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REPORT FOR SCOTTISH EXECUTIVE EDUCATION AND YOUNG PEOPLE RESEARCH UNIT

Transitions in the Lives of Children and Young People: Resilience Factors

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1. EXECUTIVE SUMMARY

- For the purpose of this study, the following definition has been used:
  Resilient children are better equipped to resist stress and adversity, cope with change and uncertainty, and to recover faster and more completely from traumatic events or episodes.

What we know about resilience:

- Evidence from longitudinal studies indicates that a large proportion of children recover from short-lived childhood adversities with little detectable impact in adult life. Prospective studies of representative populations tend to find a weaker relationship between early trauma and adult outcomes than retrospective studies.
- An excessive pre-occupation with the identification and elimination of risk factors may weaken the capacity of children to overcome adversities. Gains made by removing risk factors should be greater than any negative unintended consequences that may occur through intervening.
- All interventions in health, education and social care may do harm as well as good. Where children, families and communities have the resources to deal with adversities without remedial help, services should not seek to provide unnecessary interventions.
- Where adversities are continuous and severe, and protective factors are absent, resilience in children is a rare phenomenon.
- Contrary to the beliefs of many adults, the most common sources of anxiety for children tend to be chronic and transitional events, such as bullying, an absence of friends, extended parental conflict or changing schools, rather than, for example, bereavement, acute illnesses or environmental risks such as abduction. Chronic problems will usually have more lasting effects than acute adversities.
- While self-esteem is a crucial factor in the promotion of resilience, high self-esteem is not, as often assumed, always a protective factor. There is little empirical evidence to support the widely held belief that, for example, bullying, delinquency and anti-social behaviour are strongly associated with low self-esteem. Self-esteem is more likely to grow and be sustained through developing valued skills in real life situations, than just through praise and positive affirmation.
- It is necessary to promote children's ability to resist adversities as well as moderating risk factors.
- Resilience can only develop through exposure to stressors. Both physical and psychological resistance develop through gradual exposure to difficulties at a manageable level of intensity, and at appropriate points in the life cycle.
- A supportive family is the most powerful resilience promoting factor.
- The acquisition of valued social roles, the ability to contribute to the general household economy and educational success are resilience promoting factors.
- Experiences that promote resilience may not always be pleasant or socially acceptable.
- Poor early experiences do not necessarily "fix" a child's future trajectory. Compensatory interventions in later life can trigger resilient responses.

Problems with resilience theory:

- The literature on resilience promotion, while empirically based, includes relatively few accounts of conscious and specific strategies used to promote resilience, and fewer still that have been subject to a robust evaluation using controlled trials.

- Theories that merely describe the relationship between variables, such as poverty and low self-esteem, are an insufficient basis for practice. Knowledge must also provide grounds for action. Unless resilience theory can do this, it will have limited practical utility for health, education and social services.
- Accounts of resilience promotion can appear little different to familiar models of positive child development, notably attachment theory. While not necessarily using the term "resilience", practitioners frequently describe approaches that are very similar to those recommended by the resilience literature.

Factors that promote resilience:

- The utility of resilience theory will be weakened unless a focus is maintained on the key elements that add value to our understanding of healthy child development. Children and young people who are best equipped to overcome adversities, especially those which occur during periods of transition will have, or be helped to have:

    - strong social support networks.
    - the presence of at least one unconditionally supportive parent or parent substitute.
    - a committed mentor or other person from outside the family.
    - positive school experiences.
    - a sense of mastery and a belief that one's own efforts can make a difference.
    - a range of extra-curricular activities that promote the learning of competencies and emotional maturity.
    - the capacity to re-frame adversities so that the beneficial as well as the damaging effects are recognised.
    - the ability - or opportunity - to "make a difference" by, for example, helping others through volunteering, or under-taking part time work.
    - exposure to challenging situations which provide opportunities to develop both problem-solving abilities and emotional coping skills.

In order to promote resilience in children, services should:

- ensure that well co-ordinated health and social care services are delivered to low income mothers from early pregnancy.
- provide reliable lay or professional support to isolated mothers during the child's infancy.
- encourage the involvement of male partners in child care.
- make available high quality pre-school provision based on sound pedagogic principles.
- seek to identify children's strengths even if they are not directly related to a formal curriculum.
- encourage early mastery of skills and encourage independent thought and action.
- not shelter children excessively from risk.
- encourage problem-solving as well as emotion-coping strategies.
- offer opportunities and support in adolescence for volunteering, part-time work and other situations that enable children to exert agency.

2. INTRODUCTION

2.1 *Purpose of the report*

The aim of this report is to describe effective strategies, in the fields of health, education and social work, for helping children cope with periods of change. It has three objectives:

- To assess evidence available from the literature and recent research about factors which promote resilience and enable children and young people to cope effectively with change in their lives, whether planned or unplanned.
- To describe approaches, and identify examples of professional practice, which have been effective in easing the experience of transitions.
- To explore the policy and practice implications of the findings for Scotland. This should include an examination of organisational responses, family support and professional issues such as inter-professional working and information sharing.

2.2 *Report structure*

The main part of the report is a literature review summarising studies on the promotion of childhood resilience. The primary sources of literature are European and North American and these are discussed in section 3. Section 4 arranges the applied material according to a life chronology model, from the foetal period to transition to adulthood. For each period in the lifecycle, effective strategies to help children cope with planned and unplanned change are described. Each period concludes with a short summary of the issues and interventions discussed.

The sections are illustrated with practice examples. These are drawn both from existing literature, and from a survey of health, education and social care practitioners in Scotland carried out as part of this study. This survey was undertaken in order to root the material more firmly in the local context, and consisted of a postal questionnaire of health, education and social work services in Scotland. Its purpose was to explore to what extent conscious strategies to promote resilience in children during periods of transition are currently being designed or implemented. The survey questionnaire and respondent list is provided as Appendix A and summarised in section 5.

A reference group provided feedback on the draft findings of this report, and these comments are summarised in section 6. The topic guide used is provided as Appendix B.

2.3 *Search strategy*

A comprehensive search of on-line and CD-ROM databases was undertaken. Searches were conducted using truncated versions of children and resilience (CHILD# AND RESILIEN#), with additional search terms to identify methodological sub-sets (randomised controlled trials, meta-analyses, systematic reviews and reviews) and client sub-sets (education, delinquency, chronic illness, disability, etc). Particular attention was paid to intervention studies using control or comparison groups. The most fruitful sources of material were MEDLINE and PSYCLIT. Social care and educational studies not indexed on these databases were retrieved through CAREDATA, ASSIA, and the Barnardos' library catalogue. Search engines were also used (www.google.com; www.hotbot.com; www.lycos.com) to locate web based resources, which are discussed where relevant in the report and listed as Appendix C.

In examining the literature, we have taken a broad view of children's "transitions", taking this to mean any episode where children are having to cope with potentially challenging episodes of change, including progressing from one developmental stage to another, changing schools, entering or leaving the care system, loss, bereavement, parental incapacity or entry to adulthood. The literature located was primarily North American in origin, possibly due to the concept of resilience having a particularly strong resonance with American culture (Rigsby 1994). However, a substantial body of UK literature also exists, with the Nordic countries also being a source of material. A recent review of international resilience literature conducted in Australia was also located (Rayner and Montague 2000). Most European languages do not have a single term that replicates the English term "resilience", making international literature searches difficult. In Spanish, for example the concept may be translated as "*la defensa ante la adversidad*" (defence against adversity), in French "*avoir du ressort*" (to bounce back), in Welsh "*abl i wrthneido*" (able to rebound), in German "*unverwüstlichkeit*" (irrepressible or indestructible), in Italian "*capacita di recuperð*" (ability to recover).

2.4 *Definition of resilience*

What is resilience? As the above paragraph illustrates, the concept appears to be understood cross-culturally as the capacity to resist or "bounce back" from adversities. A well-known clinical definition of resilience is '*the maintenance of competent functioning despite an interfering emotionality*' (Garmezy 1991:466). A resilient child is one who exhibits positive adaptation in circumstances where one might expect, due to atypical levels of stress, a significant degradation in coping skills to take place (Masten and Coatsworth, 1998). The International Resilience Project, which collected data from 30 countries, described resilience as '*a universal capacity which allows a person, group or community to prevent, minimize or overcome the damaging effects of adversity*' (Grotberg 1997:7). This study noted that cultures tended to emphasise different approaches to promoting resilience. However, every country that supplied data drew on a similar range of factors, indicating that resilience, as a concept, crosses national and cultural boundaries, a conclusion also reached by a more recent cross-cultural study of resilience in adolescents (Hunter 2001). As this report required a common understanding of resilience by the respondents to our survey and advisory groups in non-clinical language, we used the following formulation to define and describe resilience:

> *Resilient children are better equipped to resist stress and adversity, cope with change and uncertainty, and to recover faster and more completely from traumatic events or episodes.*

The concept of resilience has been subjected to a number of criticisms in recent years, notably by those who argue that it differs little from strategies aimed at achieving normal childhood adjustment (Tarter and Vanyukov 1999). Perhaps a greater challenge is posed by Michael Rutter, one of the key sources for any review of resilience, who noted that, while we have an increasing understanding of the processes that drive risk and protective factors, we have 'substantially less knowledge about how to influence those processes in order to increase resilience' (Rutter 1993:630). In order to find practical applications for resilience theory, we must therefore approach resilience as a dynamic factor, subject to promotion or diminution by human agency. In other words, our actions, for better or worse, must be able to *affect* the way in which children cope with adversities during periods of transition. Simply noting child, family or environmental

issues that appear *associated* with resilience, but are not sensitive to manipulation, may be of theoretical interest but will have limited utility for health, education and social care services, and indeed the lay public. We have therefore sought to focus on strategies which have some promise for practical application.

The report focuses on interventions that fall within the immediate jurisdiction of education, health and social welfare agencies, rather than at the broader social policy level. However, in almost every dimension that is discussed, poverty and inequality are relevant and sometimes paramount factors. Better educational and health outcomes are more likely to result for children when they and the families in which they live have an income above the poverty line (Acheson 1998). All of the strategies described in this report will prove more effective in a social environment committed to the narrowing of health inequalities.

3. Resilience - general principles

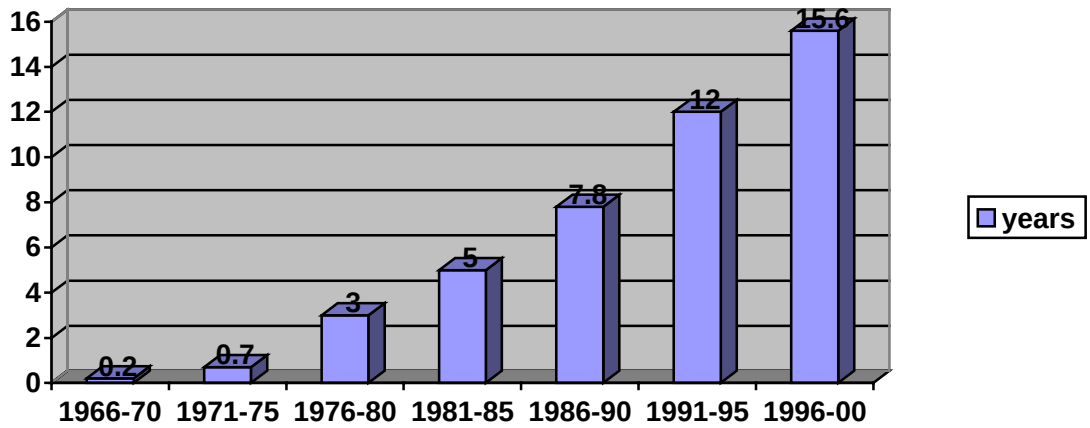
> All of us can point to people to whom everything seems to happen and to others who seem to walk between the raindrops (Antonovsky 1979:77).

While the study of resilience has been well developed in psychology, it is less familiar in the fields of education and social care (Smith and Carlson 1997). Nonetheless, resilience has been recently discussed in social work, education and allied journals in relation to sexual abuse (Spaccarelli and Kim 1995): child maltreatment (Heller *et al.* 1999): the children of alcoholics (Palmer 1997): parenting and child care (Kraemer 1999); child placement and children in need generally (Gilligan 1997; 2000): children with emotional and behavioural difficulties (Lewis 1999): looked after children (Jackson and Martin 1998): family therapy (Rutter 1999): personal development in schools (Raphael 1993): adoption (Clarke and Clarke 2001): and, more generally, as a conceptual framework for social work practice (Saleebey 1996). Why and how can the promotion of resilience help children and young people cope with the adversities that arise during periods of change and transition?

3.1 *Our growing concern with risk*

Compared to earlier generations, children, according to a recent review by the Mental Health Foundation (1999), have become less able to cope with and overcome stressors and obstacles, partly because of their being sheltered from challenging opportunities. For example, despite a child being twice as likely to be involved in a road traffic accident in 1922 as today, the proportion of seven and eight year olds making their own way to school declined from 80% in 1971 to under 10% by 1990 (Maden and Hillman 1996). While this has resulted in a decline in child mortality through traffic accidents, it has contributed to a substantial increase in child obesity and a correspondingly greater threat of chronic illness and premature death in adulthood (DiGuiseppi *et al*. 1997). Recent trends in health and social care services have tended to emphasise factors that pose risks for children, rather than opportunities for growth and adaptation (Early and GlenMaye 2000). This can be illustrated by the following figure, which shows the percentage of MEDLINE abstracts (the world's largest data base of health care research) which contain both the words 'child' and 'risk' in five year periods, from 1966 to 2000.

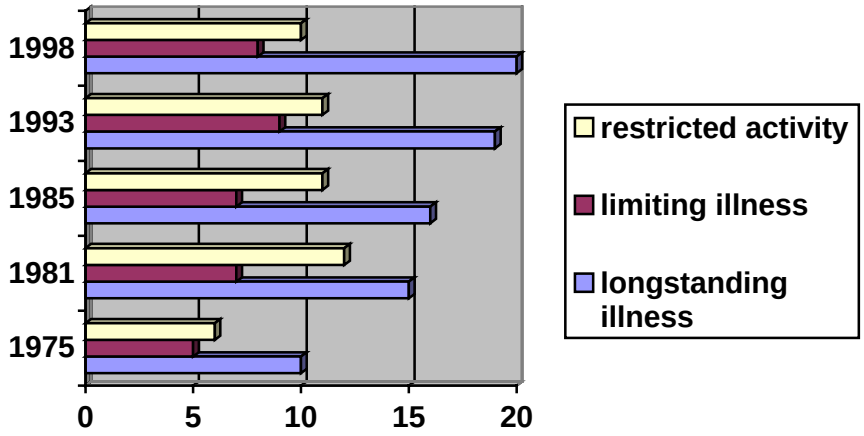
Figure 3.1 - Percentage of MEDLINE records concerning children & risk 1966-2000
(search conducted 05/09/01 www.ncbi.nlm.gov/entrez/query.fcgi)



As we can see, the proportion of studies concerned with child risk factors has increased from under 1% to over 15% over a 35 year period.

While our growing pre-occupation with the identification of potential risk factors has led to substantial improvements in many important aspects of children's physical health, it has not, unfortunately, led to a similar improvement in many dimensions of children's psychosocial well-being. On the contrary, there is a widespread consensus that a substantial increase in psychological and conduct disorders of children has taken place in most developed countries over the past half century (Rutter and Smith 1995; Slap 2001). This trend is present even in countries with such highly admired social welfare systems as Sweden (Nordberg 1994, cited in Werner and Johnson 1999). Children themselves have also reported increases in long term illnesses, as illustrated below.

Figure 3.2 - Trends in self- reported illness 1975-1998 (children aged 5 – 15 years)



(Source: Office for National Statistics, 2000)

We are thus confronted with the worrying situation of children being affected by an absolute increase in many serious problem areas, notably conduct, attention and eating disorders, self-injurious behaviours, para-suicides and suicide itself, accompanied by an apparent weakening of a capacity for natural resistance. The promotion of resilience may be an important strategy in attempting to reverse this trend, through placing less emphasis on risk factors, and more on factors that promote well-being (Rayner and Montague 2000).

