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ABSTRACT
        Resilience is defined as "the human capacity to face,
overcome, and be strengthened by experiences of adversity." This study used
an Eriksonian developmental model to examine parents', caregivers', and
children's resilience-promotion in children up to 12 years of age. Age and
gender differences and cultural/ethnic similarities and differences in
resilience promotion were examined. Subjects responded to 3 age-specific
(birth to 3 years, 4 to 6 years, and 9 to 11 years) structured situations of
adversity. Data were received from 27 sites in 22 countries for a total of
1,225 target children and families/caregivers. Findings indicated that about
one-third of parents promoted resilience. Resilience was promoted more in
situations where helplessness and need were perceived and where support
seemed feasible and less in situations in which there were perceived threats
to authority, in which blame and punishment seemed more important than
understanding or communication, and in which the person who could promote
resilience was more concerned with frustration. Younger children (4-6) relied
more than older children on help and guidance from parents to deal with
adversity; older children (9-11) promoted resilience as often as their
parents. When younger children promoted resilience, girls drew on empathy and
helpfulness more than boys. For older children, girls drew on trusting
relationships, role modeling, and promoting autonomy more than boys; all
internal resilience factors except a sense of control; and all interpersonal
skills except managing impulsivity and seeking help which were used with the
same frequency as boys. Examples from Sudan, Namibia, and Armenia suggested
differences and similarities in successful resilience promotion.
Socioeconomic status had an insignificant impact on resilience-promoting
behavior; the difference was primarily in the number of resilience factors
used. (Contains 43 references.) (KB)

THE INTERNATIONAL RESILIENCE RESEARCH PROJECT[1]

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BACKGROUND

Purpose

The primary purpose of the International Resilience Research Project (IRRP) was to address the question: What actions do parents or other caregivers and children themselves take that seem to promote resilience in the children up to age 12? Secondary questions were: a. What are the differences in the promotion of resilience as a function of the age and gender of the child; and, b. What are some cultural/ethnic similarities and differences in the promotion of resilience in children?

Defining resilience

The definition of resilience used in this research stated: Resilience is the human capacity to face, overcome, and even be strengthened by experiences of adversity. However, defining resilience is a continuing problem (Kaufman, Cook, Arny, Jones & Pittinsky, 1994), and there is still a lack of consensus about the domain covered by the construct of resilience; i.e., its characteristics and dynamics (Gordon & Song, 1994). Further, some languages do not yet have an equivalent word in the behavioral sciences (Kotliarenco, 1993). Spanish, for example, has no word for resilience in the psychological literature but, instead, used the term "la defensa ante la adversidad (defense in face of adversity)(Grotberg, 1993)." French, on the other hand, has the word but regarded the concept as used in the behavioral sciences not only as western but, more specifically, Anglo-American; however, with increasing acceptance of its appropriateness internationally (Manciaux, 1995).

There is currently sufficient agreement on many of the factors that contribute to resilience or define resilience in certain populations for discussion and study. These factors began to emerge from the early studies by researchers such as E. Werner & R. Smith (1982), N. Garmezy (1985; 87) and M. Rutter (1987; 1991). These factors have been rediscovered, reinforced or added to by other researchers. For example, S.J. Wolin & S. Wolin (1993) reinforced Werner and Garmezy's resilience factor of trusting relationships; F. Loesel (1992) reinforced Werner's resilience factor of emotional support outside the family; R. Brooks (1992) and Wolin & Wolin (1993) reinforced the resilience factor of self-esteem. J. Segal & H. Yahraes(1988) added the resilience factor of encouragement of autonomy, and D. Mrazek & P. Mrazek (1987) added hope, responsible risk taking, and a sense of being lovable. Loesel (1992), A. Osborn (1990) and M. Wang, D. Haertel & H. Walberg (1994) added school achievement as a resilience factor. J. Garbarino (1993) added belief in God and morality, and U. Bronfenbrenner (1979) had already contributed the resilience

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factor of unconditional love from someone. These contributions are not in chronological order but have emerged and reemerged over time. The earlier contributors are referenced from more recent publications.

