Promoting Resilience in At-Risk Children

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Intervening effectively with youths at risk from early deprivation, family dysfunction, poverty, abuse, and other factors is a major concern for educational and social service policymakers. Current research suggests that a majority of at-risk youths do not experience drastic outcomes, but many exhibit protective factors that buffer them from negative consequences. Longitudinal studies from Hawaii, the continental United States, and Great Britain have identified several personality, familial, and environmental variables that promote resiliency in youths at risk. This article discusses these variables and provides counselors with an assessment technique and strategies to promote a salutogenesis perspective.

It has become commonplace to identify that certain children in this modern, complex society are "at risk" of failing to succeed in life because of the adversities of their young lives. Poverty, family discord, violence, substance abuse, and illness are among the hazards. Policymakers worry not only that such children stand little chance of reaching their potential as adults, but also that they are likely to become so dysfunctional they may not be capable of self-support or rewarding relationships with others.

Children become identified as at risk because of both biological and environmental factors (Honig, 1984), although it must be noted that biology and environment are not entirely independent. Chief among the biological factors are congenital defects and low birth weight, which are more likely when low-income mothers fail to get adequate nutrition and medical care during pregnancy. Similarly, children of drug-addicted mothers may be born with serious physical and emotional problems that are really environmental in origin. Children who are born healthy may join the ranks of those at risk because of poverty, family discord and disorganization, violence and abuse, substance abuse, numerous siblings, parental mental illness, or parents with minimal education. These environmental conditions disrupt the caregiving process as parents become less able to provide either the structure or the love that are so important to the development of self-esteem and diligence.

The concept of risk has been common in the medical field. It has only recently entered the language of education (Jens & Gordon, 1991) and is frequently misunderstood. While risk implies the potential for negative outcome, it also suggests that negative outcome may be avoided.

In this article, we discuss resiliency as it refers to positive outcomes in at-risk children, review studies that have helped identify how and why some at-risk children prosper in spite of risk, and consider the specific protective or buffering factors that prove helpful to these children. We conclude with a discussion of the counselor's role in identifying at-risk children, assessing protective factors that may be present for a specific child, and helping to plan interventions that increase the likelihood of resiliency.

UNDERSTANDING RESILIENCY

The Random House Dictionary (1968, p. 1123) says that *resiliency* is "the power or ability to return to the original form or position after being bent, compressed, or stretched." Alternatively, it is "the ability to recover readily from illness, depression, adversity, or the like." Resiliency in children is the capacity of those who are exposed to identifiable risk factors to overcome those risks and avoid negative outcomes such as delinquency and behavioral problems, psychological maladjustment, academic difficulties, and physical complications (Hauser, Vieyra, Jacobson, & Wertreib, 1985). "These children are variously termed 'invulnerables,' 'superkids,' 'stress resistant,' or 'resilient' " (Bolig & Weddle, 1988, p. 255). In effect, they continue to progress in their positive development despite being "bent, compressed, or stretched" by factors in a risky environment.

The phenomenon of resiliency is not uncommon in at-risk children. In various studies of children exposed to disadvantage, illness, and parental mental illness (Bleuler, 1974; Garmezy, 1981; Rutter, 1979), "only a minority of at-risk children . . . experience serious difficulties in their personality development" (Hauser et al., 1985, p. 83). In one of the most ambitious studies of resilient children, Werner and her colleagues (Werner, 1992; Werner, Bierman, & French, 1971; Werner & Smith, 1977, 1982, 1992) followed the progress of over 200 high-risk children in Hawaii for a period of 32 years. Her participants had experienced four or more of the following risk factors: poverty, perinatal stress, family discord, divorce, parental alcoholism, and parental mental illness. Nevertheless, even with multiple risk factors, "1 of 3 of these high-risk children (n = 72) grew into competent young adults who loved well, worked well, played well, and expected well" by 18 years of age (Werner, 1992, p. 262). Furthermore, most of the high-risk youths who had coping problems as adolescents had become more effective by age 32 when last observed.

SALUTOGENESIS: SEEKING THE ORIGINS OF HEALTH

Much of the literature on children at risk focuses on the psychogenesis of the later problems that such children may experience. Such study is based on an illness model of psychology and has been useful in identifying children who are likely to experience difficulty.

