Promoting Resilient Children: Practical Applications From Research

Chair: John W. Hagen
Introduction: Naomi Goldstein
Discussant: Claire Dunham
Presenters: Jeanne Brooks-Gunn, Brenda Jones Harden

- **Early Intervention: Promoting Competence in Young Children**
  Jeanne Brooks-Gunn

- **Who Are the Children at Highest Risk, and What Can Be Done to Ameliorate Risk?**
  Brenda Jones Harden

Goldstein: Why do some children thrive in difficult circumstances while others do not? The topic is particularly relevant for the Head Start population since low-income children are more likely than others to be exposed to a range of threats to their well-being and development.

Brooks-Gunn: There are four ways to think about risks, including risks in the context of poverty, ethnicity, human capital, and psychosocial risks. The issues of ethnicity could be considered the elephant under the rug and should be thought of in terms of what can be done to alter existing ethnic gaps in school readiness that exist. It is important to realize the ethnic gaps seen in schooling; school achievements in 12^{th} grade, which are about 60–70% of that gap, exist at the time of kindergarten. How children are doing in kindergarten carries through their life.

Differences were discussed in terms of what programs are most likely to reduce the gaps between Blacks and Whites and Hispanics and Whites. In an example from a national study of vocabulary test scores between 3- and 4-year-olds, there is a significant difference in tests between Blacks and Whites. For example, if the difference is 12 points, and there is a 15-point standard deviation, which constitutes about 80% of the standard deviation gap, it is possible to take standard deviation gaps in test scores and change them into the kinds of language that people think about intuitively. This is helpful when talking about standard deviations to policymakers.

In a special issue of *History of Children* based on the work done by Duncan and Brooks-Gunn, test score gaps between Blacks and Whites and Hispanics and Whites from the ECLS-K data set were examined. There was a 60% standard deviation gap between Blacks and Whites and 71% gap for Hispanics. Many have made the argument that the life circumstances of Black and White children could not be different enough to account for the test score gap. This is an example where the bell-curve people are wrong. Looking at a simple socio-economic index and the differences between Black and White children on socio-economic status, test score gaps reflect that Black and Hispanic children live in a very different America than most White children.

Social class matters for many reasons including: purchasing child care, providing learning materials in the home, purchasing better health care, having health insurance, and being able

to move to a better neighborhood. In addition, as the work of McLoyd and others show, families who are poor are more likely to be more depressed and have more stress, leading to harsher parenting, which in turn is related to poor child outcomes. These are the pathways through which we might intervene for children.

In the special issue, authors looked at low birth weight, health conditions, parenting, and child care to see (a) if the problems of various conditions are different for Black, White, and Hispanic children; (b) whether or not any of these conditions is related to academic school readiness; and (c) if both of those things are true, how much of the test score gap could be reduced by changing these conditions so that Black, White, and Hispanic children are equal.

Data revealed that there are significant gaps between Blacks and Whites in health conditions such as, low birth weight, asthma, iron-deficiency and ADHD. With the exception of iron deficiency, all of these health conditions had effects on school readiness. Individually improving each health condition only closed about 1-2% of the cap. However, by improving all of the individual health gaps together to alter the health of Black babies, the test score gap was reduced by about 10%–14%.

The same procedure was used for parenting behavior. It considered various aspects of parenting—nurturance, discipline, teaching language, and monitoring management and materials. The effects sizes were huge. If three of these behaviors were on parity between Blacks and Whites or Hispanics and Whites, 20%–40% of the standard deviation, the test score gaps would be reduced. Regarding parenting when controlling for social class, the differences were reduced but they did not disappear. There is little difference in social class in terms of nurturance and disciple, which are not considered aspects of parenting so these would not be good areas for intervention.

In terms of child care enrollment in preschool at ages 3 and 4, and enrollment in Head Start, the quality of programs was examined. Preschool enrollment rates were higher for Blacks and Whites than for Hispanics, both for 3-year-olds and for 4-year-olds. If enrollment in preschool of Hispanic and Black children was increased to 80% for 3- and 4- year-olds, the gap would be reduced by 4% to 20% for Blacks and 12% to 52% for Hispanics. The effect is higher for Hispanics because so few Hispanics are in preschool.