However, there is more to the problem of definition, because the genetic makeup and temperament of a child are also important aspects for understanding and defining resilience. The genetic makeup and temperament of a child are continuing forces that contribute to the process of becoming resilient. Whether a child is more or less vulnerable to anxiety, challenges, stress and unfamiliarity, whether the child is inhibited or uninhibited, determines how a child perceives himself or herself, how he or she interacts with others and how he or she addresses adversities (Kagan, 1991). Closely related to Kagan's definition of temperament is that of J.H. Block & J. Block (1980) who examined ego-resilience, indicating there are ego-overcontrollers and ego-undercontrollers, referring respectively to Kagan's inhibited and uninhibited definitions of temperament. They point out that for children in functional settings, either may serve the child, but in dysfunctional settings, the ego-overcontrollers may have a better chance for developing resilience by controlling their reactions to family problems.

Ways to study resilience

An equally important concern is how to study resilience. There have been two primary ways for studying resilience: retrospective studies and concurrent studies. The retrospective studies provided the large base for identified resilience factors noted above. The concurrent studies tended to look for those resilience factors in children and adolescents in school settings (Loesel; Osborn; and Wang, Jaertel & Walberg, as referenced), or in extreme situations; e.g., in a detention setting (McCallin, 1993). The present study drew from the resilience factors identified in the retrospective studies and reinforced by the concurrent studies, but addressed the new question: How do children become resilient?

Major conceptual frameworks for studying resilience are: (a) a pathological framework examining psychopathology or social pathology, and (b) a developmental/life-span framework. More research has used the pathological framework for study. However, there is a growing body of literature focusing on the developmental/life-span model (Staudinger, Marsiske & Baltes, 1993). The shift is particularly important for the present study, which is concerned with the promotion of resilience in children as they develop over time, with or without some kind of pathology in the family or in the child.

A constant element in all of the studies, however, was to view the child in a context; i.e., the family, the social group, the school, the larger community. The child in context was also the basic unit for the present study.

International contributions

A growing international interest in resilience became evident through a series of conferences and

meetings which began in 1986. An early one was held in Durango, Colorado, (Frankenburg, 1987); another was held in Lesotho, Africa, in November, 1991 (Bernard van Leer Foundation, 1994); one was held in Washington, D.C., in December, 1991 (Institute for Mental Health Initiatives, 1991); a meeting held in Paris, France, in 1993, was related to the present study; another conference was held in New York, 1993 (Vanistendael, 1996); one in Santiago, Chile in 1995 (Kotliarenco, Caceres & Alvarez (Eds.), 1996); and Lisbao, Portugal, 1995 (Joao Gomes Pedro, no publication to date).

This series of international conferences and meetings, joined with the literature, suggested the definition of resilience used in the present study: Resilience is a universal human capacity to face, overcome and even be strengthened by experiences of adversity. Resilience may be found in a person, group or a community and may make stronger the lives of those who are resilient. The resilient behavior may be in response to adversity in the form of maintenance of normal development, despite the adversity, or as a promoter of growth beyond the present level of functioning. Further, resilience may be promoted not necessarily because of adversity, but, indeed, may be developed in anticipation of inevitable adversities. Resilience is promoted as part of the developmental process of a child over time.

This universal capacity for resilience is developed and nurtured from: 1. factors of *external* supports and resources; i.e., trusting relationships; access to health, education, welfare and security services or their equivalent; emotional support outside the family; structure and rules at home; parental encouragement of autonomy; stable school environments; stable home environments; role models; and religious organizations/morality (labeled I HAVE (Grotberg, 1995c); 2. *inner*, personal strengths; i.e., a sense of being lovable; autonomy; appealing temperament; achievement oriented; self-esteem; hope, faith, belief in God, morality, trust; empathy/altruism; and locus of control (labeled I AM (Grotberg, ibid.); and 3. *social,* interpersonal skills; i.e., creativity; persistence; humor; communication; problem solving; impulse control; seeking trusting relationships; intellectual skills (labeled I CAN (Grotberg, ibid.). Definitions of each of these factors vary, often depending on the author conducting the research. However, whatever precise definitions may be accepted or rejected, the common thrust is that resilience is promoted by factors *provided* around the child (I HAVE), by factors promoted and *developed* within the child (I AM), and by factors *acquired* by the child (I CAN). The facing of adversity requires a dynamic and balanced interaction of these factors; i.e., no one factor, one source or one way, is sufficient.

