

Is resilience still a useful concept when working with children and young people?

Cathryn Hunter

This paper reviews some of the complexities and issues surrounding the concept of resilience in order to ascertain its usefulness for practitioners working with children. The paper offers a brief history of the research as well as an investigation of how resilience is defined, measured and used in practice.

KEY MESSAGES

- Although there are many varied definitions of resilience, most suggest that it involves children displaying competent functioning despite exposure to high levels of risk or adversity.
- Resilience is not static and may be impacted by changing risk and protective factors at different ages and developmental stages.
- Resilience may be “domain specific”, with a child showing competent functioning in one area of their life (e.g., academic achievement) but deficits in another (e.g., emotional functioning).
- It is important to consider the context, and the strengths and challenges of each individual child in a holistic manner.
- No child is invulnerable. The greater the number and chronicity of risks a child is exposed to, the less likely they are to display resilience.
- An understanding of the 3 main components of resilience—risk factors, protective factors and competent functioning—is important when working with resilience in practice.
- Practitioners should understand how these components are defined and measured and how they themselves are defining and measuring them in their own practice.
- Practices and interventions aimed at increasing resilience in children generally focus on one of three outcomes: building the capacity to be resilient in all children (universal programs); the capacity to be resilient in vulnerable children or those facing chronic adversity; or the capacity to be resilient in children exposed to one-off traumatic events or disasters.

Introduction

Over recent years there has been a shift in research and service delivery from a deficits-based approach, which focuses on factors related to psychopathology and maladaptive functioning, to an approach that highlights strengths and resources that may enable adaptive functioning and positive outcomes. This focus on strengths-based approaches has led to a rise in research on resilience.

Resilience has gained popularity in service delivery and policy, particularly in the wake of the many natural disasters Australia has witnessed over recent years (e.g., *The National Strategy for Disaster Resilience*, Council of Australian Governments [COAG], 2011). Despite this popularity, there has been growing concern among the research and practice communities about the broadening meaning and use of the construct of resilience (e.g., Vanderbilt-Adriance & Shaw, 2008). The term has been used so often and in so many contexts as to lead some to ask if it still has value. This paper discusses some of the definitional and conceptual issues in childhood resilience research, with a focus on the usefulness of the concept for practitioners. It also highlights some of the progress made in the research as the concept has broadened and moved towards a more ecological framework that takes into consideration the complete context of the child. Finally, the paper discusses how resilience is being used in practice.

What is resilience?

As can be seen in Box 1, resilience is a complex, multifaceted construct that has been defined ever more elaborately over time and in different contexts.

The term originated in the areas of materials science and environmental studies and then broadened to include resilience in individuals (McAslan, 2010). In discussing resilience it is helpful to look at how the discourse around the construct has changed over time and to identify some of the concepts and ideas that have informed these changes:

- Early definitions made note of “invulnerable children” (Garmezy, 1974) or children appearing “unscathed” despite exposure to adversity (Werner & Smith, 1989) but more recently researchers have come to acknowledge that there are no invulnerable children (Masten & Obradovic, 2006).
- Although there is a range of definitions of resilience, most agree that it involves children displaying adaptive or competent functioning despite exposure to high levels of risk or adversity. Resilience cannot occur without the presence of two factors—adaptive functioning *and* exposure to risk or adversity. A well-functioning child who has not faced high levels of adversity would not be considered resilient (Vanderbilt-Adriance & Shaw, 2008).
- Resilience has moved from being considered a fixed personality trait to being a temporal process. Research suggests that resilience is not static but may wax and wane over the life course (Luthar, 2006).
- There appears to be no single path to resilience and both risk and protective factors may have different impacts on children at different stages of development (Masten & Obradovic, 2006). Identifying developmentally appropriate, adaptive functioning is important in defining resilience.
- Some children may appear resilient in terms of their behaviours but actually be experiencing internal distress (Luthar, 2006). Children may also display resilience or adaptive functioning in one domain (e.g., emotional functioning) but experience significant deficits in another (e.g., academic achievement) (Luthar, 2006).
- Resilience is a heterogeneous, multilevel process that involves individual, family and community-level risk and protective factors. Individual protective factors may include emotional self-regulation, self-efficacy and self-determination (Cicchetti, 2010). Family factors may include a close relationship with at least one caregiver and sibling attachment (NCH, 2007). Community

Box 1: The changing nature of definitions of resilience

Broader definitions

"... The capacity of a system to absorb disturbance, undergo change and still retain essentially the same function, structure, identity, and feedbacks." (The Resilience Alliance, 2011, para 9)

