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Research Paper

Resilience in Children & Adolescents: An Insight into Factors & Interventions

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ABSTRACT

Children encounter several stressors and anxiety, encompassing academic pressures, familial relationships, body image concerns, mental wellbeing, and bullying (Boystown 2013, Cross et al. 2009; Mission Australia 2011, 2013). Research indicates that 17% of children and adolescents aged 4-17 years (Sawyer et al., 2000) and 27% of those aged 16-24 have at least one mental health condition (Slade et al., 2009) but only 10%-15% of youth seek professional help for psychological problems (Lyoyd, 2004; Richwod et.al, 2007). Therefore, it is crucial to identify children at risk of failing to achieve success or sustaining fulfilling relationships due to the adversities in their early lives (Rak & Patterson, 1996). Poverty, violence, substance misuse, familial discord, and disease constitute several possible hazards. Nonetheless, numerous children who experience stress manage to thrive despite significant adversities and develop resilience (Alvord & Grados 2005). Research on resilience has been conducted for decades, yet a consensus on its definition, concepts, and applications remains elusive (Pai.N., Vella S.L., 2018). Thus, there is a need for greater clarity around the concept of resilience and how it connects to the time of childhood and adolescence. This paper offers a a) multi-dimensional perspective and conceptualisation of Resilience and addressed bot the differences and commonalities of its definition b) Origins of Research and its recent advances c) Models and Factors of Resilience d) Assessments and Interventions and finally focusing on the e) Future Directions and Applicability of Understanding of Resilience and Universal Intervention programme in Community settings.

Keywords: *Resilience, Factors, Interventions, Children, Adolescents*

Resilience in itself is a protective factor for mental well-being, and thus, knowing resilience, its associated components, and intervention are crucial since they might work as a preventive approach to mental health concerns in children and adolescents. Research on resilience phenomena has led to a change in the perspective of Assessments and Intervention (Cicchetti et.al, 2000). Assessments and intervention programs now incorporate assets (positive aspects of an individual, such as coping skills, self-efficacy, etc.) and resources (external aspects, such as social support) in addition to risks and problems, which frequently result in stigma and discourage people from seeking professional help. Strategies

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currently focus more on enhancement of Assets and Resources rather than mitigation of hazards.

Research on Resilience has started since decades but there still remains a lack of unanimity on its definition and concepts. (Pai.N.,Vella S.L., 2018). In a key 1973 work on systems ecology, C.S. Holling originated the term "Resilience" (Holling, 1973). The term Resilience has been derived from a Latin verb "Resilire" meaning to" rebound" or "leap back" (Fletcher.D. and Sarkar.M.2013). Originally, the term Resilience originates from ecology referring to the ability of an ecosystem to recover or avert damage when disturbed. Definition of Resilience ranges from viewing it as a trait, a process, an outcome and a binary mechanism (either present or absent).

A majority of definition of resilience comprises of risk or adversity paired with positive outcomes (Rutter.M., 2006). Adversity has been defined as negative life events or circumstances that are associated with adjustments (Lutha.S., Cicchetti.D., 2000) while positive outcome with reference to resilience means an individual maintaining, restoring, or exceeding their prior level of functioning which they possessed prior to exposure to the risk or adversity.

The second approach views Resilience as a personal characteristics or quality. Ahern et.al. (2008) states Resilience as an adaptive stress resistant personal quality''. Connar and Davidson (2003) define Resilience "as personal qualities that enable one to thrive in the face of adversity".

Process based approach defines Resilience as a "dynamic process that is influenced by both neural and psychological self-organizations, as well as the transaction between the ecological context and the developing organism" (Curtis and Cicchetti,2007). Luther et.al. (2000) have defined Resilience as dynamic process encompassing positive adaptation within the context of significant adversity". Research suggests that a holistic definition of Resilience should be conceptualized on a continuum rather than being either present or absent in a binary approach. This means that individual will demonstrate different digress of resilience in different severity within different contexts (Southwick.S.M.et.al 2014). Although the above reviews indicate how differently the concept of resilience has been perceived but it also focuses on a commonality of presence of risk or adversity and a subsequent positive outcome. (Pai.N., Vella S.L.,2018)

