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A PROTECTIVE FACTORS FRAMEWORK

The Strengthening Families Approach
and Protective Factors Framework:
Branching Out and
Reaching Deeper

■ CHARLYN HARPER BROWNE, PhD ■

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Center
for the
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of
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*Ideas
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The Strengthening Families Approach and Protective Factors Framework: Branching Out and Reaching Deeper
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The Strengthening Families Approach and Protective Factors Framework: Branching Out and Reaching Deeper

■ CHARLYN HARPER BROWNE, PhD ■

Background

Early childhood is considered by many scientists to be the most critical and the most vulnerable developmental period in the lifespan (see, e.g., Brandt, 2014; Brazelton & Greenspan, 2000; National Scientific Council on the Developing Child, 2007a). Burgeoning research in the fields of neuroscience, pediatrics, and developmental psychology has provided much evidence about early childhood as the developmental period in which the foundation for intellectual, social, emotional, and moral development is established (Munakata, Michaelson, Barker, & Chevalier, 2013; National Scientific Council on the Developing Child, 2007a, 2010a, 2010b, 2012a; Shonkoff, 2009). The children in this age group also are subject to the highest rates of child maltreatment¹ (Child Trends Data Bank, 2014; Longitudinal Study on Child Abuse and Neglect, n.d.; National Data Archive on Child Abuse and Neglect, 1996-2014; U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2013) and are at the greatest risk of immediate and enduring harm from traumatic experiences like maltreatment (Cohen, Mannarino, & Deblinger, 2006; Felitti, 2002a; Pynoos, Steinberg, & Goenjian, 2007; Scannapieco & Connell-Carrick, 2005; Shonkoff & Garner, 2012; Wiggins, Fenichel, & Mann, 2007; Ziegler, 2011). But the early years of life also offer

the greatest opportunity for preventing or mitigating harm and setting the course for healthy development (Brazelton & Greenspan, 2000; National Research Council and Institute of Medicine, 2000; National Scientific Council on the Developing Child, 2010a; Shonkoff, 2009; Thompson, 2001).

“Early childhood is both the most critical and the most vulnerable time in any child’s development. In the first few years, the ingredients for intellectual, emotional, and moral growth are laid down. We cannot fail children in these early years” (Brazelton & Greenspan, 2000, p. x).

The Center for the Study of Social Policy (CSSP) introduced its Strengthening Families Approach and Protective Factors Framework™ in 2003 as a research-informed, strengths-based initiative for preventing child abuse and neglect in families of children birth to 5 years old (see Horton, 2003). CSSP’s goal was to use findings from field observations, a thorough review of research studies, and advice from prevention and early childhood experts, to formulate an evidence-informed approach that would reach a broad range of children and families (Langford, 2011). Many prevention efforts involved responding to maltreatment after it had occurred; thus, the major goal of these child abuse prevention efforts was reducing the likelihood of the recurrence of child abuse and neglect (Paxson & Haskins, 2009; Stagner & Lansing, 2009). CSSP’s

¹ Child maltreatment refers to both child abuse and child neglect.

The Strengthening Families protective factors are attributes and conditions that help to keep *all* families strong and on a pathway of healthy development and well-being.

focus, however, was consistent with “the gradual—and still partial—shift in the field of child maltreatment” (Paxson & Haskins, 2009, p. 4) toward a primary prevention and promotion approach; that is, (a) addressing child maltreatment before it occurs; (b) incorporating a focus on increasing protective factors and not singularly on decreasing risk factors; and (c) promoting healthy family and child outcomes. Stagner and Lansing (2009) supported the idea of primary prevention and promotion efforts:

Whereas the traditional response aims to prevent a recurrence of maltreatment once it has already taken place, the new framework focuses on preventing maltreatment from occurring at all. Rather than identifying risk factors for maltreatment and addressing the problems and deficiencies of the primary caretaker, the new framework focuses on strengthening protective factors and building family and social networks to reinforce the ability of parents to care for their children. . . . It aims to build on the strengths

children have at particular points of the life stage and enhance the social context of the child.

. . . Rather than seeking to minimize harm to the child, it aims to maximize potential—to strengthen the capacity of parents and communities to care for their children in ways that promote well-being. (p. 19)

National Picture of the Youngest Victims of Child Maltreatment

The federal Child Abuse Prevention and Treatment Act (CAPTA), as amended by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as, “at a minimum, any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm” (Child Welfare Information Gateway, 2013, p. 2). The most recent data collected by child protective services agencies through the National Child Abuse and Neglect Data System and reported in *Child Maltreatment 2012*, provide a national picture of the youngest victims of maltreatment (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, 2013, pp. 19-20) (see text box below).

A National Picture of the Youngest Victims of Child Abuse and Neglect

(U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, 2013, pp. 19-20)

- The youngest children are the most vulnerable to maltreatment.
- The victimization rate was highest for children younger than 1 year (21.9 per 1,000 children in the population of the same age).
- More than one-quarter (26.8% or 181,493) of victims were younger than 3 years.
- Twenty percent (19.9%) of victims were in the age group of 3-5 years.
- The percentages of child victims were similar for both boys (48.7) and girls (50.9).
- More than three-quarters (78.3%) of victims were neglected, 18.3 percent were physically abused, and 9.3 percent were sexually abused.
- In addition, 10.6 percent of victims experienced such “other” types of maltreatment as “threatened abuse,” “parent’s drug/alcohol abuse,” or “safe relinquishment of a newborn.”

Child Trends Data Bank (2014) reported that “the rate of substantiated child maltreatment, as of 2012, has shown modest declines in the past five years, and is now at a level lower than at any time since 1990. The rates of physical and sexual abuse have declined the most, and rates of neglect have declined the least” (p. 2). Nonetheless, the number of maltreated children in the United States is still extremely high. “In 2012, there were approximately 686,000 [unique count²] maltreated children in the United States, a rate of 9.2 per thousand population” (Child Trends Data Bank, 2014, p. 3). But it is not just the number of maltreated children that is of great concern.

Young children are not only the most vulnerable to the *experience* of maltreatment, they are also the most vulnerable to the *effects* of maltreatment. There is substantial research that shows a relationship between child maltreatment and a broad range of developmental problems that can have a life-long impact if not properly addressed (see, e.g., Cohen et al., 2006; Felitti, 2002a; Pynoos et al., 2007; Shonkoff & Garner, 2012; Wiggins et al., 2007; Ziegler, 2011). For example, research on the developing brain has provided extensive evidence that children’s earliest experiences and most influential environments shape the young brain’s foundation for later learning, memory, logical reasoning, socialization, emotional expression, self-regulation, and executive functions; whether the foundation is strong or weak greatly depends on the nature and the quality of their experiences and environments (Center on the Developing Child at Harvard University, 2010; Hawley, 2000; National Research Council and Institute of Medicine, 2000; National Scientific Council on the Developing Child, 2004a, 2004b, 2007a, 2010a, 2010b, 2012a; Perry, 2000; Shonkoff, 2009).

The data that depict the national picture of the youngest victims of maltreatment, as well as the substantial research that shows a relationship between child maltreatment and a broad range of developmental problems, are very troubling. However, the good news is there is also strong evidence that “the course of development can be altered in early childhood by effective interventions that change the balance between risk and protection, thereby shifting the odds in favor of more adaptive outcomes”

(National Research Council and Institute of Medicine, 2000, p. 32).

Establishing the Strengthening Families Approach, Then Branching Out

The original hypothesis of the Strengthening Families approach was that, in having daily contact with young children and their parents, staff of early care and education programs could play a more intentional, active role in the prevention of child maltreatment in addition to being legally required to report abuse or neglect when it is observed or suspected. “If we could mobilize these places to be prevention agents and early warning responders, we could impact millions of children. And by focusing on positive outcomes and healthy development, we could engage more families much more easily than prevention programs based on identifying ‘at risk’ families” (Langford, 2011, p. 7). Thus, the approach was originally labeled “Strengthening Families Through Early Care and Education.”

By 2007, more than 30 states were implementing “Strengthening Families Through Early Care and Education” initiatives and many national organizations partnered with CSSP in advancing its protective factors framework (see the section in this report titled “The Strengthening Families Approach in Policy and Practice Across the United States”). That same year, a RAND Corporation’s Promising Practices Network project was initiated to assess the current state of the child maltreatment prevention field and to determine if there were new or innovative strategies emerging from the field that might substantially reduce child maltreatment (Shaw & Kilburn, 2009). A primary activity of this information-gathering project was surveying “practitioners, policymakers, researchers, advocates, and funders who work on behalf of child well-being, and in particular on preventing child abuse and neglect” (Shaw & Kilburn, 2009, p. 12). One of the items on the survey asked respondents to indicate which of seven prevention strategies or resources they had heard of. Eighty-two percent (82%) of 1,704 respondents indicated “Strengthening Families Through Early Care and Education.”

During the 11 years since its introduction, the

² “The unique count of child victims tallies a child only once regardless of the number of times he or she was found to be a victim during the reporting year” (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children’s Bureau, 2013, p. xi).

SIDEBAR 1

Five Versus Six Strengthening Families Protective Factors

Q: Are there five or six protective factors in the Strengthening Families approach?

A: The Strengthening Families approach includes five protective factors, specifically:

- Parental resilience
- Social connections
- Knowledge of parenting and child development
- Concrete support in times of need
- Social and emotional competence of children

Although some programs and systems have elected to delineate “nurturing and attachment” as a distinct sixth protective factor in order to emphasize its importance in promoting healthy outcomes in children, CSSP acknowledges that “nurturing and attachment” is an implicit component of the five Strengthening Families protective factors. Thus, it is not regarded as a separate protective factor in the Strengthening Families approach.

For example, research studies show:

- **Parental resilience** occurs when parents are able to effectively manage stressors. By managing stressors, parents feel better and can provide more nurturing attention to their child, which enables their child to form a secure emotional attachment.
- Understanding early brain development is essential in increasing **knowledge of parenting and child development**. Developing brains need attuned caregivers who interact with them in an affectionate, sensitive, and nurturing manner. Such care gives rise to the development of a secure attachment between the child and the adult.
- The course of **social and emotional development** depends on the quality of nurturing attachment and stimulation that a child experiences.

Strengthening Families approach has been branching out from daily practice in early childhood programs and is being integrated into health care and human services systems (e.g., child welfare), public policy (e.g., Quality Rating and Improvement Systems), and early intervention programs (e.g., home visiting) (see Center for the Study of Social Policy, 2013a, 2013b, 2013c, 2013d, 2014a; Langford, 2011). In addition, several jurisdictions have integrated the Strengthening Families approach into policy and practice as a strategy for promoting healthy family life, in general, and not singularly for child maltreatment prevention (see, e.g., Michigan Great Start Collaborative, 2014).

At the foundation of the Strengthening Families approach are five³ interrelated protective factors that studies show are related to a decreased likelihood of child abuse and neglect, as well as to the promotion of family strengths and optimal child development. Although the Strengthening Families approach may be implemented in contexts that serve children and families whose circumstances increase the likelihood of poor outcomes, CSSP emphasizes that the five protective factors are attributes and conditions that help to keep *all* families strong and on a pathway of healthy development and well-being.

The five protective factors are (a) parental resilience, (b) social connections, (c) knowledge of parenting and child development, (d) concrete support in times of need, and (e) social and emotional competence of children. In addition to defining the protective factors and delineating the evidence that informed the approach, numerous strategies, materials, and tools for supporting the building of the protective factors by making “small but significant changes” in daily practice have been developed as well (see Center for the Study of Social Policy, 2013a, 2014b; Strengthening Families Through Early Care and Education, n.d.).

Purpose of This Report

Since the introduction of the Strengthening Families approach, the research base that originally informed the development of the protective factors framework, as well as scientific advances in various disciplines, has burgeoned. These advances in knowledge have deepened the understanding about child development and behavior, the developmental impacts of trauma, and the pathways to child and family well-being.

³ See Sidebar 1 regarding five versus six Strengthening Families protective factors.

Key Terms

- **Concrete Support in Times of Need:** Identifying, seeking, accessing, advocating for, and receiving needed adult, child, and family services; receiving a quality of service designed to preserve parents' dignity and promote healthy development
- **Knowledge of Parenting and Child Development:** Understanding the unique aspects of child development; implementing developmentally and contextually appropriate best parenting practices
- **Parental Resilience:** Managing both general life and parenting stress and functioning well when faced with stressors, challenges, or adversity; the outcome is positive change and growth
- **Social and Emotional Competence of Children:** Providing an environment and experiences that enable the child to form close and secure adult and peer relationships, and to experience, regulate, and express emotions
- **Social Connections:** Having healthy, sustained relationships with people, institutions, the community, or a force greater than oneself

Advances in fields of inquiry as diverse as neuroscience, molecular biology, genomics, developmental psychology, epidemiology, sociology, and economics are catalyzing an important paradigm shift in our understanding of health and disease across the lifespan. This converging, multidisciplinary science of human development has profound implications for our ability to enhance the life prospects of children and to strengthen the social and economic fabric of society. (Shonkoff & Garner, 2012, p. 232)

The purpose of this report is to provide a synthesis of the ideas and research from the neurobiological, behavioral, and social sciences that further inform, the evidence base of CSSP's Strengthening Families Approach and Protective Factors Framework. This synthesis reflects CSSP's theory of change (see Figure 1) which affirms the necessity of working in all domains of the social ecology—individual, family and relational, community, societal, and policy—in order to make a difference in the lives of families and children.

CSSP's theory of change puts families and children in the center of a multifaceted model that includes building protective factors for families, reducing risk factors for children, strengthening local communities, and connecting all of this to systems change and policy—and infusing it with

a fierce commitment to equity across lines of race, ethnicity, and culture. (Center for the Study of Social Policy, 2013a, para. 3)

The next section of this report examines the ideas and research that serve as the foundation of the Strengthening Families approach. This discussion is followed by a synthesis of the research that provides the evidence base for the theoretical articulation of the Strengthening Families protective factors. The report concludes with a description of the broad uptake and diverse implementation of the Strengthening Families approach in policy and practice across the United States.

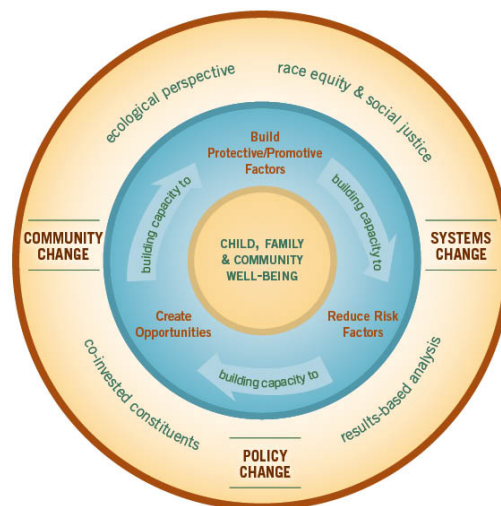


FIGURE 1. CSSP's Theory of Change

SIDEBAR 2

All Five Protective Factors Enhance Well-Being for Parents and Children

Each of the five protective factors is inextricably linked to healthy development and well-being for both parents and their children. For example:

- By effectively demonstrating *parental resilience* (i.e., managing stress), parents feel better and can provide more nurturing attention to their child, which enables their young child to form a secure emotional attachment. Receiving nurturing attention and developing a secure emotional attachment with parents, in turn, fosters the development of resilience in children when they experience stress.
- Parents' high-quality, constructive, and supportive *social connections* help buffer parents from stressors and support nurturing parenting behaviors that promote secure attachments in young children.
- Gaining more *knowledge of parenting and child development* enables parents to know and provide what young children need most in order to thrive (e.g., nurturing, responsive, reliable, and trusting relationships; regular and consistent routines; interactive language experiences; and opportunities to learn by doing).
- When parents identify, seek, and receive respectful and timely *concrete support in times of need*, this helps to ensure they and their children receive the basic necessities everyone deserves in order to grow (e.g., healthy food, a safe environment), as well as specialized medical, mental health, social, educational, or legal services.
- The *social and emotional competence of children* does not evolve naturally. A relationship with a consistent, caring, and attuned adult who actively promotes the development of social and emotional competencies is essential (e.g., creating an environment in which children feel safe to express their emotions, being emotionally responsive to children, modeling empathy).

The Foundational Ideas of the Strengthening Families Approach



The Strengthening Families approach is grounded in seven foundational ideas: (a) the two-generation approach, (b) a consideration of culture, (c) the strengths-based perspective, (d) the biology of stress, (e) resilience theory, (f) a focus on well-being, and (g) the nature of risk and protective factors.

Foundational Idea 1: The Two-Generation Approach

Strengthening Families is an approach designed to increase family strengths—in particular, parent⁴ capabilities—promote optimal child development and reduce the likelihood of child abuse and neglect. Central to the prevention of child maltreatment and the promotion of optimal child development is the capability of parents. “Success in this area requires adults and communities to provide sufficient protection and supports that will help young children develop strong, adaptive capacities. . . . Interventions that focus on adult capacity-building offer promising opportunities for greater impacts on children” (Shonkoff, 2013, para. 6).

Employing the Strengthening Families approach involves providing families with opportunities and experiences to build their protective factors, specifically parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence of children. While it may appear that four protective factors focus singularly on parents and one focuses singularly on children, this is not the case. “Parent and child well-being are inextricably linked” (Schmit, Matthews, & Golden, 2014, p. 4), and each of the five protective factors is inextricably linked to healthy development and well-being for both parents and their children (see Sidebar 2).

By focusing on the parent, the child, and the parent-child relationship together, the Strengthening Families approach is a two-generation approach⁵; that is, “a strategy or approach to promote young children’s healthy

⁴ “Parent” is used in this report to refer to an adult or adolescent who has responsibility for rearing a child, including the biological parents, grandparents, other relatives, or non-biological caregivers.

⁵ The two-generation approach is also referred to as a dual-generation, multi-generation, or whole family approach (Gruendel, 2014).

Key Terms

- **Cultural Competence:** Understanding and respecting culturally based values, beliefs, and behaviors
- **Cultural Humility:** An active self-reflection and critical consciousness of one's own assumptions, beliefs, values, and worldview that may influence one's work with and the perception and treatment of children and parents
- **Culture:** Beliefs, values, behaviors, customs, language, rituals, and practices characteristic of a particular group of people that provides them with patterns for living and interpreting reality
- **Two-Generation Approach:** A strategy or approach to promote young children's healthy development by developing the capabilities and the resources of parents or caregivers

development by developing the capabilities and resources of parents or caregivers” (The Center for High Impact Philanthropy, n.d., p. 1). Although the Strengthening Families approach applies to all families, it is particularly applicable as a two-generation approach in interventions designed to address the needs of families whose circumstances are highly challenging.

For example, several studies have found a relationship among maternal depression, parenting, and poor child outcomes (see, e.g., Center on the Developing Child at Harvard University, 2009; Coyl, Roggman, & Newland, 2002; Stark & Chazan-Cohen, 2012). Depressed mothers were found to be less effective in providing nurturing and responsive emotional and physical care; they tended to be disengaged or overly harsh with their child. As a consequence, a range of poor outcomes were observed in their children, including difficulties forming emotional bonds with others and deficits in cognitive functioning. “It is this parenting that results in poorer outcomes for children, which underlies the dire need to develop, support, and fund interventions focused on the dyad so that both the infant and his or her mother receive comprehensive mental health services” (Stark & Chazan-Cohen, 2012, p. 18). Similarly, the National Scientific Council on the Developing Child (2012a) concluded: “Because young children’s emotional well-being is tied so closely to the mental health of their parents and non-family caregivers, the emotional and behavioral needs of infants, toddlers, and preschoolers are best met through coordinated services that focus on their full environment of relationships” (p. 7).

