KIDS STRENGTHS
KIDS in the CONTEXT of MENTAL DISORDERS

Education and Culture DG
Lifelong Learning Programme
Leonardo da Vinci

Module 4: Fostering Resilience in Children in the Context of Mentally Vulnerable Parents

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1. Definitions and Preliminary Remarks

Approaching resilience can be considered a significant shift in the paradigm of how to support and promote the mental well-being of children.

> Resilience increases the ability of a person or system to cope successfully with the challenges of life in the presence of significant adverse risks (Rutter 1985)
>
> Resilience can be seen as a sector specific resource, which is acquired through interaction with the surroundings. It is the ability to activate learnt coping mechanisms despite difficult life situations (cf. Petermann & Schmidt 2006)

Resilience is not contrary to risk. Resilience focuses on the effectiveness of change and on those factors which keep the person healthy even where there are risk factors. Resilience therefore does not primarily represent a balancing construct in relation to risk, but is considered a basic ability which is activated if risk factors are occurring. We can therefore assess resilience as the basic construct.

Resilience therefore cannot only be assessed as the contrary construct relating to risk factors, but puts the human being and the supporting system in a position to be active and perform active steps towards health and well-being. Furthermore, it can be seen as a major step towards positive psychology and towards a concept which promotes health by active action and support rather than by preventing risks.

There is a major consensus that resilience factors or underlying resilience processes show buffering effects in the presence of adverse life conditions (e.g. Werner 1993; Lösel & Bender 1994; Festinger 1983, Laucht et al 1999)

Even though the scientific status in terms of validity, operationalisation or differentiation towards other constructs might still be under discussion, the construct of resilience can be assessed as a powerful concept to promote mental health, particularly in vulnerable groups.

1.1 Can resilience processes be supported and strengthened?

The clear answer is yes, even though there might be some discussion about "HOW". The strategies might depend to a great extent on the age of the person and on the area/sector in

which support processes should be implemented and the developmental or life tasks which are relevant at that time.

For our target group: children and young adolescents in the life context of mentally vulnerable parents, most strengthening processes will focus on the initiation of changes within the family system to enable the child towards a new or more healthy experience. For adolescents methods of psychotherapy might also be used. Within the scientific community (Petermann & Schmidt 2009) there is an ongoing discussion about differences between resilience, resources and other comparable constructs. Within our training context this link between the construct of resilience and internal or external resources is highlighted. In order to be able to react in a resilient way and to remain mentally healthy one will need internal and external resources.

1.2 Are resilient factors always positive?

Within the current discussion the possible double face of resilience factors is also highlighted: example e.g. if a resilience factor becomes too "extreme": self-esteem" is assessed as supportive resilience factor, however if the child shows exaggerated self-esteem ("I am the best, I am able to do everything") it might also become a risk factor.
It also can be supposed, that diverse resilience factors show different impact (e.g. the availability of a healthy attachment person or play different roles during different phases in life: the availability of peer group contacts might be assessed as more important during adolescence.

1.3 How does resilience work?

Data indicate that essentially, resilience functions on the basis of a buffering effect in the presence of adverse life events or significant stressors. However, resilience might not show significant effects if there are no major stressors. Generally speaking, evidence-based literature describes two main factor groups within the field of resilience

a. individual-centred factors and
b. social or environmental-centred factors

Within KIDS STRENGTHS the following categories will be used (Pretis & Dimova 2003) in order to be able to differentiate family related (II) and community related processes (III). Due to overlap and interdependency a strict differentiation might not always be easy or even necessary.

I. child-centred support processes (like optimism, self esteem…)
II. family -centred support processes (positive parenting)
III. support processes focused primarily on the broader environment of the child and the family (kindergarten, school, community based services)

1.5 How can resilience be supported?

In our understanding, resilience processes within the child and the family can be supported in two ways:

a. strengthening general resilience factors within the child, the family or the environment (for example the availability of a heathy attachment person, development, self-efficacy, joy, social competence, communication with peers and so on)
b. strengthening specific resilience processes within our specific target group of children in the context of mentally vulnerable parents (for example information on the health status of the parent, specific coping skills for crisis, enabling activities with healthy adults etc).

2. How to approach the strengthening of resilience factors

2.1 Philosophical Approach

If we look at the development of children through a heuristic approach (not primarily taking into account evidence-based findings) the major factors can be identified and these factors also represent themselves chronologically within the first years of an individual:

2.2.1 I-HAVE factors

These factors represent a child's external resources e.g. in terms of the availability of people who provide care for the child and ensure continuity of attachment. When a child is born he/she is to a great extent in a position of dependence on largely adult carers. Alongside the biological genetic basis of a child, I-have factors can be assessed as first stage factors.

Example: "I have people who care about me and who meet my needs in a constant way"

As the development of the child is normally correlated with greater autonomy, the next stage I-CAN factors, become relevant.

