Helping vulnerable children to become more resilient

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Abstract

Children whose parents have significant depressive illness are at greatly increased risk of developing mental health problems themselves as they get older. The research on resilience suggests that a programme which combines work with the child, the family, and strengthens community supports is likely to have a positive impact upon the child's vulnerability. We describe the content and operation of such a service, and report on the results from its first 18 months of operation, which suggest that it does have a positive impact in many areas of child and family functioning.

Key words: resilience, prevention, intervention, parental depression

Introduction

Over recent years there has been increasing interest in understanding why some children who should be at high risk of developing mental health difficulties do not do so. To understand what gives this resilience is to take a significant step towards developing methods of intervening that will reduce future risk for all such children. It has been suggested that the concept of resilience is greater than that of prevention, for while prevention is seeking disease avoidance, resilience also includes the aim of establishing wellness (Luthar, Cicchetti & Becker, 2000).

It is increasingly acknowledged that resilience is a dynamic process in which the individual and the social environment interact to produce a pattern of functioning which offers resistance to detrimental experiences (Stein, Fonagy, Ferguson & Wiseman, 2000), from which coping successfully with one situation strengthens an individual's ability to cope in the future (Garmezy, 1993). Such elements are rooted in developmental progression rather than fixed personality traits (Masten & Garmezy, 1985), and are probably part of a normative process (Masten, 2001). Thus not only do these qualities have the potential for strengthening and enhancement, but the resulting improvements in functioning seem to be enduring (Masten et al., 1999).

Work which has sought to use the concept of resilience therapeutically have consistently found that it is necessary to focus upon three broad domains – the intrinsic functioning of the child, the family atmosphere and functioning, and the support and influences that come from the wider community (Cowen et al., 1997; Fergusson & Lynskey, 1996). The Strength-to-Strength service focusses upon children whose parents have a significant depressive illness because these children have been shown to be particularly vulnerable to developing mental health problems (Beardslee, Keller, Lavori, Staley & Sacks, 1993), and that intervention with them can be successful in increasing their resilience to developing later mental health problems (Beardslee, Versage & Gladstone, 1998).

Accessing the service

Strength-to-Strength has two full time workers committed to its delivery. Both have wide experience of working with children who have mental health difficulties, and their backgrounds in social work and nursing adds to the richness of knowledge of what can be offered to the children and their families. Any professional involved with the family can refer, and all appropriate settings have specially designed packs that describe the service and contain information about how the families themselves can make contact. Strength-to-Strength actively encourages self-referral and sees this as an essential empowering practice which demonstrates from the onset to parents our interest in their proactive participation and choice.

The service was promoted widely within adult mental health teams including Community Psychiatric Nurses, Psychiatrists, Mental Health Social Work, Drug and Alcohol, and Family Therapy teams. Other Social Services departments, counselling services, school nursing and health visiting services and Mental Health organisations such as the charitable MIND organisation were also targeted. Some professionals were concerned about how to introduce the service to patients, for instance, how can the professional tell a depressed parent that their illness is likely to have a profound effect on their children without increasing their feelings of guilt. In practice those parents who are involved in the service do actually already fear the effect upon their children. In many cases they can see it and want to do something about it, and for some they themselves are the children of depressed parents. A great deal of thought was given as to how we would introduce to the parents the risk factors of the impact of their parental depression could have upon children. In practice and with parental guidance the overwhelming response has been to tell the parents "straight". This also enables us to present empirical data about both the likelihood of these difficulties emerging, and also about the interventions and their outcomes that seek to be beneficial.

The service has been running for some eighteen months, and the current pattern of referral seems to be that only in cases where the parents express concern about their children do the workers refer to Strength-to-Strength. Our hope would be that all families who fulfil the criteria would be given a pack so that they can read about the service for themselves and then decide whether they want to know more. When this occurs we envisage that most benefit from this resilience based intervention will be evident.