In addressing a strategy for reducing intergenerational poverty, Shonkoff (2013) stated:

“Greater impacts could be achieved by innovative ‘two-generation’ programs that devise effective strategies for building the common core of adult capacities that are essential for success both at home and at work, while also increasing the development of these skills in young children” (para. 9). The idea of implementing two-generation approaches in early education and human service programs is not a new one; Head Start, for example, was established almost 50 years ago (1965) as a two-generation approach (Schmit et al., 2014).

Although attention to the family “as the unit of intervention” is now and has long been an aspirational element in the delivery of human services, most of our focus from a policy, practice and program perspective has been on *either children or the parents*. . . . Emerging knowledge from the science of epigenetics—revealing that adversity in childhood leads to adult health and mental health illnesses which may be passed, through gene expression, across generations—demands that we work with children, their parents *and their parents*. (Gruendel, 2014, p. 1)

The Center for High Impact Philanthropy (n.d., p. 2) identified three two-generation strategies that are implemented in many early education and human services programs—each of which is consistent with strategies for promoting the Strengthening Families protective factors—specifically:

1. Improve relationships between parents/caregivers and children through information- and skill-building (e.g., through parent education programs, teachers’

SIDEBAR 3

Investigating Cultural Differences and Commonalities in Parenting

Investigating, understanding, and appreciating cultural differences and commonalities in parenting beliefs, values, expectations, practices, and child-rearing goals “is an important step in developing culturally-competent and effective programs and support for parents of all cultural backgrounds in the United States” (Lubell et al., 2008, p. 4).

Cross-Cultural Differences in Parenting. Numerous researchers (see, e.g., Brooks-Gunn & Markman, 2005; Cardona et al., 2000; Greenfield et al., 2006; Kim & Hong, 2007; Lubell et al., 2008; Melendez, 2005; Pinderhughes, Dodge, Bates, Pettit, & Zelli, 2000; Spicer, 2010) have examined parenting variations across cultures, including how parents perceive their role, the ways in which parents provide care, and parents’ perceptions about child development. For example, Spicer (2010) described the racial and ethnic differences that emerged from the results of the 2009 ZERO TO THREE *Parenting Young Infants and Toddlers Today* nationwide survey. Differences were observed in (a) parenting beliefs (e.g., the importance of encouraging a child to persist in difficult tasks); (b) understandings about social and emotional developmental milestones (e.g., age at which children can share and take turns); (c) influences on parenting (e.g., importance of family, faith, media, and professional help); and (d) expectations for school readiness (e.g., importance of respecting adults). “Exploring these differences is an important first step in understanding ways to more effectively engage all parents” (Spicer, 2010, p. 28).

Cross-Cultural Commonalities in Parenting. Some studies have found important common parenting themes that emerge across cultures (see, e.g., Eshel, Daelmans, Cabral de Mello, & Martines, 2006; Lubell et al., 2008; McEvoy et al., 2005). For example, Lubell and colleagues (2008) reported the findings from the Centers for Disease Control and Prevention’s *Healthy Parenting Cultural Norms Study* conducted with parents from five cultural groups in the United States: African Americans, Asian Americans, Hispanics/Latinos, Native Americans, and White Americans. Commonalities were observed in (a) values and norms about children’s behavior (e.g., be respectful, do well in school) and (b) disciplinary tactics (e.g., expressing disapproval of inappropriate behavior should precede harsh punitive measures). “These basic commonalities suggest that it is possible to reach multicultural groups with consistent healthy parenting messages and programs that contain the same core components” (Lubell et al., 2008, pp. 14-15).

- professional development)
2. Build parents’ and children’s knowledge and skills, while also addressing underlying family issues through referrals to other services and programs (e.g., home visiting programs)
 3. Address the needs of children and parents simultaneously through direct provision of a range of services (e.g., collaborative and coordinated service provision)

Foundational Idea 2: A Consideration of Culture

In the United States, ideas, research, and practice related to parenting and parent-child relationships typically have grown out of middle-class, White American ethnocentric⁶ beliefs and values about parents, children, and families (Cardona, Nicholson, & Fox, 2000; Lubell, Lofton, & Singer, 2008; Van Campen & Russell, 2010). “Most studies of family relationships have been conducted in the United States with a focus on European American (White) families; they have been based on the assumption that the meaning of parenting is similar across cultures. Such thinking hides important differences in what cultures expect of and understand about parenting, [parent-child], and parent-adolescent relationships” (Van Campen & Russell, 2010, p. 1).

Culture has a major influence on parenting beliefs, definitions (e.g., “good parenting”), values, expectations, and behaviors, as well as on children’s relationships with their parents (Cardona et al., 2000; Greenfield, Suzuki, & Rothstein-Fisch, 2006; Lubell et al., 2008; Spicer, 2010; Van Campen & Russell, 2010). Thus, using a single cultural lens through which to understand, communicate, assess, and interact with parents from diverse cultural groups increases the likelihood of interpersonal misunderstandings (Greenfield et al., 2006) and difficulties in “the acceptance, delivery, and/or effectiveness of healthy parenting programs or interventions” (Lubell et al., 2008, p. 4).

Given the increasing racial, ethnic/cultural, and linguistic diversity of the population in the United States, the Strengthening Families approach emphasizes the importance of child and family service providers

⁶ Ethnocentric refers to the tendency to view other cultures from the perspective of one’s own.

“An understanding of diverse cultural values and associated rearing practices reveals the strengths of socialization and child care practices used in diverse cultural groups” (Greenfield et al., 2006, p. 659).

being attuned to two matters of culture—cultural competence and cultural humility—in the design and implementation of their policies, programs, and practices. Cultural competence is defined as “understanding and respect for culturally-based values, beliefs, and behaviors. . . . Uncovering the differences and commonalities in values, normative practices, and child-rearing goals across cultural groups [see Sidebar 3] is an important step in developing culturally-competent and effective programs and support for parents of all cultural backgrounds in the United States” (Lubell et al., 2008, p. 4).

From Cultural Competence to Cultural Humility. Over the years, researchers, practitioners, and professional organizations have voiced concern about the need for a culturally competent workforce, as well as programs and services that are designed to be respectful of families’ culture (see, e.g., Center for Law and Social Policy, 2009; National Association for the Education of Young Children, 2009; National Center for Cultural Competence, n.d.). “For the most part, program planners have responded to this concern by delivering services in a participant’s primary language, matching participants and providers on the basis of race and ethnicity, and incorporating traditional child rearing practices into a program’s curriculum” (Daro, Barringer, & English, 2009, p. 11).

While these culturally sensitive approaches are important, and information about culturally diverse and common parenting beliefs, values, and practices may be necessary to know, alone these strategies are not sufficient. Program planners and practitioners must also conscientiously practice “cultural humility.” Reed and Oppong (2005) addressed cultural humility in regard to classroom equity, but their assertion is relevant for all service providers: “Teachers need to trouble their own ideas around race, gender, and class before being able to reflect critically on their teaching of

diverse student populations” (p. 14). Cultural humility shifts the focus from “diverse others” to an active self-reflection and critical consciousness of one’s own assumptions, beliefs, values, and worldview (California Health Advocates, 2007; Tervalon & Murray-Garcia, 1998) that may influence one’s work with and the perception and treatment of children and parents.

Cultural humility is an acknowledgement of one’s own barriers to true intercultural understanding. . . . Knowing that one’s own perspective is necessarily limited makes it much easier to be reflective and proactive in relation to one’s prejudices and assumptions that may otherwise affect interactions with members of a different culture. . . . Approaching each encounter with the knowledge that one’s own perspective is full of assumptions and prejudices can help one to keep an open mind and remain respectful of the person seeking care. (Unite for Insight, 2013, para. 4)

Culture and the Strengthening Families Protective Factors. CSSP designed the Strengthening Families Protective Factors framework as an approach that would allow for diversity in implementation in different service settings (Langford, 2011). In addition, the framework is intended to delineate protective factors that are relevant across cultures with respect to describing conditions or attributes that mitigate risk factors and actively enhance well-being in all families.

Hall (1976) conceived culture as comprised of both surface structure elements (e.g., a group’s music, traditions, style of dress) and deep structure elements (e.g., a group’s worldview, values, beliefs). Considering both surface and deep structure elements, Nobles (1990) defined culture as, “the vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies, and practices peculiar to a particular group of people which provides them with a general design for living and patterns for interpreting reality” (p. 5). Using this perspective, CSSP asserts that the five Strengthening Families protective factors are universal, in that they apply to all families, yet may be understood (deep structure) and manifest (surface structure) in culturally specific ways. In this regard, two matters of culture are essential in

respectfully helping parents to build or to reinforce the Strengthening Families protective factors: (a) encouraging parents to articulate how the protective factors are understood and manifest from their cultural and family perspective, and (b) encouraging providers to conscientiously engage in cultural humility.

Foundational Idea 3: The Strengths-Based Perspective

Strengthening Families is a strengths-based approach. That is, the Strengthening Families approach is grounded in the belief that all families possess and have the ability to use “strengths.” Moore, Chalk, Scarpa, and Vandivere (2002) acknowledged: “While no official or formal definition exists, we think of family strengths as the set of relationships and processes that support and protect families and family members, especially during times of adversity and change. Family strengths help to maintain family cohesion while also supporting the development and well-being of individual family members” (p. 1). Thus, identifying and building on a family’s strengths is regarded as essential in implementing the Strengthening Families approach.

FAMILY STRENGTHS

“The set of relationships and processes that support and protect families and family members, especially during times of adversity and change. Family strengths help to maintain family cohesion while also supporting the development and well-being of individual family members” (Moore et al., 2002, p. 1).

For more than 40 years, social science researchers and helping professions practitioners have promoted the idea of a strengths-based approach to thinking about and working with children, youth, and families as an alternative to a deficits-based model (Blundo, 2001; Brun & Rapp, 2001; Cox, 2006; Leadbeater, Schellenbach, Maton, & Dodgen, 2004; Manthey, Knowles, Asher, & Wahab, 2011; Saleebey, 2000). A deficits perspective defines individuals, families, and communities in negative terms by primarily focusing

on problems that need to be “fixed” by experts (Centre for Child Well-Being, 2011; Maton et al., 2004). This emphasis implicitly communicates low expectations of the identified individuals, families, and communities and a high probability of helplessness or failure (Abrams & Ceballos, 2012; Centre for Child Well-Being, 2011). “Looking at children and families through a deficit lens obscures a recognition of their capacities and strengths, as well their individuality and uniqueness” (Benard, 1996, p. 1) and “cripples the individual’s ability to transcend life challenges” (Brun & Rapp, 2001, p. 279).

Grant and Cadell (2009) asserted, “This focus on the negative. . . further influences [helping professionals’] attitudes toward those who receive services, so that we see [them] as somehow very different from us, and we interpret [their] actions, feelings, experiences, and beliefs from a pathological framework” (p. 425). Furthermore, a deficits-based approach tends to result in practices, programs, policies, and systems that are punitive and stigmatizing (National Technical Assistance and Evaluation Center for Systems of Care, 2008; Waldfogel, 2000). “Deficits-based social policies often disempower individuals, families, and communities facing truly difficult situations and seek solutions by diagnosing, fixing, punishing, or simply ignoring those affected. . . . Beyond that, they are framed as the objects of policies, rather than the active participants in the creation of solutions” (Maton et al., 2004, p. 5).

The meaning of “strengths-based” seems intuitive so the phrase could easily become a slogan without substance. Manthey and colleagues (2011) stated: “There has been recent concern that social work agencies, programs, practices, and therapies that claim to be strength-based often misperceive what it means. . . . [It] does not mean someone is merely being nice or ignoring problems” (p. 126). Rather, a strengths-based approach is an overall philosophical view that requires a different way of thinking about children, families, and communities in order to effectively implement strengths-based practice, research, and policy (Grant & Cadell; 2009; Saleebey, 2000, 2006).

Interest in a strengths-based perspective has been embraced by disciplines outside of the social sciences, including education (O’Connell, 2006; Resiliency Initiatives, 2011) and pediatrics. The American Academy of Pediatrics promotes the strengths-based

“A strengths-based approach focuses on what is working well to support the growth of individuals and communities. It . . . is based on the assumption that people have existing competencies and resources for their own empowerment. It assumes that people are capable of solving problems and learning new skills; they are a part of the process rather than just being guided by a professional” (Centre for Child Well-Being, 2011, p. 2).

approach as an important strategy for physicians to create and sustain competency-building alliances with families.

This approach acknowledges that parents are experts on their family and want to do right by their child. The clinician takes an active role in building parents’ knowledge and encouraging mastery while providing good ideas on how to integrate new opportunities for competency into a family’s daily life. In addition, the strength-based approach encourages and is complementary to shared decision making where . . . families can problem solve with the clinician to become more efficacious in their health decision-making. (American Academy of Pediatrics, 2013, p. 1)

Numerous researchers have challenged the criticism that a strengths-based way of thinking and working minimizes the real or perceived adversities individuals, families, or communities may be experiencing (see, e.g., Grant & Cadell, 2009; Maton et al., 2004; Sandler, Ayers, Suter, Schultz, & Twohey-Jacobs, 2004). O’Connell (2006) asserted, “the [strengths-based] paradigm does not eliminate the need to address barriers such as poverty, abuse, neglect, and other hardships that are very real and devastating for too many children and youth” (p. 6). Similarly, Grant and Cadell (2009) stated: “In contrast to the notion that the strengths perspective glosses over problems, we consider that it challenges practitioners to combine an understanding of the potentials of individuals with an acute sensitivity to the

barriers they may face” (p. 426). Sandler and colleagues (2004) argued, “the goals of building strengths and preventing problems are synergistic: A policy that promotes strengths may also provide the most sustainable and effective approach to reducing problem outcomes” (p. 31).

Foundational Idea 4: The Biology of Stress

The Strengthening Families approach is also informed by neurobiological research. Understanding the biology of the stress response is critically important in forging relationships and creating environments that support the development of resilience in parents and children. Key to this understanding is that adverse childhood experiences (see Sidebar 4) can have consequences for physical, social, emotional, and cognitive development through adolescence and into adulthood; adverse childhood experiences also can have long-term effects on physical and mental health (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, 2014a; Felitti, 2002a; Gunnar, Herrera, & Hostinar, 2009; National Scientific Council on the Developing Child, 2005/2014; Shonkoff & Garner, 2012). “Children exposed to consistent, predictable, nurturing, and enriched experiences develop neurobiological capabilities that increase their chances for health, happiness, productivity, and creativity, while children exposed to neglectful, chaotic, and terrorizing environments have an increased risk of significant problems in all domains of functioning” (Perry & Hambrick, 2008, p. 40).

The word “stress” is used in everyday conversations to refer to feeling overwhelmed, worried, tense, or sad; it is also used to refer to the challenging life experiences that trigger these feelings. Many health psychologists refer to the experiences that are perceived to be challenging or threatening as “stressors” and to the biological and emotional responses to such events as “stress” (Baron, 2001); that distinction is important in clearly understanding the biology of stress. Across the lifespan, young children, adolescents, and adults are faced with stressors that can be perceived as mild, moderate, or traumatic. When faced with a challenge or threat, the brain

The Adverse Childhood Experiences (ACE) Study

Origin of the Study

In 1985, Dr. Vincent J. Felitti, director of a Kaiser Permanente weight loss program, made an unexpected clinical observation: program participants who were most successful were also most likely to drop out of the program (Felitti, 2002a, 2002b). In follow-up interviews with many of these participants, Dr. Felitti discovered that child sexual abuse and/or physical abuse was common among the participants, and the abuse typically preceded the onset of obesity. “The counterintuitive aspect was that, for many people, obesity was not their problem; it was their protective solution to problems that previously had never been discussed with anyone” (Felitti, 2002a, p. 44). After learning about these clinical observations, researchers at the Centers for Disease Control and Prevention designed a large, epidemiologically sound study that would provide definitive evidence of the clinical observations (Felitti, 2002a, 2002b).

Methodology

The Adverse Childhood Experiences (ACE) Study was led by co-principal investigators Dr. Vincent Felitti and Dr. Robert Anda. From 1995 to 1997, more than 17,000 middle-income, middle-age (average age = 57) adults with Kaiser Permanente health insurance were surveyed to assess “retrospectively and prospectively, the long-term impact of abuse and household dysfunction during childhood on the following outcomes in adults: disease risk factors and incidence, quality of life, health care utilization, and mortality” (Felitti et al., 1998, p. 246).

The following categories of adverse childhood experiences (ACEs)—childhood abuse, childhood neglect, and household dysfunction—were examined:

- Emotional abuse
- Mother treated violently
- Physical abuse
- Household substance abuse
- Sexual abuse
- Household mental illness
- Emotional neglect
- Parental separation or divorce
- Physical neglect
- Incarcerated household member

An individual’s ACE score equals the total number of ACEs reported; the higher the score, the greater the amount of trauma experienced in childhood.

Findings

The two most important findings were that these adverse childhood experiences (a) are much more common than recognized, and (b) have a powerful relation to adult health status, even 50 years later. As the number of ACEs increase, the risk for health problems (e.g., alcoholism/ alcohol abuse, smoking, depression, liver disease, pulmonary disease, risk for intimate family violence, obesity, suicide attempts) increases in a graded fashion (Felitti, 2002a, 2002b; Felitti et al., 1998).

Researchers agree, “ACEs are not destiny” (Anda, 2013, p. 62). Thus, increasing awareness and understanding about the potential impact of adverse childhood experiences across the lifespan is essential in the development of effective early interventions for children with these multiple risk factors.

automatically triggers a series of bodily changes, such as an increase in heart rate, blood pressure, and the production of stress hormones. These changes are called the stress response system.

The National Scientific Council on the Developing Child (2005/2014) classified three types of stress responses in young children: positive, tolerable, and toxic. Positive, tolerable, and toxic stress responses are differentiated by the frequency, intensity, and duration of the stressor, as well as the availability of a caring, supportive adult (Middlebrooks & Audage, 2008; Shonkoff & Garner, 2012). The National Scientific Council on the Developing Child’s classification of stress responses is regarded in the Strengthening Families approach as applicable across the lifespan and as relevant for the development of resilience (see Table 1).

Positive Stress. Positive stress is experienced when children are faced with challenging life events that result in brief stress reactions such as an increased heart rate and mild changes in hormone levels (National Scientific Council on the Developing Child 2005/2014, 2007b). Positive stress is beneficial to children for two reasons (Easterbrooks, Ginsberg, & Lerner, 2013; Middlebrooks & Audage, 2008; National Scientific Council on the Developing Child, 2007b; Shonkoff & Garner, 2012). First, learning how to cope with positive stress is necessary for the development of a healthy stress response system. Citing the National Scientific Council on the Developing Child, Easterbrooks and colleagues (2013) stated that positive stress “occurs in the context of stable and supportive relationships.’ Such relationships help ‘bring. . . stress hormones back within a normal range’ so that children can ‘develop a sense of mastery and self-control’” (p. 102). Second, exposure to experiences that create positive stress is considered to be necessary for healthy development because children have “the opportunity to learn how to effectively manage stress, regulate emotions, and develop the social, behavioral, and cognitive coping resources needed to overcome these obstacles” (Gunnar et al., 2009, p. 4). Children who never address challenges, including never experiencing failure, will not be fully prepared for adolescence and adulthood.