Looking at the enrollment of children by race in Head Start, 20% of Black, 15% of Hispanic children, and 4% of White children were enrolled in Head Start. If Head Start did not exist, the gaps in preschool enrollment would increase for 3- or 4-year-olds put together: 9 percentage points for Black children and 31 percentage points for Hispanic children. Gaps in school readiness would increase if Head Start did not exist.

Attending high-quality preschool is associated with school readiness. These effects are more likely to occur for children whose parents are low income or have low levels of education. This has been shown in several different studies where there have been ranges of income and education. One cannot show this in Head Start or Early Head Start because all children in Head Start are poor by definition. However, one can in some of the other studies that exist.

Interestingly, there would not be as big of a reduction in the gap of school readiness by improving the quality of the preschool as increasing preschool attendance.

Programs that are likely to reduce these gaps slightly will be education programs for low-education mothers, income supplementation, and income tax credits. Modest gap reductions include enrollment in health care programs. Even though a lot of children are eligible, there is still an enrollment problem. Quality of health care is an issue that researchers are studying. WIC nutrition programs have not shown to be very effective in decreasing school readiness gaps. The programs to reduce low birth weight have not been able to do a good job. Home-visiting parenting programs changed parenting behavior, but few of them have shown changes in children aged 4 or 5 in school readiness.

Reviews of literacy and reading programs for low-literate mothers found that the targeted programs were the ones that were most likely to make a difference. These are programs with very specific curriculum. In general, programs such as Even Head Start have not shown effects on children's achievement although they have shown some effects on parents' reading. There are some programs, such as Dialogic Reading, that have shown incredible effects, and these kinds of programs need to be dropped into Head Start and other preschool programs. The same is true for programs such as Webster-Stratton's program for mothers of children with moderate behavior problems.

From the review of the literature, two things become clear. One is that specific drop-in curricula in programs need to focus on more than has been done in the past. The second is that there are some strategies that probably are not going to make a difference if the focus is on preschool academic readiness. If the focus is on something else, there may be other options; but if it is school readiness, then it is important to think carefully about the types of home-visiting programs that are implemented.

Jones Harden: Resilience is a dynamic process in which resilience at one point of development does not necessarily mean resilience at another point of development. Resilience can exist in one particular domain, but not in another. For example, in some of the work on children exposed to violence, children who appear resilient in terms of academic outcomes are high in terms of internalizing symptomatology. It is a dynamic process that has to do with domain as well as developmental timing.

In terms of adversity, resilience carries with it a whole range of contextual risks. However poverty trumps them all. It comes with many of adverse factors that children have to contend with: parental mental illness being a particularly potent one; parenting issues; child maltreatment, a range of family processing including whether families are stable or not. Although foster care is considered a protective factor for these children, upon closer examination, children moving from multiple homes to multiple homes is not always a protective factor.

Thinking about protective factors in the large ecology is desirable, but it is also important to think about protective factors in the child. Changing the ecology makes more sense than changing the child. However, Head Start, because of its child development focus, could

impact some of these child-resource level factors: physical health, the transaction between the child and the care-giving environment, temperament, and intellectual competence. In addition, there is the potential for impact in terms of ego resilience, that is of children being able to be flexible, compliant, and persistent.

Researchers focus a lot on content, fostering children's literacy and to a lesser extent numeracy, but there is not as much focus on the kind of executive functioning that might predict resilience. In terms of protective factors in the ecology, the most important data coming out of the resilience literature is the power of relationships to make a difference for children, and obviously close relationships with parents make a difference.

Poverty is the major risk factor for maladaptive outcomes. Poverty is linked to many contextual risks, which increase the vulnerability of children and families, including maternal mental illness, depression, and substance abuse. Other issues are intimate-partner violence, partner support that might cause family conflict, poor parenting, and child maltreatment. In a different group of children, not just poor children, there is a lot of depression. The Early Head Start study finds that a third of the mothers are depressed, and smaller studies show that maltreatment is a salient issue now. In Webster-Stratton's work in Washington, she found there were a significant amount of maltreated children in her sample. That resulted in efforts to better interface between the Children's Bureau and the Office of Head Start, to looking at the children in the child welfare system.

These families face many risk factors above and beyond poverty. It is important to think about those from the resilience perspective, and what can be done about them. Looking at the literature on resilience in children of parents where there is substance abuse or the psychopathology that comes from children of parents who were mentally ill, there is little about how to promote resilience in those children.