2.2.2 I-CAN factors

These I-can factors depend to a great extent on

a. the availability of role-models who demonstrate and reinforce a child's activities
b. the availability of supportive surroundings and tools (to be able to experience new challenges)
c. maturation processes in order to be able to perform new activities

Normally, children first need people who take care, teach and support the child's activities in order that they are able to do the things by themselves. These second factors can therefore be seen as I-can factors,

Example: "I can do a lot of things by myself." "I can express my wishes and needs." "I can tell what I like or what I dislike."

Obtaining feedback from other relevant people, being able to perform activities by themselves creates the concept of "mastery" within the child. This means that the child becomes able to predict their own actions or situations. This sense of "mastery" therefore correlates highly with the concept of self-esteem and self-efficacy, or the general concept of personality of a future "I-am". Therefore, within a developmental perspective, internalised I-AM factors are based on I-have and I-can factors.

Example: "I am a happy child", "I am loved."

2.2. Evidence Based Approach

In addition to the above-mentioned heuristic approach, KIDS STRENGTHS also highlights the importance of evidence-based findings. Therefore, the following resilience factors will primarily follow evidence-based data. However, the above-mentioned heuristic perspective will also be introduced in with reference to possible examples.

2.3.1. Child-Centred Resilience Processes and how to Strengthen Them

A: General factors

2.3.1.1 Health

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
> (www.who.int/about/definition/en/print.html)

The health status of a child and particularly very young children, can be assessed as a major resilience factor. Based on professional background this resilience factor must therefore always be considered and adequately assessed. If a non-medical professional has any doubt or question regarding the health status of the child (nutrition, care, injuries, non-treated illnesses, disability and so on), immediate steps towards an assessment and a check of the health status is necessary and further necessary steps (e.g. treatment) have to be performed. In this context, institutional services, such as school doctors and doctors in kindergartens etc. should also be consulted if e.g. parents do not show sufficient compliance to look for help.

In light of I-have, I-can and I-am, health issues correlate to a great extent with I-have factors, as children do not normally seek medical help by themselves but only when supported by adults or parents. Therefore, the associated "I have-aspect" is:
I have adults or others who take care of my health and provide necessary health care.

2.3.1.2 Child Development

> Child development is a multifaceted, integral, and continual process of change in which children become able to handle ever more complex levels of moving, thinking, feeling, and relating to others.
> (www.wfnetwork.bc.edu/glossary_entry.php?term=Child%20Development,%20Definition(s)%20of&area=All)
>
> **Child development** refers to the biological and psychological changes that occur in human beings between birth and the end of adolescence, as the individual progresses from dependency to increasing autonomy. Because these developmental changes may be strongly influenced by genetic factors and events during prenatal life, genetics and prenatal development are usually included as part of the study of child development.
> (http://en.wikipedia.org/wiki/Child_development)

Good developmental parameters can always be assessed as a resource for the child (Masten&Powell 2003). Children with higher cognitive development are regarded as more resilient than children with cognitive impairment. The basic hypothesis behind this data being that

a. intelligent children actively seek situations where they can improve their skills in terms of increased mastery or
b. they are to a greater extent able to anticipate and understand their situations in terms of e.g. problem centred coping strategies.

Developmental stimulation in terms of the availability of people who offer age-appropriate and challenging activities can therefore always be assessed as helpful. Related "I have"-aspects:

I have somebody who allows me to do things by myself.
I have somebody who shows me how to do things.
I have somebody who gives me feedback on what I am doing well and where I might need help

2.3.1.3 Self-esteem

> Self-esteem is the collection of beliefs or feelings we have about ourselves, our "self-perceptions." How we define ourselves influences our motivations, attitudes, and behaviors and affects our emotional adjustment
> http://kidshealth.org/parent/emotions/feelings/self_esteem.html
>
> **What is self-esteem?**
> Definitions of self-esteem vary in their breadth and sophistication, but all agree that high self-esteem means that we appreciate ourselves and our personal worth. More specifically, it means:
>
> - we have a positive attitude
> - we value ourselves highly
> - we're convinced of our own abilities
>
> we see ourselves as competent, in control of our own lives and able to do what we want.

The construct of self-esteem can to a great extent be considered in association with other ones, e.g. self-efficacy and self control. Individuals report high self-esteem if they are able to do things by themselves and receive necessary feedback from relevant others. Self-esteem can be strengthened through the idea of "mastery" and "age appropriate responsibility". In this context being able to "cope successfully with challenges" is important for the child.

However, it must be highlighted that the issue of age appropriate responsibility in the field of children in the context of mentally vulnerable parents has to be observed carefully as many of the children are burdened with age inappropriate responsibilities called "parentification" (such as taking care of the mental needs of the parent or of daily needs of siblings or even of the sometimes overwhelmed healthy partner). The promotion of self-esteem "per se", within

small children is normally not possible but needs positive feedback from others and situations in which the child is able to perform age appropriate developmental tasks.

