsman, 1989).

Similarly, Emmy Werner found caring friends a major factor in the development of resiliency in her disadvantaged population (Werner and Smith, 1982). James Coleman also cites the positive outcomes for youth who have lived with their peers in boarding schools when their families were no longer able to be supportive (1987). And, convincing evidence for the role of peers in reducing alcohol and drug use are the findings of two meta-analyses (comparing the effects of more than 200 studies) that concluded peer programs (including cooperative learning strategies) are the single most effective school-based approach for reducing alcohol and drug use in youth (Tobler, 1986; Bangert-Drowns, 1988).

Obviously, resilient youth are those youth who have and take the opportunity to fulfill the basic human need for social support, caring, and love. If this is unavailable to them in their immediate family environments, it is imperative that the school provide the opportunities to develop caring relationships with both adults and other youth. The positive outcomes prevention program—including reduced levels of alcohol and drug use—which have focused on increasing the amount of social support available to youth in their schools by facilitating the development of teacher and peer relationships (Felner et al., 1985; Eggert and Herting, 1991) or the numerous forms of peer helping programs which exponentially increase the caregiving resources available to a youth (Benard, December 1990) unequivocally demonstrate that a caregiving environment in the school serves as that “protective shield” (Felner et al., 1985; Benard, December 1990).
High Expectations

As with family environment, research has identified that schools that establish high expectations for all kids—and give them the support necessary to achieve them—have incredibly high rates of academic success (Rutter, 1979; Brook et al., 1989; Edmonds 1986; O’Neil, 1991; Levin, 1988; Slavin, Karweit, and Madden, 1989). Probably the most powerful research supporting a school “ethos” of high expectations as a protective shield is that reported by Michael Rutter in his book Fifteen Thousand Hours (1979). According to Garmezy, this work “stands forth as a possible beacon for illuminating the role of schools as a strategic force in fostering the well-being of disadvantaged children” (1991). Rutter found that even within the same poverty-stricken areas of London, some schools showed considerable differences in rates of delinquency, behavioral disturbance, attendance, and academic attainment (even after controlling for family risk factors). The successful schools, moreover, appeared to share certain characteristics: an academic emphasis, teachers’ clear expectations and regulations, high levels of student participation, and many, varied alternative resources—library facilities, vocational work opportunities, art, music, and extra-curricular activities.

A major critical finding was that the relationships between a school’s characteristics and student behavior increased over time; that is, the number of problem behaviors experienced by a youth decreased over time in the successful schools and increased in the unsuccessful schools. Rutter concluded that “schools that foster high self-esteem and that promote social and scholastic success reduce the likelihood of emotional and behavioral disturbance” (1979). The incredible power of a schoolwide ethos of high expectations has also been borne out in the protective factor research of Judith Brook and her colleagues, who found that this factor, in conjunctions with a school value of student participation and autonomy, was even able to mitigate against the most powerful risk factors for adolescent alcohol and drug use—peers that are substance-abusers (1989).

During the last several years, research on successful programs for youth at risk of academic failure has clearly demonstrated that a schoolwide climate of high expectations is a critical factor in reducing academic failure and increasing the number of college-bound youth. For example, according to Phyllis Hart of the Achievement Council, a California-based advocacy group, the establishment of a “college core curriculum” in an inner-city, disadvantaged community resulted in over 65 percent of its graduates going on to higher education (up from 15 percent before the program began). Several students participating in this program stated a major factor in their decision to attend college was “having one person who believed I could do it!” (California Department of Education, 1990). Similarly, Henry Levin’s Accelerated Schools Program and Robert Slavin’s Success for All project have clearly demonstrated that engaging students at risk for school failure in a challenging, speeded-up—as opposed to a slowed-down—curriculum has positive academic and social outcomes. These findings are in direct contrast to the dismal outcomes of children who are labeled as slow learners and tracked into low-ability classes (Oakes, 1985). Hart claims, “Even students in the worst of circumstances can
excel, given appropriate support, and watering down academic content or having low standards doesn’t help anyone” (O’Neil, 1991).

Furthermore, the research of Burk and Sher found that children from alcoholic families who were functioning successfully were still perceived more negatively and ascribed lower expectations by mental health professionals and peers once they were labeled “children of alcoholics” (1990). They conclude, “To the extent that it makes services available for those who are currently in distress, labeling can be a beneficial process. However...the benefits of labeling are lost when those who are identified suffer negative consequences as a result of the labeling process.” Similarly, Richard Barth warns from his research on services provided to prenatally drug-exposed children that “labels can create powerful expectations. There is no better example of this than the label ‘crack baby’.” According to Barth, “The outcomes from perinatally drug-exposed children are determined,...as are those of other children at risk of developmental problems,...by the extent of perinatal insult and subsequent environmental protective factors” (1991).

A powerful illustration of this high expectation model is described by Jonathon Kozol as follows: “On any given day in Massachusetts, 200 Black children from the Boston slums ride the bus to go to school in the suburban town of Lexington. They begin in kindergarten and, although they are provided with a lot of counseling, their education is the same as that which is afforded to their affluent White classmates. Virtually every non-White child bused to Lexington from Boston finishes 12 years of school and graduates; most go to four-year colleges. Low-income Black children of the same abilities, consigned to public school in Boston, have at best a 24 percent chance of the same success” (1990). While other factors may be operating in this scenario, the one factor that clearly stands out in this and other successful programs is “the expectation among staff, parents, and the students themselves that they are capable of high achievement” (O’Neil, 1991).

What appears to be the dynamic here is the internalization of high expectations for oneself. When the message one consistently hears—from family members, from teachers, from significant others in one’s environment—is, “You are a bright and capable person,” one naturally sees oneself as a bright and capable person, a person with that resilient trait, a sense of purpose and a bright future.

**Youth Participation and Involvement**

A natural outcome in schools, as in families, of having high expectations for youth is providing them with the opportunities to participate and be meaningfully involved and have roles of responsibility within the school environment. Carat’s primary finding from her research analyzing instructional factors in inner-city classrooms was that “students in these classrooms simply were not actively engaged by their teachers and with their instructional materials.” Furthermore, Carat identified the “opportunity to respond” as the key variable for differentiating classrooms that were effective or not effective (1991).
Turning once again to Michael Rutter's research on successful schools, we find unequivocal documentation of the protective nature of youth participation (1979; 1984). According to Rutter, in the schools with low levels of problems like delinquency, children “were given a lot of responsibility. They participated very actively in all sorts of things that went on in the school; they were treated as responsible people and they reacted accordingly” (1984). These schools created a variety of opportunities to ensure that all kids found something they were interested in and could succeed in. Rutter concluded, “If you bring children in for a variety of things and give them multiple opportunities for success, then I think it’s less likely that you get this anti-academic atmosphere and alienation so often found in inner-city schools” (1984). Brook et al.'s research, as well as that of Roger Mills, further validates Rutter’s findings as protective against alcohol and drug use as well (1989; 1990).

The reverse process of participation is alienation, the lack of bonding to social institutions like the family, the school, and the community, a process that has consistently been identified in study after study as a major risk factor for involvement in alcohol and other drugs, delinquency, teen pregnancy, school failure, and depression and suicide. The challenge clearly for these social institutions—and especially for the schools—is to engage youth by providing them opportunities to participate in meaningful, valued activities and roles—those involving problem-solving, decision-making, planning, goal-setting, helping others (Wehlage, 1989). Maton’s research with older adolescents and at-risk urban teenagers found that engagement in “meaningful instrumental activity” was significantly related to their life satisfaction, well-being, and overall self-esteem—and was as powerful a factor as that of social support (1990).

The power of creating these opportunities from an early age was vividly demonstrated in the High/Scope Education Research Foundation’s 15-year follow-up study, the Perry Preschool Project. This study discovered that when children from an impoverished inner-city environment were given the opportunities to plan and make decisions in their preschool environment, they were at the age of 19 significantly less (as much as 50 percent less!) involved in drug use, delinquency, teen pregnancy, school failure, etc. (Berrueta-Clement et al., 1984; Schweinhart et al., 1986).

Once again, the operation dynamic reflects the fundamental human need to bond—to participate, to belong, to have some power or control over one's life. According to several educational reformers, when schools ignore these basic human needs—of kids and adults—they become ineffective, alienating places (Sarason, 1990; Glasser, 1990; Wehlage, 1989). Seymour Sarason says it well: “When one has no stake in the way things are, when one’s needs or opinions are provided no forum, when one sees oneself as the object of unilateral actions, it takes no particular wisdom to suggest that one would rather be elsewhere” (1990).

The Club of Rome's report on human learning also claims that, in addition to that quality of anticipation discussed earlier, opportunities for active participation...
are critical to creating learning environments that will effectively prepare youth to live in an increasingly complex world. Moreover, “participation is more than the formal sharing of decisions; it is an attitude characterized by cooperation, dialogue, and empathy,” an attitude essential not only to “human dignity” but to “human survival” as well (Botkin et al., 1979).

Clearly, a preponderance of evidence demonstrates that schools have the power to overcome incredible risk factors in the lives of youth—including those for alcohol and drug abuse. Brook et al. conclude that “evidently there are drug-mitigating aspects to the school environment which are unrelated to the drug problem as such” (1989). In his classic study on school effectiveness, Ron Edmonds concluded that a school can create a “coherent” environment, a climate, more potent than any single influence—teachers, class, family, neighborhood—“so potent that for at least six hours a day it can override almost everything else in the lives of children” (1986).

And Garmezy also reiterates from his review of protective factors in the school environment that “the presence of a school in a high-delinquency area was not the determiner of behavioral or scholastic deviance. Schools exercised their effects over and above any area effects [i.e., risk factors] that existed” (1991). The value of focusing on enhancing protection, as opposed to focusing on risk, is clear. According to Garmezy, “What is apparently needed by school personnel is the proud awareness that by putting forth the best effort in their classrooms and schools they are engaged in the most worthy of societal enterprises—the enhancement of competence in their children and their tailoring, in part, of a protective shield to help children withstand the multiple vicissitudes that they can expect of a stressful world” (1991).

**Protective Factors Within the Community**

As with the other two arenas in which children are socialized, the family and the school, the community which supports the positive development of youth is promoting the building of the traits of resiliency—social competence, problem-solving skills, autonomy, and a sense of purpose and future. Community psychologists refer to the capacity of a community to build resiliency as “community competence” (Iscoe, 1974). And, once again, as with the family and the school systems, competent communities are characterized by the triad of protective factors: caring and support, high expectations, and participation. Moreover, communities exert not only a direct influence on the lives of youth but, perhaps even more importantly, exert a profound influence on the “lives” of the families and schools within their domain and, thus, indirectly powerfully affect the outcome for children and youth (Brook et al., 1989: Kelly, 1988). A competent community, therefore, must support its families and schools, have high expectations and clear norms for its families and schools, and encourage the active participation and collaboration of its families and schools in the life and work of the community.
Caring and Support

According to Kelly, “The long-term development of the ‘competent community’ depends upon the availability of social networks within the community that can promote and sustain social cohesion within the community...That is, the formal and informal networks in which individuals develop their competencies and which provide links within the community that are a source of strength [i.e., health and resiliency] for the community and the individuals comprising it” (1988). This characteristic of “social cohesiveness” or “community organization” has probably been the most frequently examined community factor affecting the outcome for children and families. The clear finding from years of research into crime, delinquency, child abuse, etc., is that communities and neighborhoods rich in social networks—both peer groups and intergenerational relationships—have lower rates of these problems (Garbarino, 1980; Miller and Ohlin, 1985). Similarly, Coleman and Hoffer found the intensity of the intergenerational social networks surrounding private, religious schools created a “functional community” that built social capital for youth and, consequently, higher achievement and lower dropout rates (1987).

