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RESILIENCE IN CHILDREN AND ADOLESCENTS WITH AND WITHOUT CHILDHOOD TRAUMA: A MULTI-STAKEHOLDER-FOCUSED QUALITATIVE STUDY ON RESILIENCE ASSESSMENT INDICATORS

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ABSTRACT **Background:** An adequate understanding of the phenomenology of resilience, specifically in the context of adverse childhood experiences can facilitate current clinical services. This has the potential for early identification and psycho-social management of the impact of adversities. However, research on this concept is limited especially in eastern countries. **Objective:** This study aimed to elucidate the perception of resilience and identify potential target areas for resilience assessment of children and adolescents experiencing traumatic life events. **Participants And Setting:** 81 participants belonging to one of the four groups: mental health professionals, parents, teachers, children and adolescents; were included a part of the Focus Group Discussion or semi-structured interviews. **Methods:** Employing an emergent-systematic design, constant comparison analysis was used to decode the participants' construction of the reality of their experiences and understanding of resilience in childhood and adolescence. **Results:** The multistage process thematic analysis resulted in 192 codes, 19 subdomains, and 5 domains named family dynamics; overall functioning; socio-cultural and environmental factors; abilities and coping skills; and occupation and play. Perception of resilience was found to be limited among teachers, least understood among parents, and hardly focused by clinicians. **Conclusions:** Sensitizing and training the teachers and parents on essential indicators of resiliency in a child can change the prevalence of mental illnesses, substance use, disability, and lack of productivity in a country. Further, mental health care professionals must objectively assess resilience components to expedite recovery and enhance quality of life, performance and well-being.

KEYWORDS :

INTRODUCTION

Resilience is a complex and multi-domain construct, which refers to a dynamic process encompassing positive adaptation within the context of significant adversity (Luthar et al., 2000). In addition, bouncing back to one's previous stage of normal functioning and post-traumatic growth thereafter are key components of positive adaptation after adversity. Again adversity is a broad word ranging from hardships, challenges to a state or instance of serious or continued threat to life or living to a condition marked by *misfortune, excessive struggles and consequent distress and negative fallouts on the individual.* Hence, understanding and recognising impact of adversity and strength of resilience both are important from holistic child development point of view.

On one hand, perception and appraisal of, efforts to cope with, and acceptance of the adversity by the individual play together an important role in resuming normalcy and going beyond the adversity to achieve something extraordinary. On the other hand, understanding own resilience, perception, appraisal, and efforts to enhance resilience (directly or indirectly; knowingly or unknowingly) are also crucial in individual's resilience. And age of the individual and characteristics of the adversity are very crucial in dealing with adversity due to developmental trajectories and their role in increased risk of adverse short and long-term (Izdebska & Beisert, 2018) mental health consequences (Chen et al., 2010; Cutajar et al., 2010; Fergusson, Mcleod, & Horwood, 2013). Research indicated a strong correlation between various traumatic life incidents (such as child sexual abuse) and severe mental disorders including anxiety disorders, depressive disorders, post-traumatic stress disorder (PTSD), eating disorders, sexual disorders, personality disorders, and substance abuse (Spataro, Mullen, Burgess, Wells, & Moss, 2004) including antisicial behaviour (Maniglio, 2009). And impact of such adversities could be child or context or adversity specific, therefore, studying phenomenology of adversity specific resilience could be beneficial not only to faster recovery and adaptive functioning of the children and adolescents but also for strengthening their existing resilience. While manifestation of adverse mental health impact of such adversities does not mean non-existence of resilience in a child, the moderate to severe impact of such incidents on body and mind can indicate poor resilience. Hence, it is important to assess common and specific resilience and then customise non-pharmacological preventive, curative, or promotive mental health intervention.

The study of resilience has advanced in three major waves of research over the past three decades. The first wave of work yielded good descriptions of resilience phenomena, along with basic concepts and methodologies, and focused on the individual. The second wave yielded a more dynamic accounting of resilience, adopting a developmental-systems approach to theory and research on positive adaptation in the context of adversity or risk, and focused on the transactions among individuals and the many systems in which their development is embedded. The third wave, now taking shape, is focused on creating resilience by preventive interventions, directed at changing developmental pathways (Wright, Masten and Narayan, 2013). Whilst the works of Grmzey, Rutter, Werner, Luthar, Masten and Ungar laid the grounds for research in resilience guiding policies and intervention, the emphasis by Ungar on 'cultural relativity' as one of four principles in understanding notion of resilience is noteworthy.