Tolerable Stress. Tolerable stress is experienced when children are faced with more severe challenges or adversity that result in bodily changes that are

TABLE 1. Classification of Stress Responses (Adapted from the National Scientific Council on the Developing Child, 2005/2014)

Type of Stress Response	Examples of Stressors	Stress Response System
Positive	Being frustrated; getting immunized; first day of a new job; meeting new people; failing a test	Brief increases in heart rate, blood pressure, or mild changes in stress hormone levels
Tolerable	Death of a loved one; frightening accident; serious illness; prejudice and discrimination	Level and duration of activation of the stress response system is based on the presence of supportive relationships and environments
Toxic	Child abuse and neglect; family violence; maternal depression; parental addiction; persistent poverty; racism	Strong, frequent, prolonged activation of the stress response system in the absence of supportive relationships and environments disrupts early brain development and can result in health, emotional, and behavioral problems later in life

stronger, longer-lasting, and have the potential to become toxic if not experienced in the context of supportive relationships and environments (Easterbrooks et al., 2013; Middlebrooks & Audage, 2008; National Scientific Council on the Developing Child, 2005/2014, 2007b). “The essential characteristic that makes this form of stress response tolerable is the extent to which protective adult relationships facilitate

the child’s adaptive coping and a sense of control, thereby reducing the physiologic stress response and promoting a return to baseline status” (Shonkoff & Garner, 2012, p. 236).

Toxic Stress. Toxic stress is experienced when there is intense and sustained activation of the stress response system due to exposure to horrific, uncontrollable events or conditions—such as

Key Terms

- **Positive Stress:** Biological and emotional responses that result from brief negative experiences (e.g., first day at new school; failing a test); necessary for the development of a healthy stress response system
- **Stress:** Biological and emotional responses to challenging, threatening, or traumatic experiences
- **Stress Response System:** The series of bodily changes, triggered automatically by the brain (e.g., increase in heart rate, blood pressure, and the production of stress hormones) that occur when faced with a challenge or a threat
- **Stressor:** An experience that is perceived to be challenging, threatening, or traumatic
- **Tolerable Stress:** Biological and emotional responses that result from more intense negative experiences (e.g., death of a loved one; frightening accident); may become toxic if not buffered by supportive relationships and environments
- **Toxic Stress:** Biological and emotional responses that result from strong, frequent, prolonged adversity (e.g., child abuse and neglect, family violence)

sexual abuse, neglect, or exposure to violence—and supportive relationships and environments are not available (Middlebrooks & Audage, 2008; National Scientific Council on the Developing Child, 2007b; Shonkoff & Garner, 2012). “Extensive research on the biology of stress now shows that healthy development can be derailed by excessive or prolonged activation of stress response systems in the body and the brain, with damaging effects on learning, behavior, and health across the lifespan” (Felitti, 2002a; National Scientific Council on the Developing Child, 2005/2014, p. 1). The National Scientific Council on the Developing Child (2005/2014) identified several damaging effects of toxic stress on early brain development that, without intervention, may compromise functioning across the lifespan (see text box below).

Damaging Effects of Toxic Stress on Early Brain Development

1. Impaired brain circuits that can result in the development of a smaller brain.
2. Disrupted stress response systems that create a low threshold for stress, thereby becoming overly reactive to adverse experiences throughout life.
3. Overproduction of neural connections in areas of the brain involved in fear, anxiety, and impulsive responses.
4. Fewer neural connections in areas of the brain dedicated to reasoning, planning, and behavioral control.
5. High levels of stress hormones that can (a) damage areas of the brain responsible for learning and memory, causing cognitive deficits that can continue into adulthood; and (b) suppress the body’s immune system causing vulnerability to chronic health problems.

Although advances in neuroscience and toxic stress studies have increased the understanding about “how the reverberations of childhood trauma may compromise adult functioning” (Pynoos et al., 2007, p. 333), research has also shown that “even when stress is toxic, supportive parenting, positive peer relationships, and the availability and use of community resources can foster positive adaptation” (Easterbrooks et

“Even when stress is toxic, supportive parenting, positive peer relationships, and the availability and use of community resources can foster positive adaptation” (Easterbrooks et al., 2013, p. 102).

al., 2013, p. 102). Thus, “appropriate support and intervention can help in returning the stress response system back to its normal baseline” (Middlebrooks & Audage, 2008, p. 4).

Foundational Idea 5: Resilience Theory

The Strengthening Families approach grows out of resilience theory. “A resilience-oriented approach draws out family strengths and potential to meet the [family’s] challenges. Beyond coping and problem solving, resilience involves positive transformation and growth. In building relational resilience, families forge stronger bonds and become more resourceful in meeting future challenges” (Walsh, 2006, p. x). Research on resilience has paralleled and been a derivative of strengths-based research (Leadbeater et al., 2004). The early studies of children who manifested healthy rather than pathological adaptation in the presence of multiple risk factors conceived this phenomena as a personality trait possessed by some individuals and not by others (Benard, 2004; Fraser, Kirby, & Smokowski, 2004; Wright & Masten, 2006). Furthermore, early researchers assumed there was something extraordinary about these children (Masten, 2001) and labeled them “invulnerable,” “invincible,” or “stress-resistant” (see, e.g., Anthony, 1974; Anthony & Cohler, 1987; Garmezy, 1987; Garmezy & Neuchterlein, 1972; Pines, 1975; Wyman et al., 1999). But these characterizations were misleading. “There is little evidence to support the implication that some children are simply not vulnerable to the effects of risk factors. . . . On balance, the term invulnerability has been superseded by the broader concept of resilience” (Fraser et al., 2004, p. 22).

Luthar (2003) defined resilience as “the manifestation of positive adaptation despite significant life adversity. Resilience is not a child attribute that can be directly measured; rather it is a process or phenomenon that is inferred from the dual coexisting

“Family Well-Being” from the Strengthening Families Perspective

The definition of “family well-being” in the Strengthening Families approach takes into account the unique characteristics and circumstances of a family, and is conceived as the effectiveness with which family members:

- Know, unequivocally, they are loved, and experience pleasure in each other’s presence
- Perform various functions (e.g., socialize children; assist with chores)
- Communicate and interact with each other
- Provide resources, goods, and services needed to support and maintain the family (e.g., supply adequate food and shelter, seek health care as needed)
- Protect its members, particularly vulnerable members (e.g., children, elders)
- Serve as buffers between its members—particularly children—and negative societal forces or conditions (e.g., racism, community violence)
- Prepare its members to navigate through or confront negative social experiences (e.g., racial profiling, discrimination based on gender identity or sexual orientation)
- Bond together as a unit to provide reciprocal care, emotional support, hope, encouragement, and guidance; resolve conflicts and seek peace; and assist each other during challenging situations and crises
- Demonstrate resilience—as individuals and as a unit—in the face of adversity

conditions of high adversity and relatively positive adaptation in spite of this” (p. xxix). Walsh (2006) added that resilience is “the ability to rebound from adversity strengthened and more resourceful. It is an active process of endurance, self-righting, and growth in response to crisis and challenge” (p. 4). There are four ideas that are fundamental to the way numerous leading researchers conceive resilience and that guide this report (see, e.g., Luthar, 2003; Luthar & Cicchetti, 2000; Luthar, Cicchetti, & Becker, 2000; Masten, 2001; Masten, Best, & Garmezy, 1990; Masten & Powell, 2003; Rutter, 2007; Walsh, 2003, 2006; Wright &

“As our society is increasingly becoming multicultural, it has become essential to discover the processes contributing to resilient adaptation in individuals from diverse cultural, ethnic, and racial backgrounds. Knowledge of these divergent developmental pathways can enable scientists to implement more culturally sensitive preventive intervention strategies to foster the development of resilient adaptation within diverse exosystemic contexts” (Luthar & Cicchetti, 2000, p. 857).

Masten, 2006), specifically:

- Resilience is a process and an outcome; it is not a personality trait
- Resilience is contextual with respect to setting, point in time, culture, and social factors
- Resilience reflects a person’s pattern of positive adaptive behavior in response to current or past risk factors or adversity
- Resilience results in personal growth and positive change

In conceptualizing resilience as “contextual,” researchers acknowledge that individuals may demonstrate adaptive behavior in response to negative experiences at one point in time or in one setting, but not at other times or in all settings; thus, resilience is not absolute (Masten & Powell, 2003). The contextual aspect of resilience also means that it is necessary “to extend concepts of resilience and strengths-building to family, institutional, neighborhood, and community levels of analysis” (Maton et al., 2004, p. 15). In this regard, it is important to investigate cultural, social, political, and ideological factors (e.g., both privilege and inequities based on race, ethnicity, class, gender, and sexual orientation) in the context of a resilience framework (Fraser et al., 2004; Luthar & Cicchetti, 2000; Maton et al., 2004; Ungar, 2005; Wright & Masten, 2006).

Foundational Idea 6: A Focus on Well-Being

The Strengthening Families approach focuses on healthy development and well-being for all families of young children, with a particular focus on families whose circumstances include multiple risk factors for child maltreatment. Building on the work of Zimmerman (2012), the Strengthening Families approach emphasizes that “family well-being” must take into account the unique characteristics and circumstances of a family and conceives “family well-being” as the effectiveness with which family members display nine essential characteristics (see text box on previous page).

When parents are overwhelmed by adverse circumstances and do not have adequate social support they may not be able to fully engage in behaviors that contribute to family well-being. As a consequence their children may suffer, for example, from the traumatic experiences of abuse or neglect, separation from their family, and out-of-home placement. Achieving well-being may be severely compromised for children receiving child welfare services due to their experiences both before and while in out-of-home care (Bruskas, 2008; Hieger, 2012). Thus, intentional, systematic, and coordinated efforts are needed for these children that promote and support their healthy development and well-being.

The goals of safety and permanency have historically been of primary focus in child welfare systems, research, policy, and practice; focusing on well-being has been a significant gap in the field (Langford & Badeau, 2013; Lou, Anthony, Stone, Vu, & Austin, 2008; Wulczyn, Barth, Yuan, Harden, & Landsberk, 2005).

However, there is a growing body of evidence indicating that while ensuring safety and achieving permanency are necessary to well-being, they are not sufficient. Research that has emerged in recent years has suggested that most of the adverse effects of maltreatment are concentrated in behavioral, social, and emotional domains. . . . Integrating these findings into policies, programs, and practices is the logical next step for child welfare systems to increase the sophistication of their approach to improving outcomes for children and their

families. (Administration for Children and Families, Administration on Children, Youth and Families, U.S. Department of Health and Human Services, 2012, p. 2)

Consistent with the domains of child well-being typically addressed in the research literature (see, e.g., Bornstein, Davidson, Keyes, Moore, & The Center for Child Well-being, 2003), the Administration for Children and Families adapted the well-being framework proposed by Lou and colleagues (2008), which identifies four domains of well-being that contribute to healthy functioning and success throughout childhood, adolescence, and into adulthood: (a) cognitive functioning, (b) physical health and development, (c) emotional/behavioral functioning, and (d) social functioning (Administration for Children and Families, Administration on Children, Youth and Families, U.S. Department of Health and Human Services, 2012).

While these four domains are clearly central to well-being. . . CSSP’s definition goes beyond these domains and explicitly takes into account the interplay between a child’s well-being and the parenting or caregiving environment around them. The well-being of families and caregivers is a defining pathway to a child’s well-being; thus, healthy family relationships and attachment to a caring and reliable adult must also be included as part of the concept and recommended actions to promote well-being. (Center for the Study of Social Policy, 2013f, pp. 1-2)

Foundational Idea 7: The Nature of Risk and Protective Factors

“Family systems do not function in a vacuum; families are always embedded within other systems. These extra-familial interactions have a profound impact on the strength of family networks” (Pell, 2006, p. 6). Similarly, risk and protective factors exist in all domains of the social ecology (Substance Abuse and Mental Health Services Administration, 2013) (see Figure 2). Thus, a combination of individual, relational, community, and societal factors must be addressed in order to promote healthy child, adult, and family well-being and to reduce the risk of negative

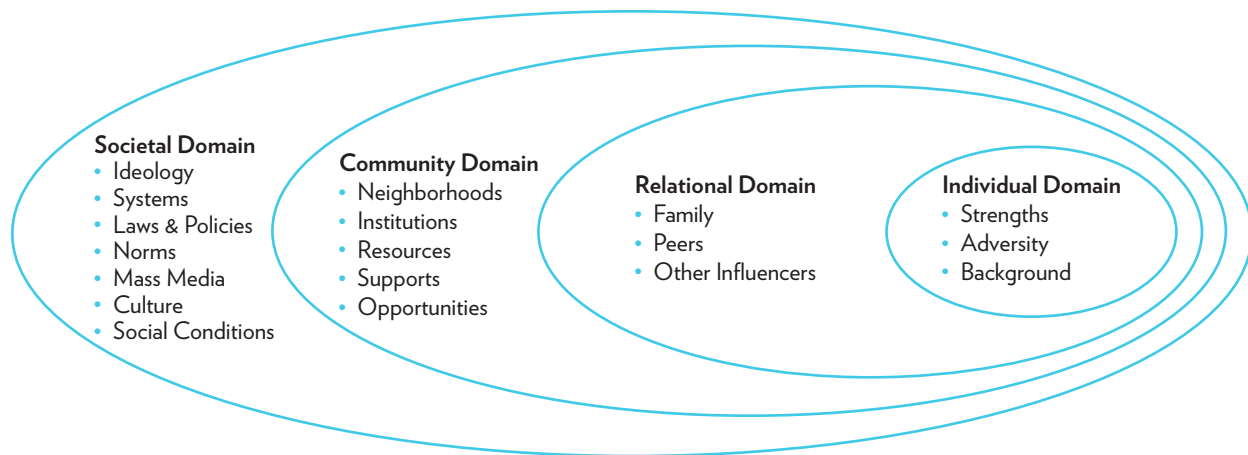


FIGURE 2. Risk, Protective, and Promotive Factors Across the Social Ecology

Adapted from the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (2013).

outcomes. Deborah Daro asserted, “the problem (of child abuse and neglect) and its solution are not simply a matter of parents doing a better job but rather creating a context in which ‘doing better’ is easier” (cited in Shaw & Kilburn, 2009, p. 7). Similarly, Secombe (2002) concluded: “Resiliency cannot be understood or improved in significant ways by merely focusing on. . . individual-level factors. Instead careful attention must be paid to the structural deficiencies in our society and to the social policies that families need in order to become stronger, more competent, and better in adverse situations” (p. 385).

Risk Factors. The Strengthening Families approach considers risk factors that threaten healthy parent and child outcomes. Families considered to be “vulnerable” are often targeted for programs and services on the basis of risk factors, that is, “influences that increase the probability of onset, digression to a more serious state, or maintenance of a problem condition” (Fraser et al., 2004, p. 14). Using a social-ecological perspective, the National Research Council and Institute of Medicine (2009) defined a risk factor as “a characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes” (p. xxviii). CSSP acknowledges a social-ecological conception of risk factors should also address characteristics, circumstances, or conditions in the societal domain that are associated with a

higher likelihood of poor outcomes, such as structural racism, lack of economic opportunity (Substance Abuse and Mental Health Services Administration, 2013), and inequitable schools. CSSP’s perspective is consistent with the mission of addressing the social determinants of health articulated by the Centers for Disease Control and Prevention and the World Health Organization (see Centers for Disease Control and Prevention, 2012).

Social determinants of health are economic and social conditions that influence the health of people and communities. These conditions are shaped by the amount of money, power, and resources that people have, all of which are influenced by policy choices. Social determinants of health affect factors that are related to health outcomes. . . . CDC is committed to achieving improvements in people’s lives by reducing health inequities. Health organizations, institutions, and education programs are encouraged to look beyond behavioral factors and address underlying factors related to social determinants of health. (Centers for Disease Control and Prevention, 2012, para. 1 & 3)

Focusing on a single risk factor when addressing child outcomes is not consistent with the reality of life for many children in vulnerable circumstances (Fraser

et al., 2004; National Research Council and Institute of Medicine, 2009; Sameroff, Gutman, & Peck, 2003; Sandler et al., 2004; Trentacosta et al., 2008; Wright & Masten, 2006). “Risk factors rarely occur in isolation. . . Outcomes generally worsen as risk factors pile up. . . Thus, it has become critical to examine *cumulative risk factors* in order to more accurately predict and understand developmental outcomes” (Wright & Masten, 2006, p. 20). Cumulative risk factors are defined as “increased risk due to (a) the presence of multiple risk factors; (b) multiple occurrences of the same risk factor; or (c) the accumulating effects of ongoing adversity” (Wright & Masten, 2006, p. 19). Sameroff and colleagues (2003) examined the results of various cumulative risk studies. “In one analysis. . . although no single risk factor had a strong relation to disorder or positive development, the accumulation of risk factors across family, parent, peers, and community had a substantial effect in predicting multiple problem outcomes” (National Research Council and Institute of Medicine, 2009, p. 86).

Numerous studies have found adverse child outcomes and problem behaviors—such as poor academic performance, hypersensitivity to stressors, early antisocial behavior, depression, and social adjustment difficulties—to be correlated with various risk factors such as poverty, maternal depression, community violence, family conflict, and parental

substance abuse (see, e.g., Fagan, Van Horn, Hawkins, & Arthur, 2007; Garbarino, Hammond, Mercy, & Young, 2004; Gilbert, 2004; Grych & Fincham, 2001; Hammen, 2003; Jenson, 2004; Knitzer, Theberge, & Knitzer, 2008; National Scientific Council on the Developing Child, 2007a; Owens & Shaw, 2003; Pearce & Pezzot-Pearce, 2007; Seifer, 2003; Szalacha et al., 2003; Wasserman et al., 2003; Williams, Ayers, Van Dorn, & Arthur, 2004). Although correlated, Carl Bell asserted (as cited in Griffin et al., 2011), “risk factors are not predictive factors because of protective factors” (p. 185).

Singularly focusing on risk factors to identify children and parents may be sufficient if the only goal is to provide services to the families most in need. While that is a necessary goal, alone it is not sufficient to achieve the goal of increasing the likelihood that vulnerable families are on a trajectory of healthy, productive child, adult, and family outcomes.

Efforts to improve child and adolescent health have typically addressed specific health risk behaviors. . . . However, results from a growing number of studies suggest that greater health impact might be achieved by also enhancing protective factors that help children and adolescents avoid multiple behaviors that place them at risk for adverse health and educational outcomes. (Centers for Disease Control and Prevention, 2009, p. 3)

Key Terms

- **Cumulative Protective Factors:** The presence of multiple protective factors; associated with a decreased likelihood of involvement in problem behaviors
- **Cumulative Risk Factors:** The presence of multiple risk factors; associated with an increased likelihood of multiple problem outcomes
- **Protective Factors:** Conditions or attributes of individuals, families, communities, or the larger society that mitigate or eliminate risk
- **Risk Factors:** Conditions or attributes of individuals, families, communities, or the larger society that increase the probability of poor outcomes
- **Social Determinants of Health:** The integrated social structures and economic systems that contribute to health disparities
- **Social Ecology:** The interplay among individual, family and relational, community, and societal factors

Protective Factors. The Strengthening Families approach emphasizes the importance of addressing protective factors that contribute to healthy outcomes in all families, not just families faced with cumulative risk factors. “No family is problem free; all face serious challenges over the life course [p. ix]. . . . Yet all families have the potential for adaptation, repair, and growth” (Walsh, 2006, p. xiv). Much of the research on protective factors, however, has focused on vulnerable family, child, and adolescent populations. Bernat and Resnick’s (2006) finding about research on protective factors for youth is relevant to families and children: “It has become clear that most youth benefit from. . . [protective] factors, whether they are at heightened risk for negative outcomes or not. Thus, recent research has begun to focus on the effects of protective factors not only in high-risk populations but also in the lives of adolescents in general” (p. S12).

