Resilience and Risk

Darlene Brackenreed

Faculty of Education, Nipissing University, North Bay, ON P1B 8L

E-mail: darleneb@nipissingu.ca

Abstract

In the age of the human Genome Project wide spread prodigious information technology, our system of education is unable to keep pace with and meet the demands for knowledge, skills, and identification and treatment of academic, emotional, social, mental and health concerns of our youth. As the Saskatchewan task force on the state of education in Saskatchewan, Canada (1999) noted, the educational system's problems mirror those problems found in society in general. Increasingly, these societal problems are being deferred to the educational institutions for identification, treatment and prevention. While all parties tend to agree that prevention of problems is desirable, there is not general agreement about the efficacy of prevention programs rather than deficit models, nor the means by which to develop resilient students. The purpose of this paper is to identify risk factors and their potency, to identify protective or resilient factors and their potency, to identify the relationship and relevancy of these two concepts for students, and to identify family, community and school practices that foster resiliency.

Keywords: Risk, Risk factors, Resilience, Protective factors

The purpose of this paper is to identify risk factors and their potency, to identify protective or resilient factors and their potency, and to identify their relevancy and relationship to students with learning difficulties and to identify family, community and school practices that foster resiliency In the age of the Hunan Genome Project and widespread information technology, our system of education is scrambling to keep pace with and meet the demands for, knowledge, skills, and identification and treatment of academic, emotional, social, mental and health concerns of our youth. As the Saskatchewan task force on the state of education in Saskatchewan, Canada (1999) noted the educational system's problems mirror those problems found in society in general. Increasingly, these societal problems are being deferred to the educational institutions for identification, treatment and prevention. While all parties tend to agree that prevention of problems is desirable, there is not general agreement about the efficacy of prevention programs rather than deficit models, nor the means by which to develop resilient students.

Describing children as being “at risk” is a means of predicting vulnerability or risk for a wide range of negative outcomes, such as school failure, dropping out of school, poverty, drug abuse, delinquency, crime, violence, unemployment, divorce, ill health and early death (Silberg, Rutter, D’Onofrio and Eaves (2003)). West and Farrington (1973), in their study of juvenile delinquent boys, determined that the most potent risk factors for delinquency were low family income, large family size, parental criminality, low intelligence and poor parenting. In the year 2010, it is disheartening to note that these same risk factors are on the rise and causing our children to be vulnerable to failure in school and in life, despite widespread efforts on the part of the educational system to address risks and provide interventions.

Adolescence is often a time of rebellion and significant physical and psychological changes Kerr & Stattin, 2000). Kazdin (1993) and Crocker & Crouter (1995) estimate that one-half of America's youth at some point in time experiences a turbulent path. Risk-taking behaviours, those activities or behaviours that are detrimental to the health and well-being of youth, frequently are part of this turmoil (Lamb, 1992). It is generally accepted that problem behaviours are undesirable in society and cause negative outcomes that adolescent problem behaviour accounts for half of the illness experienced during these years (Kerr & Stattin, 2000; Donovan & Jessor, 1985;). Youth today are more likely to participate in risky activities that intensify their probability for lifelong disability or death (Carnegie Council on Adolescent Development, 1995).Duos (1990) used the term “new morbidities” to highlight the seriousness of possible consequences as a result of adolescent problem behaviour, with reference to three particularly erratic behaviours: substance abuse, early unprotected sexual activity and youth violence. The American Academy of Pediartrics (2001) and Huggerty (1984) referred to the "new- morbidity" as a group of health problems for children and youth that are now more observed than the causes of traditional morbidity. In addition to disease and injury, biological, psychological and sociological factors that can have a substantial impact on the emotional, developmental and

learning potential of children and youth are identified. Poverty, lack of prenatal care, disruptive or dysfunctional home life, child abuse and neglect are among the factors of the new morbidity.

Poverty is the number one indicator of the many variables that increase the risk of disability (Fujiura & Yamaki, 2000;Seelman & Sweeney, 1995). The enlarged ¯world of disability is a result of such things as violence and abuse, aging, substance abuse and stress, inadequate prenatal care, low birth weight, adolescent pregnancy and child rearing, poor nutrition, environmental/toxic exposures such as alcohol, smoking, drug abuse and lead, sexually transmitted diseases, including pediatric HIV and Aids, injuries and child abuse and neglect (Seelman & Sweeney,1995; American Academy of Pediatrics (2001).

Poverty acts as a catalyst for many of the variables that increase an individual's risk of failure or disability. Insufficient prenatal care, single teenage pregnancy, poor nutrition and low educational status are frequently found among the poor. This population of poor people is comprised mainly of women and children. Currently, slightly more than half of all people living in Canada are women or female children. Women make up the large majority of single parents and continue to make up a disproportionate share of the population with low incomes. In 2004 16.6% of the total female population (Statistics Canada, 2004) were living in low-income situations, compared with 14.4% of the male population. The average earnings of employed women remain substantially lower than those of men. The earnings of women in 1997 were 73% of what men made. In 1997, 56% of lone-parent families headed by women had incomes below the poverty line income cut-offs, as did 49% of senior women who lived alone (Statistics Canada, 2000).