The package of intervention

The criteria chosen to decide which families should access the resilience service are three-fold. The first is that the child's parent suffers with depression of sufficient severity to require support from a mental health professional. This criterion of severity was established in order to include children whose parents mental health difficulties were at least of moderate severity. However, unlike most of the parents reported in the previous research, the presence of additional problems, such as alcoholism or dual mental health diagnosis, does not prevent the families joining the programme. However the psycho-educational elements do focus upon depression, as this should remain the principal diagnosis. In addition, the degree to which the parent's difficulties are viewed as intractable does not influence acceptance on the programme.

The second criterion is that the children have to be aged between 7-14 years. Such an age range keeps the intervention elements relatively uniform. Thirdly, to ensure that the focus remains on promoting resilience rather than responding to specific difficulties, the child's current problems should not be prompting concern sufficient to justify a referral to CAMH services in their own right.

On referral to the Strength-to-Strength Team, the child and their family are assessed in order to identify existing protective factors within the child and the family, the degree of community support and the family's level of involvement in community groups and activities. Because it is evident that there is considerable variation in functioning across the domains even in children who are viewed as having considerable resilience (Cicchetti, 1993), detail of these domains is gathered through interview, and an evaluation package of well-validated instruments. This package consists of the Strength and Difficulties Questionnaire (Goodman, 1997), the Self Description Questionnaire (Marsh, 1990), and the competence scales of the Child Behaviour Checklist (Achenbach & Edelbrock, 1983). The strength of family themes is assessed using the Family Adaptability and Cohesion Evaluation Scale (FACES) (Olson, Portner & Bell, 1982). For those children that require additional assessment to determine if a CAMHS referral is needed, we also have access to Child Symptoms Inventory (Gardow and Sprafkin, 1994).

The programme seeks to build on the positives that are already present in each of the three domains, together with psycho-educational work on depressive illness. Case studies in the literature highlight how children, when faced with such major negative events as parents having major mental health problems feel responsible for maintaining their parent's happiness, or feel a pressure of silence with regards to their parent's illness (Devlin & O'Brien, 1999; Focht & Beardslee, 1996). This element is of significance because of the evidence that affectively ill parents can promote resilience in their children by educating them about their illness, and encouraging the family to express emotion and affect (Focht-Birkerts & Beardslee, 2000). Such activities then lead naturally into three domains of supportive resilience work.

The initial work done to look at how such a service may be implemented (Place et al., 2002) suggested a brief intervention whereby the aspects of the package would be delivered in a systematic manner over a total of 10-12 sessions, evaluated and there the intervention would end. In practice it has proved to be a much more complex, and challenging intervention to deliver. Engagement and assessment can take 3 or 4 sessions, appointments are often cancelled due to family emergencies, or the team often find themselves the first person contacted at times of crisis. This is an interesting aspect of the work – crisis intervention is clearly not part of the project's work, yet it appears that the nature of the work develops a sense of trust with the family. This is perhaps because the majority of the work takes place in their home, and the intensity of the involvement gives a stronger sense that they will share their true feelings, some of which they are often reluctant to share with their principle service deliverers. For this reason the team have to be very aware of boundaries, and to have good relationships with referring teams and a detailed working knowledge of other local services and resources.

Agreement is also made with the families that any issues they highlight which we feel are contributing too and likely to be maintaining their depression should be passed on to the principle care services. This has enabled many families to receive support for issues that they have not often disclosed to their mental health worker. It is therefore hoped that these issues can then be supported and addressed, rather than them remaining unresolved.

The intervention for the child

The fundamental principles informing the work with the child includes enabling the child to recognise their existing strengths, skills and positive qualities and to enhance these further.

The programme seeks to build on the sense of worthiness and individuality that the child has gained from interactions with parents and other adults. In addition there is a focus on identifying positive goals for the future, including aspects of physical, emotional and social development. Enjoyment of socialising and being active combined with a firm belief that they have a parent who believes in them, are also strived for within the intervention. These goals are addressed via individual and group work.

The assessment stage is quite straightforward and includes the administration of the assessment tools. Prior to this some time is spent with the child explaining the purpose of the assessment, highlighting what information will be obtained and how this will be used to help in understanding the child's views regarding their ability, qualities and self perception. The initial assumption was that the child would be reticent to complete the assessment but in fact the children have proved quite enthusiastic about their completion, and often spend a great deal of time thinking about their responses. It is also clear that presenting the assessment as a confidential, beneficial and helpful tool to the child results in them reacting to it in a positive way, as they can understand what it is for and how it will be used.

