Family Resilience in the Context of High-Risk Situations

10

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Introduction/Background

Risk-focused research encompasses studies that test hypotheses that suggest the presence of a certain incident or quality increases the likelihood that a person will experience a negative outcome. Researchers commonly test risk models in health studies to identify predictors of various disorders. For example, understanding that smoking increases one's likelihood for lung cancer leads the medical field to identify smoking as a risk factor of this disease. Identifying risk is important for two reasons. First, recognizing risk offers implications for prevention. When risk factors are identified, preventing the presence of these factors can lead to improved health outcomes. Additionally, assessing one's level of risk may assist in diagnosis, as physicians can assess for disorders that may be predicted by one's personal and medical history.

Seeing the benefits of this approach, many leaders within the social sciences advocated for the adoption of the medical model, including its focus on risk identification and reduction. Rather than examining risk factors for various health disorders, social science researchers seek to identify risk factors that predict poor outcomes related to mental health or social functioning. For example, early studies were able to establish a connection between childhood experiences and one's risk for the development of addiction to alcohol or other drugs. Specifically, a body of literature suggests that growing up in a home with a parent who faces alcohol or drug addiction increases a child's likelihood for developing his or her own problems with addiction into adulthood (Chassin, Pitts, DeLucia, & Todd, 1999). Research based on risk models has contributed important knowledge to the social sciences as a set of risk factors have been identified, leading to important prevention and intervention efforts.

Despite the important contribution of this research, more recently researchers have recognized that risk factors are not the only predictors of functioning (Benard, 2004; Rutter, 2000; Werner & Smith, 2001). As research developed, social science leaders became interested in outliers, or the cases that failed to follow the expected trajectory based on one's risk. In other words, while researchers understand that being raised in a home with a parent facing addiction increases the likelihood that child will develop her own addiction issues, not all children raised in this situation end up experiencing this problem. What is different about these cases?

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This very question led many child development researchers to conduct studies regarding pathways toward resilience. The construct of resilience refers to situations in which individuals are able to avoid the negative outcomes associated with risk (Benard, 2004; Luthar, Cicchetti, & Becker, 2000; Rutter, 2000). Specifically, researchers are examining resilience when they look at individuals who are at high risk for a negative outcome but who maintain healthy functioning despite this risk. To explain these varied pathways, researchers interested in resilience measure not just risk factors, but also seek to identify protective factors, or the experiences and qualities that appear to buffer the negative effects of risk. Protective factors include strengths and resources that help individuals sustain functioning despite the challenges they face (Mandleco & Perry, 2000). Examples of protective factors include things like social support, a sense humor, and flexibility (Benard, 2004; Lietz, Lacasse, & Cacciatore, 2011; Werner & Smith, 2001), and are described in greater detail later in this chapter.

Resilience research was initially focused on child development and sought to identify the protective factors that help at-risk children avoid negative outcomes and grow into healthy adults (Garmezy, 1993; Rutter, 1987; Werner & Smith, 1982; Wolin & Wolin, 1993). More recently, researchers have become interested in applying the construct of resilience to family systems (Hawley, 2000; Lietz, 2006; McCubbin & McCubbin, 1996; Patterson, 2002; Walsh, 2003). Specifically, researchers have identified risk factors that can hinder the healthy functioning of a family unit. Family resilience researchers seek to examine the strengths or protective factors that help families to remain intact and functioning well despite facing a variety of risk factors known to predict family dissolution or discord.

The purpose of this chapter is to define family resilience in the context of high-risk situations. First, the literature is reviewed to describe the development of the construct of family resilience. Second, research regarding family risk factors is synthesized, providing information regarding some of the most challenging difficulties families face. Finally, the process of family resilience is presented by means of a typology that was developed through in-depth qualitative interviews with families who maintained and in some cases improved functioning despite their experience with multiple risk factors. The phases and corresponding family strengths are described, offering implications for clinical practice with families facing a variety of stressors.

Current Relevance of a Discussion of Family Resilience

A discussion of the risks and protective factors that impact family functioning offers important implications for practice and research. Considering the current economic situation, families are facing greater stress than ever before. More families are facing job loss and financial demands, requiring many to leave their communities to find affordable housing and new employment opportunities. At the same time, the social service system is stretched to capacity, leading to decreased services and support. While professional support services are hindered, personal support from extended family and neighbors is also challenged. When a family or neighbor faces a crisis, their support system typically rallies behind that family or neighbor. Because the current stressors facing families remain pervasive, the availability of this type of informal support is also limited. Finally, while financial strain and unemployment impact many, families representing all socioeconomic situations continue to face simultaneously both normative and non-normative stressors including but not limited to bereavement, health concerns, and the effects of natural disasters, creating the potential of a cumulative negative effect. Risk models simply inform us that these families are at risk for negative outcomes. More than ever, a resilience perspective that seeks to identify and build family strengths to support healthy coping and adaptation is critical to the health and well-being of our families and communities. Understanding the factors that buffer the negative effects of risk for families remains an essential part of clinical family practice.

Literature Review

The construct of resilience describes the ability to avoid negative outcomes associated with one's risk (Benard, 2004; Masten, 2001; Rutter, 2000). Luthar et al. (2000) define resilience as "a dynamic process encompassing positive adaptation within the context of significant adversity" (p. 543), while Walsh (2003) describes resilience as "the ability to withstand and rebound from disruptive life challenges" (p. 1). Early resilience research was influenced by Werner and Smith's (2001) seminal 40-year study of high-risk youth. These researchers conducted a longitudinal study that followed all 698 babies born on the island of Kauai in 1 year. One-third of the sample was identified as high-risk. These children (a) experienced perinatal stress, (b) were born into poverty, and (c) were raised in challenging circumstances including discord, addiction, or mental health issues of their parents. The sample of high-risk youth was recruited for participation and then assessed every 10 years. This study uncovered a set of protective factors, such as maintaining a relationship with at least one caring adult, that helped many of the children successfully overcome these challenges and ultimately developing into well-functioning adults. This important study prompted a growing interest in conducting research that examined how both risk and protection work together to better explain ongoing functioning (Garmezy, 1993; Garmezy, Masten, & Tellegen, 1984; Luthar, 1991; Masten & Coatsworth, 1998). This foundational research focused primarily on child development, specifically looking at how youth who experience high-risk circumstances cope with these challenges over time (Benard, 2004; Rutter, 1987).

