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Multilevel Resilience Characteristics of Youth who are at Risk for Trauma

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MULTILEVEL RESILIENCE CHARACTERISTICS OF YOUTH WHO ARE AT RISK FOR TRAUMA

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ABSTRACT

Research on resilience, or "the capacity of a dynamic system to withstand or recover from significant challenges that threaten its stability, viability, or development" (Masten, 2011, p. 494) is a burgeoning field, particularly in the area of childhood resilience. Recent literature has moved away from the idea of resilience as a trait someone has or does not have and toward the integration of resilience at multiple levels beyond the individual child, such as their family and their community (Masten, 2014b; Masten, 2015; Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014). To address this call, this dissertation presents two original studies of multilevel resilience with groups of children that have been historically underrepresented in the literature: children with refugee statuses and children with trauma histories who live in low-income, urban neighborhoods. Study 1 is a review of the extent literature on resilience characteristics of refugee children, incorporating research with groups of refugees from a number of different countries that have been resettled all over the world. Study 1 takes a new approach to the existing literature by outlining what resilience characteristics refugee children are accessing at different ecological levels, as well as the most promising treatments and interventions to help bolster resilience for future groups of refugee children.

Study 2 is an original empirical study that contributes to the existing literature by investigating resilience characteristics at the individual, family, and community levels as perceived by both children and caregivers, to get a comprehensive picture of the myriad ways children with trauma histories are currently coping with stressors and new life challenges. Study 2 uses the personal narratives of children and their caregivers to understand their own perspectives on resilience in the present, as opposed to retrospectively or through an outside observer's perspective. Results from both studies show the importance of the family level as it

contributes children's overall resilience and positive adaptation after significant trauma or stressors, and I make recommendations for the best courses of action for research, clinical, and policy implications for children who may be vulnerable to trauma or revictimization based on these studies.

CHAPTER ONE

Introduction

According to the National Child Traumatic Stress Network (NCTSN), a trauma "occurs when a child experiences an intense event that threatens or causes harm to his or her emotional and physical well-being" (NCTSN, 2003, p.1). While there is some disagreement in the field on how to define various constructs that describe trauma (see Musicaro et al., 2017), this dissertation uses the term "complex trauma" to describe children's exposure to multiple traumatic events that are severe and pervasive, such as abuse or profound neglect. Complex trauma usually occurs early in life and can disrupt many aspects of the child's development and the formation of a sense of self (NCTSN, 2003). The Adverse Childhood Experiences (ACE) Study, a longitudinal study that explored the long-lasting impact of childhood trauma into adulthood, found that of 17,000 participants, nearly 64% reported one or more incidents of childhood trauma (Felitti, 2009). In a nationally representative sample of adolescents, almost one third had experienced multiple types of trauma (Ford, Elhai, Connor, & Frueh, 2010). This rate is even higher with at-risk populations: 83% of urban youth report experiencing one or more traumas and 59-91% of youth in the community mental health system report exposure to trauma (Collins et al., 2010). Poverty is another risk factor that can exacerbate trauma and impede coping mechanisms (Koball & Jiang, 2018). In the United States, 41% of children live in low-income households (at or below 200% of the federal poverty threshold), as research suggests that, on average, families need an income equal to about two times the federal poverty threshold to meet their most basic needs (Koball & Jiang, 2018).

As the world becomes more globally connected, there is an increase in concern about immigrant and refugee children and the risks they face that may make them vulnerable to trauma. The number of immigrants and refugees settling in the United States has increased dramatically in the last decade. By the end of 2017, there were 25.4 million refugees in the world; the

highest ever seen, and approximately 6.4 million refugees were school-age children (UNHCR, 2018). Due to their refugee status, children are at much higher risk for stressors and traumas including witnessing violence and war, disruption of families and homes, and lack of resources – all of which can detrimentally affect their physical and psychological well-being (UNICEF, 2016). Due to unique historical and social conditions, there are currently large groups of children that are at high risk of experiencing trauma and corollary mental health issues.

Given the high rate of childhood trauma and the risk for potential traumas among children who have migrated or live in poverty, it is imperative to understand resilience – or how children adapt to stress and adversity – so that those who work with children, including medical and mental health providers and educators, know how to best to support and care for children with trauma histories. Resilience literature includes myriad ways of defining and conceptualizing resilience including as an immediate outcome (i.e., symptom reduction, Cicchetti & Rogosch, 2007), as a stable, innate trait (Block & Kremen, 1996), or as a dynamic process (Sanders, Munford, Thimasarn-Anwar, Liebenberg, & Ungar, 2015). A study of children receiving trauma-specific cognitive behavioral therapy comparing these three models found the most support for resilience as a dynamic process (Happer, Brown, & Sharma-Patel, 2017), or a "cluster of positive resources upon which youth can draw as they strive to achieve positive outcomes" (Sanders et al., 2015, p. 42). Based on these findings, this dissertation will use the definition of resilience as a dynamic process and examine different positive resources that exist for children at multiple ecological levels.

The current studies show that resilience exists at multiple levels, including the individual child, their family, and their community *and* it is something that can change or develop depending on the context or time. Resilience is therefore something that can be learned and

developed by the child, as well as nurtured and developed with the right supports and developmental timing within the child's environment. While scientists have urged researchers to incorporate neurobiological and molecular genetic assessments into their investigations childhood resilience (Cicchetti & Blender, 2006), this was beyond the scope of this dissertation.

One important way to understand resilience and trauma is to evaluate the resilience characteristics of children and families who have been treated for trauma with the most common modality that is used to treat low-income families. Children who have been treated for trauma often experience emotional or behavioral issues stemming from their trauma or related stressors, but are nonetheless able to make progress in treatment and persist in their development. Currently, there are no studies to my knowledge that have investigated resilience for children and families who have received in-home therapy (IHT) for trauma, even though this is one of the most common treatment modalities used for low-income families. Furthermore, IHT approaches provide a unique context for study: IHT typically includes the child and their family in treatment, often works with other providers in the community, and can be flexibly adapted for treatment with children and adolescents of different ages who have different emotional or behavioral difficulties.

Therefore, two studies were conducted to further clarify our understanding of resilience at multiple ecological levels for different groups of vulnerable youth. Study 1 is a review of the literature on resilience characteristics with a very specific group of youth, those with refugee statuses. Reviewing a combination or theoretical and empirical papers, Study 1 outlined the major stressors, resilience characteristics, and interventions for children with refugee statuses (Pieloch, McCullough, & Marks, 2016). Study 1 investigated resilience for a unique group of children, children with refugee statuses, while also taking a wider viewpoint by exploring

resilience for children from a number of different countries who have been resettled all over the world. Study 2 is an original empirical study examining resilience of a community sample of children and families who received in home treatment for trauma. Study 2 integrated data from quantitative questionnaires and qualitative interviews to better understand the resilience characteristics and therapy experiences of children with trauma histories. Both studies were informed by past resilience research that stressed the importance of looking at resilience from multiple ecological levels, and achieves this goal in Study 2 by looking at multi-level resilience in one empirical study.

Taken together, these two studies offer many important lessons and implications for clinicians who work with youth at risk for trauma or with histories of trauma. The results from Study 1 can help inform clinicians as to the most prominent resilience characteristics of children with refugee statuses with the hope that clinicians continue to bolster these characteristics in therapeutic interventions. Results from Study 2 may help expand our understanding of resilience in the face of trauma to better understand resilience characteristics for a group of children with a range of different traumatic experiences. Given that many mental health providers, medical providers, and educators work with children with trauma histories, Study 2 aims to help professionals understand children and families using the families' own stories. These clinical implications are discussed at the end of each study, and revisited together in the closing chapter of this dissertation.

CHAPTER TWO

Resilience of Children With Refugee Statuses:

A Research Review

(Pieloch, K.A., McCullough, M.B., & Marks, A.K. (2016). Resilience of children with refugee statuses: A research review. *Canadian Psychology/ Psychologie canadienne, 57*(4). 330-339. doi:10.1037/cap0000073)

Introduction

Countries around the world, including Canada, are becoming more culturally, ethnically, and linguistically diverse due to the reception of children and families through involuntary migration. Refugees are defined by the UN High Commissioner for Refugees (UNHCR) as children and adults who have migrated to other countries due to fear of persecution in their country because of factors such as race, religion, nationality, or political opinion (Fantino & Colak, 2001). As of 2014, 51 percent of the 19.5 million registered refugees across the globe were children and youth, the highest figure in over a decade (UNHCR, 2014). Every day, nearly 5,000 children become refugees, with a vast number growing up and spending their entire lives in refugee camps (UNHCR, 2014). Approximately 34,000 children are unaccompanied at the point of arrival or separated from family after arriving in a new country (UNHCR, 2014) which is notable given unaccompanied minors often experience greater time in refugee camps awaiting decisions about placement and are at greater risk for mental health concerns (Fazel, Reed, Panter-Brick & Stein, 2012; Wilkinson, 2002). Therefore, it is critical to identify factors that promote resilience at each stage of the migration process for refugee youth.

Refugee Children in Canada

Canada has demonstrated a well-established effort towards resettling families and children as well as a public interest in providing support through active volunteer groups at the individual, community and agency level (Government of Canada, 2016). Refugees from nearly every country have migrated to Canada over the years, including countries from Europe, Asia, Africa, the Middle East, Central and South America, and more recently, Iraq and Syria. According to UNHCR (2014) over the last 10 years, about 26,000 refugees arrived in Canada annually with 42% of this number successfully claiming refugee status of which 36% are

children. The countries where families are migrating from at any given time reflect the current world crises. For example, due to the current humanitarian crisis in Syria, Canada has welcomed over 29,000 refugees from Syria from November 2015 to July 2016 (Government of Canada, 2016) and is planning on receiving thousands more. This sizeable increase in the number of refugees entering Canada may yield economic concerns as the refugee population continues to increase and requires more resources. Given that the European Union (EU) is started to set restrictions on the number of refugees who can enter from Syria, Canada's role in receiving Syrian refugees as well as understanding how to promote their resilience is critical. The unique resilience factors that accompany Syrian children and families, such as peer support and a sense of community, may be protective against the development of psychosocial concerns throughout the migration process (Daud, af Klinteberg, & Rydelius, 2008).

Current Review

Due to the substantial growth in refugee children that are entering Canada and other countries around the world, there is global interest in identifying factors that are associated with risk and positive adaptation of children. Refugee children can experience numerous stressors and traumatic events due to their migration, resettlement, and acculturation experiences. These stressors can fall broadly within three periods: pre-migration (e.g., trauma experienced while in their country of origin), migration (e.g., hostility encountered while traveling through supposedly safe countries before reaching their host country), and post-migration periods (e.g., separation from family after migration; Pacione, Measham, & Rousseau, 2013). While the literature on refugee youth is filled with examples of risk for many types of mental health and educational challenges associated with each period of migration (Fazel et al., 2012) researchers are increasingly holding the viewpoint that it is important to view refugee children's experiences

through a lens of recovery and resilience (Masten, 2012) as focusing on risk alone paints an incomplete picture of refugee youth's lives.

The current paper reviews the empirical research base from the past 20 years on resilience among refugee youth to highlight the field's current understanding of resilience among refugee children as well as offer areas for future research to address. The current review aims to explore the factors and characteristics that promote resilience in refugee children at the individual, family, school, community and societal levels. By focusing on individual and contextual characteristics that are helping refugee children thrive, we hope to give an indication of the best ways to continue to support resilience for children through programs and interventions.

Resilience Framework

Though many definitions of resilience exist, resilience is defined in this paper as "the capacity of a dynamic system (individual, family, school, community, society) to withstand or recover from significant challenges that threaten its stability, viability, or development" (Masten, 2011, p. 494). As we explore resilience for dynamic systems, we use a multilevel approach to show that resilience emerges from the interactions between a number of different systems and contexts and can therefore be measured and examined at multiple levels (e.g. individual, family, school, community, and societal-levels) (Masten, 2011; Tol, Song, & Jordans, 2013). For example, the resilience of a child goes beyond their own individual characteristics (e.g., self-efficacy) and includes dynamic interactions with family members (e.g., attachment style), their community (e.g., peer relationships) and their society as a whole (e.g., cultural values and beliefs). Therefore, to fully explore resilience we must look at factors that promote resilience within a child's family (e.g. resources, extended family support), community (e.g. religious

organizations, community engagement), school (e.g. school belonging, valuing education), as well as the society in which the child lives (e.g., cultural values). Examining resilience in this population using a dynamic, multi-level lens is particularly important as refugee youth tend to experience multiple transitions and contextual shifts over the course of their migration process.

Strengths and Limitations to Resilience Methods. As we review the literature on the resilience of refugee youth, it is important to consider the strengths as well as the limitations of taking a resilience approach. The greatest strengths include the person-focused and qualitative nature of the resilience research as well the focus on positive outcomes and processes that are frequently overlooked in studies with high-risk groups such as refugees (Masten, 2011). Children and families who participate in resilience research report a preference for this type of research over more risk-based work as they are able to focus more on the positive qualities and strengths of their experiences as opposed to deficits (Weine, 2011). Qualitative research is commonly used within the resilience perspective and provides a rich and in-depth narrative of an individual or group's experience. For example, in Goodman (2004), unaccompanied refugee adolescents mentioned factors such as feeling a sense of community, making meaning of their experience, and feelings of hopefulness as promoting resilience as they traveled from Sudan to the US. However, an important limitation of qualitative studies is the findings from one group (e.g., unaccompanied youth from Sudan) may not generalize to another group (e.g., accompanied youth from Burundi and Liberia). These differences are highlighted in Weine et al., (2014) who found that adolescent refugees traveling with their families from Burundi and Liberia to the US mentioned factors such as finances for necessities and engaged parenting as important for their positive growth.

The resilience-based studies that use quantitative measures (Daud et al., 2008; Elklit, Østergård, Lasgaard, & Palic, 2012; Ferren, 1999; Hodes, Jagdev, Chandra, & Cunniff, 2008; Kia-Keating & Ellis, 2007; MacMillan, Ohan, J., Cherian, & Mutch, 2015; Montgomery, 2010; Panter-Brick, Grimon, & Eggerman, 2014) are largely correlational and measured post-migration thus making it difficult to show what characteristics before migration are associated with resilience post-migration. In more recent studies, advanced statistical techniques such as structural equation modeling, hierarchical linear modeling, and regression analyses have been used to study the relationships (associations, interactions, and moderations) among variables of interest such as level of adversity (risk) and competence (resilience) (Masten, 2011). Growth curve modeling is also being used in longitudinal studies to analyze individual and group pathways of resilience before, during, and after a traumatic event (Masten, 2011; Masten & Narayen, 2012). Using growth curve modeling to establish pathways has added depth to the understanding of why some children show greater resilience characteristics post-trauma than other children and what pre-trauma risk factors may be contributing to these pathways. Unfortunately, many of these pathways are theoretical and have yet to be tested (Masten, 2011).

Although the strengths of using mixed-methods with immigrant populations has been argued in the past (e.g., Marks & Abo-Zena, 2013), only two studies within the resilience literature we reviewed combined quantitative and qualitative techniques. Weine et al., (2014) explored refugee psychosocial adjustment through a mixed-method approach which provided not only a rich and in-depth narrative of refugee experiences but also allowed for a more structured approach to examining resilience. More recently, Dalgaard, Todd, Daniel, and Montgomery (2016) investigated the transition of trauma between parents and children in refugee families through combining themes from parent interviews on family communication styles and

relationships with questionnaires related to children's psychosocial adjustment, attachment, and parental mental health symptoms, however the children in this study did not directly experience trauma.

Further, most samples in resilience studies are non-random, samples of convenience and do not always have a comparison group. Refugee children are often faced with a number of traumatic experiences (see Table 1), therefore when using convenience samples with varying degrees of trauma it is difficult to draw conclusions between studies. The studies that do have a comparison group, such as Daud et al. (2008), often compare two high-risk groups (e.g., refugee youth with parents who have experienced trauma compared to those that have not) so it is difficult to truly examine if resilience factors would be different if studies were to compare a low-risk with a high-risk group. This type of comparison could provide more information on whether level of risk has an impact on resilience or if resilience outcomes would remain stable regardless of the level of risk, as long as there is a trauma history.

Table 1.

Examples of Stressors Associated with Each Stage of the Migration Process

Migration Status	**Stressors**
Pre-Migration	Loss of family, life-threatening events, exposure to war, torture, mass violence, and human rights violations (Bronstein & Montgomery, 2011; Kia Keating & Ellis, 2007; Goodman, 2004).
	Family loss and separation (Carlson et al., 2012; Goodman, 2004; Rousseau et al., 1998; Weine et al., 2014)
	Disruption to connections to their primary culture, community, and homes (Cook et al., 2003)
	Discrimination and trauma experienced in their home country (Earnest, Mansi, Bayati, Earnest, & Thompson, 2015).
	Exposure to political violence and exposure to family-based trauma such as parents tortured, imprisoned (Montgomery, 2010)

	Rape and sexual violence (more common for females) (Hodes et al., 2008)
Migration	Disruption of school or work (Bronstein & Montgomery, 2011; Earnest et al., 2015).
	Unsafe living conditions, insecurity of not having a place to live (Rana, Qin, Bates, Luster, & Saltarelli, 2011)
	Living in refugee camps for significant periods amidst hazardous conditions (Edge, Newbold, & McKeary, 2014).
	Living in multiple refugee camps (Goodman, 2004).
	Denial of rights during refugee process (MacMillan et al., 2015)
Post-Migration/Resettlement	Challenges navigating the system of care and protection in their new country (Bronstein & Montgomery, 2011)
	Stigma and discrimination, with discrimination often increasing with their inability to understand the language and culture (Earnest et al., 2015)
	Culture shock (Rousseau et al., 1998)
	Culture clash and alienation (Gibson, 2002; Goodman, 2004)
	Further separation from other refugees (Goodman, 2004)
	Families moving multiple times (Weine, 2011).

Review Methodology

As refugee youth become a larger part of the cultural and educational fabric of host countries, it is important for mental health and education professionals to understand the many sources of resilience for refugee children in order to promote and support their positive adaptation. Resilience can be seen in many different domains including education (e.g., academic success, staying in school) and mental health (e.g., self-esteem, positive adjustment to a new culture, fewer symptoms of psychopathology). In this review of the recent empirical literature we focused on peer-reviewed journal articles and explored resilience for refugee youth in a number of different countries and contexts. Search parameters included any peer-reviewed article that included the terms *refugee, resilience/resiliency,* or *protective.* We focused on research that was published in the last 20 years (1997-2016). Results were then filtered to focus on child and

adolescent populations and to be reported in English. In our review, we examined interventions and programs in place to help promote resilience and discuss areas where further intervention or research is needed. By examining the extant research for patterns of findings across many countries of resettlement (Australia, Canada, Denmark, Sweden, England, Scotland, the United States), this review makes a unique contribution to the literature because it incorporates multinational findings and focuses on resilience results from qualitative, quantitative, and mixed-methods studies. In addition, as the refugee populations expand and more research is conducted with these populations, this review can build upon prior quantitative reviews by Crowley (2009) and Fazel and colleagues (2012). Although this review is not exhaustive, it goes beyond quantitative findings to provide a synthesized view of resilience factors for refugees around the world that can be used to establish better interventions for refugee youth in several different settings. It is important to note that we attended to the ecological/contextual level of resilience characteristics (e.g., individual, family, school, community, society) in our review to recognize the many nested avenues for better serving refugee children as they adjust to their new communities.

Review Findings

The results from our review first focus on stressors faced by refugee children in order to provide context about their experiences during each phase of their migration (pre-migration, migration, and post-migration). A review of the resilience research at the individual, family, school, community, and society levels is then presented followed by a review of the best practices and interventions for refugee children and adolescents.

Traumatic Stressors Faced by Refugee Children

Refugees as a Unique Population. Refugee youth can face very different challenges than their immigrant youth counterparts, dependent in part on their migratory paths. In general, immigrants are considered to have largely voluntary migration patterns, choosing to leave their home countries for a number of different reasons including economic or educational opportunities. When immigrating to a new country, children can experience stress due to acculturation, language differences, discrimination, and separation from extended family members (Oppedal, 2011; Theron et al., 2011). Alternatively, refugees by definition are persons who are forced to leave their homes due to persecution (UNHCR, 1951). It is important to note that undocumented immigrant families may leave their home countries due to similar reasons as refugees (e.g., war, persecution); however, their refugee status is either under review (asylum seekers) or they are not given refugee status (undocumented immigrants) (UNHCR, 2014). Children entering countries involuntarily may experience all of the stress of voluntary immigration, with the added risks of trauma from forced migration, displacement, exposure to violence, or loss of and extended separations from family members (Suárez-Orozco, Marks, & Abo-Zena, 2015). It is also important to consider that while migration may vary in degrees of autonomy, most refugee children are not the ones making the choice to migrate and instead that choice is made for them by contextual factors such as family or their current situation. For the purposes of this paper, refugee youth also include unaccompanied asylum seekers that may only have temporary admission to the country they are living in (Kohli & Mather, 2003).

For refugee children, it is imperative to gain a better understanding of factors that promote resilience due to the growth of this population around the world and the high amount of traumatic stressors they experience. Many refugee children are exposed to a type of trauma known as *complex trauma,* which occurs when children experience multiple traumatic events for

an extended period of time during their childhood and adolescence (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). As refugee children face stressors and trauma at pre-migration, migration, and post-migration, the likelihood of multiple, chronic trauma increases (See Table 1 for a description of stressors associated with each phase of migration). It is important for people who work with refugee youth and families to be aware and assess for these stressors as complex trauma outcomes include a number of mental health disorders (e.g., posttraumatic stress disorders, anxiety disorders, affective disorders, eating disorders), physical health disorders (e.g., cardiovascular, metabolic, immunological, sexual), and revictimization (Cook et al., 2003). For example, a systematic review of psychological distress of refugee youth found prevalence rates of PTSD between 19-54% (Bronstein & Montgomery, 2011) which could be a result of experiencing multiple stressors and complex trauma.

Resilience of Refugee Children

When refugee children arrive in their host country, they are confronted with very different situations depending on the country's political, social, and cultural climate. Canada has an official policy promoting multiculturalism, which in turn has had positive impacts on refugees' impressions of the country and programs provided for refugees and immigrants (Costigan, Koryzma, Hua, & Chance, 2010). Once arriving in Canada, a person who is seeking refugee status must go through a quasi-judicial process to determine their refugee claims, which can take several years. If their claim is rejected, they face possible deportation (Citizenship and Immigration Canada, 2016). As part of Canada's *Immigration and Refugee Protection Act,* unaccompanied minors arriving in Canada are reunited with family members as soon as possible or are taken to live with a family member in Canada. If a family member does not live in

Canada, other long-term arrangements are established through government and private sponsors (Citizenship and Immigration Canada, 2016).

In the US, refugee resettlement is supported by formal resettlement packages and mutual assistance agencies. These agencies work with community members to help support newly resettled families and unaccompanied youth (Betancourt et al., 2015a). In the Southeast of England, an area that receives a large percentage of the refugees and asylum seekers in the UK, there is a policy that relocates asylum seekers to other areas across the UK including Northern England, Wales, and Scotland (Robinson, Andersson, & Musterd, 2003). When asylum seekers are relocated outside of England, however, they are no longer eligible to receive assistance from the Panel of Advisors for Unaccompanied Refugee Children (Hopkins & Hill, 2010).

With the diversity of refugee resettlement policies such as these in mind, this section discusses the factors that promote resilience for refugee children including meeting basic human services and needs, providing social activities, facilitating autonomy, keeping a connection to the home culture, religiosity and meaning making, family connectedness, maintaining a positive outlook, and having a sense of belonging or community support. Refugee children are an especially vulnerable group because their exposure to stressors and displacement occurs during important developmental transitions and may interrupt normal developmental processes (Weine et al., 2014). Therefore, it is important to take a positive perspective on refugee children's experiences and consider how best to support their resilience characteristics at multiple levels (individual, family, school, community, society) to serve as protective factors from psychological concerns.

Basic Needs. In order to promote psychological resilience in refugee children, basic human services and needs must first be met. For unaccompanied 15-17 year old asylum seekers

in Scotland, this included the need to be recognized as children, learn English, go to school, have housing, have access to health and medical care (immunizations), and access to legal representation (Hopkins & Hill, 2010). Similar patterns were found for former child soldiers and internally displaced children such that having a stable place to live and being seen as children first and refugees second promoted resilience (Drury & Williams, 2012). For refugees in the US who migrated with their parents, two basic needs to be met were finances for necessities and English proficiency (Weine et al., 2014). Similarly, 13-17 year old refugees in Canada reported that having a home in Canada was crucial to their adaptation and psychological resilience (Kanji & Cameron, 2010) while refugee youth from Africa and Middle Eastern countries living in Australia reported that they adapted faster to Australian life once they felt confident in the host country language (Earnest, Mansi, Bayati, Earnest, & Thompson, 2015).

Individual-Level Factors. In addition to basic human services and needs, there are many individual factors that promote psychological resilience among refugee children. When caregivers and professionals facilitate the agency and autonomy of children, they help promote adjustment and resilience. For example, providing adolescent refugees in Ontario, Canada with community programs that facilitated agency, self-determination, and empowerment, including allowing refugee children to lead some of these programs, facilitated their adjustment to life in Canada (Edge, Newbold, & McKeary, 2014). Additionally, giving children information to make informed decisions and providing them with interpreters with whom they have a good relationship helped promote resilience for a group of unaccompanied asylum seekers in Scotland (Hopkins & Hill, 2010). For refugee youth living in the US, a key protective mechanism came through informational supports: informing refugee children and their parents about services or preparing them for obstacles they might encounter in their host country (Weine et al., 2014).

Individual differences of refugee youth should also be considered as some research has shown differences in resilience based on gender. In one study of asylum-seeking youth, females were more impacted by traumatic events than males and this resulted in higher levels of PTSD and depression symptoms (Hodes et al., 2008).