Interest in protective factors emerged from the early strengths-based and resilience research (see, e.g., Garmezy, 1985; Rutter, 1987; Werner, 1989) as investigators sought to identify characteristics or conditions that might explain why children and youth who were exposed to the same multiple risk factors were affected differently (Benard, 2004; Cicchetti, 2003; Hanewald, 2011; Resnick, 2005). Werner (2000) analyzed several longitudinal studies that focused on resilience and protective factors in individual development across the lifespan. In speaking about protective factors, Werner (2000) concluded: “they make 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” (p. 117).

Protective factors have been conceived in two different ways in the research literature (Bernat & Resnick, 2006; Office of the Surgeon General, 2001). One view conceives protective factors and risk factors as opposite ends of a continuum. “For example, good parent-child relations might be considered a protective factor because it is the opposite of poor parent-child relations. But a simple linear relationship of this sort. . . blurs the distinction between risk and protection, making them essentially the same thing” (Office of the Surgeon General, 2001, para. 26).

Another view conceives protective factors as conceptually distinct from risk factors; that is, as

characteristics, circumstances, or conditions that mediate or moderate the effect of exposure to risk factors and stressful life events resulting in a decreased likelihood of negative outcomes (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2014; Luthar et al., 2000). Using a social-ecological perspective, the National Research Council and Institute of Medicine (2009) stated a protective factor is “a characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes” (p. xxvii).

As with its perspective about risk factors, CSSP acknowledges a social-ecological conception of protective factors should also address characteristics, circumstances, or conditions in the societal domain that are associated with a lower likelihood of problem outcomes or that mitigate the impact of risk factors, for example “social policies that can relieve some of the stresses of parenting, particularly maternity and paternity leave policies” (Deater-Deckard, 2004, p. ix).

Promoting the health and well-being of children. . . requires extending interventions beyond the family or individual levels. . . . In other words, risk and protective factors have to be considered beyond the four walls of parenting to embrace the social, economic, and political forces that affect families and communities. (Barter, 2005, p. 348)

Studies have identified independent protective factors that buffer the effect of exposure to risk or modify the response to various risk factors (see, e.g., Arthur, Hawkins, Pollard, Catalano, & Baglioni, 2002; Duncan, Duncan, & Strycker, 2000). For example, “in many studies of the impact of traumatic experiences on children, it has been found that the presence of at least one stable and supportive caregiver can ‘protect’ or ‘buffer’ the child, thereby reducing the risk that the child develops serious problems later in life” (Cook & du Toit, 2005, p. 250). Studies have also shown the presence of multiple protective factors in an individual’s life has cumulative effects (see, e.g., Carr & Vandiver, 2001; Fraser et al., 2004; Jessor, Van Den Bos, Vanderryn, Costa, & Turbin, 1995; Turner,

TABLE 2. How Protective Factors Interact with Risk Factors to Influence Outcomes

Protective Factors	Example
1. Mitigate the negative effects of risk factors	Parent behaviors that are associated with buffering the impact of child adversity and nurturing resilience in children, such as being emotionally attuned and available, empathic and accepting, listening actively, and helping children experience success (Brooks, 2006).
2. Interrupt the cumulative effects of risk factors	Cumulative risk factors such as household overcrowding, neighborhood dangerousness, and parental drug or alcohol problem are associated with early childhood problem behaviors. Parental nurturance and involvement (a protective factor) has been found to mediate the effects of these cumulative risk factors (Trentacosta et al., 2008).
3. Help to avoid the negative effects of risk factors	Poverty is identified as a risk factor for negative outcomes such as poor academic achievement and social, emotional, and behavioral problems. However, many children who grow up in poverty are able to avoid these negative outcomes. “A positive parent-child relationship and parental involvement have been found to be protective among at-risk children. . . and [researchers] found a positive relationship with parents to be predictive of nondelinquency” (Owens & Shaw, 2003, p. 274).

Hartman, Exum, & Cullen, 2007; Wright & Masten, 2006).

While the isolated effects of protective factors can be helpful in buffering or moderating the effects of high-risk environments, it should be expected that much like the effects of risk, the cumulative effects of multiple protective factors should empirically have a more substantial effect. . . . Jessor and his colleagues (1995) have documented the positive effects that multiple protective factors have within high-risk environments. . . . In short, this research generally suggests that as protection accumulates individuals are more likely to refrain from involvement in problem behaviors. (Turner et al., 2007, p. 91)

Researchers described three ways in which protective factors interact with risk factors to influence outcomes (see, e.g., Armstrong, Stroul, & Boothroyd, 2005; Barter, 2005; Fergus & Zimmerman, 2005) (see Table 2).

The Strengthening Families Protective Factors Framework



Strengthening Families is a research-informed approach that is grounded in the belief that healthy development and well-being cannot be explained simply as preventing, mitigating, coping with, or eliminating risk factors. Thus, the five Strengthening Families protective factors are interrelated attributes or conditions that simultaneously (a) prevent or mitigate the effect of exposure to risk factors and stressful life events, and (b) build family strengths and a family environment that promotes optimal child development.

Research suggests that effective intervention services for vulnerable families should focus on reducing modifiable risk factors and promoting protective factors. . . . By building on family strengths, families are better placed to cope with stress, which in turn can lead to a reduced

incidence of child abuse and neglect. . . . In a strengths-based intervention approach that focuses on building protective factors, parents themselves can identify and build on their own strengths to help enhance their parenting capacity. Promoting protective factors may also help professionals working with families to build more positive relationships with clients. (Lamont & Price-Robertson, 2013, para. 12)

The five Strengthening Families protective factors are *parental resilience, social connections, knowledge of parenting and child development, social and emotional competence of children, and concrete support in times of need*. The research that informs each protective factor will be described through the lens of a two-generation approach, addressing issues related to the parent, the child, and the parent-child relationship.

The five Strengthening Families protective factors are interrelated attributes or conditions that simultaneously (a) prevent or mitigate the effect of exposure to risk factors and stressful life events, and (b) build family strengths and a family environment

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that promotes optimal child development.

Parental Resilience

Within the Strengthening Families approach, resilience is conceived as both a process and an outcome. That is, resilience is defined *as the process of managing stress and functioning well in a particular context when faced with adversity. Resilience is learned through exposure to challenging life events facilitated by supportive relationships and environments (e.g., people, culture, institutions, conditions, policies). The outcome of resilience is positive change and growth.* This definition reflects leading researchers' ideas that (a) resilience is demonstrated when an individual is able to successfully adapt despite current or past trauma; (b) in addition to coping, resilience involves growth from the adaptive experience; (c) resilience is a function of the interaction between individuals and their environments; (d) resilience is contextual with respect to settings, situations, and time; (e) variables that promote or impede resilient functioning operate within all domains of the social ecology; and (e) resilience is not a personal trait (Easterbrooks et al., 2013; Luthar, 2003; Luthar & Cicchetti, 2000; Luthar et al., 2000; Masten, 2001; Rutter, 2007; Seccombe, 2002; Ungar, 2008, 2011; Walsh, 2006; Wright & Masten, 2006).

Resilience, by definition, is in response to current or past challenges or adversity. Accordingly, it is important to examine the relationships among stress, trauma, and resilience related to the parenting role.

Parenting Stressors and Stress

Being a parent can be a very rewarding and joyful experience. But attempting to adapt to the demands of parenthood (parenting stressors), as well as general life stressors (e.g., poor marital relationship, threat of

Resilience Is Much More Than “Bouncing Back” from Challenges and Adversity

In describing findings from the ACE Study, Felitti (2002b) acknowledged: “The Study makes it clear that time does not heal some of the adverse experiences we found so common in the childhoods of a large population of middle-aged, middle class Americans. One does not ‘just get over’ some things, not even fifty years later” (p. 1). Thus, intentional—and sometimes intensive—interventions are needed to help people learn to demonstrate resilience; that is to (a) successfully adapt despite current or past trauma and (b) achieve personal growth and positive change.

Key Terms

- **Child Traumatic Stress:** Physical and emotional responses as a result of exposure to one or more traumas during the course of the child's life; reactions persist and affect daily life after the traumatic events have ended
- **Chronic Environmental Stressors:** A constant background level of threat based in the environmental physical and social structure (e.g., racism, economic inequity)
- **Complex Trauma:** Exposure to multiple traumatic events and the impact of this exposure on immediate and long-term development
- **Daily Hassles:** Relatively minor events that occur in the course of day-to-day living (e.g., running late for work, getting a traffic ticket)
- **Normative Stressors:** Unpleasant events or experiences that typically occur in the parenting role (e.g., having to enroll an infant in child care in order to return to work)
- **Parenting Stress:** Physical and emotional responses as a result of the demands of parenting
- **Parenting Stressors:** The various demands of parenting
- **Role Strain:** The inability to fulfill the socially ascribed role of parent

eviction from home), can create aversive psychological and physiological reactions (parenting stress) (Deater-Deckard, 2004). “Stress in the parenting system during the first three years of life is especially critical in relation to the child’s emotional/behavioral development and to the developing parent-child relationship” (Abidin, 1995, p. 1). In addition, parenting stress has been identified as a risk factor for child abuse and neglect (see, e.g., Black, Heyman, & Smith Slep (see p. 52), 2001; DiLauro, 2004; Sprang, Clark, & Bass, 2005).

Various “normative” experiences characteristic of the parenting role may be a source of stress (Abidin, 1992; Curenton, McWey, & Bolen, 2009). Normative parenting stressors are unpleasant events or experiences that are expected to occur (e.g., coming home from the hospital with one’s first baby may trigger anxiety about one’s ability to care for the baby properly). Also, occasionally experiencing “daily hassles”—that is, relatively mild stressors that arise out of day-to-day living (Tolan, Sherrod, Gorman-Smith, & Henry, 2004)—is considered normative, such as having a dead car battery or not being able to soothe a crying baby. Although daily hassles typically may be perceived as relatively mild, in the context of adverse circumstances—such as very limited financial

resources and social support—even daily hassles can be extremely difficult to manage and can cause intense stress responses (Tolan et al., 2004).

Abidin (1992) developed a theory of parenting stress,⁷ which proposed that “high levels of parental distress, perceived child difficulty, and parent-child dysfunctional interactions. . . lead to increases in negative parenting. . . . Negative parenting (e.g., physical discipline), in turn, has a direct and negative effect on children’s behavior” (Mitchell & Cabrera, 2009, p. 202). Thus, parenting stress can create a vicious cycle: parenting stress creates negative parent effects on the child, which can create or reinforce negative child effects on the parent, which can further exacerbate parenting stress.

The foundation of Abidin’s theory is an ecological classification of the sources of parenting stress; specifically, stressors emanating from the parenting domain, child domain, and life domain.

- The *parenting domain* includes seven stressors—personal characteristics or situations—that are specific to the parent but may interfere with parent functioning and the parent-child relationship (see Table 3). Each of the seven factors has been identified as a risk factor for child maltreatment

⁷ The Parenting Stress Index—a widely used and well-researched measure of parenting stress developed by Richard Abidin—is an outgrowth of his theory of parenting stress.

TABLE 3. Stressors in the Parenting Domain (Abidin, 1995)

<i>Stressors in the parenting domain refer to a parent's personal characteristics or situations.</i>	
Stressor	Factor
Attachment	Lack of emotional closeness and attunement with child
Depression	Clinically significant depressive symptoms
Health	Real or perceived decline in parent's health
Isolation	Lack of social support and connectedness with others; lack of involvement in community institutions
Role Restriction	Feeling dominated by the child's needs and demands, consequently perceiving the parental role as restricting freedom and the ability to maintain an identity separate from the parenting role
Sense of Competence	Lack of practical knowledge of child development and limited range of child management skills; feeling overwhelmed by what is required in the parenting role
Spouse	Lack of emotional and active support of the other parent with respect to care and management of the child

(Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2014; Goldman & Salus, 2003).

- The *child domain* includes six perceived qualities of the child that the parent believes makes it difficult to fulfill his or her parenting role (see Table 4). Several

studies have found a relationship between perceived child characteristics and parenting stress (see, e.g., Gutermuth Anthony et al., 2005; Ostberg & Hagekull, 2000).

- Sources of stress in the *life domain* that have an impact on parenting—and consequently on

TABLE 4. Stressors in the Child Domain (Abidin, 1995)

<i>Stressors in the child domain refer to a parent's perceived qualities of the child that the parent believes make it difficult to fulfill his or her parenting role.</i>	
Stressor	Factor
Acceptability	Parent perceives child's physical, intellectual, or emotional characteristics as not meeting the parent's expectations
Adaptability	Parent perceives child is unable to adjust to change in the child's physical or social environment
Demandingness	Parent feels the child requires too much of the parent or places too many demands on the parent
Distractibility/ Hyperactivity	Parent perceives the child as restless, having a short attention span, not listening to the parent, etc.
Mood	Parent perceives the child as unhappy and depressed
Reinforces Parent	Parent does not experience child as a source of pleasure, good feelings, or positive reinforcement

the child—are social, situational, or contextual circumstances that are outside of the parents’ control (Abidin, 1995); for example, the death of a family member or financial hardship. Results from several studies have shown that family economic hardship can affect children because it increases parenting stress, which limits parents’ ability to provide consistently responsive and nurturing care (see, e.g., Aber, Jones, & Cohen, 2000; Duncan & Brooks-Gunn, 2000; McLoyd, 1990, 1998).

However, Coleman and Karraker (2000), McLoyd (1990), and Raikes and Thompson (2005) all found support for the hypothesis that family income alone does not determine the level of parenting stress; rather, various protective factors can mitigate the impact of economic hardship on parenting stress. “Although there is evidence that economic strain affects parenting behavior by increasing emotional distress, parental psychological resources, such as social support and self-efficacy, can buffer this impact” (Raikes & Thompson, 2005, p. 179).

Tolan and colleagues (2004) identified two additional types of stressors, which are described in relation to parenting in this report, specifically, role strain and chronic environmental stressors. Role strain refers to the “inability to fulfill the socially ascribed role [of parent]” (Tolan et al., 2004, p. 196). Role strain may be caused by such factors as a parent’s non-standard work schedule (see, e.g., Ceballo & Hurd, 2008; Joshi & Bogen, 2007; Schmit et al., 2014), being the non-custodial parent (see, e.g., Dudley, 1996), lack of emotional closeness with the child, unwillingness to accept the parenting role, or mental health and substance abuse problems (see, e.g., Abidin, 1995). Schmit and colleagues’ (2014) description of parenting stress for parents experiencing poverty can be regarded as role strain. They asserted:

In addition to the stresses caused by not being able to cover their bills and meet their families’ basic needs, the nature of low-wage jobs can compound family stress because of irregular work schedules and the lack of basic benefits like health insurance and paid leave when a parent or child is ill. Moreover, because poor and low-income families often lack meaningful savings, any minor setback—from a traffic ticket to illness—can quickly spiral into a crisis” (Schmit et al., 2014, p. 4).

An often overlooked source of stress is the chronic environmental stressors experienced by members of ethnic minority groups and low-income families (Anderson, 1991; Tolan et al., 2004). The construct “chronic environmental stressor” is defined as:

A constant background level of threat based in the environmental physical and social structure. It includes racism and economic inequity, but also heightened danger and the intrusion of social problems into everyday life. Chronic environmental stress impinges on optimism, sense of control, and goal-directed behavior—cognitive functions that can propel a child [or an adult] to be industrious and engaged with the world. (Tolan et al., 2004, pp. 195-196)

Parents, Children, and Trauma

Some stressors parents face can be managed easily so that problems get resolved; but sometimes the pressures parents face are so overwhelming that their ability to manage stress is severely compromised. This is the case with parents who grew up in environments or have traumatic experiences that create toxic stress. That is, as children, they experienced strong, frequent, and prolonged adversity without the buffering protection of nurturing and responsive adult support (Middlebrooks & Audage, 2008; Shonkoff & Garner, 2012). As a result, these parents may display symptoms of depression, anxiety, or other clinical disorders that inhibit their ability to respond consistently, warmly, and sensitively to their child’s needs (Mitchell & Cabrera, 2009; Whiteside-Mansell et al., 2007).

For example, depressive symptoms in either mothers or fathers are found to disrupt healthy parenting practices so that the child of a depressed parent is at an increased risk of poor attachments, maltreatment, and poor physical, neurological, social, emotional, behavioral, and cognitive outcomes (Abidin, 1995; Center on the Developing Child at Harvard University, 2009; Deater-Deckard, 2004; Gurian, 2003). Thus, parents need interventions that help them to manage clinical symptoms and reactions to their own histories of poor attachments and trauma, to protect children from adversity and trauma as best they can, and to provide more nurturing care that promotes secure emotional attachment and healthy development in their children.

Serious depression in parents and caregivers can affect far more than the adults who are ill. It also influences the well-being of the children in their care. . . . When children grow up in an environment of mental illness, the development of their brains may be seriously weakened, with implications for their ability to learn as well as for their own later physical and mental health. When interventions are not available to ensure mothers' well-being and children's healthy development, the missed opportunities can be substantial. (Center on the Developing Child at Harvard University, 2009, p. 1)

Although all children will have stressful experiences from time to time, it is estimated that 26% of American children will witness or experience a traumatic event before age 4 (Briggs-Gowan, Ford, Fraleigh, McCarthy, & Carter, 2010). "Children who suffer from child traumatic stress⁸ are those children who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the traumatic events have ended" (National Child Traumatic Stress Network, 2003, p. 1). The effects of child traumatic experiences that become evident during later developmental periods include having difficulty regulating emotions, forming healthy relationships, controlling thoughts and actions, managing stressful situations, and planning for the future (Langford & Badeau, 2013).

For example, many children in out-of-home care must endure the trauma that led to the removal from their home, the trauma of being separated from their families, and the potential trauma of multiple removals and placements (Bruskas, 2008; Frerer, Sosenko, & Henke, 2013; Hieger, 2012). "Children exposed to complex trauma [or child traumatic stress] often experience lifelong problems that place them at risk for additional trauma exposure and cumulative impairment (e.g., psychiatric and addictive disorders; chronic medical illness; legal, vocational, and family problems)" (Cook et al., 2005, p. 390). Given the potential long-term and enduring consequences of exposure to complex trauma, it would seem that creating stress-free environments for children would be a goal. But Shonkoff (2013) pointed out:

The complete elimination of stress from the lives of children is not a reasonable goal; manageable levels of adversity provide opportunities to develop the coping skills needed for resilience. Rather, the goal is to prevent or mitigate the consequences of toxic stress by buffering young children from abuse and neglect, exposure to violence, parental mental illness or substance abuse, and other serious threats to their well-being. (para. 5)

Facilitating Parental Resilience

Exposure to the daily hassles of parenting, normative stressors, or traumatic stressors are all potentially harmful to parents and their children, but this does not mean negative outcomes are inevitable. Parents are more likely to foster healthy, favorable outcomes for themselves and their children when they demonstrate resilience. CSSP conceives parental resilience as *the process of managing stress and functioning well when faced with stressors, challenges, or adversity. The outcome of parental resilience is positive change and growth.* Parents demonstrate resilience when they are able to call forth their inner strength to proactively meet personal challenges and those in relation to their child, manage adversities, heal the effects of trauma, and thrive given the unique characteristics and circumstances of their family.