3.2 *Risk and resilience*

Risk factors heighten the probability that children will experience poor outcomes. Resilience factors increase the likelihood that children will resist or recover from exposure to adversities. Positive child development is not simply a matter of reducing or eliminating risk factors and promoting resilience. The successful management of risk is a powerful resilience-promoting factor in itself (Rutter 1994). However, risk factors are cumulative. Children may often be able to overcome and even learn from single or moderate risks, but when risk factors accumulate, children's capacity to survive rapidly diminishes (Fergusson and Lynskey 1996). Risk factors are often inter-connected. For example, a child living in a deprived neighbourhood may experience a poorer education, as a result be drawn into dangerous peer-group activities, and limited job aspirations may follow. When this is accompanied by exposure to parental conflict or the poverty

that often results from single parenthood, even a child with a highly resilient personality may succumb. Transitional periods are also periods of heightened risk, illustrated, for example, by the frequent decline in academic performance of vulnerable children on transfer from junior to senior schools (Jackson and Sachdev 2001). Risk and resilience factors both operate in three dimensions: the individual, the family and the community:

Table 3.1 - Risk factors

The Child	The Family	The Environment
Learning disability	High level of parental conflict	Poverty and low social capital
Genetic factors	Parental separation	Homelessness or fragile housing
Developmental delay	Lack of consistent guidance	Racism
Difficult temperament	Parent-child hostility	Unpredictable and unmanageable crises
Problems with communication	Abuse	
Chronic illness	Parental psychological disorder	
Poor educational performance	Parental alcoholism or drug dependency	
Low self-esteem	Parental criminality	
	Poor friendship networks	

(from Pearce and Holmes 1994)

A child is unlikely to resist a continuous stream of adversities without compensatory sources. The theoretical factors that protect children through the promotion of resilience have been extensively explored. These factors are the key components of resilience, and are illustrated below.

Table 3.2 - Resilience factors

The Child	The Family	The Environment
Temperament (active, good-natured)	Warm supportive parents	Supportive extended family
Female prior to and male during adolescence	Good parent-child relationships	Successful school experiences
Age (being younger)	Parental harmony	Friendship networks
Higher IQ	Valued social role (eg care of siblings)	Valued social role (eg a job, volunteering, helping neighbours)
Social skills	Close relationship with one parent	Close relationship with unrelated mentor
Personal awareness		Member of religious or faith community
Feelings of empathy		
Internal locus of control		
Humour		
Attractiveness		

(sources: Emery and Forehand 1994:81; Palmer 1997:203; Gilligan 1997:15).

As can be seen, some of these factors are partly bio-genetic and their sensitivity to change or manipulation is limited. Most, however, are familiar variables and present a wide range of possibilities for positive change.

3.3 *Recovery*

Studies of resilience present an optimistic view of the potential for human resistance and recovery. It has been observed for many years in the study of child development that adverse life events have contributed to psychiatric disorders in some children while others, faced with identical precipitating factors, have emerged unscathed (Bleuler 1978; Kaufman *et al*. 1977; Garmezy and Rutter 1983; Anthony and Cohler 1987; Dugan and Coles 1989; Hauser *et al.* 1989; Gore and Eckenrode 1994; Katz 1997). Data suggest that only around one third of an "at-risk" child population experience negative long term outcomes; up to two thirds appear to survive without serious developmental harm (Furman 1998; Rutter, 1985; Wolin and Wolin 1995; Buchanan and Ten Brinke, 1998; Kirby and Fraser 1998). However, this observation will be far less valid when applied to children with extreme and continuous adversities, where resilience is likely to be rare (Cicchetti and Rogosch 1997; Runyon *et al*. 1998). Its validity also depends on a definition that identifies the presence of resilience where better outcomes occur than might be expected, given normative expectations of the impact of adversities, rather than a highly successful adaptation compared to children who have faced no adversities at all (Fraser *et al*. 1999). In other words, are we comparing resilient children to children in general, or just to ones that have experienced similar adversities?

It is generally acknowledged that most factors that threaten or protect children are largely inert by themselves (Rutter 1985). Their toxic or prophylactic potential emerges when they catalyse with stressful events, especially where these are prolonged, multiple and impact on the child during sensitive developmental stages. Combinations of factors that render children vulnerable have received far more attention than the personal, social and environmental formulae that may protect them (Felsman and Valliant 1987; Cowen and Work 1988; Flach 1988; Saleebey 1996). While it may often be a difficult proposition for those concerned with the welfare of children (including parents) to accept, meeting and overcoming challenges is necessary for healthy adaptation. Michael Rutter, noting the way in which all organisms adapt to both social and biological threats, observed that 'resistance to infection comes from the experience of coping successfully with lesser doses ... of the pathogen' (1993:627).

There is, however, no simple association between stress and gain. Some stressors may trigger resilient assets in children, others may compound chronic difficulties (Quinton and Rutter 1976). For example, siblings may react differently to the illness of a parent (Beardsall and Dunn 1992). Classroom discussions aimed at helping children cope with parental separation may be protective for some children and cause unnecessary anxieties for others (Gilleard 2001). Developing a construct of resilience is thus a narrow tightrope to walk. While we may recognise that adversities *may* result in enhanced competencies, we cannot ignore the consequences of multiple risk factors on children's health and development. If children are subjected to a relentless stream of multiple adversities, negative consequences are highly likely to follow (Garmezy and Masten 1994).

3.4 *Types of resilience*

While resilience can be interpreted in a number of ways, it most commonly refers to the illustration of competencies or positive adaptation in circumstances where adversities are

of such a degree that normative assumptions would expect a significant degradation of ability or functioning (Rutter 1985; Garmezy 1985; 1991; Masten and Coatsworth 1998). Three broad types of resilience tend to be described (Masten *et al.* 1990). The first type is represented by children who succeed, or do not succumb to adversities, in spite of their high risk status, for example low birth weight babies. The second type concerns children who exhibit maturity and coping strategies in situations of chronic stress, such as children of drug using or alcoholic parents. Thirdly, resilience may be exhibited by children who have suffered extreme trauma, for example through disasters, sudden loss of a close relative or abuse, and who have recovered and prospered (Gibson 1998). Resilience appears to be a dynamic rather than a fixed attribute, having the capacity to emerge in later life after earlier periods of coping problems (Werner and Smith 1992). However, while a number of psychometric instruments have been developed which attempt to quantify resilience in both adults and children (Wagnild and Young 1993; Wolin and Wolin 1993), these have not, as far as this review was able to ascertain, been adapted for use in the U.K.

3.5 *Cohort studies*

Studies that follow children over a period of time, especially through to adulthood, are probably our strongest source of information on the relationship between personal, family and environmental variables, and resilience. Early studies of resilience were retrospective accounts (for example, Khan 1964; Sobel 1973; Krystal 1975). Retrospective studies typically find higher levels of morbidity and clearer relationships between early trauma and later outcomes than are located by prospective studies (Macfarlane *et al.* 1954; Garmezy 1974; Sameroff and Chandler 1975; Murphy and Moriarty 1976; O'Grady and Metz 1986). Cohort studies, which track the same group of people over a period of time, are more reliable vehicles for estimating cause and effect. A wide range of US and UK cohort studies have given us more insight into the relationship between childhood adversities and adult adaptation. For example, Glen Elder's studies of the impact of the Great Depression in the USA illustrate how valued social roles for adolescents in periods of family stress could be protective (Elder 1974; Elder and Caspi 1987). As long as tasks were within the developmental capacity of children, participation in household tasks and part-time work appeared to result in more long term benefits for children by encouraging motivation, confidence and competence, compared to children who had no such opportunities (Bronfenbrenner 1979). Werner and Smith (1982; 1992), who followed the progress, over 40 years, of a group of children growing into adulthood on Kauai, an island of the Hawaiian chain, suggested that factors promoting resilience tend to re-occur in longitudinal studies of children, regardless of their ethnic, cultural or socio-economic backgrounds. Of particular importance were strong bonds between child and primary care giver in the early years of life, encouragement for children to be active, robust and socially active, the availability of alternative caregiving from other family members, especially grandparents and elder siblings, the forging of strong inter-generational bonds by girls with other female family members, the availability of male role models for boys and environments with kin and community networks, sharing similar cultural beliefs. Non-resilient youth lacked these factors and attributed negative life events to bad luck, fate or other factors beyond their control. In their 1982 study, a third of the children who were predicted to be at severe risk developed into well-adjusted young people at age 18. A decade later, a follow-up study found that two thirds of the "at risk" young people had become competent adults.

Meaningful work has been identified as a protective factor for adolescents (Engel 1967; Thiede Call 1996), and provides opportunities for adolescents to develop confidence and

competencies (Finch *et al*. 1991; Mortimer and Finch 1996). The New York Longitudinal Study, begun in 1956 (n=133), which set out to examine both normal and atypical child development, noted an association with instrumental work patterns and later adjustment (Chess, 1989). As well as part-time work, the value to children of developing competencies in leisure and cultural pursuits or through volunteering has been highlighted (Gilligan 2000). These diverse activities, whether paid work, domestic responsibilities, helping others through volunteering, sports, or cultural pursuits, share a common feature - the promotion of self-efficacy and self-esteem through the capacity of the child to exert agency over their environment. Extra-curricular activities in general, by connecting children - especially those at-risk - with external networks appear to have a protective function (Masten and Coatsworth 1998; Gilligan 2001a).

Unlike many longitudinal studies which explore the destinations of children coping with severe adversities, Murphy and Moriarty (1976) followed the largely secure and supportive childhood of 128 children from infancy to late adolescence, beginning in 1952, in the town of Topeka, Kansas. Murphy and Moriarty located the ability of their cohort to develop mastery of emotional, cognitive and motor competencies in the ecology of their environment and family structure. From an early age children were expected to undertake chores - tidying rooms, washing dishes, helping in the garden and looking after younger siblings. Child monitors as young as nine controlled traffic at intersections near their schools, stopping cars when school children wished to cross. Older children were allowed to roam freely and advertise their availability for labour such as baby-sitting and lawn-mowing in local newspapers.

Osborn (1990) examined data from the 10 year follow-up (n=14,906) of the Child Health and Education Study (CHES), which has followed the progress of all children born during the week 5-11 April, 1970 in England, Scotland and Wales. The most disadvantaged children were in the bottom decile. While several of the factors investigated were associated with an increased or decreased likelihood that children would develop competencies, the most powerful factor was the attitude and behaviour of parents. Non-authoritarian and child-centred parenting, along with positive attitudes to the child's education, outweighed the effects of all other variables combined. However, such positive parenting was only likely to occur where the impact of low socio-economic status was mitigated by positive factors, such as good marital relationships or supportive family and friends.

The UK National Child and Development Study (NCDS) has been a rich source of data on childhood development since its inception in 1958 as a cohort study of all child born in England, Wales and Scotland during one week in March of that year. Pilling (1990) examined a sample of 386 children at age 27 who were socially disadvantaged at ages 11 or 16 (or both). The children from the disadvantaged group who appeared to be least affected shared similar personal attributes and environmental circumstances. Personal qualities included gender, flexibility, an unwillingness to give up and valuing achievement. Their environment contained supportive characteristics, such as emotional support and security and opportunities for good life experiences. Even so, the escapees contained proportionately fewer children who had grown up in lone parent families, in families where there was chronic maternal illness or the father was unemployed. Important factors noted by Pilling were the critical role played by the fathers of the escapees, shared religious practice by the parents and encouragement at home for the child's educational pursuits. Achievers themselves saw determination and hard work as critical factors in their success.

Slightly different conclusions were reached by the Christchurch Health and Development Study in New Zealand, which followed a birth cohort of children (n=940) to age 16 years. Unlike many other similar studies, family cohesion was found to be less important as a resilience-promoting factor. Apart from higher IQ - a finding common to all studies - lower novelty-seeking behaviour and fewer affiliations with delinquent peers were most strongly associated with higher resilience.

We can see from this brief summary of some of the more important cohort studies that resilience-promoting factors remain fairly consistent, with supportive families, positive peer relationships, external networks and the opportunity to develop self-esteem and efficacy through valued social roles being of particular importance.

3.6 *Protective factors*

The combination of three basic constructs, personality (specifically cognitive skills and styles), social milieu (absence of chronic life stresses and opportunities for meaningful social roles) and family structure (high warmth/low criticism) has been consistently identified as the key protective factor for children exposed to a wide range of stressors, including child abuse, parental illness and intra-family strife (Hauser *et al.* 1985). Even in such potentially stressful areas for children as parental psychosis, the capacity of parents to promote competency is not necessarily hindered, as long as the parent retains the capacity to express warmth towards the child and to maintain non-familial social contacts (Kauffman *et al.* 1979; Musick *et al.* 1984).

The differing abilities of individuals to cope with stressful situations can be attributed to a host of inter-connected factors. These include psychological and physiological characteristics inherited or acquired in the early years of life, the timing, duration, sequence and frequency of stressful events and the geography of the individual's peer, family and community supports. Protective factors may be related to the individual or to the situational context. Factors that are associated with the former (Masten *et al*. 1990) are problem-solving abilities, attractiveness to adults and peers, perceived competence and efficacy, identification with valued role models, and a desire and capacity to exert control over the immediate environment. The ability to make and sustain intimate friendships, and the availability of support networks of friends, siblings and other important social ties, have been associated with resilience, both in childhood and later life (Beardslee *et al.* 1987). The capacity of some children to forge supportive links with adults is noted by Werner (1982), who observed that resilient children were particularly adept at recruiting surrogate parents, including teachers, parent's friends, ministers and other relatives. Pellegrini *et al.* (1986), who compared the children of parents with bipolar disorders with a control group of non-affected children, noted that resilient children were more frequently of stable temperament, had a constructive role to play in the family, networks of friends and a strong locus of self control.

A key protective factor for children who have experienced severe adversities is the capacity to recognise any *benefits* that may have accrued, rather than focusing solely on negative effects, and using these insights as a platform for affirmation and growth. While this process has been studied more in relation to acute, rather than chronic challenges, the recognition that adversities can be overcome is crucial in developing an approach to life that is active, rather than passive, and optimistic rather than pessimistic (McMillen 1999).

3.7 *Acuity and chronicity*

While responses to specific stressors will differ widely, the respective dimensions of resilience or vulnerability are primarily related to the accumulation of stressful events over time, their proximity to each other and the longevity of the stressful episodes (Sameroff *et al.* 1993; Garmezy and Masten 1994). Multiple risk factors appear to potentiate each other rather than simply having a cumulative effect (Dohrenwend and Dohrenwend 1974; Johnson and Sarason 1978). It has been argued that greater insight can be achieved into the effect of and adjustment to stress by focusing on "hassles" rather than events that are greater in magnitude but much rarer in frequency (Lazarus 1980; 1984). Hassles are more homogeneous in meaning and more closely related to outcomes than major life events, thus deserving as close attention as more acute episodes (De Longis *et al.* 1982).

This insight has particular relevance to the study of stress and coping in children. Early attempts to measure the relative magnitude of life events, in terms of their impact on children, relied on judgements made by adults. For example, Coddington (1972), in measuring their relative significance, confined his analysis to the views of mental health professionals and educationalists. The highest ranked life events - death of parents, acquisition of a visible deformity, unwanted pregnancy - were characterised by acuity rather than chronicity. However, subsequent studies, using children as informants rather than relying on proxy views, have highlighted significant differences in the views of children and adolescents compared to those of adults on the significance of major life stressors. Adults tend to identify acute and major life events as stressful, whereas children emphasise the primacy of daily hassles, for example conflict with peers or between parents, or transitional events such as changing schools (Compas 1987; Wertlieb 1991). Thus, while acute life events *may* result in adverse psychosocial impacts, the available evidence suggests that chronic adversities are more strongly associated with risk foci (Sandberg *et al.* 1993; Rutter 1994).

3.8 *Compounding factors*

Adverse risk for children where, for example, serious parental disorders are present is primarily associated with significant levels of family discord and disruption (Rutter and Quinton 1984). Children showing strong continuities in conduct and psychological disorders into adulthood are likely to have been exposed, not just to episodic periods of family illness or other distressing events, but to continually adverse circumstances throughout childhood (Quinton *et al*. 1990). As has been noted with the relationship between socio-economic class and competencies (Luthar and Zigler 1991), parental *conduct*, rather than the diagnostic condition or economic status, appears to be more closely related to child outcomes. The dominance of chronicity over acuity - of hassles over major life events - explains the strong evidence pointing to serious parental conflict and separation as a potentially more damaging event in the lives of children compared to parental death (Graham 1994). While risks derive mainly from adverse events that are chronic in nature, resilience is located not just in sources external to the child but the extent to which the child is able to - or is enabled to - interact with their environment in a way that reduces helplessness and promotes control.