A second individual-level factor of resilience is maintaining a positive outlook. Bosnian refugee youth in Boston reported that altruism, appreciation for what they had, and a sense of humor were all factors that helped them adjust to their new culture (Gibson, 2002). Similarly, 7-16 year old refugee children in Sweden who displayed more helpful and prosocial behavior were better adjusted and had fewer mental health symptoms than children with less prosocial behavior (Daud et al., 2008). Having a positive outlook was also a protective factor for unaccompanied Sudanese refugee children living in Arizona, US (Carlson, Cacciatore, & Klimek, 2012) while a group of Somali unaccompanied refugee children in Canada reported that having the drive to be self-sufficient helped promote resilience (Rousseau, Said, Gagné, & Bibeau, 1998). A sense of hopefulness and aspirations for the future were factors that helped promote resilience in a group of unaccompanied Sudanese refugee youth in Massachusetts, US (Goodman, 2004) as well as for African and Middle Eastern refugees living in Australia (Earnest et al., 2015).

In addition to having a positive outlook, meaning making and hope are characteristics that promote resilience for a number of different groups of refugees (Masten & Narayen, 2012). One Sudanese refugee child in Massachusetts said, “God wants me to be alive” (Goodman, 2004) while Afghani refugee youth in Canada reported feeling strength from “divine support” (Kanji & Cameron, 2010). A group of displaced children and former child soldiers displayed more resilience when they felt that they were “not abandoned by God” (Drury & Williams, 2012). In another study, Somali unaccompanied refugee children in Canada created a collective

meaning for their traumatic histories, which helped build community and psychological resilience (Rousseau et al., 1998).

Family-Level Factors. Living with family members buffered the impact of traumatic experiences for refugee children in London (Hodes et al., 2008). It was recommended that keeping refugee children in care with a supportive family past the age of 18 would help promote resilience. Currently, unaccompanied youth have their legal status reviewed and are moved into independent living at the age of 18 which can be a traumatic stressor on its own (Hodes et al., 2008). For refugee children migrating with their family members or who are placed with extended family members or foster families, family support and cohesion were associated with psychological resilience for adolescent refugees living in the US (Carlson et al., 2012; Weine et al., 2014), 7-16 year old refugee youth in Sweden (Daud et al., 2008), 13-17 year old refugee adolescents in Canada (Kanji & Cameron, 2010), displaced children and former child soldiers (Drury & Williams, 2012), and refugee and internally displaced children living in high-income countries (Fazel et al., 2012). Other protective family factors include healthy family communication and unity for a group of 15-25 year old Somali refugee youth in Massachusetts, US (Betancourt et al., 2015a) and a group of 11-23 year old Middle Eastern refugee youth in Denmark (Montgomery, 2010). Across wide and varied age ranges, these studies show that supportive and positive family life is fundamental for the psychological resilience of refugee children.

School-Level Factors. While the 1989 United Nations Convention on the Rights of the Child states that primary education must be free and compulsory for all children (including immigrants and refugees), in countries such as Australia and the United Kingdom, refugee youth who are over the age of 18 cannot attend secondary school, even if their education was disrupted

due to displacement and migration, and must take classes at an adult education center (Bourgonje, 2010; Earnest et al., 2015).

Having an opportunity to attend school, feeling safe at school, as well as valuing education are all associated with promoting resilience in refugee youth. One factor that has been consistently associated with promoting resilience in refugee youth is meeting their basic needs, including the need to learn the language of their host country and their need to attend school (Hopkins & Hill, 2010). For a group of refugees from Middle Eastern countries living in Denmark, those who were attending school were found to be better adapted over time (Montgomery, 2010) and a review of research on child refugees impacted by war and terrorism found that the child's perception of school as a safe place served as a protective factor (Masten & Narayen, 2012). Valuing education is also associated with promoting resilience. One salient study that explored resilience of unaccompanied refugee adolescents from Sudan who resettled in Michigan, USA (Rana, Qin, Bates, Luster, & Saltarelli, 2011) found that the value of pursuing further education and setting educational goals among youth was associated with academic resilience. Research with other Sudanese unaccompanied refugee youth (Carlson et al., 2012; Goodman, 2004) and youth from Burundi and Liberia (Weine et al., 2014) who resettled in the US also found that valuing education and having hope for a better education in the US promoted resilience.

Other factors found to promote resilience were positive school experiences and collective pride in educational achievement. Rana and colleagues (2011) found that all of the Sudanese refugee youth interviewed in their study had graduated from high school and 68% were attending college at the time which was a source of pride for the Sudanese community living in Michigan (Rana et al., 2011). For a group of refugee children and former child soldiers, those who reported

positive experiences in school were adjusting better in their host countries than children who did not have positive school experiences (Drury & Williams, 2012). A similar association was found between self-reported positive school experiences and resilience for refugee children living in Australia, Belgium, Canada, Croatia, Denmark, Finland, the Netherlands, Sweden, the UK, and the US (Fazel et al., 2012). A study with adolescents from Somalia living in the Northeast US found that a strong sense of school belonging (school commitment, involvement, and attachment) was associated with higher levels of self-efficacy and lower levels of depression (Kia-Keating & Ellis, 2007).

In addition to emotional support from family and friends, refugee youth reported that they benefited from community resources and support (e.g. scholarships) that helped them further their education (Rana et al., 2011). A group of refugees from Afghanistan living in Canada reported that factors promoting resilience in school were friendships, the fulfillment of their aspirations, and the resources provided by the school such as computers and books (Kanji & Cameron, 2010). The group of Sudanese youth living in the US (Rana et al., 2011), stressed the importance of upholding their family reputation and not wanting to bring dishonor to their family as motivating factors for doing well in school. While school belonging was not explicitly mentioned during the interviews with the Sudanese youth, it is possible that due to the strong, tight-knit community of Sudanese youth in Michigan, academic success became a tenant of their larger Sudanese community (Rana et al., 2011). Therefore, school-based interventions that focus on increasing the value of education, positive school experiences, collective pride, and support may be one way to foster resilience among refugee youth. Offering such programs within school settings may be easier in many communities than trying to directly reach families; school interventions may therefore reach more children and could be funded by resources designated for

education within schools (Ehntholt & Yule, 2006; Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005).

Community-Level Factors. Outside of the home, social activities, community support, and a sense of belonging have been found to promote psychological resilience for a number of refugee children. A study on play found that 5-13 year old refugee children living in Australia endorsed more positive post-migration feelings when their play in Australia was related being able to play "freely" and "safely" (MacMillan et al., 2015). Afghani refugee adolescents ages 13-17 living in Canada reported more control and better adaptation to their new country when they were able to find their own space to play (Kanji & Cameron, 2010). For older children and adolescents, joining social activities such as sports and religious groups helped develop new friendships and build self-worth for 15-17 year old unaccompanied youth in Scotland (Hopkins & Hill, 2010), Sudanese unaccompanied youth in the US (Goodman, 2004), and African and Middle Eastern refugee youth (ages 17-28) in Australia (Earnest et al., 2015).

Developing a sense of belonging and perceived community support are repeated themes in resilience literature for refugee children. Community support networks, particularly cultural networks or groups of refugees, promoted resilience for Somali refugee youth (Betancourt et al., 2015a), Burundian and Liberian refugee youth (Weine et al., 2014), and Sudanese refugee youth (Carlson et al., 2012) all living in the US. Burundian and Liberian refugee youth reported that community engagement gave them a sense of connection and belonging (Weine et al., 2014) while Sudanese refugee youth reported that it gave them a sense of shared experience (Goodman, 2004). A program that helped generate belongings (e.g. bikes) for unaccompanied youth in Southern England helped them find a sense of security and make connections to helpful people and led to richer social networks (Kohli & Mather, 2003). Community support also helped

provide refugee youth in Ontario, Canada with a sense of belonging and a positive identity in the face of discrimination (Edge et al., 2014).

Society-Level Factors. Maintaining a connection with home culture and religion are additional factors that promote resilience for refugee children. For example, having the same ethnic-origin foster caregivers or guardians in the community was a resilience factor for refugee children in Australia (Earnest et al., 2015) and in other high-income countries (Fazel et al., 2012). Having contact with their home culture was also crucial for African, Asian, and Eastern European refugee children in Scotland (Hopkins & Hill, 2010). Maintaining cultural practices such as religious beliefs, family values, and traditional behavior helped promote resilience for Burundian and Liberian refugee children in the US (Weine et al., 2014), for Afghani refugee children (Kanji & Cameron, 2010), and Somali refugee children (Rousseau et al., 1998) living in Canada. Having pride and loyalty for one's culture and family was also reported as a protective factor for 14-18 year old Bosnian refugee adolescents in Massachusetts, US (Gibson, 2002). Religious faith and spirituality was also reported by refugee youth as a factor that helped them adjust to their new culture; this was true for Somali refugee children (Betancourt et al., 2015a), Burundian and Liberian refugee children (Weine et al., 2014), and Sudanese refugee children (Carlson et al., 2012) living in the US.

Overall, these findings point to individual, family, school, community, and societal factors that promote psychological resilience in refugee children such as having basic needs met, empowering children to be autonomous, fostering a positive outlook, and improving a sense of belonging in the communities where they are living. Interventions focused on improving these aspects could prove beneficial to refugee children and families.

Best Practices and Interventions

Best Practices in Research. Researchers working to promote resilience of refugee children recommend using community-based participatory research (CBPR) and mixed methodological designs. CBPR invites community members, such as refugee children, to become involved in every step in the research process from the development of the study to the dissemination of the findings (Ellis, Kia-Keating, Yusuf, Lincoln, & Nur, 2007). CBPR aims to reduce the power differential between the researcher and participants and can be especially effective with understudied populations who have historically been wary of involvement in scientific research (Ellis et al., 2007). Ellis and colleagues (2007) used CBPR with a group of Somali refugee adolescents who resettled in the US. Before the study began an advisory board of community leaders was established, and this board helped negotiate ethical issues that arose around the study and allowed members of the community to feel comfortable asking questions before the study began (Ellis et al., 2007). Another study used CBPR with Somali and Bhutanese refugee children and families in the US (Betancourt, Frounfelker, Mishra, Hussein, & Falzarano, 2015b). Betancourt and colleagues (2015b) involved refugees as research assistants and after the study was complete, they disseminated study results at refugee organizations serving Somali and Bhutanese populations, local health care providers, town hall meetings, and local schools.

Other researchers recommend mixed methodological designs when working with refugee populations (e.g., Marks & Abo-Zena, 2013). An ongoing study of resilience with 12-16 year old refugees in the Netherlands is using interviews, questionnaires, experiments of how adolescents deal with frustration, and a DNA analysis to look for markers of stress and resilience (Sleijpen, ter Heide, Mooren, Boeije, & Kleber, 2013). Sleijpen et al. (2013) argue that a mixed methods approach is the best way to understand a complex construct such as resilience, especially for underserved groups. Like CBPR, mixed methods approaches allow for the integration of the

participant's perspective within the scope of the research design. As we have shown from the relevant literature, the act of being involved in research may lead to a sense of belonging in the community which in and of itself has potential promote resilience for refugee children.

Interventions for Refugee Youth. The literature examining interventions for improving the mental and academic health of refugee children has been limited with evidence-based treatments (EBTs) for refugee youth yet to be established (Jordans, Tol, Komproe, & De Jong, 2009). In a systematic review of treatments for children of war, Jordans and colleagues (2009) found that while some treatment outcome studies do exist (i.e., 12 studies), they are limited in terms of cultural relevance, few long-term outcome evaluations, lack of methodological and analytic rigor (e.g., no control groups or no effect sizes listed) as well as ecological-based recommendations that would be difficult to implement in practice as an individual or family therapist.

Individual-Based Treatments. Because PTSD has been identified as one of the most frequently occurring mental health concerns in refugee youth, Isakson, Legerski, and Layne (2015) proposed that clinicians can adapt and apply trauma-based treatment for refugee youth. A recent review of trauma-focused treatment highlights 8 components that are essential to include in treatment for PTSD and complex trauma (Briere & Scott, 2013): 1) therapeutic alliance that is empathic and provides support, validation, and respect; 2) trauma psychoeducation; 3) stress management; 4) addressing cognitive distortions; 5) developing a narrative of the trauma; 6) exposure to trauma through memories; 7) interpersonal relationship guidance; 8) Increasing self-awareness and acceptance. Some treatments that include these elements include trauma-focused cognitive-behavioral therapy (TF-CBT) and Narrative Exposure Therapy (NET).

A review from Pacione et al. (2013) noted that TF-CBT can be effective for treating PTSD as well as complex trauma in children and adolescents, however TF-CBT has yet to be evaluated specifically in refugee youth (Cohen, Mannarino, Kliethermes, & Murray, 2012). Narrative Exposure Therapy (NET), though, has been used to effectively treat PTSD symptoms in refugee youth resettled in high-income countries (Ruf et al., 2010; Schaal, Elbert, & Neuner, 2009). It has also been delivered to children currently living in high-risk situations such as refugee camps (Catani et al., 2009). NET is a manualized, short-term treatment that aims to habituate patients to traumatic events as well as help them develop a collective interpretation of their experiences through narrating events that were traumatic to them throughout their life (Schauer, Neuner, & Elbert, 2005). While NET is a promising treatment, further research should examine the effectiveness of this therapy in various settings. TF-CBT should also be examined among refugee youth in order to demonstrate for whom and in what settings these treatments are most effective.

Family and Community. While many interventions are youth-focused, research recommends including family and community members in services as well (Weine, 2011). Involving families in treatment can provide an opportunity for facilitating effective parenting practices, increase family cohesion and support, and can also give clinicians context for understanding a child's cultural values (Weine, 2011). Additionally, involving people that are often the first point of contact for refugee children (e.g., school personnel, primary care providers, and community workers) is fundamental to disseminating services and programs which meet basic human services and needs (Pacione et al., 2013). By providing community-based and school-based programs, clinicians can reach a large number of children that may help the community at large and may reduce the stigma of seeking out mental health services (Hodes,

2002). One way to include both the family and the community is through using a tiered approach to treatment, as described below.

Tiered Approach. According to the Inter-Agency Standing Committee (IASC), an effective way to involve multiple systems is to apply a tiered, or pyramid, approach to treatment. In this system, most children would receive preventive services to ensure basic safety needs are being met (the base), a smaller number would receive focused non-specialized treatment in terms of strengthening community and family supports (the middle), and individuals with the greatest need would receive specialized mental health services (the top) (Pacione et al., 2013).

Tiered programs have been successful with refugee children because they increase community engagement, reduce stigma, are cost-effective, and provide the necessary help to children who need it most. For example, a program in Canada implemented this model by having community health clinics provide children and families with general psychosocial support with children who were in need of more significant psychiatric care provided with culturally-adapted community based mental health treatment (Rousseau, Measham, & Nadeau, 2013). A program in the US also used a tiered approach to promote mental health and resilience in Somali refugee children (Ellis et al., 2013). The program began with community resilience building, then provided school-based early intervention groups for at-risk students, and the top tier provided direct intervention of trauma systems therapy for children with significant psychological distress (Ellis et al., 2013). Research on this program found it to be efficacious for improving mental health and resources for children in all tiers of the program (Ellis et al., 2013).

School-based Treatment. Educators also have an important role to play in promoting resilience for refugee children. Beyond being a referral source for mental and physical health services, teachers can implement school programs for children using creative modalities to

promote hope, social competence, and resilience. For example, a classroom program of creative expression was implemented in Canada to help immigrant and refugee children tell their migration stories and talk about their family culture (Rousseau et al., 2005). These creative workshops had a positive effect on immigrant and refugee children's self-esteem and helped decrease their emotional and behavioral symptoms at school (Rousseau et al., 2005). Another school program with 8-18 year old refugee children in Canada used artistic expression (collages, drawing, paintings, and photography) to help children explore what hope meant to them and what they are hopeful about (Yohani, 2008). Not only did this program increase hopefulness in a group of high risk refugee children, it also had a positive effect on children's families and on the community when children shared their hope projects with others (Yohani, 2008). One criticism of the work from Yohani (2008) is they did not use a standardized measurement of hopefulness pre- and post-intervention therefore it is difficult to determine to what extent the intervention impacted hopefulness.

A school in Norway with a large population of immigrant children implemented a school-wide intervention to increase positive behavior, interactions, and learning environments in school (Ogden, Sørlie, & Hagen, 2007). The goal of this program was to promote social competence through school-wide positive behavior support of all students in every grade. Teachers reported that immigrant students in the intervention group were significantly more socially competent and showed fewer internalizing symptoms than immigrant students in the comparison group at post-test (Ogden et al., 2007). Because social competence is a factor that promotes resilience in refugee children, it would be important for educators to consider implementing similar school-wide programs as they may be helpful for immigrant and non-immigrant children alike.

Overall, focusing on the multiple contexts in which refugee children are embedded is the recommended approach to treatment. Multiple partners working collaboratively are required to better understand and promote resilience, bringing different kinds of expertise to the table and the translational process (Masten, 2011). Interventions will need to be defined as an iterative process, continually informed by data from change experiments, large or small. Small probes in a change process could prove to be as informative as large-scale efforts to change the course of development (Masten, 2011).

Conclusion

Resilience is observed in the presence and aftermath of stress, strain, and risk – all of which are part of children's migratory processes. This review indicates that while resilience research on children with refugee statuses has a relatively short history, the amount of research being done in this area is growing, as seen in the recent dates of many publications presented in this review. The shifting migration patterns and the increasing numbers of refugee children around the world as well as specifically in Canada has influenced and will continue to influence this trend.

Although the Syrian refugee crisis is at the forefront of current global concern, studies have yet to be published on the resilience of refugee children from Syria. It is likely that it will take some time for more recent refugee populations to be involved in research, and this might not occur until after they are resettled. For example, the "Lost Boys" of Sudan were fleeing their homes and living in refugee camps throughout the 1980's and 1990's and most were not resettled until the early 2000's, yet most of the research with these youth was not published until the 2010's. Perhaps in 10-20 years a surge of research published on the resilience of Syrian refugee children will emerge. It would be of great interest for research to examine the resilience of

Syrian refugee youth that have resettled in Canada. Understanding the impact of whole communities, such as the Syrian community, migrating to the same communities together is an area that has yet to be studied as well as the impact that siblings or peers may have on resilience. Hopefully, the research presented in this paper will be of use to those serving the most recent waves of refugee youth in many resettlement communities today.

It is promising that there are overlapping factors that promote resilience for refugee children despite their vastly different cultural contexts and migratory experiences. These factors include social support (from friends and community), sense of belonging (including having positive ethnic identities), valuing education, positive outlooks/optimism, family connectedness, and connection to the home culture. Notably, there appears to be a strong connection between engagement in the school context, feelings of belonging, and positive adaptation across cultures. Such patterns suggest a potential role for civic involvement more broadly in promoting positive refugee youth adaptation moving forward (see Jensen & Laplante, 2015).

Future directions for resilience research also might include studies with younger children as most research is conducted retrospectively with adolescents or young adults. Working with children and youth at the time of migration may provide a more accurate and detailed picture of how resilience develops across acculturation to their new countries. As Sleijpen and colleagues (2013) pointed out, the use of mixed methodologies in resilience research would also provide a more comprehensive picture of resilience for refugee children. There is already an established literature employing interviews, focus groups, and other qualitative measures of resilience; it would be helpful to pair this data with quantitative measures and outcome studies to examine how children are coping in real time. Intervention research is another area that is in great need of further study. What types of interventions are most effective for refugee youth is an area of

inquiry that has yet to be explored in depth. Given that the current treatment research does not often examine long-term outcomes, we may be missing delayed behavioral or emotional trauma reactions that are occurring (Eisenbruch, 1988).

Examining resilience patterns across many countries highlights the importance of considering the political and contextual climates in which children are acculturating. Researchers, clinicians, and educators working with immigrant and refugee children should take into account the local and national political climates that children and families must respond to, work within, and sometimes, overcome. Some countries are becoming immigrant and refugee-receiving countries for the first time in history, while other countries that previously had more open or liberal immigration policies are now changing those policies in response to the overwhelming waves of immigrants and refugees fleeing terrorism and war in Syria and Afghanistan (UNHCR, 2014). As providers, clinicians, researchers, and educators working with children, it is imperative to view children from a strengths-based perspective and to talk directly with immigrant and refugee children to better understand their resilience experiences. Lastly, as this review has shown, to help promote resilience we must first see children as children, and as refugees second.

CHAPTER THREE

Multilevel resilience characteristics of children with trauma histories: What can be gained and what is missing from in-home interventions?

Introduction

Resilience – an individual's ability to adapt to stress and adversity – can be seen in children of all ages in the face of a number of different stressors. When resilience (also referred to as resiliency) is looked at in relation to traumatic experiences, it is sometimes conceptualized as a trait that children either have or do not have (Philippe, Laventure, Beaulieu-Pelletier, Lecours, & Lekes, 2011) or as an outcome of symptom reduction (Bonanno, 2012). However, newer research on children's resilience emphasizes resilience a multi-layered psychological construct and dynamic process that includes children's individual, family, and community characteristics (Masten, 2014b; Masten, 2015; Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014). Following this recent understanding of resilience, the current study uses a systems-based definition of resilience to mean, a "cluster of positive resources (at the individual, family, or community level) upon which youth can draw as they strive to achieve positive outcomes" (Sanders et al., 2015, p. 42). By using this definition, children's resilience characteristics can be present even in the context of continuing risk factors, including complex trauma, poverty, and mental health. Additionally, this definition emphasizes the process of recovery and the potential for change (Happer et al., 2017).

Theoretical Underpinnings

Although theoretical papers have highlighted the need for integration of different levels of resilience, there has been a lack of integration within research studies of individual, family, and community resilience characteristics (Masten, 2015). This study uses three ecological levels to categorize resilience characteristics: individual, family, and community. These three levels were chosen given their prevalence in disparate resilience literature in an attempt to integrate and contextualize research findings. Individual refers to any personal characteristics of the child

including skills, abilities, and personality traits. Family refers to any familial resources (spirituality, economic) or relationships. Community refers to any relationship that the child has outside of the family, whether it be peers, friends, school, or in the community as well as community resources and characteristics such as neighborhood safety.

Bronfenbrenner's Bioecological Model. Bronfenbrenner's bioecological model (Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Morris, 2006), an update on his original ecological systems model (Bronfenbrenner, 1977), can be used to understand children's resilience characteristics at multiple system levels. Bronfenbrenner's bioecological model of development focuses on the interrelatedness of person and context at four different levels: proximal processes, person, context, and time (Bronfenbrenner & Ceci, 1994). Proximal processes refer to any reciprocal interaction an individual has with their immediate environment, such as caregiver responsiveness to a child and a child's interactions with their friends. These processes are key factors in understanding a child's development because they describe how children come to understand their environment and their place in the world. In this study, proximal processes were assessed at the family and community levels through measures of caregiver (family) and peer (community) attachment and connectedness with others.

The person level of the bioecological model refers to characteristics such as age, gender, temperament, access to good housing, and education that can have a significant impact on a person's developmental trajectory (Bronfenbrenner & Ceci, 1994). The current study assesses personal demographic data such as age and gender as individual level characteristics, while assessing demographics like household income and caregiver education at the family level. Bronfenbrenner's context level is most similar to Bronfenbrenner's original ecological systems theory and includes the individual's microsystem (where they spend the most time, such as

school), mesosystem (interactions between microsystems), exosystem (outside the individual's system but still has an influence on development, such as a caregiver's job), and macrosystem (the system that influences all other systems, such as culture or society; Bronfenbrenner, 1977; Bronfenbrenner & Ceci, 1994). The current study used both the family and community level to capture Bronfenbrenner's "context" including microsystems such as the home and school, exosystems such as caregivers' jobs, and macrosystems such as the larger community or culture. The final level of Bronfenbrenner's bioecological model is time – what is relevant to that particular group at their developmental stage and at that point in history. While time was not directly assessed given the differences in times of trauma and treatment for the children, interview and questionnaire data was interpreted and contextualized within the current cultural and political environment of the study.

Multilevel Models of Positive Adaptation and Development. Kia-Keating, Dowdy, Morgan, and Noam (2011) developed an integrative "Protecting and Promoting" model to better understand healthy development in adolescents. The model proposed by Kia-Keating et al. (2011) combines elements of a risk and protection model ("protecting") with a positive youth development approach ("promoting") within a cultural-ecological framework. Much like the current study and Bronfenbrenner's bioecological model, Kia-Keating's protecting and promoting model includes individual, family, school, community, and cultural factors to better understand an adolescent's development, particularly as it relates to school outcomes and interventions (Kia-Keating et al., 2011). The protecting and promoting model includes eight developmental domains that are associated with healthy outcomes for adolescents. These developmental domains are: 1) Social (social support, bonding, and sense of belonging), 2) Emotional (self-efficacy, belief in oneself to perform tasks successfully), 3) Behavioral

(prosocial activities, school/community service, helping others), 4) Moral (character building, prosocial values), 5) Physiological (self-regulation, the process of managing internal feeling states to achieve adaptation or other individual goals), 6) Cognitive (perspective-building, hope, future orientation, agency, planning, goals), 7) Educational (school engagement, school performance), and 8) Structural (structure and safety, adult supervision and monitoring of adolescents) (Kia-Keating et al., 2011).

Many of Kia-Keating's developmental domains map onto the current understanding of multilevel resilience, with emotional and physiological domains being part of individual-level resilience and social and educational domains being part of community-level resilience. However, Kia-Keating's model is geared toward positive youth development in the school context, and is lacking additional consideration of the importance of the family context for childhood resilience. For example – beyond adult supervision and monitoring, what is the caregiver-child relationship like and how does this impact resilience? The current study also looked at factors outside of the school that impact community-level resilience that are not currently being captured by Kia-Keating's model, to see how these understandings of resilience and healthy development overlap and differ from one another.

Motti-Stefanidi, Berry, Chryssochoou, Sam, and Phinney (2012) developed an integrative, multilevel approach to study adaptation in immigrant youth by combining perspectives from developmental, acculturation, and social psychology. This model has three levels: the individual level, the level of interaction, and the societal level (Motti-Stefanidi et al., 2012). According to this model, the individual, the society, and the interaction between the individual and society are responsible for immigrant youth's adaptation (Motti-Stefanidi et al., 2012). While the current study does not focus on immigrant youth, many of the societal level

concepts are important for this study given the diversity of ethnic/racial identities and cultural backgrounds in our population.