Resilience has more recently been described as "the process of utilizing available internal resources or the environment to foster, sustain, or regain developmental or health outcomes, even in the face of challenges" (Gartland et al., 2022). This definition builds upon earlier conceptualizations of resilience, which viewed it as a personality trait or individual characteristic (Garmezy, 1993; Rutter, 1987). Understanding resilience as a process suggests that it is more intricate than merely maintaining favorable outcomes in difficult situations. Instead, it positions resilience as the ability of an individual and their support system to provide and access resources and assistance in ways that are culturally significant (Masten, 2014; Ungar, 2008). This is particularly pertinent for children, who may exert influence within their surrounding environment but often lack the independence to select or change the environment or system they are in. If their support system does not offer necessary resources and children do not engage with these supports, they are less likely to exhibit resilient outcomes when confronted with adversity (Masten, 2014).

ORIGINS OF RESEARCH IN RESILIENCE:

Historically, the origins of research on resilience have deep roots in the field of medicine; however, research on resilience in the behavioral sciences began to emerge around 1970 (Cicchetti, 2006; Cicchetti & Curtis, 2006; Masten, 2007, 2011; Masten & Obradovic, 2006).

The first wave of research came from scientists wanting to understand and prevent the development of psychopathology (Masten, 2011; Masten & Obradovic, 2006). These pioneer researchers acknowledged the importance of children who seemed to progress well under risky conditions (Masten & Obradovic, 2006).

The second wave of resilience research concentrated on detecting the processes and regulatory systems that accounted for protective factors associated with resilience (Masten & Obradovic, 2006).

The third wave arose due to a sense of urgency for the welfare of children growing up with adversities focusing on promoting resilience through prevention, intervention, and policy.
Developed at the conference on Resilience in Children in 2006, the fourth branch of research stems from the other three and primarily aims to integrate all the fields of research on resilience in children through multilevel analyses as well as interdisciplinary and cross-generic approach. This approach calls for co-operation and exchange between various fields of research, including genetics, neuroscience and behavioral biology. The fourth branch of research on resilience gives hope for a better and more thorough understanding of processes and multilevel relations involved in resilience (Masten, 2006; Kolar, 2011).

Advances In Research

According to UNESCO (2003), children at risk are classified among vulnerability (those children living and facing adverse situations as crisis situations, living in the street, or having a disability), minority (ethnic minorities (indigenous groups and child moved to isolate or minority groups) to whom they propose a multicultural, multi-ethnic and multilingual education.) and poverty. Thus according to UNESCO the target group to work on resilience are children at risk.

The majority of studies concerned resilience among children between 5 and 12, but three of them were focusing on preschool children, aged from 0 to 6 years old. The ages of the children varied between 3 and 12, with just two of the studies aiming at children between 3 and 6 and the rest of them from 7 to 12 years old. It was also demonstrated that younger children had better outcomes (Noether et al., 2007), and in some cases, there were differences between boys and girls (Nearchou, Stogiannidou, & Kiosseoglou, 2014). Literature review shows that in around 66% of studies over resilience with children and Adolescent, the age group has been above 9-10 years of age. Newman (2004) in his research on Resilience has divided the group into Early years (antenatal to 4 years) Middle Childhood (5-13 years) and Adolescence (13-19 years).

Rutter and the English and Romanian Adoptees study team (1998) examined the extent of developmental deficit and catch-up following adoption after severe global early deprivation of 111 Romanian children who came to the United Kingdom before the age of two years. At the time of adoption, most of the children showed significant gross physical and cognitive delays in development. However, when assessed at age four, many of the children showed substantial physical and cognitive catch-up.

Werner and Smith (2001) conducted a follow-up Kauai study which discovered that individuals, who as adolescents had problems, were able to change the course of their lives in dramatic ways by making sensible choices and taking advantage of opportunities. For example, as adults, some of those studied (a) continued their education, (b) learned new skills, (c) joined the military, (d) relocated to end relationships with peers who were deviant, and (e) chose healthy life partners.

Longitudinal studies have examined the outcome of individuals with learning disabilities and attention-deficit/hyperactivity disorder (ADHD) in order to determine factors that contribute to their resilience (Gerber, Ginsberg, & Reiff, 1992; Spekman, Goldberg, & Herman, 1992; Werner & Smith, 2001). Studies found that resilient learning disabled youth (a) look for personal control over their lives, (b) are willing to seek out and accept support, (c) set goals, (d) possess a strong will to succeed, and (e) demonstrate high levels of persistence.