"Resilience is the happy knack of being able to bungy jump through the pitfalls of life." (Fuller, 1998, p. 75)

1974

"[Resilient children are] ... invulnerable children ... those children who, despite genetic, psychological, and environmental disadvantage, continue to adapt and perform competently." (Garmezy, 1974, p. 65)

1989

"... *Resilience* of children, that is, their *capacity to cope effectively with the internal stresses of their vulnerabilities* (such as labile patterns of autonomic reactivity, developmental imbalances, unusual sensitivities) and *external stresses* (such as illness, major losses, and dissolution of the family). Even through the most stressful experiences in the most terrible homes, some individuals appear to emerge unscathed and to develop a stable, healthy personality." (Werner & Smith, 1989, p. 4)

2006

"*Resilience* is a broad conceptual umbrella, covering many concepts related to positive patterns of adaptation in the context of adversity." (Masten & Obradovic, 2006, p. 14)

"Recurring attributes of person, relationships and context emerge as predictors or correlates of resilience across diverse situations, implicating a 'short list' of probable and rather general factors associated with good adaptation or recovery following significant adversity." (Masten & Obradovic, 2006, p. 21)

"[A development in resilience research] ... was the recognition that positive adaptation despite adversity is never permanent; rather, there is a developmental progression, with new vulnerabilities and strengths emerging with changing life circumstances ... A related qualifier was that children can seem resilient in terms of their behaviours but still might struggle with inner distress in the form of problems such as depression and anxiety ... scholars now underscore the need to consider the unique profiles, and associated intervention needs, of youth who are behaviourally stellar but at the same time psychologically vulnerable." (Luthar, 2006, p. 741)

2007

"... resilience is not static, it is not a trait, and it is not a construct that can be directly measured. Resilience is a 'superordinate' construct that is indirectly inferred from two component constructs subsumed under its definition: risk exposure and 'good' adaptation." (Kim-Cohen, 2007, p. 272)

2010

"... the attainment of positive adaptation in the face of significant adversity involves a developmental progression; new vulnerabilities and challenges and/or strengths and opportunities often emerge with changing circumstances over the life course. Resilience is not something an individual 'has'—it is a multiply determined developmental process that is not fixed or immutable." (Cicchetti, 2010, p. 146)

factors may include a community's social assets such as schools, associations and sporting clubs, as well as feeling a sense of community connectedness (Dean & Stain, 2007; Maybery, Pope, Hodgins, Hitchenor, & Shepherd, 2009). Determining how and which protective and risk processes are involved is imperative for designing effective interventions (Luthar, 2006)

- More recently it has been suggested that “resilient” functioning may be a more normative response to adversity than once considered. Masten (2001) suggested that “resilience is common and that it usually arises from the normative functions of human adaptational systems, with the greatest threats to human development being those that compromise these protective systems” (p. 227).

As demonstrated above, resilience is not easily defined and involves a range of complex processes in which a child's individual situation and context must be understood. The concept has been used interchangeably depending on the purpose of the research and the outcomes sought. Therefore there is no universal definition of resilience per se, but rather an understanding that it encompasses multiple factors and may differ depending on the context in which it is used.

Where did the concept come from? A brief history of resilience

In order to understand how resilience research has evolved, a brief historical overview is provided. Major voices in resilience research have included Norman Garmezy (e.g., 1974), Emmy Werner and Ruth Smith (e.g., 1989), and Michael Rutter (e.g., 1999). Based on their research, and that of others, the concept of resilience has gone from being limited and specific in nature to being a more broad and widely encompassing construct. Research has moved from focusing on the individual to seeing the child within his or her wider family and community context and considering a much broader range of risk and protective factors.

In studying schizophrenia, Garmezy (cited in Masten & Powell, 2003) found that some sufferers appeared to display more adaptive functioning than others. He then investigated children of parents with schizophrenia and became interested in the protective factors that were involved in many of these children doing well despite being highly at risk for psychopathology.

Garmezy and others (such as Ann Masten and Auke Tellegen), through Project Competence, went on to investigate a broad range of factors involved in children's exposure to adversity, risk and resilience. The researchers found that even in high risk groups of children (such as those with physical disabilities or living in homeless shelters) there were some who still managed to display “ok” competence (ordinary or better functioning)” (Masten et al., 1999, p. 145) despite exposure to extreme adversity (Masten & Powell, 2003).

