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Jessica C. Kichler
Medical College of Wisconsin

Astrida S. Kaugars
Marquette University, astrida.kaugars@marquette.edu

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Topical Review: Applying Positive Development Principles to Group Interventions for the Promotion of Family Resilience in Pediatric Psychology

Jessica C. Kichler

*Department of Pediatrics, Cincinnati Children's Hospital Medical Center, University of Cincinnati
Cincinnati, OH*

Astrida S. Kaugars

*Department of Psychology, Marquette University
Milwaukee, WI*

As described in the call for this special issue, resilience is often defined as "achieving one or more positive outcomes despite exposure to significant risk or adversity" (Hilliard, Harris, & Weissberg-Benchell, 2012, p. 739). Resilience is particularly relevant to pediatric psychology, as youth and their families are tasked with overcoming risk factors simply by the nature of a child's diagnosis of a disease/chronic illness and subsequent medical management demands. In addition to identifying key resilience factors within this population, it is critical to develop empirically supported clinical interventions to promote healthy biological, psychological, and social

development; reduce youth psychopathology; and enhance optimal health outcomes. Although conceptually similar to the classic resilience/risk models, the positive development approach offers a distinct theoretical framework that can be used successfully in intervention development. This article describes exemplars of both resilience and positive development interventions for youth with Type 1 diabetes (T1D) and their families.

Positive Development Principles

Positive development is the search for the methods/processes that provide support and skills that directly increase successful functioning and reduce mental health diagnoses (Tolan, 2014). Similar to resilience models, a positive development framework operationalizes protective (i.e., “buffering”) factors as those influences that blunt or obviate risk factors and guard people from the potentially negative effects of stress (Yi, Vialiano, Smith, Yi, & Weinger, 2008). In addition, a positive development framework augments a resilience framework by also focusing on promotive factors that support healthy functioning—independent of whether risk factors are present (Tolan, 2014).

Positive development intervention research can be classified into four distinct frameworks (Tolan, 2014). First, social competence promotion interventions focus on supporting learnable skills that are necessary for successful negotiation of social challenges within relationships and groups. Second, social and emotional learning interventions build skills to manage emotions, including self-control and awareness. Third, positive youth development intervention efforts include enhancing settings and organizations that support individual capabilities both psychologically and socially. Finally, positive psychology interventions emphasize growth of character traits and behavioral practices to improve well-being and focus on life satisfaction (e.g., mindfulness), but not through instilling skills or competencies.

Application of Resilience and Positive Development Principles to Pediatric Psychology

Resilience interventions with various chronic illness clinical populations are described in the literature (Scholten et al., 2014).

Notably, there is a growing body of literature examining how risk and resilience factors may be related to T1D management. Among youth with low and moderate levels of resilience (as measured by a score composed of self-reported self-efficacy, self-esteem, self-mastery, and optimism items), those who reported higher levels of diabetes-related stress had poorer glycemic control and diabetes self-care; yet, for youth with high levels of resilience, these constructs were not related (Yi et al., 2008). Behavioral Family Systems Therapy for Diabetes sought to ameliorate family-level risk factors by focusing on problem-solving training to improve glycemic control as measured by hemoglobin A1c (HbA1c; Carpenter, Price, Cohen, Shoe, & Pendley, 2014). Researchers found that among those children/youth with higher baseline HbA1c levels (i.e., poorer glycemic control), those who attended at least three of four intervention sessions had a reduction in their HbA1c after treatment (Carpenter et al., 2014). Hilliard and colleagues (2012) outlined a diabetes resilience theoretical model based on much of this body of literature, but they suggest that most of resilience intervention research conducted thus far has focused on minimizing the influence of risk factors (i.e., supporting protective factors) for poor diabetes outcomes. Therefore, there is also a need for interventions that explicitly target the enhancement of functioning through skills and processes (i.e., promotive factors), regardless of the presence of risk factors. Consideration of positive development frameworks in conjunction with resilience principles offers opportunities for further pediatric psychology intervention development.

The Diabetes Group Therapy Project (Kichler, Kaugars, Marik, Nabors, & Alemzadeh, 2013) is a multifamily group intervention provided in an outpatient clinical setting that addresses both protective and promotive factors to enhance optimal health outcomes among teenagers (aged 13–17 years) with T1D and their parents/caregivers. The intervention includes group sessions that simultaneously provide peer support, family systems therapy, and diabetes education. Results from an initial evaluation of the intervention found improvements in parent responsibility for diabetes care and parent-reported diabetes-specific quality of life for the adolescents from baseline to 4 months after treatment (Kichler et al., 2013). Notably, the Diabetes Group Therapy Project intervention also includes elements of the four positive development intervention research frameworks.

Positive development interventions that promote family resilience (i.e., strengths of the family system when under stress, in crisis, or overcoming adversity) with pediatric populations must take into account the context of the youth's developmental level (Luther, 2000), the stage or course of the disease/chronic illness (Yi et al., 2008), and the bidirectional/dynamic nature of interactions within the family (Walsh, 2003). Therefore, the original Diabetes Group Therapy Project intervention has been augmented by Kichler and colleagues to even more directly enhance the process/methods of promoting optimal health outcomes among youth with T1D and their parents/caretakers by additional facilitation of promotive factors. Specifically, offering separate groups for preteens (aged 10–12 years) and teenagers (aged 13–17 years) provides opportunities to address issues that take into account the developmental context for each age-group. The bidirectional/dynamic relationship between youth and their parents over time is now being assessed using a parent–child collaboration tool, which is another example of measuring a promotive factor (Nansel et al., 2009). Finally, providing an additional booster session 6 months after baseline attends to the need for ongoing support owing to the chronic nature of T1D.

Future Directions

A number of studies that focus on resilience in pediatric psychology provide descriptive models for further expanding this area of study (Cousins, Cohen, & Venable, 2015; Kalapurakkel, Carpino, Lebel, & Simons, 2015). Numerous recommendations are offered to further advance the future development of positive development interventions to promote optimal health outcomes (Tolan, 2014). Using a common language to define and study both protective and promotive factors as well as determining how factors may interact is critical. In addition, it is necessary to articulate key components of the positive development interventions and how they work within different age-groups, as developmental needs may shift over time within the family. Finding suitable measures to assess how positive development interventions can increase healthy functioning should be paramount, as well as finding how the enhancement of these benefits, not just harm reduction, is achieved for different populations and settings. Rigorous measurements of both protective and promotive factors

should be consistently used to allow for future clinical intervention meta-analyses to be conducted.

Conflicts of interest: None declared.

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About the Authors

All correspondence concerning this article should be addressed to Jessica C. Kichler, PhD, CDE, Behavioral Medicine and Clinical Psychology, Cincinnati Children's Hospital Medical Center, 3333 Burnet Avenue, MLC #3015, Cincinnati, OH 45266, USA. E-mail: Jessica.kichler@cchmc.org