More recently, the construct of resilience has been increasingly applied to family units. This perspective involves taking a systems approach to examine familial-level risk and protective factors that explain how families overcome negative effects predicted per a variety of adverse experiences (Allison et al., 2003; Black & Lobo, 2008; Hawley, 2000; Lietz, 2006, 2007; McCubbin, Balling, Possin, Frierdich, & Bryne, 2002; Patterson, 2002; Simon, Murphy, & Smith, 2005; Walsh, 2003, 2007). It is critical to note that having a supportive family is identified as a protective factor in the early child development literature, suggesting that healthy family functioning can predict positive outcomes for children. When speaking about family resilience in this chapter, this conceptualization does not reference the family's impact on the individual, but instead takes a systems approach, looking at the family as a collective unit whose outcomes are also of interest. Specifically, family resilience is a familial-level construct that looks at the family as the unit of analysis to understand the risk and protective factors that support healthy adaptation and functioning for the family as a whole.

Risk Factors

All families face a series of stressors throughout their life as a collective unit. Normative life transitions such as marriage, childbirth, retirement, and relocations, while representing positive events, still increase the demands on the unit. Concurrently, losses, such as the death of a parent, although at times expected and part of the normal family life cycle, also remain challenging for many. Even daily hassles or minor disruptions create strain on a family, particularly when the capabilities and resources to cope are diminished (Patterson, 2002).

In addition to normative life events, many families face adverse events that also can exert a negative effect on functioning. For example, when family members experience traumatic bereavement, serious chronic or terminal health disorders, major disasters, long separations, and ongoing financial hardships, these risk factors, particularly in the context of multiple stressors, can increase the likelihood that the unit will experience family discord and dissolution.

Traumatic Bereavement

Loss is a part of being a family. Normative losses are difficult for family members even when death is expected and part of the normal life cycle. However, the level of risk attributed to bereavement is enhanced when deaths are sudden, unexpected, or occur in such a way that they are traumatic for family members (Walsh, 2007). For example, Davies (2004) notes that the death of child is "recognized as the most intense and overwhelming of all griefs" (p. 506). The loss of a child due to stillbirth, SIDS, a health disorder, accidental death, or suicide incites emotional pain that can affect the psychological functioning of individual family members as well as the functioning of the family as whole (DeFrain, Martens, Stork, & Stork, 1990; Murphy, Johnson, Wu, Fan, & Lohan, 2003).

The loss of a child creates a crisis state for families requiring role adjustment and reorganization of the system (Fletcher, 2002). Ongoing parent–child interactions, sibling relationships, and connections between couples can be impacted by traumatic bereavement. Specifically, Murphy et al. (2003) found increased marital distress for parents bereaved through homicide, and noted that a sample of parents whose children died due to accident, homicide, or suicide reported higher levels of mental distress and trauma. Song, Floyd, Seltzer, Greenberg, and Hong (2010) report that research has identified an increase in marital distress for couples who face the loss of a child and demonstrate that the level of marital closeness affects the ongoing health-related quality of life for parents. Similarly, a review by Scwab (1998) suggests that while child death does not predict increased levels of divorce, many couples do experience strain on the marital relationship. Traumatic bereavement can increase a family's level of risk relative to a variety of outcomes.

Terminal and Ongoing Health Diagnoses

When a family member is diagnosed with a serious chronic or terminal health condition, the knowledge of the presence of the disease along with the increased time and financial demands can create a hardship for many family systems. McCubbin et al. (2002) assert that a childhood cancer diagnosis creates many new challenges for families, including multiple hospitalizations, painful treatments, and new role demands while the members must grapple with the possibility of mortality. Their review suggests that childhood cancer can put families at greater risk of post-traumatic stress symptoms (PTSS), decreased marital quality, and parental emotional distress. Similarly, Pai et al. (2007) found an increase in distress and perceived level of family conflict, particularly for mothers, during the year following a pediatric cancer diagnosis.

A study by Holmes and Deb (2003) suggests that the presence of a variety of chronic illnesses can exert negative effects on the family system and that these effects are increased when the family's financial resources and insurance coverage are lacking. Similarly, Midence (1994) asserts that marital conflict and strain are often increased for couples when caring for a child with a chronic health problem. Brown et al. (2008) reviewed literature related to the effects of chronic health conditions on the family and identified negative effects on the marital relationship, including decreased satisfaction with the sexual relationship and increased financial strain. Herzer et al. (2010) acknowledge that findings regarding the association between chronic health and family functioning are inconsistent, with some studies demonstrating negative effects of chronic health problems while other studies fail to establish this relationship. These inconsistent findings again highlight the importance of taking a resilience approach when considering risk. An examination of protective factors is needed to understand the variation in functioning for families facing difficulties such as chronic health issues.

Major Disasters

Landau and Saul (2004) define "major disaster as catastrophic or cataclysmic events that result in major disruption and/or massive and unpredictable loss" (p. 287). These events include natural disasters such as Hurricane Katrina and the 2010 earthquake in Haiti or acts of war or violence such as the

attack on New York's Twin Towers. The devastation of these events can put communities and families at risk for diminished functioning on many levels. Landau and Saul suggest that major disasters cause families to face temporary or permanent separations. These unplanned separations can increase role strain and decrease cohesiveness. In addition, they report that communication may be hindered due to the disorganization and chaos present as a result of major disasters.[1] The effects of these stressors may be enhanced by increased financial strain and unmet housing necessities as families are faced with new barriers in their attempt to meet basic needs (Kilmer & Gil-Rivas, 2010).

Along with the disruption of predictable patterns of family interaction, Figley (1998) explains that family members also may suffer compassion fatigue when seeking to help loved ones who have experienced a traumatic event. Indeed, the caregiving burden can exert a strain on family relationships. Additionally, a review by Pfefferbaum and North (2008) suggests that family members experience a ripple effect when one or more experience a disaster. Specifically, they assert that the effects of trauma are enhanced for parents. That is, the negative effects for adults with children compared with adults with no children are increased due to the "physical, economic, and emotional burden of caring for children" in the wake of a major disaster (p. 4). Finally, parenting practices may be diminished due to the increased demands placed on the adults in the family during the days, months, and even years after a disaster (Pfefferbaum & North).

Military Involvement

In the development of the concept "Military Family Syndrome" it was theorized that there would be negative outcomes for children growing up in military homes (LaGrone, 1978). However, many disputed this conceptualization as lacking empirical evidence (Cozza, Chun, & Polo, 2005; Drummet, Coleman, & Cable, 2003), and further research has demonstrated that many military families are able to maintain healthy functioning and parenting practices despite the stress of deployment (Kelley et al., 2001; Palmer, 2008). Although research has found that many such families are functioning well, studies suggest some of these families are at risk for a variety of negative outcomes.