Another important aspect focuses on ones own "self perception": How do I see myself as a child, adolescent? It is supposed that children who are better aware of themselves, have a "realistic" and positive perception of themselves and of their own abilities, are easily able to differentiate between "healthy" and "sick" systems.

Associated "I-have" and "I-can" aspects:

I have people who love how I am?
I have people who provide positive feedback?
I can do things by myself?

2.3.1.4 Easy Temperament

> Most babies have easy temperaments, and they are usually in good moods. They adjust easily and quickly to new situations and changes in routine. Babies in this category usually eat on a regular schedule. When they are hungry or are experiencing some other form of discomfort, they usually react mildly. When babies with easy temperaments are fussy, they are usually able to find ways to soothe or calm themselves down. Babies with easy temperaments are generally even-tempered.
> http://www.parenting-ed.org/handout3/General%20Parenting%20Information/infant%20temperament.htm

Evidence-based literature highlights the importance of an easy temperament (Rende et. al. 1993). This means that for the parents and carers, children are "easy to be handled": they give positive feedback to the parents, e.g. by means of smiling and they can easily be comforted.

How can one support these resilience factors if the temperament turns out not be as easy as parents would wish? e.g. permanently screaming children, a child who has problems being comforted, a child which does not sleep very much and requires a lot of attention.

As the construct of temperament, with all its unclear connotations in the scientific literature tends to correlate highly with biological and genetic factors, we have to ask ourselves how we can gain influence within this area. One might suppose that the temperament of a child itself cannot be changed substantially, but what can be changed by the surroundings are the reactions towards the child's temperamental factors. If the child is screaming intensively, as a mother or father it might be good to deescalate the situation and not lose nerves. This might mean seeking help or support in this situation. If I as a parent make the observation that the

child tends to react in an avoiding way or tries to avoid challenges, it might be possible to introduce enjoyable games to reach the same goals as those reached through pressure.

However, easy temperament does not mean to give up needs easily (in terms of helplessness conditioned). Whether children with a "difficult" temperament are able to express their needs more adequately (e.g. as they might scream for a long time) remains open. Within the context of mentally vulnerable parents a "challenging temperament" tends to increase the risk of (physical) abuse due to massive perceived distress of the parents.

The associated "I have" aspects for professionals regarding the temperament of the child are

I have people who might deescalate and relieve difficult situations.
I have parents or carers who remain calm or react in a different way towards me.

2.3.1.5 Self-help

> **Self-help** consists of doing things yourself to try and solve your own problems without depending on other people
> **Self-help** consists of people providing support and help for each other in an informal way, rather than relying on the government, authorities, or other official organizations.
> http://dictionary.reverso.net/english-cobuild/self-help

Children with high self help can

a. express their own needs,
b. perform actions to reach their own goals and
c. organise help by themselves without the help of others
d. and successfully obtain help

Children able to organise help for themselves can be assessed as more resilient than e.g. helpless children (Ahmann & Bond 1992). In the context of children of mentally vulnerable parents in particular, it has to be highlighted that self-help does not mean that children take responsibilities which are not age appropriate. Sometimes we observe so called "parentification" in this context: children feel responsible e.g. for the medication of their parents, for younger siblings or the organisation of daily life (such as preparing meals). This is not usually considered self-help, even though the children might show no problems in doing these things. Self-help in our context relates to the question of "What can I do if Mum/Dad is not well in order to experience joy or meet friends?" (e.g. go to the neighbour) or "What can I do if there is a crisis?". Self-help in relation to children often correlates with

questions to the child: "What do you do if…?" and also: "What are you able to do by yourself?" Sometimes small children need some help and some examples with these questions: e.g. taking off shoes by yourself, cleaning your teeth etc.

However it has to be taken into account that self help (especially if children seek institutional help) to a high extent depends on the availability of help. Children of mentally vulnerable parents might have the feeling, that there is no specific help for them e.g. from the side of the child welfare or child protection system.

Regarding "I-have", "I-can" and "I-am factors", self-help is associated with

I can do things by myself.
I can express that I need help etc..
I obtain help when I ask for it.

2.3.1.6 Self-efficacy/Self-control

> **Self-efficacy** has been described as the belief that one is capable of performing in a certain manner to attain certain goals. It is a belief that one has the capabilities to execute the courses of actions required to manage prospective situations. It has been described in other ways as the concept has evolved in the literature and in society: as the sense of belief that one's actions have an effect on the environment as a person's judgment of his or her capabilities based on mastery criteria; a sense of a person's competence within a specific framework, focusing on the person's assessment of their abilities to perform specific tasks in relation to goals and standards rather than in comparison with others' capabilities. Additionally, it builds on personal past experiences of mastery.
> http://en.wikipedia.org/wiki/Self-efficacy
>
> Self-efficacy is "the belief in one's capabilities to organize and execute the courses of action required to manage prospective situations" (Bandura 1995, p. 2). In other words, self-efficacy is a person's belief in his or her ability to succeed in a particular situation.
> www.psychology.about.com/od/theoriesofpersonality/a/self_efficacy.htm

Self-efficacy means that a child has a concept of mastery in performing tasks as they are planned or wished by the child him/herself (Schwarzer 1993). In this context, self-efficacy correlates highly with other concepts such as self-help, self-esteem or ego-control.