Demonstrating resilience increases parents' self-efficacy—that is, their belief that they can perform a task competently and effectively—because they are able to see evidence of their ability to face challenges, to make wise choices about addressing challenges, and feel more in control of what happens to them (Raikes & Thompson, 2005). Furthermore, parental resilience has a positive effect on the parent, the child, and the parent-child relationship. By managing stressors, parents feel better and can provide more nurturing attention to their child, which enables their child to form a secure emotional attachment. Receiving nurturing attention and developing a secure emotional attachment with parents, in turn, fosters the development of resilience in children when they experience stress. All parents experience stress from time to time. Thus, parental resilience is a process that

⁸ Child traumatic stress can be conceived as a type of complex trauma, defined as "the dual problem of exposure to multiple traumatic events and the impact of this exposure on immediate and long-term development" (Jim Casey Youth Opportunities Initiative, 2011, p. 13).

Parents' Social Connections Are Valuable Resources (Jordan, 2006a)

Parents' healthy, constructive, and supportive social connections are valuable resources who provide:

- *Affiliative support* (e.g., companionship or a sense of community)
- *Emotional support* (e.g., non-judgmental affirmation of parenting skills; empathy; validation of self-worth)
- *Informational support* (e.g., parenting guidance or recommendations for health care services)
- *Instrumental support* (e.g., transportation, financial assistance, or links to jobs)
- *Spiritual support* (e.g., hope and encouragement; a sense of meaning to life)

all parents need in order to effectively manage stressful situations and help ensure that they and their children are on a trajectory of healthy, positive outcomes.

Social Connections



Within the Strengthening Families approach, social connections⁹ are conceived as parents' *healthy, sustained relationships with people, institutions, the community, or a force greater than oneself that promote a sense of trust, belonging, and that one matters*. Whether called social connections, social supports, or social networks in the research literature, the Strengthening Families approach emphasizes that all parents need people—family members (including a spouse or a partner), friends, neighbors, co-workers, and community members—who care about them and their children; who can be non-judgmental listeners; who they can turn to for well-informed advice; who they can call on for help with different tasks and in solving problems; who help fulfill their need for affiliation and social stimulation; who can provide encouragement and hope when they need it; and who can affirm their healthy parenting efforts (see text box above).

Beeber and Canuso (2012) concluded: "A parent who has close relationships that are low in conflict. . . is more strongly protected from depression, anxiety, and other stress-related mental health problems. Strong social support also protects infants and toddlers by enriching the environment and relieving some of the demands on the parent" (p. 164). Thus, it is crucial that parents' social connections are healthy,

non-judgmental, and proactive. Conversely, inadequate, conflicting, or dissatisfying social connections will not be perceived as being supportive or helpful (Keller & McDade, 2000), and can cause parental stress, rather than buffer it (Raikes & Thompson, 2005. "Social networks can themselves be sources of social stress, as well as support, when, for example, friends and relatives provide criticism even as they offer assistance with parenting problems" (Raikes & Thompson, 2005, p. 187).

Both fathers and mothers need positive, supportive social connections. "Fathers who report having high levels of social support experience better psychological well-being and demonstrate more positive patterns of father involvement and coparenting. The benefits of fathers' social support may also have important implications for child well-being" (National Responsible Fatherhood Clearinghouse, 2010, para. 1). For example, in focusing specifically on adolescent fathers, Fagan, Bernd, and Whiteman (2007) found a strong positive relationship between the adolescent father's parents encouraging him to be involved with his child and the adolescent father's self-reported level of caregiving.

Social connections are particularly important when parents are faced with stressors (Abidin, 1992; Keller & McDade, 2000; Kendall-Tackett, 2013; Kotchick, Dorsey, & Heller, 2005; Thompson, 1995). Greene and Livingston (2002) cited studies that demonstrated "being a part of a social support network has a stress-buffering effect on individual well-being" (p. 73), and Jordan (2006b) asserted, "social support has also been viewed as vital to resilience" (p. 83). Similarly, Marra and colleagues (2009) found, "emotional and instrumental (e.g., financial, transportation, physical assistance) support from family, friends, or mental health professionals can buffer the negative effects

⁹ The terms social connections, social support, and social networks are used interchangeably in this report.

of stress. . . which in turn can increase effective and consistent parenting behavior” (p. 349).

The presence of social support networks may reduce the number of stressful events experienced by parents through the provision of concrete assistance, may mediate the stress experienced by parents, and may facilitate better coping with the demands of parenting. Additionally, support networks provide role models for parents as well as a link to other sources of parenting information. (Keller & McDade, 2000, p. 286)

Parents also need to be constructively engaged in social institutions and environments (e.g., their child’s early education program, religious communities, volunteer opportunities, or parent-focused programs). Social institutions serve similar social support purposes as people do. For example, Gay (2005) described the functions of the Circle of Parents® child maltreatment prevention program, specifically:

- Emotional sustenance (e.g., connectedness with others who share similar circumstances)
- Counseling, advice, or guidance (e.g., conversations led by parents)
- Access to information, services, and material resources and assistance (e.g., real-life examples of coping strategies, parenting techniques, and community resources)
- Skills acquisition (e.g., opportunities to “practice” parenting techniques)
- Social monitoring and social control (e.g., parents develop group rules for the group that reflect their norms and values)

Social institutions also provide opportunities for parents to participate in organized activities and to “give back” to peers, their community, and to the larger

Social support is not just about *getting* help; it’s also about *giving* help. “There is a need to give, to matter, to make a difference; we find meaning in contributing to the well-being of others” (Jordan, 2006b, p. 84)

society. Jordan (2006b) pointed out: “Most social support studies have emphasized one-way support, getting love, getting help. . . . The power of social support is more about mutuality than about getting for self. . . . That is, there is a need to give, to matter, to make a difference; we find meaning in contributing to the well-being of others” (pp. 83-84). Thus, efforts to help parents forge social connections should include providing opportunities for parents to give help as well as receive help, “which lessens feelings of indebtedness” (Gay, 2005, p. 387). Giving of oneself to others, the community, and society implicitly assigns value to the giver and positively contributes to one’s sense of self-worth.

In addition, the Strengthening Families approach acknowledges the importance of spiritual connectedness or spirituality in the lives of parents. Findings from a study addressing universal concepts in parenting philosophies and practices indicated “parents spoke of the strength they derived from their own spirituality and religion to help guide them in their parenting roles” (McEvoy et al., 2005, p. 145). These sentiments also emerged in the ZERO TO THREE *Parenting Young Infants and Toddlers Today* nationwide survey (Hart Research Associates, 2009). Spirituality can be operationalized as “viewing life in new and better ways, adopting some conception as transcendent or of great value, and defining oneself

Key Terms

- **Sense of Connectedness:** A sense of belonging, attachment, reciprocal positive regard, and that one matters that develops as a result of the protective relationship between individuals and their social contexts (people, institutions, or higher power)
- **Social Isolation:** Lack of linkages with informal or formal social networks

and one's relation to others in a manner that goes beyond provincialism [i.e., narrowness of outlook] or materialism to express authentic concerns about others" (Reich, Oser, & Scarlett, 1999, cited in Lerner, Alberts, Anderson, & Dowling, 2005, p. 60). Spiritual connectedness can promote hope and an optimistic future perspective, which helps parents to find meaning and a positive purpose in their lives.

Sense of Connectedness

Providing opportunities for parents to forge sustainable, positive social connections is critically important, but alone is not sufficient. What is essential is that social connections must engender within parents a sense of connectedness that results in feelings of trust, belonging, and that one matters. The role and importance of parents' own sense of connectedness has not been widely studied; research about youths' own sense of connectedness, however, is regarded as relevant to parents. "Connectedness" is used in the youth literature to describe the protective relationship between individuals and their social contexts that promotes well-being and decreases vulnerability to negative outcomes (Bernat & Resnick, 2009; Jim Casey Youth Opportunities Initiative, 2011; Whitlock, 2004).

While healthy relationships are central to a sense of connectedness, Whitlock (2004) stated, "connectedness. . . also encompasses ideas related to belonging, attachment, and reciprocal positive regard. . . . It also implies a sense of place, respect, and belonging that comes from feeling like you and others like you are valued members of. . . a community" (p. 5). In order for a sense of connectedness and belonging to develop, individuals need a sense of "fit" with people, groups, organizations, or places, and a sense of the potential for shared or complementary values and beliefs (Hagerty, Lynch-Sauer, Patusky, Bouwsema, & Collier, 1992). When parents have a sense of connectedness, they: (a) feel loved and valued; (b) have people who care about them as individuals now and who care what happens to them in the future; (c) feel secure and confident that they can share the joy, pain, and uncertainties that come with being a parent; (d) tend to seek timely assistance and resources from people and institutions they have

learned to count on when faced with challenges; and (e) find meaning, a positive purpose in their lives, and have an optimistic view of the future.

The components of a sense of connectedness—healthy relationships, positive regard, and a sense of belonging and that one matters—"represent the opposite of social isolation and disconnection" (Bernat & Resnick, 2009, p. 376). Gaudin (2001) defined social isolation as "a lack of 'social embeddedness' in the community or an absence of linkages with formal and informal social networks" (p. 108). Social isolation has been found in numerous studies to be a risk factor for child abuse and neglect and to be related to many adverse outcomes for children and families (see, e.g., Garbarino, 1982; Polansky, Guadin, Ammons, & Davis, 1985; Zigler & Hall, 1989). For example, Gaudin, Polansky, Kilpatrick, and Shilton (1993) found striking differences between low-income mothers who were described as neglectful and low-income mothers who were not neglectful, with respect to self-reported loneliness and social isolation. "Mothers in the neglect group reported fewer social ties and had more people critical of them in their social networks. The authors recommended that case workers address loneliness and isolation in these families to help them cope with significant life stresses related to poverty, lack of access to health care, housing and other support services" (Kendall-Tackett, 2013, pp. 8-9).

Importance of Social Connections for Parents and Young Children

The research literature about the nature and the importance of social connections supports the premise that parents need opportunities to forge positive social connections with people and institutions that engender emotional, informational, instrumental, or spiritual support so that meaningful interactions may occur in a context of mutual trust and respect. Constructive and supportive social connections help buffer parents from stressors and support nurturing parenting behaviors that promote secure attachments in young children. Therefore, parents' high-quality social connections are beneficial to both the adults and the children in the family.

Knowledge of Parenting and Child Development



Early childhood is a unique developmental period; no parent knows everything about this developmental period or is a “perfect parent.” The Strengthening Families approach acknowledges that all parents, and those who work with children, can benefit from increasing their knowledge and understanding of infant and child development in order to apply this knowledge in day-to-day interactions with young children or in developing programs and policies that are designed to help young children flourish in all domains of development.

A Caveat About Parenting

Throughout this report references are made to parenting behaviors that are regarded in the Strengthening Families approach as essential for promoting healthy child development and well-being (see, e.g., the section on Social and Emotional Competence of Children). It is important to acknowledge, however, that what is considered to be effective parenting is *contextual*, particularly with

respect to culture and circumstances. For example, in challenging the assumption that “inner-city” families have poorer parenting skills due to various social conditions (e.g., economic inequities, community gang violence, and limited resources), Tolan and colleagues (2004) stated:

Despite social and economic disconnection, families protect, nurture, and support their children. . . . Emerging evidence also suggests that inner-city families may not have lesser skills or fewer of the qualities that aid child development than do families living elsewhere. What constitutes effective parenting may, in fact, depend much on the setting. Careful, controlling parenting that limits exposure to peers and to a violent neighborhood may elsewhere stifle social involvement but in the inner city, obedience is as important, or more so, than autonomy. . . . What defines good parenting may depend on the context, including how inner-city parents manage exposure to potentially harmful influences. (p. 195)

Although context must be considered regarding what is characterized as effective parenting, research has found that there are some fundamental experiences and environments—many of which

Experiences and Environments All Parents Need to Provide: Two Frameworks

Safe, Stable, Nurturing Relationships and Environments (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, 2014b, p. 7):

- *Safety*: The extent to which a child is free from fear and secure from physical or psychological harm within their social and physical environment
- *Stability*: The degree of predictability and consistency in a child’s social, emotional, and physical environment
- *Nurturing*: The extent to which a parent or caregiver is available and able to sensitively and consistently respond to and meet the needs of their child

Critical Parent Capacities for the Care and Support of Children (Center on the Developing Child at Harvard University, 2010, p. 12)

- *Time and commitment* (i.e., the nature and quality of time spent with children and on their behalf)
- *Resources*—both *financial* (i.e., economic ability to purchase goods and services) and *psychological, emotional, and social* (i.e., physical and mental health and parenting style)
- *Skills and knowledge* (i.e., human capital acquired through education, training, interactions with child-related professionals, and personal experiences)

are described throughout this report—that all parents need to provide in order to (a) increase the likelihood that children are on a trajectory of healthy development and well-being, and (b) reduce the likelihood or mitigate the effects of adverse experiences. For example, the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention (2014b, p.7) described the “essentials for childhood” as “safe, stable, nurturing relationships and environments” (see text box on previous page). Also, the Center on the Developing Child at Harvard University (2010, p. 12) described three capacities that all parents and other adults must bring to bear for the appropriate care and support of children (see text box on previous page).

Key Knowledge Areas

Parents, and those who work with children, can benefit from increasing their knowledge and understanding of the (a) physical, cognitive, language, social, and emotional development of young children; (b) signs indicating a child may have a developmental delay and needs special help; (c) cultural factors that influence parenting practices and the perception of children; (d) factors that promote or inhibit healthy

child outcomes; and (e) how to positively impact child behavior. While it is important to stay abreast of research in all domains of child development, knowledge of recent advances in the fields of neuroscience and developmental psychology are of particular relevance.

Scientists in these fields have provided much evidence of the critical importance of early childhood as the period in which the foundation for intellectual, social, emotional, and moral development is established (Munakata et al., 2013; National Scientific Council on the Developing Child, 2007a, 2010a, 2010b, 2012a; Shonkoff, 2009). Numerous research studies show this foundation is determined by the nature of the young child’s environments and experiences that shape early brain development (American Academy of Pediatrics, n.d.; Center on the Developing Child at Harvard University, 2009, 2010, 2011; Gunnar et al., 2009; Hawley, 2000). Two related aspects of child development are of focus in this report: early brain development and language development.

Early Brain Development

New brain imaging technologies have enabled scientists to understand more about early brain development and how its course impacts development,

Core Concepts About Brain Development (National Scientific Council on the Developing Child, 2007b, pp. 1-2)

1. Child development is a foundation for community development and economic development, as capable children become the foundation of a prosperous and sustainable society.
2. Brains are built over time [i.e., birth through adulthood].
3. The interactive influences of genes and experience literally shape the architecture of the developing brain, and the active ingredient is the “serve and return” nature of children’s engagement in relationships with their parents and other caregivers in their family or community.
4. Both brain architecture and developing abilities are built “from the bottom up” [i.e., from the least complex functioning to the most complex], with simple circuits and skills providing the scaffolding for more advanced circuits and skills over time.
5. Cognitive, emotional, and social capabilities are inextricably intertwined throughout the life course.
6. Toxic stress in early childhood is associated with persistent effects on the nervous system and stress hormone systems that can damage developing brain architecture and lead to lifelong problems in learning, behavior, and both physical and mental health.
7. Creating the right conditions for early childhood development is likely to be more effective and less costly than addressing problems at a later age.

behavior, and health across the lifespan. Three key findings about early brain development are summarized in this section of the report, specifically (a) core concepts about brain development, (b) the “serve and return” interaction, and (c) the impact of neglect. See Sidebar 5 for an overview of key findings about (a) synaptic connections and pruning, (b) myelination, and (c) plasticity.

Core Concepts About Brain Development.

The National Scientific Council on the Developing Child (2007b, pp. 1-2) delineated seven core concepts about brain development (see text box on the previous page) that were derived from “decades of rigorous research in neurobiology, developmental psychology, and the economics of human capital formation” (p. 1); several of these core concepts are discussed in this report.

The “Serve and Return” Interaction. Research has shown that “the architecture of the brain depends on the mutual influences of genetics [i.e., the basic plan for brain development], environment [i.e., the child’s pre- and postnatal contexts], and experience [the interaction of the child with his or her environment]” (National Scientific Council on the Developing Child, 2007a, p. 2). Young children’s early environments and experiences influence how their genetic plan unfolds (National Scientific Council on the Developing Child, 2007b, 2010a); early environments and experiences also shape the processes that determine whether their brains will have a strong or a weak foundation for later learning, memory, logical reasoning, executive functioning, self-regulation, expressing emotions, socialization, and behavior control (Center on the Developing Child at Harvard University, 2010; Hawley, 2000; National Research Council and Institute of Medicine, 2000; National Scientific Council on the Developing Child, 2004a, 2004b, 2007a, 2010a, 2010b, 2012a; Perry, 2000; Shonkoff, 2009; Thompson, 2001).

Developing brains need proper nutrition, regularly scheduled periods of sleep, physical activity, a variety of stimulating experiences, protection from environmental threats and toxins (e.g., community violence, lead), and protection or buffering from adverse childhood experiences (Center on the Developing Child at Harvard University, 2010; Thompson, 2001). Developing brains also need attuned, emotionally available and responsive parents

SIDEBAR 5

Key Aspects of Early Brain Development

The following is a synthesis of findings from the following reports: Bronfenbrenner Center for Translational Research, 2013; Child Welfare Information Gateway, 2009; Jim Casey Youth Opportunities Initiative, 2011; Moretti & Peled, 2004; Steinberg, 2011.

Synaptic Connections and Pruning

The ability of the human brain to transmit and process information is a function of neurons (nerve cells) communicating with each other. In this process, neurons do not actually touch each other but come close together at tiny gaps called synapses. A synapse is the critical communication link between neurons; a key process in brain development is the formation of synaptic connections. Although some synaptic connections are genetically programmed, others are formed through experiences. “The development of new synapses continues throughout life as we learn new skills, build memories, acquire knowledge, and adapt to changing circumstances” (Steinberg, 2011, p. 69). It may seem that having a proliferation of synapses is essential for efficient brain functioning, but this is not the case. Synaptic pruning—eliminating unused or underused synapses—is a normal and necessary process that enhances and refines the brain’s functioning.

In the developing human brain there is a massive early overgrowth in the number of connections or synapses between neurons (thus allowing a high degree of malleability in the brains of the very young). This early overabundance of synapses is countered by two major bouts of synaptic pruning, the first of which occurs in early childhood (around age three) and the second of which occurs during adolescence. . . . This cortical thinning is a marker of brain maturation and is associated with more adult-like cognitive abilities. During pruning, any neural connections that have not been consistently used are eliminated (Bronfenbrenner Center for Translational Research, 2013, para. 2-3).

Myelination

During the course of development another critical process occurs that contributes to the efficiency and refinement of brain functioning. Occurring in waves beginning in the prenatal period and continuing through young adulthood, white fatty tissue called myelin encases the projections (axons) of neurons. Myelination increases the speed and improves the efficiency of information processing between and within regions of the brain.