Lamberg (2010) concluded that military families may experience an increased risk for child maltreatment. Specifically, Rentz et al. (2007) conducted a time series analysis of child welfare data in Texas, demonstrating an increase in substantiated reports of child maltreatment that was twice as high the year after military members in this area were deployed while the rate for nonmilitary families remained consistent. In addition to child maltreatment, other family relationships can be impacted by the strain of deployment. For example, one recent study by McLeland, Sutton, and Schum (2008) found that a sample of military men reported lower levels of satisfaction with their marriages at both pre- and postdeployment phases compared to nonmilitary married men.[2] While many military families are able to cope with the challenges of deployment, the stress of deployment, particularly when families face multiple deployments in relatively short periods of time, can enhance role strain, increase marital and parent/child conflict, and decrease levels of family connectedness.

Financial Strain

Extensive literature on the topic establishes poverty as a risk factor that can impact the health and well-being of children, adults, and family systems. Wadsworth and Santiago (2008) explain that "economic stress is grueling and demoralizing, leading to depressed mood among parents. This distress then contributes to conflict among parents and other family members and, eventually, to less effective parenting" (p. 399). Specifically, lower socioeconomic status has been linked with marital distress and

[1] For more on this topic please see Chap. 26.

[2] For more on this topic please see Chap. 7.

parenting stress (Hayden, Schiller, & Dickstein, 1998), a finding confirmed by Herzer et al. (2010). Furthermore, poverty has been linked consistently to an increased risk of child maltreatment (Cancian, Slack, & Yang, 2010).

The impact of financial strain is often intermingled with other risk factors. For example, as mentioned earlier, some risk factors such as chronic health problems can increase financial strain (Brown et al., 2008). Concurrently, the presence of financial strain seems to enhance the negative effects of other risk factors (Holmes & Deb, 2003). Assessing for financial strain in the context of other risk factors thus is important for practitioners working with high-risk families.

Risk Exposure

Understanding that all families experience normative and non-normative stress, family theorists often discuss risk, not as a singular factor, but instead in relation to its cumulative effect on ongoing family functioning. In other words, at any one time, most families must manage challenges ranging from financial strain, job changes, relationship transitions such as children moving into adolescence, or a spouse leaving the workforce, to other challenges of the life cycle. At times, families also face adverse events such as health issues or unexpected traumatic loss. Family theorists have found that the effects of both normative and adverse experiences are increased by the number and degree of the stress that occur simultaneously. McCubbin and Patterson (1982) call this the "pile-up" factor to represent the idea that facing multiple stressors in close proximity increases the potential negative effects for the family.

When discussing level of risk as a familial-level construct, context becomes increasingly important. Consider the diagnosis of childhood cancer. This adverse event would represent a crisis state for any family. However, for a single father recently out of work and currently without health insurance, the potential negative effect is exacerbated considering the level of stress already placed on this system. Essentially, exposure to multiple risk factors increases a family's vulnerability to negative effects. Patterson (2002) asserts that a crisis leads to increased and potentially ongoing family distress when the demands exceed the capabilities and resources. As practitioners work with families coping with normative life changes and adverse life events, assessment should consider the cumulative effect of ongoing exposure to risk.

Protective Factors

Although risk-focused research has offered advances regarding identification of factors that predict poor outcomes, resilience research seeks to explain variability in functioning by considering the impact of both risk and protective factors. Protective factors are internal and external resources and capabilities that help children, adults, and families overcome adversity (Mandleco & Perry, 2000). Internal protective factors include personal traits such as humor or flexibility that are helpful as people cope with the difficulties in their lives. Benard (2004) classified internal protective factors found in previous child development literature into these categories: (a) sense of purpose, (b) problem solving, (c) autonomy, and (d) social skills. External protective factors, on the other hand, are the areas of support present in one's environment and include things like relationships with neighbors, friends, and faith organizations (Gilligan, 2004; Hartling, 2003). Despite early ideas suggesting resilience is an intrinsic personality trait and that some are hardier than others, current conceptualizations suggest that resilience represents the human capacity for growth and adaptation through the assistance of positive personal and relational influences (Benard, 2004; Hartling, 2003; Walsh, 2003).

When looking at resilience as a familial-level construct, researchers have identified some common protective factors found to foster family resilience, including: *Appraisal* or the meaning families attach to the difficulties they face; *Spirituality* or a belief system that provides comfort, meaning, and direction; *Communication* about the difficulties the family is facing; and *Flexibility* as exhibited by

the family's ability to adapt and find solutions to manage the adversities faced (Allison et al., 2003; Defrain & Asay, 2007; Lietz, 2007; Patterson, 2002; Thomas, Chenot, & Reifel, 2005; Walsh, 2003). Researchers also have found reliance on a positive *social support* network through friends and family or through professional resources to be an important factor influencing resilience (Allison et al., 2003; Lietz et al., 2011). The following section provides a synthesis of four research studies that include in-depth qualitative interviews with families who rated high on risk, but who maintained and strengthened family functioning over time. Some material (in particular, the use of the qualitative quotes) is adapted from the articles describing these studies (Lietz, 2007, 2011; Lietz & Hodge, 2011; Lietz et al., 2011; Lietz & Strength, 2011). These stories of successful coping and adaptation highlight ten factors families identified as protective when dealing with adversity. Implications for clinical practice with high-risk families also are discussed.

A Typology of Family Resilience

The process of family resilience may be described by means of a typology that was developed from a set of in-depth qualitative interviews with families who were identified as being at high risk for family discord or dissolution. The first study identified a sample of families who experienced a series of risk factors yet simultaneously rated within the healthy range on a standardized measurement of family functioning (Lietz, 2006, 2007). This study led to the development of a typology (Fig. 10.1) that includes five phases and a set of protective factors (family strengths) that participants described when sharing their stories of resilience.

To build upon this conceptualization, a second study was conducted that examined this process of family resilience in the context of child welfare (Lietz & Strength, 2011). Specifically, families whose children were removed due to being identified as high risk for child maltreatment, and who achieved successful family reunification, were interviewed. These stories of resilience affirmed the conceptualization of the process of resilience and uncovered an additional family strength that was incorporated into the typology. Although the situations faced by the families in the first study were quite different than those of the families involved with the child welfare system, the degree of consistency between their stories when referencing family strengths was striking. In other words, as seen in the following descriptions, similar family strengths were referenced despite the differences in the challenges faced. A third study was conducted using qualitative secondary data analysis to examine the strengths *social support* and *spirituality* in greater depth due to the salience of these particular family strengths in the child welfare study (Lietz & Hodge, 2011; Lietz et al., 2011). Finally, a fourth study looked specifically at the phase of *helping others* and explored the ways some resilient families engaged in pro-social behaviors (Lietz, 2011). This study offers additional detail to the typology around the benefits of such activities. The findings from these studies are synthesized in the following section to describe how ten family strengths (Table 10.1) were helpful to families facing high risk in different ways at different times.