However, in the field of health promotion the concept of self-efficacy is assessed as highly relevant, particularly in relation to behaviour which might be harmful, e.g. smoking etc.

Any kind of planning action performed by the child, task fulfilling action and following evaluation action therefore strengthens the concept of self-efficacy. These processes can be highly supported by professionals and other relevant family members through continuous planning ("Let's make a plan together", "What do we need in order to carry out the plan?" "Let's try a little harder each time!" and when we are finished "Let's evaluate whether our actions fit with our plans"). Everything the child can do by him or herself in this context supports the development of self-efficacy. Self-efficacy is therefore highly related to "I-can factors".

However, especially for single children or the oldest sibling task fulfilling always has to be seen within a possible context of "parentification". Children might look for solutions for the problems of their parents.

I can find solutions.
I can finish tasks which I want to achieve,
I can do things by myself.

2.3.1.7 Optimism/Joy/Positive Orientation towards the Future

> A tendency to expect the best possible outcome or dwell on the most hopeful aspects of a situation
> http://www.thefreedictionary.com/optimism
>
> Optimism is an outlook on life such that one maintains a view of the world as a positive place. It is the opposite of pessimism. Optimists generally believe that people and events are inherently good, so that most situations work out in the end for the best
> http://www.selfgrowth.com/articles/Definition_Optimism.html

Joyful interaction, feeling safe, secure and optimistic are described as major factors which contribute to the mental well-being of a child. Even though professionals might only spend a few hours with the child during a week, children do benefit from these contacts and they later (retrospectively) report that these "islands" of joyful play or interaction are perceived as supportive.

Therefore, situations of joy and optimism, laughing together with the parent or professional, are significant support factors. In every situation professionals can create enjoyment and moments of laughter together with the child. Particularly in relation to the de-escalation of negative circles, joyful games and interaction often create the basis of new supportive interactions and trust. Regarding positive events and joyful actions, the children need all three major heuristic factors:

I have a person who provides situations in which I am able to enjoy myself and laugh.
I can experience fun.
So I am a happy child.

2.3.1.8 Social competence

> **Social competence:** A generic term, of varied usage, meaning competencies and skills related to interaction, e.g. social judgment, empathy, and the repertoire of communicative behavior. In the professional context, frequently understood as the ability to act in a way appropriate to the situation and to achieve a specific result, appropriate to meeting interaction requirements related to a specific activity (e.g. role flexibility, adaptability, conflict resolution); in group work conditions, the term is occasionally used as a synonym for the term 'team player' (which is just as imprecise in its application).
> http://www.personalpsychologie.com/glossary.html

Guralnick (2007) describes 3 major skills that contribute towards social competence, which focus primarily on peer-contacts. However for children in the context of mental vulnerability any kind of contact to healthy others seem to be important – especially to minimize the risk of social exclusion.

a) to come into contact with other children
b) to share common "realities" and follow common rules
c) to solve conflicts.

Social competence needs

A) the willingness of parents to enable contact with peers or other persons
B) concrete situations to meet other children
C) Support for the child, to come into contact e.g. with other children

Associated heuristic factors

I have children with whom I can play and interact
I can come into contact with them, join games and solve conflicts
I am respected by other children and in broader context – by other persons

2.3.1.9 Hardiness

Hardiness was first described by Kobasa (1979) as a cognitive appraisal process composed of three characteristics: challenge, commitment and control.

Hardiness (Kobasa and Maddi) is the combination of an internal locus of control, appreciation of challenge as opportunity, and commitment to self.

Together with self-efficacy and ego-control, hardiness describes the ability of an individual to perform goals that are self-determined. In many children within the context of mentally vulnerable parents we see that due to reduced efforts from the parents, some children tend to show avoiding behaviour as they are not stimulated age-appropriately or obtain adequate feedback about their behaviour.

The main purpose for strengthening hardiness therefore, is always to go one step further and to try to motivate the child to try a little bit harder. However, this does not mean the child should try "harder" to save the parents (especially in the field of addiction).

These associated "I can" and subsequent "I am" factors focus on aspects such as

I can to assess whether I can change things.
I always try a little bit harder.
I can do a little bit better if I try.
I am proud of myself.

B) Specific factors:

2.3.1.10 Information about the Illness or Vulnerability of the Parents

Specific in-depth explanation find in the module "How to inform the children". Developmentally appropriate information about what is going on with their parents helps the child to "re"interpretate and "re"attribute perceived distress or their parent's "strange" behaviour ; What worries me is a "disease", there is "help", "this has nothing to do with me" and I can feel secure.

Two issues have to be highlighted:
It is important that children are able to see that their parents are motivated to seek help. Children then experience that during challenging life events it might be important to seek help.