Explaining the results of this assessment to the child is achieved using a range of art materials. This avoids a scenario of direct verbal feedback only, which is cumbersome and is very dependent upon the child being able to hold their attention whilst they absorb accurately the details without misinterpretation. The starting point is to ask the child to draw a picture of themselves and the special people in their lives. This allows the discussion to focus upon the reasons why somebody is special, and opens up avenues for exploration such as who are the key people in the child's life, identification of the roles they have, and what things are similar between the special people and the child themselves. At this stage direct information can be provided from the child's assessment sheet to then be included on the drawing, emphasising with words and pictures the child's positive qualities. This drawing is the property of the child and encouragement is prompted for their continuation of the picture in our absence, and its display to be in a prominent place. Our experience has shown that these drawings become a regular discussion point with the child, and as the intervention progresses new elements, people and words can be added. The views of the children are also explored by using discussion cards. These brightly coloured cards depict a range of expressions, emotions and feelings, and this is then used as an introduction into discussing feelings more generally. The children clearly enjoy this activity, and it is particularly useful because the children can address their views to the cards without being forced to personalise it to themselves. A flavour of the individual work with the child can be gained by describing the work with Cloe.

> During individual work with Chloe she indicated that she felt she had no special qualities, and that she did not have anybody special in her life. Asking what she thought the word special meant, Chloe said she felt her teachers were special because they helped other people and they were clever. She felt her teacher had become special by being clever, kind, sharing, having fun and most of all by being nice. For homework Chloe was encouraged to ask members of her family to describe why she was special and what special skills she had. Upon review Chloe had a heightened sense of excitement and recognition of what made her special.

Having completed the assessment, and fed back to the child their strengths, the programme then seeks to build up the areas of identified need through individual sessions with the child at home. These sessions provide a rich source of information about the child's home circumstance, their neighbourhood environment, their role within the family and how they generally function. These are powerful influences upon a child's functioning, and working in the child's home gives some sense of the levels of chaos that dominate a child's life.

> When working with Zoe the first couple of appointments had been held in her auntie's house because her aunt collected her from school. During these sessions we had explored home and family life and obtained a picture of positive relationships, friendly neighbourhood and general satisfaction. When we eventually met at Zoe's home we found that the front of the house had been covered with eggs, thrown by local youths. Two windows had been smashed and the family constantly had soil and food pushed through their letterbox. The home was sparse of furniture and had a strong smell of urine. It was evident that the family was embarrassed by their circumstances but felt powerless to overcome them, or speak about them.

It is a criteria for access to the programme that the children's difficulties are not of a degree to warrant referral to a CAMH service in their own right. However, the children usually did show a number of difficulties which predominantly stem from low self-esteem. Identifying these issues of low self-esteem is a central element of the intervention. As highlighted within the assessment many of the children are within the clinical ranges for emotional and conduct difficulties, lack of peer contact and social activity, and low levels of satisfaction with their parental relationships and general view of themselves. When working with these children we use a variety of techniques including solution-focused interventions (De Shazer et al., 1986) and narrative therapy techniques (White & Epston, 1990). These aim to help the children to develop techniques and resources that they can use in future. The method we have found very successful and which becomes a regular feature of family life is the use of scaling questions.

> Bradley, aged 13 believed that living in his family was either really good or really bad. We introduced scaling questions using 1 to 10 (1 = "things are bad" and 10 = "going well"). Bradley defined what each point between this represented. We represented the scales with pictures cut from magazines and used art as a medium for self-expression. The subsequent session then looked at Bradley's views of family life and what was needed to keep things at the point on the scale or move it up by one point.

The work undertaken within the individual sessions is reinforced during the group work sequence. All the children are offered the opportunity of joining the group sessions. As well as reinforcing why the child is special, problem solving skills, and identifying the special people in their life, this element of the package looks to enhance communication skills, identifying the benefits of community activity and foster an understanding of why all these themes are beneficial for resilience.