The guidance and counseling professions have long emphasized a model based more on health than illness. Counselors have historically been in the business of helping their clients identify their strengths and build on those strengths. Studies on resilience have sought to understand how children who are subjected to risk factors in childhood nevertheless develop satisfactorily. Their focus is on *salutogenesis*—the origins of health (Hauser et al., 1985). Through an understanding of the origins of health, counselors gain the capacity to help at-risk children, their families, and other school personnel build the elements of better lives.

MAJOR RESEARCH STUDIES ON RESILIENCY

Considerable research on resiliency has been done using longitudinal methods to study the outcomes of exposure to risk factors over years of living. Werner (1992), as previously noted, studied a large sample of youths in Kauai, Hawaii, beginning with the children's births in 1955. Of the 660 children identified, more than 200 were found to experience multiple risks attributable to perinatal problems, socioeconomic status, family instability, little educational stimulation, and poor emotional support within the family. The Werner study is particularly valuable because the participants were followed from birth to 32 years of age. Werner used a multifaceted assessment procedure to determine how well her participants adjusted to the love and work aspects of living. "The study began with an assessment of the reproductive histories and physical and emotional status of the mothers, from the fourth week of gestation to delivery. It continued with an evaluation of the cumulative effects of perinatal stress and quality of family environment of the physical, intellectual, and social development of the children at 2 and 10 years. The follow-up at eighteen assessed the long-term consequences of behavior and learning problems identified in childhood and evaluated the predictive validity of multiple screening tools" (Werner & Smith, 1977, p. 293). Later follow-up at age 32 examined competence in adult life roles (Werner, 1992).

Garmezy and his associates (Garmezy, Masten, & Tellegen, 1984) also studied about 200 children from urban environments in mainland United States, as well as samples of children with congenital heart defects and children who were physically disabled. The research examined competence as the dependent variable, using multiple measures including academic success, classroom behavior, and interpersonal competence.

Rutter (1979) studied a sample of Isle of Wight (England) and inner London children who had experienced parental marital discord, low socioeconomic status, overcrowding or large family size, parental criminality, maternal psychiatric disorder, or placement in government care. He found that a single stressor did not have a significant impact, but combinations of two or more stressors diminished the likelihood of positive outcomes, and additional stressors increased the impact of all other existing stressors.

These and other studies of resiliency have all identified protective factors in the histories of the participants that appear to have buffered the negative impact of the identified risks. These protective factors discussed in the following section include elements of the temperament of the participants as well as environmental circumstances that combine to allow an experience of greater continuity and hope than might be predicted based on assessment of the risk factors alone.

PROTECTIVE FACTORS AND THE BUFFERING HYPOTHESIS

Werner (1984) identified several factors present in the lives of resilient children: a personal temperament that elicits positive responses from family members as well as strangers, a close bond with a caregiver during the first year of life, and an active engagement in acts of required helpfulness in middle childhood and adolescence. Garmezy et al. (1984), Rutter (1986), and Meyer (1957) also emphasized a critical need to understand the impact of life experiences on children and why those experiences elicited such a range of responses in different individuals. Rutter stated that "many children do not succumb to deprivation, and it is important that we determine why this is so and what it is that protects them from hazards they face" (Rutter, 1979, p. 70). He formulated a buffering hypothesis that the availability of social support modifies the impact of stressors, thus leading to less damaging results (Rutter, 1983, 1985, 1986).

Personal Characteristics of Resilient Children

The results of many longitudinal studies (Garmezy et al., 1984; Rutter, 1983, 1985, 1986; Werner, 1984; Werner & Smith, 1982) have provided perspectives on the critical developmental personality factors that distinguish resilient children from those who become overwhelmed by risk factors: (a) an active, evocative approach toward problem solving, enabling them to negotiate an array of emotionally hazardous experiences; (b) an ability from infancy on to gain others' positive attention; (c) an optimistic view of their experiences even in the midst of suffering; (d) an ability to maintain a positive vision of a meaningful life; (e) an ability to be alert and autonomous; (f) a tendency to seek novel experiences; and (g) a proactive perspective.

It also should be noted that a significantly higher portion of resilient children were firstborn, recovered more quickly from childhood illnesses than their peers, and were remembered by their mothers as having been active and good-natured infants (Werner, 1986).

