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Practical strategies

Resilience after maltreatment: The importance of social services as facilitators of positive adaptation☆

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ABSTRACT

This practice note will show that resilience among children who have been maltreated is the result of multiple protective factors, including the quality of the services provided to children exposed to chronic adversity. This social ecological perspective of resilience suggests that resilience is a process resulting from interactions between individuals and their environments, and depends upon individual characteristics (temperament and personality), the social determinants of health that affect children and children's families, formal interventions by multiple service providers (child welfare, special education, mental health, addictions, public health, and juvenile corrections), and the social policies that influence service provision to vulnerable populations. Clinicians and researchers concerned with the resilience of chronically abused and neglected children have tended to overlook the protective processes unique to children who have been abused that are different from the protective processes that promote positive development among children who have experienced no maltreatment. Most importantly, studies of resilience among maltreated children have rarely investigated the impact child welfare interventions have on the resilience of children who have been maltreated, mistakenly attributing children's abilities to cope to be the result of individual factors rather than the responsiveness of service providers and governments to tailor interventions to children's needs. To enhance the likelihood of resilience among maltreated children, those who design and implement interventions need to address three aspects of resilience-related programming: make social supports and formal services more available and accessibility; design programs flexibly so that they can respond to the differential impact specific types of interventions have on children who are exposed to different forms of maltreatment; and design interventions to be more focused on subpopulations of children who have experienced maltreatment rather than diffuse population-wide initiatives.

Although estimates of child maltreatment are complicated by problems related to definitions of abuse and identification of cases, a substantial number of children come to the attention of child welfare authorities each year as the result of exposure to cumulative ecological risks (MacKenzie, Kotch, & Lee, 2011). Many more receive interventions from other service providers (education, youth corrections, mental health) for conditions linked to maltreatment such as delinquency and learning challenges (Wekerle, Waechter, & Chung, 2012; Wingo, Wrenn, Pelletier, Gutman, Bradley, & Ressler, 2010). In this brief practice note, the focus is on children who have experienced chronic maltreatment but who show resilience, often in contexts where they are not only exposed to maltreatment, but also multiple other risk factors associated with marginalization, such as poverty, racism, or physical and intellectual disability.

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A growing body of research is showing that a large proportion of children who experience chronic maltreatment develop normally without repeating patterns of violence and show no above average rates of mental illness or behavioral problems (Masten & Wright, 2010). The study of resilience began in the late 1970s with independent longitudinal studies of child populations exposed to heightened levels of family and community risk factors such as the mental illness of a parent (Rutter, 1990), poverty (Werner & Smith, 1982) and racial marginalization (McCubbin et al., 1998). A minority of the children in these studies showed few long-term developmental challenges as a consequence of their risk exposure (Haskett, Nears, Ward, & McPherson, 2006; Ungar, 2011b). The processes that predict these positive outcomes (resilience) have been the subject of great debate, with a shift over time from a focus on individual characteristics (called resiliency) to processes associated with individual × environment interactions (Masten, 1994; Rutter, 2006). Recent studies of neurobiology, epigenetics, and epidemiology (Anda et al., 2006; Kent, 2012) have helped to inform our understanding of resilience as the result of interactions between individuals and their social ecologies (Ungar, 2011b, 2012).

Four sources of resilience are relevant to children who have been exposed to maltreatment: (1) individual temperament and psychological coping styles influence children's abilities to avail themselves of resources (i.e., a safe foster home) when these resources are provided (Folkman & Moskowitz, 2004; Peterson, Park, Pole, D'Adrea, & Seligman, 2008); (2) the social determinants of health influence the resourcefulness of children's environments, making physical, social and economic capital (i.e., safe streets, adequate housing, food, education) available directly to children or children's caregivers (Browne et al., 2001; Murray & Zautra, 2012; Wekerle, 2011); (3) interventions by mental health, social welfare, and education service providers delivered through government and non-governmental organizations shape opportunities for children to recover from maltreatment (Bottrell & Armstrong, 2012); and (4) government policies influence which resources are made available and accessible to children who have been maltreated (Leadbeater, Dodgen, & Solarz, 2005; Ungar, 2011a). For example, among children who are abused and living in countries where there is a social welfare state mandated to protect and nurture children, there is evidence to suggest services may exert far more influence on child developmental outcomes than individual factors such as temperament or psychological traits like self-esteem (American Psychological Association, Task Force on Resilience and Strength in Black Children, and Adolescents, 2008; Beckett et al., 2006; DuMont, Widom, & Czaja, 2007).

