

Promoting Resilience

Relationships Are Essential

The definition of resilience has evolved over time but is now perhaps best understood as “the capacity of an individual or family (or system) to adapt successfully to challenges that threaten its function, survival or future development.”¹ Human resilience, instead of being viewed as a static trait, is best viewed as a dynamic, evolving process that develops over time and, while rooted in genetic potential, is profoundly responsive to caregiving, culture, experiences, and other environmental factors. The capacity for adaptation develops over time and is greatly influenced by the availability of supportive relationships in the environment at all stages of development, even though some innate capacities, such as cognitive abilities and persistence, promote positive adaptation. For the newborn and infant, the most immediate relationship is that with their parent or other caregiver, and the most immediate environment is their home. However, parents are also individuals, with their own resilience skills, who depend on their relationships and the environments they navigate every day. Resilience is thus complex and dynamic; it is ever-changing as we grow and develop and our environments shift and new challenges and supports arise. Familiarity with resilience promotion through the ages and stages of childhood creates a framework for so much of the work we as pediatricians do with families and children; it is the foundation of trauma-informed care because its focus is on relationships, hope, and building self-efficacy and self-regulation.

Ordinary Magic

Resilience research actually began in earnest shortly after World War II, as researchers explored why certain individuals had good outcomes despite highly traumatizing experiences. However, in their search for traits that

bestowed apparent “invulnerability” on such individuals, researchers instead discovered that resilience does not result from extraordinary traits or talents. Rather, research on early brain development, attachment, and resilience demonstrated that resilience is the typical way of things for a child when certain promotive and protective factors are in their environment. In fact, in Masten’s sentinel paper, “Ordinary Magic,”² she says that, for children, resilience develops in the give-and-take of safe, stable, and nurturing relationships that are continuous over time, beginning with the first relationship between newborn and parent immediately after birth and growing through play, exploration, and exposure to a variety of normal activities and resources. Thus, she coined the term “ordinary magic” to describe the positive power of everyday relationships and experiences on human development.

Researchers have, over decades, compiled a brief list of resilience factors that are common across cultures and countries for children, although there are nuances in how different people and cultures nurture and promote resilience.³ Fortunately for us pediatricians, they are factors that we are familiar with and promote in our practices every day (**Box 2-1**) and they overlap with those promotive and protective factors described independently by researchers in developmental psychology.^{1,6,7}

Researchers have described individual, family, and community factors associated with the development of resilience in individuals.⁴ While secure attachment to a safe, stable, nurturing caregiver is the foundation, it is important to consider other factors that can also be strengthened to improve the probability of resilient outcomes. These characteristics are summarized in **Box 2-1**.

Box 2-1. Characteristics, Conditions, and Supports That Favor Resilience^{1,4,5}

Individual characteristics

- Temperament: is easygoing, evokes positive responses from others
- Innate intelligence
- Secure attachment to safe, stable, nurturing caregiver
- Self-reliance, self-efficacy; can take positive action in own life
- Self-regulation
- Optimism, hope, faith
- Self-concept: has sense of self and of self in relation with others

Good coping skills

- Good health
- Internal motivation
- Mastery of age-salient developmental tasks

Positive family conditions

- Authoritative parenting style: supportive, warm, responsive, firm, rational, consistent
- Stimulating environment
- Safe, stable, responsive caregiver
- Maternal (caregiver) expression of positive emotion
- Family structure
- Family cohesion
- Supportive parent-child interactions
- Stable and adequate income

Effective community supports

- Early prevention and intervention programs
- Neighborhood safety
- Support services relative to needs in community
- Recreational facilities, libraries and similar programs
- Access to adequate health services
- Religious and spiritual organizations
- Effective culture
- Economic opportunities for families

THREADS

We have rearranged the individual-level resilience factors and developed the acronym **THREADS** (Figure 2-1) to represent the elements that weave together the fabric of a resilient human being.