Family Conditions That Promote Resiliency

Along with these personality factors, researchers have found an array of family factors that contribute to a buffering effect on children in the wake of stressors. The more salient of these factors were (a) the age of the opposite-sex parent (younger mothers for resilient male participants, older fathers for resilient female participants); (b) four or fewer children in the family spaced more than 2 years apart; (c) focused nurturing during the first year of life and little prolonged separation from the primary caretaker; (d) an array of alternative caretakers—grandparents, siblings, neighbors—who stepped in when parents were not consistently present; (e) the existence of a multiage network of kin who shared similar values and beliefs and to whom the at-risk youths turned for counsel and support; (f) the availability of sibling caretakers in childhood or another young person to serve as a confidant; and (g) structure and rules in household during adolescence despite poverty and stress.

Supports in the Environment

Werner (1984, 1986), Garmezy et al. (1984), Bolig and Weddle (1988), Beardslee and Podorefsky (1988), and Dugan and Coles (1989) identified role models outside the family as potential buffers for vulnerable children. These included teachers, school counselors, supervisors of after-school programs, coaches, mental health workers, workers in community centers, clergy, and good neighbors. Resilient children often had a number of mentors outside the family throughout their development.

Samuel Betances (1990), who grew up as a child in a low-income neighborhood in New York's Spanish Harlem and in Puerto Rico, attributes his success to his ability to accept the support and guidance of interested adults, especially one caring teacher. He also credits his single-parent mother with providing good care but acknowledges that she did not have the education or resources to provide all that he needed. Betances now holds a Harvard doctorate and is a professor, while his siblings have become the victims of their environment. He states that it is important, especially for minority children, to be taught to "reject rejection"—to pursue the help of others in their environment even if they do not at first sense a welcoming. Coun-

selors must position themselves to provide a welcome to at-risk children and to help others realize the importance of doing the same.

Self-Concept Factors

Besides the buffering factors of temperament and family and environmental support, research has shown self-concept to play a role in resiliency. The capacities to understand self and self-boundaries in relation to long-term family stressors like psychological illness, to enhance positive self-esteem as a result of adaptive life competencies, and to steel oneself in the wake of stress all act as protective factors for at-risk youths.

Beardslee and Podorefsky (1988) studied 18 young men and women whose parents had major affective disorders, sometimes in combination with other psychiatric disorders, but who nevertheless showed positive patterns of behavior. Reassessment after 2½ years found 15 of the 18 young men still functioning well even when some had become the primary caretakers of their parents. The authors concluded that the key variable in the adolescents' resiliency was self-understanding. On follow-up, these adolescents demonstrated a keen understanding of themselves and their parents' illnesses, recognized that they were distinct and separate from their parents, thought and acted distinctly from their parents' illness systems, and had made peace with their experiences and struggles with their parents' illnesses (Beardslee & Podorefsky, 1988).

Marton, Golombek, Stein, and Korenblum (1988) found self-esteem to be related to adaptive skills and to an ability to reflect a sense of self and sense of significant attachment figures as assessed through an interview. Others (Bolig & Weddle, 1988; Jens & Gordon, 1991; Rutter, 1986; Werner, 1986) have discovered that, for some vulnerable children, stressful events actually served to steel them against harm and to challenge them rather than to exacerbate their vulnerability. It appears that when stressful events do not overwhelm the ability to cope, the victory over adversity enhances a sense of self-competence.

Werner (1984, p. 71) described conditions related to self-concept in the lives of resilient children as follows:

1. At some point in their young lives, resilient children were required to carry out socially desirable tasks to prevent others in their family, neighborhood, or community from experiencing distress or discomfort. Such acts of required *helpfulness* lead to enduring and positive changes in the young helpers.
2. The central component in the lives of resilient children that contributed to their effective coping appeared to be a feeling of confidence or faith that things will work out as well as can be reasonably expected, and that the odds can be surmounted.

Models for Understanding Resiliency

Given the emerging understanding about the relationship between risk factors and childhood vulnerability and resiliency, Garmezy et al. (1984) postulated three models to evaluate the relationship between risk and resilience: compensatory, challenge, and conditional. The *compensatory* model weighs environmental risk and protective factors in combination to predict outcomes for the child. For example, consider the case of a 9-year-old girl who had progressed despite repeated illness, poverty, and an alcoholic father, with several protective factors present, including involvement with extended family and a supportive school environment. She nevertheless became overwhelmed by several risk factors that occurred within a short time period, including the divorce of her parents, a major move, and an incident of physical abuse by her father. The multiple risk factors greatly increased the probability of adverse outcomes for her.