Furthermore, the protective nature of social support across the lifespan—be it from friends, neighbors, caring help givers—is documented by volumes of studies from the field of community psychology, community health, and community mental health as well as by the overwhelming success of community-based family support programs (Schorr, 1988). These latter programs, for example, based on longitudinal research such as Kellam et al.’s, who found that the “social isolation” that often evolved from teenager motherhood was the critical variable determining an adverse outcome for the mother and child—including the child’s later alcohol and drug abuse—have clearly shown the protective effect of linking young families into a network of peer-helping and other informal systems of social supports (1982). Similarly, Feldman, Stiffman, and Jung found a significant positive relationship between the total amount of help received by families from both informal and formal sources and the child’s behavior in school (1987).

Perhaps the most obvious manifestation of caring and support at the community level is the availability of resources necessary for healthy human development: health care, child care, housing, education, job training, employment, and recreation. According to most researchers, the greatest protection we could give children is ensuring them and their families access to these basic necessities (Garmezy, 1991; Sameroff et al., 1984, Long and Vaillant, 1989; Wilson, 1987; Coleman, 1987; Hodgkinson, 1989). Conversely, the greatest risk factor for the development of nearly all problem behaviors is poverty, a condition characterized by the lack of these basic necessities. This clearly testifies to the lack of a national political will to provide the opportunities for all children to succeed. In light of our national neglect of children and families, the imperative falls to local communities to fill the gap. And, the only way communities can and have succeeded in this endeavor is through the building of social networks that link not only families and schools but agencies and organizations throughout the
community with the common purpose of collaborating to address the needs of children and families (Coleman, 1987; Schorr, 1988; Hodgkinson, 1989; Mills, 1990; Benard, October 1989). Thus, while community competence depends upon the availability of social networks within the community, it also depends on the “ability of [these networks] to respond to differential needs of the varied populations they serve, and the ability of citizens or groups to use existing resources or develop alternatives for the purpose of solving problems of living” (Barbarin, quoted in Fellini, 1987).

High Expectations

In the context of community, discussions around the issue of high expectations are usually referenced in terms of “cultural norm.” Two cultural norms appear especially salient to our discussion of protective factors in the community. The first is that in cultures that have as a norm the valuing of youth as resources (as opposed to problems), youth tend to be less involved in all problem behaviors (Kurth-Schai, 1988). According to Diane Hedin, our society tells children and youth that “they have no real place in the scheme of things, that their only responsibility is to go to school and learn and grow up. When they have learned and grown up, which is supposed to occur miraculously at age 18, they can perhaps make some modest contribution as a citizen. The young people, therefore, view themselves as strictly consumers, not as contributors” (1987).

And, speaking of consumption...

A second relevant cultural norm is that of our expectancies surrounding alcohol use. According to the longitudinal research of Long and Vaillant (1989) as well as the community work of Peter Bell (1987), “Cultures that teach children how, when, and where to drink tend to have lower rates of alcoholism than do those that forbid children to drink” (Vaillant, 1986). Furthermore, “how a society socializes drunkenness is as important as how it socializes drinking” (Vaillant, 1986). In other words, countries in which drunkenness is more socially acceptable tend to have higher rates of alcohol abuse.

Obviously, in terms of national policies, our culture measures up poorly in terms of providing protection for youth through the teaching of low-risk choice-making around alcohol use and especially through our condoning of alcohol advertising, much of which glamorizes abusive drinking and even drunkenness (Room, 1990). Similarly, we have a long way to go in terms of changing local community norms, which, of course, are strongly influenced by the big monies the alcohol industry spends on advertising and promotion at the local level. The majority of researchers who have evaluated the consistent failure of most school-based prevention programs have concluded the following: “Current social norms about chemical use are a reflection of the community. The community is a fertile, powerful, and necessary environment for changing norms. If chemical use problems of young people are to be reduced, community-based prevention programs also must challenge adults to reflect on their patterns of chemical use...Prevention cannot be a task assigned by the community to the school and focused only on youth. It is a shared responsibility” (Griffin, 1986).
Certainly, the message and expectation that speaks loudest and clearest to youth is not the one explicitly presented in substance abuse prevention programs in the school but the one implicitly communicated through the values and actions of the larger community in which they live.

**Opportunities for Participation**

The natural outcome of having high expectations for youth, for viewing youth as resources and not problems, is the creation of opportunities for them to be contributing members of their community. Just as healthy human development involves the process of bonding to the family and school through the provision of opportunities to be involved in meaningful and valued ways in family and school life, developing a sense of belonging and attachment to one’s community also requires the opportunities to participate in the life of the community. According to Kurth-Schai, several cross-cultural studies have clearly indicated the “youth participation in socially and/or economically useful tasks is associated with heightened self-esteem, enhanced moral development, increased political activism, and the ability to create and maintain complex social relationships” (1988). On the other hand, “related studies demonstrate the lack of participation is associated with rigid and simplistic relational strategies, psychological dependence on external sources for personal validation, and the expression of self-destructive and antisocial behaviors including drug abuse, depression, promiscuity, premature parenthood, suicide, and delinquency” (Kurth-Schai, 1988). Similarly, Richardson et al. concluded from their research on the heavier alcohol and drug use patterns of latchkey youth that “traditional societies had clearly defined roles for young adolescents in the life of the community. These contributory roles have largely been replaced by autonomy and leisure and frequently accompanied by no adult supervision. This time could be put to good use both in the home and in the community. The family or community that learns to direct the energy, general good will, and potential of these young adolescents into community or individual improvement projects may find that they benefit the community as well as the individual” (1989).

The challenge, then, for communities as well as for families and schools, is to find ways “to harness that force, to turn on our youth, to capture their inherent need for an ideology and group,” to meet their basic human needs for connecting to other people and to a larger meaning or purpose (Levine, 1983). Stated eloquently by James Coleman, our most fundamental task is “to look at the whole fabric of our society and say, ‘Where and how can children be lodged in this society? Where can we find a stable psychological home for children where people will pay attention to them?’” (quoted in Olson, 1987).

One approach many communities are incorporating to begin providing this “home” for youth is youth service. While no evaluated studies as yet exist on communities that have provided youth the opportunities to “serve,” that is, to provide needed human services (i.e., academic tutoring, literacy training, child care, elder care, etc.) within their communities, anecdotal evidence from the
hundreds of youth service programs operating in communities across the country bear witness to the power of this approach to engage youth as community resources (National Crime Prevention Council, 1988; Benard, January 1990).

Just as research from the field of community psychology and community development has documented the positive effects of “citizen participation”—improvements in the neighborhood and community; stronger interpersonal relationships and social fabric; feelings of personal and political efficacy; etc.—we can expect that civic participation on the part of youth will have even more powerful effects (Florin and Wandersman, 1990; Chavis and Wandersman, 1990; Zimmerman and Rappaport, 1988). Furthermore, as the Club of Rome warned many years ago, society needs the full participation and creativity of youth to address the social and environmental problems of the present and future. In many ways, nourishing the potential of our youth is society’s protective shield for the future. Citing anthropological research, Kirth-Schai states, “The imaginative experiences of childhood represent humanity’s primary source of personal and cultural evolutionary potential.” Furthermore, youth possess the capacity “to create images of the future powerful enough to guide and motivate positive social change...[as well as] to provide leadership, nurturance, and economic assistance. In a world characterized by widespread feelings of purposelessness and powerlessness, the social contributions of childhood represent a primary source of humanity’s hope for the future” (Kurth-Schai, 1988).

**Protective Factors: A Perspective**

Just as Zucker concluded that “severe drug involvement is a human act, involving a bio-psycho-social process over long spans of developmental time” (1989), the development of human resiliency is none other than the process of healthy human development—a dynamic process in which personality and environmental influences interact in a reciprocal, transactional relationship. The range of outcomes, according to Werner, is determined by the balance between risk factors, stressful life events, and protective factors (Werner and Smith, 1982). Furthermore, this balance is not determined only on the basis of the number of risk and protective factors present in the life of an individual but on their respective frequency, duration, and severity, as well as the developmental stage at which they occur. According to Werner, “As long as [this] balance between stressful life events and protective factors is favorable, successful adaptation is possible. However, when stressful life events outweigh the protective factors, even the most resilient child can develop problems” (1990).

No one is invulnerable; every person has a “threshold” beyond which he or she can “succumb” (Rutter, 1979). Thus, “intervention may be conceived as an attempt to shift the balance from vulnerability to resilience, either by decreasing exposure to risk factors and stressful life events, or by increasing the number of available protective factors...in the lives of vulnerable children” (Werner, 1990). Shifting the balance or tipping the scales from vulnerability to resilience may happen as a result of one person or one opportunity. As we have seen in this
review, individuals who have succeeded in spite of adverse environmental conditions in their families, schools, and/or communities have often done so because of the presence of environmental support in the form of one family member, one teacher, one school, one community person that encouraged their success and welcomed their participation. As protective factor researcher David Offord concludes, “A compensating good experience, good programs in the schools, or one good relationship can make a difference in the child’s life” (1991). As one street gamin reflected on his resiliency: “You’re right, the gamins are smart and strong; they survive. But it still depends on where you go, what you find, who you meet” (Felsman, 1989).

While tipping the scales toward resiliency through individual, serendipitous relationships or events is certainly important, the increasing number of children and families that are experiencing growing numbers of risks in their lives due to environmental deprivation necessitate that as preventionists we take a systems perspective and intervene with planned environmental strategies to build protection into the lives of all children and families. From this perspective, a major underlying cause of the development of social problems like school failure, alcohol and drug abuse, teen pregnancy, child abuse, etc., can be traced back to the gradual destruction of naturally occurring social networks in the community. The social, economic, and technological changes since the late 1940s have created a fragmentation of community life, resulting in breaks in the naturally occurring networks and linkages between individuals, families, schools, and other social systems within a community that traditionally have provided the protection, the “social capital,” that is, the social supports and opportunities for participation and involvement, necessary for healthy human development (Comer, 1984; Coleman, 1987). What had become clear, from not only the failure of alcohol and drug abuse programs and other prevention programs that do not address this root cause, but from the positive findings of protective factor research into why some kids succeed, is the need for prevention efforts to build these networks and intersystem linkages. Emmy Werner says it all in the following statement: The key to effective prevention efforts is reinforcing within every arena, these “natural social bonds…between young and old, between siblings, between friends...that give meaning to one’s life and a reason for commitment and caring.” To neglect these bonds is to “risk the survival of a culture” (Werner and Smith, 1982).

We must work with our families, schools, and community environments to build these social bonds by providing all individuals within these systems with caring and support, relating to them with high expectations, and giving them opportunities to be active participants in their family, school, and community life. While volumes can be written (and have!) on just how to go about this, the strategies are fairly simple and reflect not a need for behavioral interventions as much as for an attitude change—a willingness to share power within a system, to create a system based on reciprocity and sharing rather that control. For example, research on resiliency clearly implicates peer helping and cooperative learning, as well as mentoring, as strategies of reciprocity that work in all
systems throughout the lifespan to achieve all three of the protective characteristics: support, high expectations, and participation.

Furthermore, to ensure that all children have the opportunities to build resiliency—to develop social competencies (like caring and responsiveness), problem-solving skills, autonomy, and a sense of purpose and future, we must also work to build linkages between families and schools and between schools and communities. It is only at this intersystem level—and only through intersystem collaboration within our communities—that we can build a broad enough, intense enough network of protection for all children and families. While it’s certainly true that as a society America does not value nor invest in children, even when community resources do exist, they are often so fragmented they become ineffectual at dealing with the root causes of risk and, thus, with the building of a protective shield or “safety net” for children. As Sid Gardner, a national expert in children’s policy, states, “In fact, we are ultimately failing our children, not only because we haven’t invested in them, but also because as communities we have failed to work together to hold ourselves accountable for the substantial resources we do invest—and for the outcomes of our most vulnerable residents” (1989).