In their well-cited longitudinal study of children in Kauai, Hawaii, Werner and Smith (1989) expanded the idea of risk to include factors such as chronic poverty, parental divorce or psychopathology, and perinatal stress. The study found that approximately one-third of children exposed to four or more risk factors still developed into competent adults. Various child, family and community factors were related to positive adult outcomes (Werner, 1995). These factors often differed for different age groups and between boys and girls.

More recently prominent researchers such as Michael Rutter (e.g., 1999), Michael Ungar (e.g., 2004), Michael Resnick (e.g., Resnick, Ireland, & Borowsky, 2004) and Suniya Luthar (e.g., 2006) have added their voices to the discussions—critiquing and evaluating the evidence or focusing on areas such as biological and gene-environment influences, cross-cultural settings and the social construction of resilience, and protective factors in the lives of young people.

Box 2: How does resilience relate to other theories and practices?

With regards to the theory, there is some crossover between resilience and other theories such as attachment or trauma and also with strengths-based practice.

Strengths-based practice

The strengths-based approach is a social work practice that, as the name suggests, focuses on the strengths (e.g., competencies, resources, personal characteristics, interests, motivations) of the individual, family or community (McCashen, 2005; Saleebey, 1996). Strengths-based practice involves moving from the more traditional focus on deficits and pathology to a focus on abilities and resources. Strengths-based practice is built on the premise that the normal human development process is towards healthy growth and fulfilment, and that everyone has strengths that will aid them in this process (Strengths Institute, n.d.). This is in line with the finding in resilience theory that most people will do well despite exposure to great adversity (Masten, 2001).

The relationship between resilience theory and strengths-based approaches is that of theory and practice. Resilience is a theory that identifies the importance of protective factors and competencies, and the strengths-based approach is in part the practical application of that theory, although strengths-based practice also encompasses other theories and broader ideas such as empowerment, and healing and wellness (Saleebey, 1996; Strengths Institute, n.d.). As noted by Leadbeater, Schellenbach, Maton, and Dodgen (2004), "... research on the resilience of individuals has helped to characterize many of the essential features of strength-building processes" (p. 16).

It is worth noting that, not unlike resilience theory, strengths-based practice has faced a range of criticisms (e.g., Saleebey, 1996; Staudt, Howard, & Drake, 2001). It has been suggested that the practice is simply positive thinking in disguise, that it ignores how manipulative or destructive some clients or client-groups may be, and most seriously, that it ignores or lessens real problems or disorders (such as schizophrenia) (Saleebey, 1996). A review of studies of strengths-based approaches found limited evaluations of the practice and problems with its operationalisation and measurement.

Further information on strengths-based practices:

- Kansas University School of Social Welfare, Strengths Institute – What is the Strengths Perspective? <www.socwel.ku.edu/strengths/about/index.shtml>
- Project Resilience <projectresilience.com/index.htm>
- St Luke's <www.stlukes.org.au/>

Trauma theory

Trauma theory suggests that exposure to psychological and/or physical trauma (such as child abuse and neglect) may have long-lasting negative consequences for children and adults (Bromfield, Lamont, Parker, & Horsfall, 2010; Gordon, 2007). Trauma and exposure to high levels of adversity are similar concepts, although adversity may include things such as living in conditions of chronic poverty as well as other family and community factors. Trauma is often discussed in conjunction with resilience. Some theorists suggest that the two can co-occur and a child may exhibit signs of being highly traumatised and resilient at the same time (Harvey, 2007). This idea fits in with research that suggests resilience may be domain specific, with children able to competently function in some areas of their lives but not others.

Attachment theory

Attachment is another theory that is often discussed in conjunction with resilience and similar concepts. Secure attachment with at least one adult is seen as one of the most common protective factors found in resilient children (Kim-Cohen, 2007). Although there is crossover between these theories, resilience differs in that it involves protective factors beyond the attachment relationship, such as those within the individual child, the family and the wider community. A strong relationship with a key adult most certainly provides protection for the child from adversity but resilience theory suggests that there is a wide range of other factors that may also be involved. This may be particularly important if the child has experienced trauma related to the loss of the key attachment figure.

Current empirical literature on resilience: How has it been used and measured?

