International Journal of Child and Adolescent Resilience

Practical Strategies
Maltreated Adolescents: Social and Health Service Opportunities for Resilience

Christine Wekerle, McMaster University

Email: wekerc@mcmaster.ca

Abstract:

Well-being is well doing. The United Nations Rights on the Convention of the Child (CRC) and the United Nations Development Program Millennium Development Goals (MDGs) target youth health, safety, participation and empowerment as key driver's of living in a social justice context. Health and social services are two streams of resources to at-risk youth and vulnerable caregivers to promote resilience – positive adaptation and development - in adverse contexts. Child maltreatment statistics highlight the critical role of the social safety net. A policy-service gap exists for youth involved in the Child Protective Services (CPS) system. For these youth, violence prevention and personal safety remains a key component of resilience. This practical strategies paper considers youth resilience issues the context of maltreatment. Innovation in adolescent protection is an opportunity for health and social service systems to support resilience, continuity of care and violence prevention. Strategies include transition services for the switch from child to adult services, prevention programming that support mediating the environment, targeting CPS expectant teens for established maltreatment prevention programming, and system changes that recognize the emerging adulthood developmental period.

Keywords:

Adolescence; child abuse prevention; resilience; child protective services; health services; child maltreatment; violence prevention

Over the past few decades, a dysfunctional policy environment has marginalized prevention to the detriment of health outcomes. This has led to staggering rates of obesity, heart disease and diabetes, all preventable. … To deal with this change, we need new modes of distributed healthcare delivery, a health economy based on prevention, and new technological literacies. (Ranck, 2012, p. 8)

… maltreated children are likely to manifest atypicalities in neurobiological processes, physiological responsiveness, emotion recognition and emotion regulation, attachment relationships, self- system development, representational processes, social information processing, peer relationships, school functioning, and romantic relationships. (Cicchetti, 2013, p. 403)

The death of a child is a sentinel event in a community, and a defining marker of a society's policies of safety and health. (Jenny & Isaac, 2006, p. 265)

In its 20th year, the United States' Center of Disease Control and Prevention has named violence and associated injury as the public health issue of the decade (http://www.cdc.gov/injury/about/index.html). A prominent cause of injury, disability, and death is the physical, sexual, and emotional abuse and neglect of minors. The most visible sign of failure of our social safety net is the preventable death of a child abuse fatality. Child abuse fatalities are determined from a variety of sources including death review boards, crime reports, death certificates, and data from child welfare agencies. Research has shown that these sources all lead to under-representation, while combining two sources can lead to 90% ascertainment of cases (Schnitzer, Covington, Wirtz, Verhoek-Oftedahl, & Palusci, 2008), although issues in capturing neglect-related deaths remain (Palusci, Wirtz & Covington, 2010). Jenny and Isaac (2006) enumerate the issues in child maltreatment detection: (1) maltreatment is behavior that perpetrating adults are invested in disguising and is disguisable; (2) suboptimal assessments occur; (3) incomplete information owes to poor collaboration among hospitals, police, and child welfare; (4) consensus on definitions of maltreatment (and maltreatment suspicion thresholds) vary; and (5) child deaths, especially those from neglect, may not be recorded as child abuse deaths.

With these caveats noted, the U.S. child abuse fatality rate is 2.10 children per 100,000 children, or an average of four children per day (Child Welfare Information Gateway, 2013). Primarily, these maltreatment-related deaths are the result of caregivers neglecting and physically abusing their child. In emergency department cases, young children die most often due to blunt force to the infant and toddler's head, and evidence confirms that earlier suspicions are not acted upon according to mandatory reporting requirements (Gilbert et al., 2009; Levi, 2011; Wekerle, 2013). For these youngsters who ultimately die at the hands of their caregivers, healthcare was sought often beyond routine well-baby checks (King, Kiesel, & Simon, 2006; Sieswerde-Hoogendoom, Boos, Spivack, Bilo & van Rijn, 2012; Spivey, Schnitzer, Kruse, Slusher, & Jaffe, 2009; Putnam-Hornstein, Cleves, Licht, & Needell, 2013). The most common circumstances include: households with a non-related adult; the child falling and finding the child unresponsive as presenting complaints; and adults arguing about relationship break-up as precipitating events (Jenny & Isaac, 2006).