While cross disciplinary research on the role of context-specific protective and vulnerability processes in child development particularly, those relatively unique to particular subcultural groups (Luthar, 1999) are substantially augmenting the understanding of resilience, clinical assessment and resilience focused psychotherapeutic approaches specific to such sub-cultural groups are still a long way to go. Individuals respond differently to different adverse experiences in a dynamic environmental context. And the individual differences in the process of achieving normalcy or going beyond that depends largely upon the multitude of factors such as age, gender, socio-economic status, personality/temperament characteristics, family/neighbourhood/social/tertiary agency support system, availability of conducive physical and emotional environment and adversity characteristics (such as acute or chronic traumatic exposure, complex trauma, etc).

As resilience has capacity to change the physical and mental health outcomes, and promote adjustment and optimum functioning, the role of appropriate assessment tool and then integrating resilience into trauma/abused/adversity focused psychological intervention in childhood can have expectedly better curative, preventive and promotive roles in a developing child. However, the resilience-focused interventions reported so far are mainly targeting general children and adolescents without specific adversity history. A meta-analysis (Dray et al., 2017) reported that these interventions varied in terms of targeted resilience protective factors (e.g cognitive competence, problem solving/decision making, cooperation and communication, and coping skills), their theoretical framework (e.g following a cognitive behavioural therapy framework, positive psychology; social and emotional learning; social skills; life skills; coping skills; interpersonal and self-management skills; psychological well-being therapy; mindfulness; and mental health promotion), number of sessions, and mode of delivery of intervention (e.g. by teachers, clinicians and trained external facilitators, teachers in combination

with clinicians, or trained external facilitators). Studies reporting such school and community-based interventions for Indian children and adolescents are though limited over last three decades (Srikala and Kishore, 2010; Leventhal et al., 2016; Sarkar, Dashgupta, Sinha, and Shahbabu, 2017; Banerjee, Dasgupta, Burman, Paul, Bandyopadhyay, Suman, 2018), they were consistent with outcomes of resilience interventions although those never measured adversity impacts as outcome measures.

Overall, the literature on resilience-focused psychological interventions for children and adolescents with history of adversity is limited and inconclusive. Our scanning of a very recent narrative review study (Basu et al., 2020) revealed that in general, there is sparingly any resilience focused efficacious psychological intervention for children and adolescents with adversities across globe and in particularly no study in India. Resilience as a dynamic multilevel systemic process oriented construct which is changeable over time. Therefore, timely, appropriate and adequate assessment of impact of such traumatic or adverse experiences along with resilience in a child's life play crucial role in child's optimum development. With an adequate understanding of psychological impact of adverse childhood experiences, study of the resilience can facilitate current clinical services for early identification and psycho-social management of impact of adverse and traumatic life events. This needs expansion of phenomenology of resilience in context of traumatic adversities particularly in case of children and adolescents, hence understanding of children own ideas of themselves, the perception and recognition of resilience by their parents and teachers, and efforts of clinical and other professionals to emphasize upon could be beneficial to the developing resilience. Thus, studying the phenomenology of resilience from the key stakeholders through qualitative methodology is pivotal both in developing resilience assessment tools and psychological intervention with larger implications at the society level.

The primary objective of the present study is to understand resilience from perspective of the health professionals, teachers, children and adolescents (both who have had adverse experiences and who have not any adverse experience), and parents/primary caregivers using the qualitative approach. Building on the findings from the primary objective, the secondary objective of the study is to provide clinical recommendations for assessment of resilience in children who experience adversities.

MATERIALS AND METHODS

The study followed thematic analysis (Braun & Clarke, 2014) form of qualitative research to explore questions about participants' lived experiences, perspectives, behaviour and practices, the factors and social processes that influence and shape resilience, the explicit and implicit norms and 'rules' governing psychological/mental health interventions or child-rearing or teaching practices. With a phenomenological approach to explore the key objective, the study involved an inductive process of data analysis through codes generated from conduction of in-depth interview and focused group discussion (FGD's) and key interviews.

The qualitative method of in-depth interviews was conducted for consenting children between 8 and 18 years of age with a history of adverse childhood experience and with no apparent deficit in IQ (no clinical signs of intellectual disability and official record regarding that). FGDs were conducted for the group of parents and professionals who were consenting, available. The sample of the study was drawn from a tertiary care medical institute and few child care institutes run by both government and NGO ownership. Ethical permission was obtained for the study, and assent and consents were taken prior to the beginning of data collection in all the settings. A purposive sampling technique was employed for recruitment of participants belonging to three groups of sample, i.e., health professionals, children with & without history of adverse childhood experience, parents and teachers. FGD moderator guide was constructed keeping in mind the objectives addressed in the study in an Indian context. Separate questions were developed for each of the groups of parents, mental health professionals, and other health professionals. In-depth interviews were conducted with children on a one-to-one basis. The wording and intent of each question were kept simple and direct. A list of possible prompts was provided for each question such that we do not miss out on relevant information covered in the question and to keep the discussion on the topic focused. Group composition was kept homogenous consisting of minimum 4 and maximum 8 participants either taking parents or health professional or mental health professional in a group. A sample of FGD questions prepared for the group of mental health professionals has been presented in Table 1 and a sample key interview schedule is presented in Table-2.