As protectionists we must encourage the development of community-wide collaborative efforts that focus on “turning the situation around,” on translating negative risk factors for alcohol and other drug abuse and other problem behaviors into positive community action strategies that support and nurture the development of children and youth. Ultimately, as Stanton Peele states, “The mission of those concerned with adolescent drug abuse is to create a cultural climate that encourages children to value and to achieve independence, adventure, intimacy, consciousness, activity, fun, self-reliance, health, problem-solving capacities, and a commitment to the community. There is no better antidote for drug abuse than adolescents’ beliefs that the world is a positive place, that they can accomplish what they want, and that they can gain satisfaction from life” (1986).

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Introduction

In 1955, an interdisciplinary team of pediatricians, psychologists, and public health and social workers began a prospective study of the development of all babies born on the Hawaiian island of Kauai. The principal goals of what came to be known as the Kauai Longitudinal Study were 1) to document, in natural history fashion, the course of all pregnancies and their outcomes in the entire island community until the surviving offspring had reached adulthood, and 2) to assess the long-term consequences of perinatal complications and adverse rearing conditions on the individuals’ development and adaptation to life (1–4).

The men and women whose lives we followed from birth to ages 1, 2, 10, 18, and 32 years are a mixture of ethnic groups—most are of Japanese, Philipino, and Hawaiian descent. Their parents and grandparents came from Southeast Asia to work on the sugar and pineapple plantations of Kauai. Most members of this cohort were raised by parents who were semi- or unskilled laborers, and who had not graduated from high school.

We began by examining the children’s vulnerability, that is, their susceptibility to negative developmental outcomes after exposure to perinatal stress, poverty, parental psychopathology, chronic discord, and disruptions of their family unit. Our first book, The Children of Kauai (1), documents the cumulative effects of poverty, perinatal stress, and a disorganized caretaking environment on the development of these children from birth to age two years. A second book, Kauai’s Children Come of Age (2), examines the roots of the learning disorders, mental health problems, and antisocial behavior displayed by many of the high-risk children in their teens, and analyzes the likelihood of the persistence of serious problems into adulthood.

As our longitudinal study progressed, we also looked at the roots of resiliency in those children who successfully coped with such biological and psychosocial risk factors, and at protective factors that aided in the recovery of troubled children and youths as they made the transition into adulthood. Our third book, Vulnerable, but Invincible (3), contrasts the behavior and care giving environments of the resilient youngsters with that of their high-risk peers of the same age and sex who had developed serious coping problems in the first two decades of life. Our fourth book, Overcoming the Odds (4), gives an account of the life trajectories of the high-risk children in our study from birth to age 32 years.
I will review here briefly the life course of the children of Kauai from birth to their early thirties, and then summarize what we have learned about the process by which a chain of protective factors is forged that afforded vulnerable individuals an escape from childhood adversity. I will then consider the implications of our findings for prevention and intervention programs that might benefit other youngsters exposed to biological or social conditions that are hazardous to their development and psychological well-being. The interested reader can find a detailed statistical account of our study finds in Appendix I of Overcoming the Odds (4).

The Life Course of the Children of Kauai

Of the 698 children in this cohort 55% grew up in chronic poverty. Some 10% were exposed to moderate prenatal or perinatal stress, i.e., complications during pregnancy, labor, or delivery; 3% suffered severe perinatal trauma. Of every 6 children who survived infancy, 1 had physical or intellectual handicaps of perinatal or neonatal origin that were diagnosed between birth and age 2 years and required long-term specialized medical, educational, or custodial care.

In addition, 20% of the children developed serious learning or behavior problems in the first decade of life. By the time they were 10 years old, twice as many children needed some form of remedial education (usually for problems associated with reading) as were in need of medical care. By the age of 18 years, 15% of the youths in this cohort had delinquency records, and 10% had mental health problems requiring either in- or outpatient care. Of the women, 8% were pregnant as teenagers.

As we followed these children from birth to adulthood we noted two trends: The impact of perinatal stress diminished with time, and the developmental outcome of virtually every biological risk condition was dependent on the quality of the rearing environment. We did find some correlations between moderate-to-severe degrees of perinatal trauma and major physical handicaps of the central nervous system and the musculoskeletal and sensory systems. Perinatal trauma was also correlated with mental retardation, serious learning disabilities, and chronic mental health problems, such as schizophrenia, that arose in late adolescence or early adulthood.

Consistent with our findings in childhood and adolescence, we discovered significant social class differences in the adult health status of individuals who had experienced moderate-to-severe perinatal stress or delayed physical development in early childhood; 30% of the men and women who had been reared in poverty and had experienced moderate-to-severe perinatal stress, reported serious health problems by age 32 years in contrast to only 10% of the individuals who had suffered moderate-to-severe perinatal complications, but who had grown up in middle-class homes.

Of the individuals who had been considered “below normal” in physical development during the pediatric examination at age 20 months and grew up in poverty, 20% reported serious health problems by age 32 years—none of the
individuals who had received a similar rating at age 2 years, but who had grown up in middle-class homes, reported such problems. Among those with a moderate-to-severe physical handicap at age 10 years who had grown up in poverty, the proportion of self-reported serious health problems at age 32 years was 38.5%; among individuals with the same degree of handicap who had grown up in more affluent homes, the proportion of self-reported health problems was less than half (16.7%).

Among the 28 cohort members who had died by age 30 years, males from poor and unstable homes who had suffered moderate-to-severe degrees of perinatal stress, with abnormal cord and placental conditions or delivered by Caesarian section, were over-represented, as were males whose mothers had suffered serious psychological trauma and physical abuse during pregnancy. Death rates of females with moderate-to-severe degrees of perinatal stress did not differ significantly from peers of the same age and sex without such conditions.

In general, overall rearing conditions were more powerful determinants of outcome than perinatal trauma. Prenatal and perinatal complications were consistently related to impairment of physical and psychological development only when they were combined with chronic poverty, parental psychopathology, or persistently poor rearing conditions, unless there was serious damage to the central nervous system.

**The High-Risk Children in Their Teens**

We designated about one-third of the surviving boys and girls in this cohort as “high-risk” children (n = 201) because they were born into poverty; they had experienced moderate-to-severe degrees of perinatal stress; and they lived in a family environment troubled by discord, divorce, parental alcoholism, or mental illness. Two-thirds of these children (who encountered four or more of such risk factors by age 2 years) did indeed develop serious learning or behavior problems by age 10 years, and had delinquency records, mental health problems, or teenage pregnancies by the time they were 18 years old; 25% in this high-risk sample had records of multiple problems. Clearly the odds were against them!

Yet 1 of 3 of these high-risk children (n = 72) grew into competent young adults who loved well, worked well, played well, and expected well. None developed serious learning or behavior problems in childhood or adolescence. As far as we could tell from interviews and from their records in the community, they succeeded in school, managed home and social life well, and expressed a strong desire to take advantage of whatever opportunity came their way.

**The High-Risk Children as Adults**

With only 2 exceptions, these resilient children grew into competent, confident, and caring adults whose educational and vocational accomplishments were equal to or exceeded those of the low-risk children in the cohort who had grown up in more affluent, secure, and stable homes. Personal competence and determination,
support from a spouse or mate, and reliance on faith and prayer were the shared qualities that characterized the resilient individuals in their early 30s.

One of the most striking findings of our follow-up in adulthood was that most high-risk youths with serious coping problems in adolescence had staged a recovery of sorts by the time they reached their early 30s. For example, the situation of the 28 teenage mothers in the 1955 birth cohort had improved significantly over time. In almost all respects, except for marital stability, they were better off than when we saw them in their late teens and mid-20s; 60% had obtained additional schooling and 90% were gainfully employed. On the average, they had fewer children than their families of origin—about the same number as anticipated by the women in this cohort who started childbearing later. In their early 30s, they expressed a stronger belief in their ability to control their own fate than they had at age 18 years.

The paths that had led to improvement for the majority of the teenage mothers on rural Kauai were similar to those reported by Furstenberg et al. (5) for a much larger sample of black adolescent mothers who grew up in metropolitan Baltimore. The development of the women's personal resources, their competence and motivation, the support of kith and kin, and a stable marriage all contributed to positive changes in their life trajectories from high-risk pregnancy to successful adult adaptation.

Likewise, most of the 103 delinquent youths in this cohort did not go on to an adult criminal career. Only 28% of the males and only 10% of the females with a record of juvenile offenses also had a criminal record by age 32 years. The majority of the adult crimes in this cohort were committed by a small group of individuals (n = 21) with an average of four or more juvenile arrests before age 18 years, a finding similar to that reported by Wolfgang et al. (6) who followed cohorts of black and Caucasian teenagers born in Philadelphia into adulthood.

The majority of the delinquent youths on Kauai who did not go on to commit any adult crimes scored within the average range of intelligence in early and middle childhood, were not described as “trouble-some” by their teachers when they were in grade school, and grew up in intact families during their teens. One of their elders (a parent, grandparent, uncle, or aunt) provided structure and stability in their lives. Military service, marriage to a stable partner, and parenthood proved to be positive turning points in the adult lives of these “crime resistant” juvenile offenders.

By age 32 years, a significant shift in life trajectories from risk to adaptation had also taken place in one-half of the 70 individuals in this birth cohort who had been troubled by mental health problems in their teens—a finding similar to that reported by Magnusson (7) from a contemporary urban Swedish cohort. Only one-third of the individuals in need of mental health services during childhood or adolescence (n = 23) had actually received some counseling or psychotherapy—a proportion similar to that reported by Tuma (8) for nationwide
trends in the utilization of mental health services for young people. A significant minority (n = 21) had found a sense of meaning and security in their lives through active involvement in a religious group. The most salient turning points on the road to recovery for most of these troubled individuals, however, were meeting a caring friend and marrying an accepting and supportive spouse.

**Links Between Protective Factors and Successful Adult Adaptation in High-Risk Children and Youths**

A major objective of our follow-up into adulthood was to document how a chain of protective factors, linked across time, afforded vulnerable children and teenagers an escape from adversity, and contributed to positive outcomes in their adult lives [For a detailed account of our latent variable path analyses and path diagrams, see Appendix 1 in Overcoming the Odds (4)].

Five clusters of protective factors appeared in the records and interviews of the high risk children who made a successful adaptation in adult life. Cluster 1 included temperamental characteristics of the individual that helped him/her to elicit positive responses from a variety of caring persons: parents, teachers, mentors, friends, spouses, or mates. Cluster 2 included skills and values that led to an efficient use of whatever abilities they had: faith that the odds could be overcome; realistic educational and vocational plans; regular household chores and domestic responsibilities. Cluster 3 included characteristics and care giving styles of the parents reflected competence and fostered self-esteem in the child; mother’s level of education; rules and structure in the household; for girls, the model of a mother who was gainfully employed. Cluster 4 consisted of supportive adults who fostered trust and acted as gatekeepers for the future. Among these “surrogate” parents were grandparents, elder mentors, youth leaders, and members of church groups. Finally, there was the opening of opportunities at major life transitions, from high school to the work place, from civilian to military life, from single state to marriage and parenthood, that turned the trajectory of a significant proportion of the high-risk children on the path to normal adulthood. Among the most potent forces of change that provided a “second chance” for troubled youths in their 20s were adult education provided by local junior colleges and educational and vocational skills acquired during service in the armed forces. Both settings provided them with opportunities for personal growth in a structured setting and a chance to take responsibilities that enhanced their self-esteem.