Despite attention to youth injury statistics (Pinheiro, 2006), the contribution of caregiver maltreatment and other forms of violence represents a disconnect from statistics to practice: CPS youth are more likely to die by age 18 from maltreatment and "fallout" issues, such as deaths from risk-taking behaviors and suicide (Jenny & Isaac, 2006). According to the Child Maltreatment 2011 report, youth aged 8 to 11 years were represented in 4.6% of abuse fatalities; youth aged 12 to 15 years, 16 and 17 years, and 18 and above years, represented 2.2%, 1.4% and .7%, respectively (Child Welfare Information Gateway, 2013). The health and social service systems have opportunities for resilience that are missed. Prevention should be a common agenda for both services systems; yet, both are event-based (injury, maltreatment episode) in a way that limits prevention practices as a core strategy. The unnecessary loss of a child's life translates into a sizable societal financial loss: over 2 million in annual costs to the United States in lost productivity is estimated for 1,740 child deaths (Fang, Brown, Florence & Mercy, 2012). Extrapolating to the global level, the cost is staggering given that, globally, an estimated 31,000 children die due to homicide (WHO, 2010).

For young children who survive maltreatment, 8.7% exit hospital with pervasive functional impairments (DiScala, Sege, Li & Reece, 2000). One area of research and practice gap is considering the mortality and injuries among adolescents with any level of CPS involvement. To wit, CPS involvement is linked with elevated risks for first presentation to an emergency room (ER) for a suicide attempt (Rhodes et al., 2012), being hospitalized for a suicide attempt (Vinnerljung, Jhern & Linblad, 2006), repeated ER suicide presentations (Stewart, Manion, Davidson, & Cloutier, 2001; Rhodes et al., 2013), and being a

victim of all types of avoidable deaths (i.e., related to substance abuse; unintentional injuries; homicides, avoidable natural causes) (Hjern, Vinnerljung & Lindblad, 2004). Indeed, childhood abuse significantly increases the likelihoods of all types of violence in adolescence (bullying, physical fighting, dating violence, self-mutilatory behavior, suicidality) (Duke, Pettingal, McMorris, & Borowsky, 2010; Hamby, Finkelhor & Turner, 2012). Evidence suggests that a CPS investigation signals a high-risk household (Vaithianthan, Maloney, Putnam-Hornstein, & Jiang, 2013). Taken together, research points to a high need for an on-going violence prevention role for both health and social service systems, with CPS youth as a priority group for resilience programming.

In this practical strategies paper, the linkage (and overlap) in childhood maltreatment and adolescent violent victimization is considered. First, the parameters of the victimization experiences for adolescents are considered; second, the notion of resilience in the contexts of maltreatment and adolescence is discussed; and finally, the evidence-based practical strategies and areas for further empirical attention in resilience for at-risk youth are noted. Resilience is both a process (e.g., negotiation of community resources) and outcome (e.g., personal safety), whereby adaptation is relatively better than others in similar adverse contexts (e.g., maltreatment), and may be commensurate or exceed peers in some domains (e.g., via inoculation effects or post-traumatic growth) (Rutter, 2013). Health and social services coordination and innovation would seem especially salient for promoting resilient pathways at times of developmental transition (i.e., to adolescence; to legal adulthood, to parenting; Wekerle & Wolfe, 1993), as well as in fostering trajectory "turning points" (in living conditions, in the associated psychology or mind-set) from an adverse past (Rutter, 2013). Adolescence may be a sensitive developmental period for post-traumatic growth given the tasks of identity refinement, abstract thinking capacities, and interest in future roles (Myerson, Grant, Carter, & Kilmer, 2011). Post-traumatic growth could include such altered positive self-views as recognizing one's strengths, other-views as empathy for victimization, and worldviews as the value of basic human rights or the importance of some degree of interpersonal caution.

What do we know about maltreatment-related injuries to adolescents?

Adolescence is an important, extended period of development, from early adolescent years to emerging adulthood (the upper limit typically defined as 25 years IOM & NRC, 2013). The adolescent to emerging adulthood period is poised to be of increasing salience by sheer numbers: the U.S. young adult population is expected to reach 34 million or 13% of the population by 2050 (IOM & NRC, 2013). For pediatric populations, health services switch to an adult system typically by age 18, despite recognized gaps for at-risk populations, such as youth with disabilities (Gorter, Stewart, & Woodbury-Smith, 2011) and youth receiving child welfare services (Wekerle, 2013). Caregiver maltreatment of adolescents may not be in the mindset of health services practitioners, where the emphasis may be on younger children. Injuries that may present to emergency rooms or physician offices, or maltreatment that may be occurring for other presentation issues (e.g., mental health, peer-to-peer violence etc.) are relatively unknown statistics.

