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# Resiliency in parentally bereaved children and adolescents

Goodman, Teresa Marie, M.A.

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U·M·I
300 N. Zeeb Rd.
Ann Arbor, MI 48106

# RESILIENCY IN PARENTALLY BEREAVED CHILDREN AND ADOLESCENTS

by

Teresa Marie Goodman



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## APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

Philip J. Lauver
Associate Professor of
Family and Consumer Resources

April 12, 1993
Date

This thesis is dedicated to the
memory of

Kathy Byrn Holstrom,

my forever friend, my roomie, and my spiritual guide.

This is further dedicated to her resilient children,
Kari and Chad.
May God continue to protect and bless them.

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## ABSTRACT

The primary purpose of this study was to identify resiliency factors evident in parentally bereaved children and adolescents identified as "holistically well." The population for this study consisted of 7 parentally bereaved children and adolescents between the ages of 5 and 18 who were referred by the Children to Children support program for grieving youth.

The instruments used in this study were specifically developed to assess holistic wellness and evidence of resiliency factors.

The most prevalent resiliency factors evident in parentally bereaved children and adolescents identified as holistically well were: Constitutional Resiliency Factors of: social competence, positive personality characteristics, sense of purpose and hope, problem-solving skills, and autonomy. Resiliency Factors within the Home Environment of: caring and support, high parental expectations, and encouragement of participation in family. Resiliency Factors within the School Environment of: high academic expectations and caring and support.

# CHAPTER 1

## INTRODUCTION

> Should you shield the canyons from the windstorms,
> You would never see the beauty of their carvings.
> -- Kubler-Ross (1983)

The death of a parent is considered to be one of the most traumatic losses a child or adolescent can experience (DeSpelder & Strickland, 1987; Grollman, 1967). A parent's death is viewed as a loss of nurture, security, and affection as well as a loss of the emotional and psychological support upon which a child or adolescent could formerly rely (DeSpelder & Strickland, 1987). Never again will the world be as secure a place as it was before (Grollman, 1967). A parent's death is threatening to children because the whole system is shaken when part of the foundation is gone (Wass, 1991).

It is estimated that approximately 5% to 10% of the population loses one or both parents before reaching 18 years of age (Osterweis, 1984; Palombo, 1981; Wass, 1991). It is suggested that this percentage may be substantially higher in lower socioeconomic groups (Osterweis, 1984). The chances that the deceased parent will be a father rather than a mother are two out of three (Palombo, 1981). The most common mode of parental death is a sudden accident, murder, or suicide rather than an anticipated

long-term illness (Palombo, 1981). No matter how a parent's death occurs, the loss has a major impact on a child or adolescent.

Children and adolescents experience a broad range of physical, emotional, and behavioral reactions to parental loss (Osterweis, 1984). The death of a parent is a leading factor for children considered "vulnerable" or "at risk" for psychopathological and behavioral disturbances (Tucson Community Foundation, 1990). Unreconciled childhood or adolescent grief can manifest itself in antisocial behaviors such as vandalism and firesetting, in self-destructive behaviors such as substance use and abuse, and in emotional disorders leading to depression, psychosis, or suicide (Children to Children, 1990).

In spite of the negative effects that these facts portray, there is evidence that approximately one out of three vulnerable or at risk children and adolescents develop into "competent individuals who love well, work well and play well" (Werner, 1989, p. 108). These competent, well-adjusted individuals have been determined to possess a number of protective or resiliency factors (Werner, 1989). These resiliency factors are defined as traits, conditions, situations, and episodes that appear to alter or even reverse predictions of life stressors (Segal, 1986, cited in Benard, 1991). These factors are classified as (1) constitutional resiliency factors, (2) family environmental resiliency factors, and (3) external environmental resiliency factors (Werner, 1989). It appears that the balance between stressful or

traumatic life events, such as the death of a parent and the protective resiliency factors, plays a key role in determining positive adaptation and personal holistic growth for children and adolescents (Werner, 1989).

## Significance of the Study

For surviving parents and caregivers, medical and mental health professionals, educators, and parentally bereaved children and adolescents themselves, the identification and promotion of factors contributing to healthy development, and personal holistic growth is very significant. First, early intervention by parents, caregivers, or professionals for children and adolescents who have experienced the death of a parent may allow an opportunity to decrease negative risk factors and increase exposure to positive resiliency factors (Werner, 1989). Second, the fact that parentally bereaved children and adolescents are at such high risk of harmful physical, emotional, and behavioral disturbances needs to be brought to the attention of professionals and to the general public (Tucson Community Foundation, 1990). Third, increased knowledge about the protective or resiliency factors that contribute to the positive adaptation and personal holistic growth of vulnerable or at risk children and adolescents will have a profound effect on the development of many parentally bereaved individuals (Benard, 1991). Finally, knowledge of what determines whether or not a child or adolescent is resilient will provide

the professional community with necessary information to enhance the development of effective interventions for that specific targeted population.

## Statement of the Problem

Since approximately 5% to 10% of our children and adolescents will experience the death of a parent before age 18 (Osterweis, 1984; Palombo, 1981; Wass, 1991), it is important to their positive, personal growth and holistic development that appropriate caregiving and interventions be used to avoid unhealthy manifestations of their grief. However, it is estimated that approximately two out of three at risk children and adolescents manifest their grief in unhealthy ways (Werner, 1989). The other one-third "resilient" individuals adapt and oftentimes even grow from their stressful life events (Cassem, 1975). Learning more about factors associated with resilient responses to adversity may contribute to a means of reducing the pathological manifestations of the two-thirds at risk or vulnerable children and adolescents.

## Questions for Consideration

In order to develop profiles of children and adolescents that adapt well and grow following the death of a parent, this study was guided by the following questions:

1. To what extent do parentally bereaved children and adolescents identified as "holistically well" reflect Werner's Resiliency Factors (1989)?
2. To what extent are Werner's Resiliency Factors found in parentally bereaved children judged to be holistically well different from Werner's Resiliency Factors found in parentally bereaved adolescents judged to be holistically well?

It was expected that this study would show some common characteristics in parentally bereaved children and adolescents judged to be holistically well. The research for this study was conducted with the purpose of identifying important factors of "resilient" children and adolescents that warrant further investigation.

## Definitions

Because several terms are used throughout this study, the following clarification is provided:

**Bereavement**: The event of a loss. A full depressive syndrome frequently is a normal reaction to such a loss.

**Children at risk**: Children growing up under conditions of great stress and adversity.

**Grief**: A person's total emotional response to loss. Psychological pain that accompanies a major loss.

**Mourning**: The process of incorporating the experience of loss into our ongoing lives. The processing of a major loss.

**Resiliency**: The capacity to cope effectively with the internal stresses of their vulnerabilities. Resiliency is evident in an individual who overcomes adversity, who survives stress, and who rises above disadvantages.

**Resiliency or protective factors**: Those traits conditions, situations, and episodes that appear to alter or even reverse predictions of life stressors. Those variables that discriminate between those who develop behavioral and psychological problems and those who do not.

**Trauma or stressful life event**: An external event of such magnitude in its meaning to the child that the ego is overwhelmed, flooded with affects, and temporarily made incapable of dealing with or defending against the assault.

**Vulnerable**: Perceived condition of a child or youth that experiences major stress, adversity, and risk in his/her environmental systems (home, community, schools).

**Holistically well**: Wholeness in mind, body, spirit, and community resulting in not only normal health but also optimum health and functioning. The characteristics of the healthy person over the life span are

described under Adler's five life tasks: (1) spirituality, (2) self-regulation, (3) work, (4) love, and (5) friendship.

## Assumptions

The validity of this study rests partly upon the following assumptions:

1. The participants in this study were competent; e.g., were able to answer the questions given by the interviewer.
2. The participants understood the questions as intended by the interviewer.
3. The participants provided candid responses to the questions.
4. The data gathered by interview and questionnaire were reliable and valid measures of the variables.
5. The sample was representative of parentally bereaved children and adolescents, their families, and environments.

## Limitations

This study combined features of both semistructured interviews, available records collection, and questionnaires. The interview and questionnaire format carried with it some standard limitations. Specific limitations were identified as follows:

1. The participants may have answered the questions in a way which increased their positive appearance to the interviewer.

2. The results of this study do not generalize to all parentally bereaved children and adolescents since the participants were drawn from a support center for grieving children and adolescents and their caregivers and not randomly selected.
3. The results of this study do not generalize to all parentally bereaved children and adolescents because the sample was limited to a specific population in the Southwestern section of the United States.
4. The participants may have had previous contact with the interviewer in a support group at Children to Children. This previous contact may have biased responses.

## Purpose of the Study

The purpose of this study was to determine the extent that parentally bereaved children and adolescents identified as holistically well reflect Werner's Resiliency Factors. The second purpose of this study was to examine differences in Werner's Resiliency Factors reflected in parentally bereaved children identified as holistically well and parentally bereaved adolescents identified as holistically well.

## Summary

The death of a parent affects approximately 5% to 10% of children and adolescents before the age of 18 in the United States (Osterweiss, 1984;

Palombo, 1981; Wass, 1991). Early awareness and promotion of positive "resiliency factors" to outweigh the stressful trauma of a parental death contributes to the healthy development and growth of grieving children and adolescents. Increased knowledge regarding "resiliency factors" reflected by parentally bereaved children and adolescents identified as holistically well can enhance the opportunities for education of the general public and health professionals. An early awareness and intervention could mean the difference in healthy development, adaptation, and growth leading to a better quality of life for many vulnerable or at risk children.

The following chapters include a review of the available literature, an overview of the methods and procedures used in this study, the results and analysis of the study, and finally a discussion of the implications of the study, and the possibilities for future research.

# CHAPTER 2

# REVIEW OF THE LITERATURE

## Introduction

In order to more fully understand the concept of resiliency in parentally bereaved children and adolescents, a review of the literature pertaining to the relevant topics follows. This review is divided into five sections. The first section deals with the child's and adolescent's development and conceptualization of death. The second section describes the prevalence and effects of parental death on children and adolescents. The third section reviews the concept of loss and growth as it pertains to this study. The fourth section of this chapter pertains to "holistic wellness" over the life span. The fifth section discusses resiliency and the factors found in resilient individuals.

## Cognitive Development and the Child's Conceptualization of Death

A review of the literature concerning a child's or adolescent's concept of death suggests that young people develop a death concept directly related to age and are also affected by environmental factors, life experiences,

and parental attitudes. Substantial evidence indicates that children develop attitudes about death gradually and in certain defined stages (Glicken, 1978).

It is generally accepted that a newborn baby does not possess the intellectual capacity to understand the abstract concept of death (Johnson-Soderberg, 1981). Evidence does indicate that at about 3 months of age a separation anxiety begins to develop when the infant is removed from the sight of a parent and placed with unknown individuals (Deutch, 1937). Separation anxiety is thought to begin at about 5 weeks, peak at about 7 to 10 months, and then level off at about 18 months (Schaffer & Emerson, 1964). The phenomenon of separation anxiety may be the beginning of the fear of death.

Those working in the field of children, adolescence, and death do not all agree on the age at which a healthy child is able to develop a death concept. Johnson-Soderberg (1981) contended that children 3 years and younger cannot distinguish between absence and death. Elkind (1977) argued that from age 3 to 5 years children do not understand the meaning of death. Several researchers (S. Anthony, 1940; Kane, 1979; Koocher, 1974; Nagy, 1948) suggested a child's conceptualization of death follows Piaget's theory of cognitive development.

Piaget referred to four stages of children's cognitive development. The sensorimotor stage, ages early infancy to 18 months, is the foundation

for future development. It appears infants do not perceive permanence in objects, behaving as though objects lose their existence when they are no longer in sight. Certainly by the end of the first year of life a child emotionally reacts to separation from a parent (Smith, 1985).

The second stage, ages 18 months to 6 or 7 years, is the preoperational stage. Children tend to see physical objects as alive and having feelings and intentions; there is no such thing as accidental or chance occurrences, and past and future are barely grasped. A child in this stage uses egocentric thinking, seeing the world only as it relates to the child (Smith, 1985). According to Elkind (1977), death, in the sense of termination of life, is not really understood by children during the preoperational stage.