Table 1 – Sample FGD Guide for Mental Health professionals

Date: Moderator Name:	FGD No. No. of Participants: Recording no.:	Location: Duration:

Part I: Understanding Psychological trauma Resilience in Children and adolescents

1. Please define resilience (in your own terms)?
2. Recalling about your experience of dealing with children and adolescents with a history of Adverse Childhood Experiences (ACE)/TLE (traumatic life events), could you please share your experience as it comes to your mind?

Probes : How many cases in total have you seen?
For how long did you work and/or follow up with these children and adolescents?
How many of them were institutionalized children and how many living with their family in their homes?
Any atypical case? What challenges did you face, etc, or anything else?

3. What are the various factors that affect resilience?

Probe: Discuss factors in detail.

4. What do you emphasize on during assessing resilience of a child? {What all indicators you think should be measured while assessing a child's resilience?}
5. Does the nature of adversity have a relationship with resilience?
6. Do some cultural &/or religious factors play a role in determining the child's resilience?
7. Do you know what is resilience called in Hindi language or your regional vernacular ?
8. Is there any other observation related to resilience which has not been discussed till now, or which may have occurred to you during discussion but was not shared? *(If yes, would you like to elaborate on the same?)*

Part II: Questions pertaining to Scale Construction:

1. What are your thoughts on crucial components of scale construction on assessing resilience in children and adolescents (8-18 years) ?
2. What are the frequently used psychological instruments you use for assessment? (*Probe: does assessment also include qualitative assessment? which instruments are preferred for clinical and research utility purposes? reasons for the same; is domain assessment preferable or a overall composite assessment more preferable*)
3. If at all a new scale is a need, especially in Indian context, what nature of scale should we considered? (*Probes: what should be some of the specific technicalities of scale construction one must keep in mind while constructing a scale for assessment of resilience;*
could one scale in simple language be used across the age range of 8-18 years or do you suggest some way else
[Probe:should there be different versions for children (8-12 yrs) and adolescents (13-18byrs)];
should it be self-reported or informant reported;
how do we arrange the domains either from most important to least or vice a versa?;
what should be the ideal no. of items and tentatively the scale response format which would be user friendly for child and adolescent age groups?)
4. Is there anything else you would like to contribute (which has not been yet discussed and requires discussion)?

Table 2- Interview Guide For Children And Adolescents

Date:	Interview No. Recording No.:	Location: Duration:

Rapport Formation: Rapport was initiated with the child before beginning the interview
Introduction & Purpose of Meeting was Explained
Assent from the Child & Adolescent Sample & Consent by Legally Authorised Representative (for children residing in CCIs) Obtained
Sample Questions
1. How do you spend your day? What do you like most about your day?
2. Did you go to school? If yes, did you like going to school? If yes or no, what did you like or dislike about your school, respectively?
3.How long have you been here (for children residing in CCI)? What brings you here (in this CCI)?
Probes: If/When the child shares adverse experiences, probe for distressing situations, led the child into teachers, excessive anger, upset or lost.
4. In your difficult times, who or what helped you the most?
5. How is your relationship with your peers here?
6. (For run-away cases) Did any problems get solved upon leaving the home?
7. Do you know what are you best at ?
8. About you, what do the people nearby praise the most ?
9. in your difficult times, which family member and how (if any did) did they help you?
10. when you don't like something around you, what do you do ?
11. who outside your family was often available for help when you need it?
12.Who do you wish is more available for your help?
13.Who do you disclose your secrets to?
14. Has living in the institution helped you in any manner?
15. How better do you think people in the institution can help you and other children ?
16. Do you watch TV/Movies or listen to the news on radio ?
17. have you ever encountered Police ? What does the plicemen do ? Do they help you or us ?
18. Do you believe in God / Almighty ?
19. Do you pray ? Does prayer help you ? If yes, how ?
20. How do you spend your free time ?
21. what play activities do you like and why ?
Closing: Session was summarized in simple words. Child was thanked and praised for their participation. Conversation ended on discussion about neutral topics. If child displayed emotional reactions by remembering the trauma associated with the incident, a supportive session was immediately provided. Only when child felt comfortable and calm, interview was terminated.

FGD and interview procedure: Duration of each FGD and interview was 45–90 minutes.