The research to date on inflicted injuries for the early to late adolescent has focused on those related to sports, work, motor vehicles, as well as alcohol-related and crime-related injuries. In a study of one urban emergency room adolescents, aged 14 to 18 years, were screened consecutively over a three-year period, where child abuse or sexual assault was a screen-out factor. Of the ineligible youth (n=1945), 2.8% were identified as youth victims (Ranney et al., 2013). Van Wert, Ma, Lefebvre and Fallon (2013) examined justice system involvement among 8 to 15 year olds receiving child protective services (CPS). In reporting on the characteristics of these youth, Van Wert and colleagues found that 49% of these cases had two or more prior CPS openings, and that physical abuse (25%) and neglect (25%) of these adolescents were the dominant presenting concerns. These authors note that about 58% of these cases had a caregiver vulnerability issue (mental health, substance abuse, domestic violence etc.) that may contribute to the on-going risk of violence. When caregivers do not have the same perception of maltreatment events, as do their youth, youth report greater levels of impairment (Oransky, Hahn, & Stover, 2013). While

it is known that adolescent self-report yields higher levels of maltreatment than do official reports (e.g., McGee, Wolfe, Yuen, Wilson & Carnochan, 1995), CPS agencies do not typically re-assess childhood maltreatment as cases continue to adolescence or across adolescent years.

Epidemiological studies converge in identifying substantial violence risk to adolescents. In a national U.S. survey, 38% of respondents reported experiencing physical punishment to the point of injury before age 18 (Afifi, Mota, MacMillan & Sareen, 2013), contributing to both their adult physical and mental health problems (Afifi, Mota, Dasiewicz, MacMillan & Sareen, 2012; Afifi et al., 2013). In a national telephone survey, Finkelhor, Turner, Shattuck and Hamby (2013) report that prior year sexual abuse/sexual assault was reported by 10.7% of adolescent females, aged 14 to 17. Young adults followed prospectively reported high levels of maltreatment by grade 6 by a parent or adult caregiver, including repeated (3 or more times) supervision neglect (19.1%); repeated physical assault (14.2%); and contact sexual assault (4.5%) (Hussey, Change & Kotch, 2006). Given their greater strength and size, physical injury and neglect may be less life threatening, but still constitutes maltreatment.

The deleterious impact of maltreatment may manifest differently in each developmental period. For early adolescents (aged 13 to 14 years), adverse childhood events (witnessing domestic violence, physical or sexual abuse) increased the likelihood for concurrent somatic concerns (Flaherty et al., 2013). For adolescents, evidence points greater self-harm and poorer self-care (Byambaa, 2012). Resilience processes confer resistance, over the long-term, to the deleterious effects of stress. Episodic issues may ensue, but the individual develops a recovery strategy that is refined over time, in interaction with a resourced environment.

What is youth resilience in the context of maltreatment?

Resilience - as a successful adaptation over time despite significant adversity – reflects multiple components and processes. The current view is one that considers natural adaptation processes, including self-righting actions, which implies a neuroscience of resilience, founded on the principle of plasticity (Cicchetti, 2013), with genetic contributions continuing to be examined (for a recent review, see Wu et al., 2013). However, a critical feature of resilience for maltreated youth is that violence does not continue to be part of their day-to-day living environment. Mandatory reporting is a potential resilience vehicle to a set age point (typically age 16 for involvement of CPS) (Wekerle, 2013). How to protect vulnerable youth beyond 16 years of age is not a topic of sufficient policy attention.

The United Nations Rights on the Convention of the Child (CRC; http://www.unicef.org/crc/),) and the United Nations Development Program Millennium Development Goals (MDGs) target youth health, safety, participation and empowerment as key driver's of living in a social justice context. They argue that external instrumental support and social conditions need to be consistent features to support resilience development over time. It includes violence prevention and safety, as well as the capacity to function on a day-to-day basis and to enjoy life. Once violence has ceased, and coping with violence is not a direct reflection of the immediate environment, opportunity arises to transform distress (negative stress) to eustress (positive stress) that galvanizes post-traumatic growth. This process may involve a utilization of one's unhappy expertise with violence to empower one's own and others' lives where the maltreatment experience is integrated and the "silver linings" of learning are what are forged and refined. This sort mastery process may take the form of volunteering, advocacy, and other compassionate action, supporting the social connectedness that is a well-established core strategy for resiliency (Rutter, 2013). A case study of sorts is presented in this issue in terms of the advocacy sparked from one child's fatality to human rights advocacy on a national scale. The intersection between health and social services is highlighted in a tragic case of an Aboriginal youngster, Jordan River Anderson, who fell in the cracks in the jurisdictional financial support systems to provide for medically-safe home care in the context of special needs rather than hospital living, and who inspired policy shifts with "Jordan's Principle" (http://www.fncaringsociety.com/jordans-principle) without, however, the expected updated practice standard. The power of one wronged child to galvanize a community

to reach practice guidelines and international expertise is an example of developmental advocacy (Blackstock & Auger, 2013).