Children acquire concrete operations at around 6 or 7 years of age lasting until around 11 or 12 years of age according to Piaget. These operations are an internalized set of actions that allow children to do in their heads what before they had to do with their hands. The quality of thinking is less dominated by egocentric reasoning as seen in previous stages. Children in this stage of development appear to be able to internally process life experiences; however, they are not entirely capable of abstract reasoning (Smith, 1985). Hostler (1978) stated that the concept of death as a permanent cessation of life and as an inevitable and universal phenomenon occurs during the concrete operations stage. However, Kubler-Ross (1969) noted

that the child does not develop a realistic conception of death as a permanent biological process until about 9 or 10 years.

The final Piagetian stage of development begins at about 11 or 12 years of age and extends until age 14 or 15. This stage is called the formal operations stage in which it begins to occur to the child that he or she will die (Elkind, 1977). The child displays a quality of thinking that is adult in nature. The capacity for abstract thinking is evident during this stage of development. This stage of development allows an adolescent to change perspectives and look at death from various points of view. The adolescent shares the adult view of death as inevitable and universal (Smith, 1985). Time is an important factor for the adolescent because the adolescent lives intensively in the present from moment to moment. Death is only a remote possibility (Johnson-Soderberg, 1981).

Nagy (1948), a follower of Piaget, detailed three age-related stages of the child's awareness of death:

**Stage 1: Nagy, like Piaget found that children under 5 years relate to death in egocentric ways.**

"The dead are simply less alive" (Osterweis, 1984, p. 101). They consider death to be reversible subject to magical power. The child senses the pain of separation and may be actively engaged in seeking behaviors (Smith, 1985).

**Stage 2: During this stage, roughly ages 5-9 years, Nagy observed that children attributed a personality to death.**

Death is acknowledged as not reversible and understood in concrete terms, yet as something external to the child (Smith, 1985). Death happens only to other people (Osterweis, 1984).

**Stage 3: After age 9, Nagy concluded that children have realistic knowledge about death as an irreversible and inevitable human experience.**

They grasp the concept of finality of death (Smith, 1985). The causes of death can be understood as well as the association with the cessation of bodily activities (Osterweis, 1984).

Two important factors influence a child's conceptualization of death. First, the beginning of school can dramatically change a child's perception of death (Swain, 1979). A child may begin to demonstrate concepts similar to those held by older children, exhibiting less magical thinking and an increase in realistic thinking based on biological and societal factors. A second important factor in a child's conceptualization of death is socioeconomic status. In a study by McIntyre, Angle, and Struempler (1972) evidence appeared that children from low socioeconomic groups were more likely to cite violence as the general and specific cause of death, whereas middle-class children cited diseases and old age as general causes of death.

## Parentally Bereaved Children and Adolescents

The death of a parent is considered to be a critical life trauma for a child or adolescent (DeSpelder & Strickland, 1987; Grollman, 1967). In order to understand the impact of such a loss, the event itself must be considered, as well as its possible traumatic nature.

A trauma may be defined as an "external event of such magnitude in its meaning to the child that the ego is overwhelmed, flooded with affects, and temporarily made incapable of dealing with or defending against the assault" (Palombo, 1984, p. 17). It is noteworthy that emphasis is not placed on the event itself but rather on the psychological impact the event has on the child or adolescent.

Many studies (Balk, 1983; Birtchnell, 1970a, -b; Elizur & Kaffman, 1983; Kliman, 1968; Rutter, 1966; Van Eerderwegh, Bieri, Parilla, & Clayton, 1982) have focused on the pathological affects of parental death on children and adolescents. Osterweis (1984) contended that such a loss may precipitate or contribute to the development of a variety of behavioral and medical consequences as well as psychiatric disorders. Osterweis further contended that this experience can render a person emotionally "vulnerable for life."

A few of the pathological reactions that researchers have found in children and adolescents following the death of a parent are discussed by Osterweis (1984).

**Medical Consequences**

Parental death has been linked to an "activation" of specific diseases such as thyrotoxicosis, rheumatoid arthritis, and diabetes in late childhood or adolescence (Osterweis, 1984). Raphael (1983) suggested that persons who have experienced such a traumatic loss as the death of a parent are more likely to demonstrate ill health in later years as an adult. Seligman, Gleser, and Rauh (1974) linked early parental death with increased illness even as an adolescent. Schmale and Iker (1971) found a possible association between childhood loss and the development of cancer.

**Psychiatric Consequences**

Parental death has been associated with a number of psychological symptoms such as neurosis and depression. Kaffman and Elizur's study (1982) found that about 40% of paternally bereaved normal preadolescents demonstrated a significant increase in both neurosis (Remus-Araico, 1965) and psychosis (Barry & Lindeman, 1960). Researchers have even implicated early parental death as being linked to impairment to sexual identity (Archibald, Bell, Miller, & Tuddenham, 1962) and capacity for intimacy (Remus-Araico, 1965). Bowlby (1980) and Lloyd (1980) suggested that childhood bereavement may be linked to significant increases in depressive disorders even by a factor of 2 or 3.

Early childhood bereavement has even been linked to suicide attempts later in life by a number of studies (Birtchnell, 1970a, -b; Greer, 1966). Birtchnell discovered during his study (1970a, -b) that twice as many depressed suicide attempters were parentally bereaved compared with non-suicidal depressives.

A review of the literature indicates that there has been much evidence linking early parental death to unhealthy behavioral, psychological and physical consequences (Balk, 1983; Birtchnell, 1970a, -b; Rutter, 1966). The research indicates that a number of variables have been identified that affect the chances that a child or adolescent will be considered vulnerable or at risk for these pathological consequences. These include the age of the child, gender of the deceased and of the bereaved, and the nature of social supports following bereavement.

**Child's Age as a Factor**

The impact of parental death will be greater when it occurs at certain ages or stages than at others. Bowlby (1980) and Rutter (1966) have found that bereaved children under the age of 5 are more susceptible than older children to pathologic outcomes. Bowlby (1980) specifically found that children aged 6 months to 4 years were at particular risk. Rutter (1966), however, concluded that the ages 3 and 4 are a particularly vulnerable period because he found an excess of parental deaths among psychiatric clinic

patients during those years. His research indicated that children under the age of 1 or 2 are less distressed than bereaved older children because there has been less time to develop ties.

Early adolescence may also be a vulnerable time in terms of pathologic outcomes following parental death. Rutter (1966) found that the severely depressed children in their studies mostly seemed to be adolescent boys who had lost their fathers.

**Gender as a Factor**

Studies regarding the gender of the deceased and the bereaved have yielded interesting but inconsistent results. Brown, Harris, and Copeland (1977) studied both community samples and women psychiatric patients and concluded that girls are more vulnerable than boys to parental bereavement in general and more vulnerable to loss of a father during adolescence. Beginning at about age 3, yearning for the dead parent tends to be more pronounced when the opposite-sex parent dies (Kliman, 1979). Kliman further noted that special anxieties about filling the role of the deceased may develop when the same-sex parent dies.

**Social Supports as a Factor**

The social support available to the child or adolescent following the death of a parent is an important modifying variable that can minimize trauma

(Osterweis, 1984). However, most of the time the child's primary source of support would be the surviving parent. This is often unfortunate because the surviving parent may be sad and anxious processing his/her own grief following the death of a spouse.

A widowed mother may express impatience and irritation with children and adolescents following the death of the father (Bowlby, 1980; Glick, Weiss, & Parker, 1974). The common situation following a parental death may be considerable chaos, disorganization, and a sense of insecurity (Osterweis, 1984).

## Loss and Growth

Let death be thy teacher. . . .
St. Augustine

Loss is regarded by society as negative; at best it is pictured as a necessary evil. Few people seek out loss or bereavement, but it may actually serve as an impetus for growth (Cassem, 1975).

Growth and wellness are by definition positive and strongly pursued. Our society looks favorably on "personal growth" or "maturity" and sets a goal of "holistic wellness."

What does growth, wellness, and maturity have to do with loss and bereavement? It seems to be commonly accepted that the ability to endure and recover from loss is a sign of maturity. The trials of adversity and

human reactions to tragedy have long been sources of great interest. In fact, systematic psychologies such as those of Frankl and Adler have functioned around human behavioral responses to loss (Cassem, 1975).

Viktor Frankl (1984) was an European existentialist who wrote of prisoners' survival of the adverse conditions of life in Nazi concentration camps. He developed a psychological system of logotherapy organized around the concept that a sense of choice or purpose in life can determine a positive outcome even in the face of loss and tragedy. "To live is to suffer, to survive is to find meaning in the suffering. If there is a purpose in life at all, there must be a purpose in suffering. If he succeeds he will continue to grow in spite of all indignities" (p. 11).

## Holistic Wellness over the Life Span

Alfred Adler, a Viennese philosopher and psychiatrist, developed a philosophy upon which developed the theory of individual psychology. Adler (1954) observed that the final purpose of the psychic life "is to guarantee the continued existence on this earth of the human organism, and to enable him to securely accomplish his development" (p. 28). This existence and development is paramount even in the face of adversity.

Jung (1958) observed that the human seeks integration, that there is an instinctual drive toward wholeness and health. Witmer and Sweeney (1992) proposed a model of wellness over the life span based on Adlerian

philosophy. Themes of this wellness paradigm relate to wholeness of mind, body, spirit, and community. The characteristics of a holistically well individual are described under five life tasks. The characteristics of wellness are expressed through the five Adlerian life tasks of (1) spirituality, (2) self-regulation, (3) work, (4) love, and (5) friendship.

**Spirituality for Holistic Wellness**

At the center of wholeness is spirituality. "Spirituality for our purpose assumes certain life enhancing beliefs about human dignity, human rights, and reverence for life" (Witmer & Sweeney, 1992, p. 141). A number of variables help define spiritual wellness:

1. Oneness and inner peace are key components of spiritual wellness and unity for an individual. Achievement of spiritual wholeness involves a striving for inner peace, and freedom from conflict and fragmentation. Development that is perceived as harmonious with a supreme being that cares about and intervenes in human activity is considered beneficial for inner peace (Witmer & Sweeney, 1992).
2. A sense of purpose, belonging, and involvement is a second important dimension of spiritual wholeness. Dreikurs (1964) contended that we are social beings and therefore are strongly motivated by the desire to belong. A sense of security can depend on a feeling of belonging.

3. Optimism appears to be a prime factor that characterizes holistically well individuals. As a dimension of spirituality, it serves as an expression of hopefulness. Optimism allows an individual to dwell on the most hopeful aspects of a situation (Witmer & Sweeney, 1992).
4. Moral values are those that guide our ability to act in our own behalf while also demonstrating respect for others. The proverbial golden rule seems to best embrace this concept. "Do unto others as you would have them do unto you" (Witmer & Sweeney, p. 141).

**Self-regulation for Holistic Wellness**

Self-regulation includes the majority of the characteristics of a holistically well person:

1. Self-worth and a sense of control are two factors commonly combined under the heading of self-esteem. A sense of worth is marked by a strong acceptance of self and human nature. An individual with a sense of worth has accepted his/her weaknesses and imperfections without being anxious or upset. A sense of control encompasses areas such as competence, locus of control, and self-efficacy. Perceived competence enables an individual to view life as manageable allowing less anxiety and minimal physical symptoms (Witmer & Sweeney, 1992). An individual's locus of control determines

tendencies to feel and act helpless, or feel and act influentially in one's own behalf (Witmer & Sweeney, 1992).

2. Realistic beliefs about life contribute to self-regulation. Realistic beliefs are founded on seeing reality more as it is, not as one might desire it to be. Realistic beliefs of healthy individuals recognize that which is rational and logical in addition to that which is distorted or wishful thinking (Witmer & Sweeney, 1992).
3. Spontaneity and emotional responsiveness contribute to holistic wellness. A healthy individual often responds to events in a childlike simplicity and authenticity. Montagu (1981) listed children's spontaneous and emotionally responsive traits as including a sense of wonder, playfulness, joyfulness, laughter and tears, and dance and song. With nurturing, these traits can be carried into adulthood as healthy behaviors and positive emotional expressions.
4. Intellectual stimulation, problem solving, and creativity are traits that naturally unfold with a growing child. These traits include the need to know, the need to learn, the need to organize, curiosity, a sense of wonder, exploration, flexibility, open-mindedness, imagination, and creativity (Witmer & Sweeney, 1992).
5. A sense of humor is an essential component of holistic wellness. Humor facilitates problem solving, minimizes defensiveness, improves

interpersonal communication, and reduces stress (Witmer & Sweeney, 1992).