In line with the broadening of the concept, recent empirical studies of resilience have used a range of different measures of risk and protective factors, as well as outcomes that indicate resilient functioning. It is these differences in measurement that have created some ambiguity regarding resilience and its various meanings. As noted by Rutter (1999), there is a complex and very individual range of individual characteristics, plus external family and environmental factors that influence cycles of negative experiences as well as positive chain reactions. It is the diversity and complexity of an individual's experiences that may render the construct of resilience somewhat unclear. For practitioners there are three main components of resilience that have been defined and measured differently and therefore need to be understood.

What is risk or adversity?

Differences in what constitutes “exposure to high levels of adversity” have led to potential confusion and a lack of clarity around resilience. What defines “adversity”? What is “risk”? How much is “high levels”? Some studies have considered exposure to a single adverse event or type of risk. Others have suggested that exposure to adversity is rarely a one-off event and so have included measures of cumulative adversity. For example, in their studies of resilience, Hjelm, Friborg, Stiles, Rosenvinge, and Martinussen (2006) utilised a broad ranging 18-item life stress scale that measured exposure to a wide range of stressful life events such as divorce, having been bullied, serious illness in the family and exposure to violence. In contrast, Dean and Stain (2007, 2010) included only items related to the impact of long-term drought on participants living in rural and remote areas. Further to this, research suggests that it may be the *number* of risks and *chronicity* of risk exposure that is more important than any one risk factor, with children experiencing the highest levels of risk (e.g., low socio-economic status, multiple risks, child maltreatment) less likely to show positive outcomes than those experiencing lower levels of risk (Luthar, 2006; Vanderbilt-Adriance & Shaw, 2008).

What are protective factors?

Protective factors, as an element of resilience, have also been a source of variability in definition and measurement. Protective factors are considered to be those that may reduce or mitigate the negative impact of risk factors (Kim-Cohen, 2007). For example, in a longitudinal study of 205 children, Masten and colleagues (1999) included intellectual functioning and parenting quality as potential resources or protective factors, whereas Flouri, Tzavidis, and Kallis (2009) included developmental milestones, temperament, parenting and verbal and non-verbal ability. Protective factors operate at the individual, family and community level and may vary depending on the child's age or developmental stage, as well as the type of adversity being faced. While some appear to be protective across a broad range of risks (e.g., parenting quality), others may be protective only in the context of certain risk factors (Schofield & Beek, 2005; Vanderbilt-Adriance & Shaw, 2008).

What constitutes adaptive or competent functioning?

Finally, adaptive functioning, competence or positive outcomes—which are seen as key indicators of resilience—are understood and measured in different ways. Initially competence was noted as the absence of psychopathology (Masten & Powell, 2003) but more recently competence in a range of areas has been included. Masten et al. (1999) included competent performance (“close to average or better”, p. 145) on three age and developmentally appropriate tasks: academic achievement, conduct, and peer social competence. Other studies have utilised components of the Strengths and Difficulties Questionnaire, which has been found to be a valid measure of emotional problems amongst children and adolescents (Dean & Stain, 2007; Flouri et al., 2009).

Further to differences in indicators of adaptive functioning, there has been research suggesting that these outcomes may fluctuate over time and across various domains (e.g., a child may be performing well academically but not so well in other areas of his/her life) and as such, a child's specific context and developmental stage at a given time must be taken into consideration when considering adaptive functioning. Measures of competent functioning should be strongly linked to the risk factors under consideration. For example, in children of depressed parents the absence of depression may be considered competent functioning, rather than high academic achievement which may not be relevant to the risks being studied (Luthar, 2006).

Whilst the broadening of the concept of resilience may have led to some concern regarding its utility, it does not necessarily render it less useful but rather may take into account the major individual differences in people's responses to the same experiences (Rutter, 2006). If practitioners can make sense of the components of resilience then they can work to enhance it through reducing exposure to risk and increasing exposure to protective factors.

Resilience in practice

Not only has resilience been well researched but it has also been utilised in a variety of practical ways. There are popular books and practical resources for parents and families. The usefulness of the concept of resilience can be found in the many programs, guides and books offering ways for professionals to build resilience in children by focusing on reducing risk factors and enhancing protective factors.

Programs and services that focus on resilience in practice are likely to fall under one of three types: building the capacity for resilience in all children; building the capacity for resilience in vulnerable children or those facing chronic adversity; or building the capacity for resilience in children exposed to one-off traumatic events.

Building the capacity to be resilient in all children

Interventions at this level are proactive in nature and hope to improve the capacity in all children to be resilient should they encounter adversity. These programs tend to operate at the school or broader community level. MindMatters is an example of a national initiative that operates in secondary schools and aims to foster the social and emotional skills young people require to meet life's challenges (www.mindmatters.edu.au).