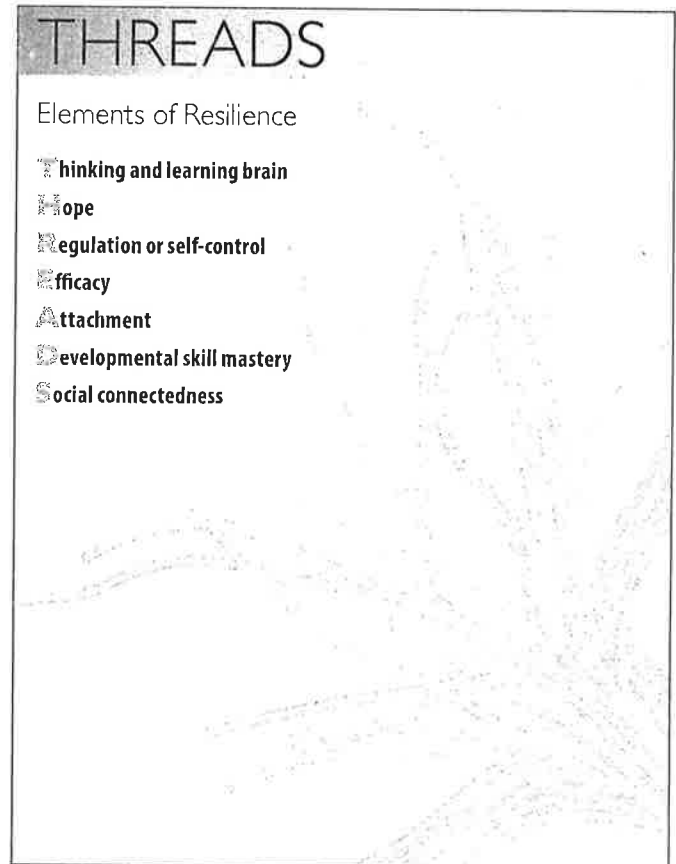


Figure 2-1. THREADS represents the elements of resilience.

Attachment: The Warp THREAD on the Loom

The fundamental underlying foundation of the resilience factors for any child is having a safe, stable, nurturing relationship with at least one caregiver who is continuous over time in their life.^{5,8-10} This is described in the literature as the child's primary attachment relationship and creates the foundation and context in which all the other resilience factors or skills emerge over time. In fact, the primary attachment relationship is so vital to healthy child development that it should be thought of as the warp thread on the loom—that is, the thread shaping and providing structure and pattern to the final product. We discuss the role of attachment relationships more fully in Chapter 3, Attachment, and consider in later chapters how we as pediatricians can support and nurture primary attachment relationships to prevent, ameliorate, and treat the impact of trauma on children and their caregivers.

Cultural Considerations

Even though the resilience factors highlighted in the THREADS acronym are common across cultures and countries, we must bear in mind that cultural variations affect their actualization. While having a safe, nurturing caregiver who is continuous over time is vital to every child, culture defines the details of how families provide that nurturance and care, their expectations for child behavior, the relative roles of primary caregivers in caring for the child, and how children are socialized to adapt to and fit into their culture. (See Chapter 5, Cultural Connections.)³ For pediatricians practicing in a multi-cultural world, it is important to partner with families to understand the meaning of parenting and attachment in their culture and lives, their strengths, and how they, in and through their culture, nurture a child's resilience.

Three Basic Questions of Resilience Research

Resilience research has been shaped over time by 3 core questions. The first is *What are the risks or challenges the individual has faced or is facing that threaten survival or well-being?* Early resilience research was focused on risk factors and identified trauma, maltreatment, neglect, poverty, war, family or neighborhood violence, hospitalization, and natural disasters as some of the major risks threatening resilience.^{11,12} The Adverse Childhood Experiences study identified cumulative intrafamilial adversities, including various forms of maltreatment and family dysfunction, that can lead to poor outcomes in a dose-dependent manner throughout the life course.^{13,14} The dose of adversities (severity, frequency, and timing) accruing in the short or long term matters. Risk factors for poor outcomes also usually occur in bundles (eg, poverty and neighborhood violence). The available buffers, or protective and promotive factors and positive childhood experiences, also matter.^{15,16}

A crucial feature of adverse childhood experiences (ACEs) is that the adversities are all intrafamilial; that is, child maltreatment, impaired caregiving, and family violence are threats occurring in the child's immediate and most important environment, their family. In this way, they are traumas occurring within the primary attachment relationship, breaching the most fundamental protective factor any child has. This type of trauma is sometimes referred to as "relational trauma" to differentiate it from other single-event or extrafamilial traumas.¹⁷ Other stressors have been found to be as impactful as the original ACEs, including felt discrimination, being

bullied, having a foster care history, and being exposed to community violence.¹⁸ Foster care history may not only be a marker for prior childhood trauma but also reflect the additional trauma of removal from family and the familiar, as well as the endemic uncertainty and further disruptions that often occur in foster care. Some populations are at higher risk of experiencing adversity and trauma (eg, those who experience discrimination because of racial/ethnic heritage, immigration status, poverty, LGBTQ identity, or foster care status), but many still have good outcomes because of adequate buffering in their home environment.^{19–24}