Within the groups however, the overriding principle is to have fun. The groups to date have been very informative in understanding the different influences facing these young people above and beyond that caused by their parental depression. The groups are carried out in local community setting and this has enabled the children to experience a community-based activity with peers, to be creative and expressive and to recognise the importance and benefit of participation. The group element also seeks to encourage the children to develop an interest in becoming a participant in other local activities. This is important because many of these children have a sense of isolation and have rarely been a part of any clubs, groups or activity sessions.

The intervention for the parent

Parenting is generally acknowledged as being stressful for all parents. The presence of a depressive illness adds extra strain and can affect the ability of the parent to meet the child's needs. For example, the lack of energy and poor concentration produced by the illness reduces the parent's ability to manage behaviour appropriately and erodes their confidence (Falkov, 1998). Commonly the parents say they have never had their diagnosis fully explained, or for those who have had the explanation it was often outdated and not applicable to their current experience of depression.

In working with the parent, the main aim is not to consider the specifics of their depression but rather to focus on the effect the depression has on their parenting skills. It is helpful to look with the parents at what is needed to be a parent, identifying the need for the inner resources of knowledge, skills, confidence and empathy, and the importance of external factors such as support from family, friends, and the community.

The assessment process highlights the parent's strengths as well as their vulnerabilities. The Strength-to-Strength intervention then seeks to help the parents acknowledge the skills they already have, and building on these, and so increase their self-esteem. This is done through individual, family and parent group sessions. For instance parents showed a very positive sense of warmth and concern for their children's well being, a good platform from which to develop other changes.

Exploration of how depression can affect parenting skills can help complete the picture and enable the parent to see where their 'story' fits in. In addition there may be problems that stem from co-existing mental health problems, such as agoraphobia. Increasing the understanding of these issues and their impact on parenting helps identify and acknowledge existing skills and strengths and helps the parents explore how they can build on these. Commonly the parents show a sense of low self-esteem; there are major relationship difficulties with their partners, and a tangible lack of peer/family support.

A main element of the programme is to seek more open communication in the family and use this to explore ways in which difficulties can be addressed.

> Cora is a 38-year-old mum of two. She suffered extreme violence and intimidation during her second marriage. She subsequently suffered from a severe depressive illness, with anxiety disorder and agoraphobia. She lacked confidence in her parenting abilities and was anxious whenever the children were out of her sight, and so tended to greatly restrict their freedom. She found it difficult to set limits on their behaviour and was unable to recognise boundaries.
> Individual sessions with Cora, and joint sessions with her current partner were positive and affirming, recognising her strengths as a parent, exploring and explaining some of the reasons for her anxieties, and improving communication between herself and her partner. Cora's belief in her ability to manage her children improved, with the result that she began to feel more confident in allowing the children to spend time with friends, join local clubs etc.

Work with the parent also involves reinforcing with them the work being carried out with the children and looking at ways in which this may be continued in family life, especially with regard to self-esteem issues. This involves talking with the parents about their children's strengths and positive qualities to begin to erode the focus on the negative, which is often a feature of depressive illness. This can then be used to help the parent develop a sense of positive achievement in acknowledging the strengths of the child. Both the parent and the child can then help each other to foster a sense of positive self-esteem.

A further aspect of the programme with the parents involves helping them to feel supported when talking to their children about their illness.

> Jimmy's parents were separated and both had a diagnosis of depression. Jimmy aged 10 lived with his mum who told us she tries very hard to hide her depression from Jimmy. This involved her telling Jimmy that she had headaches because she had a busy day, or she had toothache. This oc-

curred even when depression was at it worst, where she would be crying, very lethargic and unable to make conversation. Betty (Jimmy's mum) felt Jimmy had not noticed any of her symptoms of her depression. During a family discussion Jimmy spoke about numerous incidents of Betty's tearful episodes and felt that his mum was going mad. He had spoken to his friend about how often their mums cried and when he found these were dramatically less often Jimmy concluded she must have a brain tumour. He then did all he could to stay at home to look after her, to be constantly kind and always helping with cooking and cleaning because he thought mum was too sick to do these things by herself. Betty was surprised by Jimmy's thoughts about her illness, and sought to reassure him about the true nature of her difficulties.