Plasticity

Plasticity refers to the brain’s ability to change in response to experience or repeated stimulation (Child Welfare Information Gateway, 2009; Kendall-Tackett, 2013). “While cortex plasticity may lessen as a child gets older, some degree of plasticity remains. In fact, this brain plasticity is what allows us to keep learning into adulthood and throughout our lives” (Child Welfare Information Gateway, 2009, p. 4).

Key Terms

- **Myelination:** The process through which neurons (nerve cells) are insulated, which improves the efficiency of neuronal functioning
- **Neglect:** The deprivation of necessities, including significant absence of caregiver responsiveness
- **Plasticity:** The brain's ability to change in response to experience or repeated stimulation
- **Serve and Return:** The ongoing process in which young children naturally reach out for interaction through babbling, facial expressions, gestures, and words, and adults respond in a similar manner
- **Synaptic Pruning:** The process through which unused or underused connections between neurons (nerve cells) are eliminated, which improves the efficiency of neuronal functioning

and other primary caregivers who recognize and consistently attend to the needs of young children, and interact with them in an affectionate, sensitive, responsive, and nurturing manner (Center on the Developing Child at Harvard University, 2010; National Scientific Council on the Developing Child, 2004a).

For example, a process called the “serve and return” interaction between a young child and an adult is critical for healthy brain development. Serve and return occurs when a young child solicits interaction through babbling, gestures, facial expressions, words, cries, or focusing on an interesting object (the “serve”), and an adult shares and supports the child’s experience by responding in a manner in sync with the child (the “return”) (National Scientific Council on the Developing Child, 2004a, 2007b, 2012b; Shonkoff, 2009). The serve and return interaction helps to create neural connections in the young brain that build later cognitive and emotional skills (Shonkoff, 2009). In addition, the serve and return interaction “works best when it is embedded in an ongoing relationship between a child and an adult who is responsive to the child’s own unique individuality. Decades of research tells us that mutually rewarding interactions are essential prerequisites for the development of healthy brain circuits and increasingly complex skills” (National Scientific Council on the Developing Child, 2007b, p. 6).

Conversely, “in the absence of such responses—or if the responses are unreliable or inappropriate—the brain’s architecture does not form as expected, which

can lead to disparities in learning and behavior” (Shonkoff, 2009, p. 2). Early brain development also can be compromised when a child is exposed to an environment in which there is inadequate nutrition; no protection from environmental toxins and adversity; lack of opportunity for physical activity or social-emotional developmental experiences; little or no appropriate sensory stimulation; limited exposure to language and many words; or hostile, neglectful, rejecting or non-responsive child-adult interactions. An adverse early environment can result in faulty brain development that can have a decisively negative impact on future cognitive and social-emotional development (Center on the Developing Child at Harvard University, 2006; Grossman et al., 2003; National Scientific Council on the Developing Child, 2007a; Shonkoff, 2009; Thompson, 2001). “Once established, a weak foundation can have detrimental effects on further brain development, even if a healthy environment is restored at a later age” (National Scientific Council on the Developing Child, 2007a, p. 1). For example:

Infants and children who are rarely spoken to, who are exposed to few toys, and who have little opportunity to explore and experiment with their environment may fail to fully develop the neural connections and pathways that facilitate later learning. Despite their normal genetic endowment, these children are at a significant intellectual disadvantage and are likely to require costly special education or other remedial services when they enter school.

Types of Neglect

- *Physical neglect*: Failure to provide adequate food, shelter, and hygiene
- *Emotional neglect*: Failure to attend to a child's emotional and/or social needs
- *Medical/dental neglect*: Failure to secure adequate treatment for an identified health problem
- *Educational neglect*: Failure to meet a child's formal learning needs
- *Failure to supervise*: Failure to provide appropriate oversight to ensure a child's safety
- *Newborns addicted or exposed to drugs*

Fortunately, intervention programs that start working with children and their families at birth or even prenatally can help prevent this tragic loss of potential. (Hawley, 2000, p. 3)

Neglect

Thoughts about the maltreatment of young children tend to conjure images of physical or sexual abuse (e.g., shaking babies); but “child neglect is the most common form of child maltreatment” (DePanfilis, 2006, p. 9). Data from the National Child Abuse and Neglect Data System (NCANDS) indicated “more than three-quarters (78.3%) of the youngest victims of maltreatment were neglected, 18.3 percent were physically abused, and 9.3 percent were sexually abused” (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2013, p. 20).

Deprivation or neglect can cause more harm to a young child's development than overt physical abuse, including subsequent cognitive delays, impairments in executive functioning, and disruptions of the body's stress response. . . . When chronic deprivation leads to persistent activation of stress response systems in a young child, it can actually disrupt and weaken developing brain architecture. Over time, the wear and tear of this excessive stress response and the

chemicals it releases can lead to academic struggles, difficulties in social adjustment, mental health problems, and even chronic physical disease. (National Scientific Council on the Developing Child, 2012b, p. 2)

Child neglect—also referred to as “deprivation of necessities”—is defined in the NCANDS glossary (U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2000) as “a type of maltreatment that refers to the failure by the caretaker to provide needed, age-appropriate care although financially able to do so, or offered financial or other means to do so” (p. 7). The six types of neglect typically listed in the child maltreatment prevention literature are indicated in the text box above (see, e.g., DePanfilis, 2006; Leeb, Paulozzi, Melanson, Simon, & Arias, 2008; U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2000).

The National Scientific Council on the Developing Child (2012b) broadly defined child neglect as “the ongoing disruption or significant absence of caregiver responsiveness” (p. 2), and asserted: “Using science as our guide, we have delineated four types of diminished responsiveness and their consequences in order to provide a useful framework for developing more effective strategies to protect vulnerable children from

TABLE 5. Types of Diminished Responsiveness/Neglect (National Scientific Council on the Developing Child, 2012b, p. 3)

Type of Diminished Responsiveness	Features
Occasional inattention	Intermittent, diminished attention in an otherwise responsive environment
Chronic under-stimulation	Ongoing, diminished level of child-focused responsiveness and developmental enrichment
Severe neglect in a family context	Significant, ongoing absence of serve and return interaction, often associated with a failure to provide for basic needs
Severe neglect in an institutional context	“Warehouse-like” conditions with many children, few caregivers, and no individualized adult-child relationships that are reliably responsive

this complex challenge” (p. 3). The four types are listed and defined in Table 5.

Numerous definitions of neglect focus on failure by a caretaker to provide care for or responsiveness to a child. In a report titled “Child Neglect: It’s More Than a Family Matter,” the National Alliance of Children’s Trust and Prevention Funds (2013a) defined child neglect more comprehensively using a social-ecological framework. “Child neglect is a failure to meet children’s basic needs—whether the failure is the responsibility of parents, communities, or society—and this void places children in harm’s way” (National Alliance of Children’s Trust and Prevention Funds, 2013a, p. 2).

Although many negative impacts of severe neglect have been identified—such as cognitive and attachment problems, deficits in executive functions, difficulties with self-regulation, and academic delays (see, e.g., DePanfilis, 2006)—studies have shown timely, systematic evidence-based interventions can reduce or reverse many negative impacts (National Scientific Council on the Developing Child, 2012b). “The mere removal of a young child from an environment of severe neglect is not a guarantee of positive outcomes. Children who experience significant deprivation typically need therapeutic, supportive care to facilitate their recovery” (National Scientific Council on the Developing Child, 2012b, p. 9). In addition, various “protections” in the community and societal domains of the social ecology (e.g., family policies that provide supports families need) should

be addressed in order to prevent in the first place or mitigate the effects of child neglect (National Alliance of Children’s Trust and Prevention Funds, 2013a).

Language and Vocabulary Development

Acquiring facility with the language of one’s culture is an extremely important social, emotional, and cognitive accomplishment in early childhood; it is crucial to learning and making sense of the world, to communicating thoughts and emotions effectively, and to building relationships with others. Studies have shown that early language and vocabulary development is related to later reading skills and comprehension and school success in general (Chall, Jacobs, & Baldwin, 1990; Hart & Risley, 1995; Pungello, Iruka, Dotterer, Mills-Koonce, & Reznick, 2009).

The seminal longitudinal study conducted by Hart and Risley (1995) focused on the effects of children’s home experiences on language and vocabulary development among “ordinary, well-functioning” families. The families were grouped into three categories based on parents’ occupation, which was strongly associated with parents’ education level and family income. The categories were professional families, working class families, and families receiving welfare assistance. All 42 families who remained in the study during the two-and-a-half-year period were observed for one hour each month. A summary of findings from the study is provided in Sidebar 6.

The overall finding from this study was that, although all the children had quality interactive language experiences, there were extreme differences among the families in the amount of children's exposure to language that resulted in great imbalances in children's vocabularies over time (Hart & Risley, 2003). "The basic finding is that children who learn fewer words also have fewer experiences with words in interactions with other persons. . . and acquire a vocabulary of words more slowly" (Hart & Risley, 1995, pp. x-xi).

The research conducted by Fernald, Marchman, and Weisleder (2013) confirmed and extended earlier findings about income-based disparities in children's vocabulary (Snow, 2013). "Fernald's research extends our current understanding by not just looking at the size of children's vocabulary, but how children process words in their vocabulary [para. 2]. . . . Not only do children from lower income homes tend to have smaller vocabularies as early as 18-months, they also process language less quickly than their peers from higher-income homes" (Snow, 2013, para. 4). But as research about early brain development has indicated, the young brain is malleable and can be changed with different experiences (Center on the Developing Child at Harvard University, 2010; National Scientific Council on the Developing Child, 2007b). Thus, eliminating these language inequities will require access to new experiences and opportunities that will actively and intentionally help to cultivate children's language and vocabulary skills (Colker, 2013).

Acquiring Knowledge of Parenting and Child Development

What parents do and how they treat children is often a reflection of the way they were parented (Hart Research Associates, 2009). Acquiring new knowledge about parenting and child development enables parents to critically evaluate the impact of their experiences on their own development and their current parenting practices, and to consider that there may be more effective ways of guiding and responding to their children. Understanding the mounting evidence about the nature and importance of early brain development enables parents and educators to know what children need most in order to thrive and succeed in school and in life, specifically:

SIDEBAR 6

Findings from a Study of the Effects of Home Experiences on Language Development (Hart & Risley, 2003)

A longitudinal study of the effects of home experiences on young children's language development among professional families, working class families, and families receiving welfare assistance, found:

- The differences in children's academic successes at ages 9 and 10 were strongly correlated with the amount of talk they heard from birth to age 3.
- Children in professional families heard more words per hour, resulting in larger cumulative vocabularies. Children in each category heard an average of:
 - 2,153 words per hour in professional families
 - 1,251 words per hour in working class families
 - 616 words per hour in families receiving welfare support
- This means that "in four years of such experience, an average child in a professional family would have accumulated experience with almost 45 million words, an average child in a working class family would have accumulated experience with 26 million words, and an average child in a welfare family would have accumulated experience with 13 million words" (p. 8)—hence what has been dubbed "the 30 million word gap."
- Children in professional families heard a higher ratio of encouraging words to discouraging words than children in working class families and those receiving welfare assistance.
- When the quantity of talk by low-income parents was similar to that of more educated parents, low-income children's language development was just as good as that of more economically advantaged peers" (Child Welfare Information Gateway, 2009, p. 4).

- Nurturing, responsive, reliable, and trusting relationships
- Regular, predictable, and consistent routines
- Interactive language experiences
- A physically and emotionally safe environment
- Opportunities to explore and to learn by doing and repeating activities

Social and Emotional Competence of Children



The Strengthening Families approach reflects the well-established finding that acquiring social and emotional competence is the primary developmental task of early childhood because it impacts all other developmental domains—physical growth, language development, and cognitive skills—and lays the foundation for later development (American Academy of Pediatrics, n.d.; The Annie E. Casey Foundation, 2013; Brazelton & Greenspan, 2000; Brazelton & Sparrow, 2006; Center on the Developing Child at Harvard University, 2011; National Scientific Council on the Developing Child, 2004b; Raver, 2002; Yates et al., 2008). The Center on the Social and Emotional Foundations for Early Learning (n.d.) defined social and emotional competence as “the developing capacity of the child from birth through 5 years of age to form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways; and explore the environment and learn—all in the context of family, community, and culture” (p. 6). Similarly, the National Scientific Council on the Developing Child (2004b) identified the core features of social and emotional competence as “the ability to identify and understand one’s own feelings, to accurately read and comprehend emotional states in others, to manage strong emotions and their expression in a constructive manner, to regulate one’s own behavior, to develop empathy for

Social and emotional competence is defined as, “the developing capacity of the child from birth through 5 years of age to form close and secure adult and peer relationships; experience, regulate, and express emotions in socially and culturally appropriate ways; and explore the environment and learn—all in the context of family, community, and culture” (Center on the Social and Emotional Foundations for Early Learning, n.d., p. 6).

others, and to establish and sustain relationships” (p. 1).

In research, policy, and practice, the emphasis on cultivating cognitive development in early childhood as the foundation for school readiness has often overshadowed the importance of social and emotional competence (Aber et al., 2000; The Annie E. Casey Foundation, 2013; Boyd, Barnett, Leong, Bodrova, & Gomby, 2005; National Scientific Council on the Developing Child, 2004b; Raver, 2002; Yates et al., 2008). Yet, research has consistently demonstrated that the development of social and emotional competence is as important as cognitive competence during this critical developmental period and beyond.

The foundations of social competence that are developed in the first five years are linked to emotional well-being and affect a child’s later ability to functionally adapt in school and to form successful relationships throughout life. As a person develops into adulthood, these same social skills are essential for the formation of lasting friendships and intimate relationships, effective parenting, the ability to hold a job and work well with others, and for becoming a contributing member of a community. (National Scientific Council on the Developing Child, 2004b, p. 1)

“Social emotional development within the first few years of life sets a precedent and prepares children to be self-confident, trusting, empathic, intellectually inquisitive, competent in using language to communicate, and capable of relating well to others” (American Academy of Pediatrics, n.d., p. 1).

Furthermore, social and emotional competence and cognitive competence are not independent domains of development (Shonkoff, 2009). “Cognitive, emotional, and social capabilities are inextricably intertwined throughout the life course. The brain is a highly integrated organ and its multiple functions operate in a richly coordinated fashion. Emotional well-being and social competence provide a strong foundation for emerging cognitive abilities, and together they are

the bricks and mortar that comprise the foundation of human development” (National Scientific Council on the Developing Child, 2004b, p. 8).

Social and emotional competence in young children does not evolve naturally; it is influenced by the interaction of biological factors (e.g., the child’s temperament), social factors (e.g., adult-child relationships), and environmental factors (e.g., child abuse or neglect) (Honig, 2002; Thompson, 2001). The National Scientific Council on the Developing Child (2004b) pointed out that “emotional development is actually built into the architecture of young children’s brains in response to their individual personal experiences and the influences of the environments in which they live. Indeed, emotion is a biologically based aspect of human functioning that is ‘wired’ into multiple regions of the central nervous system” (p. 1).

Numerous research studies (see, e.g., National Research Council and Institute of Medicine, 2000; National Scientific Council on the Developing Child, 2004a, 2004b; Shonkoff & Garner, 2012; Thompson, 2001) indicate that the most significant factors in developing a strong foundation for social and emotional competence are “children’s relationships, the activities they have opportunities to engage in, and the places in which they live, learn, and play” (Center on

“The approach to teaching social-emotional development is more vague than physical or cognitive development, but there is an increasing amount of research available to support it. This being said, we as parents and educators must learn to read our child’s emotional cues so that we can help them identify their emotions; model the behavior for our children; interact with our child affectionately; show consideration for their feelings, desires and needs; express interest in their daily activities; respect their viewpoints; express pride in their accomplishments; and provide encouragement and support during times of stress” (Mid-State Central Early Childhood Direction Center of Syracuse University, 2009, p. 1).

the Developing Child at Harvard University, n.d., p. 1). More specifically, these studies have shown social and emotional competence is promoted by the conditions and experiences delineated in the text box below.

Factors That Promote Social and Emotional Competence in Young Children

- Parents and other adult caregivers whose social and emotional competence is well developed
- A warm, nurturing, and trusting relationship with at least one parent or other adult caregiver
- Intentional actions of parents or other adult caregivers designed to promote social and emotional competence (e.g., modeling skills; practicing skills with the child)
- Consistent, affectionate, sensitive, and responsive care and interaction from parents and other adult caregivers
- The positive and encouraging messages communicated to children—directly or indirectly—about themselves
- Regular and predictable routines
- A physically and emotionally safe environment that provides for basic physiological needs, protects children from harm, or mitigates the effects of adversity
- An interactive language-rich environment that promotes vocabulary development, talking, and reading, and encourages children to express their emotions
- An environment that encourages developmentally appropriate play and opportunities to explore and to learn by doing

Attachment

The construct “attachment” is conceived as the close, loving, and enduring emotional bond between an infant and a primary caregiver (usually the mother) that is essential for healthy development and survival (Center on the Developing Child at Harvard University, 2010; Laible, Carlo, & Raffaelli, 2000; Moretti & Peled, 2004; Steinberg, 2011). Several findings emerging from the research on attachment include:

- Infants’ positive or negative experiences with a primary caregiver shape their attachment response: warm, available, responsive caregiving leads to a secure attachment, whereas indifferent, inconsistent, or harsh caregiving leads to some form of insecure attachment (Center on the Developing Child at Harvard University, 2010; Laible et al., 2000; Moretti & Peled, 2004; Steinberg, 2011).
- Securely attached infants use their primary caregiver “both as a ‘secure base’ from which to explore, and as a ‘safe haven’ for obtaining support and protection in times of perceived threat” (Moretti & Peled, 2004, p. 552).
- “Early, secure attachments contribute to the growth of a broad range of competencies, including a love of learning, a comfortable sense of oneself, positive social skills, multiple successful relationships at later ages, and a sophisticated understanding of emotions, commitment, morality, and other aspects of human relationships” (National Scientific Council on the Developing Child, 2004a, p. 1).
- The nature of early experiences and subsequent initial attachment status forms the basis of an internal working model (Furman, Simon, Shaffer, & Bouchey, 2002; Kendall-Tackett, 2013; Steinberg, 2011)—that is, beliefs and expectations—that “determines to a large measure whether individuals feel trusting or apprehensive in relationships with others and whether they see themselves as worthy of others’ affection” (Steinberg, 2011, pp. 310-311).

Although some studies have found that an early internal working model regarding attachment tends to persist across the lifespan and across interpersonal domains (see, e.g., Center on the Developing Child at Harvard University, 2010; Furman et al., 2002; Kendall-Tackett, 2013; McElhaney, Allen, Stephenson,

& Hare, 2009), researchers also acknowledge young children’s internal working model can be revised across developmental periods and their secure or insecure attachment status can shift with changing experiences (Moretti & Peled, 2004; Steinberg, 2011; Thompson, 2001). Thus, a wholesome infancy that creates a secure attachment does not inoculate a child from later challenging or traumatic experiences (e.g., death of a parent) that can result in an insecure attachment. Conversely, young children who experience early trauma can have later experiences that forge a secure attachment. “Sensitive, responsive care thus remains a continuing need of young children throughout the early years at home and in child care” (Thompson, 2001, p. 26).