Focus of the study

The present study represented a departure from the previous lines of research. The intent was to examine what parents, caregivers or children do; i.e., how they use resilience factors, to promote resilience in the children. Osborn reported (1990) that mothers who are optimistic tend to have more resilient children than mothers who are not or are, indeed, depressed. However, specific actions on the parts of mothers are not identified. Garbarino (1993) stressed the primary importance of keeping a family intact to help children become resilient or at least deal with

adversity, but does not indicate what there is about an intact family that promotes resilience in children.

The present study examined resilience promoting behavior in many nations around the world. This international perspective seemed appropriate to determine similarities and differences in ways to promote resilience; the role of culture/ethnicity in determining what resilience factors are used as well as their dynamics; and the changes in resilience promoting behavior as a function of the age of the child.

The Advisory Committee

To assure the international focus of the study, an Advisory Committee made up of international organizations was formed, including Civitan International Research Center, UAB, the sponsor of the study; United Nations Education Scientific and Cultural Organization (UNESCO); Pan American Health Organization (PAHO); World Health Organization (WHO); International Children's Center (ICC); International Catholic Child Bureau (ICCB); and the Bernard van Leer Foundation. The Advisory Committee was to provide suggestions and criticisms to the International Resilience Research Project (IRRP).

THE RESEARCH

Selection of Design, Instruments and Participants

Assumptions. The design and instruments used in the IRRP incorporate the following assumptions:

> a. resilience factors that are used in response to structured Situations of adversity and in the reporting of a Personal Experience of adversity involving the target child are, in fact, used in the promotion of resilience in the children.

> b. adversity is not limited to man-made disasters, such as war, famine, poverty, confinement, refugee status, etc., or to natural disasters such as earthquakes, hurricanes, floods, fires, droughts, etc. Adversity also occurs in everyday life in the form of divorce, abandonment, abuse, alcoholism, stabbing, illness, death, robberies, loss of home or job, moving, accidents, murder.
> Further, resilience may be promoted not necessarily because of adversity but, in fact, may be developed in anticipation of inevitable adversities.

> c. the earlier years of development are accepted as a critical time for acquiring many of the basic skills, attitudes and values that tend to remain over the life span. Werner (1993) specifically stated that children 11 years of age and under are the most likely age group to develop many resilience factors.

d. The Erikson developmental model is an appropriate mode to use internationally, in spite of its lack of addressing gender or cultural/ethnic differences. And while there is concern about using western models for cross-cultural research (Grotberg & Badri, 1987; Wade, 1993), many studies (Grotberg & Badri, 1992; Sparling, 1992) have found such models useful when: a. applied without rigid age division lines; b. using flexibility in noting behaviors in observation; c. using culturally adapted measurements of developmental status; and d. being flexible in intervention activities. Many measurement instruments lend themselves quite readily to translation and cultural adaptation (Badri & Grotberg, 1984).

The design. The design for the IRRP was based on use of 15 constructed Situations of adversity. Each of the Situations included a child or children and adults, involved or nearby. (The Situations are presented below in Table 2) The first 9 Situations were used with parents of children 6 and under; the remaining 6 Situations were used with parents and/or children where the children were between 9 and 11. When a child in the age group 4-6 was able to communicate, that child also responded to Situations. The age groupings, birth -3; 4-6; and 9-11 , were within Erikson's developmental levels and permitted more reliable analysis of data than age by single years or larger age groupings. The Situations, further, were divided into 2 sets of 3 for each age group, and respondents answered questions relating to no more than 3 Situations.