Information about the mental illness also should enable differentiations: which behaviour of the parents is due to his/her mental vulnerability and which behaviour is part of his/her individual "history" in terms of personality factors (however this might be difficult in the field of "personality disorders".

This aspect helps to differentiate possible emotional reactions of the child (especially if parents do not seek help): Information about the possible mental illness does not mean that the child excuses the parents and that emotions are not allowed. Even though the child might know that the parent suffers from substance abuse, alcoholism or other mental illnesses this does not mean that the child may not be angry, sad or disturbed about this fact.

Whenever children are informed about the impact of the disease or the symptoms, this emotional impact must also be taken into account in terms of questions: What does it do to you? How do you feel about it? In an optimal setting the parent him/herself asks the child.

Particularly if children tend to take too much responsibility through parentification, there might be the risk that they also take responsibility for the illness and its treatment.

The second aspect refers to a necessary informed consent from the parents or from those persons who are in charge of custody.

It is observable that even small children of two or three years old do recognise changes in the behaviour of their parents and therefore need interpretations on what is going on with their parents. In an optimal setting the parents themselves together with the professionals provide the information about the illness. Sometimes children in this context might show some disinterest about what the professionals are saying. This can be interpreted as a sign of protection or loyalty towards the parents. In these cases we should not insist on confronting the child with the diagnosis, however hardiness is required e.g. if the parents have to stay in hospital. In this case the child has to be informed, the distress of hospital can sometimes be represented through games (e.g the teddy bear is sick, what can we do about it?).

If the case of custody is opened in court, children should be well informed about the legal situation and about procedures. There is evidence that children are able to understand procedures from the age of five or six onwards. An associated question in this context, which help to explain e.g. possible foster care is about “What do children need in order to be happy?” Children themselves might express relevant factors, in a dialogue it can be assessed to what extent these factors can be found in the family.

However – especially regarding chronic diseases – too much information e.g. about the prognosis might also represent a "burden" to the child. Children sometimes seem to be more competent regarding the illness than the parents (especially if the parents do not show good compliance).

In a heuristic way, information is connected with high I-have, I-can and I-am factors:

I have people who inform me in a child appropriate way about my situation
I have someone who helps me to understand and differentiate the behaviour of my parents
I have someone who protects me.
I can understand what is going on in my family and I can express my emotions and worries about it.
I do not feel responsible or guilty for the symptoms or health of my parents.

2.3.2 Family System Focused Resilience Factors

As small children are the focus of our attention and as in most cases the family can be considered the primary socialisation factor, supporting resilience processes can therefore be assessed as relevant. Again, this section distinguishes between general and mental-health specific resilience factors.

A: General family system focused factors and processes

2.3.2.1 (Adult) Healthy Attachment Person

> Early attachment security or insecurity is best regarded as a significant protective or risk factor respectively in the development of psychopathology
> http://www.cyf.vic.gov.au/__data/assets/pdf_file/0010/16021/cp_hri_attachment.pdf
>
> The attachment system is continually active. When babies feel secure, safe, and deeply sure of availability of their attachment person, they move out to explore with vigor, absorbed in play. If they sense danger, become alarmed, feel abandoned or threatened, their attachment needs surge and they seek proximity to their beacon of safety, their special attachment person.
> http://findarticles.com/p/articles/mi_qa4097/is_200310/ai_n9314582/

The child needs at least one healthy attachment person in his/her relevant daily life environment (Egeland et al. 1993). This does not necessarily have to be the father or the mother. It is important that it is a physically and emotionally available person. E.g. for adolescents this could also be a good (adult) friend, a neighbour or a mentor. One should try to assess whether one person is available and how to activate him/her or how to activate him/her more in relation to the needs of the child.

Associated aspects:

I (continuously) have at least one healthy person with whom I feel secure and safe and who I can rely on.
This person is (easily) available for me.

2.3.2.2 Positive Parenting

> Responsiveness (or positive parenting) is a term derived from social attachment theory and it highlights a wider range of parent responses as well as greater breadth in their contingent arrangement following child behaviour. (Wahler et al. 1997)

a) Perceiving the needs of a child, b) reacting within an adequate time span, c) in a developmentally appropriate way and d) providing emotional warmth, are factors which contribute towards the probability of the healthy development of a child.

Positive parenting needs the feeling of security and being safe, both for the child and the parent. It is a basic pre-condition for any further development of functions and needs, and requires parents who are emotionally and physically available. In our professional efforts to strengthen resilience within the child 4 aspects have to be taken into account:

a. How - and to which extent – constantly sensitive is the mentally vulnerable parent towards the needs of his/her child?
b. Is it possible and probable, that this sensitivity could be learned or increased?
c. Are there any other relevant attachment people who might compensate possible deficits?
d. Are we able to empower the child him/herself to express his/her needs in a better way?

Supporting positive parenting – within existing training programs e.g. STEEP (Erickson & Egeland 2009) is primarily about giving positive feedback to the mentally vulnerable people about what they are doing (Literature?). Feedback can be provided by video feedback, analysing the expressed needs of the children and how parents meet these needs or by role playing activities.