Family Resilience: A Process

The families who participated in these studies were at high risk for family discord and/or dissolution due to the cumulative effect of facing multiple risk factors. Specifically, these families experienced a variety of risk factors ranging from poverty or other financial strain, chronic or terminal health disorders, substance abuse, raising children with developmental delays or other special needs, caregiving for elderly parents, and growing up in unhealthy family situations. Yet, despite their adversity, these families were able to cope with the difficulties faced such that they maintained and ultimately enhanced the functioning of their family unit. Similar to other conceptualizations (Hawley, 2000; Luthar et al., 2000),

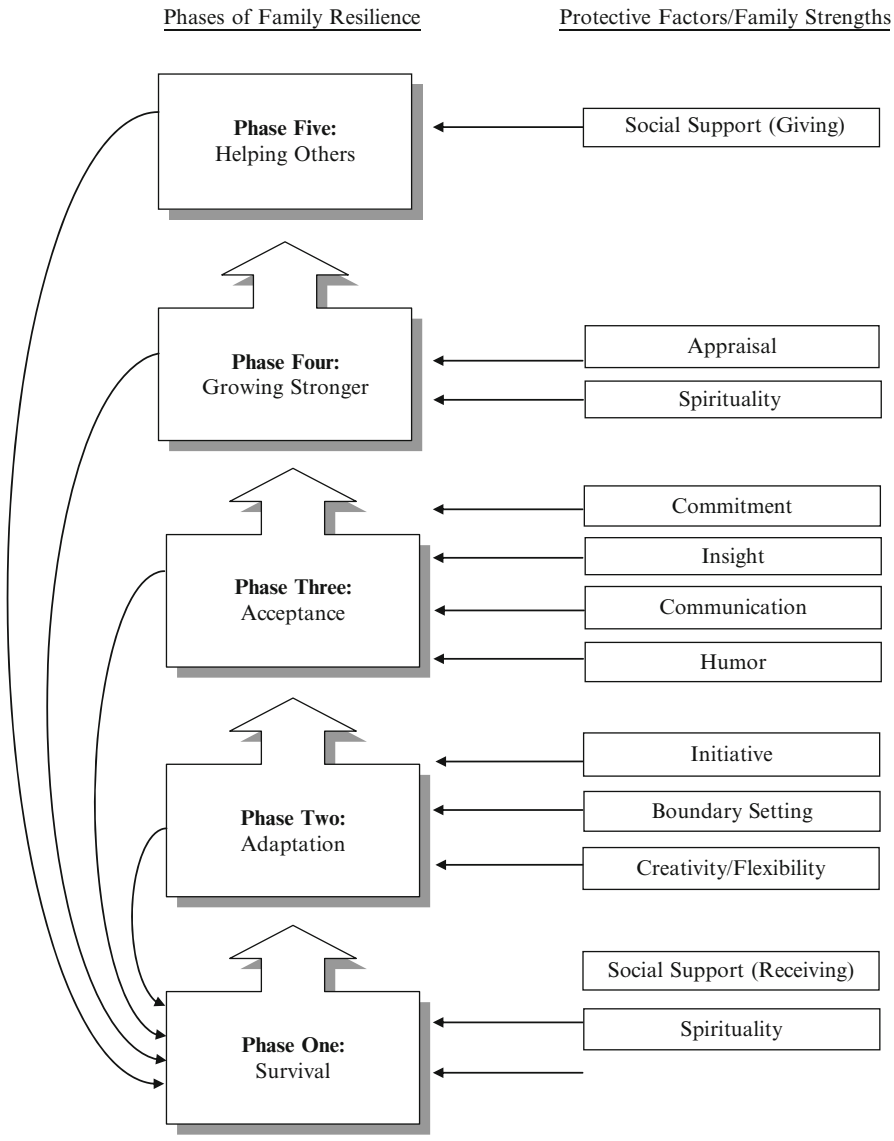

Fig. 10.1 The process of family resilience (Lietz & Strength, 2011). Adapted with permission from *Families in Society* (FamiliesInSociety.org), a publication of the Alliance for Children and Families

Table 10.1 Family strengths

Appraisal	Finding meaning in the difficulties families face
Boundary setting	The ability and willingness to separate the family system from influences that are unhealthy
Communication	Verbal and nonverbal expressions of thoughts and feelings regarding the crisis
Commitment	A strong desire to keep the family together and strong
Creativity/flexibility	The ability to find multiple solutions to a problem and the willingness to try new things
Humor	The ability to be light-hearted despite the challenges a family faces
Insight	The ability to gain understanding into a family's difficulty
Initiative	The ability and willingness to take action meeting family needs
Spirituality	A belief system that provides direction and strength to the family
Social support	Giving and receiving emotional and practical help in the context of relationships with family, friends, and service providers

Adapted with permission from *Families in Society* (FamiliesInSociety.org), a publication of the Alliance for Children and Families (Lietz & Strength, 2011)

when discussing their stories of successful adaptation, these families describe resilience as a process. Coping and adaptation do not occur in a time-limited fashion but instead grow while responding to new needs and challenges that arise.

As a result of the process-oriented nature of family resilience, many families described both their struggles and the strengths that helped them to cope effectively in narrative format. These stories represent a history-taking of the events of their lives within their context that better depict the meaning families attach to their experiences. Indeed, as researchers and clinicians listen to stories of family resilience, paying close attention to the ways characters and events are situated within in-depth descriptions can offer important clues regarding what families find helpful when seeking to overcome adversity. These stories also help to illuminate a progression, demonstrating that their needs and the corresponding protective factors change over time and offering important implications for clinical practice.

When families who participated in these studies talked about stress and coping, they identified ten family strengths that were important in different ways at different times. These ideas are conceptualized into a series of five phases as depicted in Fig. 10.1. These phases included: (a) *Survival*, a time at which families were taking 1 day at a time trying to figure out how to keep their family going; (b) *Adaptation*, which included the changes that the families made in order to incorporate their new situation into their lives; (c) *Acceptance*, which was a time at which families recall coming to adopt the new situation as their new way of life; (d) *Growing Stronger*, the moments families recognized that their unit was growing stronger as a result of the difficulties faced; and (e) *Helping Others*, described as a need for families to help others as a result of overcoming adversity.

It is important to note that the use of the term "phase" does not mean that families must progress through these moments in a linear fashion. The arrows on the side of the figure represent the idea that as families progress, they are commonly thrown back into earlier phases as new crises occur. Additionally, there is not an assumption that all families start in the same place. Instead, the presentation of phases and the corresponding family strengths help to emphasize how coping and adaptation developed for these families over time.