The individual level of the model includes characteristics such as personality, temperament, motivation, self regulation, and cognition, and fits in directly with the current study's conceptualization of individual-level resilience. The interaction level includes the contexts where the child is in continuous interaction with other people as well as the interactions between people who are in contact with the child, but that do not necessarily include the child, incorporating both family-level and community-level characteristics, depending upon who the child is interacting with (Motti-Stefanidi et al., 2012). The societal level includes cultural beliefs, social representations, and ideologies that have been shown to have an impact on immigrant youth adaptation (Motti-Stefanidi et al., 2012). Given that the societal level in Motti-Stefanidi's model (2012) is more descriptive of beliefs rather than social relationships, I also captured beliefs (in addition to relationship qualities) directly from children in the current study.

The Importance of a Multilevel Approach to Resilience

Informed by the frameworks proposed by Bronfenbrenner & Ceci (1994), Kia-Keating et al. (2011), and Motti-Stefanidi et al. (2012), this study used a multilevel approach to resilience, and investigated resilience at the individual, family, and community levels for children with trauma histories. Taking a multilevel approach helps to understand not just the child individually, but the most prominent contexts of a child's experience that are known to either hinder or promote positive adaptation and resilience. It also considers how children can thrive in different contexts of their lives (school, home, with friends, etc.) despite experiencing hardships such as trauma, poverty, or community violence. This is particularly important given that through in home therapy (IHT) for trauma, the context of this study, clinicians are given the unique

opportunity to work with children, families, schools, and communities. Before discussing multilevel resilience as a whole, the following delineates the three levels of resilience characteristics: individual, family, and community as they are used in the current study and as they've been presented in the literature.

Individual-Level Resilience. Many studies on resilience have solely focused on the individual child and what characteristics they possess that contribute to their resilience. When researching resilience of children exposed to disasters, wars, and other extreme adversities, Masten and Narayen (2012) found that individual-level characteristics including cognitive skills (general intelligence and cognitive flexibility), self-regulation, perceived agency, self-efficacy, acculturation and language skills, faith, hope, and spiritual beliefs have all been associated with resilience in children. Research on resilience in communities experiencing violence found that African American children with high spirituality had fewer PTSD symptoms than children with low spirituality, even when children were exposed to violence (Jones, 2007).

A review of resilience in adult trauma survivors found that optimism, cognitive flexibility, active coping skills, and physical activity all promoted resilience (Iacoviello & Charney, 2014). *The Individual, Family, and Community Resilience (IFCR) Profile* created by Distelberg, Martin, Borieux, and Oloo (2015), identified five individual-level factors of resilience for adults: spirituality and meaning, self-esteem, spiritual expression, internal locus control, and self-efficacy. A study of resilience in families found that individual-level sources of resilience included personality and coping skills, identity, self-image, cognitive skills, and affect regulation (Landau, 2010). Informed by child and adult resilience research, the current study used both quantitative and qualitative approaches to investigate how the resilience characteristics

of children treated with IHT are similar or different from those that are presented in the literature more broadly.

Family-Level Resilience. When children are directly or indirectly exposed to traumas, they look to their caregivers for information about how to respond (Lieberman, Padrón, Van Horn, & Harris, 2005). If caregivers develop symptoms of psychopathology after a traumatic event, this can jeopardize their child's resilience responses and adaptive functioning (Insana, Foley, Montgomery-Downs, Kolko, & McNeil, 2014). Research on the transgenerational effects of trauma has shown how trauma symptoms can spread from one familial generation to the next both through genetics and social learning (for a review, see Bowers & Yehuda, 2016). Additionally, stressors faced by children and families are often shared (homelessness, poverty, domestic violence, neighborhood violence, criminal activities). Any threat to the family system raises the risk of threat to the child, and any threat to a child is a threat to the family responsible for taking care of that child (Masten & Monn, 2015).

Recent research also has indicated that positive adaptation and resilience can be socialized within families and spread between generations (Masten & Cicchetti 2010). For example, secure caregiver-child attachment is associated with adaptive functioning in all areas of a child's life (Sroufe, Carlson, Collins, & Egeland, 2005). The bond between family members leading to family closeness or connectedness is another source of resilience for children (Distelberg et al., 2015). Research with children who have suffered trauma from wars and natural disasters continually point to family connectedness as a family-level resilience characteristic (Prince-Embury, 2013). One study found positive maternal mental health and positive parenting skills increased child resilience after witnessing interpersonal violence in the home (Insana et al., 2014). Other research has shown that effective, authoritative parenting characterized by high

warmth, effective structure or discipline, and high expectations is associated with more positive outcomes for children (academic, social, emotional) (Masten & Monn, 2015). Family-level characteristics such as spirituality and meaning making after a traumatic event, maintaining family rituals and traditions, a shared positive outlook among family members, and family structure have all been associated with resilience in children with trauma histories (Distelberg et al., 2015; Landau, 2010; Walsh, 2007). According to Masten (2014a), one of the most effective ways to enhance resilience in children involves providing a safe, stable, and loving environment. For children, the family can be both a source of risk and a model and facilitator of resilience. Therefore, it is particularly important for research on child resilience to consider the resilience characteristics of the child's family to account for potential positive developmental cascades. The current study built upon the recommendations of Masten and included both quantitative and qualitative measures of resilience at the family level including the safety and warmth present in the child's family environment and family relationships for children treated with IHT.

Community-Level Resilience. Additionally, this study investigated community-level resilience characteristics of children and their families. For the purposes of this study, community refers to any system outside the family system – namely friends, school, neighborhood, and culture. In a study of community resilience, Jones (2007) looked at "Africentric" support – connectedness (with family and community members), kinship, and spirituality- as a form of cultural resilience. Children who had more Africentric support were better at coping with stress and had fewer PTSD symptoms after exposure to violence than children with less Africentric support (Jones, 2007). Other studies with various populations and a range of traumas (e.g., war, oppression, community violence, traumatic loss) have also highlighted the importance of peer relationships (Merritt & Snyder, 2015; Prince-Embury, 2013),

community social support (Iacoviello & Charney, 2014), and access to quality resources such as healthcare and good schools (Masten & Narayen, 2012; Pfferbaum et al., 2015) as community-level resilience characteristics.

The current study aimed to capture unique resilience profiles based on community norms through questionnaires and in-depth qualitative interviews with both children and their primary caregivers. The mixed-methods approached used in this study explored the extent to which children and families accessed community-level resilience characteristics including community spirituality and religiosity, social connectedness to school and neighborhood, and community resources and support after receiving IHT services.

Multilevel Resilience. As argued above, to fully understand resilience we must go beyond the individual to understand the many ecological systems which interact to shape psychological adaptations to stressors. According to Masten and Monn (2015) resilience combines all three of these different interacting systems. Despite this recent shift to a systems perspective, there has been a lack of integration of the individual, family, and community levels of resilience in research with children with trauma histories (Masten, 2015). The purpose of this study was to therefore identify the resilience characteristics of children, families, and their communities and the resources that contribute to overall resilience for children with trauma histories in order to find resources that help boost recovery for children and families during and after accessing treatment for trauma-related difficulties.

Traumatic History

This study investigates resilience in the context of trauma and complex trauma – or exposure to multiple interpersonal traumatic events *and/or* chronic exposure of one type of traumatic event, typically beginning in childhood (Cook et al., 2003; Spinazzola et al., 2005,

2013). Complex trauma includes witnessing interpersonal violence or community violence, being abused or neglected, or experiencing repeated traumas over time with the realistic expectation of future violence or trauma (Cook et al., 2003; Musicaro et al., 2017). It is estimated that 33% of all children experience complex trauma before reaching adulthood (Copeland, Keeler, Angold, & Costello, 2007). The impact of complex trauma is exacerbated by family and community-level characteristics such as poverty, homelessness or lack of stable housing, and living in dangerous neighborhoods. Children with complex trauma have a higher risk (in some cases 3-5 times more likely; Cook et al., 2003) than children with a singular trauma or no trauma for psychopathology, behavioral problems, and emotional problems that can last into adulthood (Masten & Wright, 1998). It is for these children that fostering resilience in the face of adversity is most crucial to their survival and future well being.

Unfortunately, if the effects of complex traumas remain untreated, they can be quite damaging to a child's developmental trajectory. When children experience traumatic stress, i.e. physiological and psychological reactions that persist after a trauma occurs, (NCTSN, 2003) their bodies must allocate energy and resources to survival that would normally be dedicated to growth and development (Cook et al., 2003). Additionally, children experiencing complex trauma often do not have enough time to heal before new traumas arise, thus interfering with their ability to reach developmental milestones (Lieberman, Van Horn, & Ozer, 2005). Research shows that for many children, the harmful effects of trauma are carried throughout their lives and into adulthood, leading to further psychological and social difficulties (Briere & Jordan, 2009). Complex trauma is consistent with the time level in Bronfenbrenner's bioecological model, such that is it the extent to which trauma occurs in the person's environment of the course of days,

weeks, or years and is consistent with the micro-context level of the bioecological model as the trauma occurs within the child's social environment (Bronfenbrenner & Morris, 2006).

When compared to singular trauma, complex trauma is related to even worse outcomes for children. A study of preschool-aged children and their mothers found that a group of children with complex, on-going trauma had significantly more PTSD symptoms and behavioral problems than a group of children with a past trauma (Pat-Horenczyk et al., 2013). The authors proposed that this effect was related to relational trauma, or the co-occurrence of PTSD symptoms in both mother and child, such that mothers were cueing their children that something was dangerous even when there was no danger (Pat-Horenczyk et al., 2013). Research on children who have experienced complex trauma found that in affluent neighborhoods, dangerous neighborhoods, and in countries around the world, the more traumas and adverse life events a child experiences, the worse their medical and mental health will be in adulthood (Burke, Hellman, Scott, Weems, & Carrion, 2011; Felitti, 2009; Panter-Brick, Grimon, Kalin, & Eggerman, 2015). For children and adolescents, complex trauma has been associated with poorer health conditions (Kira et al., 2008), greater symptoms of PTSD and depression (Suliman et al., 2009), lower IQ scores (Kira, Lewandowski, Somers, Yoon, & Chiodo, 2012), and greater problem behaviors (Layne et al., 2014).

Children's risk for depression, anxiety, and mental illness is exacerbated when exposed to traumas that are unusually intense, chronic, uncontrollable, and overwhelming; such as with complex trauma (Southwick et al., 2014). A review of research on complex trauma found that children and adolescents with complex trauma had worse outcomes in the domains of attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept (Cook et al., 2003). For children who experience complex trauma, relying on their

caregivers for support may become an ineffective coping strategy if their caregiver is the perpetrator of the violence, their caregiver is trying to manage their own trauma, or their caregiver is not supportive of the child's needs at the time of the trauma (Masten & Wright, 1998). Because of this, children typically demonstrate poor understanding of roles and boundaries, mistrust of others, and difficulty understanding or expressing emotion. However, many researchers in this area believe that these behaviors, although often unproductive, are a form of coping strategies for children (Cook et al., 2003; van der Kolk, 2005).

This study investigated the multilevel resilience characteristics of children and families with a range of traumatic experiences, including additional risks (poverty, community violence) and resources (connectedness, attachment) to inform researchers and clinicians on how to help children cope with potential future trauma and risk in a healthy way. For children living in low-income, urban communities, investigating the resilience of children with complex trauma is key due to the increased risk that they face for repeated trauma.

Home-Based Interventions

To speak directly to the interplay between therapy, resilience, and trauma experiences, this study investigated children's resilience characteristics among low-income families living in urban communities who have accessed in-home therapy (IHT) for trauma-related difficulties through a community-based mental health setting. According to a review by the National Child Traumatic Stress Network, 83% of inner-city youth report experiencing one or more traumatic events and 59-91% of youth in the community mental health system report exposure to trauma (Collins et al., 2010). Despite this high risk of trauma, utilization studies show that 75-80% of children living in low-income households do not receive the mental health care they need due to

factors such as single-parent status, neighborhood disadvantage, and social isolation (Kataoka, Zhang, & Wells, 2002; Snell-Johns, Mendez, & Smith, 2004).

IHT provides a structured, consistent, strength-based therapeutic relationship between a licensed clinician and the child and family for the purpose of treating the youth's behavioral health needs, including improving the family's ability to provide effective support for the youth to promote his/her healthy functioning within the family (CBHI, 2015). IHT can lead to better family functioning for high-risk families and for families with severe problems than therapy provided outside the family and community systems (Henggeler et al., 1999; Hinckley & Ellis, 1985; Hodges & Blythe, 1992; Scannapieco, 1994). When compared to alternatives for children with severe emotional disturbances or behavioral issues, IHT is more effective than emergency hospitalization and residential care at decreasing youths' externalizing symptoms and preventing future out of home placement (Barth et al., 2007; Henggeler et al., 1999; Heying, 1985; Hinckley & Ellis, 1985; Scannapieco, 1994; Unrau, Grinnell, & Stephens, 1992).

Although IHT aims to improve family functioning and minimize the need for children to be hospitalized, there is not one treatment modality that is used across IHT clinicians. IHT is unique in that it takes a strengths-based approach and incorporates multiple interacting systems in the child's life. By allowing clinicians to choose their treatment approaches and by including multiple systems in treatment, IHT makes unique contributions to treatment including improved assessment opportunities, special treatment features that are more ideographic, and allowing practitioners to observe the family in their natural environment and to talk with extended-family members, significant others, or neighbors who might otherwise not be present at an assessment interview in an agency (Hodges & Blythe, 1992). Therefore, IHT provided a unique context for

investigation into resilience for children with trauma histories who have accessed this type of intervention.

Current Study

This study examined trauma and resilience at multiple interconnected levels: individual family, and community, to explore how children cope with past trauma, current stressors, and develop skills for responding to potential future traumas. Using a mixed-methods approach, this study provides comprehensive analyses of family experiences with trauma and resilience (Creswell, 2003). The goal of this study was to discover what differences exist between individual, family, and community level resilience for children with trauma histories, as well as how resources, such as attachment and connectedness, contribute to resilience. This research adds to the existing literature by getting in-depth perspectives from children and caregivers themselves about what was most important in their own journey of recovery and resilience after trauma. By interviewing both children and caregivers, this study was able to distinguish between child and caregiver perspectives on children's resilience characteristics and see what those differences or similarities meant for child functioning. This topic is one of extreme importance, with rapidly growing numbers of urban youth experiencing complex trauma across the lifespan.

Method

This is a mixed-methods study integrating quantitative data about children's trauma, resilience, attachment, and connectedness with qualitative interview data from children and caregivers about their current stressors, coping, and suggestions for helping families facing similar challenges.

Inclusion/Exclusion Criteria

Inclusion criteria for the child participants included that they were between the ages of 10-18, have a trauma history (determined by clinic records and confirmed with trauma questionnaire), and have received in-home therapy in the past (determined by clinic records and confirmed on the phone with caregivers). Children and caregivers had to speak either English or Spanish. Translation of the measures, consent, and assent forms into Spanish was completed by a native Spanish speaker who was fluent in English. All forms were then back-translated by another researcher who is fluent in both Spanish and English. Caregiver verbal consent was first obtained on the phone prior to scheduling the study appointment. Written child assent and caregiver consent were then obtained at the beginning of the study appointment. The Institutional Review Board of Suffolk University approved this study.

Participants

Fifty pairs of caregivers and children participated in this study (N = 100 participants). Children ranged in age from 10 to 18 years (M_{age} = 13.5, SD = 2.4) and ranged from being in the 3rd grade to being in their first year of college (M_{grade} = 7.6, SD = 2.5). Fifty-eight percent of the children identified as female (n = 29) and 42% of the children identified as male (n = 21). When asked to report their ethnicity/race using a forced-choice format, 34% of the children identified as White, 26% identified as Black or African American, 24% identified as Hispanic, 2% identified as Asian, and 10% identified as Biracial. An additional 4% (n = 2) identified as "other", one reporting their identity as "brown" and "mixed" and one reporting their identity as "human." Eighty-six percent of the children were United States citizens and 14% of children had dual citizenship in the US and another country. The majority of the caregivers that participated in the study were the children's mothers (82%, n = 41). An additional three were fathers, three were grandmothers, one was the child's aunt, one was the child's stepfather, and one family had both

the mother and father complete the questionnaires together, because they both felt they could answer questions about their child equally. Caregivers were chosen (rather than biological parents) based on legal guardianship, involvement in therapy, and willingness to participate in the study. When asked about their involvement in IHT, 70% of caregivers reported they were involved "A lot", 22% said they were involved "Quite a bit", 6% said they were involved "Somewhat" or "A little" and only one caregiver said they were "Not at all" involved.

Eighty-eight percent of children and caregivers completed measures in English, 10% completed caregiver measures in Spanish and child measures in English, and 2% completed both child and caregiver measures in Spanish. All 50 families completed all of the child and caregiver questionnaires and 32 of the 50 families (64%) also completed the child and caregiver interviews. Families completing the interviews were self-selected during the consent process, requiring both caregiver consent and child assent. For the purposes of the current study, 18 dyad interviews (n = 36 participants) were included based on their patterns of responding to the quantitative measures (described below).

Household size ranged from two people (including the child) to eight people, (M=3.5, SD = 1.34). The majority of children (80%) had lived with their current caregiver(s) their whole lives, 14% of children had lived with their current caregiver(s) between six and ten years and 6% lived with their current caregiver(s) between one and five years. When asked about moving or change of housing, 30% of children had not moved in the last five years, 30% had moved once, 26% of children had moved twice, 8% had moved three times, and 6% had moved four or more times.

The majority of families had an income below the federal poverty level (58%, n = 29) and 22% of families (n = 11) had an income between 101-200% of the federal poverty level.

Eight percent of families (n = 4) had an income between 201-300% and an additional 12% (n = 6) had an income above 300% of the federal poverty level.

Based on each family's reported zip code, a rating of neighborhood crime/safety was determined using crime data from neighborhoodscout.com, using the highest crime rate in the state as a ceiling score. From this, crime rate was calculated on a 5 point scale from 1 = safest to 5 = most dangerous. In this sample, 36% of families (n = 18) lived in neighborhoods with the highest crime rates of the state and 2% lived in "moderately dangerous" neighborhoods. Twenty-eight percent of families (n = 14) lived in neighborhoods that were "somewhat safe and unsafe" while 20% of families lived in "moderately safe" neighborhoods and 14% of families lived in the "safest" neighborhoods.

Procedure

The primary investigator (PI) collaborated with two community mental health organizations in New England to recruit families for a study on children's strengths and resilience after receiving in-home therapy. One community mental health center served primarily low-income urban communities and the other served primarily low-income urban and suburban communities. Each community mental health organization provided the PI with a list of children that were eligible to participate in the study based on age and diagnosis or presenting problem for treatment. Eligible families were contacted by phone, given a brief study overview, and asked if they wanted to participate. Families who chose to participate scheduled a study appointment with the PI and were informed that the study could take place at their house or another convenient location such as the community mental health center (whichever the participant selected). The PI was present for all of the study appointments and was joined by a Spanish-speaking researcher for Spanish-speaking families.

During the study appointment, the PI reviewed the consent and assent forms with the caregiver and child, including the purpose of the study, confidentiality, potential risks, and benefits, and allowed the child and caregiver time to ask questions (see Appendix A for forms in English and Spanish). At this time, the caregiver and child chose whether or not they wanted to participate, and chose to do the questionnaires only or the questionnaires and the interview. Caregivers had the option to consent to audio recording and transcribing (for the interview only) and to have portions of their de-identified interview available to be part of write-ups for the study. Caregivers and children were also told they would receive a $20 Visa gift card for participating in the study with the questionnaires and a $40 Visa gift card for participating in the study with interviews and questionnaires.

After consent and assent forms were signed, the caregiver and child chose whether they wanted to do the interview first or the questionnaires first (if doing both parts). The PI would interview either the child or caregiver while the other person completed the questionnaires, and then they would switch. Children and caregivers were given the option to be interviewed in a private room given sensitivity of the conversations, some children and caregivers chose to do so and other chose to stay in the same room, acknowledging that they might hear each other's responses. Children and caregivers were given the option to complete the questionnaires independently or with help (i.e., reading aloud) from the PI. Children completed three questionnaires and caregivers completed two questionnaires. Questionnaire order was counterbalanced. Questionnaires took approximately 20-30 minutes to complete and interviews took approximately 10-30 minutes to complete depending on how much participants wanted to share. The entire study appointment typically lasted an hour.

Quantitative Measures

Paper-based questionnaires were used with children and caregivers. Measures were administered in a counterbalanced order. Please see Appendices B, C, and D to view the measures that were created or edited specifically for this study (CYRM-28 English and Spanish versions, CYRM-PMK English and Spanish versions, IPPA-R Spanish version).

Demographic Information. Demographic information was collected as part of the resilience (CYRM-28) and connectedness (HMAC) measures for children and the resilience measure (CYRM-PMK) for caregivers. Demographic information that was specific to the study aims was added to the beginning of the CYRM-28 and CYRM-PMK (see Appendices B and C). On the CYRM-28, children completed open-ended questions asking about their age, sex, grade, who they lived with, how long they had lived with that person or people, how many times they had moved in the past five years, who they considered to be in their family, and their ethnic/racial identity. On the HMAC, children also answered forced-choice questions about their age, sex, grade, who they lived with, and their ethnic/racial group. On the CYRM-PMK, caregivers reported on their relationship to the child, how involved they were in in-home therapy (5-point Likert Scale from 1 "Not at all" to 5 "A lot"), zip code, highest level of education, and estimated yearly income. Caregivers reported on approximate yearly income and poverty level was calculated based on how many people lived in the house, yearly income, and federal poverty guidelines (ASPE, 2017). All demographic measures were available in English and Spanish.

Trauma History. Children's trauma history was measured using the Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR; Ippen et al., 2002) completed by the caregivers. The TESI-PRR is a 24-item measure that assesses the type of trauma, the age(s) at which the traumatic event(s) occurred, and if the child was strongly affected by the traumatic event or not. The TESI-PRR was chosen to make caregivers comfortable with participating in the

study, such that their children were not asked directly about their trauma histories. Questions range from queries for accidental trauma such as, "Has your child ever been in a serious accident like a car accident, a fall, or a fire?" to queries of sexual trauma. The TESI-PRR correlates well with another measure of trauma exposure (r = .52), indicating good construct validity (Berent et al., 2008) and has test–retest reliability kappas ranging from .50 to .79 (Ford et al., 2000).

Resilience Characteristics. The Child and Youth Resilience Measure – Youth version (CYRM-28, Ungar & Liebenberg, 2009) and Person Most Knowledgeable version (CYRM-PMK; Ungar & Liebenberg, 2009) were used to determine children's resilience characteristics from their own perspective and from their caregiver's perspective. The CYRM is a 28-item questionnaire that measures overall resilience and includes three subcategories that influence resilience processes: individual traits (e.g., cooperation, problem-solving, and social skills), relationship to caregiver(s), and contextual factors (e.g., spiritual, educational, cultural) that facilitate a sense of belonging. Subscales of the CYRM-28 and CYRM-PMK were grouped together to map onto our three levels of resilience: individual, family, and community. The Individual: Personal Skills and Individual: Social Skills subscales were combined as the "Individual Resilience Score." The Caregiver: Physical Caregiving and Caregiver: Psychological Caregiving subscales were combined as the "Family Resilience Score," which is the same as the "Relationship with Primary Caregiver" scale of the original measure. The Individual: Peer Support, Context: Spiritual, Context: Education, and Context: Cultural subscales were combined as the "Community Resilience Score," taking the "Context" scale of the original measure and adding peer support to capture peers as part of a child's community.

All items are rated on a 5-point Likert scale of how well the item best describes the child from 1 "Not at all" to 5 "A lot", with higher scores indicating increased presence of resilience

processes. Two versions were used in this study: children completed the youth version (CYRM-28), which was created for children and adolescents ages 10-23 and caregivers completed the Person Most Knowledgeable version (CYRM-PMK). Both versions have the same questions, however the youth version is from the child's perspective, i.e. "I have people to look up to" and the PMK is from the caregiver's perspective, i.e. "The youth has people he/she looks up to." Internal consistencies for the CYRM-28 subscale groupings in the current study were all considered good: individual resilience = .86, family resilience = .83, community resilience = .80. The Spanish version of the CYRM-PMK was created for this study. Internal consistencies for the CYRM-PMK subscale groupings in the current study were as follows: individual resilience = .89, family resilience = .61, community resilience = .87.

The original normed sample of over 2,000 youth used in the development of the CYRM-28 had an average total resilience score of 111.00, *SD* =16.21 (Ungar & Liebenberg, 2011). Normed data for youth with "complex needs" (traumatic history, poverty, and/or those who used of a number of social services) had an average total resilience score of 107.15, *SD* = 17.17 (Liebenberg, Ungar, & Van de Vijver, 2012). A normed sample of low-risk youth had a mean score of 114.66, *SD* = 14.32 (Liebenberg et al., 2012; Ungar & Liebenberg, 2011).

Attachment. The Inventory of Parent and Peer Attachment-Revised (IPPA-R; Gullone & Robinson, 2005) was used to measure perceived attachment between children and caregivers and children and their peers. The IPPA-R is a self-report tool filled out by children aimed at measuring psychological security derived from relationships with significant others, specifically caregivers and close friends (Gullone & Robinson, 2005). The original IPPA measure was created for use with older adolescents ages 16-20 (Armsden & Greenberg, 1987) and was revised to make the language more appropriate for children ages 9-15 (Gullone & Robinson, 2005).