Positive parenting can be empowering, however there are some limitations regarding parents who are in an acute psychotic state or even in moderate depression. Positive parenting also has to take into account that professionals easily take the role of a “better parent” and run the risk of “overruling” the parent when they are working with the child.

In terms of I-have factors:

I have people who provide me with constant secure attachment and react in a predictable and warm way
I have people who are able to perceive my needs
I have people who are able to satisfy my needs adequately and in a timely manner
Specific material (e.g. toys etc.) are available to support my development
I can express my needs.

2.3.2.3 Roles and Structure in the Family

> Routines are how families organise themselves to get things done, spend time together and have fun. Every family has its own unique routines. Routines help family members know who should do what, when, in what order and how often. For example, your family might have:
>
> - daily routines for getting ready in the morning, bath time, bedtime and mealtimes, greetings and goodbyes
> - weekly routines for housework like washing and cleaning
> - yearly routines involving holidays and extended family get-togethers.
>
> http://raisingchildren.net.au/articles/family_routines_how_and_why_they_work.html
>
> Family routines and rituals both refer to specific, repeated practices which involve 2 or more family members (Spagnola et al. 2007)

Routines, clear roles and family structure (although not too strict and sometimes flexible) provide predictability for the child in family systems (Werner 1999). It is therefore important for professionals to assess which kind of daily rhythms, rituals or structures a family shows. The assessment of these rituals could be oriented on the daily life activities of the child. Sometimes external tools such as calendars help the child to identify rituals and structures. Rituals and structures are to a great extent, external factors with the following associated aspects:

I have people who make my life predictable (e.g. by means of rituals and structures)
I have a person who gives me a feeling of security and safety by means of predictably.
I have people who inform me about plans in which I am involved.

2.3.2.4 Positive Relationship

> Relationships usually involve some level of interdependence. People in a relationship tend to influence each other, share their thoughts and feelings, and engage in activities together. Because of this interdependence, most things that change or impact one member of the relationship will have some level of impact on the other member.
> http://en.wikipedia.org/wiki/Interpersonal_relationship

As a parent, being in a (positive) partnership can in most cases be considered a resilience factor (Carro et al. 1993), unless the partnership itself is the nucleus of risk, danger or

conflict. The assessment of positive partnership needs a dialogue between all relevant partners, not only the vulnerable parent or the healthy parent). However it has to emphasised that a mental vulnerability of one partner very often represents a high burden for the whole partnership or might trigger significant life crisis (including co-dependency e.g. in the context of alcoholism). Positive partnership is related with:

"I-have" factors; "I-can" factors and "I-am" factors:

I have parents who love and respect each other
Even though one parent might be ill I can rely on the second one
I am loved and respected because my parents love and respect each other.

2.3.2.5 Educational Status/Employment of the Parents

> Educational Status: Educational attainment or level of education of individuals.
> http://www.reference.md/files/D004/mD004522.html

As pointed out in the context of the child, the cognitive skills and indirectly the educational outcome and the employment status of the parents play a decisive role, as they are usually correlated with higher (social) functionality (Sieverding 1995). It is well known that unemployment, poor educational status etc. are associated with greater perceived distress in families. As long as parents are able to perform tasks in the labour market, it can be hypothesised that the symptoms of their illness are discrete and do not impair their social and/or professional functioning. Furthermore, the availability and seeking of help is also correlated with the educational level of the parents. Secondly, employment or related activities (e.g. such as training courses for vulnerable adults) in most cases also mean that the child is able to spend some time in other settings such as child minding systems or kindergarten.

However – especially regarding chronic illnesses – unemployment is a factor which should be taken into account. Sufficient financial means – on the other hand – is a protective factor within vulnerable family systems.

Related factors:

I have parents who are well educated and who are integrated in the labour market.
I am able to spend some time of the day in healthy surroundings during the time that my parent is at work.

B: Specific factors:

2.3.2.6 Parental Mental Health and Compliance

> Compliance: The degree of constancy and accuracy with which a patient follows a prescribed regimen, as distinguished from adherence or maintenance.
> http://medical-dictionary.thefreedictionary.com/compliance

The mental health status of the vulnerable parent is a strong predictor of possible dangers or protective factors for the child (Frankfurter und Bielefelder Studie). Not the diagnosis per se, but the intensity of the symptoms play a decisive role regarding the possible impact of the illness on the child.

4 aspects are significant for the vulnerable parent in this context, and are significant factors for the assessment:

A) Own compliance (in terms of own recognition that "I am not mentally well, that I suffer from depression, psychosis, that I am taking drugs or drinking too much or too often)

B) Compliance concerning possible medication or psychotherapy

C) Compliance towards services

D) compliance towards an understanding of the childs situation and needs

Within the spectrum of psychiatric disorders, the assessment should generally be done by a highly specialised psychiatrist. Associated heuristic factor:

I have parents who are able to recognize that they need help for their mental health.
I have parent who seek help.