All of the interviews and most of the FGDs, were taken in person. In view of pandemic situation, some interviews & FGDs were held digitally. Interaction with parents (n=8) were held on video format (using video WhatsApp call), and with other health professionals and teachers (n=9) using a telephonic call or zoom audio call. All data taken in person or digitally, was recorded using MP3 audio recorder (with prior consent from the participants, in written for interviews conducted in persona and oral consent for interviews conducted digitally, oral consent being recorded) along with manual writing for the recording of content inflow generated. The first author was the moderator/ interviewer in all data. And the second author was the co-moderator in some FGDs and involved in manual recording of the verbal and non-verbal expressions made during FGDs. Precautions were taken to ensure privacy, and to prevent external noise, over dominance of one participant, or derailment from the topic during the proceedings of the discussion by stating the ground rules for discussion before the beginning of the FGD. For conducting in-depth interviews with children, adequate rapport building with each of them preceded the conduct of the interview.

To ensure trustworthiness of data, especially the confirmability of the test findings, investigator triangulation method was adopted where each obtained code, sub-theme and theme were cross verified with 3 other investigators. Iterative questioning was used wherever deemed necessary. Frequent debriefing sessions were conducted with the seniors with the aim to widen vision, discuss alternate approaches, recognize own biases and preferences (if any). The steps followed to enhance trustworthiness and reflexivity of the study the following steps were followed:

- Frequent debriefing sessions were held among the researchers to generate alternate opinions, hence limiting the risks researcher's bias.
- Repeated reviews of audio-recordings were done to rule out leading tone or emphasis on any point.
- Verbatims from all participants during FGDs was manually noted down by one of the researchers and 99% matching of both manual and recorded transcript was done aiming to reduce bias and increase the researcher's reflexivity.
- A power point presentation mentioning each checklist points as in FGD guide/key interview was used as an aid, thus the risk of leading voice or over emphasis on certain checklist points was reduced, hence increased the researcher's reflexivity and data trustworthiness.
- An open-ended question was kept at the end for the participants to add anything they wanted to add so as to reduce the possibility of losing any important information.
- The entire process was reviewed closely by at least two researchers at any point thus, followed audit trail of evolving ideas and interpretations.

The data was analysed using thematic analysis (Braun & Clarke, 2006) method which is defined as a form of pattern recognition that involves the identification of themes through careful reading and re-reading of the transcripts (Fereday & Muir-Cochrane, 2006). Through an iterative process of inductive analysis, the data were coded, organized, and reorganized several times as categories were created and as relations between and within subcategories led to the development of preliminary themes.

On identification that the way resilience is conceptualised, the related factors and/or domains are overlapping and no further FGD or interview was conducted once the themes were exhausted.

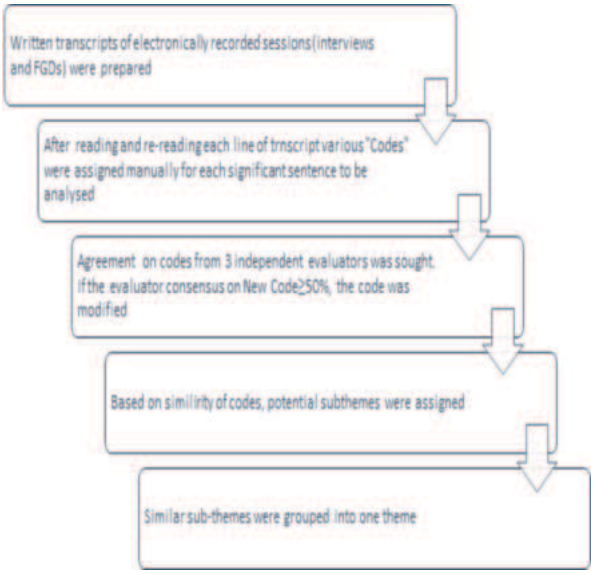

Fig.1. Flowchart of the procedure followed in qualitative analysis.

RESULTS

Findings from the qualitative data highlight the way resilience is conceptualised. The present study focused to identify current thoughts and feelings of diverse health professionals, about exploring multidimensionality in psychological trauma resilience in children and adolescents (8-18years).

Participants' Profile:

A total of 95 participants were approached, out of which 81 consenting participants were recruited (Response and retention rate is 85.3%). Three of the professionals approached for FGD could not join the group discussion, subsequently they were interviewed separately and included as Key Interviews. The 14 non consenting participants were professionals, 11 of them refused due to lack of time and 3 of them refused as their clinical experience and expertise did not match the study population (i.e. children and adolescents). All of the children, parents/caregivers and teachers approached consented to participate in the study. The children group comprised of 32 children out of which 18 were with the history of adverse childhood events and 14 without history of such events. And out of these 32 children, 21 belonged to age group of 8-12 years and 11 were adolescents. There were 14 parents, 30 health professionals (e.g. paediatric surgeons, paediatric oncologists, nurse, psychiatrist, clinical/child psychologist, counsellors in childcare institutions, etc.) directly dealing children with history of adverse childhood events in a hospital and/or a government setup, and 5 teachers. Thus, a total of 81 participants participated across focused group discussions and key interviews.