3.9 *Live now, pay later?*

The extent to which children may pay a price in later life for effective adaptation is unclear (Pound 1996). However, enough evidence exists to warn us not to draw simplistic conclusions about the simultaneous development of behavioural and emotional

competencies. In a wide variety of stress-inducing situations affecting children, for example war zones (Saylor 1993), domestic abuse (Farber and Egeland 1987) and malnutrition (Engle *et al.* 1996) behavioural competencies were not equally complemented by emotional health. Similarly cautious conclusions have been reached in studies of adolescents, where the high levels of adjustment on behavioural measures of competence found in youths was not matched by emotional strength (Luthar 1991; Luthar and Zigler 1991; Luthar *et al*. 1993; Kotchick *et al*. 1997), though other studies have found less evidence of distress (Neighbours *et al.* 1993). Statistically comparable levels of depression and anxiety were found among the children labelled resilient and those at the lower extreme of social competence, suggesting that these apparently "stress-resistant" children were by no means untroubled. In relation to child maltreatment, surprisingly high levels of age related competencies have been found in sexually abused children. These children however, often exhibited high levels of anxiety or depression, indicating that competencies and absence of symptomatology do not always go together (Kinard 1998; Spaccarelli and Kim 1995; Chambers and Belicki 1998).

While these qualifications must be noted, the tendency to identify the "price" paid for acquiring resilience to specific distal outcomes, such as depression, has been challenged (Rutter 1993). Adult adjustment, he points out, results from a trade-off of factors - an effective balance rather than eliminating *all* the negative consequences of early trauma is the main requirement. Resilient people may often retain 'a realistic baggage of sadness and unhappiness' (Garmezy 1991:466), but will also have the capacity to cope with their emotional burdens.

3.10 *Positive stress*

In challenging the preoccupation with maladjustment and pathology, Antonovsky (1979; 1987) suggests that we need to question our conviction that stressors are inevitably damaging, and consider instead what keeps people healthy, rather than what makes them sick, a process he described as *salutogenesis*. The salutogenic model in health care research has paralleled the development of resilience theory in the social sciences and has two key components: internal and external resources that comprise the arsenal of a person's emotional and material defences, and an ability to render the world understandable and hence manageable (Lindstrom 2001). Resilience develops through the positive use of stress to improve competencies (Frydenberg 1997). Expectations appear particularly important in promoting resilience. Competence, confidence and self-esteem go hand in hand; children develop immune mechanisms when the child grows in an environment which is not less protective but less *anxious*, where carers are willing to 'leave matters to the child himself even to the extent of taxing his immaturity' (Anthony 1974:541). Studying the careers of adults who, as children, grew up with alcoholic parents, Wolin and Wolin proposed that the key quality needed to trigger resilience and recovery was the ability to see childhood adversities in a new way, and to recognise that one is not a powerless actor in a drama written by others. An excessive focus on what services *do*, rather than an understanding of the source of protective influences that lie within individuals, families or communities, devalues and diminishes the naturally occurring buffers against childhood risk (Werner 1995). As was illustrated in Table 3.2, three groups of factors have been consistently identified as characteristics that distinguish resilient from non-resilient children: the personal qualities of the child, a supportive family or extended family, and supportive individuals or agencies in the immediate social environment (Garmezy 1983). Schools are particularly important to the last factor, given

that the maximisation of a child's educational potential is a key stimulant of resilient adaptation (Rutter 1979).

The promotion of resilience may, however, present problems to child welfare services in that experiences which improve a child's capacity to deal with stress, or teach competencies that protect against unwanted outcomes, are not necessarily pleasant or socially valued (Rutter 1985). For example, experiences that initially evoke fear may, after repeated exposure, result in competence and even pleasure - one need go no further than the example of a fairground rollercoaster ride. Child welfare services are under increasing pressure to avoid exposing children to any manifestation of risk. This may result in an unfortunate contradiction when interventions are provided - the consequences of providing support to children encountering adversities may be the insulation of children from the competency-enhancing experiences associated with exposure to risk.

3.11 *Resilience and self-esteem*

The promotion of resilience has been closely associated with gains in self-esteem (Gilligan 2001a). Children are not passive templates on which outcomes are etched, but have the capacity to actively play a part in shaping their own responses to family stress (Drotar 1994). Coping styles, as described in the influential work of Lazarus and colleagues (Folkman and Lazarus 1980; Lazarus and Folkman 1984) may be of two kinds:

- *Problem solving coping* - developing skills, suppressing irrelevant activities, seeking information and planning - is thought to be more effective in that it involves the affected person in taking active control of the situation.
- *Emotion focused coping* reduces emotional stress and has a supportive function, but is less adaptive in that it fails to address long term issues, though it may be inevitable in situations where the individual has no control over their circumstances.

While high self-esteem will often be a protective factor and an outcome to be welcomed, in some cases it may be a *risk* factor, especially where it results from "successful" delinquent behaviour (Hughes *et al*. 1997). A recent major review of the causes of low self esteem concluded that it is not, contrary to popular belief, a risk factor for delinquency, low educational attainment or adolescent drug/alcohol abuse, though it does constitute a risk factor for suicide and para-suicide, depression and teenage pregnancy (Emler 2001). This review expands on the influential work of Martin Seligman (1975; 1998) who proposes that self-esteem can only result from developing and testing competencies in real-life situations, and not just from praise and confidence building. It has been argued, in fact, that the recent rise in depressive illnesses among young people has been partly fuelled by the popular "self-esteem movement", which has persuaded a generation of young people that a belief in self-worth is sufficient for success, but who are then easily discouraged when success does not occur (Rayner and Montague 2000). These findings indicate the need for a more cautious and critical approach to the promotion of self-esteem than is often indicated in statutory guidance (Department of Health 2000).

3.12 *Cultural resilience*

Most communities contain ethnic or cultural minorities. Some of these minorities, due to historical reasons, factors connected to migration patterns, institutional racism or economic activity, face greater obstacles than others in resisting stressors. For example, British African-Caribbean children suffer from excessive rates of school exclusion (Okitikpi 1999), suicide and para-suicide rates are higher for gay and lesbian

young people (Bird and Faulkner 2000; Trotter 2000), unemployment disproportionately affects Bangladeshi young people (Jones 1996). Where the cultural assets of minority groups go unrecognised or under-valued by the wider community in which they live, active support for children in learning about their heritage and creating links with other members of their cultural or social group is essential. The role of racial discrimination as a compounding factor in mediating both illness status and access to health services in visible minority groups is widely recognised (Smaje 1995), as are psychosocial factors injurious to health, particularly stress and worries at home. Children from migrant cultures may typically experience a conflict between the value of their own cultural capital and that of the dominant white population, resulting in frustration, anxiety and feelings of inferiority which may show up in school (Spencer 1996). "Successful" children conversely, have more frequently experienced an environment that emphasises ethnic pride, positive self-development, awareness of racial barriers and has provided the adaptive skills necessary to overcome any associated difficulties (Harrison *et al*. 1990). A wide range of studies, mostly American, have discussed the importance of promoting resilience in black communities as a strategy for raising racial pride, confidence and problem solving capacities (Spencer 1986; Barbarin 1993; Connell *et al*. 1994; Elsass 1995; Myers and Taylor 1998; Reynolds 1998). While mentors have been widely used as intervention agents with the aim of promoting resilience (Grossman and Tierney 1998), in the UK this approach has been primarily discussed in relation to adults supporting children in the public care system (Cleaver 1997; Gilligan 1999; 2001b), though a number of UK studies discuss, positively, mentoring as a means of addressing the specific support needs of black students (Bhatti-Sinclair 1995; Meghani-Wise and Macdonald 1995). While focusing on a cultural minority - Native Americans - not represented in the UK, the drawing of strength and pride from the cultural narratives and heritage of devalued communities to promote cultural resilience is a universal message (HeavyRunner & Morris 1999: www.carei.coled.umn.edu/ResearchPractice/v5n1/heavyrunner.htm).

3.13 *Child development*

The developmental stages from infancy to young adulthood can be described in a range of ways. A resilient child will successfully pass through these stages and develop the range of competencies and adaptive skills illustrated in Table 3.3.

Table 3.3 - Development of adaptive skills in the life cycle

AGE	**COMPETENCY**
Infancy	Attachment to primary caregiver
	Development of language
	Ability to differentiate self from others and environment
Early childhood	Good social adjustment to school
	Formal learning achievements
	Positive peer interactions
	Internalisation of rules of conduct
Adolescence	Successful entry to secondary school
	Continuation of academic trajectory
	Close within and across gender relationships
	Extra-curricular activities
	Part-time work
	Autonomy and independence
	Self esteem

Despite compelling evidence to the contrary, there is a continuing belief that success or failure in the developmental process is overwhelmingly weighted towards very early childhood experiences. Examining the quality of life of adults aged 31-33 (n=4626), Ventegodt (1999) was unable to detect any significant degradation in quality of life of adults who had, as infants, been adopted, survived attempted abortions, were unwanted, or had mothers who were mentally ill in the neo-natal period compared to adults who, as children, suffered none of these experiences. Delayed development of motor competencies, in fact, proved far more important in predicting adult quality of life than early, short-lived trauma.

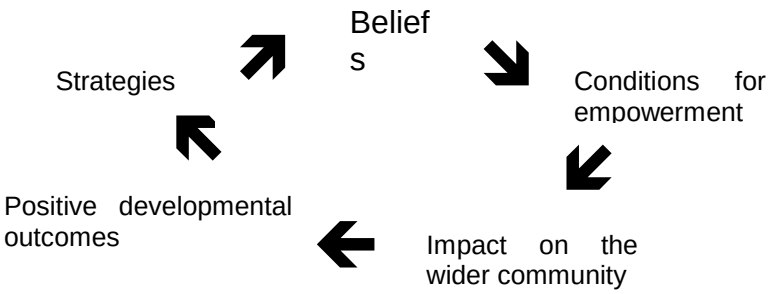
> Single traumatic events have much less influence on the adult quality of life than expected …a consequence of these findings might be that it is possible to compensate almost completely for any intense, but short-lasting, early life trauma (Ventegodt 1999: 220).

While early childhood events are indeed important, a more accurate view is that no one developmental stage of childhood is predominant, and that children's life paths can be affected for better, or worse, at any chronological stage (Clarke and Clarke 2000). Resilient responses by children will often arise naturally, and may not always need extensive professional encouragement, even in situations where stressors may appear extreme, for example, in situations of parental bereavement (Harrington and Harrison 1999; Curtis and Newman 2001), or of acute and serious illness. However, where family, community and educational assets are lacking, poverty and deprivation are a constant factor, and stressors are continuous and relentless, resilience is likely to be a rare phenomenon (Fraser *et al*. 1999). Transitional periods in the lives of children and young people are times of threat but also of opportunity for change (Rayner and Montague 2000). If children possess adequate coping skills, are in environments that protect against excessive demands, but also have opportunities to learn and adapt through being exposed to reasonable levels of risk, then a successful transition is likely. If neither coping skills nor an environment that is likely to promote them are present, then periods of transition may become points in the child or adolescent life span where serious developmental damage may occur.

3.14 *A strategic model for promoting resilience*

While specific interventions may promote resilience in different contexts and at different points in the lifecycle, these individual strategies should be based on a strategic approach, the foundation of which is a belief that children are capable of positive change (Benard and Marshall 1999).

Figure 3.3 - Resilience Framework (from Benard and Marshall 1999, Planning Framework for Tapping Resilience)



Once this *belief* is institutionalized - for example in a school or among any professional peer group - the conditions for empowering children exist. Belief in human potential creates conditions for *empowerment*, which can be encouraged through *strategies* that are known to stimulate individual, group or community learning - caring relationships; high expectations that build on people's strengths; opportunities for participation and contribution. Given these opportunities and support, children will experience *positive developmental outcomes* in terms of increased efficacy or self-esteem, and the cumulative effects will have an *impact on the wider community*, which in turn reinforces the belief that change is possible. (More information: www.coled.umn.edu/CAREIwww/ResearchPractice/v5n1/benard.htm).

3.15 *Conclusion*

Resilience is a challenging concept for child welfare services. Children living in poverty who experience severe traumatic episodes may be ill equipped to take advantage of any latent positivity in the adversities they encounter. Like risk factors, protective factors are cumulative (Bradley *et al*. 1994a; 1994b). They are no less effective if they fail to conform to any ethical or moral considerations. A person does not have to become nice or experience pleasant encounters in order to acquire resilient characteristics. In fact, those most immune to stress often have a somewhat sociopathic aspect to their personalities (Rutter 1985), as has been noted in the case of homeless youths (Rew *et al*. 2001).

Any review of literature inevitably tends to focus on the strategies that are or could be adopted by professionals in health, education and social care. This runs the risk of implying that the actions of professionals are of a higher order of importance than those of other actors. However, when children themselves are asked what helped them "succeed against the odds", the most frequently mentioned factors are help from members of their extended families, neighbours or informal mentors, and positive peer relationships, rather than the activities of paid professionals (Werner 1990; Werner and Smith 1993; Werner and Johnson 1999; Schaeffer *et al*. 2001). In developing conscious strategies to promote children's resilience, we must be careful not to undervalue these non-professional sources, and more importantly, ensure that our actions do not result in such naturally occurring sources of support being weakened. The transient involvement of a professional is unlikely to be a good exchange for a lifetime commitment from family, friends or kinfolk.

4. Promoting resilience through the life cycle

> The intention of much resilience research was implicitly to determine appropriate interventions, yet theoretical discussion of how to intervene to enhance resilience has only recently begun (Rayner and Montague 2000:25).

Transition periods are episodes which bring both threats and opportunities. They may also function as turning points, and be instrumental in changing a child's life trajectory to a more positive direction (Clausen 1995). Turning points may be transitions from one school to another, to an adult education programme, to work or a new job, to marriage, parenthood or to religious faith (Werner 1993). While this may happen as a result of serendipity, turning points can also be manipulated through an understanding of protective factors.

Protective factors operate in four dimensions (Rutter 1987; 1993), each of which presents opportunities for intervention, as illustrated below.

Table 4.1 Protective processes

Protective process	**Example of intervention**
Alter or reduce child's exposure to risk	Many children may arrive at school with no breakfast, or may return to homes where there is no space for, or encouragement to do, homework. While this situation may not be solved entirely by school based interventions, the provision of breakfast and after-school homework clubs may moderate the impact of these risk factors
Reduce the negative chain reaction of risk exposure	The presence of one risk factor increases the likelihood that others will be present (co-morbidity). Young mothers often need intense and on-going compensatory interventions - help with housing, child care, educational opportunities and access to work - in order to decrease the likelihood that unmanageable problems will accumulate.
Establish & maintain Self-esteem and self-efficacy	Young people with learning disabilities are vulnerable to social exclusion. Some attributes make social exclusion less likely - a waged job, an attractive appearance and social skills. The opportunity to pursue socially valued activities in settings used by ordinary people can start a positive, rather than a negative, chain reaction, where the development of one attribute - for example, new clothes or hairstyle - will make the development of others more likely.
Create opportunities	Extra-curricular activities broaden social networks as well as enabling young people to acquire skills and confidence. Helping young people find part-time work in service industries, especially in areas of high unemployment, will help develop "person" skills, teach reliability and help establish informal contacts and potential sources of references, which may be used at a later date when the young person is ready for full time or higher status work.

The wide range of strategies discussed in this chapter, despite their varying nature, all fall into one or more of the above dimensions. The following sections discuss challenges - both normative and atypical - which children may encounter as they mature from birth to adulthood. A modified life chronology model is used, with interventions being described at the following stages:

- *Foetal* - before birth
- *Infancy* - to age 12 months
- *Pre-school* - to age 4 years

- *First school* - ages 5 to 11 years
- *Adolescence* - ages 12 to 16 years
- *Transition to adulthood* - 16 years to early 20's

It should be noted that while this model enables material to be organised coherently, many of the issues and the interventions discussed may be relevant to more than one developmental stage.

4.1 *Foetal*

Many factors that can affect the later resilience of children are associated with the *in utero* stage, notably susceptibility to chronic illness, disability, and parental health, both physical and emotional. The Chief Medical Officer for Scotland has drawn attention to the enduring consequences of foetal events on healthy or unhealthy lifestyles in adult life (Kendall 1993). Influences in the foetal stage, and at other critical developmental points, may "programme" some metabolic processes, resulting in a heightened probability of certain illness sequelae, such as coronary heart disease (CHD) (Elford *et al*. 1991; Barker 1995). While later disadvantages and lifestyles may compound a poor early experience, there is compelling evidence that a range of chronic illnesses including non-independent insulin diabetes, bronchitis, CHD, hypertension, and possibly schizophrenia and some cancers originate *in utero* and have agency independent of later experiences (British Medical Association 1999). Protecting and promoting the health of mothers will protect the health of children (Svanberg 1998). A number of factors may threaten foetal health.

Nutrition: A foetus adapts to under-nourishment through reducing its metabolic rate. This enables the foetus to survive but the price paid can be arrested growth. A foetus malnourished in early gestation may catch up in terms of birth weight with compensation in the final trimester, but vital body organs, notably the liver, may have suffered permanent damage. This emphasises the importance of adequate maternal nutrition *throughout* pregnancy. Although birth weight appears relatively unaffected by maternal body weight, children of mothers who are both excessively over or under weight may be at increased risk of diabetes and CHD.