2.3.3. Environmental Factors

2.3.3.1 Social Contact with Peer Group Members who are Socially Well Adapted

> A peer group is a social group consisting of people who are equal in such respects as age, education or social class. Members of a particular peer group often have similar interests and backgrounds, bonded by the premise of sameness.
> http://en.wikipedia.org/wiki/Peer_group

This resilience factor focuses on the availability of contact with the peer group (children more or less the same age, mainly without observable behavioural or emotional disturbances) e.g. in a kindergarten, play group, in the neighbourhood etc. It is closely related to "I-have" factors:

I have friends with whom I can play and perform activities.
I have friends with whom I can share my worries.

But it is also highly related to I-can factors:

I can come in contact with my friends, we can play games together and I can also solve conflicts with them.
I can trust my friends

The associated I-am factor is:

I am socially accepted and well integrated.

2.3.3.2 Academic Performance

> Academic performance refers to how students deal with their studies and how they cope with or accomplish different tasks given to them by their teachers. Academic performance is the ability to study and remember facts and being able to communicate your knowledge verbally or down on paper.
> http://wiki.answers.com/Q/What_is_meant_by_academic_performance

Comparable to the child-centred resilience factor of cognitive development or development in general, positive academic performance strengthens the self-esteem of children and provides them with better life chances. Similar to the stimulation of development, institutional educational settings in particular should try to do everything to increase the level of academic skills of vulnerable children. Associated aspect:

I am good at doing things
I am able to understand what is going on around me.

2.3.3.3 Availability of Support and Help

> Social support (both in a professional and in an informal way) is the physical and emotional comfort given to us by our family, friends, co-workers and others (…) An important aspect of support is that a message or communicative experience does not constitute support unless the receiver views it as such. Social support in the narrow sense has been defined in various ways. (…) Several types of social support have been investigated, such as instrumental (e.g., assist with a problem), tangible (e.g., donate goods), informational (e.g., give advice), and emotional (e.g., give reassurance), among others. Health and well-being are not merely the result of actual support provision, but are also a consequence of participation in a meaningful social context.
> http://en.wikipedia.org/wiki/Social_support

This resilience factor focuses on available professional services which provide (some kind of support) to the child and the family. However, in the field of children with mentally vulnerable parents it can be seen that services tend to underestimate the distress of the children. At the same time the parents do not easily want to seek out services because of

- being ashamed

- being afraid to loose custody of their children,
- a lack of compliance or
- as children might not show symptoms of stress

I have professional helpers.
I can seek help.
I am autonomous (in an age appropriate way).

2.3.3.4 Other Healthy Adults

Other healthy adults with whom the child is able to perform joyful activities are a powerful resilience factor (see also "healthy attachment person"). Mostly families tend to isolate themselves socially. Therefore, professionals should focus on the careful assessment of potential adults who might be available for the child even if only for a few hours.

Related factors:

I have somebody other than my parents who takes care of me beside my parents
I have somebody who is a positive role model for me
I can do things which I cannot usually do with my parents.

2.3.3.5 Interests, Activities within the Community

This factor relates to two issues: the first one is a more child-centred one: which other interests, specific competencies does a child show? e.g. football, chess, specific interest in animals and so on. The second one is based on necessary community based services such as football associations, which can cover these needs. However, for very small children this resilience factor might not always be available as the children usually need to be a certain age to e.g. attend a football club.

Related factors:

I am interested in diverse things (e.g. sports…)
I can follow my interests.
I am active.

2.3.3.6 Spirituality/Sense of Coherence

> Traditionally, religions have regarded spirituality as an integral aspect of religious experience and have long claimed that secular (non-religious) people cannot experience "true" spirituality. Many do still equate spirituality with religion, but declining membership of organised religions and the growth of secularism in the western world has given rise to a broader view of spirituality.

http://en.wikipedia.org/wiki/Spirituality

Experience shows that children and families who are living in the context of certain values or spiritual beliefs seem to be more protected against adverse situations than children without this context. In the assessment of the children and the planning of services it should be taken into account whether specific spiritual values are important in a family system.

In this context, Antonovsky (1987) speaks about the sense of coherence, integrating

- to be able to understand a situation (why the situation is like it is)
- to cope with a situation and (what can I actively do?)
- to find sense within a certain life event (I can perceive a "sense" within a certain situation)

However, it must be pointed out that spirituality is not limited to a certain religion, but means that a child or family is following or believing in certain (social-context depending) values. Spirituality might also include aspects of patience and understanding (to accept those aspects of life, which I am not able to change). Associated aspect

I have people who follow certain values.
I can accept situation to a certain extent, which I cannot change
I believe in something
I am protected

3. References

Ahmann, E., Bond, N. J. (1992): Promoting normal development in school age children and adolescents who are technology dependent: A family centered model. Paediatric Nursing, 18, 399-405