6. Physical fitness and nutrition serve a primary role in self-regulation. Regular and proper exercise improves mental functioning, self-image and mood, while decreasing stress, anxiety, and depression (Witmer & Sweeney, 1992). Research in the area of nutrition indicates a relationship between food, physical health, moods, and optimal performance (Wurtman, 1986, cited in Witmer & Sweeney, 1992).

**Work for Holistic Wellness**

Work can provide a sense of well being to persons of all ages. Adler (1954) defined work as including everything we do to sustain ourselves and contribute to the sustenance of others. Children's play and leisure time as well as time spent in educational activities are included as the life task of work (Witmer & Sweeney, 1992). Satisfaction in work has been found to have a number of benefits such as reduced anxiety and stress, fewer physical symptoms, greater productivity, and a sense of meaning in life (Kobasa, 1982, cited in Witmer & Sweeney, 1992).

**Friendship for Holistic Wellness**

Friendship is defined by Witmer and Sweeney (1992) as "all those social relationships that involve connection with others either individually or

in community, but do not have a marital, sexual or familial commitment" (p. 144). Adler (1954) considered "social interest" as innate to human nature. Each person has the need to be connected with each other in a relationship.

A study in Michigan revealed that those persons with the least social contacts had two to four times the mortality rate of the better socially connected persons (House, Robbins, & Metzner, 1982). The lack of friendship interactions can also lead to loneliness. McWhirter (1990) has related loneliness to such variables as depression, suicide, alcohol abuse, anxiety, adolescent delinquency, and poor self-concept.

Cohen (1988) noted that in the absence of friendships, illness, a shorter life expectancy, and less satisfaction in life are likely results for individuals who fail to make connections with friends.

**Love for Holistic Wellness**

The Adlerian life task of love is defined by Witmer and Sweeney (1992) as the tendency "to be intimate, trusting, self-disclosing, cooperative, and long-term in commitment. . ." (p. 145). Vaillant (1977) examined the relationship between loving and health in a 30-year study at Harvard. His findings support the position that trust, intimacy, caring, companionship, compassion, and similar qualities of a loving relationship promote good health and longevity.

Based on the Adlerian life tasks, Witmer and Sweeney (1992) found 11 characteristics of holistically well people. These characteristics include: (1) spiritual values, (2) sense of worth, (3) sense of control, (4) realistic beliefs, (5) spontaneous and emotional responsiveness, (6) intellectual stimulation, problem solving and creativity, (7) sense of humor, (8) physical fitness and nutrition, (9) success in work task, (10) satisfaction in friendships and social network, and (11) satisfaction in intimate relationships.

## Resiliency in Children and Adolescents

In today's society, children and adolescents are faced with stressful situations on a daily basis. Stress has become accepted as an integral part of life. However, a growing number of children and adolescents are bombarded with overwhelming traumatic adversities in life. These traumatic conditions of great stress may include poverty, neglect, abuse, war, parental alcoholism or criminality, or even the illness or death of a loved one (Benard, 1991). These traumas may be of such a magnitude that the child's or adolescent's ego is overwhelmed and temporarily made incapable of dealing with or defending against the assault (Palombo, 1981). These traumatic conditions or events render a child or adolescent at risk or vulnerable for pathological emotional, behavioral, and physiological development (Johnson, 1989).

Much research of the past has focused on risks for development of "problem behavior." This type of focus perpetuates a problem perspective and implicates an inevitability of negative outcomes. However, the longitudinal research, beginning in the late 1950s, revealed some amazing findings.

In 1955, Emmy Werner began a longitudinal study of 698 infants on the Hawaiian island of Kauai. Werner followed the infants for 30 years and specifically focused on 204 individuals or 30% of the beginning cohort that were designated as being high risk due to extreme adverse conditions (Werner & Smith, 1982). After following these at risk or vulnerable individuals for the first 3 decades of their lives, Werner (1989) determined that one out of three grew into competent adults who "loved well, worked well, and played well" (p. 108D).

Werner, as well as other researchers (Garmezy, 1991; Garmezy & Rutter, 1983; Segal, 1986) identified a number of resiliency or protective factors in the families, outside the family circle, and constitutional factors within the resilient children themselves. These resiliency factors are those "traits, conditions, situations and episodes that appear to alter, or even reverse, predictions of negative outcome and enable individuals to circumvent life stressors" (Garmezy, 1991; Segal, 1986). The following specific resiliency factors have been consistently identified as describing the resilient child or adolescent and his/her environment.

**Constitutional Resiliency Factors**

Resilient children and adolescents are commonly described as being socially competent, good problem solvers, autonomous, hopeful, and possessing a sense of purpose (Werner & Smith, 1982). Each of these broad descriptions can be broken down into specific attributes of resiliency that lie inherently within the child or adolescent.

1. Social competence is a commonly identified quality of resilient children or adolescents. This attribute includes the qualities of responsiveness, flexibility, empathy and caring, communication skills, and a sense of humor.

   A responsive child can elicit positive attention from caretakers and have his/her needs met readily (Werner & Smith, 1982). A flexible child can adapt even in infancy and find alternative ways of looking at things (Werner & Smith, 1982). A good sense of humor provides a child or adolescent a means to generate comic relief as well as the ability to laugh at themselves and ridiculous situations (Masten, 1986). A child or adolescent who is viewed as empathic and caring tends to establish more positive relationships with others, including friendships with their peers (Berndt & Ladd, 1989; Werner & Smith, 1982).

2. Problem solving is a second attribute commonly identified in resilient children and adolescents. Problem-solving skills include the ability to think abstractly, reflectively, and flexibly, and to be able to attempt alternate solutions for problems. Literature provided by researchers Halverson and Waldrup (1974) indicates that "a child who can demonstrate at an early age that he or she is an agent capable of producing change in a frustrating situation tends to be active and competent" (p. 717). Rutter (1984) found in his research with high risk abused and neglected girls that planning skills provided a means to successfully negotiate the demands of their environments or not survive. The girls used their planning skills to plan marriages to nonabusive men.
3. Autonomy is defined as a "sense of one's own identity and an ability to act independently and exert some control over one's environment" (Benard, 1991, p. 4). Researchers have used different terms to refer to autonomy. Anthony and Cohler (1987) referred to a "strong sense of independence," Werner and Smith (1982) to an "internal locus of control," and Rutter (1984) and Garmezy and Rutter (1983) referred to "self-esteem" and "self-efficacy."

Adaptive distancing is identified as a part of autonomy in resilient children and adolescents. Researchers, Berlin and Davis (1989) studied children living in alcoholic families. They described adaptive

distancing as the process of breaking away from the family focus on dysfunction and viewing oneself as separate from the family problems. Such distancing provided a buffer that was protective of developmental course, of self-esteem, and of ability to acquire constructive goals (Chess, 1989).

4. A sense of purpose and hope for the future is a common thread of resilient children and adolescents. Within this heading fall several related attributes commonly identified in resiliency literature: healthy expectancies, goal-directedness, success orientation, achievement motivation, educational aspirations, persistence, hopefulness hardiness, belief in a bright future, a sense of anticipation, a sense of a compelling future, and a sense of coherence (Benard, 1991).

Hope and a sense of purpose appear to be the strongest predictor of positive outcome (Benard, 1991). A key component of effective coping with inevitable life stresses appears to be a sense of coherence, confidence that one's internal and external environment is predictable and that things will probably work out as well as can be reasonably expected. According to Seligman (1991), "learned optimism" or a sense of purpose and hopefulness, lies in direct contrast to "learned helplessness" found in individuals with emotional and social problems (1982).

Werner's research (1989) also sets forth a few other characteristics of resilient individuals such as being first born and female. Werner further pointed out a resilient child or adolescent as possessing the ability to focus attention, and having a special interest or hobby.

**Resiliency Factors within the Home Environment**

The quality of the home environment is a powerful predictor of outcome for children and adolescents. Resilient home environments provide caring and support, establish high expectations for children's and adolescent's behaviors, and encourage children's and adolescent's participation in the family.

1. Most children identified as resilient have had the opportunity to establish a close bond with at least one person (not necessarily a parent) who provided them with stable care and from whom they received adequate and appropriate attention during the first year of life (Werner, 1989, p. 108D).

Werner's reference to a child's or adolescent's need for appropriate attention during the first year of life is affirmed by Rutter (1979), but he further contended that a caring and supportive relationship is critical throughout childhood and adolescence.

Caring and support in the home environment provide tools for healthy development in children and adolescents. Werner and Smith (1982) explained that constant support from a few adults early in life

--not necessarily a parent--gave the resilient infants a sense of trust and coherence. In 1963, Erik Erickson identified the "sense of basic trust" as the critical foundation for human development and bonding, and therefore human resiliency. Bronfenbrenner (1983) discussed that in order to minimize the negative effects of stressful life events and to develop healthily, a child needs the consistent loving involvement of one or more adults in care and joint activity with that child.

2. Research in the field of resiliency has consistently identified high parental expectations as a contributing factor to resilient youth. Mills (1990) worked with families living in very difficult, stressful situations in housing projects in Miami, Florida. His research indicated that a parental attitude expressed to children and adolescents of "You have everything you need to be successful--and you can do it!" played a large role in mitigating problem behaviors such as substance abuse. Haan (1989) has made interesting findings about effects of parental expectations on the development of morality in young children. She found that "childhood resiliency and vulnerability have specific relationships to the moral climate of families that build children's expectancies about the nature of moral interchanges" (p. 40).

A family climate with high moral expectations validates the work of human beings, accepts human faults and encourages forgiveness

of self and others. A family climate with high expectations is structured and disciplined with clear rules and regulations. Families endure stressful life events better if they are able to maintain some order and clear expectations for all family members (Bennet, Wolin, & Reiss, 1988).

Werner (1990) found another key component of high expectations is that of faith. A number of studies of resilient children (Anthony & Cohler, 1987; Werner, 1989) from a wide variety of socioeconomic and ethnic backgrounds have noted that their families have held religious beliefs that provided stability and meaning to their lives, especially in times of hardship and adversity. Werner (1990) further concluded that a faith seems to allow resilient children and those in their environment a sense of coherence, a conviction that their existence has meaning, and a belief that things will work out well despite unfavorable circumstances.

3. Resilient children and adolescents are acknowledged as valued participants in the life and work of their family. Werner and Smith (1982) found that families of resilient children and adolescents provide opportunities for the youth to participate and contribute in meaningful ways. For example, assigned chores, care of other siblings, and

even parttime work to help support the family prove to be sources of feeling competent for resilient children and adolescents.

Concomitant with opportunities to participate and contribute are characteristics such as "respect for autonomy" or "encouragement of independence" (E. Anthony, 1974). This respect and encouragement acknowledges a child or adolescent as a valued person that is worthy and capable of contributing to a family's well being.

Werner (1989) further pointed out other family factors that appear to nurture resiliency. For example, a family of small size (four or fewer children) with children spaced at least 2 years apart appears to promote resiliency (Werner, 1989). All of the above-mentioned family characteristics provide an environment to facilitate the development of the constitutional resiliency factors evident in resilient children.

**Resiliency Factors within the School**

Garmezy (1991) provided evidence that the school can serve as a "protective shield" to help children endure and develop in a healthy fashion in spite of difficult life circumstances. His research identifies the important components of school environments that promote resiliency. The components parallel those identified in the home environments of resilient children

and adolescents. Caring and support, high expectations, and the opportunities for participation and involvement are those factors discussed.

1. The level of caring and support within the school environment is an important predictor of positive outcome for children and adolescents. Werner (1990) noted that teachers are among the most frequently encountered positive role models in the lives of youth. For the resilient child or adolescent, a special teacher was not just an academic instructor but also a confidant and positive model for personal identification (Werner, 1990).

   The school is also a place where caring friends and peers are available. Werner (1989) found caring friends a major factor in the development of resiliency in her vulnerable or at risk population. Interacting in a positive, cooperative system amongst peers can provide a sense of purpose and belonging for youth.

   Resilient youth have and take the opportunity to fulfill the basic human need for social support, caring, and love. If these basic needs are not fulfilled in a home environment, either temporarily or permanently, it is essential that a school become a provider. The caring and supportive environment of a school can serve as a "protective shield" for vulnerable or at risk youth and even prevent future problems (Benard, 1991).

2. Schools that establish high expectations for children and adolescents foster resiliency in validating competence. Successful schools with high expectations have certain characteristics: an academic emphasis, teachers' clear expectations and regulations, high level of student participation, many varied resources such as a library, art, and music facilities. Rutter (1979) concluded that schools that foster high self-esteem and that promote social and scholastic success reduce the likelihood of emotional and behavioral disturbance.

