

# Resiliency Factors in Jamaican Adolescents

## CITATION INFORMATION

Scott-Fisher, K. and Campbell-Forrester, S., 2000  
Caribbean Adolescent Health Survey 1996 Jamaican data.  
The Pan American Health Organisation, Caribbean Subregion, Barbadoes, WI  
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## INTRODUCTION

Adolescent health is influenced by the strengths and vulnerabilities of individual adolescents as well as the character of the settings – school, home and communities in which they lead their lives.

The fundamental issue of the resiliency approach for our adolescents is shifting our personal perspective and our paradigms from a focus on risks and deficits to a focus on protection and strengths.

The building of resilient children is a long term developmental process that involves systemic change-the fundamental altering of the family, the school, the neighbourhood, community based organizations and the workplace to make each of these arenas supportive, caring, participatory climates for all involved persons. Fostering resiliency isn't something we do to kids, it isn't about teaching them resiliency skills per se. Rather, protective factor research has clearly shown that the development of resiliency is the process of healthy human development that is based on and grows out of nurturing participative relationships grounded in trust and respect (Bernard, 1999). If we as perfectionists are truly concerned with preventing problems like alcohol and drug abuse, violence, teenage suicide, and early teen pregnancy, then it is imperative that we make our central vision and mission the creation of supportive relationships with youth and their families. If we can determine the personal and environmental sources of social competence and wellness, we can better plan preventive interventions focused on creating and enhancing these attributes that serve as the key to healthy development.

More specifically, the following attributes have been consistently identified as describing the resilient child:

- Social competence
- Problem solving skills
- Autonomy-including a strong sense of independence and internal locus of control
- Sense of purpose and direction

Looking beyond the children themselves to the environments-the families, schools and communities the protective characteristics that appear to facilitate the development of resiliency in youth fall into three categories:

- Caring and support
- High expectations
- Opportunities for adolescents to participate

These protective factors are more powerful than risk factors and serve to protect adolescents across ethnic, social class, geographic and historical boundaries.

If we are to shift our prevention approach to a resiliency focus we have to let go of our preoccupation with risk and risk factors as the research base guiding our planning and evaluation efforts.

This paper reports on some of those areas identified as resilient factors in our Jamaican adolescent. Some of the data is incomplete as it has been extracted from the general adolescent health survey which was not specifically designed as resilient factor research. The findings however are clear and serve to shed light on some important areas in which we in Jamaica can move forward in planning long term effective prevention programs for our youth in the new millennium. This should also act as a springboard for the development of opportunities for further research in the area of resiliency.

## **METHOD**

This report is based on the Jamaican data extracted from the Caribbean Adolescent Health Survey of 1996 which represents a collaborative effort of a group of people, committed to improving adolescent health in the English-speaking Caribbean.

### **The Sample**

This report is based on a school-based sample of adolescents. The students were randomly sampled from those in forms 1, 3 and 5. Power analysis determined the size of the overall sample as well as the age subsamples (<12, 13-15, 16-18). The sample size was inflated by 20% to adjust for non-attendance on the day of the survey as well as incomplete responses. The desired number of young people within each form was divided by the classroom size yielding the total number of classrooms needed with each form. From the total number of classrooms within each form, the appropriate number of classrooms was randomly drawn until the target number of students was selected.

## **Where Do the Teens Come From?**

Most of the sample came from primary and secondary schools. There was a mix of public, private and parochial schools.

***Confidentiality was maintained during survey administration.*** Confidentiality was protected in order to encourage youth to give honest responses. No names were included in the surveys. Teachers did not administer the questionnaires. Instead, questionnaires were administered by someone trained to give consistent instructions and guidance

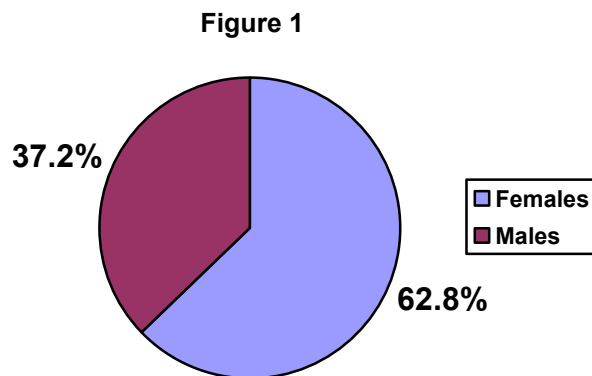
***Suspect surveys were deleted.*** Confidence in the results was increased by deleting surveys where it seemed youth might not have understood the questions, were not answering honestly, or were not paying sufficient attention to give trustworthy information. Surveys had to pass two screening criteria to be included in the analysis reported in this paper: youth must have answered most items (60% minimum) and passed eight out of nine checks for invalid or inconsistent responses (e.g., did they report using “bindro”, a fake drug included as a validity check)