When we examined the links between protective factors within the individual and outside sources of support or stress, we noted a certain continuity that appeared in the life course of the high-risk men and women who successfully overcame a variety of childhood adversities. Their individual dispositions led them to select or construct environments that, in turn, reinforced and sustained their active, outgoing dispositions and rewarded their competencies. In spite of occasional deviations during transitional periods, such as adolescence, their life trajectories revealed “interactional continuity” (9).
There was, for example, a significant positive link between an “easy” infant temperament and the sources of support available to the individual in early and middle childhood. Active and sociable babies, without distressing sleeping and feeding habits, tended to elicit more positive responses from their mothers at age 1 year, and from alternate caregivers by age 2 years. Positive parental interactions with the infant and toddler were, in turn, associated with greater autonomy and social maturity at age 2 years, and with greater scholastic competence at age 10 years. In middle childhood, such children tended to rely on a wider network of caring adults both within and outside the family circle.

A higher parental educational level was linked to more positive parent-child interactions in the first and second year of life, and to more emotional support provided for the offspring during early and middle childhood—even when the family lived in poverty. Parental education was also positively linked to the infants’ health and physical status by age 2 years. There were significant positive links between parental educational level and the child’s scholastic competence at 10 years as well; one path was direct, the other was mediated through the infant’s health and physical status. Better educated parents had children with better problem-solving and reading skills, but they also had healthier children with fewer handicaps and fewer absences from school due to repeated serious illnesses.

Scholastic competence at 10 years, in turn, was positively linked with the number of sources of help that the teenager attracted, including support from teachers and peers, as well as from family members. Scholastic competence at 10 years was also positively linked with a sense of self-esteem at age 18 years. A greater sense of self-efficacy at age 18 years was, in turn, linked to less distress and emotionality for the high-risk women in early adulthood.

Although parental competence and the sources of support available in the childhood home were modestly linked to the quality of adult adaptation, they made less of a direct impact in adulthood than the individuals’ competencies, degree of self-esteem and self-efficacy. Many resilient high-risk youths left the adverse conditions of their childhood homes (and their island community) after high school and sought environments they found more compatible. In short, they picked their own niches (10).

**Implications**

What lessons have we learned from following the lives of the children of Kauai that might be of relevance to those who care for other races, in different places, at different times?

The most precious lesson that we choose to learn from this study is Hope; a hope reinforced by reports from a handful of other long-term studies which have identified similar protective buffers and mechanisms that operated in the lives of vulnerable youths who succeeded “against the odds” (11).
The British child psychiatrist Rutter (12) reminds us that if we want to help vulnerable youngsters, we need to focus on the protective processes that bring about changes in life trajectories from risk to adaptation. He includes among them 1) those that reduce the risk impact; 2) those that reduce the likelihood of negative chain reactions; 3) those that promote self-esteem and self-efficacy; and 4) those that open up opportunities. We have seen these processes at work among the resilient children in our study and among those youths who recovered from serious coping problems in young adulthood. They represent the essence of any effective intervention program, whether by professionals or volunteers.

We noted, for example, that children of parents with chronic psychopathology could detach themselves from the discord in their household by spending time with caring adults outside the family circle. This process altered their exposure to the potent risk condition in their homes. In other cases, the negative chain reactions following the intermittent hospitalizations of psychotic or alcoholic parents were buffered by the presence of grandparents or older siblings who acted as substitute parents and provided continuity in care.

The promotion of self-esteem and self-efficacy in a young person is probably the key ingredient in any effective intervention process. We saw, for example, how effective reading skills by grade four were one of the most potent predictors of successful adult adaptation among the high-risk children in our study. More than one-half of the school failures detected at age 10 years were due to deficiencies in that skill. Such children profited substantially from short-term remedial work in the first three grades by teachers' aides and peer tutors.

Self-esteem was derived not only from academic competence. Most of the resilient children in our high-risk sample were not unusually talented, but they took great pleasure in interests and hobbies that brought them solace when things fell apart in their home lives. Self-esteem also grew when youngsters took on a responsible position commensurate with their ability, whether it was part-time paid work, managing the household when a parent was incapacitated, or most often, caring for younger siblings. At some point in their young lives, usually in middle childhood and adolescence, the high-risk youngsters who grew into resilient adults were required to carry out some socially desirable task to prevent others in their family, neighborhood, or community from experiencing distress or discomfort. Such acts of required helpfulness can become a crucial element of intervention programs that involve high-risk youths in part-time community service, either paid or for academic credit.

Most of all, self-esteem and self-efficacy were promoted through supportive relationships. The resilient youngsters in our study all had at least one person in their lives who accepted them unconditionally, regardless of temperamental idiosyncrasies, physical attractiveness, or intelligence. Most established such a close bond early in their lives, if not with a parent, then with another family member—a grandparent or favorite aunt or uncle. Some of the high-risk youths who had problems in their teens but staged a recovery in young adulthood
gained a more positive self-concept in the context of an intimate relationship with a spouse, mate, or mentor.

One of the most important lessons we learned from our adult follow-up was that the opening up of opportunities led to major turning points in the lives of high-risk individuals as they entered their 20s and early 30s.

Several routes out of poverty and despair in later life were identified in our study of the Asian-American youths on Kauai. Some of these pathways have also been traced for contemporary black teenage mothers, and for Caucasian youths of the Great Depression (13, 14). Among the most potent forces for positive change for high-risk youths on Kauai in early adulthood were education at community colleges, educational and vocational skills acquired during service in the armed forces, and active involvement in a church or religious community.

Attendance at community college and enlistment in the armed forces were also associated with geographical moves for many of the high-risk youths. Both settings provided them with an opportunity to obtain educational and vocational skills that were instrumental in moving them out of a context of poverty into skilled trades and middle-class status.

Involvement in church activities and a strong faith provided meaning to the adult lives of many high-risk youths. Such a faith was tied to identification with fundamentalist religious groups for a significant minority who had been troubled by mental health problems in their teens. For the majority of men and women in this cohort, however, faith was not tied to a specific religious affiliation. It did not seem to matter whether they were nominally Buddhist, Catholic, mainstream Protestant, or Latter Day Saints—the resilient individuals used their faith to maintain a positive vision of a meaningful life.

The central component in the lives of the resilient individuals in our study that contributed to their effective coping in adulthood appeared to be a feeling of confidence that the odds can be surmounted. Some of the luckier ones developed such hopefulness early in their lives, in contact with caring adults. Many of their troubled peers had a second chance at developing a sense of self-esteem in adulthood by virtue of encounters with persons who opened up opportunities and gave meaning to their lives.

We need to keep in mind that our research has focused on children and youths “who pulled themselves up by their own bootstraps,” with informal support from kith and kin, not children who were recipients of intervention services. Yet, there are some lessons these young people can teach us about setting priorities, about critical time periods for prevention and intervention, and about the need for a continuum of care and caring that should include volunteers, as well as professionals.

Our examination of the long-term effects of childhood adversity and of protective factors and processes in the lives of high-risk youths has shown that some of the
most critical determinants of adult outcome are present in the first decade of life. It is also apparent that there are large individual differences among high-risk children in their responses to both negative and positive circumstances in their caregiving environment. The very fact of individual variation among youngsters who live in adverse conditions suggests the need of greater assistance to some than to others.

Our findings alert us to the need for setting priorities, to choices we must make in our investment of resources and time. Intervention programs need to focus on children and youths who appear most vulnerable because they lack some of the essential personal resources and/or social bonds that buffer chronic adversity. Among them are the increasing numbers of preterm survivors of neonatal intensive care, the offspring of parents with severe psychopathology (chronic substance abuse, effective disorders, and schizophrenia), children reared by isolated single parents without roots in a community, and (pre-) adolescents with conduct disorders who have poor reading skills. From a longitudinal perspective, these youngsters appear most at risk of developing serious coping problems in adulthood—especially if they are boys.

Assessment and diagnosis, the initial part of any intervention program—whether preventive or ameliorative—need to focus not only on the risk factors in the lives of these children, but also on the protective factors. These include competencies and sources of informal support that already exist in the extended family, the neighborhood, and the community at large, and that can be utilized to enlarge a child’s repertoire of problem-solving skills, and his self-esteem and self-efficacy.

Our own research and that of our American and European colleagues who have followed resilient children into adulthood have repeatedly shown that, if a parent is incapacitated or unavailable, other persons in a youngster’s life can play such an enabling role, whether they are grandparents, older siblings, caring neighbors, family day-care providers, teachers, ministers, youth workers in 4-H or the YMCA/YWCA, Big Brothers and Big Sisters, and elder mentors. Such informal and personal ties to kith, kin, and community are preferred by most children and families to impersonal contacts with formal bureaucracies. These ties need to be encouraged and strengthened, not weakened or displaced, by legislative action and social programs.

A cooperative effort by concerned volunteers and competent professionals could generate a continuum of care that cuts across narrow disciplinary boundaries. It would involve health-care providers who give advice on family planning and deliver follow-up care for children with disabilities, preschool teachers for high-risk infants and toddlers, peer tutors for children who have reading problems in the primary grades, counselors who assist youths with disabilities with realistic educational and vocational plans, retired individuals who become mentors for potential school drop-outs or juvenile offenders, foster grandparents who work with teenage mothers and their infants, community college instructors who encourage young adults motivated to return to school to upgrade their skills,
and civic and religious leaders who provide a sense of moral values. A number of such exemplary programs already exist that involve no great expenditures of money, but a sustained commitment in time and caring (15).

The life stories of the children of Kauai now grown into adulthood teach us that competence, confidence, and caring can flourish, even under adverse circumstances, if children encounter persons who provide them with the secure basis for the development of trust, autonomy, and initiative. From odds successfully overcome springs hope—a gift each of us can share with a child—at home, in the hospital, in the classroom, on the playground, or in the neighborhood.