   The messages a child or adolescent hears from parents, teachers, and peers become internalized. If the messages evolve out of caring, support, and high expectations ("You are bright and capable."), the child or adolescent believes in a bright and hopeful future.

3. Schools that encourage student participation promote resiliency in youth. According to Rutter (1984), schools with low levels of problem behaviors provided students with a lot of responsibility. These schools created a system to ensure that all students found something they were interested in and could succeed in.

   The active component in student participation is the basic human need to belong, to participate, and to have some sense of control over one's life. Sarason (1990) expressed this well:

> When one has no stake in the way things are, when one's needs or opinions are provided no forum, when one sees oneself as the object of unilateral actions, it takes no particular wisdom to suggest that one would rather be elsewhere (p. 57).

The encouragement of participation in school validates a student's worth and competency and provides a sense of being an important participant in the world.

## Summary

The death of a parent is a critical life trauma faced by a growing number of our nation's children and adolescents. The age and developmental stage of the child at the time of the parent's death determines the conceptualization of death as it pertains to the child's world.

The majority of parentally bereaved children tend to develop varying degrees of emotional, physiological, or behavioral problems at some point in time. A number of variables have been identified that affect the development of pathological consequences. These include the age of the child at the time of the parent's death, gender of the deceased parent and of the bereaved child, and the nature of the social supports following bereavement.

The death of a parent is considered a great loss to a child or adolescent. Loss is usually considered negative. However, loss may actually serve as an impetus for growth and wellness. The suffering involved in healing from such a loss may actually provide opportunity for success and

endurance. An attitude can develop of expecting a positive outcome even in the face of loss and tragedy.

Holistic wellness, as defined in this study, encompasses an individual as a whole entity. Themes of wholeness relate to mind, body, spirit, and community. Characteristics of wellness are expressed through the five Adlerian life tasks of spirituality, self-regulation, work, love, and friendship.

Much research of the past has focused on the majority of the parentally bereaved population that manifest grief in unhealthy ways. However, there is a significant number of children and adolescents who, following the death of a parent, develop into competent holistically well individuals. These youth are considered resilient because they have the capacity to cope effectively, overcome adversity, and rise above disadvantage. Evidence of resiliency can be found in factors within the child or adolescent and can also be fostered within the family and school environments.

The key to resiliency is determined by the balance between risk factors, stressful life events, and resiliency factors. As long as the balance is favorable, with protective and resiliency factors outweighing the risks and stressful events, successful adaptation is possible.

Chapter 3 describes the procedures, sample selection, instruments used, and the methods of analysis for this study.

# CHAPTER 3

# PROCEDURES

## Introduction

This chapter discusses the procedures and methodology used in this study. It includes descriptions of the population sample, the procedures of data collection, a review of the instruments utilized, and the methods of data analysis.

## Sample Selection

The sample for this study consisted of a total of 7 participants, 5 children and 2 adolescents, between the ages of 5 and 18 who were parentally bereaved. This study also included a total of 4 surviving parents and a total of 7 school teachers of the parentally bereaved children and adolescents. The participants were former participants in the Children to Children program in Tucson, Arizona. The Children to Children program is a support program for children ages 3 to 18 who are grieving the death of someone they love.

A total of 23 children and adolescents from 15 families were initially referred. An initial contact letter with a description of the study enclosed

was mailed to each family inviting them to participate in this study. Follow-up phone contact was attempted within a week of the letter's receipt. Of the 15 families referred, 4 were very willing to participate and "help other children following the death of a parent." The remaining 11 families were not available for the following reasons: 3 families did not return numerous phone messages left either on an answering machine or with a family member; 1 family's phone had been disconnected with no new number listed; 2 families had moved and had requested unpublished phone numbers; 1 family changed its phone number to an unpublished status; 2 families were not able to be reached by phone following numerous attempts; 2 families declined participation in this study. Responses from these 2 declining families were "Find someone else because my children are a mess" and a new step-mother said "Leave them alone so they can just forget about it."

All participants were assured orally and in writing of the anonymity and confidentiality of their responses. In addition, they were free to withdraw at any time without incurring ill will or affecting any future participation in the Children to Children program.

## Procedures of Data Collection

The participants entered this study by referral from the Children to Children program, a support group for bereaved children. The recruitment protocol criteria for referral was to refer all parentally bereaved children and

adolescents, ages 5 to 18. Each child or adolescent must have a parent or guardian available to participate in the study. Each child or adolescent must also have a school teacher available to participate in the study. This project was reviewed and approved by the Human Subjects Review Committee at the University of Arizona (Appendix A).

An initial contact letter (Appendix B) with a description of the study (Appendix C) enclosed, was mailed to each family inviting them to participate in this study. Follow-up contact was attempted within a week of the letter's receipt. An interview with the child or adolescent and the surviving parent was arranged in the family home.

All participants read and voluntarily signed a Subject Consent Form (Appendix D). The participant's parent or guardian read and voluntarily signed the Parental Consent Form (Appendix E). All the participants were told they were participating voluntarily, all the information obtained would be confidential and anonymous, and they were free to leave the study at any time without adversely affecting any future participation in Children to Children support groups or incurring ill will.

After a family entered the study, information was collected by the interviewer. The data used for this particular study was obtained using direct face-to-face interview format as well as self-report inventories. In a private location within the home selected by the child or adolescent, the child or

adolescent responded to the interviewer's statements on the Child and Adolescents version of the Youth Wellness Scale (Appendix G). At the same time, the parent responded to the Parent/Caregiver version of the Youth Wellness Scale (Appendix H) and Scale I of the Resiliency Factors Inventory (Appendix I). Demographic data (Appendix F) were obtained from the files of the Children to Children program and parental report.

The designated teacher for the child or adolescent was contacted through the school principal. An interview time at the school allowed the teacher to complete Scale II of the Resiliency Factors Inventory (Appendix J).

## Instrumentation

The instruments used in this study were developed to assess holistic wellness and determine the evidence of resiliency in parentally bereaved children and adolescents.

This study was designed to use available information from multiple sources. Reports from parents/caregivers provided data related to their child's or adolescent's holistic wellness, constitutional resiliency factors, and the resiliency factors within the home. The teachers provided information regarding the child or adolescent's constitutional resiliency factors and resiliency factors in the school environment. The child or adolescent

self-reported regarding his/her holistic wellness and in all three areas of resiliency.

**The Demographic Inventory**

The Demographic Inventory (Appendix F) obtained the following data: gender of child/adolescent, school grade, school name, teacher name, names and ages of family members (alive and deceased), date of death of deceased parent, cause of death, memorial attendance by child/adolescent, surviving parent's marital status, parent's educational level, ethnic background of parents, annual income, and loss of income following parent's death.

**Youth Wellness Scale**

The Youth Wellness Scale (Appendices G & H) was designed specifically for this study and was used to assess overall wellness. The scale design was based on the Adlerian life tasks in the areas of: spirituality, self-regulation, work, friendship, and love. The assessment of "wellness" in this study is built on an integrated paradigm for wellness and prevention connecting mind, body, spirit and community. The five Adlerian life tasks provide a theoretical structure to examine the integrated paradigm of wellness. The attributes of a healthy person as described through the life tasks would indicate wellness. The YWS is a 29-item two-part wellness report. The first part of the YWS is a 29-item dichotomous self-report measure (Appendix G).

The second part is a dichotomous report made by the parent or caregiver for the child or adolescent covering the same 29 items as the first part (Appendix H). Each part has scores ranging from 0 to 29 with higher scores representing "wellness."

The Youth Wellness Scale (YWS) was first tested for clarity and effectiveness in a pilot study with 5 children and adolescents who were presented as healthy, well-rounded youth. Their parents also participated in this pilot study. This pilot sample indicated that a score of 22 or above on the first part represented holistic wellness. The score of 22 on Scale I was selected to represent wellness because it represented the presence of over 70% of the possible holistic wellness factors. This pilot sample further indicated that a score of 21 or above on the second part represented holistic wellness. The score of 21 on Scale II was selected to represent wellness because it represented the presence of over 70% of the possible holistic wellness factors. Pilot study participant responses were not included in this data.

Reliability of the YWS was determined by use of the Kuder Richardson reliability coefficients. This method of analysis was selected because of the dichotomous structure of the YWS items and the single administration of this instrument. The interitem consistency or reliability of .66, ($\underline{n}$ = 7) was obtained.

**Resiliency Factors Inventory**

The Resiliency Factors Inventory (Appendices I & J) also designed specifically for this study, was used to determine evidence of Werner's resiliency factors in the children and adolescents. Figure 1 provides an overview of each specific resiliency factor as indicated by Werner's (1989) research findings. Also represented in Figure 1 are the RFI items and the YWS items used to assess for presence of Werner's Resiliency Factors. The RFI, a two-part Likert-type scale was designed to assess resiliency as described by Werner in three areas: Constitutional resiliency factors within the child or adolescent, (2) Resiliency factors within the home environment, and (3) Resiliency factors within the school environment. Scale I (Parent/ Caregiver Version) is a 22-item measure. Scale II (Teacher Version) is a 17-item measure.

Reliability and Validity

> Reliability refers to the consistency of scores obtained by the same persons when re-examined with the same test on different occasions or with different sets of equivalent items, or under other variable examining conditions (Anastasi, 1988, p. 109).

The YWS and the RFI are both self-report and observer-report measures. Evidence of the reliability of these research instruments was indicated by the accuracy of the data reported by the subjects to the

Figure 1. Werner's Resiliency Factors measured by the RFI and YWS

| Resiliency Factor | Item RFI(I) | RFI(II) | YWS(I) |
|---|---|---|---|
| Personality Characteristics | | | |
| High Activity Level | 1, 5 | | |
| Low Degree of Excitability Distress | 2, 3, 6, 10 | | |
| Affectionate | 7, 8 | | |
| No Distressing Eating Habits as Infant | 10 | | |
| Positive Self-concept | | | 3, 19 |
| Social Competence | | | |
| Responsiveness | 8, 11 | | |
| Flexibility | | | 6 |
| Sense of Humor | | | 29 |
| Empathic and Caring | | | 2 |
| Problem Solving | | | |
| Abstract Thinking | | | 2, 18 |
| Flexibility in Thinking | | 2 | |
| Asks for Help When Needed | 13 | 17 | |
| Ability to Focus Attention | | 1 | |
| Internal Locus of Control | | | 4 |
| Autonomy | | | |
| Sense of Control Over Self | | | 4 |
| Adaptive Distancing | 14 | 12, 15 | |
| Seeks Out New Experiences | 12 | 16 | 23 |
| Relies on Informal Network of Support | 15, 16, 17 | 11 | |
| Special Interests/Hobbies | | 5, 6, 7 | |
| Sense of Purpose and Hope | | | |
| Healthy Expectations | | | 12, 3, 6 |
| Goal Directedness | | | 18 |
| Success Orientation | | | 14 |
| Persistence | | 4, 17, 2 | |
| Educational Aspirations | | 4, 16 | |
| Belief in Bright Future | | | 18 |
| Sense of Coherence and Belonging | | 14 | 1, 10 |

a. Werner's Constitutional Resiliency Factors

| Resiliency Factor | Item RFI(I) | Item YWS(I) |
|---|---|---|
| Caring and Support | | |
| Much Attention Paid to Child during First Years of Life | 18 | |
| Close Bond with at Least One Caretaker | 18 | 13 |
| Sense of Basic Trust | | 27 |
| Unconditional Love | | 13 |
| High Parental Expectations | | |
| Shared Values | | 2, 5, 16 |
| Sense of Coherence | | 1, 5, 10 |
| Role Model in Family of Same Gender | 20 | |
| Structure and Rules in Household | 21, 22 | |
| Encouragement of Participation | | |
| Caretaker of Siblings | 19 | |
| Assigned Chores as Part of Daily Life | 22 | |

b. Werner's Resiliency Factors within the home environment

| Resiliency Factor | RFI(II) Item |
|---|---|
| Caring and Support | |
| School May Serve as Home Away from Home | 12 |
| Teacher May Serve as Role Model and Confidant | 13 |
| Positive Peer Interaction | 6, 8, 9, 10 |
| High Expectations | |
| Problem Solving Skills Facilitated | 2 |
| Adequate Reading Skills | 3 |
| Perceived as Good Student | 4 |
| Encouragement of Participation | |
| Extra Curricular Activities Available and Used | 14 |
| Special Interests and Hobbies Encouraged | 6, 7 |
| Motivation to Try New Experiences | 16 |

c. Werner's Resiliency Factors within the school environment

interviewer and the fact that the instruments appear to have validity for respondents relative to the stated purpose of the research.