When asked, children were encouraged to answer the parent questions based on whoever they considered their parents to be (even if they did not live with their biological parents). Therefore, the word "caregiver" is used in place of the word "parent". The 28 caregiver items and 25 peer items of the IPPA-R assess three aspects of attachment including trust, communication, and alienation. The Trust scale measures the degree of mutual understanding and respect in the attachment relationship, the Communication scale assesses the extent and quality of spoken communication and the Alienation scale assesses feelings of anger and interpersonal alienation (Gullone & Robinson, 2005). Examples of trust questions included "My parents [caregivers]/ friends respect my feelings," communication questions include, "I tell my parents [caregivers] /friends about my problems and troubles" and alienation questions include "I get upset more than my parents [caregivers]/ friends know about."

Items are rated on a three-point Likert scale with 1 "Never True", 2 "Sometimes True", and 3 "Always true" as the response options (Gullone & Robinson, 2005). Correlations between corresponding caregiver and peer subscales were strong when tested with a sample of youth ages 9-15 (Gullone & Robinson, 2005). The IPPA-R Spanish version was created for this study. For the current study, Cronbach's alphas were .86 (trust), .73 (communication), and .70 (alienation) for parent/caregiver subscales, indicating adequate to good internal consistency. Cronbach's alphas were .89 (trust), .87 (communication), and .53 (alienation) for peer subscales. While the internal consistency alpha for the peer alienation subscale was low, this subscale also had the lowest internal consistency score ($\alpha = .67$) when this measure was developed (Gullone & Robinson, 2005).

Connectedness. The Hemingway Measure of Adolescent Connectedness (HMAC; Karcher, 2005; Karcher & Sass, 2010) short-form is a 57-item self-report measure, completed by

the child, and was used to assess children's positive connections to their social environment using a 5-point Likert scale ranging from 1 "Not at all true" to 5 "Very true". The HMAC consists of 10 subscales assessing five broader domains of connectedness: (1) school (school and teacher); (2) family (caregivers and siblings); (3) peers (friends and peers); (4) neighborhood; and (5) self (present self, future self, and reading). Connectedness to present self indicates high levels of self-esteem and positive identity while connectedness to future self indicates high levels of hope and future orientation. For the purposes of this study, only 9 out of the 10 subscales were used for analyses, excluding the reading subscale given it was not relevant to the other variables. Sample items include "My friends and I talk openly with each other about personal things," "I enjoy spending time with my parents [caregivers]," and "I always try hard to earn my teachers' trust." Although the HMAC was created and validated with adolescents (Karcher, 2005; Karcher & Sass, 2010), it has also been used with children as young as 9 years old with adequate reliability (Karcher, Davidson, Rhodes, & Herrera, 2010). Internal consistency alphas for the current study sample range from .70 to .85 (acceptable to good) across subscales.

Qualitative Interviews

To assess child resilience and strengths qualitatively, children and caregivers were interviewed separately. Children and caregivers chose the order in which they were interviewed. Children were asked similar questions as the caregivers that were developmentally appropriate for their age (see Appendix E). Each child interview started with some warm-up questions that were amended or excluded based on children's developmental level. Children answered open-ended questions about what they find stressful or challenging in their life, how they cope with stress and challenges, what has helped them cope in the past, and what advice they would give to

other children about how to cope with challenges. The child interview took approximately 10-15 minutes.

Caregivers answered open-ended questions about what their child finds stressful or challenging, how their child copes with stress and challenges, their child's personal strengths, how they themselves cope with stress and challenges, barriers to well-being for themselves or their child, advice they would give to other caregivers and children facing similar challenges, their experiences with in-home therapy, and their recommendations for what communities can do to better help children and families (see Appendix E). Child and caregiver interviews were translated and back-translated from English to Spanish by fluent Spanish speakers. Caregiver interviews lasted approximately 15-30 minutes. All interviews were audio-recorded and transcribed with caregiver permission provided on the consent form. To triangulate data, multiple data collection methods (i.e., questionnaires and interviews), data sources (i.e., child and caregivers), and investigators (i.e., 3-5 people to review and code interviews) were used (Denzin, 1978; Patton, 1999).

The primary investigator (PI) conducted all English-speaking interviews with children and caregivers. The PI identified as a straight, White woman, and had a Master's degree and experience as a trained therapist. A second researcher who spoke English and Spanish fluently conducted all of the Spanish-speaking interviews (caregivers only) with the PI present. The Spanish-speaking researcher identified as a straight, Latina woman, and was an undergraduate student at the time of the study.

Mixed-Methods Approach

The aim of this study was to combine quantitative and qualitative findings to provide a contextualized picture of the resilience experiences of children and families, using a concurrent

triangulation design (Creswell, 2003). This design uses two methods to confirm, cross-validate, and corroborate findings within a study. Using data from quantitative measures of caregiver and child-rated resilience, 18 interview dyads were chosen to illustrate families' experiences for those who had highly synchronous and highly discrepant resilience scores (6 dyads for each group). After the analysis of categories, the 18 interview dyads were coded in pairs to investigate similarities and differences between interview answers for caregivers and children.

Quantitative Data Analyses

To start, all quantitative data was determined to be suitable for parametric analysis, and were analyzed using SPSS versions 22 and 25. Correlational analyses examined the relationships between total resilience and the three contexts of resilience characteristics (individual, family, and community) and trauma, attachment, and connectedness. Two sample t-tests were used to assess if there were differences in resilience characteristics based on traumatic experiences.

A hierarchical regression approach was used to clarify children's endorsement and engagement with resilience characteristics at multiple levels, and see how these characteristics related to past trauma and other risk factors. Similar models examined the extent to which trauma, attachment, and connectedness contributed to each child's resilience characteristics. Dyadic (child-caregiver) data was examined using paired-samples t-tests to determine the relationship between caregiver and child ratings of children's resilience characteristics. Other descriptive statistics were used to characterize the sample and basic test statistics (correlations, t-tests) were used in a parsimonious, exploratory nature to link quantitative measures to major observed themes in the qualitative analysis.

Qualitative Data Analyses

Researchers. The primary investigator created interview questions with feedback from her faculty advisor. The qualitative research team was lead by the PI and included three additional undergraduate researchers. The faculty advisor served as the independent auditor. All of the researchers were familiar with background literature on resilience and trauma in youth populations.

Consensual Qualitative Coding. The research team, including the PI, transcribed the interviews verbatim and checked all of the interviews for accuracy. During transcription, any remaining identifiers (names, locations, etc.) were removed from the transcript and replaced with a general label, i.e. "child's name." All of the Spanish interviews were transcribed and translated by the Spanish-speaking interviewer. A researcher who spoke both English and Spanish checked the transcriptions.

Consensual Qualitative Research (CQR, Hill, Thompson, & Williams, 1997) procedures were used to code and analyze the interviews. Per recommendations by Hill and colleagues (1997), a team of four judges, including the PI and the three researchers who transcribed the interviews, were trained on CQR by reading the original CQR article by Hill et al. (1997) as well as the update on CQR procedures (Hill et al., 2005). The primary research team reviewed these articles together to check for understanding and clarity of procedures. This same team of four researchers analyzed the data to determine the domains, core ideas, and cross analyses for each interview.

Researcher Preparation. As suggested by Hill et al. (1997), at the beginning of each data analysis meeting, the primary research team reflected on and discussed potential biases and expectations that might influence the analysis. The primary research team also discussed power dynamics that were relevant to the team including student status and advisor-advisee

relationships. The team brainstormed ideas for the coding process such that every team member's voice would be equally heard, deciding that during each round of consensus coding a different researcher would share their ideas first. Prior to coding, the team discussed their own demographics and highlighted that they were all students (one doctoral student, three undergraduate seniors), all women, and all studying psychology. Three of the team members identified as White and one identified as Latina. One team member noted that she lived in a similar urban, low-income neighborhood as many of the participants.

The team's expectations for the participants of this study were that children would be attached to their school and possibly see it as a "second home," that caregivers would talk about neighborhood cohesion or closeness, that caregivers and children would say religiosity or faith was a way to cope with stress, and that children and caregivers would be hesitant to talk about trauma. The team was curious as to how child and caregiver perspectives on trauma and resilience would be different from each other. After discussing about these biases and expectations, the team members agreed to focus on the words of each participant while attempting to remove their own interpretations of others' experiences as much as possible.

Development of Domains. Per CQR guidelines (Hill et al., 1997), the judging team created a "start list" of domains or topic areas based on the initial interview questions. The team then coded the data from each interview into the domains, amending the list of domains as necessary. Each judge worked independently to code each interview. After each interview was independently coded, the team came together to discuss domains until they reached a consensus. The team coded the caregiver interviews first, and then coded the child interviews second to remain consistent with coding procedures.

Inter-rater reliability was calculated for the coding of domains. Per recommendations from Hallgren (2012), Cohen's kappa was calculated for judging responses for all four judges using SPSS 22. When all four judges coded the caregiver interviews, Cohen's kappa ranged from $\kappa = .73$ to $\kappa = .80$, indicating substantial agreement prior to discussing domains and reaching consensus (Landis & Koch, 1977). When two judges coded the remaining caregiver interviews, Cohen's kappa ranged from $\kappa = .89$ to $\kappa = 1.00$, indicating near perfect to perfect agreement (Landis & Koch, 1977). When all four judges coded the child interviews, Cohen's kappa ranged from $\kappa = .61$ (substantial agreement) to $\kappa = .92$ (near perfect agreement) among all four judges, prior to coming to a consensus agreement (Landis & Koch, 1977).

Core Ideas. The same four judges independently constructed core ideas, or brief summaries, for all of the material within each domain for each individual case. After coding a small group of interviews, the team came together and argued to consensus. Consensus consisted of writing the core idea (or abstract) followed by the verbatim text from the interview for each of the domains. The core ideas for the remaining interviews were then first written by one of the four judges and checked by a different judge, with any discrepancies discussed together as a team.

Audit of Domains and Core Ideas. One auditor was chosen to review the consensus version of the domains and core ideas and evaluate for accuracy and consistency. The auditor was the research mentor of the PI and was familiar with the research but not directly involved in data collection or transcription. The auditor provided written feedback about the domains and core ideas and then the PI and auditor came together to discuss feedback and determine whether to accept or reject the changes and suggestions. All of the domains remained unchanged after receiving feedback from the auditor.

Cross Analyses. After writing core ideas for each child and caregiver interview, information from core ideas were grouped into categories. All categories were taken from exactly what children and caregivers talked about in interviews and were not predetermined by researchers. Categories were then analyzed to determine their frequency of occurring in each case, based on recommendations from Hill and colleagues (2005). Given that each group had six exemplary interviews, categories were "General" if endorsed by at least one member of every dyad (six in total). Categories were "Typical" if endorsed by at least one member of 4 or 5 dyads. Categories were "Variant" if endorsed by at least one member of 2 or 3 dyads, and categories were "Rare" if endorsed by at least one member of 1 dyad, and were seen as relevant to the focus of this study. Categories were "Miscellaneous" if endorsed by only one member of one dyad and were not relevant to study aims; these categories will not be reported.

Results

Quantitative Analysis of Resilience

Overall, children and caregivers reported high levels of resilience characteristics at all three ecological levels, with children rating their own resilience levels on average of 3.94 out of 5 and caregivers rating children's average resilience level as a 3.73 out of 5 (see Table 2). One sample t-tests showed that children's total resilience scores were not significantly different than the total resilience scores of the original normed sample, the "complex-needs" sample, or the low-risk sample ($p > .05$; Liebenberg et al., 2012; Ungar & Liebenberg, 2011). Children and caregivers both rated the highest levels of resilience at the family level, which was mostly captured through questions about the child-caregiver relationship. Children also reported high scores on individual-level resilience, which was not significantly different from their ratings of family-level resilience ($p > .05$). Caregivers rated children's individual resilience as slightly

below the mean and this was significantly lower than caregivers' mean rating for family-level resilience (t = -7.56, p < .01). Both children and caregivers rated community resilience with the lowest scores compared with individual and family resilience. Children's rating of their community-level resilience was significantly lower than family-level resilience (t = -5.04, p < .01) and individual-level resilience (t = -4.21, p < .01). Caregivers' rating of children's community-level resilience was also significantly lower than family-level resilience (t = -10.31, p < .01) and individual-level resilience (t = -3.61, p < .01).

Table 2

Mean Scores for Resilience, Attachment, and Connectedness Measures

Measure	Mean	SD	Total	SD
Child & Youth Resilience Measure (CYRM; scale 1-5)[C]	**3.94**	**0.62**	**110.36**[+]	**17.44**
Individual Resilience	4.08	0.75	36.68	6.71
Family Resilience	4.19	0.73	29.34	5.11
Community Resilience	3.7	0.73	44.34	8.71
Person Most Knowledgeable (PMK, scale 1-5)[P]	**3.73**	**0.61**	**104.38**	**17.13**
Individual Resilience	3.66	0.81	32.96	7.26
Family Resilience	4.48	0.42	31.38	2.97
Community Resilience	3.34	0.82	40.04	9.86
Inventory of Parent & Peer Attachment (IPPA-R; scale 1-3)[C]				
Caregiver Trust	2.6	0.37		
Caregiver Communication	2.37	0.35		
Caregiver Alienation	1.69	0.36		
Peer Trust	2.63	0.4		
Peer Communication	2.36	0.47		
Peer Alienation	1.67	0.32		
Hemingway Measure of Adolescent Connectedness (HMAC; scale 1-5)[C]				
Present self	3.86	0.88		
Future self	3.93	0.79		
Caregivers	3.91	0.65		

Siblings*	3.75	0.9
Friends	3.91	0.9
Neighborhood	2.98	0.91
Peers	3.45	0.95
School	3.6	0.8
Teachers	3.79	0.88

Note. [C] = Child Rated, [P] = Caregiver Rated, + = Normed sample mean was 111.00. * = only includes children with siblings.

When looking at the relationship between demographic variables of our sample and resilience scores a weak but significant positive correlation emerged between total resilience score and grade ($r = .29$, $p < .05$). There were no significant relationships between total resilience score and age, gender, ethnic/racial identity, poverty level, income, caregiver education, citizenship, community mental health organization, or neighborhood crime. Given the similarity in resilience scores despite differences in demographic variables, our sample was analyzed as a whole, unless when specifically stated otherwise.

Quantitative Analysis of Resilience Resources: Attachment and Connectedness

When looking at children's resilience resources, namely their attachment and connectedness, different patterns emerged. Children showed the highest levels of both caregiver trust and peer trust indicating high levels of mutual understanding and respect in the attachment relationship with caregivers and peers (see Table 2). Children showed lower levels of caregiver communication and peer communication that were statistically significantly lower than caregiver and peer trust (see Table 3). However, these scores were still above the average score of 2, indicating a high quality of spoken communication with peers and caregivers, but not as strong as trust in attachment relationship. The lowest ratings overall were for caregiver alienation and peer alienation, which were significantly lower than both attachment trust and communication

indicating that children in this study did not endorse many feelings of anger and interpersonal alienation by caregivers or peers (see Table 3).

Our sample showed the highest levels of connectedness to themselves in the future (see Table 2), indicating that children had the highest levels of future orientation and hope. Our sample also had high ratings of connectedness to caregivers, friends, and themselves in the present, which captures self-esteem and positive identity development, which were not statistically different than future self scores ($p > .05$). On average, children in the current study showed slightly lower connectedness to school ($t = 2.99$, $p < .01$) and peers ($t = 3.22$, $p < .01$), which were both significantly lower than children's rating of connectedness to future self. Children in our sample had the lowest levels of connectedness to their neighborhood, which was significantly lower than connectedness to future self ($t = 6.92$, $p < .01$), school ($t = 4.07$, $p < .01$), and peers ($t = 2.81$, $p < .01$).

Table 3

Comparison of Children's Attachment Resources

Variables	Mean Difference (SD)	*t*-test
Caregiver Trust vs. Caregiver Communication	.23 (.23)	6.89**
Caregiver Trust vs. Caregiver Alienation	.92 (.67)	9.72**
Caregiver Communication vs. Caregiver Alienation	.69 (.64)	7.57**
Peer Trust vs. Peer Communication	.27(.30)	6.41**
Peer Trust vs. Peer Alienation	.96 (.58)	11.74**
Peer Communication vs. Peer Alienation	.69 (.62)	7.90**

Note. ** $p < .01$

Trauma History

The majority of child participants (94%) fell into the categorization of complex trauma – having a history of multiple traumatic events and/or one traumatic event that was severe and

pervasive (Cook et al., 2003). Given that most of the sample had complex trauma experiences, trauma was measured on a continuous scale with caregivers rating children's number of traumatic events, number of traumatic events children were strongly affected by, number of interpersonal traumas, and number of non-interpersonal traumas to better differentiate between traumatic experiences.

All of the children in the sample had at least one traumatic event, with an average of 6.54 events (*SD* = 3.49), the maximum number of events for our sample was 14. Caregivers also reported which events children were "strongly affected by" and on this measure, children ranged from 0 to 12 events, with an average of 4.44 events (*SD* = 3.26). Children had an average of 4.8 interpersonal traumas (range 1-11 events), which included any event perpetrated by another person. Children had an average of 1.72 non-interpersonal traumas (range 0-5 events), including traumatic medical procedures, car accidents, or animal attacks.

Resilience, Resources, and Trauma

Despite the high rate of trauma in our sample, there were no significant correlations between trauma (in any measured form) and total resilience, individual resilience, family resilience, or community resilience, when rated by the children in this study. There was a significant, weak, negative correlation between number of non-interpersonal traumas and caregiver-rated total resilience ($r = -.36$, $p < .05$), individual resilience ($r = -.33$, $p < .05$), and community resilience ($r = -.34$, $p < .05$) such that as the number non-interpersonal traumas increased, caregiver-rated community resilience scores decreased. The relationship between trauma and family resilience as rated by the caregivers was not significant.

There were, however, significant, positive correlations between the caregiver trust subscale of the attachment measure and children's number of traumatic events, number of

traumatic events strongly affected by, number of interpersonal traumas, and number of non-interpersonal traumas such that children with a greater number of traumas also reported higher levels of caregiver trust (see Table 4).

There were also significant, weak to moderate correlations between children's connectedness to present self and children's number of traumatic events, number of traumatic events strongly affected by, and number of interpersonal traumas, such that children with a greater number of traumas also reported higher levels of self-esteem and positive identity development (see Table 4). There was a significant, weak correlation between the connectedness to caregivers and children's number of interpersonal traumas, such that children with a greater number of traumas also reported higher levels of connectedness to their caregivers. There were no other significant correlations for any measurement of trauma and any of the other attachment or connectedness subscale.

Table 4

Bivariate Correlations of Attachment and Connectedness Subscales with Trauma

Measure	1	2	3	4	5	6	7
1. Total # of Traumatic Events	-	.84**	.94**	.69**	.38**	.42**	.28
2. Total # Traumatic Events Strongly Affected By	.84**	-	.79**	.59**	.32*	.38**	.18
3. Total # Interpersonal Traumas	.94**	.79**	-	.41**	.34*	.43**	.30*
4. Total # Non-Interpersonal Traumas	.69**	.59**	.41**	-	.31*	.23	.12
5. IPPA-R Caregiver Trust	.38**	.32*	.34*	.31*	-	.40**	.71**

6. HMAC Present self	.42**	.38**	.43**	.23	.40**	-	.34*
7. HMAC Caregivers	.28	.18	.30*	.12	.71**	.32*	-

Note. * $p < .05$. ** $p < .01$. IPPA-R = Inventory of Parent and Peer Attachment (child rated), HMAC = Hemingway Measure of Adolescent Connectedness (child rated). No other IPPA-R or HMAC subscales significantly correlated with trauma measures.

Resilience, Attachment, and Connectedness

When looking at the relationship between resilience and the measure of caregiver attachment, there were significant, moderate to strong positive correlations between caregiver trust and total resilience, individual resilience, family resilience, and community resilience, with the strongest relationship between caregiver trust and family-level resilience (see Table 5). Caregiver communication had moderate to strong positive correlations with total resilience, individual resilience, and family resilience. There was not a significant relationship between caregiver communication and community resilience. Caregiver alienation showed weak to moderate negative correlations with total resilience, individual resilience, and family resilience such that children with higher levels of caregiver alienation had lower levels of individual and family resilience.

When looking at the relationship between peer attachment and resilience, peer trust and peer communication showed moderate, positive correlations with total resilience, individual resilience, family resilience, and community resilience (see Table 5). Peer alienation had weak, negative correlations with total resilience and individual resilience, such that children with higher levels of peer alienation had lower levels of individual resilience (see Table 5).

Table 5

Bivariate Correlation Matrix for the Resilience and Attachment Measures

Measure	1	2	3	4	5	6	7	8	9	10
1. CYRM Total	-	.85**	.77**	.90**	.51**	.44**	-.40**	.53**	.53**	-.29*
2. CYRM Individual	.85**	-	.53**	.62**	.34*	.28*	-.29*	.51**	.50**	-.33*
3. CYRM Family	.77**	.53**	-	.54**	.72**	.69**	-.55**	.31*	.37**	-.27
4. CYRM Community	.90**	.62**	.54**	-	.33*	.26	-.25	.48**	.45**	-.17
5. IPPA-R Caregiver Trust	.51**	.34*	.72**	.33*	-	.79**	-.67**	.37**	.23	-.39**
6. IPPA-R Caregiver Communication	.44**	.28*	.69**	.26	.79**	-	-.65**	.28*	.33*	-.20
7. IPPA-R Caregiver Alienation	-.40**	-.29*	-.55**	-.25	-.67**	-.65**	-	-.29*	-.19	.57**
8. IPPA-R Peer Trust	.53**	.51**	.31*	.48**	.37**	.28*	-.29*	-	.78**	-.28*
9. IPPA-R Peer Communication	.53**	.50**	.37**	.45**	.23	.33*	-.19	.78**	-	-.20
10. IPPA-R Peer Alienation	-.29**	-.33*	-.27	-.17	-.39**	-.20	.57**	-.28*	-.20	-

Note. ** $p < .01$. * $p < .05$.

When looking at the relationship between resilience and the measure of connectedness, there were significant, moderate positive correlations between connectedness to present self and future self and resilience at all three ecological levels (see Table 6). Children who rated themselves as feeling more connected to themselves in the present and in the future also rated themselves higher on their resilience scores. There were also significant, moderate, positive correlations between connectedness to caregivers and resilience at all three levels, with the strongest relationship between caregiver connectedness and family-level resilience (see Table 6). There were not significant relationships between connectedness to siblings and any measurement of resilience.

For community connectedness, there was a significant, weak, and positive relationship between connectedness to neighborhood and total resilience as well as community level resilience (see Table 6). There were significant, weak to moderate, positive relationships between connectedness to friends, school, teachers, and peers and total resilience, individual resilience, and community resilience (see Table 6). There was not a relationship between any of the community connectedness subscales and family resilience. In sum, children who reported higher levels of trust and communication in their attachment relationships (both with caregivers and peers) also reported higher levels of resilience at all three ecological levels. Children who reported higher levels of connectedness to themselves and their parents also reported higher levels of resilience at all three ecological levels, while children who reported higher levels of community connectedness (peers, friends, teachers, school, neighborhood) also reported higher levels of individual and community resilience.

Table 6

Bivariate Correlation Matrix for the Resilience and Connectedness Measures

Measure	1	2	3	4	5	6	7	8	9	10	11	12	13
1. CYRM Total	-	.85**	.77**	.90**	.57**	.55*	.51**	.09	.30*	.34*	.47**	.41**	.39**
2. CYRM Individual	.85**	-	.53**	.62**	.57**	.60**	.35*	.01	.18	.43**	.45**	.44**	.43**
3. CYRM Family	.77**	.53**	-	.54**	.32*	.38**	.63**	.25	.23	.09	.27	.20	.13
4. CYRM Community	.90**	.62**	.54**	-	.50**	.41**	.38**	.03	.32*	.30*	.44**	.37**	.37**
5. HMAC Present Self	.57**	.57**	.32*	.50**	-	.42**	.34*	.21	.20	.39**	.49**	.56**	.50**
6. HMAC Future Self	.55*	.60**	.38**	.41**	.42**	-	.44**	.10	.36*	.59**	.50**	.51**	.28*
7. HMAC Caregivers	.51**	.35*	.63**	.38**	.34*	.44**	-	.44**	.20	.09	.36**	.20	.07
8. HMAC Siblings	.09	.01	.25	.03	.21	.10	.44**	-	.03	.03	.06	.08	.08
9. HMAC Neighborhood	.30*	.18	.23	.32*	.20	.36*	.20	.03	-	.49**	.23	.35*	.20
10. HMAC Friends	.34*	.43**	.09	.30*	.39**	.59**	.09	.03	.49**	-	.32*	.27	.21
11. HMAC School	.47**	.45**	.27	.44**	.49**	.50**	.36**	.06	.23	.32*	-	.52**	.51**
12. HMAC Teachers	.41**	.44**	.20	.37**	.56**	.51**	.20	.08	.35*	.27	.52**	-	.51**
13. HMAC Peers	.39**	.43**	.13	.37**	.50**	.28*	.07	.08	.20	.21	.51**	.51**	-

Note. ** $p < .01$. * $p < .05$. CYRM = Child and Youth Resilience Measure (child rated), HMAC = Hemingway Measure of Adolescent Connectedness (child rated).

Regressing Resilience on Attachment, Connectedness, and Risk Factors

Given the noted bivariate patterns above, hierarchical multiple regression analyses were used to explore the impact of attachment on resilience in multivariable models using an ecological approach from individual to community level variables. A three step hierarchical multiple regression was conducted with Total Resilience as the dependent variable. Risk factors (trauma, poverty, neighborhood crime) were entered at Step 1 to control for any potential impact they had on resilience. Caregiver attachment variables were entered at Step 2 to test the importance of the caregiver-child relationship. Peer attachment variables were entered at Step 3 to assess the addition of their contributions to resilience (see Table 7). The hierarchical multiple regression analyses revealed that at Step 1, risk factors did not significantly contribute to the regression model. At Step 2, caregiver attachment variables did significantly contribute to the regression model, F (7, 42) = 3.41, $p < .01$, and accounted for an additional 27% of the variance in Total Resilience. None of the caregiver attachment subscales individually explained Total Resilience at Step 2.