The second question about resilience relates to how an individual adapts to or is affected by stressors. Children's well-being is often described in terms of their developmental abilities, physical health, growth, emotional and behavioral health, academic functioning, and quality of peer relationships. For adults, other measures such as employment, educational achievement, socioeconomic status, caregiving, health behaviors, intimate relationships, and happiness are considered. Resilience, briefly, is construed as adaptive success on selected measures despite past adversities. Of course, children can be resilient in some areas of adaptive function (eg, academics) and less resilient in others (eg, social skills).¹⁷

Finally, research has focused on what factors support successful adaptation to adversities, bringing us back to the protective and promotive factors noted in the THREADS acronym. Children are not born resilient but develop resilience in the contexts of relationships and experiences. The THREADS have been shown to explain, at least in part, why some people recover and even thrive after adversities. Supportive and positive family and relational characteristics, along with community, societal, and cultural factors, are the basic adaptational mechanisms that promote the development of individual resilience.

Neurobiological processes explain how unbuffered trauma becomes biologically embedded, exerting its impact at molecular, genetic, cellular, and organ levels, ultimately leading to the body and brain symptoms we encounter in individuals. Since resilience develops over time, it must, like trauma, also become biologically embedded because of protective and promotive factors leading to healthy or typical human development.

Dose, Timing, and Genetic Potential

Five decades of research on resilience has demonstrated that the cumulative dose and types of adversities matter, and so, too, does the cumulative dose of protective and promotive factors.^{3,5,7,25-27} This finding has tremendous implications for pediatric care and public health.²⁸⁻³⁰ As pediatricians, we often meet children and their families shortly after birth (or even before) and, thus, have the opportunity to understand what parents bring to child-rearing, their risks and challenges, their burden of trauma, their strengths and resources, and their goals for their family.³¹ In the context of our relationship with parents, we have the opportunity to guide and inform, to help them build good caregiving skills, to provide insight into their child's development and behavior, and to link them to needed supports.

The timing of adversities in a child's development is crucial, since there are windows of opportunity in which brain development is more rapid and specific developmental skills emerge.^{5,16,32} This issue is explored more fully in Chapter 1, Brain Development: Early Childhood Through Adolescence. In 2012, the American Academy of Pediatrics published a landmark policy statement on toxic stress,¹⁵ which provides pediatricians with a way to think about the impact of stress and buffering by relationships. At one end of the spectrum, the authors describe milder stressors as being promotive of and even essential for learning and healthy development. However, the frequent, intensive, more prolonged traumas that occur in the absence of safe, stable, responsive caregiving are defined as being toxic because they can overwhelm a child's capacities and undermine healthy development by altering the brain circuitry supporting certain crucial skills. For example, maternal depression may lead to less responsive caregiving at a time when the brain is relying on an interactive "serve-and-return" relationship between parent and child to promote optimal development of certain neural pathways. Unless other caregivers in the environment are able to fill this need, or the mother receives appropriate treatment, the infant's inability to get their needs met stimulates a stress response that manifests initially as increased crying and irritability but that, unabated, can evolve into insecure attachment behaviors and even failure to thrive if severe enough. As pediatricians, we are developmental experts and, thus, are well positioned to identify for parents what children need at various developmental ages and stages.

For children, whose brains and immune systems are rapidly growing and developing, the environment is crucial—from the quality of caregiving to the stressors affecting and the supports available to their family, from the safety of their

home and neighborhood to the quality of child care and education, and from the access to clean water and healthy food to the recreational resources.^{5,33} Some individuals appear to have more genetic resistance to stress than others. This is termed the *differential biological sensitivity to context*.³⁴ Children with more genetic resistance to stress can do well in a variety of different environments, while children who are more sensitive to stress may thrive in enriched environments but wilt in more deprived or hostile ones. Being more sensitive to context is not a weakness, since, in a nurturing context, it can become a "superpower." But any child's capacities for resilience can be overwhelmed with enough stressors and a dearth of buffering from caregiving adults, resulting in the symptoms we encounter when the THREADS of resilience are FRAYED, a topic discussed in more detail in Chapter 7, How Trauma Can Manifest in Children and Teens.

Implications for Pediatric Practice

Medical care has historically taken a problem-focused approach in which the underlying question is "What is wrong with you?" so the medical practitioner can help heal or fix the problem. A resilience-informed perspective on child health and well-being suggests instead a partnering approach that understands the context of individual families and children and identifies and reinforces child strengths and talents and those of their caregivers and families.^{30,35} It is an approach that nurtures promotive and protective factors, while ameliorating risks and mobilizing resources that can improve outcomes.³⁶ It is child focused, family centered, and relationship building. As noted by Traub and Boynton-Jarrett,²⁹ pediatricians can promote resilience by increasing promotive and protective factors for children at every encounter. The Center on the Developing Child at Harvard³⁷ summarizes the following 3 principles for improving outcomes for children and families:

1. Prevention: Identifying and reducing risk factors; however, prevention also involves identifying and leveraging strengths.
2. Ameliorating the impact of trauma that has occurred.
3. Treating and managing symptoms in the pediatric setting and/or engaging community and mental health resources.