Validity is defined as "the degree to which the test actually measures what it purports to measure" (Anastasi, 1988, p. 28). The YWS appears to be valid because it was designed to measure specific characteristics of Wellness as determined by research findings of Alfred Adler and previous literature. The RFI appears to be valid because it was designed to measure specific characteristics of resiliency as determined by research by Emmy Werner and previous literature (Figure 1). Both instruments appear valid because they measure the characteristics and factors purported to be measured.

The YWS and the RFI scales are collected in an interview format. This method of data collection is considered to yield usable information as a component of an assessment package. Laing (1988) cited four criteria that should be met by self-reports and observed reports: (1) the respondent must clearly understand what information is requested, (2) the information requested must be available to the respondent, (3) the respondent must be willing to provide the information, and (4) the examiners must be able to interpret the response accurately. Each of the these criteria was fulfilled by the instruments used in this study. The respondents were able to clearly and concisely understand the requested information and allowed to ask for

clarification if needed. The information requested was available to the respondents either through self-report or observation. The respondents indicated willingness to provide requested information by eagerness to respond to statements. The interviewer was able to interpret the responses accurately as possible and derive valuable information from results.

## Methods of Analysis

In order to address the questions for consideration in this study, the following statistical procedures were used:

The first question guiding this study was considered by rating the mean for each specific resiliency factor.

The Likert scale design for the RFI was structured on a scale of 1 to 4 (1 = Never, 2 = Sometimes, 3 = Most of the Time, 4 = Always). Means of each specific factor above 3.0 (Tables 1, 2, and 3, pp. 64, 68, & 71, respectively) indicated a likelihood of that specific Werner's resiliency factor being present in the sample.

The dichotomous design for the YWS was structured on a scale of 1 to 2 (1 = Yes, 2 = No). Means of specific factors of 1.0 or 1.1 (Tables 1 & 2) indicate a likelihood of that specific Werner's resiliency factor being present in the sample.

The second question guiding this study was not examined because of the insufficient size of the sample ($n$ = 7).

## Summary

This study examined the evidence of resiliency factors in parentally bereaved children and adolescents identified as holistically well. Results were analyzed using the means of specific resiliency factors of the RFI and the YWS.

In Chapter 4 there is a presentation of the results of the study according to the guidelines provided by the questions guiding the study and the methods of analysis in Chapter 3.

# CHAPTER 4

# RESULTS

## Introduction

The primary purpose of this study was to identify resiliency factors evident in "holistically well" parentally bereaved children and adolescents. A second purpose was to examine the differences between resiliency factors evident in parentally bereaved children, and resiliency factors evident in parentally bereaved adolescents.

## Results of Analysis

The Youth Wellness Scale was scored on both scales to assess for holistic wellness. All 7 children and adolescents participating in the study scored at least 22 on Scale I indicating holistic wellness. All 4 parents participating scored at least 21 on Scale II, indicating holistic wellness of their child or adolescent. Thus, each participant was identified as holistically well and retained in the study for further analysis.

The results of each question for consideration in this study follows. The first research question examined was:

**To what extent do parentally bereaved children and adolescents identified as holistically well reflect Werner's Resiliency Factors?**

In order to address this question, the means of specific resiliency factors were calculated as reflected in Tables 1, 2, and 3. Table 1 reflects the means of constitutional resiliency factors, Table 2 reflects the means of resiliency factors within the home environment, and Table 3 reflects the means of resiliency factors within the school environment.

Specific results of Werner's resiliency factors evident in these parentally bereaved youth as reported by parents/caregivers, teachers, and self-report in the three areas of (1) constitutional resiliency factors, (2) resiliency factors within the home environment, and (3) resiliency factors within the school environment.

**Constitutional Resiliency Factors**

The constitutional resiliency factors as reported by parent/caregivers and teachers on Scales I and II of the RFI and by the child or adolescent on the Child and Adolescent Version of the YWS include Social Competence, Personality Characteristics, Sense of Purpose and Hope, Problem Solving, and Autonomy (Table 1).

Table 1. Means of Constitutional Resiliency Factors as reported by parent/caregiver, teacher, and self-report (n = 7)

| Resiliency Factor | Parent* | Teacher* | Self** |
|---|---|---|---|
| Personality Characteristics | | | |
| High Activity Level | 3.4 | — | — |
| Low Degree of Excitability Distress | 2.8 | — | — |
| Affectionate | 3.2 | — | — |
| No Distressing Eating Habits as Infant | 3.7 | — | — |
| Positive Self-concept | — | — | 1.0 |
| Social Competence | | | |
| Responsiveness | 3.4 | — | — |
| Flexibility | — | — | 1.0 |
| Sense of Humor | — | — | 1.0 |
| Empathic and Caring | — | — | 1.0 |
| Problem Solving | | | |
| Abstract Thinking | — | — | 1.0 |
| Flexibility in Thinking | — | 2.9 | — |
| Asks for Help When Needed | 3.3 | 3.3 | — |
| Ability to Focus Attention | — | 3.3 | — |
| Internal Locus of Control | — | — | 1.1 |
| Autonomy | | | |
| Sense of Control Over Self | — | — | 1.1 |
| Adaptive Distancing | 2.1 | 2.7 | — |
| Seeks Out New Experiences | 3.1 | 2.6 | 1.0 |
| Relies on Informal Network of Support | 2.1 | 1.8 | — |
| Special Interests/Hobbies | — | 2.7 | — |
| Sense of Purpose and Hope | | | |
| Healthy Expectations | — | — | 1.0 |
| Goal Directedness | — | — | 1.0 |
| Success Orientation | — | — | 1.1 |
| Persistence | — | 3.2 | — |
| Educational Aspirations | — | 3.0 | — |
| Belief in Bright Future | — | — | 1.0 |
| Sense of Coherence and Belonging | — | — | 1.1 |

* Parent and Teacher Report based on Likert Scale of 1 to 4 (1 = Never, 2 = Sometimes, 3 = Most of the Time, 4 = Always).

** Self-report based on Dichotomous Scale of 1 and 2 (1 = Yes, 2 = No).

Social Competence included (1) responsiveness, (2) flexibility, (3) sense of humor, and (4) empathic and caring nature. All 7 children and adolescents reported being flexible, and empathic and caring, as well as having a good sense of humor. The parents/caregivers indicated that their children or adolescents were considered responsive most of the time ($\bar{X}$ = 3.4, 3 = Most of the Time) as an infant by pediatricians. Thus, all 4 of Werner's Social Competence factors were observed in this group.

The Personality Characteristics included specific areas such as (1) a high activity level, (2) a low degree of excitability and distress, (3) affection, (4) no distressing eating habits as an infant, and (5) self-concept. All 7 children and adolescents indicated having a healthy self-concept. The parents/ caregivers reported their child or adolescent almost always had no distressing eating habits as an infant ($\bar{X}$ = 3.7, 4.0 = Always). Parents/ caregivers further reported a high activity level for their child or adolescent ($\bar{X}$ = 3.4, 3.0 = Most of the Time) as well as being affectionate ($\bar{X}$ = 3.2, 3.0 = Most of the Time). Thus, 4 of the 5 Werner Personality Characteristic factors were observed in this sample.

A Sense of Purpose and Hope was examined by characteristics such as (1) healthy expectations, (2) goal directedness, (3) success orientation, (4) persistence, (5) educational aspirations, (6) a belief in a bright future, and (7) a sense of coherence and belonging. All 7 children and adolescents

reported having healthy expectations in life, a sense of goal directedness, and a strong belief in a bright and hopeful future. Six of the 7 children and adolescents reported an orientation to success as well as a sense of coherence and belonging. Parents/caregivers reported their child or adolescent was persistent ($\bar{X}$ = 3.2, 3.0 = Most of the Time) and had educational aspirations ($\bar{X}$ = 3.0, 3.0 = Most of the Time). Thus, all 7 of Werner's Sense of Hope and Purpose factors were observed in this group.

Problem-solving Characteristics included (1) the ability for some abstract thinking, (2) flexibility in thinking, (3) the ability to ask for help when needed, (4) the ability to focus attention, and (5) an internal locus of control. All 7 children and adolescents reported being able to think in some abstract manner. Six of the 7 children or adolescents indicated an internal locus of control. Both parents/caregivers ($\bar{X}$ = 3.3, 3.0 = Most of the Time) and teachers ($\bar{X}$ = 3.3) agreed that the children and adolescents had the ability to elicit help in solving problems as needed most of the time. Teachers further reported the child or adolescent as being able to adequately focus attention ($\bar{X}$ = 3.3, 3.0 = Most of the Time). Thus, 4 of the 5 Werner's Problem-solving factors were observed in this sample.

Autonomy was examined by looking at areas such as (1) a sense of control over self, (2) adaptive distancing, (3) the ability to seek out novel experiences, (4) a reliance on an informal support system, and (5) possession

of a special interest or hobby. All 7 children and adolescents reported the ability to seek out novel experiences as a factor in their autonomy. This desire for new experiences was confirmed by parent/ caregiver report ($\bar{X}$ = 3.1, 3.0 = Most of the Time). Six of the 7 children and adolescents reported a sense of control over self. Thus, 2 of the 5 Werner's Autonomy factors were observed in this sample.

**Resiliency Factors within the Home Environment**

Werner's resiliency factors within the home environment were reported by Parents/Caregivers on Scale I of the RFI, and by the children and adolescents on the Child and Adolescent Version of the YWS as reflected in Table 2. These factors included Caring and Support, High Parental Expectations, and Encouragement of Participation.

Caring and Support were assessed by reports of (1) the amount of attention paid to the child or adolescent during the first years of life, (2) a close bond with at least 1 caretaker, (3) a basic sense of trust, and (4) unconditional love. All 7 children and adolescents reported a close bond with at least 1 caretaker, a basic sense of trust, and a perception of unconditional love. Parent/caregiver report confirmed a close bond between the child or adolescent and at least 1 caretaker ($\bar{X}$ = 3.9, 4.0 = Always). Parents/ caregivers further indicated that a great amount of attention was paid to the

Table 2. Means of resiliency factors within the home environment as reported by parent and self-report (n = 7)

| Resiliency Factor | Parent* | Self** |
|---|---|---|
| Caring and Support | | |
| Much Attention Paid to Child during First Years of Life | 3.9 | --- |
| Close Bond with at Least One Caretaker | 3.9 | 1.0 |
| Sense of Basic Trust | --- | 1.0 |
| Unconditional Love | --- | 1.0 |
| High Parental Expectations | | |
| Shared Values | --- | 1.0 |
| Sense of Coherence | --- | 1.1 |
| Role Model in Family of Same Gender | 4.0 | --- |
| Structure and Rules in Household | 3.2 | --- |
| Encouragement of Participation | | |
| Caretaker of Siblings | 1.8 | --- |
| Assigned Chores as Part of Daily Life | 3.1 | --- |

* Parent Report based on Likert Scale of 1 to 4 (1 = Never, 2 = Sometimes, 3 = Most of the Time, 4 = Always).

** Self-report based on Dichotomous Scale of 1 and 2 (1 = Yes, 2 = No).

child or adolescent during the first years of life ($\bar{X}$ = 3.9, 4.0 = Always). Thus, all four of Werner's Caring and Support within the Home factors were evident in this sample.

High Parental Expectations involved assessment of areas such as (1) shared values by the family, (2) a sense of coherence and belonging in the family, (3) the presence of a role model in the family of the same gender as the child or adolescent, and (4) structure and rules in the family household. All 7 children and adolescents reported shared values in their home environments. Six of the 7 children and adolescents indicated a strong sense of coherence in their families. All parents/caregivers reported a same gender role model for their child or adolescent in the family ($\bar{X}$ = 4.0, 4.0 = Always). Thus all 4 of Werner's High Parental Expectations factors were observed in this group.

Encouragement of participation was assessed by areas such as (1) the child or adolescent's role as a caretaker of siblings and (2) assigned chores as part of daily life. Parent/caregiver report indicated that the children and adolescents had assigned chores in the family ($\bar{X}$ = 3.1, 3.0 = Most of the Time). Thus 1 of the 2 Werner's Encouragement of Participation in the Home factors was observed in this group.

**Resiliency Factors within the School Environment**

Werner's resiliency factors within the school environment were reported by teachers on Scale II of the RFI as reflected in Table 3. These factors included High Academic Expectations, Caring and Support, and Encouragement of Participation.