Miller (2002) found that one of the most noticeable differences between resilient and non-resilient students was that those who are resilient demonstrated an ability to identify success experiences, were able to identify their strengths, and showed strong self-determination to succeed. In a long-term prospective follow-up of young adults diagnosed with ADHD as children.

Since discussions of resilience are typically framed with reference to risk and protective factors and it is the complex interplay of these factors over time that determines children's outcomes; therefore, these aspects are highlighted next.

RISK FACTORS:

Risk factor can be defined as "a phenomenon that increases the risk or probability for a certain negative outcome" (Granlund, 2015). Risk factors affect children in multiple ways and can interfere with their opportunities for education, work, good health and lead to isolation, and disappointment. The presence of a single risk probably will not have a great impact on a child's development, but the presence of more than one risk factor can lead to really negative outcomes (Flouri, Tzavidis & Kallis, 2010). To avoid the negative consequences, it is important to work against these risks in order for children to develop in an optimum way.

Biological factors

According to Rak & Patterson (1996), inherent abnormalities and low weight at birth are key biological contributors. Low nutrition and substance abuse during pregnancy, inadequate medical care may lead to such complications at birth.

Environmental factors

Children born healthy may become at-risk due to (a) poverty, (b) education level of parents, and (c) family conflict (Brooks, 2006; Luthar, 1991; Masten, 2011; Rak & Patterson, 1996). Harmful events in a person's life, such as mistreatment, violence, abuse, and neglect, are strong indicators of unfavorable life results (Brooks, 2006; Luthar, 1991; Masten, 2011; Rak & Patterson, 1996). Additionally, belonging to a minority group (Luthar, 1991; Masten, 2011) and experiencing racial prejudice (Brooks, 2006) increase the likelihood of negative outcomes for young individuals. Negative life experiences (e.g., maltreatment, violence, abuse, neglect) are predictors of poor life outcomes (Brooks, 2006; Luthar, 1991; Masten, 2011; Rak & Patterson, 1996). Minority status (Luthar, 1991; Masten, 2011) and racial

discrimination (Brooks, 2006) are also predictive of poor outcomes for children and youth. The build-up of various risk factors, whether occurring at once or gradually, is strongly associated with adverse outcomes, including substance use (Brooks, 2006; Masten, 2001; Resnick, 2000), violent behaviour (Fergus & Zimmerman, 2005; Resnick, 2000), poor academic achievement, school dropout (Brooks, 2006), teenage pregnancy, juvenile crime, mental health disorders, and emotional distress (Resnick, 2000).

PROTECTIVE FACTORS:

Protective factors are those factors which help a person to cope with stress and adversities. It can be an individual factor like Personality and acquired traits or extrinsic factors related to the individual's family, school, community or social context. The relationship among protective factors will determine the development of the child (Rutter, 2012).

Individual Characteristics

Many studies conducted over extended periods have offered insights into the essential personality characteristics that help some children remain resilient while others are overwhelmed by risks (e.g., Garmezy et al., 1984, Murphy & Moriatry, 1976; Rutter, 1985, 1986; Werner, 1984, 2000; Werner & Smith, 1982). People are born with an innate capacity for resilience. Resilient children work well, play well, love well, and expects well (Bernard, 1993, p. 44). Generally speaking, resilient children have five attributes: (a) social competence, (b) problem-solving skills, (c) critical consciousness, (d) autonomy (Bernard, 1993, 1995), and (e) sense of purpose (Bernard, 1995)

Factors such as a child's cognitive abilities, social relationships, coping mechanisms, personality, physical well-being, sex (Benzies & Mychasiuk, 2009), and intrinsic drive (Masten, 2001), as well as their bonds and attachments (Alvord & Grados, 2005), all play a role in their resilience.

Self-regulation

Researchers have identified an easy-going temperament and good self-regulation as being protective factors in resilience (e.g., Buckner, Mezzacappa, & Beardslee, 2003; Eisenberg et al., 2003; Werner, 1993). A key characteristic of resilient individuals is their confidence in their ability to navigate difficulties (Werner, 1993). Werner and Smith (2001) also found that those who are resilient make use of opportunities and resources around them.