The *challenge* model postulates that while a negative curvilinear relationship exists between risk and competence, risk factors could be potential enhancers of competence provided there are only a few. An example here would be a 10-year-old at-risk boy who was placed recently in a different class at school. Given a history of protective factors, he was able, after a stressful entry period, to adjust to the new environment and thrive.

Finally, the *conditional* model postulates that personal attributes work to modulate (dampen or amplify) the impact of risk factors. This model hypothesizes that, for example, the young Samuel Betances prospered in part because he had a temperament that made him attractive to others, an optimism about his possibilities, and a tendency to seek novel experiences.

A DIAGNOSTIC STRATEGY TO ASSESS RESILIENCE

As the understanding of risk, protective or buffering factors, and resilience versus vulnerability becomes more clear, it is incumbent on counselors to incorporate assessment and intervention strategies that will help their clients become more resilient. Counselors (school and mental health) are inundated with research on at-risk children. Yet a computer search of the counseling literature identified only a single article on resilience—as a factor in predicting suicide in children (Celotta, Jacobs, & Keys, 1987). So far, the counseling profession has not attended to the enhancement of childhood resiliency in any specific sense.

Because risk factors do not always predispose children to negative outcomes, eligibility choices for counseling and support services may be false positive (at-risk, not vulnerable, provide service) or false negative (at-risk, vulnerable, not served; Jens & Gordon, 1991). A diagnostic process that will more correctly target scarce interventions to the children who will benefit is a first step toward more effective support service.

As we began to consider a diagnostic approach to identify the roots of resiliency in children, we were reminded of the intensive assessment interview developed by Harry Stack Sullivan (1953), which carefully evaluated the life history of the clients' relationships and their impressions of those interactions with significant others over the life span. Using such an approach that focused on patterns of interactions guided the interviewer to begin to understand the complex relationships among a person's constitutional factors, relationships to others, and life events. Working from the considerable research summarized in this article, we devised an informal questionnaire, reminiscent of the Sullivan interview, to increase counselors' specificity in identifying risk factors and protective or buffering factors in the life stories of their young clients' lives (see Appendix A).

The 25-item resiliency questionnaire, intended for latency children (age 6–12 years) and adolescents, highlights the variables of temperament (personality), family environment and interactions, support outside the family, self-understanding, self-esteem, previous history of stress response, and influences on the child that promote optimism and a positive attitude about service to others and the community. In the hands of an experienced counselor, it serves as an agenda for an initial assessment interview wherein the counselor must exercise clinical judgment to assess risk and protective factors. Follow-up questions may be necessary with clients who respond with brief or yes/no answers. If the client is unable to respond to some of the questions about early childhood, it may be necessary to obtain the responses

from a significant caregiver. By evaluating both the at-risk issues and the resiliency factors of the client, the counselor can plan interventions that will either protect the at-risk client or activate his or her resiliency factors to respond to the stress or crisis. This type of assessment minimizes judgmental categorizations of young clients and facilitates a thorough evaluation of the client's life space, support system, and capacity to endure and overcome the stressful factors.

One example of a counselor's use of the questionnaire presents an 11-year-old boy who was referred to the counselor because of frequent violations of school rules and classroom disruptions. He answered yes to Item 5 stating that family members expect him to be helpful and to Item 15 saying there are rules and expectations at home. According to his report and that of his parents, he meets family expectations of helpfulness and he follows rules respectfully, with only appropriate negotiation for exceptions. The counselor used the boy's responses to the questionnaire as a basis for investigating his contrasting behavior in the two environments, seeking the conditions that triggered his resistance in school, and finally planning with the client and with teachers to create a more effective working relationship. In another example, a 14-year-old Hispanic girl who was frightened of algebra class was found to deal effectively with stress in other environments (Items 11, 17, and 22). She was helped to generalize her coping skills to this new and unfamiliar environment.