## **FINDINGS**

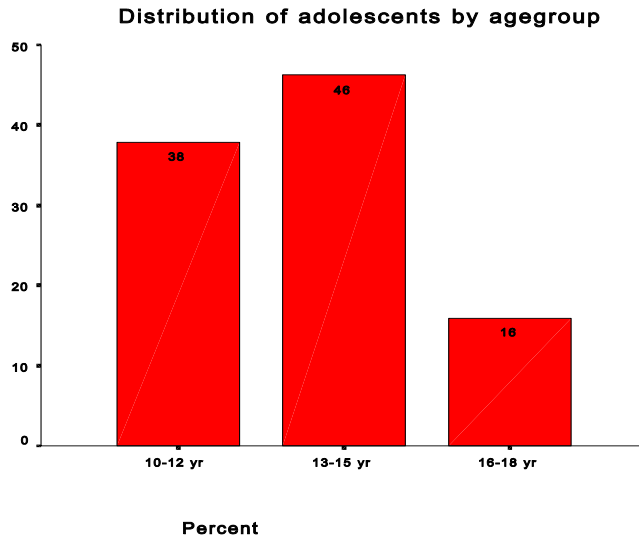
Demographic/sample characteristics

### **Gender Distribution**

Of the 2635 questionnaires analyzed, 37% were males and 63% were females (Fig.1).



The age distribution is shown in Fig. 2. Of the sample, 38% were 10-12 years, 46% were 13-15 years, and 16% were 16 years and over.



## **RESULTS**

The adolescent health survey data was used to explore how individual, family, school, spiritual and community characteristics protect adolescents in Jamaica from:

- Cigarette, alcohol and marijuana use
- Early sexual involvement and multiple partners
- Violence perpetration
- Emotional distress and Suicidal thoughts and attempts

Individual resiliency factors that are believed to influence three group factors: school connectedness, family connectedness and spiritual connectedness were carried through two statistical techniques – factor analysis and cluster analysis. The aim was to arrive at, for each factor, two homogenous groups similar among themselves and distinct from each other. The variables used to arrive at the cluster groups are as follows:

<b>Resiliency Factors</b>	<b>Variables</b>
School Connectedness	Involvement in after school activities
	Like/hate school
	Plan to finish school
	Feel their teacher knows them
	Get along with teacher (s)
	Believe the teacher cares

Family Connectedness	Live with both parents
	Live only with mother
	Live only with father
	Live with an adult relative
	Live with another adult
	Live with a youth
	Live alone
	Believe mother cares
	Believe father cares
	Feel free to discuss problems with mother
	Feel free to discuss problems with father
	Believe family understands them
	Believe family pays attention
	Parents live together
	Parents live apart
Spiritual	Consider themselves religious
	Frequency of attending religious services
	Believe the minister/priest cares

2 clusters emerged for each group

	<b>School Connected Group</b>	<b>Family Connected Group</b>	<b>Spiritual Connected Group</b>
<b>Cluster 1</b>	2038	1452	1765
<b>Cluster 2</b>	259	27	512
<b>Valid</b>	2297	1479	2277
<b>Missing</b>	338	1156	358
<b>Total</b>	<b>2635</b>	<b>2635</b>	<b>2635</b>

Each group of variables had two clusters and these clusters were further analysed in order to describe them. The clusters have been described and then compared according to their response to the following outcome variables– violent behaviour, suicidal behaviour, sexual behaviour and drug use. They have also been examined with regards to issues such as willingness to exercise, body image and school performance

### **School**

Cluster 1 members (64.3%) were more likely than cluster 2 members (35.2%) to be involved in after school activities. They were similarly more likely (85.1%) than cluster 2 (61.0%) to like school although paradoxically ,Cluster 2 members (95.4%) were more likely than their cluster 1 counterparts (85.8%) to plan to finish school. The cluster 1 members had positive relationships with the teacher – they were more likely than cluster 2 to be known by the teacher, to get along with the teacher and to feel like the teacher cares ‘a lot’.