Self-concept

A study conducted by Werner in 1984 revealed that children who demonstrate resilience commonly possess a feeling of confidence or belief in favorable future outcomes. Marton et al. (1988) found that positive self-esteem was related to have a high sense of self and sense of significant attachment figures. Some studies indicate that, for certain children facing risks, difficult experiences can build resistance to future problems rather than worsen their susceptibility (Bolig & Weddle, 1998; Jens & Gordon, 1991; Rutter, 1986; Werner, 1986). Thus, it indicates that surviving adversities brings forth a sense of self-concept rather than doubting one's ability to cope.

Family Conditions

Authoritative parenting style has been associated with optimal competence in children and adolescents (Baumrind, 1989). According to Baumrind (1991), authoritative parents have been identified as being responsive and demanding. Responsive parents are supportive, warm, and loving while also being firm and consistent, but controlling which gives a

secured environment for the child to grow. According to Eisenberg et al. (2003), children with mothers who express positive emotions tend to exhibit better social competence and adjustment. Other family protective factors of resilience include (a) family structure, (b) intimate-partner relationships, (c) family cohesion, (d) supportive parent–child interactions, (e) stimulating environments, (f) social support, and (g) a stable and adequate income (Benzies & Mychasiuk, 2009).

Community Supports

It has been found that role models outside the family like teachers, supervisors, counsellors etc. can be potential buffers for children at-risk (Beardslee & Podorefsky, 1988; Bolig & Weddle, 1988; Garmezy et al., 1984; Masten, 2001; Werner, 1984, 1986, 2000). Environments and social structures are important elements of an effective community (Alvord & Grados, 2005). Community protective factors include (a) early prevention and intervention programs, (b) safety in neighbourhoods, (c) relevant support services, (d) recreational facilities and programs, (e) accessibility to adequate health services, (f) economic opportunities for families and (g) religious and spiritual organisations (Alvord & Grados, 2005; Benzies & Mychasiuk, 2009).

According to Benzies and Mychasiuk (2009), resilience is optimised when protective factors are strengthened at all interactive levels of the socio-ecological model (i.e., individual, family, and community).

The particular factors that have been shown to be associated with resilience are listed below in relation to **Individual, family and community** domains, and in relation to school-age children and adolescent children (Daniel and Wassell, 2002).

Table No. 1: Summary of factors associated with resilience during School Years (5-12 years) (Daniel and Wassell, 2002)

Individual	**Family**	**Community**
Female	Close bond with at least one person	Neighbors and other non-kin support
Sense of competence and self-efficacy	Nurturance and trust	Peer contact
Internal locus of control	Lack of separations	Good school experiences
Empathy with others	Lack of parental mental health or addiction problems	Positive adult role models
Problem-solving skills	Required helpfulness	
Communication skills	Encouragement for autonomy (girls)	
Sociable	Encouragement for expression of feelings (boys)	
Independent	Close grandparents	
Reflective, not impulsive	Sibling attachment	
Ability to concentrate on schoolwork	Four or fewer children	
Autonomy (girls)	Sufficient financial and material resources	
Emotional expressiveness (boys)		
Sense of humour		
Hobbies		
Willingness and capacity to plan		

Table No. 2: Summary of factors associated with resilience during Adolescent Years (13-19 years) (Daniel and Wassell, 2002)

Individual	**Family**	**Community**
Male	Close bond with at least one person	Neighbour and other non-kin support
Responsibility	Nurturance and trust	Peer contact
Internal locus of control	Lack of separations	Good school experiences
Empathy with others	Lack of parental mental health or addiction problems	Positive adult role models
Social maturity	Required helpfulness	
Positive self concept	Encouragement for autonomy (girls)	
Achievement orientation	Encouragement for expression of feelings (boys)	
Gentleness,nurturance	Close grandparents	
Social perceptiveness	Sibling attachment	
Preference for structure	Four or fewer children	
Values	Sufficient financial and material resources	
Intelligence		
Sense of humour		
Willingness and capacity to plan		

MODELS OF RESILIENCE:

Models of resilience explains how individual and environmental factors influence to reduce or offset the adverse effects of risk factors (Fergus & Zimmerman, 2005; Garmezy et al., 1984; Rutter, 1985; Zimmerman & Arunkumar, 1994).

Garmezy et al. (1984) proposed three models to describe the impact of stress and personal attributes on the quality of adaptation: (a) compensatory model, (b) challenge model, and (c) protective factor model. Researchers have defined other types of protective factor models including the (a) protective–stabilizing model, (b) protective–reactive model (Luthar et al., 2000), and (c) protective– protective model (Brook, Whiteman, Gordon & Cohen, 1986, 1989).