Parent-Child Connectedness

The construct “parent-child connectedness” is rooted in, but expands, the notion of attachment to include all significant relationships that can be deliberately forged across the lifespan (Boutelle, Eisenberg, Gregory, & Neumark-Sztainer, 2009; Laible et al., 2000). Parent-child connectedness is regarded as a bidirectional, dynamic relationship in which parents and children are active agents (Boutelle et al., 2009; Lezin, Rolleri, Bean, & Taylor, 2004; Rolleri, Bean, & Ecker, 2006). Parent-child connectedness is “characterized by the *quality* of the emotional bond between parent and child and by the degree to which this bond is both *mutual* and *sustained* over time” (Lezin et al., 2004, p. 6). The high quality of the emotional bond contributes to parent-child interactions that are largely pleasant and that serve as buffers from various stressors.

“In order to develop normally, a child requires progressively more complex joint activity with one or more adults who have an irrational emotional relationship with the child. Somebody’s got to be crazy about that kid. That’s number one. First, last, and always” (Urie Bronfenbrenner, cited in National Scientific Council on the Developing Child, 2004a, p.1).

Parent Behaviors for Promoting Parent-Child Connectedness (Rolleri et al., 2006)

- Provide the basic physiological needs (e.g., food, shelter, protection)
- Build and maintain trust
- Demonstrate love, care, and affection
- Share activities with children
- Prevent, negotiate, and resolve family conflicts
- Establish and maintain structure
- Communicate effectively

Rolleri and colleagues (2006) developed a logic model of parent-child connectedness. Although the actions that promote parent-child connectedness are different across developmental periods, these researchers identified seven key parent behaviors that are essential for establishing, maintaining, and increasing parent-child connectedness, irrespective of the child's age (see text box above). The outcome of consistently engaging in these behaviors is said to be a relatively lasting bond of respect, trust, love, and affection between the parent and the child, which is actualized and observed in their interactions, as well as the child's interactions with others.

Children who have healthy relationships with their primary caregivers are more likely to develop insights into other people's feelings, needs, and thoughts, which form a foundation for cooperative interactions with others [e.g., peers] and an emerging conscience. Sensitive and responsive parent-child relationships also are associated with stronger cognitive skills in young children and enhanced social competence and work skills later in school. (National Scientific Council on the Developing Child, 2004a, p. 2)

Many children's life circumstances do not support the promotion of parent-child connectedness, and therefore of social and emotional competence. That is, many children are in environments that are unsafe, unstable, unstimulating, language-poor, or sources of toxic stress, or their care is inconsistent, unresponsive, abusive, neglectful, or rejecting. A growing body of research has shown that these types of early adverse environments and experiences place young

children at risk for limited language and cognitive skills, difficulties interacting effectively with their peers, insecure attachments, developmental delays, behavioral and mental health problems, and an array of health problems and conditions (e.g., lung disease, cancer, depression, alcoholism) later in life (Boyd et al., 2005; Center on the Developing Child at Harvard University, 2010, 2011, n.d.; Felitti, 2002a; Stark & Chazan-Cohen, 2012).

In a policy brief by Cooper, Masi, and Vick (2009), the National Center for Children in Poverty reported that unmet social and emotional developmental needs in early childhood can have negative effects later in life, such as conduct problems, delinquency, and antisocial behaviors. Their data showed: (a) between 9.5% and 14.2% of children between 0-5 years old experience social and emotional problems; (b) approximately 9% of children who receive specialty mental health services in the United States are between 0-5 years old; and (c) almost 40% of 2-year-olds in early care and education settings had insecure attachment relationships with their mothers. Thus, there is increasing evidence that addressing social and emotional development should be a priority for parents, policymakers, early childhood educators, pediatricians, infant mental health providers, social workers, and others who work with young children and their families (Boyd et al., 2005; Cooper et al., 2009; National Scientific Council on the Developing Child, 2004b; Raver, 2002). This becomes an even greater imperative when serving vulnerable and highly stressed young children and their families, given the potential for positive impact in many domains across the lifespan (National Research Council and Institute of Medicine, 2000).

Key Terms

- **Attachment:** Close, loving emotional bond between an infant and a primary caregiver
- **Executive functions:** A broad number of interrelated processes that contribute to self-regulation and influence both cognitive processes and social-emotional behaviors
- **Parent-Child Connectedness:** The close, high-quality, bidirectional relationship between a parent and a child that is sustained over time
- **Self-Regulation:** The effortful control and coordination of one's thoughts, emotions, and behaviors, as well as the ability to adapt one's behavior in order to achieve a desired outcome
- **Social Cognition:** The cognitive processes involved in the perception of others, the norms of the social world, and self-awareness and understanding

The American Academy of Pediatrics (n.d.) described the importance of nurturing and supportive relationships for young children, with respect to their early brain development, as follows:

During the first few years of life, no aspect of the child's environment is more important for proper brain development than his or her connections with others. . . . Nurturing and supportive social connections early in life promote healthy emotional regulation, and that allows for optimal brain development and function. Conversely, excessive or prolonged stress in absence of social supports activates and strengthens the neuronal connections underlying the stress response, setting up a brain that is wired more for stress and survival and less for learning and empathy. (p. 5)

The components of social and emotional competence highlighted in the Strengthening Families approach are self-awareness, self-regulation, and executive functions.

Social Cognition and Self-Awareness

Beer and Ochsner (2006) defined social cognition as “the processes by which people understand themselves and other people [p. 98]; . . . the perception of others, the perception of self, and interpersonal knowledge” (p. 99). Zelazo (2011) indicated research has shown, “children with strong social cognition tend to have stronger language abilities, emotion regulation and

executive function skills (e.g., planning skills, self-control, and cognitive flexibility). By controlling their behaviors and emotions, they are better able to take another's perspective and to get along with others” (p. ii). Perry (2002) identified six “core strengths that can help promote health and decrease risk for a host of emotional, social, behavioral and cognitive problems” (p. 2). These core strengths support the importance of promoting social cognition in young children—that is, understanding and appreciating oneself and others—specifically (Perry, 2005, p. 4):

- **Attachment:** Being able to form and maintain healthy emotional bonds and relationships
- **Self-regulation:** Containing impulses; the ability to notice and control primary urges as well as feelings such as frustration
- **Affiliation:** Being able to join and contribute to a group
- **Attunement:** Being aware of others, recognizing the needs, interests, strengths, and values of others
- **Tolerance:** Understanding and accepting differences in others
- **Respect:** Finding value in differences, appreciating worth in yourself and others

Self-awareness and self-understanding are major aspects of social cognition. Self-awareness and self-understanding are “highly dependent on the evaluation of others. . . especially those to whom the child is emotionally attached” (Thompson, 2011, p. 27). Young children's evaluative messages about themselves tend to come—directly or indirectly—from

TABLE 6. Self-Awareness and Self-Understanding Processes

Process	Definition
Empathy	Understanding and responding to the emotions and rights of others
Personal agency	Taking responsibility for one's self and one's decisions and having confidence to overcome obstacles
Perspective taking	Taking the viewpoint—thoughts, beliefs, or feelings—of another person
Self-compassion	Being kind to oneself when confronted with personal failings and suffering
Self-concept	Stable ideas about oneself
Self-confidence	Being open to new challenges and willing to explore new environments
Self-efficacy	Having realistic beliefs about one's capabilities
Self-esteem	Feelings about oneself
Social skills	Making friends and getting along with others
Theory of mind	Thinking about the minds and the mental states of others; that is, their beliefs, desires, and intentions

parents (e.g., receiving positive or negative feedback about one's abilities), peers (e.g., being well-liked or bullied), and other adults in the child's life (e.g., teachers celebrating or ignoring the child's successes).

Early perceptions of self are also linked to being securely or insecurely attached to a parent. One aspect of the comprehensive longitudinal study of risk and adaptation across the lifespan conducted by Sroufe, Egeland, Carlson, and Collins (2005) was an examination of the relationship between preschool children's attachment status and their self-reliance, self-esteem, and self-confidence. Based on teachers' rankings and classroom observations, children with insecure attachment histories demonstrated higher dependency (i.e., less self-reliance) than children with secure attachment histories (e.g., frequently seeking help with self-management or in social-management contexts, seeking help in negative ways, or sitting in the teacher's lap).

Completely parallel to these data were rankings and ratings of self-esteem and agency, or self-confidence. . . . The highest ranked children on self-esteem. . . were virtually all those with histories of secure attachment, while those ranked near the bottom were nearly all those with anxious [insecure] attachment. . . .

Likewise, children with secure histories were rated significantly higher on self-confidence. (Sroufe et al., 2005, p. 134)

Table 6 provides a list and definitions of processes involved in self-awareness and self-understanding, extrapolated from numerous sources previously cited, that begin to emerge in early childhood and continue to develop in adolescence and adulthood. These processes contribute to social and emotional competence.

Self-Regulation and Executive Functions

Self-regulation and executive functions are commonly defined in the research literature as follows (see, e.g., Boyd et al., 2005; Carlson, 2005; Center on the Developing Child at Harvard University, 2011; Choudhury, Blakemore, & Charman, 2006; Crone, 2009):

- **Self-regulation:** (a) the effortful control and coordination of one's thoughts, emotions, and behaviors (i.e., the capacity to stop doing something inappropriate or unnecessary and to start doing something that is appropriate or necessary); (b) the

TABLE 7. Executive Functions

Executive Function	Definition
Behavioral self-regulation	Staying on task even in the face of distractions
Cognitive flexibility	Seeing alternate solutions to problems; shifting perspective; moving from one situation to another
Cognitive self-regulation	Exercising control over thinking; planning and thinking ahead; making adjustments as necessary; identifying and challenging unhealthy thinking
Communication skills	Understanding and expressing a range of positive and negative emotions
Conflict resolution	Resolving disagreements in a peaceful way
Consequential thinking	Considering the outcomes of one's thoughts, feelings, and actions before acting
Emotional control	Modulating emotional responses by bringing rational thought to bear on feelings
Inhibition	Stopping one's own behavior at the appropriate time, including stopping actions and thoughts
Initiation	Beginning a task or an activity and independently generating ideas, responses, or problem-solving strategies
Patience	Learning to wait
Persistence	Willingness to try again when first attempts are not successful
Planning and organization	Having a goal and using reasoning to achieve it; the ability to manage current and future-oriented task demands; imposing order
Problem solving	Understanding what is needed to solve the problem; developing and executing a plan; evaluating the adequacy of the attempted solution
Prospective memory	Holding in mind an intention to carry out an action at a future time
Selective attention	Focusing on a particular object, while simultaneously ignoring irrelevant information that is also occurring
Self-monitoring	Monitoring one's own performance and measuring it against some standard of what is needed or expected
Self-talk	Reflecting; instructing oneself; self-questioning
Social-emotional self-regulation	Exercising control over reactions to positive and negative situations; delaying gratification; labeling one's and others' emotions accurately; expressing emotions in healthy ways; taking ownership of emotions
Visual imagery	Imagining attaining one's goals
Working memory	Following instructions sequentially and holding information in mind while engaging in another activity

ability to adapt and alter one's behavior in order to achieve a desired outcome.

- **Executive functions:** a broad number of interrelated cognitive processes that contribute to self-regulation and that influence both cognitive processes (e.g., learning new subject matter; perceptions of oneself and others) and social-emotional behaviors (e.g., delaying gratification).

The development of self-regulation and executive functions in early childhood is linked to the nature of young children's environments and parent-child experiences (American Academy of Pediatrics, n.d.; Boris & Page, 2012; Center on the Developing Child at Harvard University, 2011).

A sensitive and responsive caregiver accurately interprets the infant's expressions of distress and effectively soothes him or her. Through the experience of having a caregiver sensitively respond in a contingent fashion—that is, in a way that relates to the infant's behavior and emotional state—the infant learns how to self-regulate. Infants who are able to self-regulate can manage feelings of distress with increasing independence and self-direction. (Boris & Page, 2012, p. 130)

Also, neuroscience research has shown that the development of self-regulation and executive functions in early childhood is linked to early brain development (American Academy of Pediatrics, n.d.; Center on the Developing Child at Harvard University, 2011). As abilities that are learned, self-regulation and executive functions must be practiced. "Generally, if children do not practice deliberate and purposeful behaviors, traces in the brain are not reinforced ('use it or lose it' principle). So, if preschoolers do not practice self-regulation enough, the related brain areas will not be fully developed" (Boyd et al., 2005, p. 4). Similarly, the American Academy of Pediatrics (n.d.) stated, "the inability to turn off the body's stress response can disrupt the neuronal connections that are forming within important areas of the brain, including those responsible for learning, memory and planning" (p. 5).

The nature and importance of executive functions has received a great deal of attention due to the national concern about young children and school readiness.

Executive functions. . . help children control their attention and behavior. These executive function skills appear to be essential for school readiness and show rapid development around ages 3 to 7. . . . School success requires executive functions, including skills to direct attention, ignore distractions, control impulses, follow rules, and also flexibly adapt to rule changes. Whether a child is learning to read, minding the teacher about classroom rules, or getting along with other children, these self-regulation skills are fundamental tools for learning. Research has indicated that these "tools of the mind" are particularly important for high-risk children, and also that stressful early experiences might disrupt their development. (Masten et al., 2008, p. 5)

Table 7 (on the previous page) provides a list and definitions of self-regulation and executive functions, extrapolated from numerous sources previously cited, that begin to emerge in early childhood and continue to develop in adolescence and adulthood.

Facilitating the Social and Emotional Competence of Children

The quality of experiences parents and other caregivers provide for young children can either strengthen or undermine the development of self-regulation and executive functions (Shonkoff, 2013). But, parents and other caregivers must have these skills themselves in order to model, use, and support the development of self-regulation and executive functions in children (Center on the Developing Child at Harvard University, n.d.; Jones & Lesaux, 2013; Mid-State Central Early Childhood Direction Center of Syracuse University, 2009; Shonkoff, 2013; Stark & Chazan-Cohen, 2012).

"When their own core capacities and mental health needs are addressed, adults are better equipped to promote the development of competence in the children who rely on their care" (Shonkoff, 2013, para. 8).

Parents who grew up with consistently nurturing experiences and emotionally available caregivers are better equipped to be attuned and responsive to their own children or the children with whom they work. Being able to read an infant's and a young child's cues and being responsive to them lays the foundation for a trusting, predictable, loving relationship and supports the development of social and emotional competence. In contrast, parents and caregivers whose self-regulation and executive functions are not well developed need experiences that will cultivate their social and emotional competence. "Programs such as job-skills training that intentionally build executive function and self-regulation capacities in adult caregivers not only help them become more economically secure, but they also enhance their ability to model and support these skills in children" (Center on the Developing Child at Harvard University, n.d., p. 2).

When the mental health of parents or caregivers is severely compromised, the child's healthy development and well-being is threatened as well. For example, numerous studies have found a relationship among maternal depression, poor parenting, and negative impacts on the child (see, e.g., Beeber & Chazan-Cohen, 2012; Center on the Developing Child at Harvard University, 2009, 2010; Stark & Chazan-Cohen, 2012).

Depressive symptoms in the mother typically result in one of two interactional patterns. Depression may "blunt" a mother by stifling her conversation and eye contact, keeping her voice at a monotone, slowing down playfulness, and dampening her joy and enthusiasm toward the infant or toddler. Depressive symptoms may also disrupt a mother's responsiveness, creating irritable, intrusive, or rough patterns of mothering and preventing her from being a sensitive, supportive presence. (Beeber & Chazan-Cohen, 2012, pp. 45-46)

The effects of maternal depression on child development, behavior, and well-being are wide ranging, including problems with (a) forming a secure attachment, (b) the serve and return interaction, (c) executive functions (e.g., poor self-control), and (d) self-awareness (e.g., low self-esteem) (Gurian, 2003). In addition, "children who experience maternal

depression early in life may experience lasting effects on their brain architecture and persistent disruptions of their stress response systems. . . . Effects on stress response systems are one mechanism linking maternal depression to the child's own risk of developing depression and other emotional disorders" (Center on the Developing Child at Harvard University, 2009, pp. 3-4).

It may seem reasonable to assume that interventions focused on reducing maternal depression would have the secondary benefits of increasing the likelihood of improved parenting and better child outcomes; but this is not the case. In accordance with the Strengthening Families perspective about the important role of protective factors, reducing risk alone (e.g., maternal depression) is necessary but not sufficient to promote better child outcomes. The Center on the Developing Child at Harvard University (2009) cited several interventions "that have improved mothers' depressive symptoms but have not had measurable effects on children's development. . . . Limited but promising evidence suggests that treatments designed to improve child well-being must attend both to relieving mothers' depression and to focusing on parenting behavior and interactions with the child as central dimensions of the intervention" (pp. 7-8).

Within the Strengthening Families approach, self-regulation, executive functions, and social cognition and self-awareness are viewed as the essential components of social and emotional competence that lay the foundation for learning and problem solving, identity development, communication skills, and effective interpersonal relationships. The development of social and emotional competence is directly related to consistently nurturing and responsive care. Based on a review and synthesis of research on social and emotional competence, the Mid-State Central Early Childhood Direction Center of Syracuse University (2009) concluded:

A child's social-emotional development provides them with a sense of who they are in the world, how they learn, and helps them establish quality relationships with others. It is what drives an individual to communicate, connect with others and more importantly helps resolve conflicts, gain confidence and

reach goals. Building a strong social-emotional foundation as a child will help the child thrive and obtain happiness in life. They will be better equipped to handle stress and persevere through difficult times in their lives as an adult. (p. 1)

Concrete Support in Times of Need

All parents need help sometimes—help with the day-to-day care of children, help in figuring out how to soothe a colicky baby, or help getting to the emergency room when a bad accident happens. Whether parents are faced with very trying circumstances—such as losing a job, home foreclosure, substance abuse, not being able to feed their family, or trauma—or less challenging situations, they need access to concrete support that addresses their needs and helps to minimize the stress caused by challenges and adversity. Within the Strengthening Families approach, accessing concrete support in times of need focuses on three components: parents’ positive help-seeking behavior, the availability and accessibility of resources and services, and high-quality service delivery.

Help-Seeking

Given both the normative and more challenging experiences parents may face, they will need informal or formal sources of help for themselves and their children. Informal sources include people who are a part of the parents’ personal social network, such as family members, friends, neighbors, co-workers, and

members of one’s faith-based community. Formal sources include people attached to organizations or agencies that provide a service to parents, children, and families (e.g., pediatrician, school psychologist, mental health counselor, case manager). Barker’s (2007) definition of adolescent help-seeking is relevant to parents as well.

Any action or activity carried out by [a parent] who perceives herself/himself [or one’s child] as needing personal, psychological, affective assistance, or health or social services, with the purpose of meeting this need in a *positive* way. . . . We emphasize addressing the need in a positive way to distinguish help-seeking behavior from behaviors. . . which would not be considered positive from a health and well-being perspective. (p. 2)

Help-seeking is a form of self-advocacy. A frequently cited definition of self-advocacy is “the ability of an individual to effectively communicate, convey, negotiate, or assert one’s own interests, desires, needs, and rights. [The term] assumes the ability to make informed decisions. It also means taking responsibility for those decisions” (Van Reusen, Bos, Schumaker, & Deshler, 2002, p. 1). When parents have self-advocacy skills they are able to appropriately and realistically assess and describe their abilities and needs, as well as the desired supports and accommodations that address their needs.