Another example of a program that can be run with all primary or secondary school children is the Resilience Doughnut, created by Lyn Worsley, aimed at providing a process through which teachers, students and parents can build a child's sense of optimism and hope (www.theresiliencedoughnut.com.au).

Building resilience in vulnerable children or those facing chronic adversity

Many practitioners will work with children who face a range of chronic and severe risks. Some resources target these children in particular. Gilligan (2009) described how social workers and carers working with children and young people can promote resilience. By focusing on key protective factors found to be involved in resilience, Gilligan showed how these factors may be supported or protected in the daily lives of children living in care, adopted or in need. For example, Gilligan took the well-evidenced finding that caring, good quality relationships with key adults are one of the most important factors in children showing resilience. His book includes a chapter full of practical ways for workers to grow and support these relationships.

The Early Years: Assessing and Promoting Resilience in Vulnerable Children I (Daniel & Wassell, 2002) is one of a series of guides aimed at different aged children. *The Early Years* is targeted at

social workers and focuses on vulnerable pre-school aged children. It provides an assessment and intervention framework for boosting protective factors based on six domains (secure base, education, friendships, talents and interests, positive values and social competencies) that are considered to contribute to three crucial building blocks of resilience—a secure base, good self-esteem and a sense of self-efficacy. All assessments are based on an ecological framework that includes resources within the child (such as temperament), close family or substitute family relationships, and the wider community. The approach allows social workers to engage in positive practice that can build a network of support around the child.

Another practical guide links resilience to *Belonging, Being and Becoming—the Early Years Learning Framework for Australia* (Linke & Radich, 2010). The authors offer ways of developing resilience practices within childcare settings, in order to help infants and pre-school aged children gain skills that will assist them with coping with difficulties.

Again, it should be noted that research suggests that there are no “invulnerable” children and that the higher the number and chronicity of risks a child faces, the less likely they are to exhibit resilient functioning (Vanderbilt-Adriance & Shaw, 2008). It is also worth noting that some sources of adversity are preventable (such as child maltreatment and homelessness) and it would be far more effective to prevent these (potentially through universal public health programs and targeted services) than to attempt to address them once they have occurred (Masten & Obradovic, 2006).

Building resilience in children exposed to one-off traumatic events

Many children will face a major traumatic event in their lives (e.g., natural disaster or parental death). Although dependent on the intensity and nature of the disaster¹ or the type of negative event experienced, the literature generally suggests that most people will experience these events without long-term negative outcomes (McFarlane, 2005).

There may be approximately 5–15% of people who experience adverse effects such as chronic depression or post-traumatic stress disorder (PTSD) following loss or exposure to violence or life threatening events (Bonanno, 2004). Children and young people may be particularly vulnerable to the impacts of disaster or exposure to trauma, especially if the significant adults in their lives have also been impacted (Fullerton & Ursano, 2005; Norris et al., 2002). Children exposed to trauma are at heightened risk of PTSD, depression and separation anxiety disorder, as well as a wide range of other symptoms and behaviours (Fullerton & Ursano, 2005). These children may require individual intervention in order to recover but most children should be able to get on with life relatively unaffected. There is some research to suggest that intervening with those who are relatively well-functioning may, at the least be ineffective, and for some potentially detrimental (particularly for those receiving grief-specific therapies) (Bonanno, 2004).

It is in disaster situations that a focus on community resilience may be more useful than attempting to intervene with every individual affected by the traumatic event.² Resilience in children depends

1 What constitutes a “disaster”? (Caruana, 2010, p. 80).

In the literature, “disaster” is commonly conceived as an adverse event or situation beyond the capacity of the local community to manage. To qualify as a disaster for the purposes of the research conducted by the World Health Organization’s Centre for Research on the Epidemiology of Disasters, an event must involve at least one of the following criteria:

- 10 or more people killed;
- 100 or more people affected;
- a declaration of a state of emergency; and/or
- a call for international assistance (Rodriguez, Vos, Below, & Guha-Sapir, 2009).

Disaster events can be classified in a number of ways:

- disasters that occur naturally or result from human negligence or intent (or a combination of both);
- events that are sudden and catastrophic or unfold over a period of time; and
- incidents that are specific to a distinct geographical location or that are more diffuse in reach.