Though all four sources of resilience are important, there is far more study of individual, family, and school factors associated with resilience than the nature of the formal services that are mandated to mediate the impact of maltreatment on children's development and treat the resulting biological and behavioral sequelae. Contextualized explanations of protective processes have still not influenced the dominant discourse that shapes our perception of resilience as a psychological quality of the individual alone (Bottrell, 2009; Obrist, Pfeiffer, & Henley, 2010; Ungar, 2011b). A social ecological theory of resilience (Ungar, 2011b) suggests that resilience is a consequence of the quality of the individual's environment to make health-enhancing resources (e.g., child welfare services) available. Remarkably little work, however, has been done that links resilience to service design or culturally distinct (emic) factors that are indigenous to those who are marginalized (Edwards & Apostolov, 2007).

Among the studies addressing this problem is a multisite team coordinated by Dalhousie University's Resilience Research Center in Halifax, Canada (www.resilienceresearch.org) that is documenting protective processes among children and adolescents in more than 20 countries (for information on the many partners of the Resilience Research Center, please see their webpage). Findings from a series of qualitative (Theron, Cameron, Lau, Didkowsky, Ungar, & Liebenberg, 2011; Ungar et al., 2007) and quantitative (Ungar & Liebenberg, 2011) studies support a view that resilience is both the innate capacity of young people and the quality of their family systems to find ways of coping following exposure to acute and chronic stressors, as well as the capacity of their schools, communities, service providers, and government legislators to provide resources in ways that are meaningful to those who are impacted by maltreatment (Ungar, 2008; Ungar et al., 2007, 2008).

Quantitative work has used self-report measures, such as the Child and Youth Resilience Measure-28 (Liebenberg, Ungar, & van de Vijver, 2012), the Resilience and Youth Development Module (RYDM) of the California Healthy Kids Survey (Sun & Stewart, 2007), or the Connor–Davidson Resilience Scale (Connor & Davidson, 2003) to document correlations between risk factors such as maltreatment and positive developmental outcomes in individual, relational and contextual domains. These measures have been criticized for their lack of validity (Windle, Bennett, & Noye, 2011) and cultural bias in their construction (Ungar & Liebenberg, 2011). Qualitative studies of resilience among children who have been maltreated are less common (see, for example, Amaya-Jackson, Socolar, Hunter, Runyan, & Colindres, 2000; Munford & Sanders, 2005), though those that do exist are more likely to account for the services children receive as one component of resilience. There is little evidence in most of the quantitative literature of questions designed to assess the impact of child welfare services on resilience among maltreated children.

A growing body of research on resilience among child welfare populations and across cultures and contexts suggests the need to conceptualize resilience as the result of processes associated with services and the actions of service providers (Anctil, McCubbin, O'Brien, & Pecora, 2007; Pecora, 2012; Ungar, 2011a). Unfortunately, most studies of resilience adopt indicators of positive development known to be relevant to helping all children succeed regardless of maltreatment history (e.g., a close relationship with a safe, caring adult) which may explain why services are not well studied when children's resilience is investigated. External factors and internal coping strategies associated with resilience that are protective for children who have been maltreated may be different from those that affect non-maltreated populations (e.g., parental monitoring, parentification, delinquency, avoiding psychological distress through psychological numbing–Burton, 2007; McMahon & Luthar, 2007; Ng-Mak, Salzinger, Feldman, & Stueve, 2010; Van Voorhees et al., 2012). To understand this pattern of specificity with

regard to which factors associated with resilience affect populations of maltreated children requires a research-based understanding of the phenomenology of maltreatment and how coping strategies are shaped by the availability of opportunities in the child's environment.

For example, the OnLAC (Looking After Children) program uses the Strengths and Difficulties Questionnaire (Goodman, 2001) to assess children's capacities in contexts where there has been maltreatment (Cheung, Goodman, Leckie, & Jenkins, 2011). Factors related to the quality of service providers and foster parents, as well as service coordination between systems (emergency, health, social, legal, education services) can coalesce to enhance resilience among children identified as complex cases (Mitchell, 2011). For these reasons, practitioners have sought to intervene earlier and in coordinated ways with children who have experienced chronic maltreatment or separation from their family (see Collin-Vézina, Coleman, Milne, Sell, & Daigneault, 2011; Gilligan, 2001; Klein, Kufeldt, & Rideout, 2006).

Rarely, however, is coordination between systems mentioned as a precursor to resilience despite evidence of the immense impact that service providers have on the life course of children exposed to violence (Blackstock & Trocmé, 2005; DuMont et al., 2007; Ungar, 2005; Webb & Harden, 2003). In cases where a child is overwhelmed by the adversities he or she faces, the complexity of coping with out-of-home placement and the trauma that can result from maltreatment means that the quality of the care a child receives (continuity of attachment, coordination of services, individualized case plans, sustainability of psychological and service resources) e.g., can change the locus of control from what the child can do for him- or herself, to what the child's broader community and service providers can and should do for the child and the child's family (Obrist et al., 2010).