Phase 1: Survival

The survival phase represents a point in time when families discussed just trying to make it through each day. Many families explained that before making adaptations to their family life or even coming to accept an adverse event (often occurring in the context of multiple other normative and non-normative life stressors), they simply had to figure out how to survive. The family strengths cited as most important during this time frame included spirituality and social support.

Spirituality. Many view spirituality as an individual's existential relationship with God or the Transcendent (Gallup & Jones, 2000; Gilbert, 2000). Religion, on the other hand, represents an expression of the spiritual relationship developed in community with others who share similar experiences of a transcendent reality (Canda & Furman, 1999; Derezotes, 2006; Hodge, 2005). Therefore, religious practices are encompassed within the larger construct of spirituality. Many participants cited their family's spiritual and religious practices as highly important to their ability to cope with and find meaning in their struggles.

During the survival phase, many families asserted that the practice of prayer was an essential part of surviving during the initial days of a crisis. For example, one couple shared their story of successful child welfare reunification. They described in detail the day they were both incarcerated for drug possession. Speaking about this moment, the mother stated:

> Then while I was in jail, the CPS [Child Protective Services] lady comes to tell me I will never see my kids again, and I just fell apart. I remembered my grandmother told me that whenever you really need God in your life, to pray. And that's when I started praying. Everything felt a little lighter at that point, and I was like, well, we've got to move in the right direction now, rather than the one that I'd been on.

This mother described the moment she and her husband lost custody of their children as the most devastating event of their lives. This adverse event occurred in the context of multiple other risk factors including financial strain, substance addiction, and a recent relocation leading to isolation of this family. It was the adverse event of the removal that created a crisis state for this family that was already stressed to a great degree. In this story, both parents acknowledge a desperation that led to a decision to start praying again. As seen in this mother's narrative, she situated prayer just before the statement, "everything felt a little lighter at that point," suggesting that the strength of spirituality, through the practice of prayer, represented a transition in their process of family resilience. Their story culminated in a successful completion of the case plan, return of the children, and ultimately this family now provides training to foster parents and professionals regarding how to engage families involved with the child welfare system. The first transition in their story of resilience toward these successful outcomes is situated at this moment, "And that's when I started praying" suggesting prayer was appraised as highly important.

It is important to note that while the spiritual practice of prayer was important for many families during the survival phase, spirituality was important again for families during the growing stronger stage as beliefs support the important activity of meaning-making. Practitioners should understand that while meaning-making is important for families later, during the survival phase families are not yet ready to attach positive appraisals to difficult circumstances. For example, one family lost a child to SIDs. This family talked about feeling angered when people would make comments such as "at least your daughter is in heaven" within just weeks of her death. Later this family stated, "Knowing she is in heaven brings comfort." However, during the first weeks following their loss, this family leaned on prayer, but did not look to spirituality for meaning-making or positive appraisal.

Spirituality has been identified as an important strength that is helpful for many families (DeFrain & Asay, 2007; Lietz & Hodge, 2011; Ungureanu & Sandberg, 2010; Walsh, 2007). While spiritual practices such as prayer and meaning-making are not applicable for all families, for those who identify as spiritual, offering an opportunity for culturally responsive practices such as these may be protective for high-risk families. To accomplish this, practitioners may want to consider conducting a spiritual assessment when working with a family in crisis to help identify whether the strength of spirituality may be relevant (Hodge, 2005). Once a spiritual identity is identified, offering services that are culturally responsive to the belief system would be indicated.[3]

Social support. Social support is generally recognized as an action or relationship that exerts some positive effect on a person or group of people. House (1981) identified four types of social support: affiliation or emotional support (a sense of belonging), instrumental support (a safe place for dialogue), informational support (practical aid), and appraisal (normalization and social comparison). When looking at a familial-level construct, families report both internal (support coming from within the family system) and external (support coming from outside the family system) sources as important. The importance of social support was expressed by families throughout their stories of family resilience. However, similar to spirituality, social support offered different benefits to families facing high-risk situations at different times. Later, during adaptation, the practical or tangible support was essential. However, during the survival phase, emotional support was critical.

External social support represents assistance coming from outside the family system and includes extended family, friends, support groups, and professionals. One mother discussed the value of support from her peers when she stated, "I have a really good support system through my friends. I think I wouldn't have been able to make the decisions I did without a solid support system." While friendships were important to some, others discussed social support from extended family such as the father who

[3] For more on this topic please see Chap. 25.

stated, "My parents live here in town, and they were very strong. They were adamant making sure everything works out right." Finally, support groups were important to many. The meaning of support groups was emphasized by one family who described the support group they began attending just 3 weeks after the death of their daughter. The father explained:

> I would definitely recommend getting into a support group of people who have been through it. Even with all our friends and family…when we looked at their eyes, and they looked back at us, it was hollow. They had no idea what in the hell we were talking about…The first time I showed up at this meeting and looked across the table, that guy, that girl, they knew exactly what I was talking about, because they had been through it. And that's when it changed for me.

In addition to external social support from extended family, friends, and support groups, families also reported receiving support from within the immediate family. One family discussed how they coped when their twins were born with serious, chronic medical problems. As the parents described the stress associated with the long-term caregiving of their twins, the father talked about the support he received from within the family:

> We've been fortunate to have some good friends and our [extended] families, but I really think that I've always looked into the family, my wife and even my kids. We've had some great bosses and friends that have really been helpful listening and stuff, but I guess when I hear significant, I think of a particular person that you can look at and say 'wow, that person really got me through this.' For me it's my family. For me it's my wife. We got each other through it.

Similarly, another couple talked about caregiving for their two children who were diagnosed with severe developmental delays. During the interview, the wife described the degree to which she leans on her spouse when she stated, "Oh goodness, I'm surprised he [her husband] doesn't have an eternal dent in his side from me. I am surprised he doesn't walk around with this concave side. I don't know what I would do without him."

When the idea of social support is discussed, there can be an assumption that social support comes from outside of the family as the members of the immediate family are all too stretched to support one another as they face a crisis. However, the families in this project were clear in saying that the primary support they received came from within their own families. Especially during the survival phase, these families reported that it was important that they looked within their own families for support in addition to seeking encouragement from outside the family.