In Step 3, introducing peer attachment variables explained an additional 17% of the variation in Total Resilience and this change to R^2 was significant, F (10, 39) = 4.33, $p < .01$. Caregiver Trust also explained Total Resilience at Step 3 ($p < .05$). Overall, this pattern of results suggests that over a quarter of the variability in resilience is explained by caregiver-child attachment. Children's attachment to their peers contributes modestly to that explanation, traumatic experiences and other risk factors add no further explanation. The most robust contribution to resilience was caregiver trust, or mutual understanding and respect in the attachment relationship.

Table 7

Summary of Hierarchical Regression Results of Attachment on Resilience

Variables	ΔR^2	R^2	*Adjusted* R^2	*F*	B	SE B	β
Step 1: Risk Factors	.09	.09	.01	1.16			
Total Trauma					.97	1.33	.19
Total Trauma Affected by					-1.65	1.43	-.31
Poverty Level					4.71	2.61	.28
Neighborhood Crime					1.90	1.78	.16
Step 2: Caregiver Attachment	.27	.36	.26	3.41**			
Total Trauma					.11	1.19	.02
Total Trauma Affected by					-1.72	1.26	-.32
Poverty Level					4.10	2.29	.25
Neighborhood Crime					.91	1.58	.08
Caregiver Trust					20.92	11.03	.44
Caregiver Communication					6.11	10.66	.12
Caregiver Alienation					-1.55	8.62	-.03
Step 3: Peer Attachment	.17	.53	.41	4.33**			
Total Trauma					.13	1.07	.03
Total Trauma Affected by					-1.67	1.16	-.31
Poverty Level					3.01	2.07	.18
Neighborhood Crime					-.64	1.48	-.05
Caregiver Trust					22.20	10.90	.47*
Caregiver Communication					-.81	11.65	-.02
Caregiver Alienation					.95	9.40	.02
Peer Trust					4.20	8.69	.10
Peer Communication					13.13	7.53	.35
Peer Alienation					-4.03	8.31	-.07

Note. $^{**}p < .01$, $^{*}p < .05$.

Hierarchical multiple regression analyses were then used to determine the impact of connectedness on resilience in a similar ecological approach. A four step hierarchical multiple regression was conducted with Total Resilience as the dependent variable. Risk factors (trauma, poverty, neighborhood crime) were entered at Step 1 to control for any potential impact they had

on resilience. Individual connectedness variables were entered at Step 2, family connectedness variables were entered at Step 3, and community connectedness variables were entered at Step 4 to assess their contributions to resilience (see Table 8). The hierarchical multiple regression revealed that at Step 1, risk factors did not significantly contribute to the regression model. At Step 2, individual connectedness variables did significantly contribute to the regression model, F (6, 33) = 5.40, $p < .01$, and accounted for 50% of the variation in Total Resilience, with an adjusted R^2 of .40. Both present self and future self explained Total Resilience score at Step 2 ($p < .01$).

Introducing family connectedness variables explained an additional 9% of the variation in Total Resilience and this change to R^2 was significant, F (8, 31) = 5.62, $p < .01$. Connectedness to present self (self-esteem, positive identity development) continued to significantly explain resilience at Step 3 ($p < .01$) and connectedness to caregivers also significantly explained resilience at Step 3 ($p < .05$). When community connectedness variables were introduced, this change to R^2 was significant, F (13, 26) = 3.59, $p < .01$, however there was a decrease in the adjusted R^2, indicating that the model did not explain Total Resilience score better at Step 4 compared to Step 3. Connectedness to present self and caregivers continued to significantly explain resilience at Step 4 ($p < .05$). Overall, this pattern of results suggests that 45% of the variability in resilience is explained by connectedness to self. Children's connectedness to their family contributes modestly to that explanation (additional 9%), while community connectedness and risk factors add no further contribution. The most robust contributors to resilience were connectedness to present self and connectedness to caregivers.

Table 8

Summary of Hierarchical Regression of Connectedness on Resilience

Variables	ΔR^2	R^2	*Adjusted* R^2	*F*	B	SE B	β
Step 1: Risk Factors	.05	.05	-.06	.42			
Total Trauma					1.03	1.43	.20
Total Trauma Affected by					-1.15	1.64	-.20
Poverty Level					3.10	3.09	.19
Neighborhood Crime					1.25	2.03	.11
Step 2: Individual Connectedness	.45	.50	.40	5.40**			
Total Trauma					.07	1.09	.01
Total Trauma Affected by					-1.51	1.234	-.27
Poverty Level					-1.01	2.46	-.06
Neighborhood Crime					1.09	1.53	.10
Present Self					9.78	2.96	.51**
Future Self					8.93	2.99	.42**
Step 3: Family Connectedness	.09	.59	.49	5.62**			
Total Trauma					-.31	1.04	-.06
Total Trauma Affected by					-1.48	1.15	-.26
Poverty Level					1.40	2.49	.09
Neighborhood Crime					2.12	1.47	.19
Present Self					9.18	2.76	.48**
Future Self					5.92	3.00	.28
Caregivers					11.41	4.23	.41*
Siblings					-2.95	2.66	-.15
Step 4: Community Connectedness	.05	.64	.46	3.59**			
Total Trauma					-1.03	1.17	-.20
Total Trauma Affected by					-.80	1.33	-.14
Poverty Level					1.73	2.62	.11
Neighborhood Crime					1.71	1.55	.15
Present Self					9.34	3.69	.48*
Future Self					5.26	4.13	.24
Caregivers					12.13	4.96	.44*
Siblings					-3.20	2.81	-.17
Neighborhood					1.49	3.36	.08

Friends	-.03	3.36	-.00
School	1.44	3.42	.07
Peers	4.19	3.01	.22
Teachers	-4.72	3.68	-.25

Note. $^{**}p < .01$, $^{*}p < .05$.

As a final step, hierarchical multiple regression analyses were used to determine the collective impact of attachment and connectedness variables that significantly explained resilience in the separate models. Due to colinearity between the caregiver trust attachment and caregiver connectedness subscales (*VIF* = 2.53, $r = .71$), only caregiver trust attachment was included in this analysis to determine the relative contribution of attachment and connectedness variables. A three-step hierarchical multiple regression was conducted with Total Resilience as the dependent variable. Risk factors (trauma, poverty, neighborhood crime) were entered at Step 1 to control for any potential impact they had on resilience. Caregiver trust (attachment) was entered at Step 2 and connectedness to future self and present self were entered at Step 3. The regression model showed that at Step 1, risk factors did not significantly contribute to resilience. At Step 2, caregiver trust attachment significantly contributed to the regression model accounted for 36% of the variation in Total Resilience, with an adjusted R^2 of .28 (see Table 9).

Introducing individual connectedness variables explained an additional 27% of the variation in Total Resilience and this change to R^2 was significant (see Table 9). Connectedness to present self, future self, and caregiver trust attachment all significantly explained resilience at Step 3 ($p < .01$). Overall, this pattern of results suggests that 27% of the variability in resilience is explained by caregiver trust attachment and connectedness to present self (positive identity and self-esteem) and future self (hope and future orientation) contributes an additional 27%, with the final model explaining 63%.

Table 9

Summary of Hierarchical Regression of Attachment and Connectedness on Resilience

Variables	ΔR^2	R^2	*Adjusted* R^2	*F*	B	SE B	β
Step 1: Risk Factors	.09	.09	.01	1.16			
Total Trauma					.97	1.33	.19
Total Trauma Affected by					-1.65	1.43	-.31
Poverty Level					4.71	2.61	.28
Neighborhood Crime					1.90	1.78	.16
Step 2: Family Attachment	.27	.36	.28	4.85**			
Total Trauma					.04	1.16	.01
Total Trauma Affected by					-1.69	1.22	-.32
Poverty Level					3.96	2.23	.24
Neighborhood Crime					.78	1.54	.07
Caregiver Trust Attachment					26.81	6.34	.56**
Step 3: Individual Connectedness	.27	.63	.57	10.24**			
Total Trauma					-.53	.91	-.11
Total Trauma Affected by					-1.52	.94	-.29
Poverty Level					-.51	1.90	-.03
Neighborhood Crime					.87	1.20	.07
Caregiver Trust Attachment					17.15	5.21	.36**
Self-in-the-Present					8.92	2.40	.45**
Self-in-the-Future					7.31	2.41	.33**

Note. $^{**}p < .01$, $^{*}p < .05$.

Quantitative Relationship between Child and Caregiver-Rated Resilience

Both children and caregivers provided ratings of child resilience. When looking at the corresponding measurements of resilience, there was a moderate, significant, positive correlation between total resilience scored as rated by both children and their caregivers (see Table 10). There were also moderate, significant, positive correlations between individual resilience scores and community resilience scores as rated by both children and their caregivers, (see Table 10). Children who rated themselves higher on measures of individual, community, and total resilience

also had caregivers that rated their children higher on these same measures. Family-level resilience as rated by children and caregivers was not significantly correlated.

Table 10

Bivariate Correlation Matrix for Child and Caregiver Rated Resilience

Measure	1	2	3	4	5	6	7	8
1. CYRM Total^{C}	-	.85**	.77**	.90**	.50**	.40**	.14	.54**
2. CYRM Individual^{C}	.85**	-	.53**	.62**	.45**	.44**	.06	.43**
3. CYRM Family^{C}	.77**	.53**	-	.54**	.37**	.29*	.06	.42**
4. CYRM Community^{C}	.90**	.62**	.54**	-	.44**	.28*	.20	.51**
5. PMK Total^{P}	.50**	.45**	.37**	.44**	-	.89**	.52**	.93**
6. PMK Individual^{P}	.40**	.44**	.29*	.28*	.89**	-	.35*	.69**
7. PMK Family^{P}	.14	.06	.06	.20	.52**	.35*	-	.34*
8. PMK Community^{P}	.54**	.43**	.42**	.51**	.93**	.69**	.34*	-

Note. ** $p < .01$. * $p < .05$. CYRM = Child and Youth Resilience Measure, PMK = Person Most Knowledgeable, C = Child rated, P = Caregiver rated.

Paired samples t-tests were then conducted to evaluate the differences between child-rated and caregiver-rated resilience scores. Statistically significant differences were found between child and caregiver ratings on children's resilience (see Table 11). Children were more likely to rate themselves higher than their caregivers rated them on measures of total resilience, individual resilience, and community resilience. Caregivers were more likely to rate their children's family resilience scores higher than the children rated them.

Table 11

Comparison of Children and Caregivers' Ratings of Child's Resilience

	Children (N = 50)		Caregivers (N = 50)		
	M	SD	M	SD	*t*-test
Total Resilience Score	110.36	17.44	104.38	17.13	2.45*
Mean Individual Resilience Score	4.08	.75	3.60	.80	4.32**
Mean Family Resilience Score	4.19	.73	4.48	.42	-2.51*
Mean Community Resilience Score	3.70	.73	3.34	.82	3.28**

Note. * $p < .05$, ** $p < .01$

Mixed Methods Results

Based on the noteworthy caregiver-child differences found in reporting resilience scores, a mixed-methods approach was used to investigate these findings further. Six exemplary interview dyads were chosen that best represented each of three different child and caregiver-rated resilience score groups that were either (a) highly synchronous, (b) highly discrepant with caregivers rating the child as more resilient than they saw themselves (Caregiver > Child), or (c) highly discrepant with children rating themselves as more resilient than their caregivers thought (Child > Caregiver). Based on mean difference scores (child score minus caregiver score), dyads that were highly synchronous had difference scores that ranged from -4 to +4 (M = 2.7). Highly discrepant dyads with caregiver > child had difference scores that ranged from -11 to -34 (M = 19.5). Highly discrepant dyads with child > caregiver had difference scores that ranged from +23 to +49 (M = 32.7). These 18 dyads were qualitatively coded using the three major steps of the CQR coding process as described in the methods and then coded again in pairs to look for similarities and differences between dyads.

Six domains were used for the caregiver interviews and three domains were used for the child interviews. The caregiver domains were as follows: Stressful or Challenging Circumstances, Child Coping/Resilience, Caregiver Coping/Resilience, Community Support,

Treatment, and Advice. The child domains were as follows: Stressful or Challenging Circumstances, Child Coping/Resilience, and Advice.

Stressful or Challenging Circumstances. Overall, both children and caregivers named a number of stressful or challenging circumstances in the interviews, some of which were similar to the traumatic events caregivers reported on the questionnaire and other events that were more prevalent or recent in their minds. There was not a single stressful or challenging circumstance that was found for every dyad in any of the three groups (see Table 12.1). For the Highly Synchronous group, the most common event was a death of a family member, which received a frequency label of "Typical." Two of the children lost their father, one of which also lost her grandmother and grandfather in the same year, one child lost his aunt, and one child's brother was murdered. This was considered a family-level stressful event, and was talked about by both caregivers and children. The Highly Synchronous group did not have any other "Typical" stressful events, however caregivers and children endorsed three out of eight individual-level stressors (child's emotional/behavioral problems, change in routine/ inflexibility, and problems meeting basic needs). In addition to death of a family member, the Highly Synchronous group endorsed nine additional family-level stressors (out of 12), including sibling conflict, stressful living situations, and caregiver's financial issues. For community-level stressors, the Highly Synchronous group endorsed three out of five stressors, with the most common being school-related stress and peer conflict/ bullying. Many children in all three groups talked about school-related stress as one of their most relevant stressors.

The Caregiver > Child group also only had one "Typical" stressor, which was children's emotional/behavioral problems, an individual-level stressor. This included feelings of depression and anger as well as aggressive and oppositional behavior. In addition to this stressor, the

Caregiver > Child group endorsed five out of the eight individual-level stressors, with the most common for this group being children's low-confidence and children's distrust of others. The Caregiver > Child group talked about 11 out of the 12 family-level stressors, with some of the most common being death of a family member, separation from biological parents, and stressful child-caregiver relationship (currently living with) (see Table 12.1). For community-level stressors, the Caregiver > Child group endorsed two out of the five, school-related stress and peer conflict/bullying.

The Child > Caregiver group was the only group to have two "Typical" stressors, both of which were in the community-level: school-related issues and neighborhood problems. Many children in this group talked about how school was particularly stressful for them and a most of the caregivers said their neighbors caused them problems, or they lived in the "bad" neighborhood, which caused them a lot of stress. The Child > Caregiver group endorsed all five out of the five community-level stressors. The Child > Caregiver group also talked about four out of the eight individual-level stressors, with the most common being children's emotional/behavioral problems. For family-level stressors, the Child > Caregiver group only endorsed four out of 12 stressors, with the most common being stressful caregiver-child relationship (currently living with) (see Table 12.1).

Table 12.1

Summary of Categories and Frequencies for Stressful or Challenging Circumstances

Domain	Category	Frequency of: Highly Synchronous	Caregiver > Child	Child > Caregiver
Stressful or Challenging Circumstances	Child's Emotional/ Behavioral Problems (I)	Variant	Typical	Variant
	Low Confidence (I)	-	Variant	-
	Distrust of Others (I)	-	Variant	-
	Changing Routine/Inflexibility (I)	Variant	-	-
	Problems Meeting Basic Needs (I)	Variant	Rare	Variant
	Lack of/ Maladaptive Coping Skills (I)	-	Rare	Variant
	Social Skills Deficits (I)	-	-	Variant
	Sexual Assault of Child (I)	-	Rare	-
	Death of Family Member (F)	Typical	Variant	Rare
	Separation from Biological Parents (F)	Rare	Variant	
	Problems with Biological Parent (not currently living with) (F)	Rare	Variant	
	Stressful Caregiver-Child Relationship (currently living with) (F)	-	Variant	Variant
	Stressful Living Situation (F)	Variant	-	-
	Caregiver's arrest/ jail time (F)	Rare	Rare	-
	Caregiver's drug addiction (F)	-	Rare	-
	Divorce/Separation of Parents (F)	Rare	Variant	-
	Sibling Conflict (F)	Variant	Variant	Rare
	Financial Issues, for caregiver (F)	Variant	Rare	-
	Caregiver's worry about children (F)	Variant	Rare	-
	Caregiver's Medical or Mental Health Issues (F)	Variant	Variant	Rare
	School-related Stress (C)	Variant	Variant	Typical
	Peer-conflict/Bullying (C)	Variant	Variant	Variant
	Neighborhood Problems (C)	Rare	-	Typical
	Moving/Isolation (C)	-	-	Variant
	Caregiver's Frustration with Generational/Cultural Differences (C)	-	-	Variant

Note. I = Individual Level, F = Family Level, C = Community Level. Frequency Labels: General (bolded) = 6, Typical (in red) = 4-5, Variant = 2-3, Rare = 1.

Child Coping/Resilience. Overall, children and caregivers in all three groups had a lot to share about children's strengths and how they cope with stressful situations. All of the dyads in the Highly Synchronous group said that their child (or they themselves) copes with stress through solo/ sedentary activities like art and music and with sports or exercise (see Table 12.2). Since none of the dyads mentioned sports in the context of a team or playing with others, this

was categorized as an individual-level coping skill. In addition to these two individual-level coping skills, dyads in the Highly Synchronous group also talked about eight out of 12 individual-level coping skills or strengths, second most common were child is strong/determined, child takes care of their basic needs (showers, eats well), and child takes a break or keeps to themselves (see Table 12.2). For family-level coping skills, the Highly Synchronous dyads endorsed two out of three, with the most common being talking to caregiver as being helpful when stressed. The Highly Synchronous dyads also talked about two out of four community-level coping skills, with talking or spending time with friends and going to therapy as "typical" categories for this group.

All of the Caregiver > Child dyads also said that solo/sedentary activities were the most common way of coping for children (individual level). All six dyads also said that treatment or therapy was how children coped with stress (community level). The Caregiver > Child dyads endorsed nine out of the 12 individual-level coping skills, with child takes care of their basic needs and child is self-reliant as "typical" for this group. The Caregiver > Child dyads talked about all three categories of family-level coping skills with talking to caregiver(s) being the most common family-level coping skill for these dyads. Children and caregivers in the Caregiver > Child group also endorsed all four community-level coping skills. In addition to going to therapy, dyads in this group said that children cope by going places in the community and spending time or talking with friends (see Table 12.2).

A "General" coping skill for the Child > Caregiver dyads was also solo/sedentary activities, indicating that this was a coping skill seen in all of the exemplary interviews. Dyads in this group also talked about eight of the other 12 individual-level coping skills with sports/exercise being the second most common coping skill. Similar to the other groups, talking

with caregiver(s) was a "typical" coping skill for the Child > Caregiver dyads and they also endorsed talking with family members or siblings as a "variant" coping skill. The Child > Caregiver group talked about three out of the four community-level coping skills, with spending time or talking to friends and going places in the community as "typical" coping skills (see Table 12.2).

Caregiver Coping/Resilience. Overall, there were far fewer coping skills that caregivers used themselves compared with children's coping skills (see Table 12.2). This was a domain that was only discussed with caregivers. Caregivers in the Highly Synchronous group did not have any "General" or "typical" categories of coping skills. There was a "variant" amount of caregivers who said they lacked coping skills or had a desire to be healthier (see Table 12.2). Caregivers in this group talked about four of the five individual-level coping skills including sedentary/solo activities, exercise, and taking care of basic needs. Highly Synchronous caregivers also talked about two of the three family-level coping skills: spending time with family and going outside with family. Caregivers in this group endorsed two out of three community-level coping skills, with the most common being going places in the community as a way to cope with stress.

In the Caregiver > Child group, there were no "general" coping skills, but the most "typical" was taking care of basic needs (eats healthy, takes medicine). Similar to caregivers in the Highly Synchronous group, caregivers in the Caregiver > Child group showed a "variant" amount of desire to be healthy. Caregivers in this group also endorsed all five of the individual-level coping skills, and were the only caregivers to talk about coping through spirituality or faith. Caregivers in the Caregiver > Child group endorsed two of the three family-level coping skills: talking with family members and spending time with family members. For community-level

coping skills, they endorsed two out of three, most commonly going to therapy as a way to cope with stress.

Like the other two groups, caregivers in the Child > Caregiver group did not have any "general" coping skills. A "typical" response for this group was that they lacked coping skills or had many barriers to coping skills. Another "typical" response was that they cope by taking care of their basic needs. Caregivers in the Child > Caregiver group endorsed four of the five individual coping skills (see Table 12.2) and all of the family-level coping skills. Caregivers in this group also endorsed all three community-level coping skills, the most common being talking with friends.

Table 12.2

Summary of Categories and Frequencies for Coping/Resilience

Domain	Category	Frequency of: Highly Synchronous	Caregiver > Child	Child > Caregiver
Child Coping/Resilience	Solo/Sedentary Activities (I)	**General**	**General**	**General**
	Sports/Exercise (I)	**General**	Variant	Typical
	Child is Strong/Determined (I)	Typical	Variant	-
	Child is Sociable (I)	Rare	Variant	Variant
	Child is Self-Reliant (I)	Rare	Typical	Rare
	Child Speaks up for Themselves (I)	-	-	Variant
	Child is Self-Aware (I)	-	Variant	-
	Child is Smart	Rare	Variant	Rare
	Takes Care of Basic Needs (I)	Typical	Typical	Variant
	"Nothing gets in the way" (I)	Typical	Rare	-
	Keeps to Themselves/Takes a Break (I)	Typical	Variant	Variant
	Does not share/ Depends on the situation (I)	Variant	-	Variant
	Talks with Caregiver(s) (F)	Typical	Typical	Typical
	Talks with other family members/siblings (F)	Variant	Variant	Variant
	Spends time with family (F)	-	Variant	-
	Spends time with/ talks with Friends (C)	Typical	Typical	Typical
	Treatment/ Therapy (C)	Typical	**General**	Variant
	Goes Places in the Community (C)	-	Typical	Typical
	Helps others (C)	-	Variant	-
	Confused by coping question	-	Variant	Variant
	Barriers to Coping/ Lack of Coping Skills	Variant	Rare	Typical
Caregiver Coping/Resilience	Desire to be Healthy	Variant	Variant	Variant
	Sedentary/ Solo Activities (I)	Variant	Variant	Variant
	Exercise (I)	Variant	Variant	Variant
	Takes care of basic needs (I)	Variant	Typical	Typical
	Keeps to Themselves/Takes a Break (I)	Rare	Variant	Variant
	Spirituality/Faith (I)	-	Variant	-
	Spends time with Family (F)	Variant	Variant	Variant
	Talks with Family members (F)	-	Variant	Variant
	Goes outside as a Family (F)	Variant	-	Variant
	Goes Places in the Community (C)	Variant	-	Rare
	Therapy (C)	Rare	Variant	Rare
	Talks with Friends (C)	-	Rare	Variant

Note. I = Individual Level, F = Family Level, C = Community Level. Frequency Labels: General (bolded) = 6, Typical (in red) = 4-5, Variant = 2-3, Rare = 1.

Community Support. The community support domain included where the caregivers felt supported outside of the home, including friends, neighbors, extended family, school, or

community as a whole. Caregivers were also asked what they thought communities could do better to support families and children such as their own. For the Highly Synchronous group, there were no "general" or "typical" community supports or suggestions. Caregivers in this group had mixed experiences, with "variant" amounts of some friend support (although not living nearby) and feeling supported by friends (see Table 12.3). Caregivers also had "variant" endorsement of both feeling supported by neighbors and loss of support or no support from neighbors. Caregivers in this group also talked about generational/societal problems that were hurting their community such as bullying. In the Highly Synchronous group, caregivers most commonly suggested that communities have activities to keep children safe and communities listen to caregivers' experience/ accommodate families (see Table 12.3).

Caregivers in the Caregiver > Child group also did not have any "general" or "typical" community supports or suggestions. Caregivers also had mixed experiences, with "variant" amounts of caregivers lacking friend support, while others said they felt supported by friends (see Table 12.3). Caregivers in this group also had varying degrees of support from neighbors. One "variant" category was that caregiver said they felt supported by their community as a whole. The most common suggestion was that communities listen to caregivers' experience/ accommodate families (see Table 12.3).

For the Child > Caregiver group, a "general" experience was that caregivers felt they had a loss of neighbor support or no support from neighbors. A "typical" experience was that caregivers felt supported by friends. For community suggestions, caregivers in the Child > Caregiver group said that there should be more local activities or support for families and that there should be more support for children with mental health issues and/or traumatic experiences (see Table 12.3).

Treatment. Caregivers were asked what their experience with in-home therapy (IHT) was like and what they found most helpful about treatment. If relevant, caregivers also shared what they felt was unhelpful about treatment. This domain also captures any unsolicited comments that children and caregivers shared about their treatment experience with IHT or other treatment domains. The Highly Synchronous group had only positive things to say about IHT, with the most "typical" of experiences being that therapy was helpful due to therapist(s) and helpful due to techniques or concrete aspects of treatment. Highly Synchronous dyads also talked about positive outcomes for children and improved child-caregiver communication after therapy (both "variant"; see Table 12.3).

All of the Caregiver > Child dyads said that IHT was helpful due to therapist(s), and many caregivers and children talked about the good rapport between the child and therapist. "Typical" responses included overall positive experience with IHT, that IHT was helpful due to techniques or concrete aspects of treatment, and positive outcomes for children after IHT was finished (self-control, self-confidence, more coping skills). Dyads in the Caregiver > Child group also did not talk about having any negative experiences with therapy or treatment.

For the Child > Caregiver group, a "typical" experience was that IHT was helpful due to the therapist(s). However, caregivers in this group were also the only ones to talk about negative experiences, with "variant" endorsement of unsuccessful treatment due to therapist/ systemic problems (high rate of therapist changeover) and unsuccessful treatment due to child's resistance (no follow-through on techniques). The Child > Caregiver group was the only group to not talk about improved child-caregiver communication as a therapy outcome (see Table 12.3). This was also the only group where none of the children shared information about therapy in their interviews.