### **Family Relationships**

Cluster 1 members were more likely than cluster 2 to live with both parents. Their parents were also more likely to live together. Cluster 1 members were more likely to feel that their mother and their father cared a lot and that they could tell their problems to both parents “quite a lot.” Cluster 1 members were more likely to feel understood by their family and that their families paid attention to them.

### **Spiritual**

Cluster 1 is more likely to consider themselves ‘quite religious’ while cluster 2 refer to themselves as somewhat religious. Cluster 1 was more likely to have attended more than six religious services in the past 3 months. Cluster 1 members were more likely to feel that their priest or minister ‘cares a lot’

<b>OUTCOME MEASURES</b>	Cluster 1	Cluster 2	Significance
<b>Try at school, work for pay, body image</b>			
Cluster 1 more likely than Cluster 2 To feel happy with the way body looks	59.10%	56.50%	0.805
Cluster 1 more likely than Cluster 2 not to work for pay	89.80%	84.90%	0.237
Cluster 1 more likely than Cluster 2 to try very hard to do my best at school	74.30%	66.4	0.001
Cluster 1 more likely than Cluster 2 to describe themselves as an above average student	24.6%	32.5%	0.002
Cluster 2 more likely than Cluster 1 to try hard, but not as hard as I can	21.6	27	0.001
<b>VIOLENCE</b>			
Cluster 1 more likely than Cluster 2 to have never been involved in burglary	97.50%	95.10%	0.01
Cluster 1 more likely than Cluster 2 to have never been involved in a fight with a weapon	89.90%	86.80%	0.44
Cluster 1 less likely than Cluster 2 to be involved in a fight with weapons 3 or more times in the past one month	2.7%	4.8%	0.002
Cluster 1 more likely than Cluster 2 to never have been involved in gangs	83.30%	79.30%	0.022
<b>SUICIDE</b>			
Cluster 1 less likely to feel down or discouraged to the point of giving up	22.4%	27.8%	0.034
Cluster 1 less likely to have attempted suicide	9.0%	17.10%	0.0001
<b>SEXUAL PRACTICES</b>			
Cluster 1 more likely than Cluster 2 to have never had sex	64.00%	57.90%	0.027

Reasons given for those not having sex			
a)Cluster 1 more likely than Cluster 2 to want to wait until married	58.00%	46.40%	0.002
b)Cluster 2 more likely than Cluster 1 to fear pregnancy	37.70%	42.70%	0.144
c)Cluster 1 equally likely as Cluster 2 to fear contracting a disease	29.60%	30.50%	0.795
d)Cluster 1 more likely than Cluster 2 to be influenced by religious values	21.60%	12.90%	0.002
e)Cluster 1 equally likely as Cluster 2 to be influenced by parental values	29.70%	28.50%	0.715
f)Cluster 1 equally likely as Cluster 2 to feel guilty	21.40%	20.20%	0.664
Cluster 2 more likely than Cluster 1 to have started having sex at age 10	48.20%	53.40%	0.911
Cluster 1 more likely than Cluster 2 to have started having sex at an older age	14.40%	9.70%	0.911
Cluster 1 more likely than Cluster 2 to have had one sexual partner	34.60%	27.20%	0.112
Cluster 2 more likely than Cluster 1 to have had many sexual partners (4 or more persons)	4.6%	20.0%	0.06
Cluster 1 equally likely as Cluster 2 to have been sexually abused	11.60%	12.50%	0.614
<b>SUBSTANCE USE/ABUSE</b>			
Cluster 1 more likely than Cluster 2 to have not smoked a cigarette in the past 12 months	89.90%	83.50%	<.0005
Cluster 1 less likely than Cluster 2 to be experimental smokers (once or a few times)	14.10	9.2%	<.0005
Cluster 1 equally likely as Cluster 2 to have never used liquor	51.90%	50.00%	0.043
Cluster 1 more likely than Cluster 2 to have never smoked marijuana	94.3%	91.1%	0.066
Cluster 1 less likely than Cluster 2 to be experimental users of marijuana	6.7%	4.6%	0.066



The same variables were then examined **individually** against various high risk behaviours.

**Adolescents who discuss their problems with their parents**

Adolescents who feel they are able to discuss their problems and concerns with their parents report less sexual intercourse

	<b>Can Communicate Problems</b>	<b>Can't Communicate Problems</b>
<b>Sex</b>	34.10%	66.90%
	451	223
<b>No Sex</b>	65.90%	56.40%
	870	289

p < 0.0005

Adolescents who feel they are able to discuss their problems and concerns with their parents report fewer fights with weapons.