The questions for adults were:

> What did the adult do?
> How did the adult feel?
> What did the child do when the adult did that?
> How did the child feel?
> How did things come out or how are things now?

The questions for children were:

> What did the adult do?
> What did the child do when the adult did that?
> How did the child feel?
> How did things come out or how are things now?

The one question, How did the adult feel? was left out because of concern about rousing anxiety in the child or the adult by asking the question requiring assessment of the adult's feelings. The Advisory Committee advised against using the question.

The same questions were used when the adult or the child reported a recent Personal Experience of adversity that involved the target child, except that the questions were personalized.

The 15 Situations, developed by the Project Director, were critiqued and modified: (1) through

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consultation with members of the IRRP Advisory Committee; and (2) through field testing by graduate students at the University of Maryland School of Nursing, under the supervision and training of Peggy Parks, Ph.D.

Instruments. Instruments used in addition to the Situations and Questions consisted of several standardized tests.

> Social Skills Rating System: SSRS-Student Form; Elementary Level; and the Parent
> Form, Preschool level (Gresham & Elliot, 1990)
> Nowicki-Strickland Locus of Control Test (1973)
> Parental Bonding Inventory (PBI) (Parker, Tupling & Brown, 1979)

Each of these tests was used in North America to validate the selection of resilience factors that were assumed to measure social skills in the interpersonal area, locus of control as an inner strength, and the parental contribution to resilience from external supports. The resilience factors were validated by the tests, with the Parental Bonding Inventory validated in Canada (Hiew & Cormier, 1994); and in cross-cultural groups (Arindell, Hanewald & Kolk, 1989). Participants. The participants of the IRRP were selected because of their professional status and work and because of their interest in resilience. They held positions as directors of research at their institutions; professors, medical doctors in health services; directors of training programs; and practicing psychologists. Some of the participants trained students at graduate or undergraduate levels to gather data for the IRRP. The director of the project, in consultation with the Advisory Committee and Dr. Parks, developed a Guidance for the research process and a Manual for the Training of Interviewers.

Data received between September, 1993 and August,1996, are from the 22 countries and 27 sites geographically distributed as follows: Europe: Krasnador, Russia; Yerevan, Armenia; Martuni, Azerbaijan; Helsinki, Finland; Vilnius and Kaunas, Lithuania; Prague, Czeck Republic; Budapest, Hungary. Africa: Khartoum, Sudan; Nairobi, Kenya; Pretoria and Johannesburg, South Africa; Windhoek and Katatura, Namibia. Latin America: Sao Paulo, Brazil; Santiago, Chile (2 sites); San Jose, Costa Rica; Panama City, Panama. North America: Los Angeles, California; Syracuse, New York; Canada: Fredericton, New Brunswick; Edmonton, Alberta. Pacific countries: Taipei, Taiwan; Tokyo, Japan; Bangkok, Thailand; Hanoi, Vietnam; Perth, Australia.

Methodology. The methodology was based on purposeful samples of selected families with children in specific age groups and included structured interviews for parents with children 4-6; 9-11, as well as with the children. Parents of children in the 3 and under age group were also interviewed. To assure similarity in methodology, each participant received a paper summarizing the research on resilience (Grotberg, 1993a); the Methodology Guidance and the Manual for the Training of Interviewers; a demographic sheet; a packet of the Situations and forms with the Questions to be answered; a request for the report of a Personal Experience of adversity, asking the same Questions; and additional standardized tests when requested. The participants were

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informed that once raw data were standardized, they could use the data any way they wished. They understood they would receive a print-out of their summarized data and a disc with the data for each target child in a form compatible with their processing machines. And, they were asked to provide data from a minimum of 25 target children. Participants returned the initial data for scoring by the project director and data analysis at Civitan. Each participant included a description of the country, city or area where the study took place and provided information about the cultural setting, especially where the target child lived.