Low birth weight babies' survival rate has increased dramatically over the past few decades. In the US, rate of deaths caused by injuries has plummeted from 57.5 deaths per 100,000 injuries in 1950 to 29.4 deaths per 100,000 injuries in 1986 (National Center for Health Statistics, 1999). In Canada, the infant mortality rate has remained consistent at 5.3% from 1993-2003. However, the result of surviving prematurity, injury, heart attack or stroke may be a disability that can reduce a person's quality of life and the need for continuing support services. Additionally, the environment for child rearing can have a profound impact on cognition and physical and psycho-social development. Environmental stress, insufficient medical attention, and the increased likelihood of physical and emotional abuse are intensified in low socio-economic settings.

Violence and abusive behaviours are major causes of death, injury and stress. Women, children and older adults most often are the ones harmed, as violence is an exercise of power and control over more vulnerable individuals or groups of people regardless of gender, race, culture or economic background. Violence can take many forms including physical, sexual, emotional, psychological and economic abuse with ramifications for physical injury, sexually transmitted diseases, post traumatic stress, emotional trauma and death.

Violence among youth is a serious problem in schools and all of the persons involved in education, running the gamut from the students themselves, to parents, administrators, teachers, support staff and professional service personnel. A study by the Center for Disease Control and Prevention (2002) determined that nearly 50 killings or suicides occur each year at or near U.S. schools. Homicide is the second leading cause of death for young people ages 15 to 19 overall (Statistics Canada, 2004) and that addressing; violence in the schools will require a total community effort.

Edelman, in 1996, listed some of the issues facing American teachers in schools today. Every four minutes a baby is born into poverty in the United States and every 15 minutes a baby dies. A child is killed by a gun every two hours. Every day in the United States approximately 2,660 children are born into poverty, 8,493 children are reported as having been abused or neglected, 15 children are killed by firearms, 2,833 dropped out of school, 2,700 girls became pregnant and 790 infants are born with low birth weights. More than one-third of poor children in the United States live in working-poor families. Fourteen percent of the working poor children have teenage mothers, and half of them live in married, two parent households (The Children's Defense Fund Yearbook, 2008). In Canada, the average homicide rate for infants under the age of one year was 25 for every 1 million. The motive for homicides of young children was most often frustration while teenagers aged 14-17 were most often killed as a result of an argument. In Ontario, 1 in 5 has a mental health problem and 11% of Ontario students from grades 1-12 report having seriously considered suicide. (Urquahart, 2006). The explanation offered is that good jobs are not available for low-skilled, low-educated people, while those persons with special skills in areas such as technology, have been able to earn more. A 1996 census report in the United States shows that from 1947 to the mid- 1960's the poor and middle class families share of the wealth was growing, ,and then declined. Since 1982 the gap between the rich and poor has increased. Low income families are often single parent families with higher costs for child care. Francis, in 1996, asserted that the key to addressing inequality is education (Francis, 1996).

Educational disabilities are often a result of abuse. Up to 25 percent of abused children may endure permanent disabilities as a consequence of abuse and about 52 percent of neglected children may suffer permanent disabilities. The primary causes of this are from head trauma and malnutrition. Consequences of violence may be delayed in nature or have a cumulative effect. The stress incurred may develop into severe emotional trauma or physical illness. Children with disabilities are more vulnerable than other children, with estimates that they are mistreated 4-10 times that of other children (Sleeman & Sweeney,1995). The Uniform Crime Reporting Survey states that in 2003, just under 28,000 physical assaults and over 9,000 sexual assaults against children and youth aged 17 and under were reported. According to the data, the risk of violent victimization for c + and youth is highest for older children. Rates of victimization for both female and male children are under 500 per 100,000 population for children under 8 years of age. By age 14, rates are 4 times higher at 2,000, per 100,000. Of the 15,000 sexual assaults reported in the survey, 61% of victims were 17 and younger. About 4/5 of these victims were girls and more than 2/3 were between 11 and 17 years old. One fifth (1/5) of all reported crimes were committed against children and youth aged 17 and under, representing 30% of the total reported crime in Canada (Government of Canada, 1992).

Socio-economic status is related to children's degree of risk of injury as a result of abuse and neglect. In families with incomes of less than $15,000, the rate of physical abuse was three and one-half times greater and the rate of sexual abuse six times greater, than for other children. Physical abuse was more frequent than sexual abuse in both high and low income families (Sedlak, 1986) the degree of injury or disability was related to family income. The rate of serious injury was roughly seven times greater, of. moderate injury was five times greater, and of potential injury seven times greater, for children from lower socio-economic status than those from high income families (Sedlak,1991). There were approximately 21.52 investigations of child abuse and neglect per 1,000 children in Canada in 1998 (Public Health Agency of Canada, 2001). 34% of the physical abuse investigations were found to be substantiated compared to 38% for sexual abuse, 43% for neglect, and 54% for emotional maltreatment. Child and spouse abuse tend to occur in tandem as Gayford (1975) reported that 37 percent of the women and 54 percent of the men who had been victims abuse beat their children.

Psychological disorders may be considered a new morbidity of childhood. Nearly one in five children have one or more developmental, learning or emotional disorders (delays in growth or development, a learning disability or an emotional or behavioural problem that lasts three

months or more or requires psychological treatment APA, 2000). The elevated divorce rate, the increased number of children living in dysfunctional families, the greater rate of survival of low birth weight babies and prenatal exposure to drugs are among the variables these high numbers. The Education Commission of the States (2000) that 12 percent of children endure damage that interferes with their potential for learning. In Canada the rate is closer to 10% (Hutchinson, 2005).Twenty percent of all Canadians will experience a mental illness during their lifetime. In 1999, 3.8% of all admissions to general hospitals were due to psychological disorders (Stats Can, 2004). Preventable factors identified with development of learning problems were: low birth weight, maternal smoking, prenatal alcohol exposure, prenatal exposure to drugs, lead poisoning, child abuse and neglect and malnutrition.