	<b>Can Communicate Problems</b>	<b>Can't Communicate Problems</b>
<b>Fight with a weapon</b>	8.40%	12.80%
	115	66
<b>No Fight with a weapon</b>	91.60%	87.30%
	1253	452

p < 0.015

Adolescents who feel they are able to discuss their problems and concerns with their parents report less attempted suicide

	<b>Can Communicate Problems</b>	<b>Can't Communicate Problems</b>
<b>Attempt Suicide</b>	6.10%	16.10%
	88	87
<b>No Suicide Attempt</b>	93.80%	83.90%
	1338	455

p < 0.015

**Adolescents whose families pay attention to them**

An adolescent whose family pays attention to them is less likely to report sexual intercourse

	<b>Family Pays a lot of Attention</b>	<b>Family Pays little Attention</b>
<b>Sex</b>	35.50%	43.70%
	536	121
<b>No Sex</b>	64.60%	56.30%
	976	156

p < 0.013

An adolescent whose family pays attention to them is less likely to report fights with weapons

	<b>Family Pays a lot of Attention</b>	<b>Family Pays little Attention</b>
<b>Fight</b>	9.20%	90.80%
	144	1428
<b>No Fight</b>	12.90%	87.20%
	34	231

p < 0.0005

An adolescent whose family pays attention to them is less likely to report attempted suicide

	<b>Family Pays a lot of Attention</b>	<b>Family Pays little Attention</b>
<b>Attempt Suicide</b>	6.90%	22.50%
	13	66
<b>No Suicide Attempt</b>	93.10%	77.50%
	115	227

p < 0.0005

An adolescent whose family pays attention to them is less likely to report extreme anger

	<b>Family Pays a lot of Attention</b>	<b>Family Pays little Attention</b>
<b>Want to hurt &amp; kill almost always</b>	3.70%	9.90%
	60	29
<b>Never want to kill</b>	64.70%	49.10%
	1055	144

p < 0.0005

**Adolescents who feel their parents care**

When an adolescent feels that their parents care, they are less likely to report sex

	<b>Parents Care</b>	<b>Parents Do Not Care</b>
<b>Sex</b>	34.80%	47.30%
	635	121
<b>No Sex</b>	65.20%	52.70%
	1190	135

p < 0.0005

When an adolescent feel their parents care, they are less likely to fight with a weapon

	Parents Care	Parents Do Not Care
<b>Fight</b>	9.30%	14.40%
	176	36
<b>No Fight</b>	90.70%	85.90%
	1714	214

p < 0.005

When an adolescent feel their parents care, they are less likely to experience extreme anger

	Parents Care	Parents Do Not Care
<b>Want to hurt &amp; kill almost always</b>	4.60%	8.90%
	91	24
<b>Never want to kill</b>	60.50%	56.90%
	1189	153

p < 0.011

When an adolescent feels that their parents care, they are less likely to attempt suicide

	Parents Care	Parents Do Not Care
<b>Attempt Suicide</b>	8.10%	24.90%
	115	67
<b>No Suicide Attempt</b>	89.90%	75.10%
	1253	202

p < 0.0001

When an adolescent feels that their parents care, they are less likely to report poor or fair health

	Parents Care	Parents Do Not Care
<b>Poor Health</b>	4.00%	11.80%
	76	29
<b>Good/Excellent Health</b>	96.00%	88.20%
	1822	216

p < 0.015

### Adolescent gets along with their teacher

When an adolescent gets along with their teacher they are less likely to report fights with weapons

	Get Along With The Teacher	Do Not Get Along With The Teacher
<b>Fight</b>	8.40%	19.70%
	170	14
<b>No Fight</b>	91.60%	80.30%
	1854	57

p < 0.0005

When an adolescent gets along with their teacher they are less likely to report alcohol use

	Get Along With The Teacher	Do Not Get Along With The Teacher
<b>Drink Liquor Habitually</b>	2.90%	9.10%
	115	7
<b>Drink Liquor experimentally</b>	42.90%	32.90%
	52.2	25
<b>Never Drink</b>	1125.00%	57.9
	890	44

p < 0.015

When an adolescent gets along with their teacher they are less likely to report sexual intercourse

	<b>Get Along With The Teacher</b>	<b>Do Not Get Along With The Teacher</b>
<b>Sexual Intercourse</b>	35.90%	52.30%
	715	35
<b>No Sex</b>	64.00%	47.80%
	1273	32

p < 0.0005

When an adolescent gets along with their teacher they are less likely to report extreme anger

