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A Brief Review of Resilience to Traumatic Events in Children and Adolescents

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Resilience:

Resilience in children and adolescents is considered the capacity to resist negative psychosocial consequences resulting from adverse events. It is not the absence of psychopathology following a potentially traumatic event, but an active process which maintains personal stability in difficult circumstances over time. It developed originally from interest in the prevalence and risk factors for psychosocial morbidity in children and young people and then onto protective factors which identify those whom seemed to be less vulnerable to adverse experiences.

Michael Rutter, a pioneer in the scientific evaluation of psychological disturbances and social well being in children and adolescents was important in developing the concept. He defined it "by the young person doing well in some sense in spite of having experienced a form of stress which in the population as a whole is known to carry a substantial risk of an adverse outcome". (Rutter 1981)

Resilience has developed over the last three decades, into a target of social policy initiatives. Initially to increase the capacity of children and adolescents to reduce the psychosocial impact of adversities and subsequently, to help communities to resist adverse experiences and community wide exposure to traumatic events. Importantly raising awareness of parents, carers, professionals and the whole community to the issue and equipping them with the resources to protect and foster resilience in vulnerable and exposed children and adolescents are logical developments.

Normal Trajectories After Traumatic Events:

A considerable amount of research has developed from the investigation of potentially traumatic events to produce subsequent psychosocial morbidity. The extent to which people often show resilience and don't go on to develop post traumatic stress symptoms is more common than generally recognised. Bonnano et al 2011, in a recent review, characterised this by describing different functional trajectories from a potentially traumatic event.

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For example from the literature 5-10% of the population exposed develop chronic dysfunction from traumatic events. Even allowing for individuals who may demonstrate delayed reactions to traumatic events, 0-15%, 35-65% show minimal effects and 15-25% recover from some significant early effects and impairments. (Bonanno et al 2011).

Little Distress May Express Resilience Not Pathology:

The lack of evidence of disturbance in an individual has been seen in the past as an abnormal response to traumatic events as if no reaction was pathological itself. We now see this as being with-in the range of normal reactions. This person is just expressing resilience to the event compared to others. Even if the percentages of individuals showing dysfunction may become higher in extreme events, many show resilience.

It has also now been recognised that resilience is contributed to by a large range of quite different and unrelated attributes. Even in children who show resilience, they use a large range of strategies to achieve it. Generally we know more about risk factors for poor adjustments than resilience per se.

The "Dose-Response Gradient" from Trauma Exposure and Resilience:

The factors commonly considered important for resilience in adults have been gender, education, age, and personality. In children and young people difficulties in expressing distress and complex social, developmental interactions and discontinuities over time make these less certain. Factors associated with exposure, particularly injury and the experience being life threatening, generally increase negative outcomes and thus are likely to test resilience more. Thus the traumatic experience is said to have a "dose-response gradient." The worse the exposure, the greater likelihood resilience is overwhelmed. Post exposure factors such as fewer consequences, better economic capacity and the availability of instrumental social support are associated with improved resilience. Previous and repeated exposure increases vulnerability, particularly childhood adversity. Some children and young people can also be seen as more vulnerable in adverse events. Those with disabilities being the most clear example. (Peek and Stough 2010)

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In children and adolescence, the factors relating to resilience is more limited, but would be expected to follow these trends. For example, the consequence of exposure being the loss of a parent or significant disruption to social supports may be much more significant for a child. Some evidence does support that exposure and continuing exposure to adverse events increase the impact on children of a traumatic event (Fernardo et al 2010, Kronberg et al 2010, Kithakye et al, 2010) and may also work through the exposure of parents and caregivers in the same events by reducing their capacity to protect their children (Masten and Osofsky 2010).

Attributes Associated with Resilience in Children:
Some specific attributes and social factors have been able to be identified in research as important in resilience to adversity in children and young people. Self-regulation skills in children seem to follow the protective factor characteristics they do in adults (Masten and Osofsky 2010). In more extreme situations faced by child soldiers and victims in war, community acceptance was an importance factor in better longer-term social adjustment (Forstmeier et al 2009).