These discussions offer important implications for practice. First, understanding that families appraise social support as highly critical to their successful coping and adaptation suggests that practitioners would do well to assess and build up the emotional and practical support provided to families. Strengths-based assessment (Early, 2001) that includes an evaluation of social support may be helpful in this regard (Dunst, Jenkins, & Trivette, 1984). The discussions by these families also emphasize the value of family services that lend professional support to families. Particularly when services were framed in the context of supportive therapeutic relationships, the external support provided was highly valued (Lietz et al., 2011). Additionally, as clinicians seek to build up external social support, it is also important to help family members look to one another for needed emotional support.

Phase 2: Adaptation

As families begin to move beyond the initial state of crisis as illustrated in the survival phase, they find quickly that they must make immediate changes to the way the family structures daily living. This phase of adaptation represents a time when such changes are made, even before a family truly may have come to accept the nature of their current circumstances. The family strengths discussed as most relevant during this time frame included initiative, flexibility/creativity, and boundary setting.

Initiative. The strength of initiative refers to a family's willingness to take charge and face a situation head on. Whether dealing with a medical problem, making funeral arrangements following a

death, or responding to the crisis of child removal, families acknowledged the role their own initiative played within their stories of family resilience. For example, one family who faced traumatic bereavement spoke about the value of initiative. The father stated:

> My wife and I attacked it head on from the very beginning. We went to a support group immediately…With our children, if they want to talk about it, we talk about it. We don't hide anything from them. So, I think it was really important for us to deal with it immediately, head on, together.

Similarly, one family with three small children faced tremendous risk as the mother was battling cancer and the father was facing addiction to alcohol. The father talked about the importance of taking the initiative needed to make necessary changes. He stated:

> I was pleading on their behalf, don't punish them for my mistake, please don't take the kids from her, it's not her fault, it's mine. I'll do whatever. At that time, the investigator said, "how about in-home or inpatient therapy?", and I said, "I'll do it." And that day I was on the horn and finding help and literally that week we were off and ready to check in.

Another mother talked about initiative when she described her response to the child welfare case plan. She stated, "I just worked—overworked the program. Everything they told me to do, I did and more. They told me to jump through a hoop, I jumped higher. I called them and asked, 'Is there anything else you want me to do? I want my babies back.'" This type of initiative was important to many of these families as they began to make the changes needed to move forward.

Boundary setting. Another family strength discussed during the adaptation phase was boundary setting. One mother who was in recovery for alcoholism felt she was making improved choices for her family because she was "learning to put up healthy boundaries." Boundary setting refers to a family's ability to separate from unhealthy influences. While social support was highly important to these families, staying away from family and friends who were not supportive of the family in making changes was also identified as critical. One couple who was caregiving for their twins with serious chronic health issues discussed how their stress led to marital conflict. The father stated, "The only time that our marriage was really pulled apart was when the stress was pushing us into relationships with other couples that had unhealthy marriages, and we just kind of began to mimic them, but we realized it really quickly." The wife continued by explaining, "We talked about it one day and realized together at the same time that that was unhealthy. That we needed to disengage from these relationships, and so we did." As families make adaptations in response to stress, it is critical that the changes prompt positive coping, rather than an increase in unhealthy behaviors.

Similarly, one single mother who faced addiction to methamphetamines discussed the need to make adaptation to her family's peer group as she sought recovery. When referring to her current friendships, she stated, "I can probably count them on one hand, but they are sober, and they're doing what they should be doing, and that's where I want to stay." Finally, one couple discussed how their history of drug addiction led to extensive marital conflict, financial difficulties, and problems in their parenting. As they talked about making changes, the wife stated, "There's a lot of stuff that doesn't happen that used to happen just because we're not making stupid choices." Making healthy choices and separating from unhealthy influences allowed several of the families to make positive adaptations during their progression toward family resilience.

Creativity/flexibility. Creativity refers to the ability to find multiple solutions to a problem while flexibility is the willingness to try new things. According to Olson (2000), healthy family functioning requires a balance of both stability and flexibility in order to achieve the comfort that comes from predictability along with the ability to remain responsive to life changes. Working in conjunction with the family strengths initiative and boundary setting, creativity and flexibility help families facing adverse events respond to the needs created by adversity.

One mother who was in treatment for substance addiction shared a story regarding one way that she coped with loneliness while her child was placed in foster care. She stated:

> One thing I found helpful, when I would get the urge [to abuse drugs], when I would get triggers being alone, I would literally jump on the bus and ride around for hours. See, when you are by yourself, that's a trigger, and having all these people around me helped.

This mother was able to complete her program and make the changes necessary to be reunited with her daughter. This creative solution was situated in her story of resilience, representing an important transition that she felt contributed to her successful adaptation.

Similarly, one couple described a time when the family was caregiving for two elderly parents in the home, one diagnosed with Alzheimer's disease, while also facing a variety of other stressors. The wife talked about the strain on their marital relationship. She explained:

> I know something, it's very personal but…I was very self-conscious as far as having sex, because our parents were living here. You know, they're sleeping in the room next to you, and you feel very uncomfortable. And I can remember going home, and we still had his mother's apartment, so we would tell the kids we were going to the grocery store, and we would go over to his mother's apartment [Laughing].

In this story, the wife described this creative solution that she and her husband found to be able to achieve the privacy that was important for their relationship while still caring for their parents. Families are often required to make both immediate and long-term adaptations to the ways they function in response to many adverse events such as medical diagnoses, traumatic bereavement, and separations. Simon et al. (2005) advocate a "resilience-driven" approach that seeks to discover the family's interests, successes, and coping strategies. As practitioners work with families facing these stressors, identifying and fostering family strengths such as initiative, boundary setting, and creativity/flexibility may help families to make the necessary changes.

Phase 3: Acceptance

Once the families survived the initial crisis and began to make necessary adaptations, they discussed the importance of accepting the adversity, learning to adopt these difficulties as part of their new family life. When discussing how to accept their challenges, they identified four family strengths within their stories of family resilience. These included commitment, insight, communication, and humor.

Commitment. Family commitment refers to a powerful desire to keep the family together. Silberberg (2001) asserts that commitment "is showing dedication and loyalty toward the family as a whole. Strong families often view the well-being of the family as a first priority" (p. 54). As the families came to accept their current circumstances, facing their new reality was challenging for many. However, the family strength of commitment facilitated the units' willingness to move forward despite their difficulties. Speaking of commitment, one mother stated, "Our only focus in life was to get our kids back," while a father stated, "I'll do whatever I need to do to make this right." One mother talked about how important it was to remain focused on her five children as she sought treatment for her drug addiction. She stated, "It was my babies. I needed them back. I wasn't about to let them go to the state." Similarly, the single father who struggled with depression talked about his commitment to his two children. He stated, "My kids mean everything to me. I gotta do what I gotta do for them. That was my main focus. My kids come first no matter what."