Table 12.3

Summary of Categories and Frequencies for Community Support and Treatment

Domain	Category	Frequency of: Highly Synchronous	Caregiver > Child	Child > Caregiver
Community Support	Lack of Friend Support	Rare	Variant	Rare
	Some Friend Support (not nearby)	Variant	-	-
	Feels Supported by Friends	Variant	Variant	Typical
	Feels Supported by Family	Rare	-	Variant
	Loss of Neighbor Support/ No Support	Variant	Variant	**General**
	Feels Supported by Neighbors	Variant	Variant	Rare
	Feels Supported by Community	-	Variant	Variant
	Not supported by School	-	-	Rare
	Generational/ Societal Problems	Variant	Rare	Rare
	Community Suggestions: Local Activities/ Support for Families	-	-	Variant
	Community Suggestions: Mental Health/ Trauma Support	-	Rare	Variant
	Community suggestions: Activities to keep children safe!	Variant	Rare	-
	Community Suggestions: Listen to parents' experience/ Accommodate Families	Variant	Variant	-
	Community suggestions: More affordable programs/ Without insurance requirement	Rare	Rare	-
Treatment	Overall Positive Experience with IHT	Variant	Typical	-
	Positive outcomes: Improved Caregiver-Child Communication	Variant	Rare	-
	Positive outcomes for Child	Variant	Typical	Variant
	Helpful due to therapist(s)	Typical	**General**	Typical
	Helpful due to techniques/ concrete aspects	Typical	Typical	Variant
	Helpful: Supported Caregiver	Rare	Variant	Variant
	Helpful due to family aspects	Rare	Variant	Rare
	Negative Experience with therapist/system	-	-	Variant
	Unsuccessful due to child's resistance to treatment	-	-	Variant

Note. I = Individual Level, F = Family Level, C = Community Level. Frequency Labels: General (bolded) = 6, Typical (in red) = 4-5, Variant = 2-3, Rare = 1.

Advice. At the end of each interview, children and caregivers were asked what advice they would give to children and what advice they'd give to caregivers facing similar challenges. Children and caregiver in all three groups gave a range of answers for child and caregiver advice. In the Highly Synchronous group, "typical" answers for advice to children were to talk with

others / express your feelings and have patience/ don't give up (see Table 12.4). The most common advice that Highly Synchronous caregivers gave to other caregivers was to go to therapy/seek help (see Table 12.4).

In the Caregiver > Child group, similar to the Highly Synchronous group, a "typical" answer for advice to children was to talk with others / express your feelings (see Table 12.4). The most common advice that caregivers in this group had for other caregivers was all geared toward children: to emotionally and physically support your children and to see things from your child's perspective (see Table 12.4).

Child > Caregiver dyads did not have any "general" or "typical" categories when giving advice. Dyads in this group had eight different types of advice for children, and were the only dyads to tell children to be more independent/ make their own decisions (see Table 12.4). For advice to caregivers, the most common piece of advice was to be informed / advocate for your child, because they felt that the "caregiver knows best" (see Table 12.4).

Table 12.4

Summary of Categories and Frequencies for Advice

Domain	Category	Frequency of: Highly Synchronous	Caregiver > Child	Child > Caregiver
Advice	Hesitant to give advice/Unsure	Variant	Rare	Variant
For Children	Talk with others / express your feelings	Typical	Typical	Variant
	Therapy/ Listen to Therapist		Rare	Variant
	Do something to take your mind off things	Rare	Variant	Variant
	Do something relaxing/ Makes you feel better	Variant	-	Variant
	Trust Parents/ Respect Parents	-	Variant	Variant
	Be more independent/ Make own decisions	-	-	Variant
	Be future-oriented	Rare	-	Variant
	Be kind to yourself	-	Variant	-
	"Take it Easy"/ Let it go	Variant	Variant	-
	Listen to others	Variant	-	-
	Don't engage in risky behaviors	Variant	Rare	
	Have Patience/ Don't Give Up	Typical	Variant	Variant
For Caregivers	Go to therapy/ Seek Help	Variant	Rare	Rare
	Be informed / Advocate for your child	Rare	-	Variant
	Emotionally & Physically Support your children	-	Variant	-
	See things from Child's Perspective	-	Variant	-

Note. I = Individual Level, F = Family Level, C = Community Level. Frequency Labels: General (bolded) = 6, Typical (in red) = 4-5, Variant = 2-3, Rare = 1.

Qualitative Relationship between Child and Caregiver-Rated Resilience

After interviews were coded into domains, core ideas, and categories, they were analyzed as pairs, looking for similarities and differences between children's answers and caregiver's answers as well as evidence and descriptors of the caregiver-child relationship. There were no significant differences between the three groups of exemplary interviews and any of the background variables (age, grade, ERI, gender, caregiver's education, caregiver completing measures, community mental health organization, poverty, crime).

Highly Synchronous. The first group of exemplary dyads is called the Highly Synchronous group, distinguished by having the most similar child and caregiver-rated total

resilience scores. After analyzing these dyads, a number of similarities emerged in the qualitative data as well. First of all, many of the children and caregivers spoke about the same traumatic event, typically the loss of a loved one. It was clear that caregivers could see that not only was this event traumatic for their child, but it was also traumatic for them. Caregivers in this group also reflected on how problems or challenges they've experienced in their lives are similar to that of their children, and were able to use this to empathize with their children. For example, one mother said, "And we both have the same kind of anxiety so I know where she's coming from, so I kinda try to coach her through it." Caregivers were also able to reflect on how their behavior or feelings affected their children and were sensitive to the impact this may have on them.

In addition to being empathetic, many caregivers in this group were optimistic and had a positive view of their child's progress, even if they acknowledged that the child is still growing and learning. Many of the caregivers and children were able to name the child's coping skills that were overall, very similar, caregiver knew how their children liked to cope and who they preferred to go to talk about their issues. Caregivers and children also often had similar ways of coping themselves, whether it be taking a walk, listening to music, or having some alone time.

Caregivers in the highly synchronous group also placed a great emphasis on the importance caregiver-child communication and family communication. One mother said that her child does not often talk to people, but he will talk to his mom and dad and that they work hard as a family to help the child open up. Two other caregivers said improving caregiver-child communication was the main success of in-home therapy. Caregivers in this group also gave examples of intergenerational resilience – whether it was something simple such as mother and daughter both using humor to cope with problems, or a mother recognizing that when she felt calm, her child also felt calm.

Despite having very similar resilience scores, there were some examples of caregivers and children not being on the same page during interviews, one example being caregivers not being aware of the different stressors their children's experience. While one caregiver said things don't get in the way of their child's well-being, their child said her depression gets in the way. Another caregiver did not talk about the child's father going to prison as being traumatic, while the daughter said thinking about this is very upsetting and gets in the way of her being able to stay healthy and happy. One child did not acknowledge bolting (running way) when talking about stressful events, however his mother described that the child "blacks out" during these situations and may not be aware of how it affects himself or others.

Caregiver > Child. In general, dyads in the Caregiver > Child group were described as caregivers who saw their children very positively, and children who saw themselves in more negative ways, thus resulting in caregiver-rated resilience scores that were significantly higher than child-rated resilience. When looking at the dyads more closely, there was a lot of evidence of caregivers that had very positive views of their children. One mother was able to see how her daughter's depression had improved and how her daughter's relationship with her sister had improved. Another mother said that her daughter was more conscientious and reacted better to her problems. This particular mother had a focus on the importance of love of her family and talked about all of the ways in which her daughter has gotten better since treatment, showing great improvement from much of the oppositional behaviors she had prior. For another family, both mother and grandmother contributed to the interview and child's grandmother was very vocal about child's strengths. The child's mother also said she could not name any barriers the child might face in being able to stay healthy and happy, while the child said being "unmotivated" gets in her own way.

For the Caregiver > Child group, caregivers' positive views of their children was contrasted with many children's negative views of themselves. One child had a very difficult time thinking of any skill or activity that helped her feel better when stressed. Another child said she still feels low confidence at times, despite her caregiver saying it had improved. When asked about stressors, one child said he finds it difficult to take care of himself if he is stressed or feeling depressed and doesn't want to socialize, however his grandmother did not acknowledge these feelings of depression. One grandmother said therapy helped her grandson feel more positive about himself, so it is possible that this indicates that the child had a negative view of himself prior to therapy or is something that continues to be a challenge for this child.

Similar to the Highly Synchronous group, many of the children and caregivers in the Caregiver > Child group were on the same page when it came to reporting what the most stressful event for the child was or had children and caregivers with similar traumas. However, in this group, there were a number of dyads that showed how the child was handling the trauma better than the caregiver. One dyad experienced trauma due to the caregiver's drug addiction, with the child reporting her caregivers' drug addiction to the school, which caregiver said, "saved her life." Another caregiver said that she was strongly impacted after her daughter was raped, and believes that now that her daughter has gotten better, she needs help to cope, saying, "Since a year ago things have been getting better [for child]. But, it's, now, I'm the affected one because, now I'm low. So, I'm looking for help."

Child > Caregiver. Dyads in the Child > Caregiver group were described as caregivers who perceived their children's behavior in more negative ways and children who viewed themselves in more positive ways, thus resulting in child-rated resilience scores that were significantly higher than caregiver-rated resilience. While there were some examples of children

being less aware of certain problems or stressors, overall they did not view themselves in overwhelmingly positive ways. For example, one caregiver brought up that her child has a lot of problems interacting with peers but also lacks social skills, and the child did not talk about any peer problems. Another dyad had recently moved to an apartment in the suburb and the mother felt isolated, which was a huge problem for her, but not mentioned as much by the child.

Comparatively, what distinguished dyads in this group from dyads in other groups was the high occurrence of caregivers talking negatively about their children, and caregivers and children describing difficult caregiver-child relationships. One mother said that her biggest barrier to her own well-being was her son, and when describing his problems she said, "it's like an alien came from my body." Another mother told her daughter if she did not behave in school and was hospitalized, "she wouldn't bother to go [see her]." When speaking about her son's strengths, one mother said he was, "too smart" and talked about even his strengths in negative ways. This mother also said her son has "separation anxiety" and described her son's behavior toward her as "stalking." She said her Child was "pushed aside" from birth until age five because the caregiver's mother was sick with cancer.

While some caregivers in this group were able to name their children's coping skills, there were some dyads that showed that they were unaware of how their children cope with stress. One child talked about a best friend that she talks to when stressed, while her mother said that she doesn't have many friends. Another child was very excited when sharing about a text therapy service she uses, but her mother did not mention this. Her mother also said the child does not talk with her about her problems, so it is possible that their lack of communication impedes knowledge of child's coping skills.

Discussion

This study is one of the first to take an in-depth look at resilience characteristics at multiple levels through direct interviews and questionnaires with children and their caregivers, and to do so for largely low-income, urban group of families. This research makes unique contributions to our understanding of how at-risk children and their caregivers use resilience resources at multiple ecological levels to protect themselves from future trauma.

Trauma and Resilience. The rate of complex trauma found for the children in this study (94%) was much higher than the 33% rate of complex trauma found by Copeland et al. (2007) when looking at trauma in a representative group of over 1,000 children. Given the high rate of trauma in our sample, it was impressive that the children in our sample exhibited levels of resilience that were not significantly different from those of a low-risk normed sample. While there was not a statistically significant relationship between resilience and trauma history, this does not mean that trauma is not important when thinking about resilience for children in this study, because their traumatic experiences contextualize their resilience for themselves and their families. For example, this study demonstrated that children with a greater number of traumas also reported higher levels of caregiver trust and connectedness to their caregivers. Since all of the children in this study had already received therapy, much of which was focused on the caregiver-child relationship, it is possible that children with the highest rates of trauma were able to make the most strides in improving the child-caregiver relationship during therapy, thus feeling more connected to their caregivers afterwards.

Individual-Level Resilience. Overall, children rated their individual-level resilience equally as high as their family-level resilience and children showed the highest levels of individual-level connectedness, which significantly contributed to overall resilience. This

included connectedness to themselves in the future (hope and positive outlook) and connectedness themselves in the present (self-esteem and positive identity development). These two variables made the largest and most significant contributions at explaining resilience compared to other connectedness and attachment variables. This supports the Emotional and Cognitive domains of Kia-Keating et al.'s (2011) model and the individual-level of Motti-Stefanidi et al.'s (2012) model. Additionally, children with a greater number of traumas reported higher levels of self-esteem and positive identity development. The qualitative interviews showed vast evidence of individual-level coping skills and strengths that children had, and it is likely that through therapy or over time, they were able to build more individual resilience to help them cope with past traumas. This lends further support to the importance of the individual-level in Motti-Stefanidi and colleagues' (2012) model of youth adaptation, but for a group of children with trauma histories.

Family-Level Resilience. This study found that for a group of children with trauma histories, the most important family-level contributors to resilience were caregiver trust (mutual understanding and respect in the attachment relationship) and connectedness to caregivers. This supports the interaction levels of Motti-Stefanidi et al.'s (2012) model and parts of the social and structural domains of the Kia-Keating et al. (2011) model. However, neither model fully captures the importance of the caregiver-child relationship for children's development of resilience and positive adaptation. Not only is caregiver-child relationship crucial to resilience, it is specifically the mutuality of the relationship that is important, such that caregivers and children respect and understand each other. This was illustrated most clearly in the interviews with the highly synchronous pairs of caregivers and children. Caregivers showed that they were empathetic and understanding of their children's problems and past traumas, while also having optimistic views

of their child's progress. Additionally, children and caregivers in this group emphasized the importance of open communication with each other that helped build resilience for the child, and possibly for the caregiver as well. This was also evident in the discrepant dyads, one of which included a caregiver who said her son had few resilience characteristics but also said that her son was "pushed aside from birth to 5" indicating a connection between early attachment problems in the caregiver-child relationship and difficulties perceiving resilience characteristics later in development.

Community-Level Resilience. The lowest type of resilience as rated by children and caregivers was community level resilience. While this is not to say that community-level resilience is not important, there were aspects of community-level resilience that children in our sample were not accessing, specifically spirituality/religiosity and community service. None of the children in our exemplary interviews said they used spirituality as a coping skill and only a couple of children said they like to help others in their communities. It is possible that these activities are more likely to be seen later in development and were not fully captured in our sample given the wide age range. This is supported by the positive correlation between grade and resilience, showing that as children are more educated, their resilience (and possibly the ways in which they are resilient) expands. Promoting the use of community resilience resources for children may therefore be a new area for clinicians to target to bring about increased overall resilience. It was also evident that only a few caregivers spoke about religiosity and none of the caregivers spoke about community service, so it is likely not a message of importance that children were hearing.

Dyadic Perspectives. By triangulating data through multiple reporters and data sources, this study provided a rich, detailed picture of the resilience experiences for a group of low-

income, urban, children and families who have survived and are recovering from past trauma. One aim of this study was to investigate what differences would be found between how caregivers and children rated and talked about children's resilience. Interestingly, the correlation between child-rated and caregiver-rated family resilience score was not significant. In general, caregivers rated children's family-level resilience higher than children rated themselves. This was not surprising given that most of the questions about family-level resilience were measuring the relationship with caregivers, and it is likely that caregivers wanted to make themselves look good based on social pressures of completing measures in front of researchers. When looking at the interviews, it was the caregivers who seemed to be less aware of children's coping skills that were having the most challenges at home and the most negative caregiver-child interactions (Child > Caregiver group). It was not that children were over-inflating their views of themselves, it was that caregivers were rating their resilience scores far below the mean and not talking about children's coping skills in interviews.

When looking more closely at these dyads, there were a number of examples of caregivers talking much more about children's stressors or challenges and far less about their coping skills or strengths. Even when caregivers were specifically asked about coping skills or were pressed on the issue, they would talk about coping or strengths in a negative way, either saying that their child used to have a coping skill and they don't have it any more, or their strength had somehow become a weakness. This is problematic for children's ability to build resilience in the future because they do not have the support or encouragement form their caregivers to bolster these skills. Many of the caregivers in this group talked about different ways they felt unsupported, which may prevent them from seeing the good in their child. Therefore,

helping to support caregivers in various ways (child care, finances, emotional support) will also help them to support their children.

In the Caregiver > Child group, caregivers spoke very positively about their children while their children had negative views of themselves. These pairs were in agreement about different stressors or traumatic events, and many of these traumas impacted the caregivers as well. Based on caregiver and child report, it appeared as though children were handling their traumas better than their caregivers, and caregivers could see this. While much of this behavior was very mature on the part of the child, there were some pairs where the child was parentified, such as a child who reported her caregivers for illegal drug use. While it is good that caregivers in this group are optimistic and encouraging of their children and their children's strengths, it is important to also help bolster children's self-esteem to help them build more resilience in the future.

Based on these findings, it appeared that the most positive outcomes occurred for both children and caregivers when they were on the same page, such as in the Highly Synchronous group. While experiencing the death of a family member was not a unique experience to this group, it was a typical experience for caregivers and children in the Highly Synchronous group. It is possible that experiencing family-level stressors such as the death of a family member or caregiver contributed to the synchronicity between children and caregivers as they are both experiencing the same traumatic event.

Treatment. In-home therapy (IHT) was an important context for this study because it is the most commonly used form of treatment for low-income families with trauma histories. In general, families in our study were very happy with IHT and spoke very highly of the clinicians that they worked with. The majority of the families in our exemplary pairs said that IHT was

helpful specifically due to the clinicians and the relationship between clinicians and children. This finding is important for the success of IHT given that there is no set modality of therapy used, but clinicians and community mental health organizations can first focus on the clinician-family relationship as a crucial step to treatment success. Many of the families also talked about techniques or concrete aspects of treatment that were helpful for the child or family. This included things such as giving the child a coping tool, doing family games or activities, or making a behavior chart for the child. The results of these techniques can be seen in the vast number of individual-level coping skills for most of the children in this study. The idea of "coping skills" was very familiar to families and every single family in the exemplary pairs talked about different solo or sedentary activities the children did to cope with stress, many of which were encouraged or developed by their IHT clinicians.

Many families spoke about the importance of the child-caregiver relationship and how this was bolstered by IHT. Most of the dyads in the Highly Synchronous group said that there was improved child-caregiver communication during and after therapy. Additionally, talking with caregivers was a typical coping skill for children in all three groups of interviews, showing that this was a coping skill that either already existed or improved with therapy. The one group of families that had negative experiences with therapy was the only group to not talk about improved child-caregiver communication.

Limitations. One limitation of this study is that while the study was conducted using IHT as a context, it was not treatment study. Therefore, while many of the families had positive feedback about IHT, it is not possible to say whether or not families would have had a similar outcome if they received a different type of treatment. Additionally, while it was made clear to families that the answers to the questions would not impact their relationship with the

community mental health organization, it is possible that families were less likely to share negative experiences with therapy given that the researchers were affiliated with the IHT organizations. That being said, interviewing the families at home appeared to put families at ease and most caregivers and children appeared very forthcoming with the researchers. There may have also been selection bias such that the families that had positive experiences with IHT were more likely to participate in the study and choose to complete the interview questions.

Although conducting this research with an IHT sample was important for the aims of this study, one limitation is that results may not be generalizable to a population of all youth who have experienced trauma. Additionally, school contexts were not specifically asked about in the qualitative interviews and any mention of school by children or caregivers was unprompted. While many children talked about school as stressful, there were no direct questions on how school might help foster resilience. Given that grade was positively correlated with resilience, interviewing children in the school context or interviewing children in older grades could facilitate children's ability to talk about resilience and coping.

Future Directions. Future research could use the structure of this study to conduct similar research comparing school-based and community-based therapy. It is likely that there is much to be learned from exploring resilience characteristics in the school setting and asking teachers for their perspectives on children's resilience would help to better understand the community-level of resilience. Future research could also compare IHT with clinic-based treatment or more individualized treatment, or compare approaches used within IHT (such as manualized vs. unstructured). To gain a better understanding of resilience, future research should also use a longitudinal design to explore resilience characteristics before and after treatment.

Clinicians could use the child and caregiver-rated resilience measures as a way to quickly and easily determine resilience characteristics and synchronicity between children and caregivers. Using the findings from this study, differences in resilience scores would lead the clinician to intervene within the child-caregiver relationship in different ways, depending on the differences in scores.

One positive finding of the interviews was that when asked to give advice to children, most of the caregivers and children said it was important for children to talk to others and express their feelings. While there is still stigma about mental health issues and therapy, it is encouraging to hear so many families talk about sharing feelings and seeking help and is further evidence for their success with therapy. One way to improve IHT and similar family-based interventions would be to focus on the support and coping of caregivers. When compared with children's coping skills, many caregivers could only name one or two ways in which they cope with stress, or couldn't name any at all. For those who did name coping skills, many of them were activities that were easy for caregiver and didn't cost money (taking care of basic needs, going for a walk, taking time to themselves). Helping caregivers to develop coping skills and helping children recognize that their caregivers need time and space to cope with stress would be essential to helping children and families and also help support families after therapy is over. Based on our findings, continuing to support the caregiver-child relationship including trust, mutual understanding, and communication would be key to future success of therapy. Helping children, especially those with trauma histories, feel heard and understood is crucial to building resilience and future success.

CHAPTER FOUR

Discussion

Resilience research is a burgeoning field that has continued to grow in the past five to ten years. While there is recognition in the field that studying childhood resilience is important, there have been varying degrees to which this topic has been approached in research. For this dissertation, Study 1 took an overarching view of resilience in refugee children while Study 2 used a more in-depth, mixed methods approach to study resilience for a specific group of children with trauma histories. Both studies looked at resilience at multiple levels, incorporating resilience characteristics of children themselves (individual-level), their families (family-level), and their greater communities and societies (community-level, school-level, etc.).

Individual-Level Resilience. In regards to individual-level resilience, both studies found that self-esteem and positive identity development were important factors in children's resilience and positive adaptation. For children with refugee statuses, the development of a positive ethnic identity, self-determination, and empowerment were all important for promoting resilience. Caregivers in Study 2 described their children as strong, determined, and self-reliant. The presence of self-determination in both studies is important to consider, and indicates that a significant part of children's resilience is due to their own ability to learn how to cope and recuperate independently of others. Children in both studies also showed high levels of connectedness to what would be considered "future self" in Study 2, demonstrating the importance of a positive outlook and hope. While these characteristics were present with the children in Study 2, they may have been more pronounced in Study 1 given the older age of the children (some being young adults) and given that much of the research with refugee children has been done retrospectively, thus better enabling children to consider their past, present, and future.

Family-Level Resilience. Both studies found that resilience at the family level is essential for children's positive adaptation and growth. Study 1 found that a common resilience characteristic for refugee children from multiple ethnic groups was family connectedness while Study 2 found that mutual understanding and respect in the child-caregiver attachment relationship made significant contributions to resilience for a group of children with trauma histories. Study 2 also found that supporting child-caregiver communication and bolstering family cohesion were crucial to successful in home therapy interventions, while caregivers who did not feel supported tended to see their children as having fewer resilience characteristics. Similarly, Study 1 recommended that families and communities be involved in treatment using similar models to the in-home therapy model as well as tiered treatment approaches to support the child's entire ecological context and learn more about each child and family's specific culture.

Community-Level Resilience. Study 1 found much more evidence of community-level resilience characteristics; especially school-related support that were not as evident in Study 2. One reason for this is that therapy, not school, was the primary focus of Study 2, so any talk of school was brought up in the resilience conversation but was not inquired about directly in qualitative measures. It is also possible that since many of the children with refugee statuses were older than the children in Study 2, they saw more of the value of education as a way to help them advance and find a place for themselves. Additionally, given that the children in Study 1 had a range of familial support, with many children not living with family members, it may be that school had become a place for them to find their supportive "family." Contrastingly, it is evident from the interview data that many families from Study 2 saw their clinicians as part of their family.

Research Implications. The two studies presented in this dissertation are only the beginning to a movement in the field of resilience research toward multi-level investigation. One place for future research is to expand the community-level of Study 2 and break it down into more specific contexts (school, neighborhood, society, culture) as was done in Study 1. While school contexts were not a specific inquiry in this study, asking children and caregivers about their connection to school or support from school would be important given the capacity for school-level interventions seen in Study 1. Additionally, as technological advances in biopsychology and neuropsychology increase researchers' access to measurement tools, incorporating biological and neurological markers of resilience would add even more to the full picture of children's resilience. Given the known impact of trauma on brain development (Burke et al., 2011), understanding how children's brains change in relationship to different resilience characteristics would lend even greater support to treatments and interventions aimed at bolstering resilience.

Study 1 found that for children with refugee statuses, allowing for community and civic engagement facilitated positive adaptation and adjustment to their new countries. In Study 2, many caregivers suggested that communities listen to families and emphasized their desire to be involved in their communities. Given this evidence of desire to be involved as well as positive outcomes when children are involved, future research should strive to involve children and families as much as possible. This could look like a mixed-methods approach with caregiver and child focus groups or interviews such as those used in Study 2, or children and caregivers could be involved in study design, implementation, and dissemination, using an approach such as community-based participatory research (Ellis et al., 2007).

Clinical Implications. These two studies outline a number of places in which clinical interventions can be tailored to help build resilience in children with and without refugee statuses, many of whom have significant trauma histories. As previously stated, both studies demonstrated the importance of involving the child's micro and macrosystems in therapy, particularly families. Even when therapy does not take place at home, involving caregivers in treatment goals and planning helps to validate their perspectives and opinions, which Study 2 found helps caregivers to feel supported. For children and families with trauma histories, clinicians and mental health organizations should strive to support caregivers and families because this will lead to additional support and positive outcomes for children. As Study 2 showed, caregivers who felt supported were better able to support their children and better able to see their children's strengths and resilience characteristics. Additionally, this research showed the importance of children and caregivers being on the same page when it comes to understanding children's stressors and coping skills. Taking time in therapy for children and caregivers to talk with each other will help to improve the child-caregiver relationship and enhance resilience characteristics.