Antonovsky, A. (1987): Unravelling the mystery of health: How people manage stress and stay well. Jossey-Bass, San Francisco

Carro, M. G., Grant, K. E., Gotlib, I. H., Compas, B. E. (1993): Postpartum depression and child development. An investigation of mothers and fathers as sources of risk and resilience. Development and Psychopathology, 5, 567-579

Egeland, B. Carlson, L., Stroufe, L. A. (1993): Resilience as a process. Special issue: Milestones in the development of resilience. Development and Psychopathology, 5, 517-528

Erickson, M.F., Egeland, B. (2009). Die Stärkung der Eltern-Kind-Bindung: Frühe Hilfen für die Arbeit mit Eltern von der Schwangerschaft bis zum zweiten Lebensjahr des Kindes durch das STEEP-Programm. 2. Aufl. Stuttgart: Klett-Kotta

Festinger, T. (1983) No one ever asked us. A postscipt to foster care. New York: Columbia University Press

Guralnick, M. J., Neville, B., Hammond, M. A., & Connor, R. T. (2007). The friendships of young children with developmental delays: A longitudinal analysis. Journal of Applied Developmental Psychology, 28, 64-79

Kobasa, S.C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. Journal of Personality and Social Psychology, 37(1), 1-11

Laucht, M., Esser, G., Schmidt, H. (1999): Was wird aus Risikokindern? In: G. Opp, M. Fingerle, A. Freytag (Hrsg.), Was Kinder stärkt. Reinhardt, München, 71-93

Lösel, F., Bender, D. (1994) Lebenstüchtig trotz schwieriger Kindheit. Psychische Widerstandskraft im Kindes- und Jugendalter. Psychoscope 7, 14-17 Maybery, D.J. (2006) Prevalence of parental mental illness in Australian families. http://pb.rcpsych.org/cgi/content/abstract/33/1/22 retrieved 8.7.2009

Masten, A.S. & Powell, J.L. (2003). "A Resiliency Framework for Research, Policy and Practice". in Luthar, S. (ed.) Resiliency and Vulnerability: Adaptation in the Context of Childhood Adversity. Cambridge University Press: Cambridge, pp.1-29.

Spagnola M.. Fiese, B., H. (2007). Family Routines and Rituals. A context for development in the lives of young children. Infants & Young Children, 20.4., 284-299

Petermann, F., Schmidt, M.H. (2006) Ressourcen – ein Grundbegriff der Entwicklungspsychologie und Entwicklungs-pathologie? Kindheit und Entwicklung, 15.2, 118-127

Petermann, F., Schmidt , H.M. (2009) Ressourcenorientierte Diagnostik – eine Leerformel oder nützliche Perspektive. Indheit und Entwicklung, 18.1, 49-56 Pretis, M. (1998).

Pretis, M., Dimova, A. (2004). Frühförderung bei Kindern psychisch kranker Eltern. München: Reinhardt

Rende, R. D., Plomin, R., Reiss, D., Hetherington E. M. (1993): Genetic and enviromental influences on depressive symptomatology in adolescence: individual differences and extreme scores. Journal of Child Psychology and Child Psychiatry, 34, 1387-98

Rutter, M. (1985): Resilience in the face of adversity: protective factors and resistance to psychiatric disorder. British Journal of Psychiatry, 147, 598-611

Wahler, R.G, Meginnis, K.L., Wahler Strengthening Child Compliance through Positive Parenting Practices: What Works? Journal of Clinical Child Psychology, Vol. 26, 1997

Werner, E. E. (1993): Risk, resilience and recovery: Perspectives from the Kauai Longitudinal Study. Development and Psychopathology, 5, 503-515

www.who.int/about/definition/en/print.html

www.wfnetwork.bc.edu/glossary_entry.php?term=Child%20Development,%20Definition(s)%20of&area=All

http://en.wikipedia.org/wiki/Child_development

http://www.parenting-ed.org/handout3/General%20Parenting%20Information/infant%20temperament.htm

http://en.wikipedia.org/wiki/Self-efficacy

www.psychology.about.com/od/theoriesofpersonality/a/self_efficacy.htm

http://www.thefreedictionary.com/optimism

http://www.selfgrowth.com/articles/Definition_Optimism.html

http://www.personalpsychologie.com/glossary.html

http://www.cyf.vic.gov.au/__data/assets/pdf_file/0010/16021/cp_hri_attachment.pdf

http://findarticles.com/p/articles/mi_qa4097/is_200310/ai_n9314582/

http://raisingchildren.net.au/articles/family_routines_how_and_why_they_work.html

http://en.wikipedia.org/wiki/Interpersonal_relationship

http://www.reference.md/files/D004/mD004522.html

http://medical-dictionary.thefreedictionary.com/compliance

http://en.wikipedia.org/wiki/Peer_group

http://wiki.answers.com/Q/What_is_meant_by_academic_performance

http://en.wikipedia.org/wiki/Social_support

http://en.wikipedia.org/wiki/Spirituality