Scoring responses. The unit of scoring responses to the constructed Situations and Personal Experience was the complete episode of response; i.e., there was a beginning, a process and an ending, each part of which used resilience factors for promoting resilience in the children. A 3 point scale was used for scoring responses. A score of 3 was assigned to a complete episode promoting resilience. A score of 2 was given to responses mixing resilient and non-resilient promoting behavior. And a score of 1 was given to responses that would prevent the development of resilience in the children.

When a response was scored 3, the resilience factors derived from the literature were used to identify which resilience factors were used in promoting resilience, identifying the specific external supports and resources; the inner factors used; and the social, interpersonal skills used. A score of 3 did not require the use of factors from each of the categories; what was important was the successful process of overcoming the adversity.

The project director scored each response to provide a consistent scoring procedure. An intrascorer reliability check consisted of returning to earlier episodes and rescoring. There was an 85% consistency in scoring. A second reliability check was made with the local scorer of the participants in Canada. Comparing 50 scored episodes, 32 had identical scores of 1, 2, or 3 (64%); and 18 (36%) had a plus or minus one point disagreement. The higher score was given by the senior rater, indicating a perception of more resilience in the responses. However, the high comparability of scoring suggested an acceptable level of interscorer reliability.

FINDINGS

Data provided in the findings came from the 22 countries and 27 sites identified above. The data are presented in Table 1, Description of Population. The population consisted of a total N of 1225 target children and their families or caregivers; 590 (48%) girls and 635 (52%) boys. 213 of the children (18%) were 3 and under; 454 of the children (36%) were 4-6; and 558 (45%) were 9-11. Health data were not reliable using the WHO standards relating to age and height, because some countries had children far below the standards but who were quite healthy. When questioned, the report was that the people are genetically small. 90% of the children were in some kind of school situation. 87% of the caregiver respondents were parents, with 13% being teachers or other caregivers. 85% of the families were in some kind of urban or semi-urban setting, including compounds, suburbs, or separate sections of a town. 17% of the fathers were absent and 2% of the mothers. 46% of the target children had one or more older siblings and

45% had one or more younger siblings. The mean size of families, included all who lived in the same residence, was 5.3, with an average family size of 3 to 5. 20% of the fathers had education beyond High School and 22% of the mothers had education beyond High School. 12% of the families reported a serious outside problem and 48% reported a serious intra-family problem within the past five years. The cultural/ethnic identity broke down into 9% with a religious identity; 28% with a national identity; 9% with a racial identity; 23% with a tribal identity; and 10% a mixed national/racial identity.

The 6 major outside problems the family experienced within the preceding 5 years were, in rank order: earthquakes; floods; robberies; war; fires; and riots. The 6 major within family problems the family experienced within the preceding 5 years, were, in rank order: death of a parent or grandparent; loss of job or income; separation; illness of parent or siblings; and family or a friend moving.

Table 1
Description of Population

Target children: N=1225   Girls: N=590 (48%)   Boys: N=635 (52%)
Ages 0-3: N=213 (18%)   4-6: N=454 (36%)   9-11 N=558 (45%)
School or Preschool: 90%   Parent respondents: 87%   Other caregiver respondents: 13%
Residence: Urban or semi-urban: 85%   Mean family size: 3-5 members
Fathers absent: 17%   Mothers absent: 2%
One or more older siblings: 46%   One or more younger siblings: 45%
Education beyond Grade 12: Fathers: 20%   Mothers 22%
Serious outside problem for family: 12%   Serious within family problem: 48%
Ethnic/cultural identity: Religious: 9%   National: 28%   Racial: 9%   Tribal: 23%   Mixed: 10%

Evidence of resilience promoting behavior

The interviews were conducted between September, 1993 and August, 1996. The percentage of responses to each of the 15 constructed Situations that provided evidence of resilience promoting behavior; i.e., earned scores of 3, are provided in Table 2: Percentages of Resilience Promoting Responses to Situations. Following that Table is an analysis of each constructed Situation to determine the differences in resilience features used and in the responses that indicated behavior that would limit the promotion of resilience in children.