Socio-demographic characteristics

Mean age of 32 children & adolescents who participated in the study was 10.9 years and 15.3 years respectively; with a male-female ratio of 17:15. For parent group, mean age was 35.36 years. With 10 males and 20 females 30, professionals had a mean age of 37 years with an average of at least 5 years of clinical experience or experience of working with children. For teachers, mean age was 31 years and all were females (Table 3).

Table 3 - Socio-demographic Characteristics Of Participants

Total Number of Professionals	**30**				
Specializations of MHP's	Psychologist N=18	Psychiatrist N=4	Paediatrician & paediatric oncologist N= 2	Counsellors N=2	Welfare Officers N=4
Mean Age	32.7 years				
Gender distribution	M=10, F=20				
Total Number of Parents	**14**				
Mean Age	35.36 years				
Gender distribution	M=1, F=13				
Total Number of children	**32**				
	Children (8-12years) N=21 Trauma (M=3, F=5); Non trauma (M=9, F=4)	Adolescents (13-18yrs) N=11 Trauma (M=4, F=6); Non trauma (M=1)			
Mean Age	10.9 years	15.3 years			
Total Number of teachers	**5 (female)**				
Mean age	31 years				
Total no. of participants	**81**				

Qualitative Analysis

Findings from the focus groups and interviews suggested that the understanding of construct of resilience was present only amongst health professionals and teachers. Nevertheless, the children and adolescents (both who have had adverse experiences and who have not any adverse experience), and parents/primary caregivers, although did not formally know the construct of resilience contributed knowledge by describing what factors contribute to resilience and/or healthy development of children and adolescents despite adversities.

Thus, the study findings are presented in two sections based on the two objectives of the study.

First, qualitative themes are presented to elucidate - the notion of resilience as conceptualised and understood, the difference between resilience and trauma resilience, perspective on whether resilience is innate, relationship between adversity and resilience, similarity or difference in resilience between a child experiencing psychological trauma vs. life threatening illness, and perspective on stability of resilience - by health professionals and teachers.

Second, across all focus groups and interviews of participants (health professionals and teachers, children and adolescents (both who have had adverse experiences and who have not any adverse experience), and parents/primary caregivers) the transcripts were coded, grouped into themes and sub-themes to identifythe manifestation of resilience across various different domains in children and adolescents who experience adversities. Final analysis revealed 5 domains that participants viewed as being most crucial for assessment of resilience.

First Objective :

Emerged themes from Table (Table 4):

Resilience was perceived and defined in multiple ways by the health professionals and teachers. While teachers had a very restricted and limited understanding of the concept itself, health professionals lacked sensitiveness in recognition, objective assessment and integration of reliance into the holistic health care delivery framework. ** to be completed.

A total of 15 themes emerged when the transcripts were read and re-read to explore in depth the perception and understanding of the construct of resilience as deciphered through various definitions by professionals and teachers, the manner in which they differentiated resilience from trauma resilience, the relationship between adversities and resilience etc.

The four themes emergent in definitions of resilience were, ability, Bouncing back from challenging/demanding situation, Resuming normal functioning / functioning at an optimum level, Coping.

The two emergent themes in how teachers see resilience in their client/ child were help seeking behavior of the child and remaining involved in activities of child's interest.

The three themes the interview group used to differentiate trauma resilience from resilience were same construct but operates in a continuum, the manner in which child's introjected the trauma and personality traits of the child.

The group of professionals and teachers largely agreed that even though resilience is an ability and can be built upon, its also largely innate, yet dynamic.

In comparing resilience among psychological trauma vs. physical trauma, main theme was that contribution of external resilience factors are better in life threatening illnesses.

Three themes emerged when the group described link between

adversity and resilience, these were, emotional connections with people at the centre of the adversity, the type of adversity and inverse relation b/w severity of adversity and resilience.