Prevention is a vital activity of pediatricians. We do it every day as part of anticipatory guidance in primary care. Resilience promotion requires an *intentional* focus on the quality of the parent-child relationship and promoting safe, stable, nurturing caregiving; positive parenting skills; and child and parent resilience in each and every

encounter (see Chapter 4, Parenting).^{28,38} As an example, we can, in addition to screening for developmental milestones, screen for or ask about assets, strengths, and resilience. Messages, of course, must be tailored to the child's age and stage of development. For example, we can explain "serve and return" and its importance in infant brain development to parents of newborns, and we can discuss attuned, attentive, reflective listening with parents of adolescents. We can encourage at least short periods of parent time-in with their child each day that is focused on a child-led activity. We can explain the links between child behavior, emotions, and thinking because behaviors tell us something about thinking and emotions. We can identify risk factors that might adversely affect caregiving and/or child development and alert parents or link families to resources that might reduce the risk (ie, quality child care, early childhood education). Resilience promotion is prevention, and it is the foundation of care even after risks have been identified, exposure to trauma has occurred, or symptoms have developed.

Many children have risk factors or trauma exposure but no symptoms, while others have mild symptoms that can be managed in the pediatric primary care setting. Secondary prevention, ameliorating the impact of childhood trauma after exposure, is an important pediatric intervention. In addition to resilience promotion as described earlier in this section, we will need to identify when exposure has occurred (see Chapter 10, Surveillance and Screening), understand the impact of trauma on the developing child or adolescent (see Chapter 7, How Trauma Can Manifest in Children and Teens), and provide simple psychoeducation to the child and/or family regarding the impact of trauma. Some of the work we do is to support the caregiver in building their own resilience and regulation so they can be more available to their child. An empathic, motivational interviewing style coupled with using the family's language to explore issues can create the emotional safety that families and children need to share concerns if and when they arise.³⁹

We will be able to treat some families in the practice setting, while others, depending on symptom severity, may benefit from referral for trauma-informed mental health or evidence-based treatment, if it is available.

Finally, some children will manifest more concerning symptoms after trauma exposure, depending on a variety of factors: the nature, severity, and frequency of the trauma; baseline resilience; age and stage of development; caregiver support; and family stressors. Managing childhood trauma symptoms includes a variety of strategies that are discussed in much further detail in Part 3, Promoting Recovery From Trauma. We address the language we use to explain the impact of trauma, in order to reassure the child that they

will get better and that their reaction to trauma is a normal response to one or more abnormal experiences. We discuss how to help parents understand their child's response to trauma in ways that provide the parents with simple³⁰ yet important things to do to help their child; for example, reassure the child that they are safe, establish routines, and co-regulate with the child (see Chapter 11, Pediatric Management). We discuss ways to build on protective factors by supporting the attachment relationship, improving the quality of parenting, and building on self-efficacy and self-regulation. We offer approaches to focusing on family and child strengths by mobilizing community and other resources to meet basic needs such as having food and housing, having access to child care, engaging with the school, and others. And we discuss evidence-based treatment and trauma-informed mental health care, which are tertiary prevention (see Chapter 14, Integrated Care).

Ultimately, trauma-informed care requires consideration of how we train health care professionals, design health systems, and pay for health care to build the infrastructure, skills, and care that can improve outcomes for children and families. Trauma- and resilience-informed care is primary, secondary, and tertiary preventive care that can improve the trajectories of families and children before, during, and after trauma. If we can reduce the impact of adversity on children, the cost savings in health care alone will be substantial and will be augmented by improved outcomes for children, families, and society. The path to improved health outcomes later in the life course begins with investment now in childhood, adolescence, and families.

Summary

Understanding the basics of resilience can provide pediatricians with the framework we need to nurture healthy development, even in the face of adversity and trauma. Overall, pediatricians are perfectly positioned to prevent, identify, ameliorate, and initiate treatment of childhood trauma. We can play a major role in translating the science of resilience into the lived experience of children and families in ways that support safe, stable, nurturing relationships and, thus, promote a child's healthy development, their sense of self-efficacy, and their regulation of emotions and behavior. We can also advocate in our communities for programs that we know reduce and mitigate stressors, promote child and family resilience, and ameliorate the impact of trauma when it occurs. As we hone our own knowledge and skills, we can educate the next generation of pediatricians about this important work. Finally, we must impress on payers and government entities the importance of this work and the potential cost savings to the individual, families, payers, and society as a whole.

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