There was a total of 2,204 responses to Situations from parents or other caregivers and 1,194 responses from children 4-6 and 9-11. The first 9 Situations were presented to parents of children 6 and under and to children 4-6. Situations 10 to 15 were presented to parents of children 9-11, as well as to children in that age group.

Table 2
Percentage of Resilience Promoting Responses to Situations

Situation	Parents		Children		
	N	% 3s	N	% 3s	
				Boys	Girls
One	87	75	None	-	-
(Infant cries and screams. Parent does not know what is wrong.)					
Two	236	37	48	9	14
(Infant finds dirty rag on floor and begins to suck on it. Parent sees it and fears illness.)					
Three	38	52	None	-	-
(Infant does not sit up or respond to parents.)					
Four	240	21	59	4	5
(Two year old takes sweet from store and screams when mother tries to take it away.)					
Five	231	31	42	9	30
(Two and one-half year old refuses to eat. Screams and kicks when urged to eat.)					
Six	76	40	None	-	-
(Three yer old cannot walk and wants to go out. Throws things because mother is too busy.)					
Seven	181	34	47	14	12
(Boy annoys parents and guests with his playing. Told to stop, and screams in protest.)					
Eight	139	28	38	2	4
(Children use scarce food to play store. Father sees them and knows the food is precious.)					
Nine	107	65	37	30	42
Six year old is disabled and cannot reach building sticks. Frustrated, he throws them and cries.)					
Ten	186	34	156	30	34
(Nine year old is teased and pushed as she walks to school. Is fearful and pretends she is sick.)					
Eleven	158	23	143	22	25
(Boy climbs tree in school yard, is being pulled down by others and kicks one in the face.)					
Twelve	137	40	153	42	39
(Girl and younger brother are alone. The brother catches his foot, it hurts, and he screams.)					
Thirteen	141	49	152	39	43
(Seven year old goes to new school alone. Children tease him. Teacher sees his plight.)					
Fourteen	124	29	160	35	32
(Four children 9 - 11 years old are in the market when they hear gun shots.)					
Fifteen	123	18	159	17	12
(Older slow learning children chase younger ones who tease them. Teacher sees the chase.)					

Analysis of Responses Promoting Resilience

An overall finding indicated that socio-economic status had an insignificant impact on amount and kind of resilience promoting behavior. Resilience was promoted in children as frequently in lower-income families as in higher income families. The differences were largely in the number of resilience factors used; parents of children from higher-income families using more factors.

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Resilience was also promoted in children who were considered less intelligent or, indeed, intellectually impaired. Many were taught how to reach out for help when faced with difficulties.

Further analysis indicated that parents of children 6 and under had a 42% average in scores of 3 in response to the first 9 constructed Situations, ranging from 21% to 75%. The higher percentages of scores of 3 involved dealing with situations of an infant crying (One), a disabled child needing help in building a house (Nine), and a child who is developmentally delayed (Three). Each of these involved a relatively helpless child needing support, receiving empathy, building confidence in the child, and helping the child acquire skills of self-calming and mastery of a task. The higher percentages of resilience promoting behavior had themes of children making fewer demands on the parents in terms of conflict or challenging authority, and in which parents had a clear opportunity to help.

The lower percentages of scores of 3 involved children making a scene at a market (Four), children taking food without permission (Eight), and a child who refuses to eat (Five). Each of these involved anger, frustration, rather severe punishment, and leaving the children in a state of no resolution, learning or reconciliation. The lower percentages of resilience promoting behavior had themes of loss of parental control, need to punish, and unresolved feelings of anger and helplessness.

The number of children 4-6 who were able to respond to the constructed situations was considered too small for analysis.

Parents of children 9-11 had a 31% average in scores of 3 in response to constructed Situations 10 - 15, ranging from 23% to 49%. The higher percentages involved a child going to school alone (Ten), and a girl taking care of her brother who became injured (Twelve). Both of these involved a relatively helpless child needing care and support, empathy, and resolution of a problem. The higher percentages of resilience promoting behavior had themes of using outside supports to help family members, fostering a sense of autonomy in children, and expressing empathy for the victim.