Table 4 - Summary Of Themes Obtained From Qualitative Analysis

Open-ended questions			Subthemes
	Professional	Teachers	
Define or tell us about your understanding of resilience in children and adolescents	Resilience mostly to me is bouncing back, that ability than can, that ensures that after any adversity or roadblock that's perceived by an individual, that ability to bounce back from that situation where in the functioning is optimal level, so much so that you can go throughout, go through your daily routine and you are able to work through and your social occupational functioning is not impaired so not working at a level where everything is impaired so you are able to overcome and bounce back from any given specific situation. Resilience will be the ability to cope with any manner of stress and to find effective strategies to deal with the stress both mentally and physically. Ability to come out of something which you have experienced at worse life situations which you have seen. How do you come out of it and what are the factors which play a protective role while you are coming out of it, so that you come back to your normal routine as quickly as possible.	Resilience is you bounce back, how a child adapts to a challenging situation. Innate power, how well you can deal, handle something, interpret something which is coming on to your way whether it's a shield you can call onto yourself or whether ways you actually deal with it. Certainly, its temperament also so where in the person has own ability to cope up with a demanding situation that is somewhere under resilience also. Resilience does not have to be about dealing with big situations that seem very obviously challenging but even how you cope with everyday situations little steps you take to overcome so it can be a very everyday thing. Also may be we just need to be able to recognize it resilience is also sometimes how on everyday when you are dealing with something on everyday basis.	Ability Bouncing back from challenging/demanding situation Resuming normal functioning / functioning at an optimum level Coping
Can you give an example of resilience of resilience that you have seen in a/your child/client/student		In schools there are counselors and teachers - a system is there so actually reach out and tell you know I need help here I think that's also a great quality - that also means you are in touch with what you can do and what you cannot do so it's not necessarily being dependent, but knowing that with a little bit of support and guidance I can do it. so if a child or somebody is stuck in a situation and if we are able to see and if we are able to reach out for help, that is also a great sign of strength & I do tell a lot of children, please reach out. a lot of times you encourage them to do things on their own but at times it is important to teach them this is why seeking help is important and it doesn't make you weak. For ex if I feel close to one particular activity, if I love reading, I am able to express myself through painting; if I am able to pursue that, able to do that – if I am not losing interest in those activities, I think these are small activities which keep us going, help us survive every day, to stay true to or a sense of who I am can sort of help to go through that situation.	Help seeking behavior of the child Remaining involved in activities of child's interest

Resilience vs. Trauma resilience	Simple resilience capacity is something that most of the people may have that kind of capacity to deal with every kind of stresses. But for the traumatic resilience that is the main challenging point for a person because if a child has to face such kind of like traumatic event till what extent the person can fight with that stress or trauma. So, trauma resilience will be specific to that situation while resilience can be in terms of any stress whether it would be mental, physical, social, financial. In terms of anything but essentially it's a mental construct if we are talking in terms of mental health resilience would be a mental construct. Trauma would obviously one form as in resilience to trauma would be one aspect of resilience. I don't think these two are much different, there will be a major overlap between trauma resilience and resilience in particular apart from some factors which might be different in cases of trauma like nature of trauma and the personality factors of the individual who suffered from the trauma or in case of children, how the child introjected trauma, those things might be some of the things but apart from this there will be a major overlap between the two things.		Same construct but operates in a continuum Child's introjection of the trauma Personality traits of the child
Explain whether resilience is innate?	May be inherent but everyone may not get a sufficient chance to work on it	What you are actually talking about resilience being an innate factor is definitely I relate it to something about our personality so resilience becomes like a power to each one of us and it is an individual innate thing, I strongly believe resilience is something innate and has a very strong individual power	Largely innate
How is adversity linked to resilience?	For example, death of the grandmother will be the same incidence for the both children. That child is not showing that kind of responses but one child is showing the traumatic responses because of the emotional connection. Incidence will be the same but reaction will be different because of the emotional component. While minor trauma in a different manner the child may not be able to bear it. I don't think that the resilience per say is different for different trauma, but it is rather the other way around. The child maybe be resilient to trauma, but he may not be resilient to the other type of trauma irrespective of the severity. As the severity grows higher the chance of the child being resilient becomes lesser and lesser		Emotional connections with people at the centre of the adversity Type of adversity Inverse relation b/w severity of adversity and resilience
Comment the similarity or difference in resilience between a child experienced a rape and another who suffers a life-threatening illness.	Even though I am not sure, I feel / believe somebody having a core psychological trauma, a psychological disorder may evolve because the stress would be different. In psychological trauma I feel the environment itself is often the cause unless you say the psychological trauma is outside the parental influence. Quite often its family trauma – often the trauma is experienced at home and thus the factor which would have otherwise protected the child is already influenced.		Contribution of external resilience factors are better in life threatening illnesses
Does resilience change over time?	It's like a continuum where people move to and fro, it's not like one person - I am resilient now doesn't mean that after two years repeated failure or something might change my resilience also so it is something people move to and fro it's not a static thing, it's now .. 80% resilient, no, I might change.		Resilience is dynamic

Emerged Themes (Table-5):

A total of 192 codes were generated across 19 subthemes and 5 themes. A total of 6 subthemes (happiness, optimism and hope, disclosure and expression of difficulties, problem solving skills, hardiness, and self-efficacy) were emerged from the theme child's abilities and coping skills, followed by 4 subthemes each in overall functioning (biological functioning, interpersonal functioning, emotional functioning and self-care) and socio-cultural and environmental factors (chronic adverse conditions, institutional support, social support, and religious affiliation), 3 subthemes (academic involvement, recreational interest, and motivation to assume roles and responsibilities) in theme recreation and play, and 2 sub-themes (family environment, and familial attachment, connectedness, and support) in theme family dynamics. A total 47 codes were recorded against the theme abilities and coping skills followed up by 40 codes in overall functioning, 36 codes in socio-cultural and environmental support, 35 codes in family dynamics, and 34 codes in occupation and play theme. However, attachment and connectedness with family generated the highest frequently mentioned codes (F=20) followed by emotional functioning and reaction (F=18), recreational interest (F=17), problem solving ability (F=16), family environment and institutional support each with 15 codes. Religious affiliation, happiness, motivation to assume roles and responsibilities, and self-care codes were very less frequently occurred codes.