References

### 40 Developmental Assets

Search Institute has identified the following building blocks of healthy development that help young people grow up to be healthy, caring, and responsible.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ASSET NAME AND DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support</strong></td>
<td>1. Family support — Family life provides high levels of love and support.</td>
</tr>
<tr>
<td></td>
<td>2. Positive family communication — Young person and her or his parent(s) communicate.</td>
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<tr>
<td></td>
<td>3. Other adult relationships — Young person receives support from three or more nonparent adults.</td>
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<td></td>
<td>4. Caring neighborhood — Young person experiences caring neighbors.</td>
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<td></td>
<td>5. Caring school climate — School provides a caring, encouraging environment.</td>
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<td></td>
<td>6. Parent involvement in schooling — Parent(s) are actively involved in helping your person succeed in school.</td>
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<tr>
<td></td>
<td>7. Community values youth — Young person perceives that adults in the community value youth.</td>
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<td></td>
<td>8. Youth as resources — Young people are given useful roles in the community.</td>
</tr>
<tr>
<td></td>
<td>9. Service to others — Young person serves in the community one hour or more per week.</td>
</tr>
<tr>
<td></td>
<td>10. Safety — Young person feels safe at home, at school, and in the neighborhood.</td>
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<tr>
<td><strong>Empowerment</strong></td>
<td>11. Family boundaries — Family has clear rules and consequences and monitors the young person’s whereabouts.</td>
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<tr>
<td></td>
<td>12. School boundaries — School provides clear rules and consequences.</td>
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<td></td>
<td>14. Adult role models — Parent(s) and other adults model positive, responsible behavior.</td>
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<tr>
<td></td>
<td>15. Positive peer influence — Young person’s best friends model responsible behavior.</td>
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<td></td>
<td>16. High expectations — Both parent(s) and teachers encourage the young person to do well.</td>
</tr>
<tr>
<td><strong>Boundaries &amp; Expectations</strong></td>
<td>17. Creative activities — Young person spends three or more hours per week in lessons or practice in music.</td>
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<tr>
<td></td>
<td>18. Youth programs — Young person spends three or more hours per week in sport, clubs, or organizations at school or in the community.</td>
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<td></td>
<td>19. Religious community — Young person spends one or more hours per week in activities in a religious institution.</td>
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<tr>
<td></td>
<td>20. Time at home — Young person is out with friends “with nothing special to do” two or fewer nights per week.</td>
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<tr>
<td><strong>Constructive Use of Time</strong></td>
<td>21. Achievement motivation — Young person is motivated to do well in school.</td>
</tr>
<tr>
<td></td>
<td>22. School engagement — Young person is actively engaged in learning.</td>
</tr>
<tr>
<td></td>
<td>23. Homework — Young person reports doing at least one hour of homework every school day.</td>
</tr>
<tr>
<td></td>
<td>24. Bonding to school — Young person accepts and takes personal responsibility.</td>
</tr>
<tr>
<td></td>
<td>25. Reading for pleasure — Young person reads for pleasure three or more hours per week.</td>
</tr>
<tr>
<td><strong>Commitment to Learning</strong></td>
<td>26. Caring — Young person places high value on helping other people.</td>
</tr>
<tr>
<td></td>
<td>27. Equality and social justice — Young person places high value on promoting equality and reducing hunger and poverty.</td>
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<td></td>
<td>28. Integrity — Young person acts on convictions and stands up for her or his beliefs.</td>
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<tr>
<td></td>
<td>29. Honesty — Young person “tells the truth even when it is not easy.”</td>
</tr>
<tr>
<td></td>
<td>30. Responsibility — Young person accepts and takes personal responsibility.</td>
</tr>
<tr>
<td></td>
<td>31. Restraint — Young person believes it is important not to be sexually active or to use alcohol or other drugs.</td>
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<tr>
<td><strong>Positive Values</strong></td>
<td>32. Planning and decision making — Young person knows how to plan ahead and make choices.</td>
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<tr>
<td></td>
<td>33. Interpersonal competence — Young person has empathy, sensitivity, and friendship skills.</td>
</tr>
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<td></td>
<td>34. Cultural competence — Young person has knowledge of and is comfortable with people of different cultural/racial/ethnic backgrounds.</td>
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<tr>
<td></td>
<td>35. Resistance skills — Young person can resist negative peer pressure and dangerous situations.</td>
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<tr>
<td></td>
<td>36. Peaceful conflict resolution — Young person seeks to resolve conflict nonviolently.</td>
</tr>
<tr>
<td><strong>Social Competencies</strong></td>
<td>37. Personal power — Young person feels he or she has control over “things that happen to me.”</td>
</tr>
<tr>
<td></td>
<td>38. Self-esteem — Young person reports having a high self-esteem.</td>
</tr>
<tr>
<td></td>
<td>39. Sense of purpose — Young person reports that “my life has a purpose.”</td>
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<td></td>
<td>40. Positive view of personal future — Young person is optimistic about her or his personal future.</td>
</tr>
<tr>
<td><strong>Positive Identity</strong></td>
<td>41. Positive view of personal future — Young person is optimistic about her or his personal future.</td>
</tr>
</tbody>
</table>
Risk and Protective Factor Framework

The following graphic supports a public health model using a theoretical framework of risk reduction and protection enhancement. Developments in prevention and intervention science have shown that some characteristics of individuals, their families, and their environment (i.e., community neighborhood, school) affect the likelihood of negative outcomes including substance abuse, delinquency, violence, and dropping out of school. Other characteristics serve to protect or provide a buffer to moderate the influence of the negative characteristics. These characteristics are identified as risk factors and protective factors (Arthur, Hawkins et al., 1944; Hawkins, Catalano, Miller, 1992).

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Adolescent Problem Behaviors</th>
<th>Protective Factors</th>
<th>Social Development Model (SDM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOMAINS</td>
<td></td>
<td></td>
<td>SDM is a synthesis of three existing theories of criminology (control, social learning, and differential association). It incorporates the results of research on risk and protective factors for problem behavior. It is based on the assumption that children learn behaviors.</td>
</tr>
<tr>
<td>COMMUNITY</td>
<td>Availability of drugs</td>
<td>✓</td>
<td>Opportunities for prosocial involvement in community</td>
</tr>
<tr>
<td></td>
<td>Community laws and norms</td>
<td>✓</td>
<td>Recognition for prosocial involvement in community</td>
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<tr>
<td></td>
<td>favorable to drug use</td>
<td>✓</td>
<td></td>
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<td></td>
<td>Transitions and mobility</td>
<td>✓</td>
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<tr>
<td></td>
<td>Low neighborhood attachment</td>
<td>✓</td>
<td></td>
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<tr>
<td></td>
<td>and community disorganization</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extreme economic deprivation</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>FAMILY</td>
<td>Family history of the problem</td>
<td>✓</td>
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</tr>
<tr>
<td></td>
<td>behavior</td>
<td>✓</td>
<td></td>
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<tr>
<td></td>
<td>Family management problems</td>
<td>✓</td>
<td></td>
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<tr>
<td></td>
<td>Family conflict</td>
<td>✓</td>
<td></td>
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<tr>
<td></td>
<td>Favorable parental attitudes</td>
<td>✓</td>
<td></td>
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<tr>
<td></td>
<td>and involvement in problem</td>
<td>✓</td>
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</tr>
<tr>
<td></td>
<td>behaviors</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>SCHOOL</td>
<td>Academic failure</td>
<td>✓</td>
<td></td>
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<tr>
<td></td>
<td>Lack of commitment to school</td>
<td>✓</td>
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<td>Early and persistent antiso</td>
<td>✓</td>
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<td></td>
<td>cial behavior</td>
<td>✓</td>
<td></td>
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<tr>
<td></td>
<td>Rebelliousness</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>INDIVIDUAL/PEER</td>
<td>Friends who engage in the</td>
<td>✓</td>
<td></td>
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<tr>
<td></td>
<td>problem behavior</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Favorable attitudes toward</td>
<td>✓</td>
<td></td>
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<tr>
<td></td>
<td>the problem behavior (including low</td>
<td>✓</td>
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<tr>
<td></td>
<td>perceived risk of harm)</td>
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<tr>
<td></td>
<td>Early initiation of the</td>
<td>✓</td>
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<tr>
<td></td>
<td>problem behavior</td>
<td>✓</td>
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<tr>
<td></td>
<td>Constitutional factors</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Healthy Behaviors

- Healthy Beliefs and Clear Standards
  - Bonding to family with healthy beliefs; clear standards
  - Attachment to family with healthy beliefs; clear standards
  - Opportunities for prosocial involvement
  - Recognition for prosocial involvement

- Bonding and attachment to school
  - Opportunities for prosocial involvement
  - Recognition for prosocial involvement

- Bonding to peers with healthy beliefs; clear standards
  - Opportunities for prosocial involvement
  - Increase in social skills

- Opportunities Skills Recognition
  - Bonding
  - Attachment Commitment
  - Individual Characteristics

SDM is a synthesis of three existing theories of criminology (control, social learning, and differential association). It incorporates the results of research on risk and protective factors for problem behavior. It is based on the assumption that children learn behaviors.
Fostering Resilience In A Time of War

(Source: American Psychological Association) http://www.apa.org

A time of war can be scary to children/teens, especially because terrorism has brought fear so close to home and events are uncertain for them. Their friend's parents, or perhaps their own parents, may be called away to serve in the military. They look to parents and teachers to help them feel safe in a time of war.

As children/teens hear about and study subjects that teach them about the world outside their homes, they need help from caring adults to sort it all out. You might be that person and may wonder how you can teach children and youth to move beyond the fears that a time of war brings. The good news is just that as children/teens learn reading and writing, they can also learn skills of resilience—the ability to adapt well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress.

The tips below can help parents/teachers foster resilience in children and teens:

- Talk with children/teens and answer questions honestly
- Make home and school a safe place emotionally
- Limit the amount of news children/teens watch—particularly during a time of war
- Realize the stresses of war may heighten daily stresses
- Map out a routine and stick to it—particularly in a time of war
- Make sure to take care of yourself
- Let children/teens know that they will be all right when you can
- Watch children/teens for signs of fear and anxiety—he/she may not be able to put his or her feelings, thoughts into words
- Enlist your child's/teen's help—give them opportunities to be involved
- Put things in a positive perspective, when possible
Building Resilience in Children in the Face of Fear and Tragedy

By: Richard Gallagher, Ph.D. and Anna Chase
http://www.aboutourkids.org/aboutour/articles/crisis_resilience.html

The psychological state of the people of the United States was altered dramatically by the attacks of September 11. We learned that we are not protected from massive violence directed at ordinary citizens. We learned that typical experiences could be fraught with unexpected danger, so that travel, airplanes, tall buildings, and, eventually, the daily mail could be deadly. This new awareness has caused fear, anxiety, and emotional distress in New York, Washington, and rural Pennsylvania as well as in the rest of the country. The attacks created an emotional flu that was contagious, spread rapidly, and, then, gradually dissipated for most people. However it continues to affect many. Government officials and experts highlight the need to remain alert, indicating that other terrorist attacks, perhaps much smaller in scope, are likely to occur in the future.

Educators, pediatricians, and parents have been advised to be aware of symptoms of excessive distress in children who have directly or indirectly witnessed the attacks or who seem preoccupied with news about the attacks, the war against terrorism, and biological terror. Based on knowledge gained after the Oklahoma City bombing and other places where terrorism or war have struck, we are aware that the likely forms of distress include heightened anxiety, avoidance of feared situations, physical symptoms indicating stress such as stomachaches, headaches, and general malaise, and, in adolescence, increased use of substances. Children who were worriers before the attacks may have had their worries intensified or confirmed. We also know the traumatic nature of the death can complicate the bereavement process for children.

Despite the potential for mental health problems, research on the capacity of children to overcome disastrous life events or living circumstances indicates that children can emerge from horrific life experiences with positive outcomes. Studies have carefully reviewed the adjustment of children in war-torn countries such as Cambodia, Bosnia, and Kosovo, areas of high terrorist activity, such as Lebanon, Israel, and the Palestinian territories, and areas of violence and poverty, such as slum regions of the United States. Follow-up studies of children who have lost loved ones through death and reviews of children’s adjustment after they have witnessed life-threatening natural disasters provide evidence that children can do well under certain circumstances. Many children who have experienced tragedy or witnessed life-threatening events emerge with a positive outlook on life, have a good capacity to form positive, fulfilling relationships, achieve a high level of personal success, and develop effective resources for dealing with future negative events.
People caring for children and adolescents can do much to foster such positive outcomes.

Following are some suggestions for adults to help children and adolescents cope with frightening and tragic events:

- **Take steps to ensure children’s safety:** Government agencies, organizations, and private citizens have all made efforts to increase surveillance and security. Be aware of recommendations from security experts to determine what steps should be taken in the future. Make sure that settings where children gather have closed any security gaps. Ask questions to determine who is able to visit settings where children spend their time. Be alert in settings where large numbers of people gather. Also, raise appropriate questions of public officials to make certain that policies and procedures reflect our new reality. Secure environments will enable children to spend their time on the main tasks of childhood: playing, learning, and growing.

- **Help children establish and maintain a close relationship with an adult:** Under even the harshest circumstances, children do well when they have a relationship with at least one adult who is extremely supportive and accepting. Children who have someone who frequently spends time with them, is concerned about their welfare, and provides them with guidance, discipline, and information do much better than children without such a relationship. Most often this relationship is with parents, but others can also supply support, guidance, and affection. Sometimes it may be necessary to reach outside of the family to obtain this relationship, especially if one of the child’s parents is mourning the loss of the other parent.