Though resilience can be conceptualized as social ecologies and individuals interacting, the bulk of the research in the field of mental health and resilience pays scant attention to the influence of social policies or service design. Notable exceptions are the work by those concerned with the social resilience of communities (Chaskin, 2008; Leadbeater et al., 2005; Peters, 2005) in which the positive outcomes for children are attributed more to the quality of government policies and social welfare services than individual motivations to thrive. There are excellent examples of research that shifts the focus to macro-systemic factors in international and culturally diverse contexts where the lack of formal supports is compensated for by "orphan competent communities" (Skovdal & Campbell, 2010), "kinship care" (Rama & Richter, 2007; Trocmé, Knoke, & Blackstock, 2004) and other systemic responses to child vulnerability.

Those who have looked at resilience as the result of how social service systems respond to adversity, or as a contextually specific construct, have shown that the majority of the change in a sample of abused and neglected children can be accounted for by structural changes to the child's environment (i.e., provision of a safe foster home, access to individualized curriculum at school, peer supports, restricted, reduced, or supervised access to perpetrating parents) rather than individual qualities alone (Sroufe, Egeland, Carlson, & Collins, 2005). In order to broaden our understanding of this link between service use patterns, risk mediation and resilience, the author led an Atlantic Canadian study of 497 adolescents who have used more than one social service in the last six months (Ungar, Liebenberg, Armstrong, Dudding, & van de Vijver, 2011). The youth were drawn from the caseloads of child welfare agencies, mental health centers (inpatient and out-patient), juvenile corrections programs (secure custody, probation, and community supports post-incarceration) and special education classes or counseling services in the schools. The sampling design ensured that all participants were those known as complex cases who faced a number of risks requiring multiple interventions. Among the many findings related to resilience, results showed that the quality of the care provided by one service provider is more predictive of good outcomes (e.g., school engagement, avoiding delinquency) than the quantity of services accessed. Specifically, adolescents who were selected because of their pattern of concurrent use of multiple services were asked whether they felt they belonged at school, about their behavior at school, and whether they felt their school responded to their needs. They were also assessed for their level of risk exposure at home and in their communities, as well as the personal risks they faced for externalizing and internalizing problem behaviors. This relationship between service use, resilience, and functional outcomes like school engagement is not unlike what others have reported in the literature: schools provide the highest levels of reported engagement for children from the most stressed families (the school becomes a source of individual support to the child even though GPAs may remain low; Shernoff & Schmidt, 2008).

This is just one example of how systemic factors can account for much of the variance in individual child outcomes when children are growing up in threatening environments. Though there is little evidence yet to show that interventions that build resilience are effective (Afifi & MacMillan, 2011), there is the assumption that service providers who adapt environments around children who have experienced maltreatment will help those children function better (Skovdal & Campbell, 2010). It remains to be proven, however, how effectively a quality service provider can be tailoring service to the individual needs of maltreated children when the goal is to build individual, relational, and community capacities associated with resilience.

How Interventions Can Affect Children's Resilience

Although there is no comprehensive review of interventions that promote resilience among maltreated children, nor agreement on what precisely constitutes a resilience-related response to maltreatment (should we work with the child, the family, the community, social policy, or all of these at once?), a broad reading of the intervention literature and a review of published papers in an edited volume such as Ungar's (2012) *The Social Ecology of Resilience: A Handbook of Theory and Practice*, shows that interventions by service providers that affect children's resilience follow certain patterns: (a) a population wide intervention may only be effective for those who are most at-risk, with little or no reported impact on children who are better resourced (Nix, Pinderhughes, Bierman, & Maples, 2005); and (b) interventions focused on the needs of children at

risk may not be effective unless they address the contextual barriers to children's successful coping (Obrist et al., 2010; Ungar, 2011b).

Support for the first pattern (those most at risk benefit most from interventions) can be found in a study of a parent and school intervention program in Medellin Colombia that sought to change patterns of maltreatment experienced at home and at school. In a context that was among the most violent on earth at the turn of the century, child emotional and physical abuse was an accepted part of both parenting and educational practice (Duque, Klevens, Ungar, & Lee, 2005). A community-wide intervention was designed to teach educators and parents alternative non-punitive or abusive ways of controlling children's problem behaviors. The program, adapted from work by Tremblay (Bernazzani & Tremblay, 2006), showed the greatest impact on behavior among those children from the most disadvantaged homes, but no impact or a negative impact for children who at baseline demonstrated lower levels of conduct disorder and exposure to family and community violence. In other words, children who experienced very little maltreatment may have performed less well after their caregivers received the program, while those children with the highest levels of exposure to violence improved. Similar patterns have been found for children with and without conduct disorder, with the impact of changes in parenting styles and school and home communication changing the behavior of only those children at the highest levels of risk for problem behaviors (Nix et al., 2005).