2 Masten and Osofsky (2010, p. 1037) suggested several ways, based on research findings, in which families and communities may help protect children from major adversity. See the article for full details but important factors include:

- ensuring that attachment relationships are protected and restored as soon as possible (e.g., through keeping children with their parents during evacuations);
- ensuring that first responders are trained in the range of developmental responses to trauma that may be expected for children of different ages and remember that first responders for children may include parents, teachers and carers; and

upon resilience across interconnected systems (e.g., family, school, community) and it is under conditions such as natural disasters that whole communities are likely to be impacted. This links child resilience to community and family resilience which is particularly important in times of major disaster when systems may collapse at multiple levels and have far reaching effects at a number of levels (Masten & Obradovic, 2006).

For further information, see forthcoming CFCA Paper, *Natural Disasters and Community Resilience: A Framework for Support* (Price-Robertson & Knight).

Is resilience still a useful concept for practitioners?

As can be seen in the practical examples above, resilience theory is still being used as the basis for programs, and research on the topic continues.

Despite some methodological and definitional concerns, resilience is still a useful concept in that it moves beyond simply identifying risk factors that may lead to negative outcomes, to including protective factors that may help lessen some of the negative influences of adversity. An awareness of the specific risk and protective factors at work in a child's life allows practitioners to target their practice to reduce the risks and boost relevant protective factors in order to offer the child the best chance of experiencing positive outcomes.

For practitioners to ensure effective practice application, the notion of resilience requires an in-depth understanding that:

- resilience involves complex processes of interrelated risk and protective factors at the child, family and community levels;
- resilience is not static and may fluctuate at different ages and developmental stages of the child;
- when utilising the concept, practitioners should be clear on how they are defining risk, protective factors and adaptive functioning; and
- the individual situation and needs of each child, and an understanding that no child is invulnerable, should be key considerations. The greater the number or chronicity of risks the child is exposed to, the less likely the child is to display resilient functioning (Vanderbilt-Adriance & Shaw, 2008).

Conclusion

Researchers have understood “risk” and “protective” factors in varied ways and definitions of what constitutes competent functioning and positive outcomes have also differed across situations and studies. Resilience researchers have also been criticised for producing long lists of risk and protective factors that are of limited practical use because a given intervention cannot address all known risk and protective factors (Luthar, 2006).

Issues such as these have led some to question whether resilience is still a useful concept, particularly for practitioners working with children who face long-term chronic adversity. It has been suggested recently that rather than focusing on what makes a person resilient, it may be more helpful to focus on what particular processes tend to cultivate resilience for particular people (Harney, 2007).

An understanding of the processes involved and the complexity of the concept, as well as a continued focus on the unique context of each individual child, will ensure that the concept of resilience can still be useful in practice.

■ restoring children's routines and activities, such as opportunities for play, and restoring schools and community organisations that support these routines as soon as feasible.

Acknowledgements

The author would like to thank Jennie Hannan, Linda Mondy, Rhys Price-Robertson, Elly Robinson and Shaun Lohar for their helpful comments and feedback.