Resilience processes may be based on past success strategies, current applications, future reasonable expectations and, for maltreated persons, a concerted effort to address power abuses: "Dreams in which failure is feasible….To never simplify what is complicated or complicate what is simple. … To respect strength, never power" (Roy, 1999, p. 104-105). Glad, Jensen, Holt and Ormhaug (2013) examined post-traumatic growth among adolescents receiving trauma-focused cognitive behavior therapy, wherein a central goal is to de-sensitize to the anxiety-inducing impact of trauma cues, while forming a coherent narrative of the trauma event. Most youth experienced more than one form of trauma (witnessing domestic violence, sexual abuse, sudden loss etc.) and identified adverse effects only at pre-treatment. At post-treatment, a substantial number reported some positive learning in personal and interpersonal areas, and age was predictive of post-traumatic growth. Resilience findings emphasize the importance of personal development processes, such as planning, self-reflection and self-agency, to improved outcomes (Rutter, 2013). Youth with more positive self-views are more likely to show change from pessimism towards greater optimism towards living (Duke, Skay, Pettingel, & Borowsky, 2011). CPS youth who score higher on self-compassion (i.e., the cognitive and affective orientation of viewing failures compassionately and seeing struggles in the larger context) evidenced fewer self-harming behaviors than their lower scoring counterparts (Tanaka, Wekerle, Schmuck, Paglia-Boak & The MAP Research Team, 2011). More generally, self-compassion has been found to contribute to adolescent well-being, over and above other factors, including maternal support (Neff & McGehee, 2010). Little work has been done in terms of compassion programming for CPS youth. One randomized trial provided cognitively-based compassion training to foster care, mid-adolescent females to test whether innate, inflammatory responses to an experimentally-induced stressor would be minimized among the intervention youth relative to wait-list controls (Pace et al., 2012). The intervention consisted of twice weekly, 1-hour sessions that included teaching and practice in meditation, as well as a meditation CD for home practice wherein relaxation, as well as practicing kind/warm thoughts, is the main emphasis. No group effects were noted beyond a trend in a reduction in state anxiety; within group differences were found favoring the number of practice sessions and a reduction in morning salivary cortisol. Given the novelty of this approach for adolescents, and maltreated youth in particular, further inquiry into the parameters of meditation practices for CPS youth to yield demonstrable therapeutic gain as stand-alone interventions would seem useful. Review of the potential utility of such meditative practices support it as promising in addressing indices of stress reactivity in adults (Hoffman, Grossman & Hinton, 2011). Further, there is an emerging literature on technology-based mental health service delivery (for a review, see Zinck et al., 2013). which may be a good fit for the delivery of a mediation-based intervention. The area of resiliency mechanisms among maltreated adolescents remains a research priority for supporting the identification and tailoring of practice strategies.

What are promising practical strategies in resilience for maltreated adolescents?

It has been argued that randomized controlled trials of CPS-level interventions are both ethical and feasible (Tanaka, Jamieson, Wathen, & MacMillan, 2010), and can help pave the way forward for assessing resilience programming from a rigorous standpoint. Such resilience programming may be at a systems level. Systems science has been suggested as applicable to physical health issues, such as pediatric obesity (Black & Hager, 2013) that considers how policies affect the healthcare system, that in turn supports a youth within a family context with environmental resources that are both physical (e.g., community centers) and social (e.g., cultural practices). A continuity of care model seeks to ensure medical resources to optimize youth functioning, energize community resources to support youth continued skill-building, ensure on-going social connectedness over extended periods (e.g., emerging adulthood), and support the transition from prevention to treatment services as needed (Weisz, Sandler, Durlak & Anton, 2005).

The current context is that there has been an increase in the millions of U.S. young adults living at home (IOM & NRC, 2013). At-risk youth from CPS should not be at a greater disadvantage than their non-CPS or non-maltreated counterparts. Particularly when a CPS youth has a corporate parent when a youth is in permanent out-of-home placement, CPS as a social service system *de facto* becomes a healthcare broker. The institutional norms within CPS may not be facilitative of optimizing resilience, especially if caseloads are so high that case management is crisis-driven, rather than building a healthful day-to-day living environment (Toth & Manly, 2011). Given that CPS youth are aged out of social services, dedicated transitional services that have meaningful partnering among health, social, and community services, would seem to be an important area for innovation for continuity of care within a community (Christian & Schwartz, 2011; Gorter et al., 2011).