Poverty and other environmental factors create more children at risk but youth of all backgrounds make daily choices that can significantly alter their lives. Joy Dryfoos (1998) says as many as half of all 10 to 17 year olds can be categorized as moderate to very high risk because of their level of involvement in delinquent behaviour, substance abuse, early sexual intercourse or problems in school. Edelman says, "Children of rich and poor alike are growing up amid family breakdown, divorce, and easy access to drugs and sex, without any sense of direction. Physical poverty is killing our children's bodies, but spiritual poverty is squashing their souls" (Edelman, 1996, p.15). James Coleman (1996) contends that our children are suffering from a loss of "social capital" – the norms, values and human resources that parents and adults in the community must make available to children for their educational and social development. For a variety of reasons and involvement with other adults in relationships that do not cross generations (such as in most work settings) – the resources of the adults in the community are not available to assist the psychological health and the social and educational development of children. With the absence of these adults for guidance, youth turn to peers, the mass media or other sources, for the norms and values they use in making choices. Peers can be either a motivating influence or an impediment to academic achievement. In his study, Brown (1990) found that peers generally supported getting a diploma and earning reasonable grades, but through other means such as cheating, rather than through hard work. The mass media influences academic achievement by stealing time away from studying and influencing the attitudes and decisions about issues such as the use of drugs and alcohol, sexuality or academic achievement. American adolescents spend $40-45 billion on themselves yearly and are prone to violence when others try to

steal their jackets or sneakers, and youth, rich with drug money, set impossible standards for material belongings, with which honest youth are unable to compete.

"A new class of untouchables' is emerging in our inner cities, on the social fringes of suburbia, and in some rural areas, young people who are functionally illiterate, disconnected from school, depressed, prone to drug abuse and early criminal activity, and eventually, parents of unplanned and unwanted babies. These are the children who are at high risk of never becoming responsible adults" (Dryfoos,1990).

However, there are problems inherent in the reliance on the concept of risk as a means of addressing problems faced by our youth. Many of the students who are identified as being at risk are those whose appearance, language, culture, values, traditions, home communities and family systems are different from the host culture, causing one to question the basis for identification (Keating,1996). Often the primary factor for being identified as being at risk is difficult or problem behaviour while the quiet, withdrawn child may be at as much or more risk (O'Reilly & Fleming,1993). Finally, there are problems in using what has been called a deficit model, where we try to change children to make them fit into the structures of our institutions and programs rather than attempting to make the institutions and programs fit the needs of students. It has been argued that early identification practices create lowered teacher expectations regarding the abilities of the students, while blaming poor school performance on conditions outside of their control (Slee and Werner, 2001). Successful interventions become less likely when identification occurs after a pattern of poor performance sets the expectations for future poor performance, in the minds of teachers and students alike (Lewis and Norwich, 2001).

Beginning in the 1950's, there has been a resurgence of interest in the concept of resilience, the positive attributes in individuals and institutions. Rather than focussing on those persons who were unsuccessful, in part due to the vulnerability of their lives, studies began investigating the persons who were successful in spite of those existing conditions. According to Masten, Best and Garmezy (1990) resilience is defined as the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances. Bernard (2001) and Marshall (2004) describe resilience as a set of qualities, or protective mechanisms that give rise to successful adaptation despite the presence of high risk factors during the course of development. Linquanti (1992) stated that resilience is:

...that quality in children who, though exposed to significant stress and adversity in their lives, do not succumb to the school failure, substance abuse, mental health and juvenile delinquency problems they are at greater risk of experiencing.

Definitions vary but the researchers tend to agree that resilient individuals have traits in common such as higher intelligence, lower thrill seeking, lower associations with delinquent peers, and an absence of anti-social behaviours, substance abuse and juvenile delinquency (Werner,1989).

Wemer and Smith (1989, 1992) studied over 600 people in Kauai, Hawaii over a span of over 40 years and Garmezy and Rutter (cited in Van Patten, 1990) investigated over 200 children in the mainland of the United States. These researchers found that the majority of children, despite the high risks inherent in their lives, grew up to be healthy and successful adults. Werner and Smith (1989) determined that most children appear to posses self righting abilities and can flourish in the face of adversity. They concluded that specific risk factors appeared to have less impact on individual lives than the existence of positive and caring relationships, and that it is apparently never too late to effect change in a person's life. In 1992, Werner published *Overcoming the odds: High risk children from birth to adulthood* in which she offered evidence that risk factors are not as powerful as protective factors in predicting adult outcomes.

Masten, Garnnezy, Tilligen, Pellegrini, Lurkin and Larsen (1990), however, caution that labeling children as resilient can be as misleading and potentially as harmful as labeling children at risk. They assert that children can be more or less resilient in different situations and at different points in their lives, depending on the interplay and aggregation of individual and environmental factors (Brooks & Goldstein, 2002). Masten et al. identified three types of resilience. The "overcoming the odds" type of resilience refers to the belief that individuals have personal strength that allows them to withstand adversity. It also can refer to coping with sustained and acute negative circumstances, such as family conflict, and thirdly, it can refer to a recovery from trauma such as the death of a parent. It was Rutter in 1990 who pointed out that, 'resilience cannot be seen as a fixed attribute of the individual. If circumstances change, the risk alters' (Rutter, 1990, p.345).