The lower percentages involved developmentally delayed children protecting themselves from teasing by others (Fifteen), and a child in a tree protecting himself from being pulled down by kicking at those who were pulling at him (Eleven). Both of these involved punishing the victims rather than the perpetrators, absence of concern for the children's self-esteem and need for understanding, and an arbitrary resolution of the problem by an authority figure. The lower percentages of resilience promoting behavior had the themes of misdirected punishment, ignoring the need for communication, lack of sharing of feelings, and no resolution or reconciliation.

Children aged 9-11 had a 31% average in scores of 3 in response to the same Situations: 10 -15, ranging from 15% to 49%. The higher percentages involved a girl taking care of her younger brother who became injured (Twelve), and a group of children in a market where gun shots are

heard (Fourteen). Both involved a need for autonomous action, seeking of help, calming themselves and finding a solution.

The higher percentages of resilience promoting behavior had themes of self-esteem, confidence, autonomy and problem solving. The lower percentages involved the developmentally disabled children and the boy in the tree and included blaming and punishing the wrong persons, absence of concern for the children's self-esteem and need for understanding. The lower percentages of resilience promoting behavior had the themes of being unfairly treated and punished, feeling helpless and misunderstood, and finding no satisfaction in the outcome.

Results from reports of Personal Experiences of adversity were not incorporated into this report because they tended to show the same average percentages of resilience scores of 3 as in the Constructed Situations and drawing on the same resilience factors.

Age and Gender Differences

Table 2 also provides information on age and gender differences in the promotion of resilience. Children 4-6 demonstrated minimum use of factors promoting resilience and relied primarily on their parents for its promotion. The parents of those younger children, in fact, demonstrated more promoting of resilience (42%) than parents of children 9-11 (31%). When the younger children promoted resilience, the girls used resilience promotion behavior more than boys in the situations involving the young child refusing to eat and the disabled child trying to reach the building sticks. They showed empathy and helpfulness in both situations.

Children 9-11, both boys and girls, had average resilience scores of 31%. The differences between the children and their parents were not in the overall promotion of resilience, but rather in the resilience factors used. Parents drew on trusting relationships, role modeling and promoting autonomy from external resilience factors; seeing their children as being lovable, showing empathy, having self-esteem, feeling autonomous, and being confident from internal resilience factors; and communication, problem solving behavior from interpersonal resilience factors. Overall, children 9-11 drew on role modeling and encouragement of autonomy less than their parents; drew on being lovable or showing empathy less than parents; and manageming their own behavior less than parents. The only resilience factor these children used more than their parents was seeking trusting relationships for help.

Further analysis by gender indicated that girls drew on trusting relationships and receiving help in becoming autonomous more than boys from the external factors. Girls drew on internal factors of being lovable, autonomous, having self-esteem, feeling confident and showing empathy more than boys. And girls relied more on communication, problem solving, and relating to others than boys. There were no differences in which boys used a resilience factor more than girls. Both boys and girls used, with the same frequency, having services available, receiving emotional support and having a role model; feeling a sense of control; managing their own behavior, and reaching out for help

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Boys generally drew on fewer resilience factors to deal with adversities, while having the same overall percentage of resilience promoting responses as girls. Apparently the ones they did use were sufficient to deal with the adversity.

Cultural/ethnic Similarities and Differences

In examining the cultural/ethnic similarities and differences in the promotion of resilience in children from 22 countries and 27 sites, the following overall descriptions summarize the findings: The similarities involve some common concerns about children being able to face, overcome, and even be strengthened by experiences of adversity. These include: providing loving support, being role models, seeking help, recognizing the child's need to be responsible for his or her own behavior, and having rules. The differences include wide variations in age-related expectations, the ability to encourage a sense of autonomy in the children, the degree to which punishment is viewed as strengthening children, the resources available to draw on , the presence of hope and faith in outcomes, skills in communication, and problem solving.