In addition to supporting caregivers, the importance of the clinician-child relationship and therapeutic alliance was highlighted in Study 1 with research by Briere & Scott (2013) and supported with interview data in Study 2. The majority of the exemplary families in Study 2 said that the child-clinician relationship was one of the most important and most helpful parts of therapy. Even caregivers in Study 2 who felt that therapy was not successful overall had positive things to say about their clinicians, including that they were supportive of the child and caregiver and helped their child open up. This is especially important for the families in Study 2, knowing that many children and caregivers felt distrustful of other people or described themselves as

keeping to themselves and not opening up to others, yet were able to make positive connections with their clinicians. Many families in Study 2 also shared examples of clinicians who went above and beyond their role as clinicians: being on call via phone at all times, bringing food or clothes to the family, and advocating for the child in other domains such as at school or with legal issues. While these roles are outside of the scope of many clinicians in the community, knowing this information is important to help recognize clinicians' sacrifices and encourage community mental health centers and clinics to continue to support these clinicians both emotionally and financially, as they are committed to doing very intense and taxing therapeutic work.

Clinicians working with children and families can also use the results of these studies to inform how to ask about resilience characteristics (either directly or indirectly) and to tailor treatment to the different resilience characteristics of each child and family. These studies can also help clinicians with outside consultation, for example if a family uses spirituality or faith as a basis for their resilience, then a clinician can consult with religious leaders to help inform treatment.

Community Implications. Given that Study 2 took place in the context of community mental health, there are number of ways in which community centers and community mental health organizations can help lift up families and entire communities. Making their presence known in communities, particularly low-income or low-resource communities, will help families know where to go when they feel like they need help and may make families feel more comfortable seeking out mental health care. In Study 2, many caregivers suggested that communities have more local and affordable activities for children, including mental health care. Seeing that families have the desire for these resources in their communities provides evidence to

support the development of these programs in low-income communities. Study 1 also showed the positive outcomes of using tiered approaches as ways to help more members of a community as well as save money by helping families proactively, instead of retroactively. In the case of both studies, community mental health centers are often the first or second line of help and intervention, but may vary in expertise in trauma-informed or culturally competent care, especially when working with refugee groups that may be new to a country. These studies lend further evidence of the importance of community mental health organizations. Communities and local governments who are looking to support families in need should increase the support provided to community mental health centers to help improve the level and reach of care.

Knowing a child's resilience characteristics also has important implications for their educational growth. As Study 1 demonstrated, school is an important context for children's resilience building. Results from these studies can help teachers understand what their students may be going through after experiencing stressors or trauma and help them to see how a child may be resilient in some areas of their life but not in all areas of their life. If a child is struggling at school, teachers can use some of the methods used in these two studies to better understand how best to support their students who may have trauma histories.

Policy Implications. These two studies come at a crucial time in informing mental health and immigration policy in the United States. The United States is currently facing an immigration crisis, with numerous children and families who are fleeing violence and persecution in their home countries caught in the crosshairs of political debate in the US. Many of these children will have similar trauma trajectories as the children in Study 1, namely pre-migration stressors such as life-threatening events, migration stressors such as separation from family members and unsafe or unstable living conditions, and post-migration stressors such as

discrimination. This research can be used to support policies that are pushing for family reunification and safer living conditions in an attempt to ameliorate the traumas that children have already experienced, especially given the importance of the caregiver-child relationships and family cohesion emphasized in both studies. Additionally, the current political rhetoric in the US against immigrant and refugee families is a dangerous message that will only continue to harm children when or if they are resettled in the US. Listening to immigrant children and families and hearing their stories of trauma and resilience, such as in these two studies, can help increase empathy, understanding, and acceptance.

Finally, it is our goal that these families' stories are shared with clinicians, researchers, and families themselves in an effort to give families that may be facing similar challenges hope. Giving more families chances, whether in therapy or through research, to share their own unique stories will help to show families that providers are listening, and that this in turn will help increase resilience of children, their families, and their communities.

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APPENDIX A

Caregiver Consent and Child Assent Forms – English and Spanish Versions

CAREGIVER PERMISSION FORM

This form describes the research study you and your child are being asked to help with. This form includes all of the information about the study. Please take as long as you want to decide if you want to be a part of the study. You can ask any questions at any time about the study. If you want you and your child to help with the study, you will be asked to sign this form. A copy of this form will be given to you for you to keep.

Multilevel resilience characteristics of children with trauma histories: What can be gained and what is missing from in-home interventions?

PURPOSE OF STUDY:
You and your child are being asked to help with a research study. The purpose of this study is to learn more about your strengths and coping skills after finishing in-home therapy. You and your child are asked to help because you have received in-home therapy and have a trauma history.

RESEARCH PROCEDURES:

- Your child will be asked to answer three sets of questions that will take about 30 minutes to complete. A researcher will help children answer questions if they want help. Questions will be about your child's strengths, things they are good at, and their relationships with others.
- You will be asked to answer two sets of questions: one about your child's strengths and one about your child's trauma history. These will take about 15 minutes to complete.
- After you and your child complete the forms, we also have an interview for you and your child about your strengths and coping skills. Interviews will take place separately and each will take about 30 minutes.

You and your child will answer questions in separate rooms in any quiet space. The meetings for the forms and interview will be audio recorded. To keep information private, your name and your child's name will not be matched to any audio recordings or forms completed.

RISKS AND/OR DISCOMFORTS:
You and your child may feel uncomfortable when talking about trauma and therapy. To help decrease these risks, we will focus on your family's strengths and what has helped you feel better. You or your child can take a break at any time and move onto something else.

BENEFITS:
We do not expect you to directly benefit from the study. However, you will be helping your communities and other families like yours by learning more about the strengths of your family and helping other families with similar challenges.

ALTERNATIVES:
You can choose to not participate in the study or stop at any time without any negative consequences for you and your child.

PRIVACY AND CONFIDENTIALITY:
Your child's privacy will be kept safe by always meeting in a private space with only the researcher and the caregiver nearby.

All information collected will be kept private by the lead researchers, Amy Marks and Kerrie Pieloch. You and your child's names will not be matched to your forms or interviews. All forms and audiotapes will have a code instead of a name. All records are kept in a locked room and only the leader researcher will have access to these records. Any information gathered from records will be deidentified with a code. Coded records will be kept in a locked room at Suffolk University in a locked drawer. Only the lead researchers and small research team (3-5 people) will have access to the records. Records will be kept for three years and after three years they will be destroyed.

Specific information about you and your child gathered during this study will not be shared with anyone at the clinic outside of the lead researcher, Kerrie Pieloch.

As required by Massachusetts state law, the lead researchers will break confidentiality if there is concern to believe a child (under the age of 18) is being abused or neglected and report this to the Department of Children and Families.

COMPENSATION:
As a thank you for helping with this study, your family will be given a $20 Visa gift card for completing the question forms and a $20 Visa gift card for completing the interview.

VOLUNTARY NATURE OF PARTICIPATION/ RIGHT TO WITHDRAW:
Participating in this research is voluntary. You and your child have the right to refuse to participate. If you decide to participate, you may withdraw your consent at any time and any information collected from you will be destroyed. Your withdrawal will not result in any penalty or loss of benefits and/or services that you might be entitled to receive and will not affect your relationship with your care team or with your community mental health clinic. The lead researcher may also determine that it is in your best interest to discontinue your participation at any time.

CONTACT INFORMATION:
If you have any questions about this study, you may contact Kerrie Pieloch at 617-545-4728 or kapieloch@suffolk.edu or Amy Marks at 617-573-8017 or akmarks@suffolk.edu.
If you have questions about your child's rights in this research study, you may contact Suffolk University's Institutional Review Board at (617) 557-2006 or irb@suffolk.edu.

CAREGIVER PERMISSION:
I have read the information in this form including the risks and benefits about the study. All of my questions about this study have been answered and I have had time to think about whether or not to allow my child to help with the study. I understand I am allowed to receive a copy of this form to keep.

Please initial all that you agree to:

_____ **I give my permission for myself and my child to help with this study.**

_____ I agree to having this study audio-taped and transcribed.

_____ I agree to the use of the written transcript in presentations and papers.

_____ _____ _____

Caregiver's Signature	Printed Name of Caregiver	Date
_____	_____	_____
Custodian's Signature (if applicable)	Printed Name of Custodian	Date
_____	_____	_____
Signature of Person Obtaining Consent	Printed Name of Person Obtaining Consent	Date

FORMA DE PERMISO DEL CUIDADOR

Este formulario describe el estudio en el cual pedimos que participes tu y tu hijo/a. Este formulario incluye todo la información del estudio. Por favor tomen su tiempo en decidiendo si quieres ser parte del estudio. Puedes hacer preguntas a cualquier hora acerca del estudio. Si quieres que tu y tu hijo/a participen en este estudio, té pediremos que firmes este formulario. Te daremos una copia de este formulario para que usted pueda mantener.

Características de resistencia multi nivel de niños con historia de trauma: Que es lo que se puede ganar y que se hace falta de intervenciones desde casa?

PROPOSITO DEL ESTUDIO:
Te pedimos a tu y tu hijo/a que participen en este estudio de investigación. El propósito de este estudio es aprender más acerca de sus fortalezas y habilidades de afrontamiento después de terminar la terapia en el hogar. Te pedimos a tu y tu hijo a ayudarnos porque han recibido terapia en el hogar y tienen una historia de trauma.

PROCEDIMIENTOS INVESTIGATORIOS

- Le pediremos a tu hijo que conteste tres formularios de preguntas que le tomará acerca de 30 minutos para completar. Un investigador estará disponible para ayudar a los niños contestar preguntas si quieren ayuda. Las preguntas serán relacionadas a fortalezas, cosas que eres buenas en y sus relaciones con los demás.
- Te pediremos que contestes dos formularios: uno acerca de las fortalezas de tu hijo y uno acerca de el historial de trauma de tu hijo. Este formulario le tomara acerca de 15 minutos.
- Después que tu y tu hijo completen los formularios, también tenemos una entrevista para ti y tu hijo acerca de tus fortalezas y tus habilidades de afrontamiento Las entrevistas serán separados y cada uno tomara acerca de 30 minutos.

Tu y tu hijo contestarán preguntas en cuartos separados en cualquier lugar callado. Las reuniones para los formularios y las entrevistas serán grabadas en audio. Para mantener la información privada, tu nombre y el nombre de tu hijo no serán asociadas con las grabaciones de audio o los formularios completados.

RIESGOS Y/O DISCONFORMES:
Tu y tu hijo se pueden sentir incomodo hablando de trauma o terapia. Para tratar de reducir estos riesgos, enfocaremos en las fortalezas de tu familia y que les ha ayudado a sentirse mejor. Tu y tu hijo pueden tomar un receso en cualquier momento y continuar en lo siguiente.

BENEFICIOS:

No esperamos que este estudio te beneficié directamente. Pero, vas a ayudar a tus comunidades y otras familias como la tuya con el aprendizaje acerca de las fortalezas de tu familia y ayudando a otras familia con desafíos similares.

ALTERNATIVAS:
Puedes decidir no participar en el estudio o para en cualquier momento sin ninguna consecuencia negativa para ti y tu hijo.

PRIVACIDAD Y CONFIDENCIALIDAD:

La privacidad de tu hijo se mantendrá seguro por reuniones hechas en lugares privadas con solo el investigador y el cuidador acerca.

Toda la información se mantendrá privado por los investigadores principales, Amy Marks y Kerrie Pieloch. Tu nombre y el de tu hijo no será asociada con tus formularios o entrevistas. Todas los formularios y grabaciones tendrán un condigo en vez de un nombre. Todo los archivos se mantienen en un cuarto con llave y solo el investigador principal tendrá acceso a estos archivos. Cualquier información colectados de los archivos serán identificados con un código. Archivos con código se mantendrán en un cuarto con llave en la universidad de Suffolk en un cajón con llave. Nada mas los investigadores principales y pequeño equipo (3-5 gente) tendrán acceso a los archivos. Archivos se guardaran por tres años h después de tres años serán destruidos.

La información específica sobre usted y su hijo colectado durante este estudio no será compartida con nadie en la clínica fuera de la investigadora principal, Kerrie Pieloch.

Según lo requerido por la ley estatal de Massachusetts, los investigadores principales romperán la confidencialidad si existe la preocupación de creer que un niño (menor de 18 años) está siendo abusado o descuidado e informar este información al Departamento de Niños y Familias.

COMPENSACION:
Como forma de agradecimiento por ayudar en el estudio te daremos a tu familia una tarjeta pre-pagada de $20 por completar el formulario corto y una tarjeta pre-pagada de $20 por completar el formulario más elaborada.

PARTICIPACION VOLUNTARIO/ DERECHO A RETIRAR:
Participar en este estudio es completamente voluntario. Tu y tu hijo tienen el derecho de rechazar a participar. Si decides participar, puedes retirar tu decisión de consentimiento a cualquier momento y todo la información colectada será destruido. Su retiro no resultará en ninguna penalidad o pérdida de beneficios y/o servicios que usted pudiera tener derecho a recibir y no afectará su relación con su equipo de atención médica o con su clínica comunitaria de salud mental. El investigador principal también puede determinar que está en su mejor interés interrumpir su participación en cualquier momento.

INFORMACION DE CONTACTO:
Estamos feliz de contestar cualquier pregunta que tengas ahora o mas tarde. Solo contacta a Kerrie Pieloch a 617-545-4728 o kapieloch@suffolk.edu o a Amy Marks a 617-573-8017 o akmarks@suffolk.edu.

Si tienes preguntas sobre los derechos de tu hijo puedes llamar al cámara institucional de reviso (Institutional Review Board o IRB) de la universidad de Suffolk. Puedes llamar o mandar correo electrónico a (617) 557-2006 o irb@suffolk.edu.

CONSENTIMIENTO DEL CUIDADOR:
He leído la información en esta forma incluyendo los riesgos y beneficios sobre el estudio. Todas mis preguntas sobre este estudio han sido contestadas y he tenido tiempo de pensar si permitir o no a mi hijo (a) para ayudar con el estudio. Entiendo que se me permite recibir una copia de este formulario para mantenerlo.

Por favor marque todo lo que usted acepta:

_____ **Doy mi permiso para que yo y mi hijo/a ayudemos en este estudio.**

_____ Estoy de acuerdo en que este estudio sea grabado y transcrito.

_____ Estoy de acuerdo con el uso de la transcripción escrita en presentaciones y documentos.

_____	_____	_____
Firma de el Cuidador	Nombre de el Cuidador	Fecha
_____	_____	_____
Firma de el Guardián (si aplicable)	Nombre de el Guardián	Fecha

_____	_____
Firma de la persona obteniendo consentimiento	Fecha

_____
Nombre de la persona obteniendo consentimiento

CHILDASSENT FORM
10-12 years old

Hi! My name is Kerrie. We are doing a research study about your strengths and the things you are good at. A research study is a way to learn more about people and how they think or behave. It is like an experiment.

We are asking you to be in this study because you and your family participated in in-home therapy. If you decide take part in our study, you will be asked to answer some short questions and some longer interview questions. Each set of questions will take about 30 minutes.

Some of these steps may make your tired or sad when we talk about some bad things that have happened to your in the past.

We think this study may benefit you. A benefit is when something good happens to you. We think the benefit(s) might be learning more about yourself and your family members. We may learn something that will help other children that have also had bad things happen to them.

It is your choice to take part in this study. You do not have to be in this research study if you do not want to. If you choose not to, you will not get in trouble in any way. You can say yes now and change your mind later. You can even decide to stop participating once you have started, without getting in trouble. You can also skip any questions that make feel uncomfortable or weird. No one will be mad at you. Even if your caregiver (Mom, Dad, another guardian) says you can participate, you can still say no.

To thank you for helping with the study we will give your family a $20 Visa gift card for completing the short question forms and a $20 Visa gift card for completing the longer interview questions.

All the information you share with us will be kept in a safe place. If we write a report about what we learned, we will not use your name. This way no one will know you were in the study. If you tell us about someone in danger, someone who may be getting hurt or someone who might get hurt in the future, we might have to tell other adults so that we can keep that person safe.

We are happy to answer all the questions you have. Even if you do not have any questions now but have some later, you can still ask them. Just contact Kerrie Pieloch at 617-545-4728 or kapieloch@suffolk.edu or Amy Marks at 617-573-8017 or akmarks@suffok.edu.

If you have questions about what it means to be part of a research study, you can call (888) 634-4387.
If you sign your name below, it means you agree to take part in this research study.

_____	_____
Sign your name here	Date
_____	_____
Signature of Person Obtaining Assent	Date

FORMA DE CONSENTIMIENTO PARA NIÑOS
10-12 años

¡Hola! Mi nombre es Kerrie. Estamos haciendo un estudio acerca de tus fortalezas y en las cosas que eres bueno. Un estudio de investigación es una manera de aprender mas sobre la gente y como piensan y actúan. Es como un experimento.

Te pedimos que partícipes en este estudio porque usted y su familia participaron en terapia en el hogar. Si decides ser parte del estudio, te pediríamos a contestar unas preguntas cortas y unas más elaboradas. Cada cuestionario tomará alrededor de 30 minutos.

Cierta pasos te podrían hacerte sentir cansado o triste cuando hablemos acerca de ciertas cosas malas que has vivido en el pasado.

Pensamos que este estudio te sea de beneficio. Un beneficio es cuando algo bueno te pasa a ti. Pensamos que unos de los muchos beneficios serán aprender mas sobre ti mismo y sobre tus familiares. Tal vez aprendemos cosas que ayudará a otros niños que también han vivido cosas malas.

Es tu decisión ser parte de este estudio. No tienes que ser parte de este estudio de investigación si no lo deseas. Si decides no hacerlo, no abra ningún problema. Puedes decir si ahorita y cambiar de decisión

después. También puedes decidir parar aunque hemos empezado, sin ningún problema. También puedes ignorar preguntas que te incomodan o te hacen sentir raro. Nadie se va enojar. Aun si tu guardián (Mama, Papa, otro guardián) dice que puedes participar, tu puedes decir que no.

Como forma de agradecimiento por ayudar en el estudio te daremos a tu familia una tarjeta pre-pagada de $20 por completar el formulario corto y una tarjeta pre-pagada de $20 por completar el formulario más elaborada.

Todo la información que compartas con nosotros se quedará en un lugar seguro. Si escribimos un reporte sobre lo que aprendimos, no usaremos tu nombre. De esta manera nadie sabrá que participaste en este estudio. Si nos cuentas de alguien en peligro, alguien que pueda ser lastimado ahora o en el futuro, tal vez tengamos que decirle a otros adultos para mantener esa persona segura.

Estamos feliz de contestar cualquier pregunta que tengas. Si no tienes preguntas ahora pero las tienes después, todavía puedes preguntarlas. Solo contacta a Kerrie Pieloch a 617-545-4728 o kapieloch@suffolk.edu o a Amy Marks a 617-573-8017 o akmarks@suffolk.edu. Si tienes preguntas sobre que es ser parte de un estudio de investigación, puedes llamar a (888) 634-4387.

Si firmas tu nombre abajo, significa que aceptas ser parte en este estudio de investigación.

_____	_____
Firma su nombre aquí	Fecha
_____	_____
Firma de la persona obteniendo consentimiento	Fecha

CHILD ASSENT FORM
13 -17 years old

Hi! My name is Kerrie. We are doing a research study about children's strengths and things they are good at. This form describes the study we are asking you to participate in. Please read it carefully. When you are finished you should know what the research study is about, what you will be asked to do and what are the likely risks and benefits. If you agree to participate, you will be asked to sign this form. A copy of the form will be given to you.

Multilevel resilience characteristics of children with trauma histories: What can be gained and what is missing from in-home interventions?

PURPOSE OF STUDY:
We want to learn more about what you are good at. A research study is a way for scientists to learn more about people and their behaviors. In order to do this, scientists need volunteers to participate in their research. You are being asked to volunteer because you and your caregiver participated in in-home therapy.

RESEARCH PROCEDURES:
If you want to participate, you will be asked to answer short questions about your strengths and about different relationships in your life and answer longer questions about your strengths and your family's strengths. Each set of questions will take about 30 minutes.

RISKS AND/OR DISCOMFORTS:
It is possible that some parts of the study may make you feel uncomfortable or sad when we ask about how you have coped with the challenges in your life.

BENEFITS:
We think this study may benefit you. A benefit is when something good happens to you as a result of your participation. We think these benefits might be learning about your own personal strengths and the strengths of your family members. We may also learn something that will help other children who have had problems similar to yours some day.

ALTERNATIVES:
You have the option of not participating in the study. If you do not want to participate, please let Kerrie know at any time.

PRIVACY AND CONFIDENTIALITY:
The information that is collected in this research study will be kept private and confidential. This means that we will do our best to not let anyone see or hear the information you give to us while you participate or after. We will protect your information by using a special code on your forms and interview so that it cannot be matched with your name. The information that you share with us will not be shared with anyone at your community mental health clinic or on your care team. If you tell us about someone in danger, someone who may be getting hurt or someone who might get hurt in the future, we might have to tell other adults so that we can keep that person safe.

COMPENSATION:
To thank you for helping with the study we will give your family a $20 Visa gift card for completing the short question forms and a $20 Visa gift card for completing the longer interview questions.

RIGHT TO WITHDRAW:
It is your choice to take part in this study. You do not have to be in this research study if you do not want to. If you choose not to, you will not get in trouble in any way. You can say yes now and change your mind later. You can even decide to stop participating once you have started, without getting in trouble. You can also skip any questions that make feel uncomfortable or weird. No one will be mad at you. Even if your caregiver (Mom, Dad, another guardian) gives permission for you to participate, you can still say no. If we think it is best for you not to be in the research study, we may take you out of the study.

CONTACT INFORMATION:
We are happy to answer any questions you have about the study now or later. If you want to contact the researchers you may call Kerrie Pieloch at 617-545-4728 or email kapieloch@suffolk.edu or call Amy Marks at 617-573-8017 or email akmarks@suffok.edu.

If you have any questions about your rights as a volunteer in this research study, you can call Suffolk University's Institutional Review Board. The IRB is a group of people who ensure the rights and welfare of research participants are protected. You can call or email them at (617) 557-2006 or irb@suffolk.edu.

PARTICIPANT CONSENT:
You can take your time in deciding if you want to participate. If you sign below it means you agree to participate. It also means that you have read this document, understand what it means and the researchers have answered all of your questions.

_____ _____ _____

Signature of Participant Date Printed Name of Participant

_____ _____
Signature of Person Obtaining Assent Date

_____
Printed Name of Person Obtaining Assent

FORMA DE CONSENTIMIENTO PARA NIÑOS: 13+ años

¡Hola! Mi nombre es Kerrie. Estamos haciendo un estudio acera de tus fortalezas y en las cosas que eres bueno. Esta formulario describe el estudio en el que pedimos tu participación. Por favor léalo detalladamente. Cuando termines debes saber de que es el estudio, que te preguntaremos y cuales son los riesgos y beneficios. Si decides participar, te pedimos que firmes este formulario. Recibirás una copia de este formulario.

Características de resistencia multi nivel de niños con historia de trauma: Que es lo que se puede ganar y que se hace falta de intervenciones desde casa?

PROPOSITO DEL ESTUDIO:
Queremos aprender mas acerca de las cosas en lo que eres bueno. Un estudio de investigación es una manera de aprender mas sobre la gente y como piensan y actúan. De manera para hacer esto, científicos necesitan voluntarios que participen en la investigación. Te pedimos que partícipes en este estudio porque usted y su familia participaron en terapia en el hogar.

PROCEDIMIENTOS INVESTIGATORIOS:
Si decides participar, te pediríamos contestar unas preguntas acerca de tus fortalezas y diferentes relaciones en tu vida y contestar preguntas mas elaboradas acerca de tus fortalezas y las fortalezas de tu familia. Cada cuestionario tomará alrededor de 30 minutos.

RIESGOS Y/O DISCONFORMES:
Es posible que ciertos pasos te podrían hacerte sentir incómodo o triste cuando preguntamos acerca de como has adaptado con los retos en tu vida.

BENEFICIOS:
Pensamos que este estudio te sea de beneficio. Un beneficio es cuando algo bueno te pasa a ti como resultado de tu participación. Pensamos que unos de los muchos beneficios serán aprender mas sobre las fortalezas de ti mismo y de tu familia. Tal vez aprendamos cosas que ayudaran a otros niños que han tenido problemas similares a los tuyos.

ALTERNATIVAS:
Tienes la opción de no participar en el estudio. Si no quieres participar, por favor déjeles saber a Kerrie a cualquier hora.

PRIVACIDAD Y CONFIDENCIALIDAD:

La información que sesta colectada en este estudio de investigación se mantendrá privada y confidencial. Esto significa que haremos todo lo posible para no permitir que nadie vea o escuche la información que nos das mientras participes o después. Protegeremos su información usando un código especial en sus formularios y entrevista para que no pueda coincidir con su nombre. La información que compartes con nosotros no se compartirá con nadie en su clínica comunitaria de salud mental o con su equipo de atención. Si nos habla de alguien en peligro, alguien que puede estar sufriendo heridas o alguien que podría resultar herido en el futuro, quizás tengamos que decirle a otros adultos para que podamos mantener a esa persona seguro.

COMPENSACION:
Como forma de agradecimiento por ayudar en el estudio te daremos a tu familia una tarjeta pre-pagada de $20 por completar el formulario corto y una tarjeta pre-pagada de $20 por completar el formulario más elaborada.

DERECHO A RETIRAR:
Es tu decisión ser parte de este estudio. No tienes que participar si no lo deseas. Si decides no participar, no habrá ningún problema. Puedes decir si ahora y cambiar tu decisión mas adelante. Y puedes decidir parar de participar después de haber empezado sin ningún problema. También puedes pasar sin contestar preguntas que te hagan sentir incómodo o raro. Nadie se enojarán contigo. Aun si tu cuidador (Mama, Papa, u otro guardián) te da permiso, todavía puedes decir que no. Si pensamos que es mejor que no hagas el estudio, tal vez te saquemos de el.

INFORMACION DE CONTACTO:
Estamos feliz de contestar cualquier pregunta que tengas ahora o mas tarde. Solo contacta a Kerrie Pieloch a 617-545-4728 o kapieloch@suffolk.edu o a Amy Marks a 617-573-8017 o akmarks@suffolk.edu.

