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Protective resilience factors in institutionalised portuguese adolescents

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Abstract

Background: The term resilience, long used in physics, has only “recently” been adapted to psychology, but it immediately assumed great importance in human development studies. Aim: To verify the most important resilience factors among institutionalised adolescents. Method: A cross-sectional, descriptive-correlational, quantitative study. The subjects were 40 institutionalized adolescents, aged between 12 and 17, selected through non-probability convenience sampling. Data was collected during 2012, with a research protocol consisting of: a form of socio-demographic characteristics, the Wagnild Resilience Scale, the Self Perception Profile for Adolescents Scale (both validated for the Portuguese population) and an adaptation of the Social Competence Scale. Results: Mostly female adolescents with a mean age of 14.33 years. There is a relationship between resilience and self-esteem, self-concept and social competence. Males from CBEI – Our Lady of Sorrows Child Welfare Centre of Mafra manifest higher levels of resilience than females from the Santa Isabel Home. There is no relationship between religious practice, age and education and resilience. Conclusion: The inferences from this study lead us to reflect on the importance of creating intervention programmes for institutionalised children and adolescents in order to optimise their resources enhancing the protective factors of resilience, and ultimately resilience itself.

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1. Introduction

Resilience is by definition, “an elastic quality...the manifestation of competence with regards to risk and adversity” (Simões, 2009). The term has been used in physics for two centuries, but it was incorporated in psychology only about twenty years and refers to “the process or phenomenon that reflects children and adolescents’ positive adjustment despite the hazardous conditions” to which they have been subjected (Anaut, 2005).

The origin of resilience is understood “not only as a characteristic of the individual, as an innate ability...but also, as part of the dynamic interaction that exists between the individual characteristics and the complexity of the social context,” since the latter turns out to condition the subject’s responses, even using the tools it will provide during the events that will constitute his life (Carvalho et al., 2007).

Children and adolescents have a potential to develop their resilience. For this, it is necessary to take into account not only the child's vulnerability to events, but mainly, the factors that can contribute to the promotion of resilience; so-called protective resilience factors (Simões, 2009). Children or adolescents at risk thus have the potential to promote their resilience throughout the course of their lives. The ability to learn when facing situations of difficulty is crucial, as is the ability to learn their lessons to apply in the future (Walsh, 2003).

There are factors to protect personal resilience related to dispositional attributes and other resources related to the environment, including a social and emotional support network. Affective bonds should offer emotional support, since the social support system in the form of school, church, peer group, etc., should provide competence, individual determination and a belief system for life. Dispositional attributes such as sense of self-efficacy, mood, activity level, sociability, self-esteem and autonomy, among others, are very important; but they do not mean resilience in and of themselves. The subject’s individual characteristics must also be taken into account. They cause the applicability of the protective resilience factors to vary (Silva, 2005).

The family, community, school and peers are highly constraining of internal resource, such as personal and social skills. On the other hand, self-concept is important as a “moderator of the impact of negative life events in general well-being” (Simões, 2009). Along with the family, they are considered the major factors in protecting resilience.

Assis, Pesce and Avanci (2007) stress the importance of aspects of the family environment, such as how it is organized, the relationships among its members, established educational models, and the supervision of adopted behaviours by the family’s children and adolescent members, in developing resilience.

Not all children can rely on the family as a source of help and support. Reasons for institutionalisation can range from economic factors that put families in precarious situations, even situations of child labour, abandonment, neglect or abuse, physical or psychological, also linked to a lack of parenting skills.

Children brought up in precarious situations by abusive parents revealed common social and emotional skills. The role of individual factors in this manifestation of resilience stood out, “a sociability that attracts people, self-confidence, a persistent optimism in the face of defeat and frustration, the ability to recover quickly from setbacks is a serene nature” (Goleman, 1997).