Working with parents in a group is an element that was introduced after reviewing the cases of the first twenty families to use the service, and was a response to the high levels of social isolation, low self esteem and lack of confidence around parenting issues, and lack of support which these families showed. It is intended neither as a depression support group nor as a parent training group, but rather one which combines elements of the two. The focus is again on identifying and acknowledging existing skills, and also on shared experiences and providing mutual support. The group is run along cognitive lines and tends to be needs based, each course consists of 6-8 sessions looking at a different theme, for instance problem solving, decision making, as directly related to parenting. Each course is fully evaluated and group members' comments taken forward when planning the next course.

Janice is a 39-year-old single parent who has suffered from depression for two years. She has a very negative self-concept and although able to acknowledge her strengths she tends to counter these with her perceived negative qualities. The group was helpful in challenging some of these negative perceptions, but she was only able to acknowledge her tendency to do this through watching somebody else in the group do exactly the same thing. This has led to a general improvement in her self-awareness and in her ability to self reflect.

The final element of the programme for parents is to encourage their involvement in the local community. Facilities vary from area to area, but those most successfully accessed include women's centres and local branches of the city college.

Margaret is a 28-year-old married mother of one, who has been socially isolated for several years. With lots of support and encouragement she joined the parents group. While discussing the computer she had bought her daughter for Christmas with other parents she mentioned that she wouldn't even know how to turn it on. Several of the other parents had attended or were attending I.T courses and encouraged her to do likewise. She had never considered the possibility of doing something like this, feeling it would be totally beyond her, but she came back the next week having enrolled on the next course.

The intervention for the family

The work that focuses on the family unit consists of four stands we endeavour to address. These are firstly to develop a systemic understanding of the families strengths and areas for development; secondly psycho educational discussions which addresses each family member's understanding of depression, thirdly the recognition of important relationships and the roles they play, and finally, the recognition of the importance of communication.

The definition of "family" is all who live in the house. It is therefore sometimes possible to become involved with children in the family who are out of the services age range, to exclude these would be a barrier to understanding the general functions of family life. Listening to these older siblings experiences of family life helps to generate ideas about the types of rules, boundaries and expectations that are placed upon the children who are the primary focus of this intervention. This may enable previously successful family coping strategies to be identified and perhaps strengthened. Including younger siblings highlights the long-term benefits that the intervention could have by equipping families with skills that can also be of benefit to these young children throughout their development.

The assessment of the family looks for existing strengths and protective factors including areas such as family dynamics, the individual's roles and responsibilities, networks of support, and the rules and boundaries that are expected to be followed. The cohesiveness and adaptability experienced within the family is also assessed both within the family meetings and through the FACES questionnaire (Olsen et al., 1982). These initial conversations are positively orientated, and also aim to reinforce the philosophy of the intervention, i.e. to be goal and solution orientated, whilst also recognising strengths. Such an emphasis allows families to form a positive understanding of the purpose of the intervention and maintain their focus on hope, rather than dwelling on the belief that things have always been bad and they will continue to be so. However, such an approach needs to be tempered by the recognition that the families have all had a degree of psychiatric intervention that has had description of the problem as its starting point. The initial sessions therefore tend to focus on family members sharing their feelings and concerns combined with an exploration of alternative ways of addressing their needs.

Experience to date has shown that speaking in a positive way in front of their children has a beneficial effect on family functioning and communication, replacing previous conversations, which had been largely based upon the negative impact of depression, which the children may not have fully grasped. Part of the improved communication process is helping the child understand the impact of depression, identifying its benefits and suggesting appropriate ways to achieve this. Parents are always sceptical in doing this and are often surprised just how much their children understand depression, which they base upon their observations of their parents.

The psycho education sessions do not assume one particular theoretical model of depression but rather apply a range of explanations, facts and questions, which enables the family to enhance their understanding. The meaning of depression to children is introduced using the method of externalising the problem, adopted from narrative therapy (White & Epston, 1990). Drawings, discussion and the generation of questions for the children to ask about their parents depression has proved a useful way of exploring a sensitive and emotional issue. Children enjoy the creative chats and artwork while parents often say they feel this method has enabled them to cope well with particularly difficult questions from their children.