High Academic Expectations in the school environment were assessed by specific factors such as (1) facilitation of problem-solving skills, (2) adequacy of the child's or adolescent's reading skills, and (3) the teacher's perception of child or adolescent as a good student. Teacher report indicated that the children and adolescents were perceived as good students ($\bar{X}$ = 3.4, 3.0 = Most of the Time). Teachers further reported that the children and adolescents ($\bar{X}$ = 3.1, 3.0 = Most of the Time) had adequate reading skills. Thus 2 of the 3 Werner's High Academic Expectations factors were observed in this sample.

The Caring and Support in the school environment was examined by specific factors such as (1) the school being considered as a "home away from home," (2) a teacher serving as a role model and confidant, and (3) positive peer interactions. Teacher report indicated that the children and adolescents had positive peer interactions with fellow students ($\bar{X}$ = 3.2, 3.0 = Most of the Time). Thus, 1 of the 3 Werner's Caring and Support in the School factors was observed in this group.

Table 3. Means of resiliency factors within the school environment as reported by teacher (n = 7)

| Resiliency Factor | Teacher* |
|---|---|
| Caring and Support | |
| School May Serve as Home Away from Home | 2.5 |
| Teacher May Serve as Role Model and Confidant | 2.6 |
| Positive Peer Interaction | 3.2 |
| High Expectations | |
| Problem-solving Skills Facilitated | 2.9 |
| Adequate Reading Skills | 3.1 |
| Perceived as Good Student | 3.4 |
| Encouragement of Participation | |
| Extra Curricular Activities Available and Used | 2.8 |
| Special Interests and Hobbies Encouraged | 2.3 |
| Motivation to Try New Experiences | 2.6 |

* Teacher Report based on Likert Scale of 1 to 4 .
(1 = Never, 2 = Sometimes, 3 = Most of the Time, 4 = Always).

The Encouragement of Participation was assessed by specific factors such as (1) the availability and use of extracurricular activities, (2) the encouragement of the child or adolescent to share a hobby or special interest, and (3) the motivation to try new experiences. Teachers indicated that at school the children and adolescents did not show evidence of Werner's resiliency factors in this area. Thus, none of Werner's Encouragement of Participation in School factors was observed in this group.

This study also sought to answer a second question:

**To what extent are Werner's Resiliency Factors found in parentally bereaved children judged to be holistically well different from Werner's Resiliency Factors found in parentally bereaved adolescents judged to be holistically well?**

The small sample size (n = 7), 5 children and 2 adolescents, did not provide sufficient information to answer this question.

## Additional Findings

This study assessed 4 additional Werner's Resiliency Factors. Results of these additional findings follow.

Two Werner's constitutional resiliency factors as reported by the Demographic Inventory were being (1) first born and (2) female. Four of the

7 children or adolescents were either first born or only children. Four of the participants were female.

Two Werner's resiliency factors within the home environment reported by the Demographic Inventory were (1) four or fewer children in the family, and (2) a space of two or more years between the child or adolescent and siblings. The families of all 7 children or adolescents participating in this study had 4 or fewer children. Six of the 7 children or adolescents had at least 2 years space between them and their siblings.

## Summary

All 7 children and adolescents, who agreed to participate, were preliminarily identified as holistically well with results of the Youth Wellness Scale. Werner's Resiliency factors were identified for these holistically well children and adolescents in three broad areas as designated by Werner's research findings: (1) Constitutional Resiliency Factors within the Child or Adolescent, (2) Resiliency Factors within the Home Environment, and (3) Resiliency Factors Within the School Environment. Figure 2 provides a brief summary of Werner's Resiliency Factors as reported present. The summary indicates the observation of 5 areas of constitutional resiliency factors, 3 areas of resiliency factors within the home, and 2 areas of resiliency factors within the school environment.

Constitutional

1. Social Competence
2. Personality Characteristics
3. Sense of Purpose and Hope
4. Problem Solving
5. Autonomy

Home Environment

1. Caring and Support
2. High Parental Expectations
3. Encouragement of Participation in Family

School Environment

1. High Academic Expectations
2. Caring and Support

Figure 2. Summary of Werner's Resiliency Factors reported present in sample

One of the two questions for consideration guiding this study was answered. The small sample size ($n$ = 7) did not provide sufficient information to answer the second question for consideration.

Chapter 5 is a review of the findings, discussion, and conclusions about the findings, discussion, and conclusions about the findings, limitations of the study, and recommendations for further study.

# CHAPTER 5

# SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

## Introduction

This chapter summarizes the study, draws conclusions based on the findings, and offers recommendations for future study.

## Summary of the Study

The primary purpose of this study was to identify resiliency factors evident in parentally bereaved children and adolescents identified as "holistically well." A second purpose was to examine the differences between resiliency factors evident in parentally bereaved children identified as holistically well and resiliency factors evident in parentally bereaved adolescents identified as holistically well. The sample for this study consisted of 7 participants, 5 children and 2 adolescents between the ages of 5 and 18. They were referred to this study by the Children to Children support program for grieving youth.

The instruments used in this study were specifically developed to assess holistic wellness and evidence of Werner's Resiliency Factors. The Youth Wellness Scale was developed with the five Adlerian life tasks as it's

foundation. The Resiliency Factors Inventory evolved from Emmy Werner's longitudinal resiliency study.

The most prevalent resiliency factors evident in parentally bereaved children and adolescents identified as holistically well were:

1. Constitutional resiliency factors such as (a) social competence, (b) positive personality characteristics, (c) a sense of purpose and hope, (d) adequate problem solving skills, and (e) a sense of autonomy.
2. Resiliency factors within the home environment such as (a) caring and support, (b) high parental expectations, and (c) encouragement of participation in family.
3. Resiliency factors within the school environment such as (a) high academic expectations and (b) caring and support.

## Discussion and Limitations of the Results

There were several components of the results of this study that will be discussed in this section. The key topics of the results include an interpretation of the results, the limitations of the study, generalizations, implications and recommendations for future research.

The study was guided by two questions.

1. To what extent do parentally bereaved children and adolescents identified as holistically well reflect Werner's Resiliency Factors?

2. To what extent are Werner's Resiliency Factors found in parentally bereaved children identified as holistically well different from Werner's Resiliency Factors found in parentally bereaved adolescents identified as holistically well?

Data appropriate to the study were collected for 7 bereaved youth, analyzed and reported. This data provided enough information to support the first question. Parentally bereaved children and adolescents identified as holistically well do reflect a number of Werner's Resiliency Factors.

It appears from the results of this study that the foundation of resiliency lies within the child or adolescent as constitutional resiliency factors. The participants of this study, their parents/caregivers and teachers created a portrait of how a resilient child or adolescent might appear following the death of a parent.

Participant responses indicated a resilient child or adolescent that has experienced the death of a parent would be well taken care of because of his/her social competence. People would enjoy being with him/her because of the youth's affection and responsiveness. The flexible nature of the child or adolescent would allow him/her to reframe the difficulty of a situation and view it from a different perspective. A good sense of humor would permit the child or adolescent some comic relief as well as those people around him/her. Another important factor for surviving a stressful life event would

be the ability to be empathic and caring for others and taking the focus off of self.

The basic personality of the parentally bereaved child or adolescent plays an important role in his/her survival. All of the children and adolescents reported a positive self-concept in spite of the loss they have experienced. The basic belief of being a worthwhile individual and an important part of society would provide motivation for healing. **"I am worth it."**

Another characteristic reported by these resilient children and adolescents was a sense of purpose and hope. The resiliency literature, as reviewed in Chapter 2 indicates this is the most powerful predictor of positive outcome for youth. A key component to rising above disadvantage is the belief that things will probably work out. The participants in this study validated this with their report of believing in a bright and hopeful future. This picture of a bright future allows them to set goals for their future and maintain healthy expectations for themselves and the world around them.

The participants of this study further reported themselves as adequate problem solvers. They seem to believe they have the ability to exert some control over their environment and their future. They see themselves as actively determining their course in life and not just sitting on the sidelines. This "internal locus of control" allows these youth to act in their own best interest. These children and adolescents have a realistic understanding that

they do not have all of the answers to life's problems within them. However, they do have the ability to elicit help when needed as confirmed by both parents/caregivers and teachers.

Autonomy is the final Constitutional Resiliency Factor examined in this study. The participants reported feeling they have choice and some control over their life and environment. One of the choices that these children and adolescents make for themselves is independence. They are able to act cooperatively but independently of their surrounding environment. All of the participants in this study reported accepting the challenge of new experiences and learning new things. New experiences and new knowledge provide a sense of one's own identity separate from outside influences. This independence was validated by parents/caregivers and teachers.

Following the death of a parent, a resilient child or adolescent might appear independent and socially competent with a good self concept and a strong sense of hope. This individual has a strong foundation for overcoming stressful life events such as the death of a parent because of the constitutional resiliency within. However, this child or adolescent is not resilient in isolation. The first environment that is encountered is that of the home. The participants in this study and their parents/caregivers have portrayed what a home environment that fosters resiliency might look like.

The caring and support within the home environment appears to be an important characteristic of a home that fosters resiliency. All of the participants validated the resiliency literature by reporting a basic sense of trust, a perception of unconditional love and a close bond with at least one caretaker. The parents/caregivers confirmed the close bond with the resilient child or adolescent as well as indicated that a great deal of attention was paid to the youth during the first years of life.

The resilient children and adolescents of this study reported high parental expectations, even following the death of a parent. A sense of shared spiritual, moral, and human values, as well as a feeling of coherence appear to play a key role in fostering resiliency. The parents/caregivers of these resilient children reported modeling the high values they expect from their children and adolescents as well as providing a role model of the same gender as the child or adolescent. The youth is not only taught spiritual, moral and human values, but also shown what a male or female with high values looks like.

The parents/caregivers of the resilient youth indicated that the family encourages youth participation for the well being of the family unit. Assigned chores for the child or adolescent provides a sense of being needed as a worthwhile, contributing member of the family structure.

Two further factors provided by the demographic data indicated that these families have 4 or fewer children, mostly spaced at least 2 years apart. These may be important components in providing children the individual attention and guidance necessary for resiliency.

The death of a parent changes the home environment for all members of a family. However, a home that provides caring and support, promotes high expectations and encourages meaningful participation by all family members appears to contribute to the resiliency of children and adolescents. It seems that an environment such as this would provide the fertile soil for the growth and nurturing of a basic sense of trust essential for human development.

A resilient child or adolescent acquires a strong background in the home environment. However, moving outside the home is inevitable. Usually this movement leads to a school environment. Teachers of the resilient children and adolescents described a few key components of a school that contributes to the healthy development of a resilient child or adolescent.

High academic expectations appear to contribute to a resilient youth's development and motivation. The academic literature states the schools that expect a great deal from their students, commonly get what they expect. Teachers involved in this study reported their perception of the resilient child or adolescent as a "good student." The teacher's perception would

undoubtedly contribute to the child or adolescent being treated as a good student. The teacher's conveyance of the message "You are a good student" fits well with the resilient youth's healthy self-concept. Therefore, the child or adolescent internalizes the concept of being a good student.

The school environment provides another setting outside the home for caring and support. Following the death of a parent, the role a school plays as a place of stability and security is important. A teacher may serve as a role model and confidant. School is also an ideal place for a resilient youth to try out his/her social competency. Teachers in this study commonly reported the child or adolescent as having positive peer interactions and being well liked and accepted by fellow students. This provides a sense of being worthwhile and valued as an individual.

The teachers participating in this study did not provide sufficient evidence to conclude that the resilient children or adolescents were encouraged to actively participate in their school environment.

The school environment that fosters resiliency is portrayed by the teachers involved in this study as maintaining high academic expectations and providing care and support. These are the same type of factors within the resilient child or adolescent's home environment identified previously as key components to resiliency.

The second question that guided this study was not answered by the data collected and analyzed. It was not possible to draw conclusions about the differences between the resiliency factors evident in parentally bereaved children identified as holistically well, and the resiliency factors evident in parentally bereaved adolescents identified as holistically well.

Werner's resiliency factors that were not found evident in this sample of parentally bereaved warrants some discussion. The constitutional resiliency factor of adaptive distancing was not reported as being observed in these participants. It seems the homes of these children and adolescents provided enough positive influences that adaptive distancing was not required for coping. Perhaps the families that were not available to participate in this study would have provided insight into the coping function of adaptive distancing.