Resilience refers to protective factors that are internal and external to the individual. Like risk factors, protective factors have a cumulative effect. The more protective factors a child has, the more resilient he is likely to be (Brooks & Goldstein, 2002). Rutter (1990) cautions against viewing the child as strong or weak, but as whether

the child is able to negotiate risk situations. It serves no purpose to merely put an optimistic spin on what is known about risk factors. Rutter (1990) describes four types of protective processes that he believes moderates a risk factor. Firstly are those that reduce a person's exposure to risk, secondly, those that reduce negative reactions to bad experiences, thirdly, those that promote self-esteem through achievement and finally, positive relationships that provide opportunities in life.

Protective factors within the individual child are things such as higher levels of autonomy, social competence, problem-solving skills, independence, empathy, task orientation, curiosity, peer relations and a sense of purpose and future. Rutter (1987) describes social competence as children's ability to think of several solutions to social problems. The Consortium on the SchoolBased Promotion of Social Competence (2004) claims:

... social competence involves the capacity to integrate cognition, affect and behaviours to achieve specified social tasks and positive developmental outcomes. It comprises a set of core skills attitudes, abilities and feelings given functional meaning by the contexts of culture, neighbourhood and situation.

The Consortium (2004) goes on further to state that social skills cover a range of contexts, including the ability to appropriately respond to social cues, such as facial expressions, to effectively solve interpersonal problems, to realistically anticipate consequences to one's actions, to effectively behave socially and to express positive optimism about personal actions.

Werner (1989) suggests that 'required helpfulness' is a factor in resilient children's experiences. These experiences include responsibilities and tasks that involve them working in the community and school, such as taking care of siblings, being responsible for pets or cleaning the school playground. Rutter claims that a positive outlook and a sense that one can withstand challenges is a key ingredient. He describes self-esteem and self-efficacy as:

... a feeling of your own worth, as well as a feeling that you can deal with things, that you can control what happens to you. One of the striking features of problem families is that they feel at the mercy of fate, which is always doing them an ill-turn. So one important quality is a feeling that you are in fact master of your own destiny (Rutter, 1984, p.76).

Other important factors related to resiliency are age, social support, locus of control, competence, self-esteem, temperament, social maturity, need for achievement, past coping ability and family and community variables. Wolin & Wolin (2004) use the word resiliency to describe clusters of strength. They include resiliencies of insight, in dependence, relationships, initiative, creativity, humour and morality. Winfield (1994) describes resilient children as those who have parents who are concerned about their children's education, who offer guidance and support to their children on a daily basis and who are aware of their child's interests and aspirations. Research identifies protective factors related to the family, such as the consistency and quality of care and support to the child during development. West and Farrington (1973) pointed to the importance of adequate and consistent parental role models and compatibility between the parents, parents who spend time with their children and pass on social achievements, parents who demonstrate productive use of leisure time and parents who present as firm and consistent without the use of rejection.

Werner and Smith (1989) identified familial factors as family size (four or less), the number of caregivers in the home, in addition to the mother, manageable workloads for the mother, structure and rules for the child during adolescence and few chronic, stressful life events during childhood and adolescence. Resilient families have celebrations such as birthdays have a stabilizing effect during times of crisis, believe in their ability to control life and establish routines for a variety of activities, for example meal time (Brooks & Goldstein, 2002; McCubbin & McCubbin,1983).

Children of lower socio-economic status are considered to be at greater risk than students who come from more affluent backgrounds, but there are certain characteristics of communities that appear to afford protection, such as the support afforded by families and the social services available to youth and their families (Pence, 1996; Wolin & Wolin, 2004). Many argue that caring and support is the key ingredient for resilience (Rutter, 1987; Garmezy, 1985; Masten et al., 1990; Wolin & Wolin, 2004). Caring and support was identified by Erikson in 1963 as the basis for future healthy development. Increased vulnerability of youth and families may be due in part to the depersonalization of the community, a shift "...from a human context ruled by face-to-face interactions and the weight of public opinion to an anonymous social context ruled by abstract laws and institutional rules" (Csikszentmihalyi, 1993, p. 49). The lack of community involvement and responsibility contributes to isolation and alienation of individuals. The Manning Theory of ecological psychology (Barber, 1968; Schoggenh, 1989) and the psychological concept of over populated environments support this point of view. In an overpopulated environment, the ratio of opportunities and roles to people is low, where individuals

have less tolerance for individual differences and feel less valued and less responsible. In overpopulated environments, the ratio of opportunities to people is relatively high and people feel more valued, more responsible and are more tolerant of individual differences. An underpopulated community is also more likely to have face-to-face interactions with increased community involvement, support and responsibility. Therefore, a dimension of resilience may be the extent to which the environment is under populated thereby providing meaningful engagement for involvement and responsibilities.

Children and families in communities are distinguished by the educational, health and social phenomena of their lives and also by the labels attached to them. They are composed of the ethnic, racial, social class and gender groups they represent. Immigration, the first language spoken in the home and the language currently spoken in the home are contributing factors to risk and resiliency, as are personal and religious beliefs they hold and the traditions, practices and customs they value. How we as a society respond to this diversity affects the prevention programs we value and the generations of people that will follow us.