Smoking: Maternal and passive smoking in pregnancy may result in the programming of the foetal respiratory system predisposing the child to chronic bronchitis and asthma in later life (Spencer and Logan 1998). It increases the risk of Sudden Infant Death Syndrome (SIDS) and reduces birth weight (Blair *et al*. 1996), may affect the development of motor skills and possibly contributes to attention deficit disorders (Landgren *et al.* 1998). More than twice the percentage of women in poorer households smoke in pregnancy compared to professional women (Action on Smoking and Health 1993).

Alcohol and drug use: While Foetal Alcohol Syndrome (FAS) is rare, excessive maternal consumption of alcohol during pregnancy increases the risk of miscarriage and foetal abnormalities (Royal College of Physicians 1995). Heavy alcohol use is frequently indicative of both smoking and illicit drug use which, in combination, increase the risk of SIDS and low birth weight (Nathanielsz 1996).

Depression: Inadequate levels of social support during maternity increases the likelihood of depressive illnesses, and renders the mother more vulnerable to risk

behaviours, including dependence on alcohol, cigarettes and narcotics, which increase the level of foetal risk. Adequate social and emotional support can both protect against maternal depressive illness (Stewart-Brown 1998) and may, given the suspected links between emotional and physical morbidity (Wilkinson 1996), protect maternal health more broadly.

Practice example: Social Support and Pregnancy Outcome Study (Oakley 1992)
Five hundred mothers with histories of lbw babies received routine care during pregnancy or regular visits from midwives plus a 24 hour helpline. Control group mothers were more likely to have ante-natal hospital admissions, non-spontaneous deliveries, poorer post-natal health including more depression, and reported less helpful partners. At one year follow-up, the mothers who had received the enhanced intervention were less depressed, in better health and less likely to smoke. Their babies were also less likely to be unwell.

Vaccination: A worrying decline has occurred in vaccination rates for the measles, mumps and rubella (MMR) vaccine. Immunity to rubella is also crucial for maternal health, as foetal infection by rubella may result in a distressing range of complications including deafness, diabetes and encephalitis (Hall and Peckham 1997).

Prenatal diagnosis: Effective and informed prenatal diagnosis can ensure that any affected foetus can be treated immediately at birth. This is especially important where mothers may be suffering from hepatitis B infection, are HIV+ or have a sexually transmitted disease, especially syphilis.

Domestic violence: As well as medical conditions, the importance of screening for domestic violence has been highlighted, as, apart from any harm to the mother, foetal injuries frequently result in premature birth and low birth weight (British Medical Association 1998).

Summary: Developmental stage - Foetal

Developmental challenges	Resilience promoting Strategies
Threats to foetal metabolic processes	- Adequate maternal nutrition throughout pregnancy - Avoidance of maternal and passive smoking - Moderate maternal alcohol consumption - Pre-natal identification of foetal illness - Maternal MMR vaccination - Social support to mother from partner, family and external networks - Good access to ante-natal health care - Interventions to prevent domestic violence

4.2 *Infancy*

The degree of risk inherent in early experience has undergone changes of emphasis. While the general proposition that adverse life experiences may precipitate mental disturbances is as old as psychiatry itself (Garmezy and Rutter 1983), it is now widely accepted that the highly influential work of Bowlby, which stressed the potentially damaging impact of maternal loss (Bowlby 1951) was, while being sound in outline,

overly pessimistic in terms of the inevitability of damage and the difficulty of recovery (Rutter 1972). Where the circumstances of children who suffer extreme adversities in early childhood improve, both intellectual and personality development is frequently far better than is predicted (Tizard and Varma 1992).

Family support: The risks associated with pre-term birth and low birth weight, and the economic costs to both parents and the state, are well documented (Petrou *et al*. 2001). The largest single risk factor for low birth weight is poverty, which is itself an indicator of poor access to health care and other environmental adversities. Data from twin studies (Wilson 1985a; Wilson 1985b) and longitudinal studies (Werner and Smith 1982; 1992) have illustrated the importance of peri-natal stress on subsequent development. While low birthweight babies (below 1750 grams) from high socio-economic status (SES) families tended to reach their expected IQ score by aged six years, the IQ scores of low SES babies tend to remain depressed, indicating both genetic and environmental factors. Interventions are thus more productively directed to low SES families. Developmental processes possess self-rectifying tendencies, and if this natural process is encouraged, damaging physical and psychological trajectories can be avoided, or at least diminished (Clarke and Clarke 2000). Where peri-natal adversities are more moderate, parent-focused support from birth is highly effective (Blair and Ramey 1997).

Adoption: In more extreme cases, early adoption offers the best chance of a radical restructuring of all possible non-genetic adversities (Clarke and Clarke 2001). The capacity of children to "catch up" under all circumstances should not, however, be overestimated. While the positive benefits of adoption in accelerating physical development and cognitive gains was confirmed in a recent study of late adopted Romanian children, there appeared to be a ceiling on gains, with deficits persisting up to five years following adoption (O'Connor *et al*. 2000). While children seem to be able to recover from even severe early traumas remarkably well, the continuing presence of risk factors appears to have a cumulative effect, which may only be countered by a similarly broad range of resilience promoting strategies (O'Grady and Metz 1987).

Multiple adversities: Where low birthweight (lbw) babies are born into conditions of poverty, multiple protective factors are needed. In a study of lbw babies (n=243) from poor families, Bradley and colleagues (1994a; 1994b) sought to identify resilience promoting factors that were able to protect children. Six factors were identified: household density, safe play areas, acceptance, variety, presence of learning materials and responsivity. Resilient children all had 3 or more of these factors present at age 36 months. Where two or fewer factors were present, resilience was absent. The findings were extraordinarily powerful; even the presence of other factors, such as high maternal intelligence or good child health - both known protective factors - could not outweigh the effect when multiple stressors were present. The best guarantee of a resilience-promoting environment is high parental income, lack of over-crowding and maternal educational qualifications. While not all resilience-promoting factors can be simultaneously addressed, fewer poverty-related adversities in the first year of life will substantially decrease the cumulative risks. Premature birth, for example, a known predictor of future difficulties, is not likely to compromise the child's developmental progress when the personal resources of the parents and the support systems available to them are adequate (Belsky, 1984).

Home visiting: Early and regular involvement by health and social care practitioners, most notably health visitors and community nurses, has proven positive effects on the health of mothers (Macdonald and Roberts 1995), with one study suggesting that programme costs were paid back over four years in the form of reduced use by mothers of health and social care services (Olds 1988; 1997). Interventions at home often prove more convenient for young mothers than clinic visits. A short counselling course provided to mothers suffering from ante-natal depression in Scotland was reported as successfully reducing the intensity and longevity of depressive episodes (Holden *et al*. 1989).

Practice example - The Elmira Prenatal/Early Infancy Project (Olds *et al*. 1988; 1997).
This programme, based in the USA, is one of the best evaluated early interventions. Based on an ecological model (Bronfenbrenner 1979), which assumes the inter-dependence of the parent and child relationship, the wider family and the community in which they live, interventions seek to influence all these components. Four hundred low income mothers were randomly selected, half received home visits from nurses who delivered parenting advice, social support and health advice from pregnancy until the child was two years old. The children in the intervention group had fewer visits to emergency departments, had better IQ scores and were less likely to be abused or neglected than children in a control group. The best results were experienced by single teenage mothers. At a 15 year follow-up, children in the intervention group were less likely to have verified reports of abuse and neglect, and their mothers had fewer convictions, claimed less welfare benefit, had fewer births and were less impaired by alcohol or drugs. Savings on remedial help were reported as exceeding the intervention cost by the time the children were four years old.

Breast feeding: Resilience is associated with IQ. We have robust evidence that babies who are breast fed to 3-4 months have an increased chance, compared to non-breast fed babies, of a higher IQ up to age 10 years (Morrow-Tlucak *et al*.1988; Lucas *et al*. 1992). They also have less chance of needing treatment for diarrhoea (Howie *et al*. 1990), respiratory infections (Wright *et al*. 1989), urinary tract infections (Pisacane *et al*. 1992) and of developing diabetes mellitus (Mayer *et al*. 1988). Breast feeding has traditionally had a steep social class incline, though this has decreased slightly in recent years. The single biggest variable affecting the mother's decision whether or not to breast feed is the attitude of the male partner. Women with partners who are supportive are far more likely to breastfeed (Giugliani *et al*. 1994; Littman *et al*. 1994). This strongly suggests that education should be aimed not just at mothers, but at fathers also.

Maternal support: Strong evidence exists of the protective effect on maternal health of social support, whether this support comes from professional staff such as health visitors (Oakley 1992) or from experienced mothers (Johnson *et al*. 1993). Less satisfactory results were found in an evaluation of NEWPIN services, where the model of intervention was family-centre rather than home-based. Some difficulties were noted with women failing to attend, and those who did, attending for short periods of time (Oakley 1995).

Practice example - Community Mothers Programme (Johnson and Malloy 1995)
This programme, based in Dublin, recruited and trained non-professional but experienced mothers to support highly disadvantaged first-time mothers. Each "community mother", supported between five and 15 women. Lengthy visits were

made at least monthly for the first year of life. The large majority of women, almost 90%, remained in the programme. A control group received standard nursing support. Compared to the control group, the children in families visited by the community mothers were read to more frequently, had better diets, played more games with their mothers and were more likely to have had essential immunisations. Mothers in the intervention group reported less depression and more sociability.

Summary: Developmental Stage - Infancy

Developmental challenges	**Resilience promoting strategies**
Low birthweight	- Adequate parental income - Social support to moderate peri-natal stress - Good quality housing - Parent education - Safe play areas and presence of learning materials
Nutrition	- Breast feeding to three months - Support from male partner
Parental isolation	- Family and social support - Continuous home based input by health and social care practitioners, lay or professional
Extreme adversities	- Where removal from home becomes imperative, early adoption offers the best chance of moderating all non-genetic adversities

4.3 *Pre-school*

Some of the strongest evidence we have for the promotion of resilience can be found in pre-school educational interventions. Disadvantaged children are liable to benefit the most (Oliver and Smith 2000). Programmes, however, need to be of high quality for gains to be achieved and maintained, with key features being a developmentally appropriate curriculum, small class sizes, skilled and well-supported staff, attention to children's non-educational needs, and outreach work to increase parental engagement (Weissberg and Greenberg 1997). Progress for disadvantaged children will not be maintained unless high quality compensatory provision continues (Clarke and Clarke 2000).

Day care: Well-structured, targeted and content appropriate pre-school programmes are claimed to lead to improved adult outcomes in education, income and social capital including less involvement with criminal activity and higher commitment to marriage, claims that are supported by an influential randomised controlled trial (RCT) (Weikart 1996) and by a systematic review of RCT's in day care (Zoritch *et al*. 1998). A 12 year longitudinal study of over 1500 children in Chicago, who entered a pre-school programme and received support to age 9 years, concluded that children who were exposed to the programme for four years did better in terms of academic achievement than a non-intervention comparison group (Reynolds 1994). Effective pre-school education is reported to pay for itself by its input costs being outweighed by savings in remedial welfare (Sylva and Moss 1992).

Practice example from Scotland - Castleview Children and Family Centre

Based in Stirling, Castleview CFC has provided services since 1990 to children aged three and under and their families, helping families recognise their children's developmental needs, promoting social and cognitive skills, and preparing both parents

and children for school entry. Link workers are provided for all families and the centre runs parent and toddler groups and early intervention programmes. A toy library is also available.

Alternative care givers: Early childhood abuse places children at heightened risk for neurological, cognitive and psychological problems. In terms of academic achievement, neglect appears to place children at greater risk of poor performance than any other kind of abuse (Kurtz *et al*. 1993). Alternative care givers, whether permanent, temporary or supplementary, can promote resilience through:

- affectionate and attentive care
- addressing painful memories
- the provision and retention of predictable routines
- acceptance and attachment to a family, social or faith based group (Lowenthal 1998)

Practice example - Resilient peer mentoring (Fantuzzo and Atkins 1995; Fantuzzo *et al*. 1996)

One of the few randomised controlled trials deliberately designed to promote resilience was focused on maltreated and withdrawn pre-school children (mean age 4.5 years). Pairing the children with resilient peers in classrooms (maximum of two pairs per class), under the supervision of a parent teacher, the children were encouraged to share play and creative activities using humour, which is a constantly noted feature of resilient children. Significant improvements were noted by teachers - who were blind to the children's status - which were maintained in a 2 month follow-up. No such improvements were noted of the children in a control group.

Reducing maternal isolation: The promotion of resilience in primary care may often be a matter of simple common sense, such as helping isolated mothers to make contact with others in a similar situation, finding nursery schools or after-school activities for vulnerable children and encouraging parent-child communication (Spender *et al*. 2001). However, pre-school support alone may not be sufficient to ensure resilience continues to protect the child through the lifespan. Where continuous adversities persist, even children who show resilient features in the pre-school years are likely to regress unless prophylactic measures continue for both mother and child (Luthar and Zigler 1991).

Diet: An adequate diet is crucial to the growing child. Food supplements have a particularly strong effect on children living in poverty, appearing not just to improve physical health but also cognition, improving academic performance (Engle *et al*. 1996).

Social capital: "Social capital" includes adequate parental support, extended or extra-familial support or other social networks, neighbourhood ties and membership of community groups such as churches (Abbott-Chapman 2001). Families that contribute to, as well as are supported by such resources and networks are said to be strong in social capital. Where levels of social capital in families of pre-school children are higher, children show similarly higher levels of positive emotional and behavioural development. Mutual support and strong neighbour ties are health-promoting factors, even under unfavourable conditions (Acheson 1998). Social capital has been found to be more positively correlated with child well-being in disadvantaged families than any other indicator (Runyan *et al*. 1998). Where social capital is high, the probability of children in even unfavourable environments prospering is significantly increased.

Practice example - Communities that Care (France and Crow 2001)
CTC is a nationwide programme of locality based prevention initiatives, supported by the Joseph Rowntree Foundation, that seeks to increase social capital within communities. Working in partnership, professionals and local people together identify risk factors that threaten communities, such as lack of neighbourhood identification or delinquent behaviour, and design interventions based on robust evidence of 'what works'. An interim evaluation of this programme has provided encouraging results, and a final evaluation will be published in 2003
(summary available at www.jrf.org.uk/knowledge/findings/socialpolicy/671.asp)

Summary: Developmental Stage - Pre-school

Developmental challenges	**Resilience promoting strategies**
Preparation for first school Inadequate home care Parental isolation	- High quality pre-school day care. Benefits are substantially greater for disadvantaged children - Preparatory work with parents on home-school links to encourage parental engagement with education - Pairing with resilient peers - Availability of alternative caregivers - Multi-faceted home based support and health advice - Food supplements - After-school activities - Creation of links with other parents - Creation of links to local community networks and faith groups - Community regeneration initiatives

4.4 *First school*

A key British longitudinal study examining the development of resilience in children aged 5 -10 years concluded that the most powerful protective factor was the presence of positive, supportive and interested parents (Osborn 1990). The development of resilience was weakened when poverty, parental psychological disorders and low social capital coincided - a condition especially affecting unwaged and supported lone mothers with more than two children, who were suffering from depressive illnesses.

School entry: During the pre-adolescent period, children appear more negatively affected by what to adults may be relatively undramatic events, such as changing or entering schools, or daily "hassles" with friends, siblings or parents (Smith and Carlson 1997). Entry to the formal education system may be perceived by the child as the first major transitional period in their life. The personal attributes of children at school entry may function as risk or protective factors. The pre-school experiences of some children, both at home and in the pre-school settings, may have equipped them with characteristics that challenge school entry, especially when their styles of communication or behaviour do not fit with classroom norms. By age 4-5 years, children will have internalised the styles of behaviour that are normative within their homes and cultures. Excessively rigid and culture-specific expectations may devalue adaptive skills which children have developed in response to difficult home or community circumstances. This may result in children, particularly from some ethnic minorities, being labelled as "difficult" or in need of remedial help, a label which may

follow them through their school career. School entry strategies can inadvertently function as risk-enhancing rather than protective, where children are prematurely classified as a result of an inability to meet the requirements of a classroom culture that may be initially alien to them. The valuing of help-seeking behaviour, rather than independent learning, and the use of peer-learning groups have been identified as effective protective mechanisms, as they lead to improved skills in inter-personal relationships with both adults and other children (Winfield 2001). Promoting home-school links are of particular importance, as the following examples illustrate.