INTERVENTIONS

Guidance and Counseling With At-Risk Children

Perhaps the most important reminder for counselors who work with at-risk children is that only a minority of such children actually experience unusual difficulty in the process of maturing to coping adults. It is very easy to set a negative, self-fulfilling prophecy for at-risk children, excusing them from behaving as responsible persons and teaching them that they will not succeed. The stance of the counselor must include a firm commitment both to the principles of salutogenesis—looking for the strengths rather than the weaknesses—and to a sensitive understanding that life may be difficult for children who do not have the advantages of material possessions and a stable home.

Counselors can initiate strategies that reinforce the client's historical patterns of resilience or teach and model behaviors that buttress the client's capacity to self-manage and cope with problems and stressors. School counselors can develop age-appropriate guidance groups to teach students resiliency skills. Given one or more capacities of temperament, the counselor can use a solution-focused counseling approach (de Shazer et al., 1986). In brief, a solution-focused model emphasizes the client's perception of the problem and rating of its severity, discovers the client's goal for solving it, uncovers other solution-focused behavior used by the client in the past, and establishes a weekly trial in which the client practices the solution behaviors. Solution-focused counseling is beneficial with adolescents with conduct, substance use or abuse, coping, academic, and social problems. It also has been applied with youths and adolescents struggling with loss, either separation or divorce of parents or death of a significant other. The research of de Shazer et al. indicated that a solution-focused approach prepares clients to cope with new problems in their lives. Incorporating a solution-focused strategy allows counselors to operationalize a salutogenesis perspective with clients.

Counselors should also develop realistic approaches to enhancing self-concept that focus on building transferable skills. The following are suggested techniques: (a) role play that assists youths in improved self-expression; (b) conflict resolution techniques that assist clients in working through their interpersonal struggles at home and in school; (c) a nurturing stance by counselors that conveys to youths an unconditional positive regard, positive reinforcement, and genuine hope; (d) modeling the principles of a healthy self-concept to clients in counseling; (e) peer support models; (f) creative imagery; and (g) bibliotherapy.

Although we recognize the struggles of mental health and school counselors to enhance the self-concepts of youths, we believe that the literature in resiliency provides a new paradigm for understanding this complex problem.

Assistance for Families

Many of the risk factors experienced by young children are associated with disorganization and disruption in the family and with poverty. Few parents have any training in the art of parenting, and when their coping abilities are stressed by work, money problems, physical or mental health problems, or marital discord, children's needs may be neglected and frustration may be vented on them (Patterson & Welfel, 1994). Who makes up the nuclear family changes for many, and about half of the children born in the last 10 years will spend some time in a single-parent family (Hetherington, Stanley-Hagan, & Anderson, 1989).

Counselors in schools and agencies can assist at-risk children by providing individual and group consultation to parents. Parents need to know that children prosper in an environment where they are loved and where there are clear expectations for responsible behavior (Smith, 1991). It is important that love be verbalized regularly and that love not be withdrawn as punishment for misbehavior. Communication is a two-way process, and many parents need help in learning how to listen to their children and to validate their children's concerns and needs. Packaged training programs like "Systematic Training for Effective Parenting" (Dinkmeyer & McKay, 1989) can be used with groups of parents to develop communication and support skills.

Counselors can help parents understand that children's capacity for resilient behavior is diminished when they experience a high degree of uncertainty and emotional turmoil in the family. Parents who are anxiety-ridden have difficulty creating a consistent environment in which children know what is expected of them. Punishment is often more related to the parents' moods than to the child's behavior. Counselors may assist parents in making specific plans to support their children's effective behaviors and to set logical consequences for misbehavior. Campbell (1993) outlined strategies to reduce parents' resistance to consultation and augment the parents' role in providing support and structure to struggling students. Parents who have many responsibilities and are managing parenting along with long hours of employment can be encouraged to place priority on their responsibilities as parents and to assess who else in the family or neighborhood might be able to supplement the care and support their children receive.

In cases in which the stresses of life have overwhelmed parents' emotional stability, individual or couples counseling dealing with personal problems, marital problems, and patterns of coping may be necessary before consultation on parenting behaviors can succeed. Such counseling with the parents or family counseling may, at times, be the intervention of choice—even more powerful than counseling with the children themselves—and may even focus on whether parents should stay together.

One family circumstance that creates especially high risk is early parenthood, often without marriage, followed by economic hardship

and repeated pregnancies. The parents, often single mothers, become overwhelmed with responsibilities, have trouble providing physical necessities, and experience stresses that make it difficult for them to provide an emotionally supportive environment.