Compensatory model

According to Garmezy et al. (1984), a compensatory factor neutralizes exposure to risk. There is no interaction with a risk factor; instead, it has a direct and independent influence on the outcome (Fergus & Zimmerman, 2005; Zimmerman & Arunkumar, 1994). While young people experiencing poverty have a higher likelihood of engaging in violent behavior compared to their non-impoverished peers, adult supervision can mitigate the detrimental impact of poverty (Fergus & Zimmerman, 2005). Specifically, the presence of a protective factor is expected to directly reduce instances of delinquency, mental health issues, or substance abuse (Zimmerman & Arunkumar, 1994). Problem-solving strategies can reduce or neutralize the adverse effects of adversity on mental well-being by moderating or mediating (or both) the effects of stressors on emotional distress (Nezu 2013).

Challenge model

In the challenge model, a stressor enhances one's capacity and competence provided the amount of stress is not extreme (Garmezy et al., 1984). According to Zimmerman and Arunkumar (1994), too little stress is not challenging, but at the same time high levels leave the individual helpless resulting in decline in the adaptive behavior and functioning. However, an optimal level of stress provides the individual a challenge which if he overcomes strengthens his capacity to overcome adversity without giving up. Yates, Egeland, and Sroufe (2003) portray resilience as a continuous developmental journey in which children acquire the ability to utilize resources when faced with adversity. 'Stress inoculation therapy', is a type of cognitive behavioural therapy is based on the compensatory model focusing on strengthening coping strategies and self-efficacy (Meichenbaum 2007).

Protective factor model

The protective factor model is also known as the immunity-versus vulnerability model, Garmezy et al. (1984) explains that personal attributes can strengthen or weaken the impact of stress. The presence of protective factors can lessen the chance of negative outcomes, even when risk factors are present. For example, for youth with high levels of parental support, the relationship between poverty and violent behavior is reduced (Fergus & Zimmerman, 2005).). "Transforming lives through resilience education", developed by Marry. A. Steinhardt (2008) Professor of Health Education at The University of Texas at Austin, developed a universal Resilience Intervention programme based on the Protective factor Model of resilience (Steinhardt.M.A, 2008).

Protective–stabilizing model

A protective factor helps the individual to stabilize the individual's wellbeing even in face of adversity. Therefore, when the protective factor is absent risks increases while when a protective factor is present risks decreases. Youth lacking sufficient parental support (a risk) and without an adult mentor (a protective factor) are more likely to engage in delinquent behaviors; however, having a mentor outside the family can mitigate this risk (Fergus & Zimmerman, 2005).

Protective–reactive model

According to this model, the connection between the risk and outcome is stronger when the protective factor is not present. According to Fergus and Zimmerman (2005), young people who use drugs have a higher probability of participating in risky sexual behaviors. Nevertheless, this connection might be weaker for those who receive thorough sexual education in school than for those who do not.

Protective–protective model

In the protective–protective model, Brook et al. (1986, 1989) propose that a presence of one protective factor can increase the effects of other protective factors in creating an outcome. For example, Fergus and Zimmerman (2005) found that the synergy between parental support and academic proficiency can result in greater academic success than what each factor could achieve independently. Although, this model may not be called a resilience model as it does not involve the presence of a risk factor.

RESILIENCE IN CHILDREN AND ADOLESCENTS – ASSESSMENT TOOLS:

There are numerous ways of assessing resilience. Tools such as checklists, scales, and interviews have been created to evaluate resilience, risk and protective factors (e.g., Baruth & Carroll, 2002; Vance, Fernandez, & Biber, 1998), or to measure proficiency in various

areas (e.g., Ewart, Jorgensen, Suchday, Chen, & Matthews, 2002). Tedeschi and Kilmer (2005) suggest that significant shifts in clinical practices are crucial for effective resilience assessment. However, according to Naglieri and LeBuffe (2005), a multidimensional approach to intervention is encouraged, greatly increasing the likelihood of positive adjustment. Multiple potential risk and protective factors should be targeted as opposed to one or two.

According to Tedeschi and Kilmer (2005), fundamental strategic changes within clinical functions may define the key action of resilience assessment. Clinicians continue investigating core functional domains including home, school, and friends for children and youth. However, in addition to recognizing difficulties to be addressed, potential protective factors must also be identified. These targeted factors may be used to enhance existing capabilities, encourage healthy adjustment trajectories, and nurture resilient adaptation.