Practice example from Scotland - Home School Link, Ayr.
Funded by the North Ayr social inclusion partnership, the project works with six primary and two secondary schools. Its objectives are to establish closer home school ties, greater involvement of parents in their children's education, closer co-operation between schools in Ayr and improving educational achievement and attendance. The project has a particular emphasis on periods of transition, including the move from junior to secondary school, where vulnerable children are identified and they and their parents given appropriate support and information. Both parents and children receive help, with the overall aims of building networks of support, increasing parent and child confidence and promoting a positive and participative approach with school and education in general.

Practice example from England - School Start (Seal 1997)
Primary schools in Wiltshire identified an increasing number of children who were presenting behavioural and other adjustment problems at entry level. This was associated with a range of problems, including lack of parental involvement with their preparation for school. Twelve infant schools were recruited to a School Start project. Educational Support Assistants (ESAs), mostly mothers who lived locally, were recruited, some to work with a single school and some between several smaller village schools. Their aim was to help prepare children for school entry, increase parental support with their children's education and improve inter-agency co-operation. Teaching programmes took place both at home and in the classroom. Particular attention was paid to making schools less intimidating to less-confident and isolated parents. The outcomes sought were fewer behavioural problems in the first year of primary school and more engagement of parents with the schools. Over a two year period, almost all the children referred to the scheme were accepted and entered the programme (n=142). Less than 3% of parents declined the service. An evaluation of the service, while having no control group, reported both parental and teacher satisfaction with higher levels of parent engagement, fewer behaviour problems, and better preparation for children and parents for school entry.

School performance: Academic performance is a key protective factor and strongly associated with the development of resilience. Effective pedagogic techniques thus have a crucial contribution to make. There is strong evidence that, despite effects fading over time, the most disadvantaged children continued to benefit from the long term effects of the Reading Recovery approach, with these children maintaining long term gains. The substantially greater expense of the model compared to conventional methods was asserted by the authors of the study to be no more expensive - and more effective - than educating any child with reading difficulties (Hurry and Sylva 1997). Positive experiences inside school, whether academic, sports, or friendship related, will have a proportionally greater resilience promoting effect on children facing multiple adversities (Luthar *et al*. 2000). In middle childhood, gender differences are already

evident. Girls are more likely to be "knocked off course" by unexpected shocks to their learning trajectory, such as having poorer marks than expected in maths or reading, indicating - in this context - lower levels of resilience, possibly arising from cultural expectations (Kowaleski-Jones and Duncan 1999).

A comprehensive approach: The International Resilience Project surveyed almost 600 children (aged 11 years and under) and their families in 30 countries. The twelve most frequently mentioned adversities were (in order of frequency) death of parents/grandparents; divorce; parental separation; illness of parent/siblings, poverty, moving home, accidents, abuse, abandonment, suicide, remarriage and homelessness (Grotberg 1997) .The findings identified 36 factors, which were relevant to differing degrees in all cultures, which promoted resilience, as illustrated below.

Table 4.1 - Promoting resilience - action model (from Grotberg 1997)

I HAVE	I AM	I CAN
Trusting and loving relationships with others: parents, siblings, teachers, friends.	*Loveable*: the child possesses, or is helped to develop, qualities that appeal to others.	*Communicate*: the child is able to express feelings and thoughts, and listen to those of others.
Structure at home: clear rules and routines, comprehensible and fair sanctions when breached, praise when followed.	*Loving*: the child is able to express affection to others, and is sensitive to their distress.	*Solve problems*: the child can apply themselves to problems, involve others where necessary, and be persistent.
Role models: parents, other adults, peers, siblings, who model good behaviour and morality.	*Proud of myself*: the child feels they have the capacity for achievement and Resists discouragement.	*Manage my feelings*: know and understand emotions, recognise the feelings of others, and control impulsive behaviour.
Encouragement to be independent: people who offer praise for growing autonomy.	*Responsible*: the child accepts and is given responsibilities, and believes that their actions can make a difference.	Understand my temperament: have insight into their personality and that of others.
Access to health, education and social care: consistent direct or indirect protection for physical and emotional health.	*Hopeful and trustful*: the child has faith in institutions and people, is optimistic the future and is able to express their faith within a moral structure.	*Seek out trusting relationships*: the ability to find people - peers or adults - in whom they can confide and develop mutual trust.

While attempts to implement broadly based strategies, based on these principles and with an explicit commitment to promoting resilience are rare, a number of attempts have been made, including the following example from the USA.

Practice example - The Minneapolis school system (CTARS 1991)

Since 1994, the Minneapolis public school system, building on work done over many years at University of Minnesota, has trained the majority of its teachers in resilience strategies using a training manual titled *'Moving beyond risk to resilience*'. Based on the work of Emmy Werner, five specific resilience-enhancing strategies are promoted for children who need extra support:

Offering the opportunity to develop positive attachment relationships, including:

- the opportunity to develop supportive relationships with a caring adult
- mentoring programmes in schools consisting of a one-to-one relationship with a school staff member
- building support systems for people on whom the children rely, particularly parents, which may involve parent education workshops, involving parents in school, positive feedback to parents on children's work, or simply additional supportive contact by letter, personal contact, or phone.
- the scheduling of extending teaching sessions to extend contact with one teacher rather than constantly changing classes
- the use of peer helpers and cross age teaching to link young and vulnerable children with older and more resilient pupils.

Increasing children's sense of mastery in their lives, including:

- student recognition activities, certificates of achievement and the celebration of important developmental milestones.
- teaching strategies that recognise different learning styles and alternative grading systems.

Building social competence as well as academic skills, including:

- peer groups and social skills development programmes
- linking curricula with events and people in the community to illustrate the application of school-based learning to real life.

The reduction of unnecessary stressors, including:

- pastoral support for children with emotional problems.
- group rather than individual decision making for younger children.

The mobilisation of resources outside the community, including:

- familiarising teachers with local resources and getting to know important and influential local people.
- Involving people from the wider community, including former pupils, in school-based programmes.
- locating supportive social welfare services within schools, both for all children and for specific cultural groups.

(More information from: www.ncrel.org.sdrs/cityschl/city1_1b.htm)

Children facing extreme adversities: Where children have encountered abuse, notably sexual abuse, strong and trusting relationships with the non-abusing parent, or where this is not possible, a close and long term relationship with an unrelated adult have resilience-promoting properties (Mrazek and Mrazek 1987). The strength of the parent-child bond was the most powerful factor associated with resilience in a sample of children aged 6-11 with mothers affected by AIDS (Dutra *et al*. 2000). When combined with help to perform better in school, developing other talents such as sporting or musical abilities and an attribution style that enables the child to take credit for good events and reject responsibility for bad ones, the promotion of resilience is addressed

across a range of important variables (Heller *et al*. 1999; Spaccarelli and Kim 1995). Enabling children to exert control over their lives by promoting both self-efficacy and self-esteem is also an effective strategy in situations where the hurt cannot be "undone". For example, in cases of bereavement, a conscious attempt to build resilience is likely to be more effective when designed as an educational process aimed at improving confidence and competence, rather than as a primarily therapeutic tool (Barnard *et al*. 1999). In such cases, support groups, where children are able to share their experiences with others in the same situations, can lead to new and more effective ways of coping, and not just as a means of helping to deal with feelings about an unchangeable past. Where disruption occurs to familiar routines through loss, divorce or illness, the maintenance of familiar and important routines has an important protective factor. For example, where alcoholic parents managed to maintain the routine of family meals and other shared rituals, their children were less vulnerable to problems with alcohol in later life themselves (Wolin *et al*. 1980; Bennett *et al*. 1987; Velleman and Orford 1999). Actual stability may be insufficient as a protective mechanism; the insecure child must *believe* in the security of their social ties (Sandler *et al*. 1989). Where the child may have reason to fear a loss of security, familiar family rituals and other means of re-assurance become correspondingly more necessary. In situations where primary school children are at risk of exclusion from school or developing anti-social behavioural patterns, there is some encouraging evidence from an on-going study of mentoring that high quality staff can be recruited and retained, and that their relationships with children are effective in improving behaviour (Roberts and Singh 1999).

Practice example from Scotland - Laces

Laces is a new Glasgow-based service, started in 2000, and aimed at looked after children under 12 years who are experiencing mental health problems. The service was developed from research conducted by the local CAMHS. Children who have had multiple placements or highly disruptive family backgrounds are the main population served. Laces works with children and foster carers to help difficult behaviour to be managed while retaining a warm and nurturing environment, using psychodrama, role modelling and providing a safe space for the children to explore their thoughts and feelings.

Practice example from Scotland - Dundee Social Work Department Children's Service's Permanence Team

The team works with children from birth to eleven years, helping bridge the gap when children are first moving from home to care and then finding permanent placements. Security, confidence and self-esteem are promoted through close support of foster carers, maintaining an appropriate level of contact with birth parents, providing a warm and secure home, challenging leisure pursuits, dealing with the consequences of any abuse and establishing trusting relationships with the children. Life story books and photo albums are developed with the children at appropriate ages and, where children have been in a succession of homes, on-going links are maintained with previous carers to ensure that the child has a sense of continuity, identity and of being valued.

Parental separation: Divorce or parental separation, too, may affect children at any age. Pre-adolescent children, however, are most at risk (Wallerstein *et al*. 1988), and boys appear more vulnerable than girls (Block *et al*. 1986). While both the process and outcome of divorce on the health of children is less well explored in minority ethnic

communities, a wide range of studies concur that the family environment with fewest risks for unsuccessful child development is an intact, harmonious, two parent family (Buchanan 1999). The loss of a parent through divorce may be a greater distal risk factor for dependent children than parental death (Kendler et al. 1992). However, few differences between children in divorced or non-divorced families are detectable where there is an absence of conflict with the non-resident parent and the single parent is able to provide a positive and nurturing home environment (Hetherington and Stanley-Hagan 1999). Despite positive effects on parental health being noted through mediation and counselling, few interventions, for example, school based peer-groups, have been found to help children directly, and where positive effects have been found, they have been very moderate (Lee *et al*. 1994; Roosa *et al* 1997). Children's capacity to resist and recover from the trauma of parental separation seems most closely associated with the capacity of the parents to maintain, or to be helped to maintain, non-conflictual relationships, and especially where the child is able to maintain a close relationship with one parent (Jenkins and Smith 1990). For risk factors to be neutralised, it appears necessary for the protective element to be present in the same domain; for example the impact of marital discord will be moderated by a good relationship with one parent, but not necessarily by good relationships with peers (Rutter 1999). Despite the high risk posed by parental separation to children however, marital transitions can - and are - survived by the majority of children, and risk factors can be further lowered by direct attempts to resolve or reduce parental conflict. Where children are able to take on a manageable level of valued household responsibilities for which they receive praise, improved self esteem and locus of control is often a consequence (Hetherington 1989)

The power of positive thinking: Children may learn to respond to stressors and challenges with helplessness - "I can't influence events, what will happen will happen" or optimism - "what I do will make a difference, I can affect the world around me". Longitudinal studies suggest that learned helplessness can persist throughout childhood and manifests itself in poor school achievement, depression, conduct disorders and inter-personal problems (Nolen-Hoeksema *et al*. 1995). Programmes that help children "learn" optimism promote both problem-focused and emotion-focused coping; that is, children become able to actively influence their environment through their deeds, and to affect the way they interpret and respond to events through their emotional state (Seligman 1975). The development of positive thinking in children is an important factor in protecting children against depressive disorders. There is considerable evidence that children's latent resilience can be stimulated by interventions aimed at promoting learned optimism through the medium of cognitive restructuring (Seligman, 1998). While these initiatives are not necessarily unique taken separately, their explicit association with the promotion of resiliency through close attention to the research base is less likely to be encountered in the UK. Also less familiar is the conscious interrogation by staff of the environmental architecture to assess the resilience promoting potential of both attitudinal and structural variables affecting the child, based on an explicit search for salutogenic factors (Benard, 1995). This is particularly important in the case of young people whose circumstances may render them vulnerable to pessimistic cognitive styles of thinking, resulting in lowered levels of self-esteem.

Practice example - The Penn Prevention Programme (Seligman 1998)

The changing of children's patterns of thinking from negative to positive through the medium of cognitive behavioural therapy has been implemented with some success in the school-based Penn Prevention Programme, delivered to a general not a clinical

population. Strategies involved the use of comic strip characters ("Hopeful Howard", "Gloomy Greg", "Pessimistic Penny", "Say-it-Straight Samantha"), role playing, games, discussions and videos, in a 12 week programme. A 50% drop in levels of depression was noted in the intervention group and no change in the control, where both groups had similar baseline profiles.

Insecure accommodation: Homelessness can affect children at any age; younger children whose families are in unstable accommodation, threatened with eviction or are highly mobile are at particular risk, especially asylum seekers and refugees. Enrolment in pre-school programmes provides a context of continuity and security, and an opportunity to develop both emotional and behavioural coping mechanisms. Where early childhood programmes are combined with secure accommodation, formerly homeless children appear to recover quickly, achieving similar levels of developmental progress to matched peers living in their own homes (Douglass 1996). Resilience in homeless adolescents has been found - contrary to other situations - to be negatively correlated with social connectedness (Rew *et al*. 2001), indicating that extreme self-reliance may be a necessary, albeit sad, adaptive strategy for young people with no reliable social networks.

Summary: Developmental Stage - First school

Developmental challenges	**Resilience promoting strategies**
School entry	- Flexible reception classes that tolerate a range of culture and community specific child behaviours - Home-school links for at-risk children that promote parental confidence and engagement - Effective pedagogic approaches to core learning outcomes - Positive school experiences, whether academic, sports or friendship related - Trusting relationships with teachers - Development of competencies, independence and mastery of tasks
Stressors at home	- Clear routines, fair sanctions and praise for accomplishments - Where abuse is present, attachment to supportive non-abusive parent, other family member or unrelated adult - Maintenance of family routines and rituals - Promotion of self-efficacy, self-esteem and positive thinking through manageable contributions to the household economy - Where parental disharmony is an issue, attachment to one parent, reduction in overt parental discord and encouragement to play positive role within family - Recognition of the importance of minor and continuous as well as acute stressors. - Provision of breakfast and after-school clubs - Stable accommodation

4.5 *Adolescence*

School transitions are a highly stress inducing period for children. There is robust evidence to suggest that, where active attempts are made to manage this transition period, with special attention paid to continuity of relationships between children, their

peers and teachers, the outcomes are better exam results, less absenteeism, higher self-esteem and a more positive attitude towards school (Felner *et al*. 1982).

Practice example from Scotland - Unit 2 Project

Based in Stirling, Unit 2 was set up in 1987 to serve children aged eight to 13 years by the Aberlour Child Care Trust and the then Central Region Council. The project aims to prevent the unnecessary reception into care of young people by local authorities. Specific programmes are provided to help children cope with the transition from junior to secondary school. A variety of therapeutic approaches are used, with the overall aims of building the young people's trust and confidence in a safe environment, enabling children to make informed choices about their futures, helping families cope with transition related problems and, through acting as advocates for young people, enabling the voices of young people to be heard.

Promoting resilience in schools: Schools have been identified as one of the key areas where resilience-promoting strategies can be implemented (Wang and Gordon 1994; Wang and Haertel 1995). Children who face particular obstacles, notably those with emotional and behavioural problems, need additional help to overcome motivational styles which militate against the mastery of tasks and which result in their frequently considerable energy being directed at the subversion of achievement and the reinforcement of learned helplessness. This tendency may be countered through a curriculum which has as a major aim the development of 'positive self-views that will lead to the promotion of individual resilience' (Lewis 1999:16) and where the importance of the personal qualities of teachers is recognised. Schools which appear to be successful despite significant apparent disadvantages appear to have common characteristics, notably an optimistic and inclusive philosophy that all children can succeed despite the odds (Maden and Hillman 1996). During a period that has seen a steep decline in children's emotional health and their capacity to cope with stressors (Mental Health Foundation 1999), increasing links are being highlighted between social and emotional competence (Sharp and Cowie 1998), as illustrated below.

Table 4.2 - Key ingredients of effective programmes for the development of social competence and emotional literacy (from Elias and Clabby 1992)

Emotional skills	Cognitive skills	Behavioural skills
- Understanding feelings - Expressing feelings - Managing feelings - Delaying gratification - Controlling impulses - Reducing stress	- self instruction in coping and behaving - challenging negative thoughts - interpreting social cues - setting goals - identifying alternative courses of actions - understanding the perspectives of others - having positive and realistic expectations.	- communication through eye contact, expressions, voice and gesture - making clear requests - securing support from others - responding appropriately to criticism - resisting delinquent pressures - listening to others - helping others

The positive impact of school based programmes that encourage emotional literacy and emotional competence has some empirical support (Greenberg *et al*. 1995). Many of these factors are strongly associated with resilience, notably developing a strong locus of control, good emotional regulation and ability to empathise with others. While questioning the common proposition that high IQ and resilience are positively correlated, a study of 144 15 year olds found the strongest relationships between children who were able to master challenging situations, and who possessed good inter-personal skills, and resilience (Luthar 1991). Given that these are variables that can be affected by classroom based interventions promoting problem-focused coping (Seligman 1998) or school based personal development programmes (Raphael 1993), this study gives clear targets for interventions. Social work-led interventions in schools with a resilience focused approach - the reduction of risk and promotion of protective factors - enjoy some empirical support. In a recent review of 21 controlled trials directed at improving the mental health of at-risk children in school settings, a wide range of positive outcomes were noted, including reduced bullying, increases in self-esteem, reduced exclusions and improved adult-child relationships (Early and Vonk 2001). This review included one UK study, which reported reduced thefts, truancy and drug use in the intervention group, though in this study group assignment was non-randomised (Bagley and Pritchard 1998).