Table 5- Summary Of Domains And Sub-domains Obtained From Qualitative Analysis

S.No.	Domain	Sub-domains	Frequency of codes in each sub-domain	Total no. of codes
1.	Family dynamics	Family environment	15	35
		Familial attachment, connectedness and support	20	

2.	Overall Functioning	Biological functioning	7	40
		Interpersonal functioning	10	
		Emotional functioning/reaction	18	
		Self care	5	
3.	Socio-cultural & environmental factors	Chronic adverse conditions	9	36
		Institutional support	15	
		Social support	11	
		Religious affiliation	1	
4.	Abilities & coping skills	Happiness	3	47
		Optimism & Hope	7	
		Disclosure & expression difficulties	7	
		Problem solving	16	
		Hardiness	9	
		Self efficacy	5	
5.	Occupation & Play	Academic involvement	13	34
		Recreational interest	17	
		Motivation to assume roles & responsibilities	4	
Total	Domains: 5	Sub-domains: 19	**Codes: 192**	

DISCUSSION

Domain 1: Family Dynamics

In the present study, family dynamics emerged as one of the most common themes associated with assessment or resilience. As table indicates, some of the key dynamics of family affecting the child's resilience were family environment, parental relationship, familial attachment, connectedness and support. Most children were concerned that both parents were present / lived with them, parents shared a cordial relationship amongst themselves, and they expressed affection and care towards the children giving them attention and desired commodities. Since parents are primary attachment objects for children, the kind of interaction and interpersonal bond between the parent and child influences one's resilience. Many researches are provide evidence for the same. Smeekens, RiksenWalraven, and van Bakel (2007) investigated the predictive value of attachment in developing resilience, which they conceptualized as socio-emotional development. Attachment disorganization was found to predict lower ego-resiliency at the age of five years. Arend et al. (1979) also found a significant correlation between attachment classification at 18 months and ego-resilience at age of five years. Caldwell and Shaver (2012) found a potential pathway from attachment insecurity to lower levels of mood repair, which in turn contributed to lower levels of ego-resilience. Karreman and Vingerhoets (2012) found resilience to be the mediating factor in a significant correlation between quality of attachment pattern and degree of well-being. Insecure-anxious attachment style was associated with lower resilience. Close attachment bonds with a caregiver and effective parenting protect a young child in multiple ways that are not located "in the child".

Domain 2: Overall Functioning

Another prominent theme which emerged is the ways in which resilience is manifested in observable behaviours of the children in terms of their biological functioning, interpersonal functioning, emotional functioning/ reactions and self care. Children and adolescents with low resilience are likely to show change in their usual sleep pattern, eating pattern, bowel & bladder habits, their interaction with others including age mates/peers, and other adults. Changes may also be observed in child's temperament such as they may become more aggressive or sensitive to day to day issues, may cry more easily, may be irritable more frequently or may become aloof. Broadly, "good" adaptation has been described as success at achieving stage-salient developmental tasks or the absence of mental disorder or both. Many risk factors can have an impact on a number of different domains of functioning. For instance, child maltreatment increases the risk for conduct problems and depression. Luthar and colleagues (2000) noted that when the risk is especially deleterious for a particular outcome, it should be given priority. They also suggest that consideration must be given to whether multiple or single outcomes should be measured. Investigators have begun to question the utility of global, combined measures of outcomes in studying resilient processes. Luthar and colleagues (2000) proposed that if the outcomes examined represent largely discrete constructs, it is most meaningful to examine them separately. Just as comorbidity of psychiatric conditions signals greater severity of illness, the co-occurrence of manifest resilience across a number of domains would logically indicate a greater degree of health and adaptational success.

Domain 3: Socio-cultural and Environmental factors

One of the central goals of resilience studies, is to identify what makes a difference, the processes that account for how well individuals can meet the challenges to adapt. These are the promotive or protective factors that may explain how some people recover or thrive while others flounder or break down. These factors or processes can be studied at multiple levels of analysis, from the molecular or neurobiological to the cultural or societal level. For example, Barrera (1986) suggests that, in adults, the relation between stress and distress is higher within a context of low social support. Beneficial effects of social support also have been observed in youth (F. Cohen, 1987; S. Cohen and Wills, 1985; Daniels and Moos, 1990; Dubow and Tisak, 1989; Johnson, 1986). When preadolescents reported low satisfaction with their social support, the probability of having problems of anxiety, depression, or sleep disturbances is high (Bolognini et al., 1992). In adolescents and young adults, low satisfaction with social support is associated with depressive or psychosomatic symptoms, anxiety, and interpersonal sensitivity (Burke and Weir, 1978; Compas etal., 1986).