Table No. 3: Tools Measuring Resilience as a Multidimensional Construct

SN	***Name of the Instrument***	***Author and Year***	***Domain***	***Response Format***	***Age Range***	***Number of Items***
1	Devereux Student Strength Assessment (DESSA and DESSA-mini)	LeBuffe et al. (2009)	Social-emotional competencies: self-awareness, social awareness, self-management, goal-directed behavior, relationship skills, personal responsibility, decision making, and optimistic thinking	Behaviour rating scale: 5-point Likert format	5–14 years	72 items and 8 items, respectively
2.	Resilience Scale for Children & Adolescents (RSCA)	Prince-Embury (2006)	Sense of Mastery Scale (three subscales), Sense of Relatedness Scale (four subscales), Emotional Reactivity Scale: (three subscales). The three scales can be administered individually or in combination	5-point Likert format (0 = *never*, 1 = *rarely*, 2 = sometimes, 3 = *often*, 4 = *almost always*)	9-18 years	64 items

SN	*Name of the Instrument*	*Author and Year*	*Domain*	*Response Format*	*Age Range*	*Number of Items*
			. In total, allow 9–15 min for adolescents and 15–25 min for children.			
3.	Child and Youth Resilience Measure (CYRM)	Ungar & Leibenberg (2005)	Resources: individual, relational, communal and cultural	3-point Likert-type scale (*no*, *sometimes*, *yes*)	5–23 years	58 items (self-report)
4.	Assessing Developmental Strengths Questionnaire (ADS)	Donnon and Hammond (2007)	12 internal and 19 external strengths across 10 factors (covering individual assets, family assets, and social supports)	12 internal and 19 external strengths across 10 factors (covering individual assets, family assets, and social supports)	Nine and above	94 items
5.	The Connor-Davidson Resilience Scale	Connor and Davidson (2003)	Personal competence, high standards, and tenacity Trust in one's instinct, tolerance of negative effects, and strengthening effects of stress, Positive acceptance of change and secure relationships, Control, Spiritual influences	5-point Likert-type scale ranging from *not true at all* (0), *rarely true* (1), *sometimes true* (2), *often true* (3), and *true nearly all of the time* (4). A higher score indicates higher resilience	Older adolescents and adults	25 items
6.	The Bharathiar University Resilience Scale Form-A and Form-B	Annalakshmi (2009a)	Duration taken to get back to normalcy, reaction to negative events; response to risk factors (disadvanta	5-point Likert-type scale ranging from 1 (*not at all appropriate in describing me*) to 5 (*most appropriate in describing me*).	14–20 years	30 items

SN	*Name of the Instrument*	*Author and Year*	*Domain*	*Response Format*	*Age Range*	*Number of Items*
			ged environment) in life, perception of effect of past negative events, defining problems, hope and confidence in coping with future, and openness to experience and flexibility			
7.	The Resiliency Attitude and Skills Profile (RASP)	Hurtes & Allen (2001)	Insight, independence, creativity, humor, initiative, relationships and values orientation	4-point Likert format (*strongly disagree*, *disagree*, *agree*, *strongly agree*)	12-19 years	34 items

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A BRIEF REVIEW OF RESILIENCE-FOCUSED INTERVENTIONS:

The most effective intervention programmes are the multi-systemic interventions involving a mixture of risk, asset and process-focused targets located at the child, family, and community level (Yates and Masten, 2004).

Specific interventions promoting resilience:

The first Classification of Intervention Programmes is based on Age Groups

The following interventions are listed in relation to the age of the child that that they aim to benefit: (1) Antenatal and preschool (0-4 years); (2) Middle school (age 5-13 years); and (3) Adolescent and older teenage (13-18 years) (Newman, 2004).

1. Antenatal and preschool (0-4 years)

Prenatal/Early Infancy Project (PEIP)- The US Elmira Prenatal/Early Infancy Project (PEIP, Olds 1998), also known as the Nurse-Family Partnership, provides parent education and enhanced family support. This programme is for new mothers belonging from the lower income group and works to prevent early parenting problems which might further lead to behavioral and emotional problems in children.

Perry Preschool Project- The US Perry Preschool Project focusses on families with low socio-economic status and having pre-school aged children who are at risk of school failure. It includes a structured classroom-based programme that focuses on language skills, numerical skills and social development, with the aim of promoting school readiness in high-risk populations.