Youth from diverse ethnic and cultural backgrounds are disproportionately represented in juvenile justice, special education and emergency health care systems (Statistical Briefing Book, 2004). Many are homeless and live in poverty (Statistical Briefing Book, 2004). Some are from single-parent households and some live in extended family arrangements. Some persons due to migration, are separated from their natural support systems and rely on their own internal support systems together with family's traditions of care and self-help. The diversity of family life must be honored in our approach to prevention while helping families to access help from community. We must foster interventions that help families develop coping strategies that are appropriate within their traditions and customs of care, while helping them to gain familiarity with the support systems that can foster the resiliency to survive (Bernard, 2004). "The family is potentially the most effective social institution for rearing healthy children. From this it follows that the defense of the family is the first line of defense of the child" (Eisenberg, 1975, p. 801). Additionally, the centrality of the community in the lives of youth and families is essential to resiliency. This centrality recognizes that the family is dependent on other institutions for its endurance. As a society we need a proclamation that states that 'no family is an island'. The school, church, businesses, parks, recreation facilities, and transportation links that constitute the components of community are all essential supports of a family unit (Earls & Carlson, 1993, p. 116).

School also can serve as a protective factor for children and adolescents. Children are more likely to display resilience if they attend schools that have good academic records and caring teachers. The positive experiences that children can derive from school may involve academic success, sporting or musical achievement, assuming responsibility in the school or developing positive relationships with teachers and peers (Rutter, 1979; Marshall, 2004). Clark (1983, Weist, 1997, Wolin & Wolin, 2004) found that an intact family was not consistently linked with resiliency but that an important factor of resilient children is having at least one significant adult in their lives. Often, the significant adult identified is a teacher.

Success at school may be supported through a pragmatic and relevant curriculum and accommodating school personnel. Werner and Smith (1989) and Marshal (2004) found that teachers who took a personal interest in their students and provided positive role modelling were the most frequently identified non-family influences for resilient students. Interventions in schools also can have an effect on the resilience of children. Edmonds (1986, p. 45) concludes that: a school can create a coherent environment, a climate, more potent than any single influence--teachers, class, family, neighbourhood--so potent that for at least six hours a day it can override almost everything else in the lives of children.

In the field of education, some programs and policies have been based on resiliency research. The Comprehensive Training to Assure Resiliency in Students project (1999) outlines five strategies to support resilience. Schools should offer opportunities for students to establish significant relationships with compassionate adults. Secondly, schools should build on social competencies and academic skills to provide experiences of competency and success. They should offer students the opportunity for meaningful engagement and responsibility within the school and the community. Fourthly, schools should identify, work with and support services for children and youth. Finally, schools should ensure that they do not contribute with faulty practices to the risks already encountered by their students.

Bernard (1993, 1995, 2001) agrees that schools should foster the ability to form relationships (social competence), to problem solve (metacognition), to develop a sense of identity (autonomy) and to plan and hope (a sense of purpose and future) in their students by offering caring relationships, high expectations and opportunities for students to participate in the school. Teachers have the power to tip the scales from risk to resilience. These teachers provide and model three protective factors that enable positive development by

meeting youth's basic needs for safety, love and belonging, respect, power, accomplishment and learning and meaning. Teachers can provide caring relationships by listening to students and offering validation for their feelings and showing kindness, compassion and respect (Centre for Effective Collaboration and Practice; Higgins,1994; Meier, 1995). They should be nonjudgmental and should not take students' behaviours personally.

Teachers' high expectations can structure and guide behaviour and challenge students to perform (Delpit,1996). These teachers recognize students' strengths and help students to self-identify their strengths. They assist students to grow from damaged victim to resilient survivor by helping them to not take the adversity in their lives personally, not see the adversity as a permanent state and not see setbacks as pervasive (Seligman,1995; Siligman & C, 2000). Teachers who promote resilience in their students let students express their opinions and imagination, make choices, problem solve, work with and help others, and give back to the community in safe and structured ways. They treat students as responsible individuals, allowing them to participate in all aspects of school (Rutter et a1., 1979; Rutter, 1984; Bernard, 2001).

The development of resilience lies in relationship, beliefs and expectations, and willingness to share power. Bernard (1997) states that certain approaches can provide the structure for developing these relationships, and for providing opportunities for student involvement. The curriculum should be thematic, experiential, challenging and mufti-perspective. Instruction should accommodate a diverse range of learning styles, interests, and experiences and allow for reflection on the part of the learner, critical thinking and dialogue. Resilience can be supported with grouping students in such a way as to promote diverse perspectives and inclusion, cooperation, shared responsibility and a sense of community. Additionally, Marshall (2004) states that administrators should create a school climate that supports teachers' resilience, reach a staff consensus about innate resilience, support school-community collaborations, and support teaching practices that foster resiliency in students.

Evaluation practices that support resilience focus on multiple intelligences, authentic assessment and self-reflection; a number of ways of being successful are made available to students. Effective schools have students spending time working independently, interacting with teachers and expressing more positive statements about their schools. The students express more satisfaction with their schoolwork and peer relationships, perceive their parents as more involved with their schooling, and believe that their teachers hold high expectations for them. Frequently the students report higher aspirations and motivations and better social and academic self concepts. In addition, they report more engagement with school, a belief that their teachers are more supportive and that classroom rules are clear and understandable to them. Regardless of their demographics, schools with high achievement scores are more orderly and structured than low achieving schools and the parents have higher expectations for academic achievement for their children (Wang et at, 1995; Krovetz, M. 1999).