Opportunities for all: The transition to middle school is a key point in a child's progression towards adulthood, and is particularly crucial to children who are at risk of exclusion through academic difficulties or vulnerability to delinquent peer groups. Wide ranging curricula, opportunities for sports, parental and community involvement encourage more pro-social behaviour, give opportunities to enhance or learn competencies, and increase the likelihood that most if not all children will be able to find at least one part of their educational experience in which they can excel (Winfield 2001).

Practice example - The Tribes Learning Community (Gibbs 1995)

The promotion of resilience using community-based approaches has been extensively pioneered in the USA, primarily through the educational system. Drawing on the work of Garmezy, Rutter and Werner on resilience, and using the concept of ecological systems (Bronfenbrenner, 1979), programmes have been developed that work on the principle of "fixing environments, not children". The "Tribes Learning Community" approach is widely used in North America, Canada and Australia. Its mission is '*to assure the healthy development of every child so that each has the knowledge, skills and resiliency to be successful in a rapidly changing world*.' Developed 25 years ago to mitigate delinquency through involving young adults in positive peer groups, it aims to equip children with the knowledge, skills and resilience to cope with a rapidly changing social environment. Based on small, long term learning collectives ('tribes') of 4-6 members, the Tribes concept seeks to ensure that children remain included by delegating responsibility for both learning and the welfare of students to peer groups. Tribes is a process rather than a curriculum. Lessons have two objectives; the learning of academic content and collaborative skills. The size of the groups ensures no-one is left out, no-one is afraid of asking questions, and young people with less developed social skills can learn from, and be supported by peers. Teachers in classrooms where the Tribes system has been adopted have reported substantial decreases in problem behaviours.
(More information from : www.coled.umn.edu/CAREIwww/ResearchPractice/v5n1/masten.htm)

Extra-curricular activities: There is some evidence, albeit limited, that extra-curricular activities in general appear to provide a range of benefits, including lower school drop out rates and higher levels of engagement in school (Masten and Coatsworth 1998), especially where such activities offer the opportunity for meaningful participation.

Practice example from Scotland - Children's Inclusion Programme (CHIP)
Begun as a partnership between Barnardo's and the Strathclyde Poverty Alliance in 1995, CHIP works mainly with young people aged from 5-16, enabling them to speak out on issue that affect themselves, their families and communities. Young people have participated in research studies, using audio and video facilities as well as more conventional methods, and communicated their views to policy makers. A more recent initiative, funded through the Barnardo's/GlaxoSmithKline project Right Fit, developed a sports participation pilot scheme, which has given young people the opportunity to sample a range of demanding activities, including abseiling, canoeing and gorge walking, helping them learn new skills and become more confident in their abilities.

Valued social roles: Protective factors may include care for a younger sibling (Spender *et al*. 2001) or other responsible roles within the household, a conclusion also reached by Zimrin (1986) in relation to children recovering from abusive environments. Valliant and Valliant (1981) suggest that adolescent work histories and the corresponding acquisition of valued social roles is a good predictor of psychological adjustment in adulthood. Children, it appears, need roles - and need to be seen to have roles - which are valued and environments that promote such roles offer some of the ingredients of a resilient personality (Weiss 1979; Pound 1982; Simeonsson and Thomas 1994).

Gender: Gender differences are pertinent to the promotion of resilience both in the adolescent period and for younger children. Resilience in girls tends to be promoted by parenting styles which emphasise reasonable risk taking and independence. For boys, the presence of male role models, support for expressing emotions and higher levels of supervision appear important in the promotion of resilience (Werner 1990). Fathers have a particularly important role to play. Boys with a strong locus of control and high self esteem are twice as likely to have fathers who take an interest in their school work and spend time with them (Katz 2000).

Drug/alcohol use: Adolescent drug use has increased substantially in recent decades, with a large majority of children reporting alcohol, tobacco or illicit drug use by age 18. Preventive programmes, despite enormous investment in both Europe and North America, have yielded only moderate impacts (Ennett *et al*. 1994). Drug education programmes have been primarily based on "no-use" risk perspectives, where children's critical decision making skills are likely to be inhibited. A resilience promoting approach, on the other hand, seeks to build on young people's decision making abilities through broader educational programmes and to strengthen the most powerful resilience promoting factor in mid-adolescence - positive relationships with competent adults (Brown 2001). A randomised controlled trial (RCT) specifically aimed at promoting resilience has reported some success at moderating drug and substance use through a combined drug prevention programme of role-playing, group work and computer assisted learning (Gropper *et al*. 1995). Group work in promoting resilience in stressed inner-city young people has also received some support from a RCT (Cowen *et al*. 1995). "Knowledge-only" programmes must be complemented by the acquisition of competencies to achieve any lasting effects.

Children affected by parental illness and disability: Where parental mental disorders are present, successful child adaptation and subsequent resilient behaviour is most strongly indicated by parenting performance rather than parental psychopathology (Tebes *et al*. 2001). While information and support based interventions for children affected by parental illness based on groupwork may be effective (see, for example, Greening, 1992; Walsh-Burke, 1992, on children affected by parental cancer), the promotion of emotion focused coping needs, in order for a child to actively manage their situation, to be complemented by programmes that enhance problem solving. Where groupwork is undertaken, programmes appear to be most effective where peers have a common stress experience which, through sharing, is able to promote adaptive functioning (Sandler *et al*. 1997). The extent to which children are able to affect the course or texture of the adversities they encounter should influence the nature of the intervention. A focus on children's own capacity to cope in some situations will be justified; in others, interventions are likely to be more effective if they also seek to manipulate factors in the external environment (Roosa *et al*. 1997). Several randomised controlled trials aimed at increasing the resilience of children of affectively ill parents have concluded that therapeutic help is successful at preventing depressive disorders (Beardslee *et al*., 1992; 1997a; 1997b; Focht and Beardslee, 1996), especially where children are helped to understand and articulate the effects of their parent's behaviours (Focht-Birkerts and Beadslee 2000). While calls have been made to identify all children affected by parental illness and disability so that remedial help may be offered (Dearden and Becker 1997), care should be taken that this does not become a risk rather than a protective factor. Evidence from work with the children of alcoholics suggests that negative stereotyping and false attributions by professionals and peers is a common result of being given an unwanted label (Burk and Sher 1990). Where children live with chronically ill or disabled siblings, the positive benefits that may accrue from undertaking helpful and valued social roles within the household should be considered (McHale and Harris 1992; Burton and Parks 1994), and factors that enable children to cope successfully, rather than just those which act as a threat, should be explored (Leonard 1991). Where children *themselves* are ill, a positive family environment where independence, self-sufficiency and open expression of feelings are encouraged has been found to be strongly associated with the presence of resilience (Hauser *et al*.1985).

Practice example from Scotland - Hopscotch

Based in Arbroath, set up in 1997 and established in partnership with the Health Education Board for Scotland (HEBS) and Tayside Council on Alcohol, Hopscotch helps children up to 16 years who live in families where there are serious drinking problems. The focus of the work is based on research commissioned by HEBS and Barnardo's and carried out by Glasgow University. Hopscotch provides family support, counselling and befriending, aiming to raise the affected child's self-esteem and confidence and reduce the future likelihood of their abusing alcohol as adults. The importance of transitional periods, such as changing schools is recognised by the project and is a major feature of the support provided.

Refugees: Forty per cent of refugees in the UK are under 18 years. Many have been exposed to highly distressing events and are likely to be vulnerable to mental health problems (Jones and Gill 1998). Those who appear best placed to maintain positive mental health have supportive and cohesive families, identification with a community and

the aims of that community, and the opportunity to take part in meaningful social rituals which affirm their cultural values (Hodes 2000).

Friendship networks: Periods of transition, especially educational ones, render children highly vulnerable to loss or disruption of friendship networks (Benard 1995). These may have different impacts on adolescents, depending on the degree of problem behaviours being exhibited. When children in institutional settings exhibit relatively low levels of behavioural problems, extending peer friendship networks has a protective effect. However, where deviant or delinquent behaviour is more evident, peer relationships tend to compound rather than diminish problems (Bender and Losel 1997). Similarly, although social support for adolescents coping with severe adversities is normally a protective factor, support of an intensity or type which renders the young person vulnerable to stress when it is withdrawn, or causes excessive dependency, may have undesirable consequences (Compas 1987).

Looked after children: Children within the care system face particular challenges, and may often have many of the key resilience promoting factors weakened, notably capacity to exert agency, parental support and positive educational experiences (Gilligan 1997; Schofield 2001). Educational success is strongly associated with parental involvement and interest (Osborn 1990). Moves in care, lack of staff continuity, absence of private space in which to do homework, and more generally, an environment in which education as a route to positive adult outcomes is undervalued are typical barriers to educational success which looked after children encounter. Support for looked after children's educational careers remains a far lower priority compared to other perceived needs in both residential and foster care settings. The crucial contribution of educational success to adult outcomes and social inclusion, especially for looked after children in the adolescent period, suggests that some serious re-prioritising is urgently required (Jackson and Martin 1998). A resource guide on promoting resilience in looked after children (Gilligan 2001b) stresses the importance of multiple roles for young people, for example a part time job, where they may be able to excel and different aspects of their personality can grow and be appreciated; a secure base where they can be assured of unconditional emotional and physical support; and maintaining links with family, with whom care leavers will frequently re-establish relationships even after a lengthy period of estrangement.

Maltreated children: Abused children may display a range of behaviours in residential, adoptive or foster care settings which, while challenging to their carers, result from effective adaptation to abusive settings. Resilient maltreated children tend to exhibit:

- *loyalty to parents* - by being able to recall good times as well as bad
- *a capacity to normalise their abusive environment* - while professionals tend to regard the abused child's belief that their circumstances are "normal" as pathological, for many children this normalising attribution is a protective behaviour, designed to make their lives more predictable and manageable.
- *invisibility* - resilient children become skilled at "staying out of the way".
- *self-value* - the belief that someone outside the abusing environment, which may include a faith in God, is more important or stronger than the abuser and believes in the child is a powerful protective mechanism.
- *future vision* - the capacity to believe that the future holds something better, and that the child can help bring this better future about by their actions.

(Henry 1999)

Behaviours resulting from these themes need to be understood and treated as positive adaptations, rather than as negative attributes.

Parental alcoholism: Many of the adaptive skills developed by maltreated children are noted in children affected by parental alcoholism. A study in Scotland identified "escaping", seeking external activities and supportive confidants outside the immediate family as key coping strategies (Laybourn *et al*. 1996). This may affect children at any age, from the foetal period to early adulthood. Drug and alcohol use by children however, tends to become a major risk factor in early adolescence. One of the few intervention studies aimed at promoting resilience which has used an experimental design found positive outcomes for children in the intervention group on measures of father/child, mother/child and sibling bonding, reduction in drug and alcohol use and increased knowledge of the effects of excessive drug and alcohol use. The key intervention strategies were aimed at improving family communication and enabling children to play a greater part in setting family "rules", with the strategies themselves adapted from already well validated programmes (Johnson *et al*. 1998). Pride in survival, rather than developing the identity of a victim has been constantly identified with resilient, rather than non-resilient children of alcoholics (Boyd 1999).

Training staff in resilience strategies: The difficulties in translating the theory of resilience into concrete strategies should not be underestimated, especially where children are facing severe adversities or unpredictable life paths. A pilot project in a Scottish social work department focusing on accommodated children found a broad consensus from participating staff that while the concept was sound, its main attractiveness was that it validated what staff were trying to do anyway (Daniel *et al*. 1999). Staff, however, were concerned that the typically ecological approach of resilience theory - identifying a wide range of potential interventions across all dimensions of a child's life - was simply too large an agenda for social workers to address. This is perhaps a confirmation of the argument (Benard and Marshall 1999) that a strategic approach to the promotion of resilience requires the creation of a network of people with a shared commitment to identifying children's strengths rather than weaknesses, and potential areas where change can be effected.

Summary: Developmental Stage - Adolescence

Developmental challenges	**Resilience promoting strategies**
School transition	- Continuity of teacher-child and peer relationships - Programmes that encourage emotional literacy - Inclusive philosophies that promote positive motivational styles, problem solving coping and discourage 'learned helplessness' - Opportunities for all children to develop valued skills through broad based curricula. - Programmes that encourage peer co-operation and collaboration - Availability of extra-curricular activities
Stressors at home: Parental alcoholism	- Avoidance of unnecessary labelling, increased role in setting family 'rules', pride in survival, support of external role model or mentor

Parental illness/disability	- Social support for parents, enhancement of problem solving coping, contact with other young people in similar situations
Child illness	- Maintenance of independence, normal routines and open expression of feelings
Refugee status	- Connections with cultural or faith community - Opportunity to maintain familiar social rituals
Looked after children	- Reduction of moves in care - Emphasis on educational achievement - Positive peer relationships - Opportunities to exert agency
General:	- Improve locus of control through valued household tasks or roles, part-time work outside the home, or volunteering.

4.6 *Transition to adulthood*

In late adolescence, young people face typical challenges associated with the growth of independence and changing life circumstances which may test their latent resilience in a variety of ways.

Further education: Many young people who live in families with prior experience of higher education will have easy access to advice, information and resources about educational options from family and friends. However, young people with low levels of social capital - from fragmented or re-constituted families, in care, having parents with no interest in their educational futures, or living in communities where the prevailing peer culture militates against continued learning - will face greater barriers in entering higher education, regardless of the level of their academic ability. For such students, engagement with post-school options in the mid-school period and encouragement to engage in post-school planning, contact with colleges, linking with mentors and counselling programmes are necessary to compensate for the protective factors that they may not otherwise encounter (Winfield 2001). For some young men - and increasingly young women - joining the armed forces may provide a stable and disciplined environment, greater maturity, opportunities for further education, vocational training and broadening of horizons, although, as with all potential turning points, negative outcomes may also occur (Rayner and Montague 2000). Long term benefits to self-esteem and hardiness of personality are associated with deployment in stress inducing situations, where the nature of the work is perceived by military personnel as being meaningful and rewarding (Britt *et al*. 2001).

Practice example: Partnership for Youth (Wrangham and Crowley 2001)

Partnership for Youth is a voluntary residential activity programme set up in 1996 for young offenders in South Wales, delivered by a collaboration between the local Youth Offending Team (YOT) and Army Cadet Force. Creating a partnership between social services staff and professional soldiers required major, and mutual, re-assessment of stereotypical attitudes. The four day programmes have, to date, been delivered to almost 250 young people. Activities include first aid, the Duke of Edinburgh Award scheme, field craft and low level military tactics, with the intention of promoting trust and respect for others, an ability to work within clear rules and boundaries, self-control, and opportunities for personal achievement. An independent review by NACRO Cymru in 1999 found that, of the first 92 participants, 86% completed the programme, 79% had not re-offended and positive change was reported by social workers in 81% of the participants. While not necessarily appropriate for all young people, the project provides

the kind of "turning-point" opportunities highlighted in resilience literature, as well as promoting many of the qualities associated with the development of resilience.

Health: Adult transitions are stressful periods for most young people, with changes often taking place in locations, peer networks, family contacts and financial circumstances. Where young people are in unsupported accommodation or living away from home for the first time, registration with a local GP and dentist should be encouraged. The association between emotional and physical health, while not entirely clear, is increasingly well attested (Stewart-Brown 1998). Within limits, better emotional health will lead to better physical health; for example, susceptibility to the common cold appears greater in people with weaker and less supportive social networks (Cohen *et al*. 1997; Cohen *et al*. 1998).

Faith: As with other support networks, faith networks also appear to have a significant protective function. While most of the research in this area derives from the USA - where religious affiliation is much higher than in the UK - participation in religious communities has been associated with increased empowerment, ability to cope, self-esteem and a sense of belonging, all factors associated with the growth of resilience (Pilling 1990; Vanistendael 1995; Haight 1998; Hodge 2001; Spender *et al*. 2001)). In the UK, while information about most community services is made widely available to vulnerable young people, it is less common for simple information about church, temple, mosque or synagogue services and associated pastoral support to be publicised in drop-in and community centres, or other public information outlets.