Head Start and, in particular, Early Head Start, focus on pregnancy and can have an impact on children' dosage of toxic drugs. It is difficult to get mothers who are addicted to drugs to stop using them. The most successful programs suggest that having a baby is a good window of opportunity to intervene in these mothers' lives. It is possible to work for abstention during pregnancy, and then after delivery of the baby, usage goes right back up.

Availability of responsive, safe care is another issue that comes out in the literature. Having a grandmother, an aunt, or another responsible adult in the house who provides safe care for the child when the cocaine-using mother disappears for days, enables the child to be more resilience.

Maternal commitment to treatment does not work. The work of De Mason and others shows that even in high-level treatment programs, mothers are not abstaining. This raises the question as to why Head Start would try to make them abstain if the good treatment programs do not work. However, the mother's commitment to try and work on these issues seems to make a difference in terms of her relationship with her child and how she thinks about her child. For example, when she gets ready to disappear on her 4-day binge, is she

able to call her sister and say, “I’m getting ready to leave the kid, can you come over here?” Her ability to do that much suggests that she will be able to promote resilience in her child.

Because of the abundance of data on the negative impact of depression on children, researchers have started to look at resilience more. One of the things that came out in the literature is that a secure attachment, even to a depressed mother, is important. Just because a mother is mentally ill does not mean she cannot be a good parent. Some of the data suggest that if she has a relationship and a positive interaction with her child, even if she is struggling with her own depression, the child will have more adaptive outcomes.

Some interesting data have come out of a study of a learning center, where they change the parent management strategies of depressed mothers so that they are more appropriate in their parenting. That has reduced the depression. By relieving the stress of the mother, her child has more adaptive outcomes. When mothers are more warm and sensitive in their interactions, less controlling, and less intrusive, their children have better adaptive outcomes.

One of the things that came out in the literature is the level and type of exposure to violence the children had, and in particular, the child’s psychological distance from the traumatic event. For example, direct victimization would have more of an impact on children. McAlister-Groves addressed the importance of someone helping the child understand that the traumatic event was not something that they caused.

Thinking about that and decreasing the severity and chronicity of the exposure will help children; however, there are some other things that seem to promote more adaptive outcomes. For example, once again there is the relationship with the caregiver. When thinking about the data from children of war, children in Katrina, whatever kind of trauma to which the child is exposed, there needs to be someone to help process what is going on, and to help them feel safe. That could be a parent-teacher or child-care provider.

If the person who is victimizing the child is a caregiver that s/he trusts, then it makes sense that the child may not be as adaptive. In addition, family factors like maternal mental health and coping in a maternal history of maltreatment, seem to have a relationship with positive adaptation. Children in high risk are not doomed to have poor outcomes. Relationships are key as adaptation changes over time. Early intervention may be a long-term protective factor.

Head Start can do many things. To do that, its prevention emphasis is a comprehension approach: it can tag specific child and family risk factors and use the family-support component to do a variety of things, as well as focus on the child. Emotion regulation is something that the Head Start community also can work on. By focusing on the child’s social and emotional health, creating a predictable routine, and developing relationships all help children cope with trauma. There is the provision of a safe haven, along with the opportunity for symbolic playing and language development, hat work well for trauma. Symbolic play also promotes intellectual confidence, which is Head Start’s goal.

Dunham: Resilience is a state of being and the social, emotional core of the human experience. It describes the way that a child or a parent sees themselves in the world. Do they feel safe, secure, loved, and supported? Do they believe that they can have an impact on their own lives and solve problems, get past barriers? Do they think something positive is going to happen in the future? When children are surrounded by a lot of risk factors, they can still thrive and develop if they are surrounded by enough positive relationships. A child's resilience can be increased by surrounding him with relationships, particularly focusing on the frequency, consistency, and quality of the relationships with the adults in his world.

The Head Start and Early Head Start Program Performance Standards are built on these ideas. Research thus far has shown that by putting the Performance Standards into practice, many good outcomes will result for some of the families. However, that is not good enough. The challenge is to move beyond the conventional wisdom of the current program designs and deepen the understanding of what works to reduce risks and produce resilience. Positive relationships with families are important; however, without an intervention that directly addressed risk factors, positive relationships do not matter.

There is still much to be learned about how to develop effective prevention programs. The more that is assessed and understood about the true nature of the challenges faced by the children that Head Start serves, the more that will be understood about why so many of interventions are falling short. Prevention programs are designed to provide a range of supports to a target population. While these supports are therapeutic in many cases, they are not therapy.