It would appear that direct practices, over which teachers have the greatest control, is what differentiates effective from ineffective schools. These practices relate to student abilities, motivation and behaviour, classroom management, student/teacher relationships, and the amount and quality of instruction. However, it is difficult to pinpoint specific successful strategies for integrating a system of delivery that takes into account the, needs of the students and the strengths and weaknesses of the school setting. Wang et al., (1995) suggest that existing community resources be coordinated with school resources and that all organizations contribute staff and finances, mutual leadership and clear communication.

In Canada we have a commitment to education for all people regardless of economic, social, ethnic, and religious backgrounds. All persons are provided equal access to public education and there is a continuing effort to make education available to a diverse range of people. Teachers, who face an increasingly diverse population of students must adapt to continually changing societal values and educational needs.

Throughout the ages people have been concerned about the moral values of youth. Dag Hammarskjold stated that there are some problems we can never solve, we just grow out of them as we reach another language of trust and compromise (cited in Van Patten, 1997, p. 34). John Dewey believed the ideology of democracy was both a historical construction and a referent for dignifying politics, human efficiency and social struggle (Dewey, 1916). Socrates, over 2,000 years ago, taught the importance of character development and morality. During Colonial times, corporal punishment and social ostracism were used to maintain social order based on a tight knit community with the family at the center. The Puritans taught respect for authority, neatness, punctuality, responsibility, obedience, self-responsibility and respect for the rights and property of other persons. The industrial period was replaced with the age of information and social conflicts and fragmentation and as a result, codes of ethics were developed as an aid to solving disputes and identifying moral issues.

Generally the Code of Professional Practice for teachers, like codes of ethics in other professions, is a moral guide that includes ideals of society developed through our evolution as a civilization. As societal concerns are ever-growing in our educational system, individuals have a diverse range of views and opinions about the role of ethics, values and morals in education (Benninga, 2003). Many advocate for the return to authoritarian discipline and the unquestioning obedience to rules, regulations and mandates. Others believe in democratic discussion, interaction and networking about moral and ethical conduct of students (Savulescu & Kahane, 2009). Burron (1996) points out that parents and guardians have ethical and moral obligations toward their children's care and are interested in their schooling. On the other hand, society, not parents, pays for unwed mothers, absentee fathers and unsocialized children. Value conflicts in our society require continuing efforts to address the potential decline in civilization. Current technological and scientific advances have lead us rapidly into new innovations and discoveries, but in the face of this we are suffering from social conflicts and lack of an integrated community.

The question becomes, "What does this look like in real life?" My personal experiences may lead to some understanding of the turmoil of the resilient individual. At age 4 my oldest sibling, a brother aged 17, accidentally died in a hunting accident. My older sisters who are 12 and 7 years older than I reported that prior to this tragedy our family had been happy and well-balanced. Not so afterwards.

The older girls left home at early ages to go to University, leaving me and my little brother who is 2 years younger alone with our parents. It is often said that a tragedy can pull a family together or blow it apart. Somehow the latter was chosen in our case. Parental issues ranging from extramarital affairs, alcohol misuse and abuse, violence and neglect became the norm for my brother and I. We were 9 and 7 years old. We had maternal grandparents who were worried and involved with us at arm's length and our sisters came home often, worried at what they would discover. It was an age of "not getting involved' and Child and Family Services followed the creed and did not get involved. We were in a small rural farming community where not only did we know everyone, we knew what was going on in most of the homes. Despite this, no one came forward to intervene on the behalf of my brother and I. I felt as if the world did not care and felt a lapse of faith in a God who did not protect me.

Who were the significant people in my life who believed in me and helped me to become resilient? Obviously, the sisters were a source of caring and support but being sisters they offered sources of conflict and bitterness as well. Living in a community where any adult might correct a child or offer guidance was another source of support but at the same time there were people in this group who were not trustworthy. I learned this when I entered puberty and was cornered in the community curling rink a few times by older men, friends of my father, who had no scruples about mauling a pre-pubescent girl.

There were teachers who showed empathy and understanding and who seemed to genuinely want to help. My grades were routinely amongst the highest in the class causing most teachers to admire my work. Teachers were surprised when they asked my parents to attend meetings or other functions at the school and were met with resistance and open refusals. When asked why, I was unable to explain the situation as it was my shameful secret that I felt compelled to protect. The teachers who demonstrated compassion and understanding and who encouraged me in my school work helped me to understand that an education was one of the best tickets out of there that I could hope for and since I was an A student, I applied myself. This may sound like an over-simplification but it is the simple truth. Unfortunately, in my grade 12 year I experienced what is now referred to as "date rape" and became pregnant. I left my home town to live with one of my older sisters and gave the baby up for adoption. I felt that giving the child up was the best hope she had for a well-balanced and happy life. It also provided me with the best chance to go to university and establish myself with a career.

I earned a Bachelor of Arts degree and then a Bachelor of Education degree to become a teacher. From there I earned a Masters degree and then a Ph. D. in education and several certificates from the Department of Education. This need to achieve comes from a place deep inside that is as urgent and mysterious to me as it is to anyone else. It also is derived from the fact that I had the prerequisite skills to accomplish these things. I have the intelligence and the drive. As I mentioned, the drive came from the need to escape, to get out of an intolerable situation. Once I escaped, the drive continued and I continued to study and gain more achievements. Where this exigency will ultimately lead is a question I cannot answer.