Mentoring: The involvement of a reliable and committed person from outside the immediate family is widely reported as a factor associated with resilience. Some robust evidence exists for the effectiveness of mentoring schemes, and they are seen as having particular value for care leavers during periods of transition, notably in relation to enhancing self-confidence, developing new skills, reducing risk of substance abuse and improving the ability to make relationships with adults (Alexander 2000; Todis *et al* 2001).

Practice example from Scotland - Skills Towards Employment Project (STEP)
Based in Ayr, the STEP project began in 1999 and works with young people aged 16-21 years who are homeless. It helps them develop employment skills through a variety of training courses and links with other agencies. The project was based on research that indicated the massive impact that homelessness had on excluding young people from further education and the job market. STEP works with young people to help them develop skills necessary to access job markets through both practical training and on-going support, as well as helping vulnerable young people with day-to-day problems that may constitute, without external help, insurmountable barriers to work or further education.

Practice example from Scotland - Launchpad
Launchpad is situated in Glasgow and has been operational for seven years, though only for two under its current name. It provides support for young people aged 15-23 years who are or have been in care. Launchpad offers support from the social work department and careers service, and works across the whole city. Its aims are to help young people towards stability in their lives through accessing further education or work and coping with the transitional stresses of moving from late childhood to early

adulthood. Young people are supported in the training and commitments they take on through a key worker system, and courses are run in crucial work-related skills such as numeracy, literacy and computer technology.

Practice example from Scotland - Who Cares? Scotland
Who Cares? Scotland provides independent support and advocacy for all looked after children, with an age limit of 25 years. Services provided include information on rights, advocacy and support in encounters with social work staff including at review meetings, and publicising issues affecting looked after children, both when children are in the care system and as young adults. Particular emphasis is given to enabling young people to support and learn from each other, develop confidence and self-esteem and to organise and arrange their own events.

Work: While entry to the job market presents problems for many unqualified young people, disabled youths often face particular difficulties, as their educational routes may not have considered open or supported employment as a realistic option. In such cases, there is strong evidence from a recent systematic review that placing disabled people directly in a work setting and supporting them is more likely to result in long term employment than a setting that provides training only with the intention of the young people "moving on" at a later date (Crowther *et al*. 2001).

Practice example: Dr. B's Kitchen, Belfast (Newman *et al*. 2001)
Dr. B's is a Belfast city centre restaurant operated by Barnardo's since 1990. It provides training in the catering trade for young people with learning disabilities. Almost three-quarters of the trainees who have completed the programme have found either open employment or work through the Employment Support Scheme, where they receive ongoing support to the degree necessary from Dr. B's staff. An NVQ programme has been offered since 1995 in Food Preparation and Cooking, Kitchen Portering and Food and Drinks Service. Trainees are also able to study for the Essential Food Hygiene Certificate. Training lasts two years, and a 35 hour week is worked, which includes social skills training as well as work in the restaurant itself. Compared to many other young people with learning disabilities, trainees usually leave Dr. B's with a qualification, a job and a future.

Summary: Developmental Stage -Transition to adulthood

Developmental challenges	**Resilience promoting strategies**
Further education	- Where low levels of social capital are present, early engagement with post-school options and active exposure to the full range of post-school opportunities
Health	- Supportive social networks, prevention of social isolation, registration with GP and dentist when living away from home for first time - Membership of faith groups and networks
Work	- Opportunities to enter and be supported in the job market, and help to consider alternative options
Coping with change	- Where family support is weak, the involvement of supportive adults or mentors throughout and beyond the transitional period

5. Survey of services in Scotland

To accompany the literature review, a survey of education, health and social work services in Scotland was carried out by postal questionnaire. The survey explored the extent to which the issue of transitions for children was an important theme in the work of the respondents, what methods were used, how success was measured and whether the promotion of resilience was a conscious and explicit goal. The full questionnaire is provided as Appendix A, which also lists the respondent agencies. The following summarises the material in the questionnaires returned.

5.1 Range of services

There were 140 questionnaires sent to projects and services run by Barnardo's and other agencies. There were 71 completed questionnaires returned (51%). The type of work the projects carried out varied greatly.

Education

Lecropt is a primary school for young people with emotional and behavioural difficulties. Their team works with the young person in school and in the community. Use is made of 'befrienders' to give the young people extra support. They also work closely with the parents or carers.

St. Clements Primary School is a mainstream school with a behaviour resource base used to maintain children in their school who have emotional and behavioural difficulties and help them in their transition to formal education. The school works with identified children throughout the curriculum and seeks help from outside agencies such as child psychologists.

Secondary Support Service, Stirling is a service that encourages pupil inclusion in mainstream education. It offers support in the transition from primary school to secondary school, and secondary school to the work place or college.

Foster care and Adoption

The Scottish Adoption Service offers support to all those affected by adoption in the form of counselling and play therapy

Family Placement Service place children in foster homes and adoption placements. The young people they work with are already deemed vulnerable and through review meetings and planning they try and place the child or young person in an appropriate home.

Homelessness and non- permanent accommodation

Barnardo's Street Team works with young people aged 12–25 with no stable accommodation. They provide support and advice in situations such as eviction from hostels, family breakdowns, custody and access to children. They work as advocates for the young people and refer them to appropriate services.

STEPS is a service which helps disadvantaged young people to learn new skills and find employment. They help young people in varying circumstances, including young people who have previously offended, drug users and the homeless.

Family and community support
North Ayr Community Forum aims to improve the social, economic and physical environment of the people in the local community. They also have a specific team that works with young people between the ages of 11 and 19 and involve them in a development and inclusion programme.

Bo'ness Family Centre provides family and community support, challenging disadvantage and exclusion. They deal with a number of transitional periods in the lives of the families they serve. They provide support for families with pre-school children, provide parents groups and groups for adolescents, and deal with a range of issues depending on the needs of the young people.

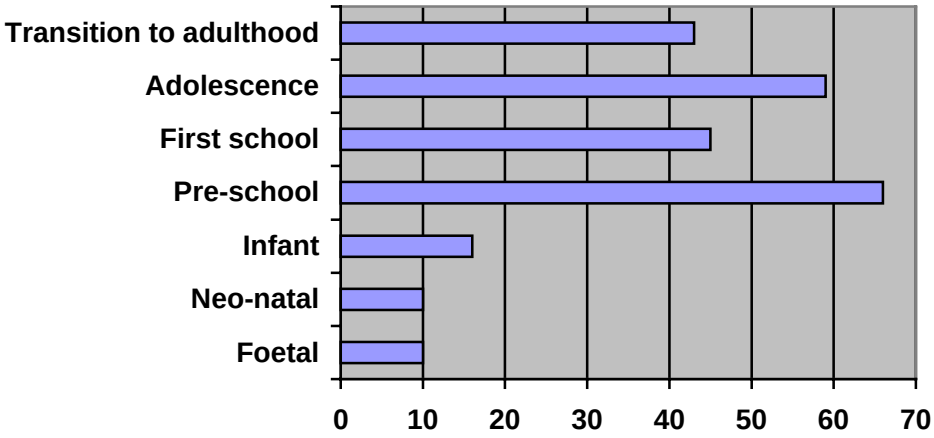
Dundee Family Support Team delivers support for young people with disabilities and their families. They provide short break care, siblings groups and parent groups to enable the families to support their disabled young person at home.

Other projects and services that were less common in the sample were projects that worked with young people who:

- were leaving care and needed further support with accommodation, independent living and finding college courses or work
- had been sexually abused
- had parents or carers with HIV
- had been recently bereaved
- had parents who were substance abusers
- had experienced domestic violence

5.2 Transition as a theme in the work carried out by services
The majority of the services stated that transition played a large role in their work.
Most of the projects and services dealt with more than one of the periods of transition used in the questionnaire.

Figure 5.1 - Number of services working with transition periods



The specific types of transitional periods the projects and services addressed varied according to which areas of the children's lives the service was concerned with. However, many said that they were often faced with everyday transitional concerns that

the average person would have to deal with, yet it was made more difficult because of the circumstances the family or the young person were already in. The main transitional periods noted by the projects were:

- Unplanned and traumatic life events, such as bereavement, family breakdown, terminal illness of a family member.
- Looked after children being moved from placement to placement.
- Young people leaving care or moving from children to adult services.
- Young people being received into care.
- Transition from childhood to adulthood, responsibilities, employment and independent living.
- The transition from special education to mainstream education.
- Going through the care system.
- Disability, its progression through the life span, and the effect it can have on all the family.
- Living with parents who are in and out of rehabilitation.

Schools that sent in responses tended to focus more on the transitions from home to school and from primary school to secondary school. The schools did not necessarily focus on other aspects of transition. However, when describing the programmes they use, many addressed different aspects of childhood challenges.

5.3 Proportion of young people facing difficulties at the point of transition

Frequently, young people who use these services go through more than one of the transitional periods. Proportions cited were as follows:

Table 5.1 - Difficulties at points of transition

Proportion of young people facing difficulties at point of transition	**No. quoting the proportions**
The majority	21
100%	14
A small proportion	5
No answer	4

Other services said that the proportion of young people with whom they worked who were going through transition ranged from 8% to 95%. Other responses suggested that the proportions varied from year to year (especially in the mainstream schools) and sometimes it was not easy to know when unplanned difficulties will occur. The majority of the services said that they identified young people who were going through transition stages but many also suggested that the young people's needs were already defined when they were using the service. Despite this, many said that the young people often faced different transitional periods while attending their particular service.

5.4 *Procedure and methods used to identify vulnerable young people who need assistance*

The information given by the services varied. Schools tended to run leavers programmes and they did not necessarily look to single out people to offer assistance, whereas other agencies, such as a project for young offenders, had selection criteria that meant they were referred through the Children's Hearing System and by social workers. The most popular are illustrated below:

Table 5.2 - Procedures used to identify vulnerable children

Specific procedure	**No. of projects using the procedure**
Work closely with school	14
Meeting with the family and young person	12
Referral from social workers	7
On going assessments	5

Other ways in which the young people were identified were through:

- good communication between the school and home
- future needs assessments
- outreach street work (for the homeless)
- befriending
- good links with pre-school groups

Many of these procedures involved assessments and drawing together of assessments to determine the needs of the young people. In some cases where the need was more immediate this was not the case.

5.5 *Origin of methods chosen*

This question explored how services had chosen their particular approach. The most common answers are illustrated below.

Table 5.3 Source of methods used

Methods derived from	**No. projects basing their practice on these methods**
Evidence based practice	12
Locally tried and tested practice	11
Custom and practice	11
Own experience	6
Statutory guidelines	4

Other answers that were less common were:

- research informed practice.
- Department of Health guidelines.
- having the support and guidance of other agencies to develop and inform practice, for example, using the help of the careers' service to provide support for young people seeking employment or new skills.

5.6 *The approaches most commonly used to promote resilience*

Many services felt that they provided support and services to aid the young people's ability to cope with transitional periods. They were asked to indicate which of the four resilience-promoting strategies (see Table 4.1) they used.

Table 5.4 - Service approaches to promoting resilience

Approaches to resilience	No. of projects using the approach to resilience
Reduce exposure to risk	39
Reduce chance of chain reaction	52
Increasing the child's self esteem	63
Create opportunities for growth	60

The projects and services implemented these approaches in a number of different ways:

- being an advocate for the young person at difficult times in their lives
- linking young people to work placement and real job opportunities
- setting up visits to new schools before the child starts to attend the school
- play therapy
- counselling, therapy and support for young people who have been sexually abused and have displayed inappropriate sexualised behaviour
- teaching young people and their families coping strategies
- allowing the young people and their families new experiences
- creating stable homes for young people

The services, projects and schools all aimed to improve the circumstances of young people and many long-term services sought to adapt to the needs of the young people. Many focused on equipping the young person and their parents or carers to cope better with their circumstances. The services considered themselves to be responsive to the needs of children and young people. This varied according to the type of service.

Many of the projects felt they identified the needs of the young people after certain events had happened in their lives that would effect transition, or of children who were already thought to be at risk. There were fewer that aimed to work with populations of people and young people to pre-empt difficulties by building networks of support and enabling young people to build life skills and resilience. The majority of the schools tended to give support to all pupils who were going through the transition from primary to secondary education, where they were able to discuss issues that concerned them and to learn more about the school they were going to attend. In some cases they would also identify those who were particularly vulnerable and give them extra support.

5.7 *How successful are these approaches?*

The majority of the services said that they felt their approaches were successful. Their reasons for saying this were that they had reached targets and had seen positive changes in the people with whom they were working. Often the service providers would cite statistics from their own evaluations and records as well as giving anecdotal evidence. For example:

- thirty children who were at risk of being excluded from school were involved in a project to keep them in mainstream school. Almost three-quarters of those worked with remained in mainstream school.
- success has occurred when vulnerable children are observed to be less anxious.
- 'Very successful if you measured by placement disruption rate which is low.'

Many respondents suggested that it was a difficult question to answer because a lot of the work carried out does not produce easily quantifiable outcomes. Respondents also felt that a lot of the time, the circumstances of each person and their willingness to change depended on whether the outcomes were positive. Some new services understandably felt that they could not comment on this at such an early stage.

5.8 *How is success judged?*

The services measured their success in many different ways. Some used more than one method to show how their service performed. The majority of the services used

feedback from their service users, young people and their families to form ideas on how they would plan and continue the service. The feedback from the service users was collected in a number of ways such as informal discussion, questionnaires and through contact with school and social workers. Other services used different indicators either separately or in conjunction with the evaluation and questionnaire feedback. These were indicators such as:

- improved circumstances for the young person and their parents or carers
- positive changes in behaviour
- improved coping abilities
- attendance figures
- young people attaining college places or jobs
- increased self confidence

5.9 *Conclusion*

The information collated indicates that many of the respondents did employ strategies to promote resilience. However, how consciously this is done is hard to evaluate. The projects and service seem to relate to the idea of resilience in other words or contexts such as building a child's self confidence, encouraging coping strategies, and enabling families to support each other. All of these things are mentioned as factors that can aid resilience in people, which suggests that work to promote resilience was not necessarily carried out consciously.

6. The views of professionals

As part of this review into transition and resilience, the executive summary of the report (first draft, 16/11/01) was sent to a reference group of professionals in Scotland with a request for comments. Reference group members were working across the sectors of health, education and social care. Eleven replies were received. Responses were based on a short questionnaire (see Appendix B), though some respondents offered additional material. This section summarises the comments received.

6.1 *The definition of resilience*

All eleven respondents felt that the expression of resilience in the report matched their understanding of the topic. However, a few were concerned about the way it was worded. One respondent observed:

'It is very hard to get a clear definition of resilience…the title refers to the probable consequences of being resilient, but does not explain what resilience is'.

A description that explained the contents or substance of resilience rather than its consequences would be, it was suggested, more useful to people working with children and young people.

6.2 *Issues concerning the resilience of children*

The areas covered by the report were seen as relevant and pertinent. Some made suggestions of other areas of children's and young people's lives that could be taken into account when considering working towards the promotion of resilience. In one case it was the negative consequences of resilience such as bullying, crime and drug taking. Other factors mentioned were:

- the impact of male partners on child care and low income families.
- child abuse and resilience.
- people other than family members forming relationships with children and young people to promote resilience (for example, community, schools and youth workers).
- resilience and young people with learning difficulties.

Two of the main criticisms of the areas covered were:

- there was a danger that resilience and knowing when to intervene could be used as a rationale for inaction or deliberate exposure to physical, emotional and psychological risk in cases where there should have been intervention.
- a closer look was needed at the distinction between fixed resilience factors such as intelligence, gender and ethnicity, and those which were more open to change.

6.3 *Do the findings correspond with the respondents' understanding of resilience?*

The majority of the respondents said that the findings did relate to their understanding of resilience and the role it plays within the fields in which they work. The areas mentioned in the report found to be particularly relevant to their experience and understanding were:

- children with chronic problems finding it difficult to build resilience.
- support from families being the most powerful aspect of building resilience.

One respondent suggested that although they believed the latter point to be true, that not all influences that affect a child's resilience come from the family unit. An example given was the involvement of children with anti-social peers and the corresponding effect on the child's resilience. Another respondent suggested that there needed to be more empirical research on resilience factors in the field of health promotion to identify which aspects of practice are more effective. A third commented that there needs to be recognition that a child's source of anxiety is potentially different to the anxiety of an adult. For example, an adult may be concerned about where a child is going to live, whereas a child may be more concerned about whether they will be near their friends.