In Australian populations, the child's reported social connectedness also has been reported as protective (McDermott et al 2010). An early return to schooling has been endorsed as by several leading researchers as best practice for children experience disasters and has protective utility. Ager et al. 2010.

Perry has identified several characteristics that he thinks are important in individual children who demonstrated resilience. They are: a higher temperamental tolerance to distress, the experience of an attuned caregiver, healthy attachments and opportunities to gradually practice and use their social supports. He also includes a capacity for hope, the ability to learn quickly and a sense of uniqueness and being "special" engendered by a fostering adult.

Many of these attributes are dependent on adults being sensitive to the needs of children and providing opportunities over time for the child to develop these attributes. Carers and parents need the capacity, information, access to resources and necessary other supports to achieve this. This is basic to the development of resilience in children and young people in preparation for a potentially traumatic event or disaster.

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Interventions that Foster Resilience in Children:

Generally recommendations for preparedness and response to disasters for children are summarised by Masten and Ofosky 2010. They recommend these areas for consideration briefly summarised here as:

- Protecting and restoring secure attachment relationships
- Training first responders for expected responses in children (first responders include parents, teachers and child care workers) not just the emergency workforce
- Supporting the return of normalised routines such as schooling
- Attending to community resilience and functioning

Potential Risk with Interventions:

Several risks have been identified by interventions to improve resilience in individuals and also in children. One is the impact of information; another is the suitability of the intervention in the developmental or cultural context.
An intervention may alter people's perceptions of risk that may make them less prepared or encourage the development of maladaptive behaviours. Considering the developmental stage of children and adolescents for initiatives is essential to avoid inappropriate information that may exacerbate risk. Importantly extrapolations from one cultures experience may not be transferable to another culture where resilience is developed in a different contextual framework.

Specific Personal Interventions with Children and Adolescents:

As a carer or worker with children in distress, knowing what to do with children to support their capacities to manage distress and trauma is not always clear. Paul Bernard and Ian Morland (Bernard, Morland and Nagy, 1999) set out some specific key points from their experience from working with children, adolescents and their families in difficult circumstances.

These are:
- o The value of listening and of listening uncritically
- o The value of story telling to someone who has something they want or need to say
- o The value of peer group support
- o The need for all inclusive support amongst friends and family and a recognition that professionals can only ever be present to help a small portion of the time
- o The value of activity or action to channelling feelings.

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As with being a parent, developing this intuition for the needs of children requires substantial attention and calmness. In situations where there are many stressful competing demands, they will be hard to find, but still is the basis of protecting and nurturing resilience in children and adolescents.

Community Resilience Building Interventions for Children and Families:

In the " Building Community Resilience for Children and Family" document produced by the Terrorism and Disaster Centre and the National Traumatic Stress Network (2007) there are presented guidelines for all community sectors to prepare and respond to facilitate resilience in children and families faced with a disaster. These action directions generally include:

- Working across all sectors (emergency services, health care, mental health media and community organisations) to disseminate "risk messages' and other resilience promoting materials to everyone in the community, mindful that children may also hear these messages.
- Emphasizing messages
    - Being simply and clearly stated
    - Developmentally appropriate
    - Culturally sensitive
    - Resilience promoting
    - And include basic instructions such as where to find mental health service support
- Encourage utilisation of existing support systems
- Develop agencies to recognise unmet needs
- Review and research to learn from the experience

Organisational and Workforce Support Issues:

Besides communication strategies, institutional inter-organisational issues are key to improving resilience in a community. Conflicts over roles and responsibilities and co-ordination impair efficient responses. The impact on workers is also a key area to resolve. Necessary emotional support and resources are required for them to maintain their support for the community. Much of the community's resilience for children and families faced with a disaster or traumatic events is dependent not only on personal resilience and resources, but on operational effectiveness of agencies and services when much is dislocated by the event.

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Businesses, schools and mental health services are highlighted as key players and resources in the response for children and families. Resilience against adversity is still a relatively new concept through now widely discussed. Much remains to be understood. It is clear than many of the principles of good public health prevention are applicable to develop resilience against disasters and potentially traumatic events in the community. Children and adolescents are vulnerable and require sensitive and developmentally appropriate consideration if their own capacity to be resilient is to be fully developed.

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