The hallmark of a formal therapy relationship is that there is some acknowledgment on the part of the client that there is something in their life that they want to change. They are usually in pain when they come to treatment, and they seek out help to try to deal with it. This is significantly different from how a parent in a family enters into a prevention program like Head Start. Families come because they want something better for their children. Parents are recruited with stories about how programs are going to help their children learn how to read better and how to be successful in school. Head Start reaches out to parents, to involve them in their child's education. It tries to set goals for parents as well as their children, but they often do not participate in ways that researchers think would be most effective. Engaging a high-risk family is one of the primary challenges.

Once these children are in Head Start, the focus is on the classroom environment, skills, the knowledge set of the teachers, the quality of the supervision and the coaching, and how well Performance Standards are adhered to. Much attention is spent on that, yet there is still a struggle to connect with parents. The parents are the key.

There are specific skills or activities that some families do differently than others. In order to design a program that addresses these differences, it is necessary to understand not only the differences, but why these differences exist. Teen parents are tired and cranky when they come to pick up their children. They are not enthusiastic about seeing our staff hovering around the classroom trying to talk about their children's education, trying to schedule a

home-visit, trying to get them to come to a parent group, or to get involved in the parent policy committees. Everyday, Head Start tries to balance making the program appealing to high-risk families so they will participate in the direct teaching instruction, and learn the knowledge and skills to make effective changes in their and their children's lives.

There is always the fear that the highest risk families in the program will not continue if they are pushed too hard to make real changes. These families feel like they are not resilient enough to absorb our direct interventions. Head Start tries to create space for the families who have never felt consistency and routine in their relationships. Those families are afraid that if we find out who they really are and what they are really dealing with, Head Start will probably reject them too.

Relationships are the key point in engagement with these families. Home-visiting programs are marketed to families as a way to build a better, stronger relationship with their child. That is a specifically stated goal of the program that is repeatedly expressed to young parents. Parallel process is used to reinforce the relationship between the home visitor and the parent, paralleling the relationship between the parent and the child in achieving consistency in routine, trust, and support. These are characteristics of positive relationships. There is a connection between feelings of success in a relationship and the parent being able to develop the next level of skills. How are they going to be able to enhance their language, teaching, and the provision of materials for their child, if they do not have a sense of being confident and successful in their relationship with their child? In center-based settings, support groups, art, artistic performances, and family literacy events are used to get families to participate. This creates a way of increasing the number and the quality of relationships that the children in our program are experiencing with adults in their lives.

Another strategy that helps to promote resilience and relationship is videotaping. This modality has been worked with for over 20 years. There is a multi-level method using videotaping to try to deepen the relationships and build skills in parents, program staff, and supervisors. Staff is trained to do videotapes of parents and children in daily routines.

Bath time, when the child is getting dress, and mealtime are the nuts and bolts of family life when intimate relationships are forged. By watching the tapes with the parents, pointing out the moments when they read their children's cues correctly, and talking about how a successful interaction with their child feels builds positive experiences for parent and child. Together, the home visitor and parent wonder about what they could do next.

Once a parent begins to feel comfortable with this level of intervention, they are videotaped watching another tape with the home visitor. That allows a deeper intervention as to what the home visitor is doing and what is done with those tapes. The supervisor looks at those with the home visitor and they talk about what is working and wonder together about what they could do in the next interaction to try to get deeper and deeper inside. For example, "it looks like the relationship is working this way, what do you want do now?"

The next level is for the supervisors to tape themselves working with their staff. They bring those tapes to training and support groups at the Ounce of Prevention, where we watch the

tapes with groups of supervisors looking at how they are attending to the supervision and addressing the developmental needs of their staff. This builds self-awareness as a professional competency. It also allows them to see themselves in action in their work, which is a powerful professional development strategy. They can create profound feelings of building competence, which is critical for success in a program.

The last strategy is using assessments. The number and the type of assessments that have been used in both center-based and home-based programming have been expanded. More measures of language and literacy development and social and emotional development are being used in center-based programming. Teachers and parents assess the same children using the same scales, compare and contrast, and discuss the results. The assessments focus on more individualization for particular children. In the home-based program, more assessments of social support, maternal depression, and parental efficacy are being conducted, all of which help to focus more extensively on the relationship. These strategies are helping to get more and more specific about what we need to do with particular families.