These quotes illustrate the powerful role that commitment to family played in these stories of successful child welfare reunification. As clinicians work with families facing adversity, identifying and fostering commitment to the family unit may be particularly indicated. Activities that encourage families to discuss shared memories and articulate the family's unique identity help to establish boundaries around the family system that enhance levels of connectedness. Facilitating internal social support so that family members seek encouragement and tangible support from one another to foster levels of connection and commitment may represent additional interventions with at-risk families.

Insight. Insight refers to a family's ability to gain understanding of the problems they face. In many of these stories of family resilience, insight was situated as an element suggestive of a transition in the story.

One mother's transition from survival and adaptation to acceptance was apparent when she stated, "I started to be a mother more after I stopped doing drugs. And I realized I'm happier just being sober." Initially, this mother acknowledged that she engaged in substance abuse treatment because it was required in her case plan. However, once she started making progress, she developed new insight that allowed her to see the positive impact of recovery.

One mother talked about the insight received through her counseling. Although she acknowledged an initial resistance to receiving feedback, she came to accept the help. She explained, "Even though what she [the practitioner] said to me I didn't feel like hearing, it made me realize, I need to do this, I know what's right, and I need to do what's right." The insight gained through professional services allowed this mother to accept the idea that she needed to make changes within the family. Similarly, the family who lost their baby to SIDS also discussed how insight helped them to achieve acceptance. The father described this moment:

> I think just one day, I just talked to myself and realized that I had done everything that I could do. I was the best dad that I could be, and there was nothing I could have done about it. And, by being ready to let go, doesn't mean I've forgotten about her or that I don't love her. It just means that I am ready to move on.

The insight described by families accomplished two things. First, it demonstrated a progression toward acceptance. In addition, this insight was instrumental in helping these parents move forward, demonstrating the process of resilience. These discussions lend support to the value of clinical work with at-risk families. Counseling services can help to foster insight needed to help families develop new perspectives when coping with loss, trauma, and other high-risk situations.

Communication. As the families discussed accepting their situation, they identified communication as a family strength that helped them to achieve acceptance while also demonstrating that acceptance was indeed happening. Patterson (2002) suggests there are two types of family communication, affective and instrumental. Affective communication includes expressions of love, care, and concern and is essential for fostering a sense of family cohesion. Instrumental communication represents the patterns used to accomplish necessary tasks such as role assignment and rule setting. A family's ability to communicate care and concern effectively while accomplishing needed tasks is especially important as families face a crisis. One of the single mothers in the study said, "We communicate a lot. We are communicating, and we're getting along, and you can just feel it, just the energy in the house, you can tell when things are going good." Similarly, one of the children who participated in the family interviews was asked, what helps your family deal with problems? This 8 year old responded, "Well, we just like try to stop making the problem get worse, like by talking about it. We talk about the problems."

Many of these families talked about how increased communication helped them to accept what they were facing. The narrative tradition suggests that language is important in the construction of a family's story (White & Epston, 1990). As families use language to define their struggles, this acknowledgement fosters acceptance. Concurrently, as families speak about their problems, this communication also demonstrates that acceptance is happening. Again, these discussions support the potential benefits of clinical work with families such as these. Family therapy can offer a forum that creates space for families to find the words and courage to speak about the challenges they face.

Humor. The family strength humor refers to a family's ability to be light-hearted in the face of adversity. In these family narratives, humor was discussed as something that helped them come to accept their difficulties. Similar to communication, it also was a sign that acceptance was happening. It seemed that once families were able to make light of their situations, this activity eased their pain while also demonstrating that they were beginning to accept what they were facing. A father raising two sons with special needs stated, "If you don't have the humor in the family, then it's just too much. You need something to break the stress." His wife followed, asserting, "And it's too serious, the things that we deal with on a daily basis are very serious, and we have to find the silly things that get us through."

Similarly, the couple who cared for two elderly parents despite the wife's physical disability talked about what helped. The wife stated, "Sense of humor is probably one. I think that's helped us get through a lot of things. I mean really, it can relieve tension. I think a sense of humor is really helpful."

One family was caregiving for an elderly parent when their son was diagnosed with cancer. The father shared the following story regarding his father's stroke, and how he and his father used humor to begin to discuss and to accept the physical consequences of the stroke. Previously, the grandfather had cut his adult son's hair for many years. After the stroke, this changed, and the father used this exchange to demonstrate acceptance:

> He had his stroke, and he was paralyzed on his left side, and I went and got a haircut from somebody else, and I just said, "Dad, I'm sorry," I said, "I can't just go to a one armed barber anymore," and he laughed. He thought that was funny. We thought that was kind of funny, and I said, "now don't get jealous now [that] I've found another barber."

As professionals work with families facing adversity, it may be important to know that some families find humor helpful. This does not suggest that practitioners make light of difficulties. It is critical that families appraise the meanings attached to their difficulties and that they are given the ability to take the lead regarding light-heartedness. Clinicians can create space in sessions for humor while being cautious to speak about family difficulties with the utmost respect.

Phase 4: Growing Stronger

As families move past survival, early adaptations, and acceptance, the process of family resilience suggests that progress continues at a new level. Growing stronger represents a time during which families recognize and experience reinforcement for the changes they have made thus far.

Appraisal. The family strength most apparent during the growing stronger phase was appraisal, the meaning families attach to their experiences. Patterson (2002) asserts, "the meaning-making process is a critical component of family resilience, especially when the significant stress is due to adversity or trauma" (p. 244). When families experience loss and difficulty, yet find meaning in it, they seem better able to avoid the negative consequences typically associated with high-risk situations. For example, one mother described how she now views the incarceration of herself and her husband just before the holidays. She explained, "I just looked at it as a positive thing. This is what we needed. The best Christmas present I ever got was being in jail." Similarly, the father who struggled with alcoholism appraised his CPS involvement this way: "So, ultimately, yes, this was the most important thing to happen to me. I needed CPS to come in. As hard as it was to swallow, it had to happen, because it changed my life." Finally, the mother who faced homelessness and addiction stated:

> If it wasn't for CPS, I wouldn't be where I am now. I think I would still be stuck on drugs, because I was heavy into it. I now feel in my heart I've learned a lot and changed a lot, and I'm a different person now. So, it happened for a reason, that's what I believe.

These comments demonstrate the positive appraisals families attached to their child welfare involvement. At the same time, it is important to note that these families did not always see it this way. During the survival and even the adaptation phases, these families identified being angry, and most talked about "fighting" or "resisting" the child welfare case plan. However, family resilience is a process. Growing stronger is seen as families move from their initial anger and fear, to acceptance, and ultimately to a place where they appraise the situation positively, seeing a purpose in what they have faced.