References

- Bonanno, G. A. (2004). Loss, trauma, and human resilience. Have we underestimated the human capacity to thrive after extremely adverse events? *American Psychologist*, *59*(1), 20–28.
- Bromfield, L., Lamont, A., Parker, R., & Horsfall, B. (2010). *Issues for the safety and wellbeing of children in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse, and mental health problems* (NCPC Issues No. 33). Melbourne: National Child Protection Clearinghouse, Australian Institute of Family Studies.
- Caruana, C. (2010). Picking up the pieces: Family functioning in the aftermath of natural disaster. *Family Matters*, *84*, 79–88.
- Cicchetti, D. (2010). Resilience under conditions of extreme stress: A multilevel perspective. *World Psychiatry*, *9*(3), 145–154.
- Council of Australian Governments. (2011). *National strategy for disaster resilience: Building our nation's resilience to disasters*. Canberra: COAG. Retrieved from <www.coag.gov.au/coag_meeting_outcomes/2011-02-13/docs/national_strategy_disaster_resilience.pdf>
- Daniel, B., & Wassell, S. (2002). *The early years: Assessing and promoting resilience in vulnerable children I*. London: Jessica Kingsley Publishers.
- Dean, J., & Stain, H. J. (2007). The impact of drought on the emotional well-being of children and adolescents in rural and remote New South Wales. *The Journal of Rural Health*, *23*(4), 356–364.
- Dean, J. G., & Stain, H. J. (2010). Mental health impact for adolescents living with prolonged drought. *Australian Journal of Rural Health*, *18*, 32–37.
- Flouri, E., Tzavidis, N., & Kallis, C. (2010). Adverse life events, area socioeconomic disadvantage, and psychopathology and resilience in young children: The importance of risk factors' accumulation and protective factors' specificity. *European Child & Adolescent Psychiatry*, *19*, 535–546.
- Fuller, A. (1998). *From surviving to thriving: Promoting mental health in young people*. Camberwell: The Australian Council for Educational Research Ltd.
- Fullerton, C. S., & Ursano, R. J. (2005). Psychological and psychopathological consequences of disasters. In J. J. Lopez-Ibor, G. Christodolou, M. Maj, N. Sartorius, & A. Okasha (Eds.), *Disasters and mental health*. West Sussex: Wiley.
- Gilligan, R. (2009). *Promoting resilience: Supporting children and young people who are in care, adopted or in need*. London: British Association for Adoption & Fostering.
- Garnezy, N. (1974). Children at risk: The search for the antecedents of schizophrenia. Part II: Ongoing research programs, issues, and intervention. *Schizophrenia Bulletin*, *9*, 55–118.
- Gordon, R. (2007). Thirty years of trauma work: Clarifying and broadening the consequences of trauma. *Psychotherapy in Australia*, *13*(3), 12–19.
- Harney, P. A. (2007). Resilience processes in context: Contributions and implications of Bronfenbrenner's person–process–context model. *Journal of Aggression, Maltreatment & Trauma*, *14*(3), 73–87.
- Harvey, M. R. (2007). Towards an ecological understanding of resilience in trauma survivors: Implications for theory, research, and practice. *Journal of Aggression, Maltreatment & Trauma*, *14*(1/2), 9–32.
- Hjemdal, O., Friborg, O., Stiles, T. C., Rosenvinge, J. H., & Martinussen, M. (2006). Resilience predicting psychiatric symptoms: A prospective study of protective factors and their role in adjustment to stressful life events. *Clinical Psychology and Psychotherapy*, *13*, 194–201.
- Kim-Cohen, J. (2007). Resilience and developmental psychopathology. *Child and Adolescent Psychiatric Clinics of North America*, *16*, 271–283.
- Leadbeater, B. J., Schellenbach, C. J., Maton, K. I., & Dodgen, D. W. (2004). Research and policy for building strengths: Processes and contexts of individual, family, and community development. In K. I. Maton, C. J. Schellenbach, B. J. Leadbeater, & A. L. Solarz (Eds.), *Investing in children, youth, families and communities: Strengths-based research and policy*. Washington DC: American Psychological Association.
- Linke, P., & Radich, J. (2010). *Children's resilience: Working with the Early Years Learning Framework*. Canberra: Early Childhood Australia Inc.
- Luthar, S. S. (2006). Resilience in development: A synthesis of research across five decades. In D. Cicchetti, & D. Cohen (Eds.), *Developmental psychopathology: Risk, disorder and adaptation* (pp. 739–795). New York: John Wiley & Sons.
- Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227–238.
- Masten, A. S., Hubbard, J. J., Gest, S. D., Tellegen, A., Garnezy, N., & Ramirez, M. (1999). Competence in the context of adversity: Pathways to resilience and maladaptation from childhood to late adolescence. *Development and Psychopathology*, *11*, 143–169.
- Masten, A. S., & Obradovic, J. (2006). Competence and resilience in development. *Annals New York Academy of Sciences*, *1094*, 13–27.
- Masten, A. S. & Osofsky, J. D. (2010). Disasters and their impact on child development: Introduction to the special section. *Child Development*, *81*(4), 1029–1039.
- Masten, A. S., & Powell, J. L. (2003). A resilience framework for research, policy, and practice. In S. S. Luthar (Ed), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 1–25). Cambridge: Cambridge University Press.
- Maybery, D., Pope, R., Hodgins, G., Hitchenor, Y., & Shepherd, A. (2009). Resilience and well-being of small inland communities: Community assets as key determinants. *Rural Society*, *19*(4), 326–339.
- McAslan, A. (2010). *The concept of resilience: Understanding its origins, meaning and utility*. Adelaide: Torrens Resilience Institute.
- McCashen, W. (2005). *The strengths approach*. Bendigo: St Luke's Innovative Resources.