The impact of the service

After eighteen months of operation 68 children have been assessed by the service, and 64 of these have been judged to meet the programme criteria. The information gathered from the first 24 families to have been followed up after involvement with the programme shows that changes have been brought about in various areas (Table 1). The youngster's ability to socialise and participate in activities has increased, along with their sense of self-esteem and general confidence both in school and more generally. The families have become more cohesive and adaptable in their functioning, a change which makes them more likely to cope with future stressful events. Finally, although none of the children showed emotional or behavioural difficulties of an order to warrant referral to specialist services, the end of the intervention reduced the difficulties that they did show.

Table 1
The Results of Preliminary Evaluation of the Resilience Package (n = 24)

	Initial Evaluation		Outcome Results		t-test
	mean	std dev	mean2	std dev2	
Strengths & Difficulties Questionnaire					
Prosocial Behaviour Score	5,7	2,2	7,7	2,8	2.81**
Hyperactivity	5,5	3	3,4	2,1	2.87**
Emotionality	5	2,8	3,8	2,5	1.60
Conduct	3,2	1,8	2,2	1,5	2.13
Peers	3,9	2,5	2,9	2,4	1.44
Total Deviance Score	17,6	7,2	12,7	5,9	2.63*
CBCL (Competence Scales)					
Activity level	4,6	1,9	5,4	2,6	1.24
Participation in groups	0,3	0,5	3,5	2,4	6.53**
Social total	7,1	2,3	8,2	2,2	1.73
FACES					
Cohesion	25,4	17,2	36,4	7,1	2.96**
Adaptability	20,5	14,7	32,9	6,9	3.82**
Self-Description Questionnaire					
Physical abilities	30,9	9,3	31,2	6,3	0.13
Physical appearance	26,2	10,7	31,7	6,1	2.23*
Peer relations	24,2	12,1	30,7	7,5	2.28*
Parent relations	35,1	6,2	33,5	5,4	0.97
General school	28,8	10,1	31,2	6,2	1.01
General self	33,9	9,9	29,1	8,1	1.88
Reading	28,4	13	34,3	5,1	2.11
Maths	31,1	10,8	29,8	8,9	0.46
Academic	25,8	11,7	31,7	5,5	2.28*
Non- academic	25,5	11,3	30,6	4,6	2.09
Total	25,6	11,2	31,1	4,3	2.29*

Calculations assume instruments show a normal distribution, and applying Bonferroni correction post-hoc * = $p < 0.05$, ** = $p < 0.005$

Conclusion

The Strength-to-Strength programme seeks to offer an intervention to a group of children who are particularly vulnerable to developing mental health problems in later life (Baldwin, Baldwin & Cole, 1990). The programme has its roots in published research (Place et al., 2002) and demonstrates a very positive impact both in terms of formal evaluations and the responses of the families. The programme seeks to strengthen various areas of functioning which have been identified as significant to resilience, although it is not clear if such a wide ranging response is more successful than a closely targeted one. It may be that good functioning in one area, for instance positive family dynamics and networks, may by itself significantly reduce the risk to these children. However, some of the potentially beneficial elements are difficult to establish. For instance, empirical evidence indicates that being active and having a good range of outside interests is a strong protective factor (Garmezy, 1993; Hechtman 1991), and the service strongly promotes this theory. However the reality is that in many areas there are few, if any, accessible low cost activities for children. Most of the families have very limited income which severely limits these opportunities, and for many the group work which forms part of the intervention is the only chance many of the children have to join in an activity outside of school.

It is evident from the work so far that the most successful and sustained outcomes are where the parental depression is of relatively short duration and they have a sense of improvement. This is consistent with other research work (Billings & Moos, 1986). Most of the families who have been through the programme report improvement in many areas. However, the central question is whether these improvements are sustainable in the longer term. Perhaps even more crucial is whether this type of intervention is able to limit vulnerability to future mental health difficulties. The programme is geared to retain contact with families to try to answer this question but certainly not for the present. The outcomes indicate that a more positive family environment has been created for most of these children, and this in itself, must be seen as a positive benefit to these children.

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