Data from a sampling of three countries provide examples of these similarities and differences in the promotion of resilience. The three sites compared are Metropolitan Khartoum, Sudan; Windhoek, Namibia; and Yerevan, Armenia. Children 9-11 from each country and their parents responded to constructed Situation 10, the girl walking to school alone, being harrassed, and refusing to go to school, claiming illness, when her mother knew she was well.

Parents in each country used similar and/or different resilience factors in promoting resilience in their children. Sudanese children from metropolitan Khartoum, are expected to be autonomous and self-reliant in facing adversities; Namibian children receive more empathy and communication, are seen as lovable, and are encouraged to seek help. Parents from Yerevan, Armenia, use resilience factors of each of the other sites, but, in addition, encourage autonomy, and foster confidence.

Children 9-11 from each site drew on the resilience factor of trusting relationships, but in Yerevan, Armenia, the children also expect help in becoming more autonomous. From the resilience factors of inner strengths, children from each site drew on different factors. In Sudan the children rely heavily on autonomy; in Namibia, the children rely on being responsible for their behavior; and in Armenia, the children drew from confidence and hope, seeing themselves as lovable, and having self-esteem. The social, interpersonal skills resilience factors included the common one of problem solving in each country, with the children in Sudan and Armenia drawing on seeking help, and in Armenia, alone, communicating feelings and alternative solutions.

The cultural differences do not prevent the promotion of resilience in children. More important seems to be which resilience factors are used within the cultural context. In Sudan, for example, the children are expected to be more autonomous than in the other two countries; in Namibia, there is a good deal of support, but an expectation that the child will be responsible; in Armenia,

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there is more interaction with the child facing an adversity and a greater availablilty of support as the resolution of the adverse situation proceeds.

SUMMARY

Data from parents and children from 27 sites in 22 countries around the world indicated that about one-third are promoting resilience in children up to age 12. Resilience, however, is promoted more in situations in which helplessness and need are perceived and where supportive help seems feasible. Resilience is promoted less in situations where there is a perceived threat to authority, blame and punishment seem more important than understanding or communiction, and the person who could promote resilience is more concerned with feelings of frustration.

Younger children (4 - 6) rely more on help and guidance from parents to face, overcome and even be strengthened by experiences of adversity; older children (9-11) promote resilience with the same frequency as their parents. When younger children do promote resilience (7%), the girls drew more on empathy and helpfulness than the boys. For the older children, even though the average score on resilience promoting behavior was the same for girls and boys (31%), the girls drew more on trusting relationships and encouragement of autonomy; all of the internal resilience factors, except a sense of control; and all interpersonal skills except managing impulsive behavior and seeking help, which were used with the same frequency as boys. Both boys and girls drew on having services available, receiving emotional support and having role models from external resilience factors. It is not clear why these gender differences occur. Is it the fact that girls are more open in talking about what they draw on for dealing with adversities or is it that boys do not need to draw on so many resilience factors to achieve the goal of overcoming the adversity? However, the consistent drawing on trusting relationships for most responses to situations of adversity, suggests the significance of the basic need for such trusting relationships for optimal human development.

The variability in ways to promote resilience involve not only age, sex and familial differences, but also cultural/ethnic differences. It appears tht parents and children draw on similar and different resilience factors and fewer or more factors to promote resilience. The cultural/ethnic differences and similarities do not mitigate against the promotion of resilience. Examples from Sudan, Namibia and Armenia suggest some differences and similarities in successful ways to promote resilience.

An unexpected finding was that socio-economic status had an insignificant impact on the promotion of resilience, the difference being primarily in the number of resilience factors used. Also, many respondents who were intellectually limited, as indicated by parent information, knew how to reach out for help or had someone alert to needed help.

Resilience is being promoted around the world without intervention or, indeed, without the word in the vocabulary. However, there is much room for giving greater attention to promoting resilience in children for them to be able to face, overcome and even be strengthened by

experiences of adversity. About two-thirds of the participants in the International Resilience Reseach Project would benefit from such information. No one is spared adversities and the paradigm of I HAVE; I AM; I CAN (Grotberg, 1995c) is a useful guide for learning how to promote resilience in children.

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