Parents and teachers reported that support from an informal network of peers, teachers, and elders was not a necessary element of these participants' resiliency. Their high level of caring and support in the home environment appears to provide adequate support for coping even following the death of a parent.

Several of Werner's resiliency factors in the school environment were not observed in this sample. The school environment did not serve as a home away from home, nor did a teacher serve as a role model and

confidant. Again, the caring nature of the home environment and the close bond between the youth and their surviving parent would not require searching outside the home for these needs.

There were a number of limitations of this study. These limitations lie within the sampling methods, the instruments, and the sample.

The sample of bereaved children and adolescents were drawn from the Children to Children support program for grieving children. This program facilitates children and adolescents healing process following a significant death in their life. The fact that the sample were former participants in the support program would indicate that they were given an opportunity for growth and healing perhaps not available to all parentally bereaved children. This would be an important bias to consider in examining the results of this study.

The small size of the sample would definitely be an important component to consider in this study. Results based on a small sample tend to be unstable; that is the values may fluctuate from one sample to the next. Small samples tend to increase the probability of obtaining a markedly deviant sample. In the case of this study, the small sample yielded insignificant statistical results as well as failed to answer one of the guiding questions. The small sample would not provide opportunity for generalizations to be made to other samples outside this study.

The sampling method was not random selection but instead a form of self-selection. Once the referral was made by Children to Children, the interviewer gathered demographic information from the files of Children to Children. Then the interviewer made initial contact with the family by mail. Follow-up was attempted or made by phone contact. At this point the families were allowed the chance to communicate their willingness to participate or not.

Another limitation of this study was the inability to access all referred families. Those families that were willing to participate were happy to "help other parentally bereaved children." A great many of the remaining families were unable to be reached due to moving, unanswered phone messages, or unpublished phone numbers. Those families verbally rejecting the opportunity to participate were adamant in not sharing information regarding the children or the death of the parent outside the family. The demographics of the responding families and nonresponding families reveal some interesting facts.

The cause of parental death may provide some interesting information. The 4 responding families experienced a parental death due to a long-term illness. This would provide time for anticipatory grief and preparation for all 7 (100%) of the participating children. Demographics indicate that the 11 nonresponding families, with a total of 17 parentally bereaved children eligible for this study experienced a very different set of circumstances with regard

to the parent's death. Only 3 of the 17 nonresponding children and adolescents experienced the death of a parent due to a long-term illness. This accounted for only 18% of the nonresponding children or adolescents. The other 14 nonresponding children and adolescents experienced the sudden, unexpected death of a parent. The causes of these unexpected deaths were sudden heart attacks, drug overdoses, vehicular accidents, or unknown causes. This accounted for 82% of the nonresponding families. A sudden death would not provide opportunity for preparation or anticipatory grief processing. It is of interest that these families were not available for this study.

Several of the participants and their parents/caregivers had previous contact with the interviewer at the Children to Children support groups. This prior relationship may have biased the responses of the participants.

The high education level of the participating parents may have been a bias to study responses. Three of the 4 parents/caregivers held masters degrees in various fields. The fourth parent has an advanced nursing degree. This would indicate a value for education and knowledge, which may have contributed to their eagerness to participate. The responses of such well-educated parents and their children may have biased the study responses.

The instruments used in the study were designed specifically to assess holistic wellness and evidence of Werner's resiliency factors in parentally bereaved children and adolescents. The first scale of the Youth Wellness scale was designed and modified in order to be used with a wide age range of 5 to 18. The statements were worded in a simple concise manner in order for a 5-year old to understand. The wording of the statements seemed to work well with the younger participants, but the adolescents may have felt a little insulted by the simplistic wording. The scale itself may have biased responses to the wellness assessment. The second instrument, also designed for this study was the Resiliency Factors Inventory. One scale was completed by the parent/caregiver and the second completed by the teacher of the child or adolescent. After the data was collected, the interviewer compiled data from both scales of the RFI as well as the Child and Adolescent Version of the Youth Wellness Scale in order to assess for Werner's resiliency factors. The two scales were structured differently. The YWS was a dichotomous scale and the RFI was designed in a Likert format. This became confusing in assessing the results. The structural differences in the construction of the scales may have limited the results of the study.

Caution always needs to be used when interpreting the results of any study to generalize to other people, places, or times. This study is no

exception. This study only provides a snapshot of what this small group of parentally bereaved children and adolescents looked like at this particular point in time. Other groups of parentally bereaved children and adolescents may provide a very different picture. A sample from another geographical location may provide different results based on different cultural values or lifestyles. This same group of participants may also provide different results at another point in time. Additional life experience and growth would effect development and responses.

## Conclusions

It can be concluded that this study was able to identify specific evidence of Werner's resiliency factors in the sample of parentally bereaved children and adolescents. The knowledge and promotion of these factors may be of use in a counseling situation.

Most importantly, it can be concluded from this study that there is a need for more research in this area. Recommendations for future research follows.

## Recommendations

Future research examining the resiliency factors of parentally bereaved children and adolescents identified as holistically well can improve upon the

present study in a number of ways. Some brief recommendations are presented below.

1. Use more of a random sample of parentally bereaved children and adolescents rather than a self-select sample.
2. Replicate the study in other geographical regions to improve generalizability of results.
3. Use a larger sample size so that statistical significance can be yielded and more stable results.
4. Design the Resiliency Factors Inventory to include a third scale for the child or adolescent to self-report resiliency.

## Summary

The results of this study provide confirmation that resiliency factors are evident in parentally bereaved children and adolescents identified as holistically well. The results further support previous studies that identified resiliency as residing within a child or adolescent, within the home environment and also within the school community.

The key to resiliency, as validated by this study, is determined by the balance between risk factors, stressful life events, and resiliency factors. As long as the balance is favorable, with protective and resiliency factors outweighing the risks and stressful events, successful adaptation is possible.

These results have implications for all individuals involved in the lives of children and adolescents who have experienced the traumatic event of parental death. This study has provided important information for surviving parents and caregivers, medical and mental health professionals, and teachers who are actively involved in a parentally bereaved youth's healing process. The identification and fostering of specific resiliency factors for parentally bereaved children and adolescents may contribute to healthy development and personal growth. This study may have provided a foundation for future study in this area.

In the time it takes to read this study, several more children and adolescents have experienced the death of a parent. This traumatic event no longer has to be a sentence to severe emotional, physical or behavioral manifestations. It is imperative that the parents and professionals surrounding these young individuals invest in their future by fostering their inner strength and resiliency.

Resiliency appears to be a common thread that runs throughout the life of a holistically well parentally bereaved child or adolescent. This common thread begins deep within the child or adolescent and runs throughout their surrounding world. What develops from this common thread, weaving in and out of the life of this child, is a tapestry of a world. A world that supports and nurtures an individual who overcomes adversity, who survives stress, and who rises above disadvantages.

# APPENDIX A

## HUMAN SUBJECTS COMMITTEE APPROVAL LETTER

THE UNIVERSITY OF
ARIZONA
HEALTH SCIENCES CENTER

Human Subjects Committee

1690 N. Warren (Bldg. 526B)
Tucson, Arizona 85724
(602) 626-6721 or 626-7575

February 26, 1993

Teresa M. Goodman, B.A.
c/o Betty J. Newlon, Ph.D.
School of Family & Consumer Resources
Counseling and Guidance, 218
Main Campus

RE: **HSC A93.31** RESILIENCY IN PARENTALLY BEREAVED CHILDREN AND ADOLESCENTS

Dear Ms. Goodman:

We received your above cited research proposal. The procedures to be followed in this study pose no more than minimal risk to participating subjects. Regulations issued by the U.S. Department of Health and Human Services [45 CFR Part 46.110(b)] authorize approval of this type project through the expedited review procedures, with the condition(s) that subjects' anonymity be maintained. Although full Committee review is not required, a brief summary of the project procedures is submitted to the Committee for their endorsement and/or comment, if any, after administrative approval is granted. This project is approved effective 26 February 1993 for a period of one year.

The Human Subjects Committee (Institutional Review Board) of the University of Arizona has a current assurance of compliance, number M-1233, which is on file with the Department of Health and Human Services and covers this activity.

Approval is granted with the understanding that no further changes or additions will be made either to the procedures followed or to the consent form(s) used (copies of which we have on file) without the knowledge and approval of the Human Subjects Committee and your College or Departmental Review Committee. Any research related physical or psychological harm to any subject must also be reported to each committee.

A university policy requires that all signed subject consent forms be kept in a permanent file in an area designated for that purpose by the Department Head or comparable authority. This will assure their accessibility in the event that university officials require the information and the principal investigator is unavailable for some reason.

Sincerely yours,

William F. Denny

William F. Denny, M.D.
Chairman, Human Subjects Committee

WFD:rs
cc: Departmental/College Review Committee

# APPENDIX B

## INITIAL CONTACT LETTER TO PROSPECTIVE STUDY PARTICIPANTS

Dear Smith Family:

I am a graduate student in the Counseling and Guidance Department at the University of Arizona. I am currently engaged in research for my Master's Thesis titled "Resiliency in Parentally Bereaved Children and Adolescents."

I also have had the opportunity to be associated with the Children to Children organization since April, 1991. I have worked as a facilitator for both the children and teen groups. Most recently I enjoyed working as an Angel Project volunteer with Children to Children. I believe strongly in the organization's philosophy and am honored to work with such quality people. They truly make a difference in many people's lives.

During the next two months I will be conducting my Resiliency study in conjunction with Children to Children. I will be concentrating on children and adolescents, 5 to 18 years of age who have experienced the death of a parent. Interviews will include the child or adolescent, a parent or caregiver and possibly a school teacher. I will be assessing for holistic wellness and evidence of resiliency in the child or adolescent and his/her environment.

I believe this will be a valuable experience for all families involved, as well as informative for professionals working with bereaved children and adolescents. The children will be supported and encouraged during the interview sessions. I am aware of how important a healthy grief process is for a child or adolescent's healing following the death of a loved one.

I am contacting your family because you have experienced the death of a parent in the recent past. Your help in the project would be greatly appreciated. I am enclosing a copy of my study description for you to look over and discuss as a family. I will be contacting you in the next 2 weeks to discuss the study and your opportunity to participate. Thank you in advance for your consideration of participation. Should you have any questions, please give me a call.

Sincerely,

Teresa Goodman
Counseling Intern

# APPENDIX C

# DESCRIPTION OF STUDY

"RESILIENCY IN PARENTALLY BEREAVED CHILDREN AND ADOLESCENTS"

A Study Conducted by Teresa Goodman

PURPOSE:The purpose of this study is to identify and examine resiliency factors in parentally bereaved children and adolescents.

BENEFITS:This thesis study will provide important information to parents, counselors and professionals working with grieving children and adolescents.

CRITERIA:Subjects must be 5 to 18 years of age and have a parent or caregiver available for the study. Subjects must have experienced the death of a parent at least 6 weeks prior to beginning of study.

TIME COMMITMENT: Child/Adolescent - approximately 15 to 30 minutes. Parent/Caregiver - approximately 1 hour. Teacher - approximately 30 minutes.

CONFIDENTIALITY/ANONYMITY: Subject's name will not be attached to any instruments nor will subject's name be published. Data will be retained until thesis study is complete at which time data will be destroyed.

VOLUNTARY PARTICIPATION: Participation in this study is strictly voluntary and the subjects may withdraw at any point in time.

RATIONALE FOR THIS STUDY

I hold a strong belief that we all have within us the ability to heal following the death of someone we love. Children and adolescents are great examples of this healing process.

Many studies in the past looked at the risks children and adolescents face when they have a loved one die. In this study, my focus is on examining positive factors that exist within a child or adolescent and their environment. I believe these factors make them resilient to difficulties in life.

I appreciate your consideration of this worthwhile project and look forward to working with your family in the near future.

Teresa Goodman

# APPENDIX D

## SUBJECT CONSENT FORM

SUBJECT CONSENT FORM
"Resiliency in Parentally Bereaved
Children and Adolescents"

I am asking you to participate in a study about how children and adolescents heal after a parent dies. I am asking children and adolescents, 5 to 18 years, to help in this project. You were selected because you had a father or mother die recently. I will ask you to respond to some statements for me at least one time, for about fifteen minutes. Only you and I will be present during this interview. I will also ask your parent or caregiver some questions, as well as your school teacher.