- **Be sure that children and teens know ways to calm themselves:** All people manage stress better if they know some method for relieving mental and physical tension. Even in war zones, children usually find a means to play, which naturally relieves tension. Give children the opportunity to relax through play, talk, art activities, music, or physical comforting. Exercise, muscle relaxation techniques, deep breathing exercises, and using calm mental images are techniques proven to reduce stress. Teenagers should be advised to avoid unhealthy means of stress reduction such as smoking, alcohol, and drugs. Talk to a professional to learn more about these methods.

- **Help children understand the real statistical probability of tragedy and disaster:** We have a tendency to believe events that have a great impact on our lives happen with greater frequency than they really do. Children easily identify with others, so they may personalize negative events and believe they could easily happen to them. This belief may lead to undue fright and persistent anxiety. Help children recognize that the awful events are very unlikely to happen to them or members of their family. Keep in mind several facts. Despite the great loss of life that occurred on September 11, many people were not physically harmed on that day. Many people on airplanes at the
time of the attacks returned to the ground safely, the vast majority of people in the World Trade Center and the Pentagon were not physically harmed, and many other buildings, cities and areas throughout the United States were not physically affected. A realistic outlook should help children remain alert to dangers, but free from constant worries that they will be harmed.

- **Watch for negative reactions and provide early assistance, or treatment, when necessary:** Although it may seem that the attacks are long past, psychological reactions to the attacks are still likely. In fact, people often do not experience problematic reactions until three months after an event. Be on the alert for anxiety reactions manifested as chronic irritability, persistent worries about safety for themselves and others, avoidance of situations that arouse anxiety, and limited concentration on usual activities. Some older children and teens may demonstrate signs of depression such as limited investment in their futures, lack of energy, pessimistic statements, and involvement with substances. Some children may demonstrate increased aggression and anger. Behaviors that interfere with daily functioning and that last for more than a week or two should be discussed with the child’s doctor or school personnel. Mental health professionals should be consulted for a full assessment so that appropriate treatment can be provided. Untreated anxiety, depression, and aggression can interfere with a child’s ability to function at home, in school, with friends.

- **Keep children informed about related events:** Information filters down to children, even in preschool settings, through overheard conversations, news reports, and discussions among older children. Thus, children may get a distorted understanding that may be more frightening than the truth. The important adults in children’s lives should provide an age-appropriate report of the facts, which will enable the children to understand the scope of the events. Help children understand the nature of any threats to their safety and the safety of family and friends. Be careful how information is presented, however. Repeated exposure to violent images is not useful to anyone of any age, but it can be especially harmful to children. It is not helpful for children to focus on images of destruction, injury, or death, and it is harmful for them to hear recollections of gruesome details provided by witnesses and survivors. Therefore, limit news coverage and keep discussions focused on the facts as much as possible.

- **Help children establish a set of values to guide their actions:** Children who base their actions on values suffer less from depression and anxiety than others. Prosocial values help children look to the future, help them feel connected to a larger social group, and engage in more positive behavior. This is even true for children who have been first-hand witnesses of violent acts. Many witnesses become highly empathic and very concerned about the welfare of others. Even children who share the values of groups that endorse violence have better adjustment than children who have no values at all.
• **Help children develop a positive outlook for the future:** Children and youth are generally optimistic; they have a natural tendency to see the future positively and expect that their experiences will be pleasant and fulfilling. Traumatic events can shake that optimism. However, children who believe that negative events are temporary have a much more positive outcome than children who get mired in negative views of the future. It is important that caretakers help children develop a sense of self efficacy and belief in their ability to effectively deal with stress. Children who believe that they can take steps to make their future better and who believe that adults are working to create a better world have better mental health even when they experience years of traumatic events. Remember, our history contains many more positive times than negative times with great stages of growth often emerging following tragedy and conflict.

• **Finally, take care of your own physical and mental health:** Children need caretakers who are available and supportive. Make sure that you are safe, as calm as possible, appropriately rested, as healthy as possible, and in good mental health so that children can develop strength in your presence. You do not need to be perfect in your demeanor, health, and adjustment, but it is important that you get support, assistance, and rest so that you have reserves available for the youth in your life.
Promoting Resilience in Military Children and Adolescents

Michael E. Faran, Mark D. Weist, Diane A. Faran and Stephen M. Morris

Michael E. Faran and Stephen M. Morris, Child and Adolescent Psychiatry Service, Tripler Army Medical Center, Honolulu, HI 96859
Mark D. Weist, University of Maryland School of Medicine, Baltimore, MD 21201
Diane A. Faran, Hanahau‘oli School, Honolulu, HI 96822

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We would like to sincerely thank Dr. Albert Saito for allowing us to incorporate data from a project he organized into this chapter. We also want to recognize the leadership and support we have received from the Hui E Malama Project, particularly from Gary Griffiths, Oahu Central District School Superintendent and Linda Yoshikami, Principal, Solomon Elementary School. We also want to thank Colonel William Evans, MD, Consultant for Child and Adolescent Psychiatry to the Army Surgeon General, for providing information on Army active duty child and adolescent psychiatrists.

Promoting Resilience in Military Children and Adolescents
Children and adolescents of military families (military children) face numerous challenges that their civilian counterparts do not experience. Stressors are particularly intense now related to sustained military deployments in Afghanistan and Iraq. These stressors including the frequent deployments of parents, the associated fear of losing a parent, the move of remaining family members “closer to home” while the active duty parent is deployed, and the financial stress of only having one person work with no second job, all test the resilience of the military child and his or her family. With a much smaller military than the United States (U.S.) has had in the past, the onus of protecting the nation falls to highly trained and effective but less numerous forces. This translates into more frequent deployments for many.

Other common stressors that are a constant even during times of peace for soldiers and their families are moves on an average every three years, often to other countries and/or remote places such as Alaska and Hawaii, being isolated from their support system (e.g. extended family) and transitioning into new cultures. Children may be required to learn new languages, which while beneficial, is still stressful. For single parent families or families where both parents are active duty, the military requires a “care plan” designating who will care for the children in the event of parental deployment. This forces families to deal with the reality of separation in a very tangible manner.
Because of the moves and periodic deployments, children are faced with the loss of friends and familiar surroundings and must meet the challenge of forming new relationships when they change schools. This can be particularly stressful for some, but also may contribute to building resilience in others. While many civilian families must contend with a parent who travels, when an active duty parent goes on a “business trip” there are major differences. The service member is often placed in imminent danger, and most school age children understand that their parent is in a potentially dangerous place. The children must cope with the knowledge that their parents may be harmed or killed as well as the uncertainty of how long the parent will be gone. Communication with the parent is unpredictable. In addition to missing key family events, such as birthdays and holidays, the active duty parent may return to find a child at a different developmental stage. In the case of children with ongoing mental health problems, the child may also be in a different place therapeutically. For example, one of us (MEF) recently treated an 11-year-old girl with Bipolar Disorder whose father had been deployed to Korea for one year. When the father returned he said he did not recognize his daughter, and while she was doing better therapeutically, he missed the aggressive, moody, and oppositional girl that he left behind.

Given public awareness and media coverage, the non-deployed parent may find it very difficult to shield children from the frightening realities of combat conditions where their dad or mom is stationed. For many families who are stationed overseas, when the active duty parent is deployed, the remaining family returns to the U.S. Mainland to be closer to home and their extended family and friends. Although this may improve day-to-day functioning of the family, it is highly disruptive to the children’s school lives. For the recent deployment of troops from the 25th Infantry Division at Schofield Barracks, Hawaii, many of the remaining families are taking their children out of school and returning to their “homes” on the mainland.

When children are being constantly challenged as described above, resilience becomes a requirement for healthy functioning. In this military system children and families must be flexible and adaptable, capable of coping with stressors most families do not have to endure. Resilience in both parents and children directly contributes to “soldier readiness” and ultimately has an impact on how well a military unit is able to accomplish its mission. Those that have difficulty coping are often referred for support services. If a family member is having significant problems, particularly externalizing behaviors, this member may be sent back to their home of record.

**Background**

The military plays an important role in the lives of its families and provides a wide range of family support (Jensen, Lewis, & Xenasis, 1986). Most of the early research concerning military children was centered on observational data, clinic-based studies, anecdotal evidence and hypotheses. Only within the last twenty years have there been good cross-sectional controlled studies. Though it is helpful
to look at the work done by these early researchers, it is important to keep in mind that today’s military family is very different than those originally studied. Currently, there is no draft, the military is a downsized force, there are more active duty women, and more single parent military families. The military is invested in promoting resilient families and providing resources for families’ emotional health.

Cantwell (1974) wrote on the prevalence of psychiatric disorders in military children ages 8–11 seen in a pediatric clinic. He used a semi-structured interview with the parents, a behavior questionnaire with teachers and a diagnostic play interview with the child. He found that 35% of the children had a psychiatric disorder. In 1978, LaGronne described what he coined the “Military Family Syndrome” based on a review of clinic records of 792 children and adolescents seen in a military mental health clinic. He stated: “the greatest number of behavioral disorders, nearly 93%, came from the authoritarian families (p. 1042).” He described a system where children had higher rates of mental disorders than their civilian counterparts, fathers were autocratic and controlling, scapegoating of family members was common, and the children suffered as a result of the paranoid system.

Morrison (1981) first challenged the “Military Family Syndrome” in a prospective clinic-based study of 140 military children and adolescents and 234 non-military patients. The only difference he found between the two samples was that the non-military children had a higher prevalence of schizophrenia and schizophrreniform disorder. Jensen, Xenasis, Wolf, and Bain (1991) re-examined the “Military Family Syndrome” by surveying 213 military families and compared their results to national norms. Parents and teachers rated the children’s behavior using established measures of internalizing and externalizing behavior, children completed measures of depression and anxiety, and parents reported on their life stress and depression and anxiety. Based on the use of established and commonly used measures of psychosocial functioning, Jensen et al. (1991) concluded that rates of psychopathology in military children, aged 6 to 12 years old, were not different from national normative data. However, they did find that mothers rated a greater proportion of the children as presenting clinically significant levels of emotional and behavioral problems than did fathers or teachers. Jensen et al. (1991) attributed the higher ratings of child emotional/behavioral problems by mothers as reflected the higher stress they were experiencing in maintaining the household as the non-deployed parent. This is an important finding for treatment efforts with military families; that is that reported child behavioral problems may signal problems in parental, particularly maternal coping. Finally, Jensen et al. (1991) found no evidence of a “Military Family Syndrome.”

In 1995, Jensen, Watanabe, Richters, Cortes, Roper, and Liu assessed the prevalence of mental disorders in a sample of the 294, 6- to 17-year-old military children, using a similar measurement approach to that used in the Jensen et al. (1991) study, with the addition of structured diagnostic interviewing using the NIMH Diagnostic Interview Schedule for Children (Schaffer et al., 1996). The
military parents were 70.1% enlisted (median rank Staff Sergeant E-6) and 29.9% officer (median rank Major O-4) with median incomes of $25,000–$30,000 a year. Structured diagnostic interviewing identified the following prevalence rates of disorders in the 294 children: 25.2% with any anxiety disorder, 4.3% with Major Depressive Disorder (MDD) and Dysthymic Disorder, 20.0% with Attention Deficit/Hyperactivity Disorder (ADHD) and 5.2% with Oppositional Defiant Disorder (ODD). The total prevalence was 40.8% of children with any disorder (many children qualify for more than one disorder with mean number of disorders being 1.3), which is lower that the rate seen in the U.S. civilian population as described in the Methodology of Epidemiology in Children and Adolescents (MECA) study of 48.5% for subjects 9–17 years of age (Schaffer et al., 1996). When these rates were further restricted by the requirement of diagnosis-related impairment and “need for services/use” the prevalence rates decreased to 114% for any anxiety disorder, 0.6% for MDD/Dysthymia, 2.7% for ADHD, and 3.3% for ODD. The rates of ADHD were higher than seen in the MECA study, but the levels of ODD and conduct disorder were lower. In summary, Jensen et al. (1995) found lower rates of psychopathology in the military children than found in the civilian population, again discounting the “Military Family Syndrome.”