2. Middle school (age 5-13 years)

Social and emotional aspects of learning (SEAL): SEAL is a UK-based, school-based programme for promoting the social and emotional aspects of learning like self-awareness, emotion regulation, motivation, empathy and social skills. It is a curriculum-based programme and can be used with primary and secondary school children. Primary SEAL has seven aspects like New Beginnings, Getting on and falling out, Say no to bullying, Going for goals. Good to be me, Relationships and Changes.

Penn Resiliency Programme: The US-based Penn Resiliency Programme is a school-based intervention curriculum designed to build adaptive coping skills and problem-solving. It is a manual-based intervention comprising twelve 90-minute group sessions. The curriculum teaches cognitive behavioral and social problem-solving skills. The skills taught can be utilized in multiple domains of life like family, peer group, academics and in other interpersonal relationships.

3. Adolescent and older teenage (13-18 years)

FRIENDS is a universal prevention and early intervention project that can be used by schools and in clinical settings, and originates in Australia, where it has been widely tested. It aims to increase social and emotional skills in order to prevent common mental health problems such as anxiety and depression in children. The programme involves 10 structured sessions plus two booster sessions, and is based on Cognitive Behaviour Therapy. The programme promotes self- esteem, problem-solving, psychological resilience, self-expression, and building positive relationships with peers and adults.

PATHS focusses on emotional regulation, emotional awareness, affective-cognitive control, and social-cognitive understanding. The intervention is to be conducted 3 times per week for a period of 20–30 minutes over three terms, using didactic instruction, role-play, class discussion, modelling by teachers and peers, social and self-reinforcement, worksheets and generalization techniques.

The second classification of Intervention programs are based on intensity of risks and symptoms that are being manifested by the population

1. Universal Resilience based Intervention: are that kind of Intervention program which can be provided to non-clinical population i.e. children and adolescents who are not diagnosed or at risk of a mental illness.

A. The Resolving Conflict Creatively Program (RCCP). It was developed by Lantiers and Roderick (1985) and targeted at kindergarten to class XII students. It aims at conflict resolution, communication skills, anger management and parent training.

B. Transforming Lives Through Resilience Education

The Intervention Program used in the current study is **"Transforming lives through resilience education",** Developed by Steinhardt (2008), Professor of Health Education at The University of Texas at Austin, this program is based on the Protective factor Model of resilience (O' Leary, 1998). The intervention has its roots in cognitive–behavioural therapy, rational–emotive therapy, and internal family systems therapy and uses a psycho-educational mode.

Transforming Lives Through Resilience Education consists of four mini-lectures, or modules presented in audio form, accompanied by Flash animation and short interactive quizzes to promote learning: a) Transforming Stress into Resilience b) Taking

Responsibility c) Focusing on Empowering Interpretations and d) Creating Meaningful Connections.

Other than the above two, FRIENDS and Building Resilience in children aged 0-12 years, A Practical Guide by Beyond Blue also falls under the criteria of Universal Resilience based Intervention program.

2. Selective Resilience Based Intervention are such programs which are provided to children and adolescents who are at risk of developing a mental illness.

A. The Koping Adolescent group program (KAP) by Child and youth Mental Health Service developed in 1999.It has a group therapy approach and focuses on children (12-18 years) of parents having a mental illness. Area of work focuses on a) psychoeducation b) sharing lived experiences c) coping strategies

B. The Pathways to Resilience Project (Ungar, 2005) has been developed in Canada and it is aimed towards adolescents of 13-18 years. The area of work is a) pro-social behavior, b) community involvement, c) school engagement of adolescents who are at risk for depression, substance abuse and conduct problems.

Other Selective Resilience based interventions includes the Leadership Education Development (LEAD) by Sheldon et.al 2005), Resilient Therapy (Hart et.al 2008) and Penn Resiliency Program (PRP) by Gillham et.al 2008.

3. Indicated Resilience Based Intervention are such programs for children and adolescents who manifest subclinical symptoms of mental illness and thus needs early intervention.

A. The Resilience Enhancing Program (Velter et.al,2010). It is aimed towards Adolescents of 13 years and older and has a group therapy structure. It focuses on psychological first aid, crisis intervention, supportive work and activities like expressive art, play, sports, climbing etc.