For children with less stress and more resources, interventions can provide an unusable, unnecessary, or intrusive (i.e., potentially stressing) resource. The protective process of the intervention, and the added care and relationships a quality intervention can provide maltreated children, are unlikely to be helpful to children who are not exposed to high levels of violence. In this regard, community-wide health promotion efforts may be effective at changing attitudes about child abuse, but for individual children who have experienced chronic abuse and neglect, more direct interventions focused on their needs is required. Therefore, to build resilience, the most effective interventions are likely to be those that target the children who experience maltreatment rather than broad-based schemes that attempt to change attitudes toward child abuse or normative behavior among all caregivers. The mistakes made when designing programs are to either: (1) assume that community health promotion efforts are useful in and of themselves, when there is little to suggest that individual victims of maltreatment will benefit directly from unfocused interventions; or (2) overlook the potential harm interventions may cause children who have not been exposed to violence. The best interventions to nurture resilience among maltreated children would seem to be those focused specifically on the needs of children who must cope in threatening contexts and delivered directly to them.

These more focused interventions, however, are effective only to the extent that they provide maltreated children with resources that they find meaningful (Ungar, 2008). As risk exposure changes, what is, and is not, a useful intervention also changes. To illustrate this interaction between effectiveness and risk exposure, Kassis and Moldenhauer (2011) conducted a study of 5,149 adolescents in Germany, Slovenia, Austria and Spain. Among the youth surveyed in schools, 9% had witnessed physical partner violence at home in the past 12 months, 15% had experienced physical abuse by from a parent, and 8% had experienced both. Standardized *Z*-scores for those who had experienced abuse were tricotimized into 3 approximately equal groups, low, median, and high exposure. Factors associated with resilience such as emotional self regulation, self-acceptance, parental supervision, school climate and close relationship with a teacher were only associated with lower levels of depression for maltreated children who experienced low levels of violence, but not for those with median and high levels of exposure. For these higher risk children, no amount of resilience protected them against depression. Kassis and Moldenhauer reasoned that unless the exposure to violence is ended first, the protective functions of factors associated with resilience do not become available. In practice, such findings suggest that focused interventions to promote resilience among maltreated children need to be sensitive to the context in which the children live. The nature of the violence they experience will determine which protective processes are most likely to be associated with better mental health. In more dangerous environments, processes that mitigate exposure to violence are likely to be more important than processes that improve other aspects of a child's positive development.

Child Welfare Settings: Practical Strategies to Foster Resilience

With this in mind, three statements can be made that are supported by research on resilience:

- *Statement 1*: Individual capacities, the social and economic determinants of well-being, multiple services, and social policies that make resilience-related resources available and accessible are important to children who experience maltreatment.
- *Statement 2*: The more children experience maltreatment, the more important specific protective factors will be to a child's biopsychosocial development (i.e., the principle of differential impact).
- *Statement 3*: The level of maltreatment within a population of children should be used to decide whether interventions by service providers are focused (protecting a small number of children who have been the target of maltreatment) or diffuse (promoting the well-being of all children when the exposure to trauma is community-wide).

Providing a child with access to the resources (personal, relational, contextual) that he or she may need later when a crisis occurs is good health promotion, but the factors that are protective at lower levels of exposure to maltreatment may not be the same factors required to protect a child who is exposed to higher levels of abuse and neglect. To resolve this intervention paradox, it is recommended that systems that respond to children change to ensure they prevent child maltreatment, or

can respond flexibly when called upon to do so. Service providers mistakenly try to fix children when risk exposure is high rather than fixing the system to meet maltreated children's needs (Ungar, 2005). In this regard, more research is needed to discern which interventions are most effective with which children who have experienced different amounts of maltreatment. A defiant attitude, a strong bond with a non-kin adult, an internal locus of control, empowerment, a say over one's service plans, and an ability to become a resource to others who are abused are all examples of factors that have been shown to be helpful sustaining the well-being of maltreated children (Afifi & MacMillan, 2011; American Psychological Association Task Force on Resilience and Strengths in Black Children, and Adolescents, 2008; Boyden & Mann, 2005; Ungar et al., 2007). However, it remains unclear which combination of protective factors at what intensity is required in specific contexts. Resilience, therefore, is a complex set of processes that depends on the interaction of the individual and his or her environment (including services and service providers) to decide which factors, under which circumstances, are the most protective. Arguably, the research and practice evidence suggests that the effectiveness of services that are both promotive of positive development and protective against further traumatization will depend on a flexible case management structure provided by the child welfare system.

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