One specific issue is the adolescent pregnancy and parenting. The expectant adolescent is an important target for resilience programming. Among adolescents who gave birth in California in 2009, 44.9% had been reported for childhood maltreatment, 20.8% had their maltreatment substantiated, and 9.7% had a foster care placement (Putnam-Hornstein, Cederbaum, King, Cleveland, & Needell, 2013). In a Swedish study, CPS-involved youth were more likely to become teen parents than non-CPS youth (Vinnerljung, Franzen, & Danielsson, 2007). The well-established maltreatment prevention programs (Olds et al., 1998; MacMillan et al., 2009) show improvement to the parent, as well as the target child. It may be very appropriate in urban centers to have CPS partner with public health to ensure the receipt of these maltreatment prevention programs as one means of fostering the resilience of the adolescent parent. As Currie (2011) advances, we need to care about the prenatal environment in terms of environmental stressors (adult intimate partner violence, substance use, environmental pollutants) as difficulties come to more costly systems at crisis levels, when the trajectory of dysfunction and disadvantage has an earlier starting point. However, beyond prevention programming in pregnancy, prevention programs that target young adults, especially when risk issues co-occur, are currently limited (IOM & NRC, 2013).

Mental health is developing collaborative, early help models that may be transferable to the CPS context. Access to mental health care is viewed as facilitated by addressing the primary care context, bolstering community engagement, and providing tailored intervention, and recognizing that the potential service recipient is uncertain of help (i.e., when to seek help, where to seek help, help options) (Gask et al., 2012). Following an understanding of candidacy for help, other processes ensue, including resource navigation (e.g., the use of a community health or social worker; continuity of care with interfacing with primary care provider, partnerships with volunteer organizations etc.). As applied to the CPS context, this would involve standard screening in mental health and other health risk issues that could detect sub-clinical, chronic concerns (e.g., level of distress).

One prevention model that may be promising for CPS populations focuses on tailoring intervention to stylistic ways of thinking and responding emotionally (Conrod et al., 2013). Delivered in the school context, a brief (two sessions), group-based cognitive-behavior therapy intervention is offered following screening on risk behavior (alcohol use) and personality vulnerabilities (e.g., depressive; anxiety-sensitive; sensation-seeking; impulsive). To date, promising results h ave been reported in reduced substance use. Resilience programming on healthy relating to oneself and to others as the core therapeutic strategy may have the potential to address a range of adolescent health risk behaviors.

The United States' Centers of Disease Control and Prevention articulate safe, stable, and nurturing relationships (SSNRs) as inoculations to counter violence risk (http://www.cdc.gov/violenceprevention/pdf/cm_strategic_direction--long-a.pdf). Consistently, close relationship networks emerge in resilience reviews (e.g., Afifi & MacMillan, 2011; Cicchetti, 2013; Herman, Stewart, Diaz-Granados, Berger, Jackson, & Yuen, 2011). One broad-scale resource, available in schools or in communities, is the Big Sisters, Big Brothers program, with demonstrated gains in randomized trials (Herrera, Grossman, Kauh, & McMaken, 2011). Such youth mentoring programs can strengthen parental involvement (Spencer, Basualdo-Delmonico & Lewis, 2011). The importance of school

connectedness to buffering psychological symptoms among youth who have received CPS is evident in a population-based study of Ontario students (Hamilton, Wekerle, Paglia-Boak & Mann, 2013). Fostering social connectedness is greatly challenged when youth are multiply challenged, such as housing insecure (Edinburgh, Harper, Garcia & Saewyc, 2013), and with intellectual disability. For example, youth with mild to moderate intellectual disability receiving on-going CPS services fare more poorly than their average IQ counterparts in terms of distress levels and relationship violence, particularly among those reporting a more avoidant approach (Weiss, MacMullen, Waechter, Wekerle & The MAP Research Team, 2011; Weiss, Waechter & Wekerle, 2011). Given the multiple needs of CPS youth, it seems particularly important to address the mediating environment that can carry maltreated youth forward in a way that does not sustain an experience with violent victimization. There are so many service points where the safety net for maltreated children could have provided more support. It seems fundamental to social justice, public health, injury prevention, and good government to ensure that maltreated youth we are aware of and brought into a child protection context are able to transit to emerging adulthood with resilience. Finally, it is a matter of replenishing the social safety net by ensuring financial success with the contribution and workplace engagement of CPS youth as adults (Currie & Widom, 2010).

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