I did not experience some of the more salient risk factors, namely school failure, poverty, crime, unemployment, or divorce that are deemed to affect a person's ability to prosper in the face of adversity. On the topic of divorce, I used to wish that my parents would separate because their relationship with each other

and with us was so volatile we lived in fear of what would happen next. Sometimes divorce is not the worst thing; having the parents stay together for the sake of the kids can be.

I know that the students I went to school with suffered greatly when they were incapable of school success. They were ashamed, humiliated, and downtrodden from the steady stream of failures. They lived in fear of failing a school grade until they became hardened to the sense of failure and learned to protect themselves from teachers whose very presence was a reminder of their failure. Truly, we cannot create a situation where all students have the gift of cognition, but we can as teachers create an environment where all talents are cherished and admired, not just the academic achievers. We can create a climate of acceptance and community where members support one another in their endeavours. We can offer accommodations and assignments for students that more closely meet their learning needs and learning styles. We can be empathic and understanding and offer support to all students in their quest for identity and achievement.

A common goal of teachers can be seen as to serve the public with respect, concern, courtesy, and responsiveness to the needs of their students. The collective agreement as to what these needs are and the best means of addressing them is lacking and causes a dilemma. Should we place our focus on the risk factors for failure and deliver interventions based on a deficit model, or should we determine what protective factors mediate the negative outcomes of risk factors and deliver programming based on a preventative model? I flourished with the support offered to me by a couple of my teachers and believe that this is the route we should take, focusing on the positive rather than dwelling on the negative. Those of us in at risk are well aware of our deficits and need to understand our strengths. As teachers, we ought to encourage each other and our students to mine their talents and share their gifts with others, contributing to our society in meaningful ways and creating happy people.

References

Bernard, B. (2001). Competence and resilience research. *Lessons for prevention.* National Resilience Resource Center.

Bernard, B. (1995). Fostering resilience in children, EDO-PS-95-9.

Bernard, B. (1993). Fostering resiliency in kids, *Educational Leadership*, 44-48.

Brooks, R. & Goldstein, S. (2002). *Raising resilient children: Fostering strength, hope and optimism in your child.* Toronto: McGraw Hill..

Burron, A. (1996). Parents' rights-Society's imperatives: A balancing act, *Educational Leadership,* 80-82.

Canada Incidence Study of Reported Child Abuse and Neglect (CIS) available at: www.phac-aspc.gc.ca

Carnegie Council on Adolescent Development (1995). *Turning points: Preparing American youth for the 21st century.* (Report of the Task Force on Education of Young Adolescents). New York: Carnegie Foundation.

Children's Defense Fund (2008). *The state of America's children 2008.* Washington: Children's Defense Fund.

Clark, R. (1983), *Full-service schools: A revolution in health and social. services for children, youth and families.* San Francisco: Jossey-Bass.

Coleman, J. (1988). Social capital in the creation of human capital, *American Journal of Sociology, 94,* S95-S120.

Csikszentmihalyi, M. (1993). Context of optimal growth in childhood, *Daedalus, 122*(1), 31-55.

Dryfoos, J. (1990). *Adolescents at risk: Prevalence and prevention.* New York: Oxford University Press.

Dryfoos, J. (1994). *Full service schools: Revolution in health and social services for children.* San Francisco: Jossey-Bass.

Dryfoos, J. (1995). Full service schools: Revolution or fad? *Journal of Research on Adolescence, 5*(2), 147-172.

Dryfoos, J. (1993). Preventing substance use: Rethinking strategies, *American Journal of Public Health, 83*(6),793-796.

Dryfoos, J. (1991). School-based social and health services for at-risk students, *Urban Education, 26*(1),118-38.

Edmonds, R (1986). Characteristics of effective schools. In U. Neisser, Ed., *The school achievement of minority children: New- perspectives.* Hillsdale: Lawrence Erlbaum.

Eisenberg, L. (1.975). The ethics of intervention: Acting amidst an ambiguity, *Journa of Child psychology and Psychiatry, 16,* 93-104.

Francis, D. (1996). Despite growth, families struggle to prosper in U. S, *The Christian Science Monitor, 1*(8).

Garmezy, N, (1987). Stress, competence and development: Continuities in the study of schizophrenic adults, children vulnerable to psychopathology, and the search for stress-resistant children, *American Journal of Orthopsychiatry, 57,* 159-174.

Garmezy, N. & Masten, A. (1986). Stress, competence and resilience: Common frontiers for therapist and psychpathologist, *Behaviour Therapy, 17,* 500-521.

Garmezy, N. (1985). Stress-resistant children: The search for protective factors, in Stevenson (Ed.) *Recent research in developmental psychopathology*. Oxford: Pergamon.

Government of Canada. (2008). *Statistics Canada: Women in Canada 2008.* Ottawa: Queen's Printer.

Government of Canada (1992). *Uniform crime reporting survey.* Ottawa: Queen's Printer.

Haggerty, R. (1984). The changing role of the pediatrician in child health care, *American Journal of Diseases of Children, 127,* 545-49.

Higgins, G. (1994). *Resilient adults: Overcoming a cruel past.* San Francisco: Jossey-Bass.