B. The Building Resilience Program (Kent,2009) focuses on child and Adolescents undergoing PTSD. It has five modules a) Body Awareness b) Engaging positive emotions c) Social Relatedness d) Revisiting Trauma e) Looking to the future.

A Review with an Indian Focus:

A search for a review of resilience-focused interventions done in India on children and adolescents did not yield satisfactory results. Though plans for pilot studies and culture-specific resilience models (Vyas and Vyas, 2021) have been laid down, there still exists a clear lack of implementation of the same, as is evident from the fact that in the referenced meta-analyses, only one study was available for review from India (Pinto et al., 2021). While some studies have been conducted with a focus on the mental health of college students (Herbert and Manjula, 2022; Kadian et al., 2022), early intervention is indeed necessary for longer lasting impact. A recent study by Banerjee et al. (2018), identified factors like quality parental time for children and adolescents and their engagement in physical activities as associated significantly with high resilience. Identification of other relevant factors, coupled with a culture-sensitive model of resilience can help in designing intervention programs which definitely holds promise for the Indian mental health scenario. This is further supported by the favourable results obtained from a review of CorStone's

Youth First Program: a school-based psychosocial resilience program delivered via trained government school teachers, that seeks to improve the mental, physical, social, and educational well-being of early adolescents. 322 adolescents from Bihar participated in the study. Those youngsters who had been exposed to the Youth First program had greater awareness of problems, perspective-taking, problem-solving strategies, helping approaches, awareness of their own strengths, and visions for the future when compared to the control group (Leventhal et al., 2022). Currently, in operation in Kenya, India and Randwa, this program holds much promise in terms of resilience building.

Another study based in Chennai examines the effectiveness of the Penn Resiliency Program (PRP) on school going children in an urban Indian setting. The PRP is designed to reduce depression in young adolescents and has been shown to successfully modify how children explain life events. This research aimed to explore the attributional style of Indian early adolescents, identify potential negative patterns, and investigate the effectiveness of the PRP in altering explanatory styles within this population. The study, involving 58 children, demonstrated that the PRP was effective in shifting negative attributional styles among upper-class Indian school children (Sankaranarayanan and Cycil, 2014).

FUTURE DIRECTIONS:

The growing recognition of the importance of resilience protective factors and their relation to mental health problems in children and adolescents has opened up promising avenues of future research prospects. There is an urgent need to meticulously investigate the strengths and limitations of the existing resilience-focussed interventions and tailor them in accordance with the anticipated conditions of the world's youth population (Dray, 2021), as rigorous intervention trials are crucial to ensure that the field is informed by the best possible evidence. Furthermore, the sociocultural context within which these trials should be undertaken also requires due exploration, in particular the school and community setting. However, no intervention plan will be successful without proper implementation, which brings to the fore the question of who will be the major driving force in this regard. Given the importance of educational institutions in one's formative years, strategies should be developed to support schools in leading and sustaining implementation.

From the perspective of designing interventions, due importance should also be given to subgroups within the target population (for example, age, gender, religion, c the protective factor measure has reliable and valid psychometric properties (Dray, 2021) and is relevant in that sociocultural context. As several systematic reviews and meta-analyses have revealed, further research is needed to develop and apply robust measures of resilience-promoting factors in interventions aimed at enhancing resilience (Windle et al., 2011; Renbarger et al., 2020).

The concept of community resilience, which focusses on planning for, resisting, absorbing and recovering from disruptive events, has also gained traction over the recent years. The COVID-19 pandemic demonstrated the constant pressure that that the health systems are under worldwide – by threats both acute and chronic; natural and man-made. A community-centered approach provides the essential framework for facilities and organizations to improve their performance, resilience, and contribution to community-wide recovery; and highlights the importance of the complex interactions between physical, social, and economic infrastructure that enable community resilience (Koliou et al., 2018). To bolster community resilience, especially in regions vulnerable to climate change and livelihood threats, India is implementing initiatives like the Community Conservation Resilience

Initiative (CCRI), emphasizing participatory approaches, skill development, and resource identification.

While the literature recognizes the importance of community resilience assessment and interventions, there is an urgent need for future research to address significant gaps in understanding. The growing awareness and gradually expanding research field on resilience suggest that we can expect to see more and more universal, community-based resilience intervention programmes developed and implemented, with the potential for larger-scale dissemination.

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Conflict of Interest

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