Si tienes preguntas sobre tus derechos como voluntario en este estudio, puedes llamar al cámara institucional de reviso (Institutional Review Board o IRB) de la universidad de Suffolk. El IRB es un grupo de gente que se aseguran de los derechos y que el bien estar de los participantes estén protegidos. Puedes llamar o mandar correo electrónico a (617) 557-2006 o irb@suffolk.edu.

CONSENTIMIENTO DE EL PARTICIPANTE:
Te puedes tomar tu tiempo en decidir si quieres participar. Si firmas abajo significa que quieres participar. También significa que leíste este documento, entiendes lo que significa, y los investigadores han contestado todas tus preguntas.

_____ _____
Firma su nombre aquí Fecha

_____
Nombre de el Participante

_____ _____
Firma de la persona obteniendo consentimiento Fecha

_____
Nombre de la persona obteniendo consentimiento

APPENDIX B

Child Youth and Resilience Measure – Youth Version (CYRM-28) in English and Spanish:

With Added Demographic Questions

Child and Youth Resilience Measure (CYRM-28)
English Version

Directions:
Listed below are a number of questions about you, your family, your community, and your relationships with people. These questions are designed to help us better understand how you cope with daily life and what role the people around you play in how you deal with daily challenges.

There are no right or wrong answers.

Please complete the questions below:

1. How old are you? _____
2. What is your sex? _____
3. What grade are you in now? _____
4. Who do you live with? _____
5. How long have you lived with these people? _____
6. How many times have you moved homes in the past 5 years? _____
7. Please describe who you consider to be your family (for example, 1 or 2 biological parents, siblings, friends on the street, a foster family, an adopted family, etc.)
   _____
   _____
   _____
8. People are often described as belonging to a particular racial or ethnic group. How would you describe your race or ethnicity?
   _____
   _____
   _____

To what extent do the sentences below describe you? Circle one answer for each statement.

	Not at All	A Little	Some -what	Quite a Bit	A Lot
1. I have people I look up to	1	2	3	4	5
2. I cooperate with people around me	1	2	3	4	5
3. Getting an education is important to me	1	2	3	4	5
4. I know how to behave in different social situations	1	2	3	4	5
5. My parent(s)/caregiver(s) watch me closely	1	2	3	4	5
6. My parent(s)/caregiver(s) know a lot about me	1	2	3	4	5
7. If I am hungry, there is enough to eat	1	2	3	4	5
8. I try to finish what I start	1	2	3	4	5
9. Spiritual beliefs are a source of strength for me	1	2	3	4	5
10. I am proud of my ethnic background	1	2	3	4	5
11. People think that I am fun to be with	1	2	3	4	5
12. I talk to my family/caregiver(s) about how I feel	1	2	3	4	5
13. I am able to solve problems without harming myself or others (for example by using drugs and/or being violent)	1	2	3	4	5
14. I feel supported by my friends	1	2	3	4	5
15. I know where to go in my community to get help	1	2	3	4	5
16. I feel I belong at my school	1	2	3	4	5
17. My family stands by me during difficult times	1	2	3	4	5
18. My friends stand by me during difficult times	1	2	3	4	5
19. I am treated fairly in my community	1	2	3	4	5
20. I have opportunities to show others that I am becoming an adult and can act responsibly	1	2	3	4	5
21. I am aware of my own strengths	1	2	3	4	5
22. I participate in organized religious activities	1	2	3	4	5
23. I think it is important to serve my community	1	2	3	4	5
24. I feel safe when I am with my family/caregiver(s)	1	2	3	4	5
25. I have opportunities to develop skills that will be useful later in life (like job skills and skills to care for others)	1	2	3	4	5
26. I enjoy my family's/caregiver's cultural and family traditions	1	2	3	4	5
27. I enjoy my community's traditions	1	2	3	4	5
28. I am proud to be a citizen of _____ (insert country)	1	2	3	4	5

Child and Youth Resilience Measure (CYRM-28)
Spanish Version

Instrucciones:

A continuación, se enumeraran una serie de preguntas sobre ti, tu familia, tu comunidad y tus relaciones con las personas. Estas preguntas han sido diseñadas para entender mejor como nos enfrentamos a la vida y el papel (rol) que juegan las personas que están a nuestro alrededor en estos desafíos diarios.

Por favor completa las preguntas. No hay respuestas correctas o incorrectas.

1. ¿Cuántos años tienes? _____
2. Sexo: _____
3. Nivel de estudios actuales (grado en la escuela): _____
4. ¿Con quien vives? _____
5. ¿Cuánto tiempo has vivido con estas personas? _____
6. ¿Cuántas veces te has cambiado de casa en los últimos 5 años? _____
7. Por favor, describe que personas consideras que son tu familia. (Por ejemplo: padres biológicos, hermanos, amigos de la calle, familia de acogida, familia adoptiva, etc.).
   _____
   _____
   _____
8. Las personas normalmente son descritas según el grupo étnico, cultural, o racial al que pertenecen. ¿A que grupo sientes que perteneces?
   _____
   _____
   _____

Por favor, circule el número que mejor exprese su sentir acerca de cada aseveración (ítem).

		No/ nunca	Poco	Algunas veces/algo	Si/ Siempre	Una gran cantidad
1	Tengo personas a quienes admiro	1	2	3	4	5
2	Coopero con la gente que me rodea	1	2	3	4	5
3	Obtener una educación es importante para mi	1	2	3	4	5
4	Sé cómo comportarme en distintas situaciones sociales	1	2	3	4	5
5	Mis padres o encargados/as me supervisan de cerca	1	2	3	4	5
6	Mis padres o encargados/as saben mucho acerca de mi	1	2	3	4	5
7	Si tengo hambre hay suficiente comida disponible	1	2	3	4	5
8	Me esfuerzo por terminar lo que empiezo	1	2	3	4	5
9	Mis creencias espirituales son fuente de fortaleza para mi	1	2	3	4	5
10	Me siento orgulloso (a) de mi herencia cultural	1	2	3	4	5
11	La gente piensa que soy una persona divertida con quien estar	1	2	3	4	5
12	Le hablo a mi familia acerca de cómo me siento	1	2	3	4	5
13	Puedo resolver mis problemas sin lastimarme o lastimar a otros/as (por ejemplo, usando drogas y/o siendo violento/a)	1	2	3	4	5
14	Me siento apoyado por mis amigos	1	2	3	4	5
15	Sé a dónde acudir en mi comunidad para recibir ayuda	1	2	3	4	5
16	Me siento parte de mi escuela	1	2	3	4	5
17	Mi familia me respalda en tiempos difíciles	1	2	3	4	5
18	Mis amigos/as me respaldan en tiempos difíciles	1	2	3	4	5
19	Soy tratado (a) justamente en mi comunidad	1	2	3	4	5
20	Tengo oportunidades para mostrar a otros/as que me estoy convirtiendo en un adulto y que puedo actuar de manera responsable	1	2	3	4	5
21	Conozco mis fortalezas	1	2	3	4	5
22	Participo en actividades religiosas	1	2	3	4	5
23	Pienso que es importante servir a mi comunidad	1	2	3	4	5
24	Me siento seguro (a) cuando estoy con mi familia y/o encargados	1	2	3	4	5
25	Tengo oportunidad de desarrollar habilidades que después me serán útiles en la vida (por ejemplo, habilidades de trabajo o de cuidar por otros/as)	1	2	3	4	5
26	Tengo oportunidades para desarrollar destrezas que me serán útil más tarde en mi vida (tal como destrezas de trabajo o destrezas para cuidar a otros)	1	2	3	4	5
27	Disfruto las tradiciones culturales y familiares de mi familia y/o encargado/a	1	2	3	4	5
28	Me siento orgulloso(a) de ser _____	1	2	3	4	5

APPENDIX C

Child Youth and Resilience Measure – Person Most Knowledgeable version (CYRM-PMK) in English and Spanish: With Added Demographic Questions

Person Most Knowledgeable Questionnaire

1. What is your relationship to the child? _____
2. How involved were you in the in-home therapy?
   Not at all/ A little/ Somewhat/ Quite a bit/ A lot
3. What is your zip code? _____
4. What is your highest level of education? _____
5. What is your approximate income (yearly)? _____

To what extent do the sentences below describe the youth? Circle one answer for each statement.

	Not at All	A Little	Some-what	Quite a Bit	A Lot
1. The youth has people he/she looks up to	1	2	3	4	5
2. The youth cooperates with people around him/her	1	2	3	4	5
3. Getting an education is important to the youth	1	2	3	4	5
4. The youth knows how to behave in different social situations	1	2	3	4	5
5. The youth is watched closely by his/her caregiver(s)	1	2	3	4	5
6. The youth's caregiver(s) know a lot about him/her	1	2	3	4	5
7. If the youth is hungry, there is enough to eat	1	2	3	4	5
8. The youth aims to finish what he/she starts	1	2	3	4	5
9. Spiritual beliefs are a source of strength for the youth	1	2	3	4	5
10. The youth is proud of his/her ethnic background	1	2	3	4	5
11. People think the youth is fun to be with	1	2	3	4	5
12. The youth talks to his/her caregiver(s) about how he/she feels	1	2	3	4	5
13. The youth is able to solve problems without harming him/herself or others (for example by using drugs and/or being violent)	1	2	3	4	5
14. The youth feels supported by his/her friends	1	2	3	4	5
15. The youth knows where to go in his/her community to get help	1	2	3	4	5
16. The youth feels/felt that he/she belongs/belonged at his/her school	1	2	3	4	5
17. The youth's caregiver(s) will stand by him/her during difficult times	1	2	3	4	5
18. The youth's friends stand by him/her during difficult times	1	2	3	4	5
19. The youth is treated fairly in his/her community	1	2	3	4	5
20. The youth is given opportunities to show others that he/she is becoming an adult and can act responsibly	1	2	3	4	5
21. The youth is aware of his/her own strengths	1	2	3	4	5
22. The youth participates in organized religious activities	1	2	3	4	5
23. The youth thinks it is important to serve his/her community	1	2	3	4	5
24. The youth feels safe when he/she is with his/her caregiver(s)	1	2	3	4	5
25. The youth has opportunities to develop skills that will be useful later in life (like job skills and skills to care for others)	1	2	3	4	5
26. The youth enjoys his/her caregiver's cultural and family traditions	1	2	3	4	5
27. The youth enjoys his/her community's traditions	1	2	3	4	5
28. The youth is proud to be a citizen of _____ (insert country)	1	2	3	4	5

La Persona Más Conocedora Cuestionario

1. ¿Cuál es su relación con el niño? _____
2. ¿Que tan involucrado estuvo usted en la terapia en-casa?
   Para nada/ Un poco/ Mas o menos/ Seguido/ Mucho
3. ¿Cual es su área postal? _____
4. ¿Cual es su nivel mas alto de educación? _____
5. ¿Cual es su ingreso aproximado? _____

Hasta que punto estas frases describe al joven? Por cada frase, marcar su respuesta con un circulo.

	Para Nada	**Un Poco**	**Mas o Menos**	**Seguido**	**Mucho**
1. El joven tiene personas que admira	1	2	3	4	5
2. El joven coopera con la gente que le rodea	1	2	3	4	5
3. Recibir una educación es importante para el joven	1	2	3	4	5
4. El joven sabe como comportarse en diferentes situaciones sociales	1	2	3	4	5
5. El joven es vigilado de cerca por su(s) cuidador(es)	1	2	3	4	5
6. El/Los cuidador(es) del joven sabe(n) mucho sobre él/ella	1	2	3	4	5
7. Si el joven tiene hambre, hay suficiente de comer	1	2	3	4	5
8. El joven tiene como objetivo terminar lo que empieza	1	2	3	4	5
9. Creencias espirituales son una fuente de fortaleza para el joven	1	2	3	4	5
10. El joven esta orgulloso/a de sus raíces	1	2	3	4	5
11. La gente disfruta de la compañía del joven	1	2	3	4	5
12. El joven habla con su(s) cuidador(es) de sus sentimientos	1	2	3	4	5
13. El joven puede resolver problemas sin hacerse daño o causar daño a otros (por ejemplo el uso de drogas y/o de la violencia)	1	2	3	4	5
14. El joven se siente apoyado por sus amigos/as	1	2	3	4	5
15. El joven sabe donde ir para recibir ayuda en su comunidad	1	2	3	4	5
16. El joven siente/sintió que pertenece/perteneció a su escuela	1	2	3	4	5
17. El/los guardián(es) del joven están a su lado en tiempos difíciles	1	2	3	4	5
18. Los amigos del joven están a su lado en tiempo difíciles	1	2	3	4	5
19. El joven es tratado justamente en su comunidad	1	2	3	4	5
20. El joven recibe oportunidades para demostrar a otros que se esta convirtiendo en un adulto y que puede actuar con responsabilidad	1	2	3	4	5
21. El joven esta consciente de sus fortalezas	1	2	3	4	5
22. El joven participa en actividades religiosas	1	2	3	4	5

23. El joven piensa que es importante servir su comunidad	1	2	3	4	5
24. El joven se siente seguro/a cuando esta con su/sus guardián(es)	1	2	3	4	5
25. El joven tiene oportunidades de desarrollar habilidades que serán útiles en el futuro (como habilidades para trabajar y cuidar a otros)	1	2	3	4	5
26. El joven disfruta de las tradiciones culturales y familiares de su(s) guardián(es)	1	2	3	4	5
27. El joven disfruta de las tradiciones de su comunidad	1	2	3	4	5
28. El joven es orgulloso de ser un ciudadano de _____ (escribe el país)	1	2	3	4	5

APPENDIX D

Inventory of Parent and Peer Attachment – Revised (IPPA-R): Spanish Translation

Inventory of Parent and Peer Attachment – Revised
Spanish Version

Formulario de Padres	**1 Nunca Cierto**	**2 Algunas Veces Cierto**	**3 Siempre Cierto**
1. Mis padres respetan mis sentimientos.	1	2	3
2. Mis padres son buenos padres.	1	2	3
3. Yo quisiera tener padres diferentes	1	2	3
4. Mis padres me aceptan como soy	1	2	3
5. Yo no puedo depender de mis padres para ayudarme a resolver un problema	1	2	3
6. Me gusta obtener el punto de vista de mis padres sobre cosas que me preocupan.	1	2	3
7. No me ayuda mostrar mis sentimientos cuando estoy molesto/a	1	2	3
8. Mis padres se dan cuenta cuando estoy molesto/a por algo.	1	2	3
9. Me siento tonto/a o avergonzado/a cuando hablo de mis problemas con mis padres	1	2	3
10. Mis padres esperan demasiado de mí.	1	2	3
11. Yo me pongo molesto/a fácilmente en casa.	1	2	3
12. Yo me molesto mucho mas de lo que mis padres se enteren	1	2	3
13. Cuando yo hablo con mis padres sobre cosas, ellos escuchan lo que pienso.	1	2	3
14. Mis padres escuchan mis opiniones.	1	2	3
15. Mis padres tiene sus propios problemas, así que yo no los molesto con los míos.	1	2	3
16. Mis padres me ayudan a entenderme a mi mismo/a mejor.	1	2	3
17. Yo les cuento a mis padres de mis problemas y dificultades.	1	2	3
18. Yo me siento enojado/a con mis padres.	1	2	3
19. Yo no recibo mucha atención en casa.	1	2	3
20. Mis padres soportan el hablar de mis preocupaciones.	1	2	3
21. Mis padres me entienden.	1	2	3
22. Yo no sé de quien puedo depender.	1	2	3
23. Cuando me enojo sobre algo, mis padres tratan de entender.	1	2	3
24. Yo confió en mis padres.	1	2	3
25. Mis padres no entienden mis problemas.	1	2	3

26. Yo puedo contar con mis padres cuando tengo que hablar de un problema.	1	2	3
27. Nadie me entiende.	1	2	3
28. Si mis padres saben que estoy molesto/a por algo, ellos me preguntan sobre eso.	1	2	3
Formulario de Colegas	**1 Nunca Cierto**	**2 Algunas Veces Cierto**	**3 Siempre Cierto**
1. Me gusta obtener la opinión de mis amigos sobre cosas que me preocupan.	1	2	3
2. Mis amigos se dan cuenta cuando estoy molesto/a por algo.	1	2	3
3. Cuando hablamos, mis amigos escuchan mi opinión.	1	2	3
4. Me siento tonto/a o avergonzado/a cuando hablo de mis problemas con mis amigos	1	2	3
5. Yo quisiera tener amigo/as diferentes	1	2	3
6. Mis amigos me entienden	1	2	3
7. Mis amigos soportan el hablar de mis preocupaciones	1	2	3
8. Mis amigos me aceptan como soy.	1	2	3
9. Yo siento la necesidad de estar alrededor de mis amigos con más frecuencia.	1	2	3
10. Mis amigos no entienden mis problemas.	1	2	3
11. Yo no siento que pertenezco cuando estoy con mis amigos.	1	2	3
12. Mis amigos escuchan lo que yo tengo que decir.	1	2	3
13. Mis amigos son buenos amigos.	1	2	3
14. Es bastante fácil hablar con mis amigos.	1	2	3
15. Cuando yo me enojo sobre algo, mis amigos tratan de entender.	1	2	3
16. Mis amigos me ayudan a entenderme a mi mismo/a mejor.	1	2	3
17. A mis amigos les importa como yo me siento.	1	2	3
18. Me siento enojado/a con mis amigos.	1	2	3
19. Yo puedo contar con mis amigos para escucharme cuando algo me está molestando.	1	2	3
20. Yo confió en mis amigos.	1	2	3
21. Mis amigos respetan mis sentimientos.	1	2	3
22. Yo me molesto mucho más de lo que mis amigos se enteran.	1	2	3
23. Mis amigos se molestan conmigo sin razón.	1	2	3
24. Yo les conto a mis amigos/as sobres mis problemas y dificultades.	1	2	3
25. Si mis amigos saben que estoy molesto/a sobre algo, ellos me preguntan sobre eso.	1	2	3

APPENDIX E

Child and Caregiver Interviews (in English and Spanish)

Interview for Children

[Introduction] Hi *[child's name]*. My name is Kerrie. *[This is a warm up – it can vary based on the situation/person, but should stay comparable to the following.]* Are you ready to help me learn more about you in this interview? Great! My first question I like to ask is… what is your favorite kind of dessert? Really? Mine is… I wish we had some right now! If it's OK with you, I'd like to spend some time talking about some of the wonderful ways you help yourself stay healthy and strong. These are questions I'm asking a lot of kids just like you who have had some stressful or hard times in their past, and have learned good ways to deal with them. I'm hoping that you can teach me some of your favorite ways to stay healthy and happy, so that we can teach other people what you know. But don't worry, I won't tell anyone that it was YOU who said these things – I'll just tell them it was a really smart kid I got to learn from. I'm going to ask *[caregiver]* some of these same kinds of questions when we are done, too. Are you ready?

1. OK. Everyone has stressful or very hard things happen to them in their lives. What kinds of things do you find really stressful in life? Can you tell me about a time that was really stressful or challenging for you?

2. What did you do to be healthy or help yourself after that happened?

3. When you have something difficult happen in your life, do you like to talk with other people about it? Who do you go to? *[If no, ask about barriers: "Why don't you like to talk to other people?"]*

4. When something challenging happens to you, do you have certain things you *do* – like activities, hobbies, places you can visit – that help you feel better? Please tell me about them…

5. What are your favorite ways of taking care of yourself? What do you do to take care of your mind and body?

6. Does anything ever get in your way of taking good care of yourself? *[Follow up prompts for all these questions to get more details will include "how so" and "tell me more please" depending on the conversation.]*

7. If you were going to give advice to other kids *[teenagers]* your age about how to take care of themselves when something really stressful happens, what would you tell them to do? Why would you tell them that?

8. Is there anything else you'd like to tell me about how kids in general can learn how to help take better care of themselves when they have challenges or stress?

Thank you so much for helping me with this research study, and for sharing all your wonderful advice with me. I really appreciate it!

Interview for Caregivers

[Introduction] Thank you again for agreeing to do this interview part of our study. I'd like to ask you some questions about your child's strengths and the things that help them feel better when faced with really difficult or stressful events.

1. What do you think I mean by difficult or stressful event?

2. What is an example of a time your child faced something that was really difficult or challenging?

3. Thank you. Can you now please tell me about a time when you felt like *[child's name]* managed *[his/her]* problems well – how did they do it?

4. What personal strength(s) does *[child's name]* have that have helped them with overcoming difficult events? Do they do certain activities to help? How about talking with others?

5. When you have a really difficult or stressful time, what things do you do to help yourself feel better? What are your favorite ways to stay healthy and strong? Are there particular things your friends or neighbors do that help you when things get really stressful?

6.
    a. Are there things you can think of that might get in the way of *[child's name]* being able to stay healthy and happy?
    b. How about for you?

7. A while ago, when you worked with *[Clinician's name]*, was there anything that *[Clinician's name]* did that helped *[child's name]* get better during or after treatment? What type of things did you do in treatment that were the most helpful? *[Ask about clinician traits, child traits, and therapy traits]*

8. If you could give any advice to other caregivers whose children face really challenging and stressful events in their lives, what would it be? Why? What advice would you give to the children themselves?

9.
    a. Is there anything else you can tell me about how to help families who face really challenging events live happy and healthy lives?
    b. What can communities do to help?

Thank you so much for your time!

Entrevista para Niños

Hola *[nombre del niño]*. Mi nombre es *[nombre de investigador]*. *[Esto es una practica – puede variar dependiendo la situación/persona, pero debe ser relativamente parecido en lo siguiente.]* ¿Estas listo a ayudarme aprender mas de ti en esta entrevista? ¡Excelente! La primera pregunta que me gusta hacer es... ¿cual es tu postre favorito? ¿En serio? El mío es... me encantaría tenerlo en este momento. Si esta bien contigo, me gustaría pasar un tiempo hablando de unas excelentes maneras que usas para permanecer fuerte y sano. Estas son preguntas que estoy haciendo a muchos niños como tu, quienes han pasado situaciones estresantes o difíciles en el pasado, y encontraron buenas maneras de resolver las situaciones. Espero me puedes enseñar algunas de tus maneras favoritas de estar feliz y saludable, para que podemos enseñarles a otras personas lo que tu sabes. Pero no te preocupes, no le voy a decir a nadie que fuiste TU quien dijo estas cosas – solo les diré que fue un niño bien inteligente del cual yo aprendi esto. Voy a preguntar a *[cuidador/guardián]* unas preguntas parecidas cuando terminamos, también. ¿Estas listo/a?

1. OK. Todos tenemos cosas estresantes o difíciles que nos pasan. ¿Que tipo de cosas encuentras bien estresante en tu vida? ¿Me puedes contar sobre una situacion que fue bien estresante o que fue desafiante para ti?

2. ¿Que hiciste para estar saludable o a ayudarte después de esa situación?

3. ¿Cuando occuren cosas difíciles en tu vida, te gusta hablar con otras personas sobre la situación? ¿Con quien hablas? [*Si no, pregunta acerca de los obstáculos: "¿Porque no te gusta hablar con otras personas?"]*

4. ¿Cuando algo desafiante te pasa, tienes cierta cosas que haces – como actividades, pasatiempos, lugares que puedes visitar – que te ayuden sentirte mejor? Por favor cuéntame sobre esas cosas...

5. ¿Cuales son tus maneras favoritas de cuidarte? ¿Que haces para cuidar tu cuerpo y tu mente?

6. Cuando te estas cuidando hay momentos donde ciertas cosas te meten en el camino? *[Preguntas siguiendo todas estas preguntas para obtener mas detalles van incluir "¿como así?" y "dime mas por favor" dependiendo de la conversación.]*

7. Si ibas a dar consejos a otros niños *[adolescentes]* de tu edad acerca de como cuidarse cuando algo muy estresante pasa, ¿que les recomendarías? ¿Porque les recomendarías eso?

8. ¿Hay algo mas que te gustaría compartir conmigo acerca de como los niños en general pueden aprender a cuidarse mejor cuando tiene dificultades o estrés?

Muchas gracias por ayudarme con este estudio, y por compartir tus consejos conmigo. De verdad te lo agradezco.

Entrevista para Cuidadores

Gracias otra vez por participar en esta parte del estudio, que es la entrevista. Me gustaría preguntarle acerca de las fortalezas de su niño, y las cosas que le ayudan a sentirse mejor ante situaciones dificiles or estresantes.

1. ¿A que cree usted que me refiero cuando digo situaciones dificiles o estresantes?

2. ¿Cual es un ejemplo de una situacion donde su hijo/hija enfrento a algo muy difícil o desafiante?

3. Gracias. Ahora usted me podria contar de una situacion donde usted sintio que *[nombre del niño]* enfrento a sus problemas bien – ¿como lo hizo?

4. ¿Que fortalezas tiene *[nombre del niño]* que le han ayudado a enfrentar momentos de dificultad? ¿Hace ciertas actividades que le ayudan? ¿Habla con alguien?

5. En tiempo de dificultades o estrés, ¿cuales son las cosas que usted hace para sentirse mejor? ¿Cuales son sus maneras favoritas de mantenerse fuerte y sano? ¿Hay cosas especiales que hacen sus amigos o vecinos que le ayuden en tiempo de mucho estrés?

6. ¿Piensa ustead que hay cosas que tal vez se meten en el camino de *[nombre del niño]* en su esfuerzo de mantenerse saludable y feliz? ¿Y para usted?

7. Hace un tiempo, cuando usted trabajó con *[nombre del clínico/therapista]*, ¿hubo algo que *[nombre del clínico/therapista]* hizo que ayudo a *[nombre del niño]* a mejorarse durante o después del tratamiento? ¿Que tipo de cosas hizo usted en el tratamiento que fueron mas utiles? *[Pregunta sobre características del clínico/therapista, características del niño, y características de la terapia]*

8. Si usted pudiera dar consejos a otros guardianes cuales hijos/as enfrentan situaciones difíciles y estresante en sus vidas, ¿cual seria su consejo? ¿Porque? ¿Que consejos le daría a los niños?

9. ¿Hay algo mas que me podria decir acerca de como ayudar familias que enfrenten situaciones desafiantes a vivir vidas felices y saludables? Que puede hacer la comunidad para ayudar?

¡Muchas gracias por su tiempo!