Deployment

A few reports have looked at how children and families experience deployment at different times during the deployment cycle. Logan (1987), writing about Navy wives whose husbands routinely went out to sea, listed seven stages of deployment, broken into three phases of Pre-Deployment, Deployment, and Post-Deployment. Pre-Deployment consists of Stage 1–Anticipation of Loss, occurring one to six weeks prior to deployment and Stage 2–Detachment, which happens during the last week before deployment. Deployment itself includes Stages 3–5, and consists of Emotional Disorganization, Recovery and Stabilization, and Anticipation of Homecoming, respectively. Post-Deployment consists of Stages 6–7, Renegotiation of Marriage Contract, and Reintegration and Stabilization. Nice (1983) studied the course of depressive affect in Navy wives whose husbands were deployed as compared to those wives whose husbands remained at home using a depression questionnaire that was completed on a biweekly basis beginning six weeks prior to deployment and ending two weeks after return (a seven-month period). He found that the wives of the deployed group reported significantly more depression that the wives of the non-deployed group and that their mood improved to baseline within two weeks of their husbands’ return. Age correlated with depressive symptoms, with younger wives having more symptoms than older ones.

Pincus, House, Christenson, and Adler (2001) modified the deployment cycle of Logan to five stages: Pre-Deployment (preparation for leaving), Deployment (leaving), Sustainment (on assignment away from the home base), Re-Deployment (preparing to return home), and Post-Deployment (back at home base). This model was based on the authors’ observations of families during deployment. Based on our experience, it appears to provide a better fit to what actually
occurs. Pincus et al. (2001) emphasized the potentially large emotional impact deployment may have on children and spouses. They reported: “Each stage is characterized both by a time frame and specific emotional challenges, which must be dealt with and mastered by each of the family members (p. 15).” According to Pincus et al (2001), Pre-Deployment is a highly stressful period when numerous crucial tasks need to be accomplished to get ready for deployment. During the Deployment and Sustainment stages, the remaining spouse becomes a “married single parent.” She or he must take on full responsibility for the children and household, then relinquish it when the deployed spouse returns home. The role of head of household takes on a “revolving door” quality in many military families.

Pincus et al. (2001) found that a child’s response to the deployment of a parent is variable and listed some of the “negative changes” seen in children. For ages 1–12 the behaviors reported were “cries, tantrums, clingy, potty accidents, whining, and body aches, with irritable sad moods (p. 19).” For adolescents 12–18 of age, behaviors listed were “isolates, uses drugs with mood changes of anger and apathy (p. 19).”

In a study of Army children’s response to parents (90.8% fathers) being deployed for Desert Shield/Storm in 1990/1991, Rosen and Teitlebaum (1993) assessed parent-rated emotional and behavioral problems in 1,798 children, and depression and anxiety in the non-deployed spouse. The following were found to be significant predictors of children’s symptoms: symptoms of mother and other siblings, history of counseling, history of poor school performance, history of being on medication for hyperactivity, health problems, learning disabilities, younger age, and male gender. For example, high depression and/or anxiety in the mother was correlated with more symptoms in the children, such as eating problems, nightmares, sadness, and “perceived need for counseling.”

In a study of the Army wives during the Operation Desert Shield/Storm deployment of their husbands, Rosen and Teitlebaum (1994) reported that in general, younger spouses had more difficulty coping with deployment and utilized more medical resources than older spouses. In an earlier study (Rosen & Moghadam, 1991) of Army wives, the strongest predictor of general well-being (e.g., marriage, friendship, financial satisfaction, military life stress, and role satisfaction) was previous general well-being. Predictability of husband’s schedule, marital satisfaction, financial satisfaction, and experiencing a sense of “mastery” over their lives and obligations was predictive of wives’ well-being.

In 1989, Jensen, Grogan, Xenakis, and Bain studied the effects of an Army father’s absence on his children’s and wife’s psychopathology. Families whose father was gone greater than one month in the last year were compared to families in which the father was gone less than a month. Children for whom father was gone more than a month had significantly more depressive and anxiety symptoms than children whose fathers were gone less than a month. Mothers’ report of child behavior problems correlated with the amount of stress experiences by the mother and the level of her self-reported psychiatric
symptoms. Jensen et al. (1989) suggested that children’s difficulties as a result of father’s absence were related to family stresses and the level of emotional/behavioral problems experienced by the mother.

Jensen, Martin, and Watanabe (1996) examined children’s response to parents being deployed during Operation Desert Storm, specifically looking at children prior to deployment and after with respect to age and gender. A sample of 383 children ages 4–17 and their parents were examined using a measurement approach similar to Jensen et al. (1991) as well as measures of coping and social resources. Findings from the study showed that children of deployed parents reported significantly more depressive symptoms than children whose parents were not deployed. Boys of a deployed parent reported significantly more depressive symptoms than control boys and significantly more than either girls with a deployed or non-deployed parent. The caretaking spouses of deployed soldiers also had more depressive symptoms and more reported stress than controls, but no differences with non-deployed spouses in marital adjustment, social supports, or coping were shown. The lower the military rank the greater symptoms in the non-deployment parent. Previously, Nice (1983) reported the same pattern of increased depressive symptoms in Navy wives and children, with more depressive symptoms during fathers’ deployments, returning to the baseline after their return. These findings support the notion that in military children having problems it is likely that the caretaking parent also had elevated levels of stress and depression. We have also found this to be true in our clinical experience.

Kelley, Hock, Smith, Jarvis, Bonney, and Gaffney (2001) studied internalizing and externalizing behaviors in very young children (mean age of 3.1) of enlisted Navy mothers who were deployed and compared these behaviors to children of non-deployed Navy mothers and civilian controls. 83% of the deployed women were separated from their children for 5 or 6 months. When the three groups were compared, 12% of children of deployed mothers presented clinically significant levels of internalizing behaviors as compared to 1% of children of non-deployed mothers, and 3% of civilian control children. No significant differences were found for externalizing behavior between groups, although children of deployed Navy moms had slightly higher scores. Kelley et al. (2001) summarized that for deployed mothers their very young children may be susceptible to anxiety and sadness during deployment periods similar to results found in previous studies of deployed fathers even though the effects are small and not suggestive of higher psychopathology.

**Risk and Protective Factors in Military Children**

As shown in the above literature review, the concept of the “Military Family Syndrome” has been repeatedly debunked. Military children, if anything, exhibit less psychopathology than their civilian counterparts. This is remarkable given the additional challenges of growing up in a military family that moves every three years on average, in which one parent may be absent for prolonged periods on a regular basis. There have been no controlled studies that we know of that have specifically examined protective factors in military children. Some
military-related protective factors that have been hypothesized are lower divorce rates in military families; relative job security; screening of the active duty member for the criminal history or significant history of psychopathology; free medical, behavioral health, legal and recreational services; and more family support from allied agencies such as Family Advocacy, Alcohol and Substance Abuse Program, and the Exceptional Family Member Program. These latter organizations are specifically designed to assist families with problems, whether it is family violence, substance abuse, or a family member with a chronic illness or mental disorder. Undoubtedly these programs have benefit and, in some instances, greatly improve the lives of families, which we have witnessed on numerous occasions.

As we have demonstrated, deployment is a notable risk factor for emotional/behavioral problems in military children, and non-deployed spouses (usually mothers; e.g., Jensen et al. 1989, 1991, 1996; Kelly et al., 2001; Rosen and Teitelbaum, 1994). Other risk factors for the development of emotional/behavioral problems in military children have been suggested. These include: lower rank of the soldier parent, isolation from extended family and friends, frequent moves and school changes, dual active duty parents, single active duty parent, frequent parental deployments, and history of emotional/behavioral problems. Other risk factors are the same as those experienced by civilian families, such as family discord and divorce, parental substance abuse, younger age of the child, male gender (particularly for father’s absence), illness, sibling position, (Jensen et al., 1996). Lower rank families’ susceptibility to more stress and emotional/behavioral problems may be explained by a combination of factors, such as greater financial stress, less time and experience with the military, and younger age of parents (see Jensen et al., 1996). Regarding frequent moves, in a review article, Jensen et al. (1986) wrote that the difficulties with moves “are probably time-limited” and “may actually represent growth opportunities and increase coping capacities for most military families” (p. 230). More pronounced problems may occur in a small proportion of families, with negative attitudes about moving associated with dysfunction.

**Promoting Resilience in Military Children and Adolescents in 2004**

Operation tempo (OPTEMPO) is loosely defined as the rate of military actions or missions in clued training exercises, garrison duties, and deployments affecting the unit, the soldier, and the family. Since the Iraqi War the OPTEMPO in the military has greatly increased to a level most soldiers have not experienced in their military lives. The military and civilian populations are at heightened alert, and a great number of active duty personnel are in harm’s way. The reasons for this are many. Since 1990 the military had downsized from 2,043,705 to 1,411,634 (Department of Defense [DOD] statistics, web1.whs.ods.mil/mmld/military/miltop.htm, September, 2003). The Army’s numbers have decreased from 732,403 to 499,301 active duty soldiers during the same period (DOD statistics, September 2003). Combined with the greatly increased OPTEMPO, the likelihood of a soldier being deployed is much higher and the probability of more frequent deployments is greater.
Also, military technology has drastically improved over the last decade, requiring more training experience. The individual soldier's life is growing in complexity. A soldier must be capable of functioning for prolonged periods of time, under any environmental conditions, in dangerous places, and be highly effective 24 hours a day. In addition, performance of duty has become more public, as was the case when reporters were embedded within units fighting in Afghanistan. Soldiers themselves must be very physically fit and emotionally resilient.

Military demographics have also undergone considerable changes. In a review of the demographics of Army active duty and families members, data from 1990 to 2001 show that family members outnumber the actual number of active duty military, comprising 57.9% of the total military population in 2001 (Military Family Resource Center, www.mfrc-dodpol.org/, 2002). There were 1,221,951 military children and adolescents under the age of 18 (in 2003), of which 497,743 (41%) were 5 years old and younger, 426,151 (35%) were 6 to 11 years old, and 297,957 (24%) were 12 to 17 years old. The percentage of females on active duty has also dramatically increased from 1.4% in 1970 to 14.9% on 30 July 2003 (Women in the Military www.gendercenter.org/military.htm, multiple sources listed). Currently there are about 33,913 dual-military marriages and 87,475 single parent active duty families (Navy having 7.8%, Army 7.5%, Air Force 5.0%, and Marine Corps 3.2%).

Even though the military has expanded the types of behavioral health services available to families, there are still problems of stigma in seeing a military mental health care provider, “stove piping” (i.e., separate silos with their own bureaucracies) of services, and shortages in certain specialties, such as child psychiatrists that are actually seeing children. The stigma about seeing a mental health provider is not unique to the military, but is probably amplified by the fear that military commanders might discover that a soldier or sailor, for instance, seeks help and this might in some way affect their career. Confidentiality issues remain a concern for the active duty military, even though in most circumstances confidentiality in seeing a provider is closely maintained. Because of the recognized concern that soldiers and/or family members might not seek assistance when needed, the Army instituted a new program called “Army One Source” that began in August 2003 (www4.army.mil/ocpa/read.php?story_id_key=5183). This program provides 24/7 telephone access for information/counseling and referral, if requested, from a social worker or psychologist. The program offers six sessions from a civilian social worker that are free of charge and completely confidential. It is hoped that individuals and families that would not otherwise seek help within the system will take this opportunity to get assistance.