Schools and social service agencies have developed programs for teen parents that serve multiple purposes: teaching child-care techniques, discussing the consequences of multiple pregnancies, and addressing parenting skills. Although counselors may not have primary responsibility for creating such programs, they can provide support for the establishment of programs, provide consultation to the staff regarding the principles of risk and protective factors, and offer direct consultation and counseling to individual parents and groups of parents needing help with nurturing their children.

Environmental Supports

Counselors, particularly those who are based in schools, community centers, and youth organizations, are in primary positions to communicate to faculty and staff that many at-risk children prosper because of the contacts they make outside the home. It is crucial that these be welcoming environments that place value on each child and hold out the expectation that each child will succeed in life. Time taken in establishing a personal quality to relationships is time well spent. Each staff member has the potential to become a role model and mentor in the eyes of the children served, according to the retrospective reports of at-risk children who have overcome their adversities. Organizations such as Big Brothers, Big Sisters, and Police Athletic League were created to directly supplement the mentoring provided by parents, but the persistent interest of a teacher who meets the child daily in the classroom can be just as vital. Counselors can take the lead in setting the tone and in organizing formal programs designed to enhance the nurturing environment.

Consultation with teachers and other community supports is an essential responsibility of the counselor and can enhance the development of resilience in young clients. Dustin and Ehly (1992) discussed the emerging centrality of the counselor's involvement with system or agencywide responses to at-risk youths and the critical role of effective consultation to muster collaborative services for this population. Dickinson and Bradshaw (1992) developed a model for combining counseling and consultation services with children and adolescents. These authors identified consultation as preferred with elementary and preschool children experiencing problems with aggression, students of all ages with academic problems, and adolescents with severe emotional problems from disorganized families. Through consultation, counselors can develop a network of outreach, advocacy, and support for youths at risk.

CONCLUSION

Contrary to the thrust of much current literature, the future for children who are at risk because of poverty, family discord, violence and abuse, illness, parental illness, and many other factors need not be bleak. Protective factors including the temperament of the child, unexpected sources of support in the family and community, and self-esteem lead a majority of at-risk children to succeed in life. In this article, we provided a conceptual base for counselors to look for the strengths in children thought to be at risk and to specify possible protective factors operating for specific clients. In addition, we discussed ways the counselor can maximize protective factors experienced by at-risk children. It is clear that counselors can enhance the random experiencing of protective factors and help at-risk children themselves maximize their own chances for success.

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APPENDIX A

A RESILIENCY QUESTIONNAIRE

1. What is your position in the family? Oldest? Youngest? Middle? Oldest girl? Oldest boy?

2. Do you have any memories or recollections about what your mother or father said about you as a young baby? Or anyone else?

3. Did anyone ever tell you about how well you ate and slept as a baby?

4. Do members of your family and friends usually seem happy to see you and to spend time with you?

5. Do you feel like you are a helpful person to others? Does anyone in your family expect you to be helpful?

6. Do you consider yourself a happy and hopeful (optimistic) person even when life becomes difficult?

7. Tell me about some times when you overcame problems or stresses in your life. How do you feel about them now?

8. Do you think of yourself as awake and alert most of the time? Do others see you that way also?

9. Do you like to try new life experiences?

10. Tell me about some plans and goals you have for yourself over the next year. Three years. Five years.

11. When you are in a stressful, pressure-filled situation, do you feel confident that you'll work it out or do you feel depressed and hopeless?

12. What was the age of your mother when you were born? Your father?

13. How many children are in your family? How many years are there between children in your family?

14. What do you remember, if anything, about how you were cared for when you were little by mom and others?

15. When you were growing up, were there rules and expectations in your home? What were some?

16. Did any of your brothers or sisters help raise you? What do you remember about this?

17. When you felt upset or in trouble, to whom in your family did you turn for help? Whom outside your family?

18. From whom did you learn about the values and beliefs of your family?

19. Do you feel it is your responsibility to help others? Help your community?

20. Do you feel that you understand yourself?

21. Do you like yourself? Today? Yesterday? Last year?

22. What skills do you rely on to cope when you are under stress?

23. Tell me about a time when you were helpful to others.

24. Do you see yourself as a confident person? Even when stressed?

25. What are your feelings about this interview with me?

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