Needing formal or informal help does not automatically result in seeking help (Keller & McDade, 2000). Some parents are reluctant to seek help because they perceive it as a sign of personal inadequacy or find it embarrassing because the services they or their

Key Terms

- **Formal Help:** Help provided by individuals in their professional role (e.g., teachers, school counselors, psychologists, social workers, psychiatrists, religious leaders, traditional healers)
- **Help-Seeking:** Actions that are intended to meet one’s needs in a positive way
- **Informal Help:** Help provided by family members, friends, and other significant people who are not acting in a professional role
- **Self-Advocacy:** Effectively communicating, conveying, negotiating, or asserting one’s own interests, desires, needs, and rights

Variables Related to Parents' Reluctance to Seek Help (Boulter & Rickwood, 2013; Giro-Herrera, Owens, & Langberg, 2013; Keller & McDade, 2000)

- Preference to seek help from informal sources (e.g., friends, religious leaders) rather than formal sources (e.g., mental health clinics)
- Poor past treatment in formal or institutional settings (e.g., paternalistic treatment by human services providers)
- Lack of trust toward those who may be in a position of authority or hostility toward those who may be economically better off
- Difficult past experience trying to matriculate through the process of getting services
- Limited awareness of and ability to recognize children's problem symptoms or behaviors
- Fear that child may be removed from the family if a problem is identified
- Lack of awareness of relevant available services
- Lack of available and accessible resources and services

children need have a stigma associated with them, such as special education programs, domestic violence shelters, or homeless shelters (Dempster, Wildman, & Keating, 2013). Other variables that have been found to be related to parents' reluctance to seek formal sources of help are listed in the text box above.

It is important for child- and parent-serving programs to provide guidance to parents about navigating the complex web of medical, mental health, human services, and social services systems and to communicate that seeking help is not an indicator of weakness or failure as a parent. On the contrary, seeking help is a step toward improving one's circumstances and learning to better manage stress and function well—even when faced with significant challenges, adversity, and trauma. When parents ask for help, it is a step toward building resilience. “Seeking help and advice is one problem-focused coping strategy that has been associated with better adjustment” (Schonert-Reichl, 2003, p. 3). It is also essential for child- and parent-serving programs to self-reflect on attitudes and practices displayed in their programs that may be contributing to parents' reluctance to seek help. “Service providers need to reestablish trust with parents by providing services that are culturally sensitive, instructive, and supportive, rather than punitive. Efforts also need to be made to provide childrearing information in innovative and appealing ways” (Keller & McDade, 2000).

The Availability and Accessibility of Resources and Services

Many parents have self-advocacy skills and are willing to seek formal help, but the needed resources and services may not be available or easily accessible. Using a social-ecological framework, Perkins, Crim, Silberman, and Brown (2004) suggested what sometimes appears as individual problems (e.g., not seeking help), “are often rooted outside the individual, family, or group and ultimately become community [or societal-level] problems” (p. 322). Community and societal barriers that impact the availability and accessibility of concrete support that parents and children may need include:

- Lack of local resources altogether (e.g., lack of funding to establish mental health services in the community)
- The inequitable distribution of services and a high-quality workforce (e.g., medical workforce shortages in rural areas; inexperienced, unqualified, out-of-field, or ineffective teachers being disproportionately distributed in schools located in poor communities)
- Services that are not easy to reach (e.g., having to travel long distances to access services)
- Services that are poorly coordinated (e.g., among schools, primary health care providers, and other social services systems)
- Lack of health insurance or restrictions by insurers

on coverage for particular services (e.g., mental health or substance abuse treatment services)

Thus, the Strengthening Families approach underscores the importance of building neighborhood capacity and addressing local, state, and federal policies—and other barriers beyond the individual and family domains—in order to achieve the effective provision of concrete support in times of need. Building neighborhood capacity includes “empowering local communities to develop and obtain the tools and resources they need to transform neighborhoods of concentrated poverty into neighborhoods of opportunity that support the optimal development and well-being of children and families” (Center for the Study of Social Policy, 2012a, para. 1). Building neighborhood capacity should also include addressing specific local, state, or federal policies that “can be made more effective by strengthening community control and implementing programs in more coordinated and integrated ways” (Perkins et al., 2004, p. 334).

Research and experience shows that families do better when they live in strong and supportive communities. In short, place matters. Yet many communities face challenges of high poverty, unemployment, failing schools, and housing instability. These outcomes are influenced by unequal access to opportunity and decades of disinvestment in neighborhoods of concentrated poverty. An equitable approach to ensuring that all neighborhoods become the kinds of places that enable all children and families to succeed and thrive requires intentional efforts to build, sustain and operationalize certain types of community capacity. (Center for the Study of Social Policy, 2012b, para. 1)

The Nature of Service Delivery

When services and resources are available and accessible, the manner in which concrete support in times of need is provided is a critical factor in influencing whether parents will seek help in the first place or benefit from help when it is provided. The Strengthening Families approach emphasizes that it

is essential to provide concrete support in a manner that does not increase stress. Services should be coordinated, respectful, caring, strengths-based, and trauma-informed.

Strengths-Based Practice with Parents and Children. Using a strengths-based approach to working with parents is advised whether working specifically with mothers, fathers (see, e.g., Tehan & McDonald, 2010), adolescent parents (see, e.g., Price-Robertson, 2010), or grandparents (see, e.g., Kropf & Robinson, 2004; Whitley, White, Kelley, & Yorke, 1999). The American Academy of Pediatrics (2013) advised:

The strength based approach at the core gives parents and children the ability to continue their development by encouraging a family’s growth and competency building across time. This approach acknowledges that parents are experts on their family and want to do right by their child. The clinician takes an active role in building parents’ knowledge and encouraging mastery while providing good ideas on how to integrate new opportunities for competency into a family’s daily life. In addition, the strength based approach encourages and is complementary to shared decision making where. . . families can problem solve with the clinician to become more efficacious in their health decision-making. (para. 4)

The principles of strengths-based practice with parents can be summarized as follows (American Academy of Pediatrics, 2013; Dion et al., 2013; Grant & Cadell, 2009; Holzer, Bromfield, & Richardson, 2006; Nissen, 2009; Saint-Jacques, Turcotte, & Pouliot, 2009; Tehan & McDonald, 2010):

1. It is essential to forge a trusting relationship between parents and service providers.
2. Strengths-based practice must focus on an individual parent’s unique strengths, with particular emphasis on their value in the parent-child relationship and what they can further contribute to the child’s well-being.
3. Parents have knowledge, competencies, and unrealized resources that must be identified, mobilized, and appreciated, regardless of the number or the level of adverse conditions they are experiencing.

4. Parents also have resources within their family or community that can be called on to help mitigate the impact of stressful conditions and to create needed change.
5. In addition to addressing each family's individual challenges, strengths-based practitioners must understand the structural inequities and conditions within the community and larger society that contribute to the family's difficulties.
6. Parents must be active participants in the change process and not passive recipients of services.

In addition, the Strengthening Families approach acknowledges the value of finding a balance between respecting culturally ascribed parenting roles and addressing parenting roles that may be contributing to family stress and discord (e.g., mother as exclusive nurturer). Overall, a strengths-based approach helps parents feel valued because they are regarded as knowledgeable and competent. A strengths-based approach helps parents develop a sense of self-confidence and self-efficacy because they have opportunities to build their skills, experience success, and provide help to others when needed.

Trauma-Informed Care with Parents and Children. Given the recent advances in the fields of neuroscience and developmental psychology, service providers must be knowledgeable about and take into account: (a) the neurological, social, emotional, and psychological development that takes place during early childhood; (b) the immediate and long-term impacts of trauma on young children; and (c) the enduring impacts of childhood trauma that may be reflected in the parent's behavior and emotions. Thus, another important aspect regarding the manner in which concrete support in times of need is provided is whether the workforce is providing help through a trauma-informed lens. That is, is the workforce cognizant of the child's and parent's trauma history, the connection between that history and the family's current functioning and behavior, and knowledgeable about and skilled in evidence-based, trauma-informed care and trauma-focused services (Chaffin & Friedrich, 2004; Klain & White, 2013; Taylor & Siegfried, 2005).

Based on a recommendation of the National Center for Trauma-Informed Care (2012), a trauma-

aware and trauma-informed workforce changes the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" "Trauma-informed care is an approach to engaging individuals with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives" (para. 2). The National Child Traumatic Stress Network (n.d., para. 2-3) stated that a trauma-informed child- and family-service system is one in which programs, agencies, and service providers:

1. Recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers
2. Routinely screen for trauma exposure and related symptoms
3. Use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms
4. Make resources available to children, families, and providers on trauma exposure, its impact, and treatment
5. Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma
6. Address parent and caregiver trauma and its impact on the family system
7. Emphasize continuity of care and collaboration across child-service systems
8. Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience

Providing Appropriate Concrete Support in Times of Need

Helping parents to identify, find, and receive concrete support in times of need helps to ensure they and their children receive the basic necessities everyone deserves in order to grow and thrive (e.g., healthy food, a safe and protective environment), as well as specialized health, mental health, social, legal, educational, or employment services. Parents need experiences that enable them to understand their rights in accessing services, gain knowledge of relevant services, and learn how to navigate through service systems. These services must

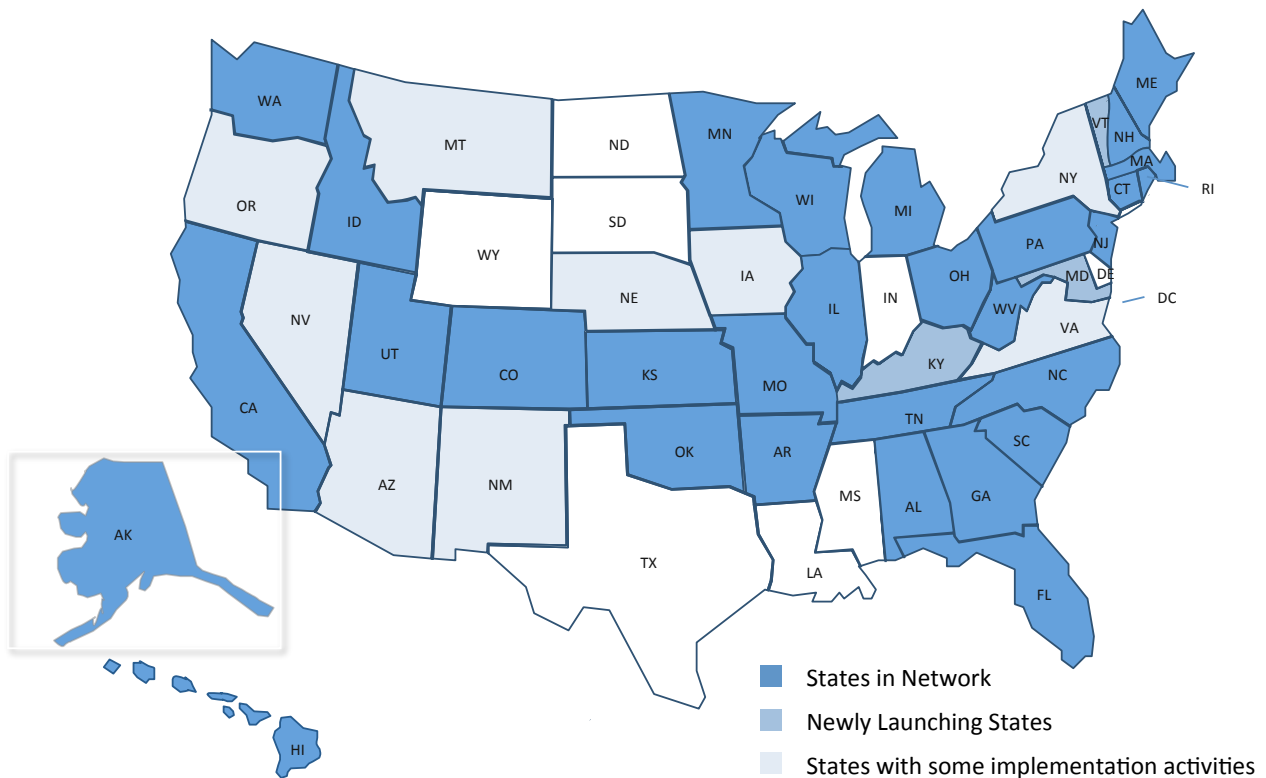


FIGURE 3. The Strengthening Families National Network

be provided in a manner that preserves parents’ dignity; provides opportunities for skill development; promotes healthy development, resilience, and the ability to advocate for and receive strengths-based, trauma-informed services and resources; and helps to minimize the stress caused by challenges, adversity, and traumatic experiences.

The Strengthening Families Approach in Policy and Practice Across the United States

In 2004, CSSP worked with seven pilot states implementing “Strengthening Families Through Early Care and Education” by organizing interagency

teams, helping states to develop strategies for the adoption of the Strengthening Families approach in at least 10% of early care and education programs, developing and sponsoring professional development experiences, and integrating the approach in requirements for programs and contracts. In addition, key national partners supported CSSP’s efforts in promoting the idea of a protective factors framework as a strengths-based approach to child maltreatment prevention in their own networks and programs. For example, the National Alliance of Children’s Trust and Prevention Funds led the way in raising awareness and providing guidance to states about the overall Strengthening Families Approach and Protective Factors Framework (see National Alliance of Children’s Trust and Prevention Funds, 2013b), and ZERO TO THREE: National Center for Infants, Toddlers, and Families developed a high-quality training curriculum for experienced trainers (see ZERO TO THREE: National Center for Infants, Toddlers, and Families, 2013).

Eleven (11) years after its introduction, the Strengthening Families initiative is not the same as it was in 2003 (Langford, 2011).

- In 2007 the Strengthening Families National Network was created to support and provide peer learning opportunities for any state adopting the Strengthening Families approach. Thirty-four (34) states and Guam are part of the Strengthening Families National Network (see Figure 3). An additional eight states plus the U.S. Virgin Islands are implementing the Strengthening Families approach at a state-wide level, though they are not an active part of the network.
- Most network members are implementing the Strengthening Families approach in more than one of four key areas: early care and education, child abuse and neglect prevention, home visiting, and child welfare. Consequently, the tagline “Through Early Care and Education” has been replaced with “A Protective Factors Framework” to acknowledge the shift to a more comprehensive approach with a focus on stronger families and child well-being.
- Ideas for implementing and sustaining the Strengthening Families approach in states and communities are regularly shared among the national network (see Center for the Study of Social Policy, 2013g) with emphasis being placed on the importance of collaboration across multiple service systems (see Center for the Study of Social Policy, 2013h) and the critical role of parent and community partnerships (see Center for the Study of Social Policy, 2013i).
- States are shifting policy, funding, and training in support of programs working with families to build the Strengthening Families protective factors (see Center for the Study of Social Policy, 2013j).
- Many more national organizations (e.g., United Way, Prevent Child Abuse America) have embraced the Strengthening Families Protective Factors Framework and are supporting their constituencies in implementing the Strengthening Families approach (Center for the Study of Social Policy, 2013k).
- Federal partners have incorporated the protective factors framework into program guidance for applications for federal funds (e.g., Departments of Education and Health and Human Services Race

to the Top Early Childhood Challenge Grants and Preschool Development Grants, Administration on Children, Youth and Families Discretionary Grants, Office of Early Learning), and others (e.g., Department of Defense, Family Advocacy Program) have incorporated the protective factors framework in programs focused on family violence as well as child maltreatment (see Military OneSource, 2013).

- Instruments have been developed to measure the Strengthening Families protective factors and for programs to examine the strategies they use to implement the Strengthening Families approach (Center for the Study of Social Policy, 2013l; Counts, Buffington, Chang-Rios, Rasmussen, & Preacher, 2010; FRIENDS: National Resource Center for Community-Based Child Abuse Prevention, 2013; Harper Browne, 2014).
- Efforts are under way to gauge the alignment of indicators of constructs assessed on existing family inventories (e.g., the Family Assessment Form) with the Strengthening Families protective factors.
- Efforts are being made to adapt existing family assessment tools to enhance their alignment with the Strengthening Families protective factors (e.g., the Family Development Matrix, and an adaptation of the Family Assessment Support Tool—FAST—being developed in Utah).
- Linkages are being encouraged and forged between programs that already work with families in a strengths-based, capacity-building way (e.g., Parents as Teachers, Period of PURPLE Crying) and state Strengthening Families efforts (see Center for the Study of Social Policy, 2013m).
- The Administration on Children, Youth and Families funded a five-year research project—the National Quality Improvement Center on Early Childhood—aimed at testing and rigorously evaluating four different evidence-based or evidence-informed approaches that supported parents in building the Strengthening Families protective factors (see Sidebar 7).

Conclusion

The Center for the Study of Social Policy works to create new ideas and promote public policies that produce equal opportunities and better futures for all children, youth, and families, especially those most often left behind. The foundation of all of CSSP's work is a child, family, and community well-being framework that includes a focus on protective factors. The Strengthening Families Approach and Protective Factors Framework exemplifies CSSP's commitment to identify, communicate, and apply research-informed ideas that contribute to improved outcomes for children, youth, and families. Parents, system administrators, program developers, service providers, and policymakers can each benefit from learning about and using the Strengthening Families Approach and Protective Factors Framework in their efforts to ensure parents and children are on a path that leads to healthy development and well-being.

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SIDEBAR 7

The National Quality Improvement Center on Early Childhood

The Center for the Study of Social Policy was funded through a cooperative agreement with the Children's Bureau (2008-2013) to address critical issues about child maltreatment prevention along with two partner organizations—the National Alliance of Children's Trust and Prevention Funds and ZERO TO THREE: National Center for Infants, Toddlers, and Families. The National Quality Improvement Center on Early Childhood (QIC-EC) was established to meet the nation's urgent need to identify and to test innovative approaches for reducing the likelihood of abuse and neglect of children ages 0-5 years old.

The QIC-EC funded four research and demonstration (R&D) projects that tested different child maltreatment prevention approaches, each with different target populations (see the September 2014 special issue of *The Journal of Zero to Three*). All R&D projects were guided by several key perspectives, specifically (a) increasing the Strengthening Families protective factors in addition to decreasing designated risk factors in their particular child maltreatment prevention intervention; (b) improving adults' capabilities to increase the likelihood of optimal child development; (c) developing effective collaborative partnerships for the successful provision of integrated services; and (d) addressing multiple domains of the social ecology to affect positive child and family outcomes.

In addition to the site-specific and cross-site findings (see ZERO TO THREE: "National Center for Infants, Toddlers, and Families," 2014), the QIC-EC's work highlighted the importance of:

- Focusing on well-being in maltreatment prevention efforts
- Addressing all domains of the social ecology in order to make a difference in the lives of families
- Exploring the role of culture in helping parents to build their protective factors
- Forging community partnerships in planning and implementing approaches designed to improve the well-being of parents and their children
- Employing a developmental evaluation approach for complex interventions and research projects
- Developing strengths-based parent assessment tools

At the outset of the QIC-EC, the leadership team found that although there were various instruments that included measurement of indicators of some of the Strengthening Families protective factors, there was not a single instrument that was designed to measure the presence, strength, and growth of all five factors. In addition, many parent assessment tools reviewed by the QIC-EC leadership focused on the identification of a parent's problems and weaknesses. But a single emphasis on deficits obscures the recognition of a parent's strengths and capabilities that could serve as resources for addressing family challenges and crises.

Thus, a major product of the QIC-EC was the development of a strengths-based parent survey now called the "Parents' Assessment of Protective Factors" (PAPF). The PAPF was designed to measure the extent to which parents acknowledge beliefs, feelings, and behaviors identified as indicators of the Strengthening Families protective factors.

Overall, findings and lessons from the QIC-EC will contribute to a shift in thinking about the interconnected goals of the prevention of child maltreatment and the promotion of healthy child and family development and well-being.

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