Phase 5: Helping Others

As families appraised their difficulties in a positive way, many expressed reaching a moment at which they desired to help others, often seeking to reach out to other families who were facing struggles similar to their own. Some suggest that altruistic pro-social behaviors help families to find

meaning in adversity (Lietz, 2011; Mandleco & Perry, 2000; Patterson, 2002). In other words, families described their participation in several pro-social behaviors as an effort to assist others while also helping themselves. Specifically, some participants provided public speaking or trainings to raise awareness about a social issue while others led support groups or volunteered for nonprofit organizations. Furthermore, some of the families engaged in fundraising for social causes or created foundations to honor a lost loved one. For example, one family was caring for a child diagnosed with developmental delays when they lost their third child to stillbirth. This family now provides support to other grieving parents through their participation in a nonprofit organization, a way of bringing meaning to their loss. Another mother's narrative described how her young son was killed in a violent crime. As this mother and her family sought to overcome the pain of this loss, they created a foundation in his name that fundraises for funeral costs for low income parents whose children die. Finally, one family who cares for their children who are affected by ongoing, serious health issues provides education to other parents through their website and speaking events about how to advocate for children within the healthcare system.

Giving social support. Social support was identified as the family strength associated with this phase. However, during this phase, social support was not about receiving, but instead represented the meaning families attached to the experience of *giving* social support. One couple was asked to speak at child welfare trainings regarding their experiences. Speaking about helping others, the father started by saying, "We want to be a part of something to try and give back somehow. And it helps us." The wife continued, "Maybe it'll help someone, maybe we're here to help someone." The couple raising children with severe developmental delays wrote a book to educate other parents about working within the educational system. When referencing this choice, the mother stated, "I can handle what I have went through, and I can accept what I went through, if I can pass that along and help somebody else." These stories of helping others illustrate how the process of resilience grows from the survival stage during which families are desperate to receive social support to a place of helping others in which it becomes their turn to give back.

Understanding that helping others may be protective for families facing adversity offers important implications for practice. As Simon et al. (2005) suggest, "a major goal of treatment is to encourage families to recognize and utilize their inherent capacity for growth and change" (p. 432). A strengths-based assessment may ask specifically about altruistic intention and behaviors as a strength that can help families positively appraise the difficulties they face. Social service organizations also may consider creating interventions that foster opportunities for helping. Although the findings of these studies do not suggest that all families will benefit from this practice, offering opportunities to help others may be beneficial for some high-risk families.

Clinical Implications

These findings offer important implications for clinical practice with families facing high-risk situations. First, practitioners should understand the importance of balancing their focus on risk with the identification and building of family strengths. While risk modeling helps to explain a family's vulnerability for discord and dissolution, many families sustain and even improve functioning despite exposure to both normative and non-normative risk factors. While the effects are cumulative and families experiencing multiple risk factors in a short period of time are at greater risk for poor functioning, the findings demonstrate that family strengths can help many families to overcome the negative effects of adversity. Remaining mindful of a resilience perspective may lead practitioners to adjust their approach when working with families facing high risk.

As practitioners adopt a family resilience perspective that integrates the effects of risk and protection in clinical work, findings also suggest they view resilience as a process that develops over time.

Being sensitized to the process-oriented nature of resilience can help practitioners to understand that families need different things at different times. In the time period during and just following an adverse event, families may not yet be ready for positively appraising loss or trauma. However, later on, meaning-making may be highly important to moving forward. Practitioners should assess risk and protection while remaining mindful that the timing of the intervention is as important as the activity attached to a particular intervention. Remaining aware and responsive to client preferences represents an essential part of a family resilience framework.

The process of resilience as described in the typology highlights the process-oriented nature of family resilience while identifying ten strengths families identified as helpful. Although strengths assessment should involve narrative interviewing that allows additional strengths to be uncovered, knowing these specific strengths were helpful for our sample of families may be relevant for others. Having an awareness of these particular strengths may help practitioners to become more sensitized to the ways these strengths are helpful, allowing clinicians to more easily identify and build such capacities with the families with whom they work. In addition, conducting a strengths assessment such that the family's strengths can be incorporated throughout the counseling is indicated per these findings.

Finally, a striking finding from our research was the conceptualization of social support as being something that stems from both within and outside of the family system, that involves both giving and receiving. The idea that social support is helpful remains pervasive within many areas of practice. This typology highlights the idea that while support from extended family, faith organizations, and one's community is helpful, support from within that family is also highly valued. Furthermore, while families lean on social support during their most desperate of times, these families also spoke about the benefits of providing social support through altruistic pro-social behaviors that simultaneously helped others while helping themselves. Such findings suggest that practitioners would do well to seek opportunities for giving and receiving social support within and outside of the family unit.

Research Implications

Further research is needed that continues to examine the protective factors families identify as helpful for healthy adaptation and coping when facing high-risk situations. Although the studies synthesized in this chapter offer important implications for clinical practice, more research is needed to explore family resilience in the context of various life stressors beyond the scope of these current studies. For example, despite a dramatic increase in the number of women deployed by the U.S. military in the recent OIF/OEF missions (Department of Defense, 2007), more research is needed that explores family reintegration when the member of the family who is returning is a woman (Manos, 2010). Ongoing research is needed that examines emerging areas such as these from a family resilience standpoint.

Furthermore, little work has been done that tests the effectiveness of adopting a resilience perspective within family practice. Although extensive research informs practice by identifying the strengths families discuss as helpful, more studies are needed that would conceptualize these research findings into a specified model of clinical practice that can be implemented with adherence to these practice principles and then tested regarding the model's impact on outcomes. One limitation of strengths-based practice is the need for more empirical work that evaluates its effectiveness (Lietz, 2009). As leaders within various helping professions advocate incorporating the best available evidence when making clinical decisions as a critical part of evidence-based decision making (Thyer & Myers, 2011), further implementation and testing of these findings would help to move the field forward in this area.

Conclusion

The concept of resilience is increasingly being applied as a familial-level construct. Understanding the risk factors that challenge family functioning and the protective factors or family strengths that support healthy coping is important for practitioners working in family practice. In this chapter, a set of risk factors that predict family break-up and discord was identified. When possible, prevention efforts should seek to avoid these negative impacts. However, when risks are unavoidable or already present, family practitioners can engage in the intervention of strength identification and building to support families in healthy coping and adaptation. The process of resilience highlights ten strengths that can help families in varied ways at different times to cope with risks or even improve functioning despite the challenges faced. Although further research is needed to examine both the implementation and outcomes of taking a resilience approach with high-risk families, these stories of resilience offer important implications for clinical practice with families facing high-risk situations.

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