**School Mental Health as a Vehicle to Promote Resilience in Military Children**

The movement toward more comprehensive school mental health approaches, involving school-community partnerships to provide a full continuum of mental health promotion and intervention (see Weist, Evens, & Lever, 2003), is beginning to develop in military schools. Faran, Weist, Saito, Yoshikami, Weiser,
and Kaer (2003) described the first such comprehensive program—the Hawaii Wellness for Education Program (HWEP) on a military installation that included prevention, early identification and treatment of students within the school environment. In this partnership between Triplet Army Medical Center (TAMC) and the Hawaii Department of Education, child psychiatry fellows and a group of allied mental health trainees and professionals are providing a full continuum of mental health promotion, early intervention and treatment to youth and families in one elementary school (Solomon) on Schofield Barracks and is expanding to two others (Hale Kula and Wheeler Elementary Schools on military bases in Oahu, Hawaii). Preliminary analyses of data indicate that the project is having a positive impact on the students and teachers from the participating schools. Over a period of 2 1/2 years at Solomon Elementary School on Schofield Barracks, 123 students have been treated. Of these students referred for emotional/behavioral problems, only one was referred to special education (SPED), which contrasts within the rest of the Central Oahu District schools where about 25% of referrals to SPED are for emotional/behavioral problems. Parent satisfaction data at Solomon and school climate data at Wheeler Elementary School also strongly support the positive impact HWEP is having.

Importantly, the HWEP program is building interventions for students and families based on reducing the impact of risk/stress factors and on enhancing protective factors. Currently, Schofield Barracks, Hawaii, is getting ready for the deployment of soldiers to Afghanistan and Iraq. The goal is to prepare students as best as possible for a parent being sent into a dangerous environment for a period of a year or more. This is a daunting task. It is remarkable that military families, in general, function so well in coping with profound stressors such as this. Fortunately there are several other Army Agencies involved in the process of preparing families, such as Army Community Services (ACS), Community Mental Health Services, Family Readiness Groups, and Behavioral Health at Tripler Army Medical Center. At present, HWEP staffs are holding “Teach the Teacher” sessions with teachers, childcare providers and child recreational staff on how to communicate with kids about the deployment of a parent. Within the school, in-class sessions with the children discussing deployment of their parents are also planned. Numerous other activities are being planned or are in progress that involve all the above agencies listed. At present the response to the coming deployment is fluid and attempts to adapt to the needs of the community.

In addition to the major focus on preventing and addressing deployment related stresses, HWEP is seeking to build interventions in each of the three elementary schools to reduce unique stressors on military families. Advisors are trained in positive mental health (including relevant stress and protective factors, and information on coping with deployment), and in turn reach out to support other families, and to help connect them to needed resources, such as the HWEP program. Protocols are being developed to assist in identifying families who might be at particular risk (e.g., younger families, lower rank, evidence that non-deployed spouse is highly stressed).
The HWEP program is attempting to expand resources through connections with training programs in Hawaii for psychologists and social workers, and through the development of research grants. As staffs in HWEP expand, a training agenda is beginning to be developed that provides guided readings and training programs on reducing stress and risk and enhancing protective factors in military children and families. For example, the training program will include segments on: unique stressors of military families (e.g., deployment, risk, moves, isolation); transitioning to new communities/cultures; developing relationships in new communities; improving parent-child communication; controlling access to negative media; avoiding school disruptions; stress reduction; promoting positive family management, rituals and routines; sound financial management; promoting healthy marriage; and helping families connect to available Army resources. This training program is being developed based on the literature reviewed in this chapter.

Areas of Need and Future Research

Our involvement in practice and research in child and adolescent mental health and school-based mental health for military children and families supports a number of realities. As confirmed in this chapter, there is limited literature on factors that place military children and families at risk for both problems, and a limited literature on factors that may help them promote resilience. But there are many gaps in the literature. First, there is evidence that deployment is a major stressor for military children and families, but there is little empirical evidence on child and family functioning during other periods (e.g., pre- and post-deployment). There is a strong need to study the impact of Operation Enduring Freedom (operations in Afghanistan and Iraq) on military children and families, as was done in the past during Desert Storm. Importantly, our literature search failed to identify any comprehensive approach to assist families in coping with deployment, and similarly there was no literature on strategies to promote positive functioning during other deployment phases. There is a clear need for the future development of programs and connected research agendas related to assisting military children, families, and soldiers in coping with and showing resilience during all phases of Pre-Deployment, Deployment, Sustainment, Re-Deployment, and Post-Deployment.

There are many other related research agendas ready to be pursued, such as exploring protective factors that operate for military children, understanding relationships between family well-being and systems negotiation within the military, understanding negative and resilience promoting aspects of military culture, evaluating the impact of programs to support non-deployed parents, strategies to train school-based staff in reducing stress and enhancing protective factors (as is beginning to be done in HWEP), and methods to promote family routines and rituals, and to promote communication (within the family and with the deployed spouse).

Similarly, our literature review highlighted problems in traditional clinic-based mental health services for military children and families, and identified only a
few innovative approaches to bringing needed mental health promotion and intervention services to them. One of these innovative approaches is expanded school mental health (ESMH) for military families, and we are fortunate to be a part of a leading ESMH-military school program in Hawaii and the U.S. (see Faran et al., 2003). But again, the literature and research here is extremely limited. There is much mutual advantage to school-military partnerships. For schools that serve high percentages of military families, partnering with the military mental health community brings a high level of expertise and resources into the school, makes military officers (e.g., medical personnel with ranks of Captain or higher) human and accessible to school staff and families, and as shown by the HWEP experience, leads to outcomes valued by the families and the schools. For the military, well done ESMH provides needed care for military children and families, enhances support to them, and contributes to soldier readiness.

In spite of these advantages, the reality is that there are very few ESMH programs in military schools, and the research literature on effectiveness within them is very limited. There is a tremendous opportunity to advance an interconnected program development and research agenda related to ESMH in military schools, consistent with the field's national development (see Weist, Evens, & Lever, 2003).

It is also noteworthy that nationwide there is a critical shortage of child and adolescent psychiatrists. Kim (2003) analyzed data from the American Physician Masterfile for 2000, and found that there were about 6,300 child and adolescent psychiatrists in the U.S., which correlates to a national average of one psychiatrist per 15,000 youths under the age of 18. He stated, “...if a child and adolescent psychiatrist is to take care of the most severely impaired children and adolescents (5% of the population), each one has to carry a case load of 750 severely disturbed children and adolescents at any given time.”

In the Army there is also a shortage of child and adolescent psychiatrists, although not as severe in Hawaii. There are 57 Army active duty child and adolescent psychiatrists, of which only 8-12 (15-20%) are serving in full-time child and adolescent psychiatry positions (Colonel William S. Evans, personal communication, December 12, 2003). If it is assumed that there are 12 practicing child and adolescent psychiatrists, then this translates into one provider per 39,659 children and adolescents under the age of 18 (total population of 463,903). The remaining child and adolescent psychiatrists in the Army are practicing predominately adult psychiatry, although many of those (40-50%) see children on a space available basis.

These data are comparable with previous reports. Jensen et al. (1986) stated that of the 45 child and adolescent psychiatrists in the Army at that time, less than 20 “were actually serving in child psychiatry positions” given an estimated population of 630,000 children. The reason for this is there is also a shortage of psychiatrists in the Army, and many child and adolescent psychiatrist are needed to care for active duty soldiers. The military has relied predominately on the TRICARE, U.S. Department of Defense (DOD) Military Health System (primarily
a civilian system), to provide the additional services necessary to provide care, although there are DOD civilian psychiatrists at certain installations. For those who are referred to TRICARE providers, again the civilian system is greatly strained, in addition to the fact that in some geographic areas, TRICARE’s payment rate for child and adolescent psychiatrists are below the norm for that region of the country. We found in a review of patients referred to the TRICARE network on the island of Oahu, Hawaii, only about 50% of the children were ever seen by any mental health provider.

Thus, on the one hand HWEP provides an important example of the potential for child psychiatry and ESMH, but shortages of child psychiatrists generally and in the military are a factor that will mitigate against such involvement. This underscores the need for interdisciplinary approaches involving child psychiatry, psychology, social work, and education working closely together to develop plans to promote student mental health and assist youth in need (Weist, Prodente, Ambrose, Proescher, & Waxman, 2001). It also underscores a need for advocacy within the military regarding the need for (e.g., to promote resilience in the face of deployment) and benefit (e.g., to promote soldier readiness) of enhancing involvement of child mental health professionals in interacting with students and families, such as the schools, as in the expanded school mental health approach. Clearly, an outcomes focus, as begun in the HWEP project on the impacts of ESMH in military schools, will propel further research, the growth of resources, and the advancement of the field.

References

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Bounce Back

By Tom Jackson
Adapted from: More Activities That Teach
www.active-learning-site.com; (888) 588-7078

Topic Area: Resilience and Self-Esteem

Activity Concept: Bouncing back from problems is one reason we feel healthy self-esteem and personal resilience are such vital parts of a person’s character. It is the difference between feeling things are your fault or the feeling that outside forces have created a problem for you, but you can handle it. When we feel there isn’t any way we can successfully handle a situation due to a low impression of our own abilities, then we find ourselves less likely to risk moving out of our comfort zone to attempt new things. If this pattern is repeated over and over again, we soon find ourselves unwilling to try something new and staying right where we were in the first place while others around us are moving ahead.

Method: Small or large group demonstration

Time Needed: 10 minutes plus discussion time

Materials Needed: One inflatable beach ball

Activity: Have beach ball inflated before you begin demonstration. Begin presentation by explaining that you are using the beach ball to represent a person’s resilience. Show the group how resilient the beach ball is. It can be pushed in on one side and it will pop back to its original shape. You can drop it on the floor and it will bounce back up.

Now ask the group to list the things that might physically, emotionally, socially, intellectually or spiritually impact the ability of National Guard and Army Reserve kids to be resilient when their parents or loved ones have recently been deployed and/or have come home from serving in the current global war on terrorism. Let the group know that you are going to let some air out of the beach ball every time they name an event or situation that would lower their ability to be resilient. Caution: Don’t let too much air out for each item listed. You will want to stop when about one third to one half of the air has been let out of the beach ball.

Now once again push the side of the beach ball in and let them see if the ball returns to its original shape. Then drop the ball and point out that it did not bounce back. After the discussion time, blow the ball back up and show that we can foster resilience and raise self-esteem. Refer to the discussion questions about ways to foster resilience and repeat what they have said as you blow the beach ball back up a little at a time. Bounce the ball as a final reinforcement to emphasize the point you are making.
Discussion Ideas:
• What happened to the beach ball when I pushed on it when it had lots of air?
• What happened to the beach ball when I dropped it when it had lots of air in it?
• What happened to the beach ball when I pushed on it when it had less air in it?
• What happened to the beach ball when I dropped it when it had less air in it?
• What are some of the things that lower military kids self-esteem and their ability to be resilient?
• Who are the people around us that affect our self-esteem and ability to be resilient? Why do they?
• Is a low level of resilience a permanent thing? Why or why not?
• Is our ability to be resilient the same throughout the day? Explain.
• How can we raise our levels of self-esteem and resilience?
• Who can help us raise our self-esteem and ability to be resilient?
• How can we help others raise their self-esteem and ability to be resilient?