- McFarlane, A. C. (2005). Psychiatric morbidity following disasters: Epidemiology, risk and protective factors. In J. J. Lopez-Ibor, G. Christodolou, M. Maj, N. Sartorius, & A. Okasha (Eds), *Disasters and mental health*. West Sussex: Wiley.
- NCH – The Bridge Child Care Development Service. (2007). *Literature review: Resilience in Children and young people*. London: NCH – The Bridge Child Care Development Service. Retrieved from <www.actionforchildren.org.uk/media/145693/resilience_in_children_in_young_people.pdf>
- Norris, F. H., Friedman, M. J., Watson, P. J., Byrne, C. M., Diaz, E., & Kaniasty, K. (2002). 60,000 disaster victims speak: Part I. An empirical review of the empirical literature, 1981–2001. *Psychiatry*, 65(3), 207–239.
- Price-Robertson, R., & Knight, K. (Forthcoming). *Natural disasters and community resilience: A framework for support* (CFCA Paper 5). Melbourne: Child Family Community Australia, Australian Institute of Family Studies.
- Resnick, M. D., Ireland M., & Borowsky I. (2004). Youth violence perpetration: What protects? What predicts? Findings from the National Longitudinal Study of Adolescent Health. *Journal of Adolescent Health*, 35(5), 424.e1–424e10.
- Rodriguez, J., Vos, F., Below, R., & Guha-Sapir, D. (2009). *Annual disaster statistical review 2008: The numbers and trends*. Geneva: WHO Centre for Research on the Epidemiology of Disasters.
- Rutter, M. (1999). Resilience concepts and findings: Implications for family therapy. *The Association for Family Therapy*, 21, 119–144.
- Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of the New York Academy of Science*, 1094, 1–12.
- The Resilience Alliance (2011). *About RA*. Retrieved from <www.resalliance.org/index.php/about_ra>
- Saleebey, D. (1996). The strengths perspective in social work practice: Extensions and cautions. *Social Work*, 41(3), 296–305.
- Schofield, G., & Beek, M. (2005). Risk and resilience in long-term foster-care. *British Journal of Social Work*, 35, 1283–1301.
- Staudt, M., Howard, M. O., & Drake, B. (2001). The operationalization, implementation, and effectiveness of the strengths perspective: A review of empirical studies. *Journal of Social Service Research*, 27(3), 1–21.
- Strengths Institute. (n.d.). *What is the strengths perspective?* Retrieved from <www.socwel.ku.edu/strengths/about/index.shtml>
- Ungar, M. (2004). *Nurturing bidden resilience in troubled youth*. Toronto: University of Toronto Press Incorporated.
- Vanderbilt-Adriance, E., & Shaw, D. S. (2008). Conceptualizing and re-evaluating resilience across levels of risk, time, and domains of competence. *Clinical Child & Family Psychology Review*, 11, 30–58.
- Werner, E. E. (1995). Resilience in development. *Current Directions in Psychological Science*, 4(3), 81–85.
- Werner, E. E., & Smith, R. S. (1989). *Vulnerable but invincible: A longitudinal study of resilient children and youth*. New York: Adams Bannister Cox.

Cathryn Hunter is a Research Officer with the Child Family Community Australia information exchange at the Australian Institute of Family Studies.



Australian Government

Australian Institute of Family Studies

Child Family Community Australia

© Commonwealth of Australia 2012
With the exception of AIFS branding, the Commonwealth Coat of Arms, content provided by third parties, and any material protected by a trademark, all textual material presented in this publication is provided under a Creative Commons Attribution 3.0 Australia licence (CC BY 3.0) <creativecommons.org/licenses/by/3.0/au>. You may copy, distribute and build upon this work for commercial and non-commercial purposes; however, you must attribute the Commonwealth of Australia as the copyright holder of the work. Content that is copyrighted by a third party is subject to the licensing arrangements of the original owner.

The **Child Family Community Australia** (CFCA) information exchange is an information and advisory unit based at the Australian Institute of Family Studies, and funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs. The CFCA information exchange collects, produces and distributes resources and engages in information exchange activities that help to protect children, support families and strengthen communities.

The Australian Institute of Family Studies is committed to the creation and dissemination of research-based information on family functioning and wellbeing. Views expressed in its publications are those of individual authors and may not reflect those of the Australian Institute of Family Studies or the Australian Government

Australian Institute of Family Studies
Level 20, 485 La Trobe Street
Melbourne VIC 3000 Australia
Phone: (03) 9214 7888 Fax: (03) 9214 7839
Internet: <www.aifs.gov.au>

ISSN 2200-4106

ISBN 978-1-921414-86-2