I would like you to know that there are no known mental or physical risks for your participation in the study. You will not be paid for your participation in this study. It is important for you to know that you may ask questions and that you may leave the study at any time.

Your responses will be seen by myself and my supervising instructor only. Later when I talk about or write about the study, I will not use your name. Your identity will remain secret at all times. This consent form will be filed in an area chosen by the Human Subjects Committee, which is a group of people whose job it is to see that your rights are protected.

The results of this study will provide health care professionals more information about how children heal following the death of a parent.

* * * * * * * * * *

"I have read the above Subject Consent. The type of study and its demands, risks and benefits have been explained to me. I understand that I may ask questions and that I am free to withdraw from the study at any time. I also understand that the consent form will be filed in an area chosen by the Human Subjects Committee. A copy of this consent form is available to me if I ask for one.

Subject's Signature _____ Date _____

Parent or Guardian's Signature _____

Witness' Signature _____

# APPENDIX E

## PARENTAL CONSENT FORM

PARENTAL CONSENT FORM

This research is being conducted to study resiliency in parentally bereaved children and adolescents. The professional involved in interviewing children and adolescents would like to provide as positive experience as possible for them while obtaining accurate and complete information. Each child or adolescent will spend about 15-30 minutes in an interview with a female clinician who will conduct the interview. You will also be involved in an initial interview. Follow-up interviews may be conducted with you as well as your child or adolescent's teacher. The identity of your child or adolescent will be kept confidential in reporting the results of the study. However, should your child or adolescent report or indicate that he/she has been abused, by law, the information shared by the child or adolescent as well as his/her identity must be reported to Child Protective Services or the Police.

I _____ (parent/guardian) give permission for my child or adolescent _____ to participate in the research study described above which includes at least one interview with my child or adolescent and at least one interview with me. I also further understand that I may be asked for an additional follow-up interview. I give my authorization for the researcher to interview my child or adolescent's teacher for additional information. I further authorize the researcher to obtain demographic information from files in the possession of Children to Children regarding my child or adolescent. I further understand that if my child or adolescent reports or indicates that he/she has been abused, the information shared by the child or adolescent as well as his/her identity must be reported by the interviewer to Child Protective Services or the Police.

_____
Parent/Guardian's Signature

_____
Witness

_____
Date

# APPENDIX F

# DEMOGRAPHIC INVENTORY

DEMOGRAPHIC INVENTORY
"Resiliency in Parentally Bereaved
Children and Adolescents"

SR # _____ Age _____

Male_____ Female _____

School _____ Grade ____

Teacher _____

Names and Ages of Family Members:

Mother: _____ Age _____
Father: _____ Age _____
Sibling #1 _____ Age _____
Sibling #2 _____ Age _____
Sibling #3 _____ Age _____
Sibling #4 _____ Age _____
Sibling #5 _____ Age _____
Deceased Parent _____ D.O.D. _____
Cause of Death _____

Did Child Attend Funeral/Memorial? Yes No

Surviving Parent Remarried? Yes No

Date of Remarriage _____

Parents Education:

Mother _____

Father _____

Ethnic Background:

White ___ Black ___ Asian ___ Hispanic ___ Other___

Current Annual Income:

$0 - 8,000 ____ $8,000 - 20,000 ____
$21,000- 30,000____ $31,000 - 40,000 ____
$41,000- 50,000____ $51,000 ^ _____

Loss in income since parental death? Yes No

# APPENDIX G

## YOUTH WELLNESS SCALE I:

## CHILD AND ADOLESCENT VERSION

# YOUTH WELLNESS SCALE

Instructions: Please tell me if each of the following statements are true for you or not. Answer yes if the statement is true for you. Answer no if the statement is not true for you. If you do not understand the statement, tell me so and I will repeat it for you.

| | | | |
|---|---|---|---|
| 1. | My family helps each other. | Yes | No |
| 2. | I believe that I should "treat other people the way I want them to treat me." | Yes | No |
| 3. | I know that I am not perfect, but I like myself just the way I am. | Yes | No |
| 4. | I feel that I am not able to make my own choices. | Yes | No |
| 5. | My family appreciates and loves each other. | Yes | No |
| 6. | I like to have people like me, but it's O.K. if they don't. | Yes | No |
| 7. | I enjoy acting silly and playful sometimes. | Yes | No |
| 8. | Sometimes I feel I have more problems than I can solve. | Yes | No |
| 9. | Sometimes I feel like dancing and singing. | Yes | No |
| 10. | My family spends time talking with each other. | Yes | No |
| 11. | I exercise or play hard at least two or three times a week. | Yes | No |
| 12. | I need to do things perfectly all the time. | Yes | No |
| 13. | My parent loves me just the way I am. | Yes | No |
| 14. | I am satisfied with my work at school. | Yes | No |
| 15. | I almost always tell the truth. | Yes | No |
| 16. | My family believes in prayer. | Yes | No |
| 17. | Sometimes I feel like crying, but know that I shouldn't. | Yes | No |

| | | | |
|---|---|---|---|
| 18. | I am sure that my life in the future looks bright and hopeful. | Yes | No |
| 19. | I am as good as other people. | Yes | No |
| 20. | My family has fun together. | Yes | No |
| 21. | I get mad at myself when I do silly or embarrassing things. | Yes | No |
| 22. | People at school like to be with me. | Yes | No |
| 23. | I like to learn about new things. | Yes | No |
| 24. | I sleep well at night for about 7 to 8 hours. | Yes | No |
| 25. | I have a hard time with my friendships. | Yes | No |
| 26. | I enjoy my play or leisure activity time. | Yes | No |
| 27. | I trust my family and feel comfortable talking with my family about my problems. | Yes | No |
| 28. | I never do anything wrong. | Yes | No |
| 29. | I can usually find something to laugh about, even when things seem hard. | Yes | No |

# APPENDIX H

## YOUTH WELLNESS SCALE II:

## PARENT/CAREGIVER VERSION

YOUTH WELLNESS SCALE

PCV

Instructions: Please tell me if each of the following statements are true for your child/adolescent or not. Answer yes if the statement is true. Answer no if the statement is not true. If you do not understand the statement, ask me to clarify for you.

| | | | |
|---|---|---|---|
| 1. | Our family helps each other. | Yes | No |
| 2. | My child/adolescent treats "others as he/she wants them to treat him/her". | Yes | No |
| 3. | My child/adolescent accepts not being perfect all the time. | Yes | No |
| 4. | My child/adolescent would like to be able to make more choices on his/her own. | Yes | No |
| 5. | Our family appreciates and loves each other. | Yes | No |
| 6. | My child/adolescent enjoys being liked by people, but can also handle not being liked by people. | Yes | No |
| 7. | My child/adolescent enjoys acting silly and playful sometimes. | Yes | No |
| 8. | My child/adolescent sometimes seems overwhelmed by his/her problems. | Yes | No |
| 9. | My child/adolescent sometimes enjoys dancing and singing. | Yes | No |
| 10. | Our family spends time talking to each other. | Yes | No |
| 11. | My child/adolescent exercises or plays hard at least two or three times a week. | Yes | No |
| 12. | My child/adolescent feels that he/she needs to do things perfectly all the time. | Yes | No |
| 13. | My child/adolescent feels that I love him/her just the way he/she is. | Yes | No |
| 14. | My child/adolescent is pleased with his/her school work. | Yes | No |

| | | | |
|---|---|---|---|
| 15. | My child/adolescent almost always tells the truth. | Yes | No |
| 16. | Our family believes in prayer. | Yes | No |
| 17. | My child/adolescent has difficulty expressing feelings, even crying. | Yes | No |
| 18. | My child/adolescent is hopeful about his/her future. | Yes | No |
| 19. | My child/adolescent feels that he/she is as good as other people. | Yes | No |
| 20. | Our family has fun together. | Yes | No |
| 21. | My child/adolescent gets mad at himself/herself when he/she does silly or embarrassing things. | Yes | No |
| 22. | People at school enjoy being with my child/adolescent. | Yes | No |
| 23. | My child/adolescent enjoys learning about new things. | Yes | No |
| 24. | My child/adolescent sleeps well at night for about 7 or 8 hours. | Yes | No |
| 25. | My child/adolescent has a hard time with friendships. | Yes | No |
| 26. | My child/adolescent enjoys play and/or leisure activity time. | Yes | No |
| 27. | My child/adolescent trusts family and feels comfortable talking with family about his/her problems. | Yes | No |
| 28. | My child/adolescent never does anything wrong. | Yes | No |
| 29. | My child/adolescent is usually able to find something to laugh about, even when things seem hard. | Yes | No |

# APPENDIX I

## RESILIENCY FACTORS INVENTORY I:

## PARENT/CAREGIVER VERSION

# RESILIENCY FACTORS INVENTORY

## SCALE I

To what extent does your child or adolescent reflect the following factors? Please mark your answer to each statement as it pertains to your child. Thank you.

A = Always
M = Most of the time
S = Sometimes
N = Never

| | | | | | |
|---|---|---|---|---|---|
| 1. | Child or adolescent has fairly high activity level. | A | M | S | N |
| 2. | Child or adolescent has low degree of excitability. | A | M | S | N |
| 3. | Child or adolescent has low degree of distress. | A | M | S | N |
| 4. | Child or adolescent has high degree of sociability. | A | M | S | N |
| 5. | As an infant, child or adolescent was active. | A | M | S | N |
| 6. | As an infant, child or adolescent was easygoing. | A | M | S | N |
| 7. | As an infant, child or adolescent was affectionate. | A | M | S | N |
| 8. | As an infant, child or adolescent was cuddly. | A | M | S | N |
| 9. | As an infant, child or adolescent was even-tempered. | A | M | S | N |
| 10. | As an infant, child or adolescent had distressing eating habits. | A | M | S | N |
| 11. | As an infant, pediatricians noted alertness and responsiveness. | A | M | S | N |
| 12. | Child has tendency to seek out novel or new experiences. | A | M | S | N |
| 13. | Child or adolescent has tendency to ask for help when needed. | A | M | S | N |
| 14. | Child or adolescent is adept at recruiting "surrogate parents or caregivers." | A | M | S | N |
| 15. | Child or adolescent relies on an informal network of neighbors for counsel and support. | A | M | S | N |

16. Child or adolescent relies on an informal network of peers for counsel and support. A M S N

17. Child or adolescent relies on an informal network of elders for counsel and support. A M S N

18. Child or adolescent had opportunity to establish a close bond with at least one caretaker from whom he/she received positive attention during first years of life. A M S N

19. Child or adolescent is a caretaker of younger children in the family. A M S N

20. Child or adolescent had some role model in family of the same gender as the child or adolescent. Yes No

21. Child or adolescent has routine structure and rules in household. A M S N

22. Child or adolescent has assigned chores as part of daily life. A M S N

# APPENDIX J

## RESILIENCY FACTOR INVENTORY II:

## TEACHER VERSION

SCALE II

To what extent does your student reflect the following factors? Please mark your answer as it pertains to your student. Thank you.

A = Always
M = Most of the time
S = Sometimes
N = Never

| | | | | | |
|---|---|---|---|---|---|
| 1. | Child or adolescent has adequate ability to concentrate on assignments. | A | M | S | N |
| 2. | Child or adolescent has adequate problem solving skills. | A | M | S | N |
| 3. | Child or adolescent has adequate reading skills. | A | M | S | N |
| 4. | Child or adolescent is a good student. | A | M | S | N |
| 5. | Child or adolescent uses talents effectively. | A | M | S | N |
| 6. | Child or adolescent has special hobby that can be shared with a friend. | A | M | S | N |
| 7. | Child or adolescent has interests, hobbies, activities that are not considered gender specific. | A | M | S | N |
| 8. | Child or adolescent is well liked by classmates. | A | M | S | N |
| 9. | Child or adolescent has at least one class friend. | A | M | S | N |
| 10. | Child or adolescent usually has several class friends. | A | M | S | N |
| 11. | Child or adolescent relies on informal network of peers for counsel and support. | A | M | S | N |
| 12. | School has become a home away from home for child or adolescent. | A | M | S | N |
| 13. | Child or adolescent has a favorite teacher who serves as a role model and confidant. | A | M | S | N |
| 14. | Child or adolescent receives emotional support from extracurricular activities that allow him/her to be a part of a cooperative enterprise. | A | M | S | N |

15. Child or adolescent selected a "surrogate parent or caretaker." A M S N

16. Child or adolescent has tendency to seek out novel or new experiences. A M S N

17. Child or adolescent has tendency to ask for help when needed. A M S N

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