	<b>Get Along With The Teacher</b>	<b>Do Not Get Along With The Teacher</b>
<b>Want to hurt &amp; kill almost always</b>	4.20%	7.90%
	89	6
<b>Never want to kill</b>	62.20%	59.20%
	1321	45

p < 0.0005

When an adolescent gets along with their teacher they are less likely to report attempted suicide

	<b>Get Along With The Teacher</b>	<b>Do Not Get Along With The Teacher</b>
<b>Attempt Suicide</b>	9.20%	22.30%
	116	17
<b>No Suicide Attempt</b>	90.80%	77.60%
	1927	59

p < 0.0005

**Adolescents who regard themselves as religious**

Adolescent who regard themselves as religious report less sexual intercourse

	<b>Religious or Spiritual Person</b>	<b>Not at all Religious</b>
<b>Sex</b>	37.90%	44.50%
	305	207
<b>No Sex</b>	55.50%	62.10%
	258	500

p <

0.022

Adolescent who regard themselves as religious reported better health

	<b>Religious or Spiritual Person</b>	<b>Not at all Religious</b>
<b>Poor Health</b>	4.30%	6.70%
	36	31
<b>Excellent Health</b>	49.00%	75.60%
	410	350

p <

0.001

Adolescents who plan to finish high school report less fighting with weapons.

	<b>Plan to finish high school</b>	<b>Don't Plan to finish high school</b>
<b>Fight</b>	10.10%	7.90%
	217	7
<b>No Fight</b>	89.90%	92.00%
	1940	81

p <

0.0005

## **DISCUSSION**

This report has served to highlight the importance of resiliency and protective factors for the successful healthy development of our youth. The protective factors identified are interrelated and mutually reinforcing and cut across various high risk behaviours - violence, suicide, initiation of sex and substance use. The findings clearly point us to the importance of environments that encourage adolescents through caring and support, opportunities for active participation and contribution, and high and positive expectations for their achievement.

The life stories of resilient adolescents who have now grown into adulthood teach us that competence, caring, and confidence resulting in the highest levels of productivity can flourish even under adverse circumstances if children encounter persons who provide them with a secure basis for the development of trust, autonomy, and initiative.

Research done by Werner and Smith, 1992 finds that these positive, buffering relationships makes a more profound impact on the life course of children who grow up under adverse conditions than do specific risk factors or stressful life events.

How do we in Jamaica propose to break the cycle and provide for these relationships under circumstances where parents are succumbing to the stresses of poverty and unemployment and are not always there to provide this powerful buffer? In the absence of predictable care giving at home, the school becomes a refuge. But for the school to be a refuge, teachers must be able to feel adequate, appreciated and supported by their colleagues in making decisions and planning activities. This will enable them to become less punitive in their actions, display more patience and compassion and engage in more effective problem solving.

We must work to build our linkages between families and schools and between schools and communities. It will only be through this collaborative effort that we can build a broad enough network of protections for our adolescents.

As change agents, we have to begin focusing on what works, on what protects adolescents living in high risk environments. Moving to a resiliency approach requires a personal transformation of vision. (Bonnie Bernard, 1999)

We need to shift our thinking. We need to stop thinking of adolescent problems as the principal barrier to youth development and start thinking of youth development as the most effective strategy for preventing adolescent health problems. Youth development means purposely seeking to meet our adolescents' needs and build on their competencies.

### **How do we do this?**

- We must continue to focus on physical competence encouraging physical fitness,



good nutrition and understanding the consequences of risky behaviours.

- We must foster social competence including flexibility, communication skills, a sense of humour and the ability to ask for support.
- We must teach cognitive competence including good reasoning, problem solving and planning skills.
- We must provide for Vocational Competence-allowing our adolescents a sense of purpose and future, providing job opportunities and healthy expectations for achievement.
- Finally, we need to instill Moral Competence. We need to continue to develop the character and values of our adolescents and reestablish a sense of civic pride and community service. (NYDIC 1999)

This adolescent health survey has provided us with very important baseline data from which we now have a responsibility to act. Some of the protective factors for our local population have been elucidated, and these, in conjunction with previous international research done in the area of resiliency should help us to move forward in our prevention planning efforts. It will only be in attempting to strengthen those protective factors that filter through all aspects of adolescents lives that we will be able to create true, positive and long lasting change.

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