Kazdin, A. (1993). *Psychotherpy for children and adolescents.* New York: Oxford University Press.

Keating, N. (1999). *Eldercare in Canada.* Ottawa: Statistics Canada, Housing, Family and Social Statistics Division.

Kerr, M. & Stattin, H. (2000). What parents know, how they know it, and several forms of adolescent adjustment: Further support for a reinterpretation of monitoring. *Developmental Psychology*, *36*(3), 366-380.

Krovetz, M. (1999) *Fostering resiliency: Expecting all to use their minds and heart well.* Toronto: Sage Thousand Oaks.

Lamb, J (1992). *American Psychiatric Association task force on the homeless mentally ill: Treating the homeless mentally ill.* Washington: American Psychiatric Association.

Levin, B. (1998). *Women's mental health services: A public health perspective*. Thousand Oaks: Sage Publications.

Lewis, A. & Norwick, B. (2001). A critical review systematic evidence concerning distinctive pedagogies for pupils to difficulties in learning. *Journal of Resilience in S. Educational Needs.* Available at www.nasen.org.uk.

Linquanti, R. (1992). *Using community-wide collaboration to foster resiliency in kids: A conceptural framework.* Portland: Western Regional Center for Drug-Free Schools and Communities. (ERIC Document Reproduction Service No. ED 353 666).

Marshall, K. (2004). Resilience research and practice and national resilience resource center. Bridging the gap. In H.C. Waxman, Y.N. Pudron and J. Gray (Eds*.) Educational Resiliency; Studentt, Trucher and School Perspectives.* Greenwich, CN: Information Age Publishing.

Masten, A., Garmezy, N., Tellegen, A., Pellegrini, D., Larkin, K., & Larsen, A. (1988). Competence and stress in school children: The moderating effects of individual and family characteristics. *Journal of Child Psychology and Psychiatry, 6,* 745-764.

Masten, A., Best, K., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity, *Development and Psychopathology,* 425-444.

Masten, A. & Coatsworth, J. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children, *American Psychologist, 53* (2), 205-220.

McCubbin, H. & McCubbin, E. (1983). *Stress and the family.* New York: Brunnerl/Mazel.

Meier, D. (1995). *The power of their ideas: Lessons for America from a small school in Harlem.* Boston: Beacon Press.

Merman, L. (1991). *Alive and well: A research and policy review of health programs for poor young children.* New York: National Center for Children in Poverty.

National Center for Health Statistics (1999). *Child health* (Report compiled by Office of Public Affairs). Washington: U. S. Department of Health and Human Services.

O'Reilly, S. & Fleming, T. (1993). *Down and out in Canada: Homeless Canadians.* Toronto: Canadian Scholar's Press.

Pence, A. (1996). *Canadian national child care study: Shared diversity: An international report on child care in Canada.* Ottawa: Statistics Canada.

Rutter, M., Maughan, B., Mortimore, P., Ouston, J., & Smith, A. (1979). *Fifteen thousand hours.* Cambridge: Harvard University Press.

Rutter, M. (1979). Protective factors in children's response to stress and disadvantage. In Kent & Rolf (Eds.), *Primary prevention of psychopathology: Vol. 3. Social competence in children.* Hanover: University Press of New England.

Rutter, M. (1987). Psychosocial resilience and protective mechanisms, *American Journal of Orthopsychiatry, 57,* 316-331.

Rutter, M. (1990). Psychosocial resilience and protective mechanisms. In Rolf, Masten, Cicchetti, Nuecherlein & Weintraub (Eds.), *Risk and protective factors in the development of psychopathology.* New York: Cambridge University Press.

Rutter, M. (1984). Resilient children, *Psychology Today, 3,* 57-65.

Schoggen, P. (1978). Ecological psychology and mental retardation. In G. Sackett (Ed.), *Observing behaviour.* Baltimore: University Park Press.

Sedlak, M. (1986). *Selling students short: Classroom bargains and academics reform in the American high school.* New York: Teachers College Press.

Seelman, K. & Sweeney, S. (1995). The changing universe of disability, *American Rehabilitation, 21*(3), 2-14.

Seligman, M, (1995). *The optimistic child.* Boston: Houghton Mifflin.

Siligman, E. & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, Millenial Issue

Wang, M. & Haertel G. (1995). Educational resistance. In Wang, Reynolds &Walberg (Eds.), *Handbook of special education: Research and practice (2nd ed.)* Tarrytown: Pergamon-Elsevier Science.

Werner, E. (1989). High-risk children in young adulthood: A longitudinal study from birth to 32 years, *American Journal of Orthopsychiatry, 59,* 72-81.

Werner, E. (1996) How kids become resilient: Observations and cautions, *Resiliency in Action, 1,* (1),18-28.

Werner, E. & Smith, R. (1992). *Overcoming the odds: High risk children from birth to adulthood.* Ithaca: Cornell University Press.

Werner, E. (1982). *Vulnerable but invincible: A longitudinal study of resilient children and youth.* New York: McGraw Hill.

West, D. & Farrington, D. (1977). *The delinquent way of life.* London: Heinemann Educational Books.

West, D. & Farrington, D. (1973). *Who becomes delinquent? Second report of all Cambridge study in delinquent development.* London: Heinemann.

Winfield, L. (1991). Resilience, schooling and development in African-American youth: A conceptual framework, *Education and Urban Society, 24* (1), 5-14.