6.4 *Points of disagreement with the report*

The majority of the respondents agreed with a considerable proportion of the report. However, a number of qualifications and observations on missing elements were made. These included:

- the need to revise or explain further the concept of "transition" itself.
- the extent to which resilience and how a child is perceived as being resilient is a value laden concept. The literature appears to suggest that there are only certain ways of being resilient, with a bias towards resilient behaviour that is socially acceptable.
- the value to children of simply enjoying themselves and having fun was felt by some to have been underestimated, in favour of more technocratic terms like 'emotional maturity'.
- not mentioned in the report was the need to consider the resilience of *staff*, whose capacity to promote resilience in children may be weakened by under-resourcing and the devaluation of their commitment and competencies.
- the suggestion that resilience may be promoted through contributions to the "family economy" was queried by a number of respondents, on the basis that the term implied a child's contributing money to the family. They argued that using a phrase that was more sensitive to children and young people's cultural background and age would be more appropriate.
- the failure to highlight the value and potential influence of positive peer relationships, where children are vulnerable to offending behaviour.
- the perceived bias towards quantitative studies in resilience literature may tend to devalue the impact on children of warm, open and honest relationships with adults who are seeking to help them.

6.5 *Implications of the findings*

There were a number of different perspectives on the implications of the findings. Most related to changes in policy and practice, and in some fields raising awareness of the need to recognise the concept of resilience. Main points were:

- the need to provide input into professional education on the importance of early intervention.
- the importance of recognising that interventions may cause harm as well as do good.
- the importance of school in encouraging and supporting less academically able pupils to develop strengths in other areas within or outside the curriculum.
- the need for greater understanding of the impacts of childhood traumas and their contribution to challenging behaviours.

- the importance of integrating resilience strategies into Scottish educational and social care strategies, specifically in developing children's personal learning plans in schools and how children in need should be identified and supported.
- the need for assessments that can identify resilience factors during periods of transition and the nature and type of support required.
- there need to be better resources and tools for practitioners if support for children and young people is to become more long term.
- the importance of building on the strengths of families.
- areas strong in social capital will be more likely to develop and sustain informal social links which will reduce the need for interventions by statutory services.
- the importance of conveying a commitment to children through all aspects of the service, through a high quality physical environment as well as through relationships.
- the need for joined up health and social care services, particularly as part of early intervention strategies. The poor linkages between child health and related policy areas were noted by some respondents.
- while not specific to this review, the lack of a Scottish equivalent to the Social Care Institute for Excellence (SCIE) raised for some respondents the issue of effective dissemination of the study findings, and how this is to be accomplished in Scotland.

6.6 *Recommendations to the Scottish Executive*

Most of the recommendations made by respondents are reflected in the above section. However, the following additional observations were made:

- panel members responsible for the annual review of care plans should be aware of the destabilising effect on children of years of uncertainty, and should become acquainted with the factors that can promote the resilience of looked after children.
- the report recommendations indicate a need to consider how long term service commitments to the most disadvantaged children can be sustained.
- consideration should be given as to how the health visitor service, which was perceived by several respondents as having been diminished in recent years, can be revitalised.

6.7 *Conclusion*

The summary was, on the whole, well received and stimulated the respondents to consider their own policy and practice concerning resilience, and how the promotion of resilience could be developed in everyday practice with children and young people. While there were a number of points of disagreement, the overall consensus was that the promotion of resilience is an important concept and highly relevant to child care practice.

7. Conclusion

The literature on resilience, while being extremely broad based, is characterised by a relatively narrow range of features. Both literature in the clinical field, despite being often inaccessible to non-professionals, and popular accounts written for lay audiences (for example Fitzgerald 1995, Marsh and Dickens 1997; Wolin and Wolin 1993; Katz 1997) discuss similar constructs of resilience, and suggest similar promotional strategies, albeit in very different language. As we have seen, key concepts are:

- strong social support networks.
- the presence of at least one unconditionally supportive parent or parent substitute.
- a committed mentor or other person from outside the family.
- positive school experiences.
- a sense of mastery and a belief that one's own efforts can make a difference.
- participation in a range of extra-curricular activities that promote self-esteem.
- the capacity to re-frame adversities so that the beneficial as well as the damaging effects are recognised.
- the ability - or opportunity - to "make a difference" by helping others or through part time work.
- not to be excessively sheltered from challenging situations which provide opportunities to develop coping skills.

It is also widely acknowledged that resilience is most effectively promoted as part of a broader strategy, which is likely to involve a range of agencies and institutions, as well as communities and ordinary individuals.

6.1 *The limits of resilience*

Conversely, the difficulties in applying the lessons arising from resilience literature to real life are similarly widely recognised. The personal, familial and environmental features that are associated with resilient behaviour in individuals are well explored. Some are relatively fixed (for example gender, IQ, a sense of humour), others may be very hard to influence (for example, parental support, a secure neighbourhood) especially where children are confronted with multiple and continuous adversities. The question, however, remains as to whether children become resilient because they have been helped to cope better, or whether they cope better because they are inherently resilient (Masten and Coatsworth 1998). The literature, taken as a whole, is heavily biased towards theoretical discussion, albeit with a strong empirical base. Actual descriptions of strategies that have been consistently successful in promoting resilience, and which have been validated and replicated, are far fewer in number. Many "resilience promoting" interventions do not appear - in execution if not in intention - notably different from interventions that simply seek to promote positive child development. Many parallels have, in fact, been noted between resilience and the most popular developmental framework for child development, attachment theory (Schofield 2001). When attempts are made to apply resilience theory, practitioners may recognise its value but find it hard to distinguish its implications from strategies they may already be using (Daniel *et al*. 1999). Resilience may also be construed differently by different practitioners - a socially withdrawn non-offending youth may be resilient to a youth justice worker but emotionally disturbed to a psychiatrist (Rayner and Montague 2000). Respondents to the postal survey described in section 5 echoed many of the

observations made by social workers in this study, indicating that considerable gaps still remain between theory and practice. In a recent volume, resilience theory has been criticised as a concept 'whose time has come and gone' (Kaplan1999:72), not because it is essentially flawed but because it may excessively simplify the very different ways individuals are affected by their environments. We must also be careful not to adopt an excessively technocratic approach to the promotion of resilience. Several members of our advisory group pointed out the simple value of warm, reliable and supportive relationships, a factor of particular importance where an element of mutuality is present, that is, support that is given as well as received (Turner 2001).

Nonetheless, while acknowledging these points, the weight of evidence currently available suggests that actively incorporating resilience promoting strategies in services to children and young people can have significant potential (Roosa 2000). Ultimately, however, the utility of resilience theory will be judged by the extent to which its implementation can bring concrete and lasting benefits to children. The following table summarises the benefits to children that should arise when the corresponding intervention is delivered. The extent to which we can be confident these outcomes *will* occur depends on our actively promoting resilience strategies in service design, and ensuring that these services are carefully evaluated. In particular, it is crucial that programme evaluations pay attention to process as well as outcomes, as simple pre- and post-test designs may falsely assume that the programme was implemented correctly (Smokowski 1998). In other words, we must pay attention to what people are *actually* doing, as well as what they report doing.

Summary: All developmental stages - Key resilience promoting interventions

Intervention	**Benefit**
Opportunities to take part in demanding and challenging activities	Children will become less sensitive to risk and more able to cope with physical and emotional demands
Where children are in situations of conflict at home, contact with a reliable and supportive other	Reduction in exposure to and impact of parental conflict
Facilitating contacts with helpful others or networks who can provide activities or opportunities for work	Helps break the sequence of negative 'chain effects' that occur when children are in highly vulnerable situations
Exposure to manageable demands and opportunities to succeed in valued tasks	Promotes self-esteem and self efficacy
Compensatory experiences - exposure to people or events that contradict risk effects	Helps counter the belief that risk is always present
Opportunities for careers or further education	Greater likelihood of adult stability and increased income
Teaching coping strategies and skills and being helped to view negative experiences positively	Capacity to re-frame experiences and be an active rather than a passive influence on one's own future

(from Rutter et al. 1998)

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Appendix A - **Questionnaire and Respondents - practitioner survey**

RESILIENCE IN TRANSITION

Survey of service provision in Scotland

Barnardo's is conducting a study, commissioned by the Scottish Executive, on how the resilience of children and young people may be promoted in transitional stages of their lives. By resilient, we mean the following:

Resilient children are better equipped to resist stress and adversity, cope with change and uncertainty, and to recover faster and more completely from traumatic events.

This survey forms part of the Resilience Study. We are writing to a range of providers of services for children and young people in Scotland, to find out how far they are concerned with resilience, and to what extent they consider this during stages of transition. We would very much value your contribution, and would ask whether you would complete this questionnaire, or as many parts of it as apply to yourselves, in order to build up a picture of what is currently being offered to children at key stages of their lives.

1.	Name of agency or unit or team.
2.	Focus or aim of your agency or unit or team.
3.	To what extent and in what ways are transitions an issue or theme for children or young people with whom you work?
4.	In your work with these children and young people, do you focus on assisting them in these transitions? If so in what ways?

5.	Of the seven stages of childhood listed in the "Life Chronology Model", which are of direct concern or interest to you in your work with children and young people? Tick alongside any stage relevant to you in your work	
	1. Foetal	
	2. Neo-natal	
	3. Infant	
	4. Pre-school	
	5. First school	
	6. Adolescent	
	7. Transition to adulthood	
6a.	Do you, in your work, identify vulnerable children or young people at transition points?	
	Yes	
	No	
6b.	Comments	
7.	Of the children and young people with whom you work, what proportion face difficulties at transition points?	
8.	Do you have specific procedures, methods or processes to assist the identification of vulnerable children and young people? If so, please specify.	
9.	If you answered yes to question 8, where are these procedures, methods or processes derived from (for example evidence-based, custom and practice, locally tried and tested approaches)?	

10a.	In your work, which of the following approaches to promoting resilience do you focus on? Tick alongside any approaches relevant to your work, and give examples if you wish	
	1. Reduce expose to risk.	
	2. Reduce chance of chain reaction following exposure to risk.	
	3. Increasing the child's self-esteem or efficacy.	
	4. Create opportunities for growth, learning and accomplishments.	
10b.	Please comment or expand if you wish.	
11.	How successful is your approach?	
12.	On what basis do you judge the success of your approach?	
13.	In addition to normal transitional stages, are there specific additional transition points relevant to your work with children and young people? If so, please describe them.	

14.	Completed by:
15.	Contact details - Address Telephone No. Email address
16.	Would you be willing to speak to us by telephone if we need more information about your service? YES/NO

Name of Project/Agency or Service	Location
Lecropt	Bridge of Allen
S.P.A.C.E Supporting Primary Aged Children Early.	Dundee
Polepark Family Centre	Dundee
CHOSI Challenging Offending through Support and Intervention	Motherwell
Shield project education support	Glasgow
Caern project	Edinburgh
Cluaran project	Falkirk
Bridge project	Dundee
Dundee Family Support Team	Dundee
Inverclyde Family Support Team	Port Glasgow
Family Ass. Support Service	Livingston
B's Street Team	
West Lothian Family Support	Bathgate
Aberhill Project	Methill
Riverside Project	Edinburgh
Skylight project	Edinburgh
Scottish Adoption Service	Glasgow
Family Placement Service	Edinburgh
Bo'ness Family Centre	Bo'ness
Blackford Brae Community Support Team	Edinburgh
Unit 2 project- appropriate accommodation for young people in local authority care	Stirling
STEPS-Skills Towards Employment Project	Ayr
St. Clements Primary School –Behaviour Base	Dundee
Cloventstone Primary School	Edinburgh
Lornshill Academy Secondary School	Alloa
The Big Step, social inclusion partnership	Glasgow
Secondary School Support service	Alloa
Home School Link Project	Ayr
Social work Dept. children's services	Dundee
Comely Park Primary School	Falkirk
Alloa Academy Secondary school	Alloa
Falkirk Day Unit	Falkirk
Grangemouth Community School	Falkirk
Falkirk Council Ed Services SEN	Falkirk
Edinburgh Compact Career development	Edinburgh
15:24 project career development	Edinburgh
Pinewood School	Blackburn
Who Cares? Independent support and advocacy for young people in local authority care	Glasgow
Lilybank School	Port Glasgow
Care Assessment Team Dundee	Dundee
Quality Contact Project	Dundee
Launchpad Project Glasgow city council	Glasgow
St Cuthberts' Primary School	Glasgow
Ballikinrain School	Balfron
Laces Project	Glasgow
Mountain Florida Primary/ Shield	Glasgow
Notre Dame Centre	Glasgow

Sighthill Primary	Edinburgh
Drummoyne Primary	Glasgow
Wellshot Primary	Glasgow
Secondary Support Service Stirling	Stirling
Youth Support Team Ayrshire	Ayr
North Ayr Community Forum	Ayr
Cedarbank School	Livingston
Pre- school Assessment Development Unit	Greenoch
West Lothian Support Team	Bathgate
Arbroath Academy	Secondary School
Scottish Play Therapy Development Group	Glasgow
Through Care Support	Ayr
Glasgow Psychological Service	Glasgow
Moray P.S.	Grangemouth
Hopscotch	Arbroath
Murrayburn Gate Social work Centre	Edinburgh
South Ayrshire Women's Aid	Ayr
Falkirk Social Work Services	Falkirk
Sighthill Primary school	Glasgow
Simshill Primary school	Glasgow
CHIP (children's inclusion partnership)	Glasgow
Parkview	Dundee
Dundee city council social work department	Dundee
Glasgow Women's Aid	Galsgow
Granton Primary	Edinburgh
Woods education support service	Edinburgh
Home School Link	Ayr
Women's Aid Glasgow	Glasgow
Cardonald Primary School	Glasgow
Edinburgh Women's Aid	Edinburgh
Delta Plus	Dundee
Ayr Homelessness Service	Ayr
Saracen Primary	Glasgow

Appendix B - **Topic guide for professional advisors**

1. Does our use of the expression “resilience” accord with your understanding of the topic?

2. Do you feel that we have covered the range of issues concerning the resilience of children?

3. If not, can you suggest further ground which should be covered?

4. Do our findings correspond with your acquaintance with, and understanding of, this subject?

5. Which points particularly strike a chord with you from your own work and experience?

6. Are there any features of our summary with which you disagree? If so, could you elaborate?

7. What do you see as the implications, if any, of our findings?

8. On the basis of our findings (and your own work), do you have any recommendations to make to the Executive?

Appendix C - **Web site resources**

Much of the clinical literature on resilience has originated in the United States, as has the majority of more accessible material, including a proliferation of 'self-help' texts, many of which are based on findings from more academic studies. A great deal of information is available from of web-sites, some of which are connected with academic institutions, and some with private agencies. The advantage of much of this material is that it is prepared with the general, rather than the academic reader in mind. Most include links to associated sites. Among the most useful are:

www.projectresilience.com
A private initiative based in Washington DC, and run by Drs. Steven and Sybil Wolin, the site offers general information, resilience based materials, an inter-active discussion group and training resources.

www.tusconresiliency.org
Located in Arizona, the site focuses on strategies to promote resilience in schools, communities and families.

www.cyfernet.org/research/resilreview.html
The Children, Youth and Families Education and Resource (CYFERNet) defines resilience as "the family's capacity to cultivate strengths to positively meet the challenges of life'. It contains a very useful overview of resiliency in individuals, families and communities, prepared by Dr. Ben Silliman.

www.nnfr.org
The National Network for Family Resiliency has recently been incorporated into CYFERNet. A number of special interest groups can be accessed, most of which focus on promoting resilience in families.

www.empowerkids.org
Run by Strengths Based Services International in Virginia, the site is concerned with promoting and developing, resilience based initiatives in public educational and social welfare policy through advocating for and with children.

www.education.umn.edu/CAREI/Reports/RPractice
The Center for Applied Research and Educational Improvement, which is part of the College of Education and Human Development at the University of Minnesota, is one of the key US centres for research into resilience. The site focuses largely on educational strategies that can be developed in schools and communities. A wide range of highly accessible material can be viewed and downloaded from this site, including general descriptions of resilience practice (by Benard and Marshall), a description of the TRIBES learning community (by Jeanne Gibbs), details of Project Competence, a longitudinal study following the careers of ordinary school children over a 20 year period (Professor Ann Masten), and lessons on resilience from native American cultures (HeavyRunner and Morris).

www.ncrel.org

The North Central Regional Educational Laboratory website provides a description of the CTARS (Comprehensive Teaming to Assure Resiliency in Students) project, a comprehensive strategy to promote resilience among students in the Minneapolis public school system and a monograph on developing resilience in urban youth by Linda Winfield.

http://ohioline.osu.edu/b875/index.html

Based at Ohio State University, this web site offers a very useful summary (Bulletin 875-99) of resilience promoting strategies, including practical examples, that are particularly relevant to work with families.