Domain 4: Abilities and Coping skills

Another emergent theme is the child's developed abilities and coping skills that he/she mobilises to deal with the stressors. Most of the adult's (professionals, parents & school-teachers) believed that seeking support, being able to put across their problems is a catalyst in the road to recovery post witnessing a traumatic event or experience. Children who are generally optimistic and feel hopeful about future, will be better able to recover after witnessing adversities. Furthermore, problem solving skills in children are an asset to effectively deal with adversities, by often separating from the source of trauma or traumatic situation; for instance some adolescents reported on witnessing physical violence they sought information around and decided to run away and seek shelter in some NGO or child care homes. Masten and Barnes (2018) highlighted resilience of a developing person is not circumscribed within the body and mind of that individual. The capacity of an individual to adapt to challenges depends on their connections to other people and systems external to the individual through relationships and other processes.

Domain 5: Occupation & Play

Researches have emphasized that resilience assessment requires a focus on constructs of adaptive function or development, the criteria by which adaptive success can be evaluated. Again, resilience studies have encompassed a wide range of criteria, including success in age-salient developmental tasks, such as learning to talk or read, behaving well in school, taking care of your children, or other expected achievements of individuals in a given historical and cultural context; emotional or physical health; and psychological well-being. Similar to what researchers have highlighted, the participants believed academic involvement, recreational interest and motivation to assume roles and responsibilities may be an important area to be encompassed under assessing resilience in children and adolescents.

Perception of Resilience as a Construct

On the basis of the detailed manuscript analysis, few key discussion points emerged for further thinking:

Rapidly changing physiological and physical changes during

childhood: Resilience in a developing human being is complex and dynamic—always changing because the individual and context are continually changing as a result of myriad interactions among people and their environments as well as due to ongoing interactions within a living person.

Manifestation of Resilience in Adversity: We have four situations in the context of developing child and dynamic resilience: a) A child has experienced a visible adversity in terms of disclosure made by the child or extent of help required by the child or the manifestation of bio-psycho-social-behavioural symptoms after the adversity; b) A child has experienced an adversity, did not make it visible to others but planned, withstood, and safeguarded him/herself and resumed pre-adversity level of functioning; c) A child does not experience any adverse childhood but manages life stage specific stress and strains well; d) the same child though managed well the daily stressors well breaks down terribly when a particular traumatic life incident happens to him/her. Typically, we infer the presence of resilience from its manifestations in adaptive behaviour or outcomes of bouncing back to normalcy in the context of any visible adversity. Nevertheless, resilience doesexist in all these four children, even if the adversity is visible/overt. It is perhaps an extension of abilities and life skills that the child applies to deal with daily hassles of life.

Whether Resilience is innate or learnt: Majority of verbatims indicated towards the domination of abilities, temperament, and coping skills next to child's feelings of family connectedness and attachment. While cognitive abilities are largely innate few (e.g memory, planning, problem solving, attention) can be enhanced with focused professional training, the ability to regulate emotions and build social relationship are more amendable through child-development and child-rearing practices.

Assessing Indicators of Resilience: It is theoretically possible, although it may be complex and difficult, to assess potential capacity for adapting to challenges prior to a demonstration of good adaptation to adversity. Yet practitioners often are called upon to make judgments about the capacity of a parent or a family or a community to handle a specific impending crisis. One of the ongoing challenges in resilience science is developing strategies of measurement that reflect the dynamic complexity of the concept.

Thus, it can be summarized that resilience is partly innate, but a dynamic and multifaceted construct responsive to child's environment. Capturing or measuring resilience in a child or adolescent who is at a dynamic developmental stage requires a multi-domain assessment of both internal and external factors, which in interaction are expected to influence the child's ability to withstand adversity. This assessment has potential for early intervention to strengthen child's resources at an induvial level and inform policy makers for need of emphasis on resilience building in at school &/or community level. Assessment of resilience in regular intervals could help both the child & clinician to strengthen child's ability to hone resilience factors to deal effectively with adversity and/or to facilitate well-being.

CONCLUSION

Despite availability of dearth of policy and programs and national and international level on child-friendly, child-focused, and child-enabled family, and society the fact still remains that adults at large are not sensitized to resiliency as an important indicator to be identified and strengthened from the childhood. And this happens at family, school, neighborhoods, state, and national level as there is lack of systematic integration of resilience as an extremely potential ability and life skill aspect of child development.

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