Considering that the aim of this study is to look into a population for whom the families of origin represent risk rather than protection, individual factors assume crucial importance, since the ability of the child to overcome the bitterness that memories may cause and accept institutionalisation as a positive change that will give hope for the future, depend largely on them. In this context, Goleman (1997) states that “the qualities of temperament can be modified for the better” in the sense of providing children with “capabilities that will enable them to face life”, thus advocating educational activity with regard to promoting resilience.

Lemos and Meneses (2002) stress the importance of social competence in human development and functioning, arguing that this refers to a set of learned socially accepted behaviours which include sharing, positive interactions, appropriate requests for assistance, and demonstrations of gratitude. They also relate low social competence with low academic achievement, and may also be the cause of adjustment problems or even psychopathology. Despite integrating the group of individual resilience protective factors, social competence is extremely influenced by the family. According to Granic and Patterson (2006, cited in Raymond, 2011), children with emotionally positive parents, with a secure bond and low family stress show enormous social competence and few behaviour problems. In contrast, poverty, low socio-economic level, residence in areas with high crime rates, and parental conflict or divorce are ecological predictors of behaviour problems in children and/or adolescents, indirectly influencing the relationship between parents and children and affecting exposure the child/adolescent to peer groups with
behaviours considered deviant (Silva, 2009). The capacity to interact with others is an important manifestation of social competence and can be inferred in large part by the level of social acceptance the individual finds. This ultimately influences, and at the same time has a dependent relationship with self-concept, which, in turn, will determine the subject’s self-esteem.

Self-concept is often defined as the totality of the perceptions that the individual has of himself, formed through assessments and reinforcement by his significant others, as well as by his self-attributions, behaviour and experiences and interpretations from his environment (Shavelson & Bolus, 1982 cited in Albuquerque & Oliveira, 2002). James (1980, cited in Albuquerque & Oliveira, 2002) underlines the importance of the social component of the “I” in the multidimensional and hierarchical construct, which for the author is the concept of the self. He distributes the dimensions of self-concept in a pyramidal hierarchical structure, placing perceptions of specific behaviours at the base, deductions related to self-concept in the middle, and overall perception of the self at the top.

Self-esteem can be understood (Harter, 1990, cited in Papalia, Olds & Feldman, 2001) as a component of self-concept, linking the cognitive, emotional, and social parts of the personality, and influencing the subject’s state of mind: while subjects with high self-esteem tend to be cheerful, when self-esteem is low there is a tendency for depression.

The relationship maintained with the family is extremely important for children’s self-esteem, not only because of their judgment they make regarding their competence, but also because of the family’s expression of interest in relation to the child and his activities. Schaffer (2004) highlights the importance of bonding patterns which originate in the child’s early experiences. These are crucial to develop internal working models related to self and others, affecting the quality of interpersonal relationships, ultimately reaching the sense of self. “Studies of abused children indicate, in fact, that a markedly deviant relationship could have profound implications for the child’s development of the self.” Nevertheless, the same author highlights the fact that the significant others able to influence the child’s own perception and evaluation of himself cannot be summed up by the family’s influence. Rather, acceptance among peers is becoming increasingly important throughout the development process, stating that “rejection and isolation from the peer group promotes low self-esteem” (Harter, 1998 cited in Schaffer, 2004), which is also found in children who are victims of bullying. Still, Erikson (1982, cited in Papalia, Olds & Feldman, 2001) underlines the importance of the competence perceived by the child, from an early age as a determining factor for self-esteem, overriding even general social support. Harter (1999) supports assessment and intervention in specific areas of self-esteem during childhood and adolescence with a view to preventing psychological illness in the future, since the sense of self as incapable may persist into adulthood.

Resilience appears to us, therefore, as an investment area in order to provide tools particularly to members of groups considered at risk at the outset. These tools will enable them to maximize their intra-psychic resources in interacting with their environment and with the adversities they face. Taking Werner (1989, cited in Silva, 2009), into account, deepening of knowledge in the area of resilience is greatly important to create or improve cadres of clinical intervention. This author considers it hopeful to mitigate the tendency for human beings to oscillate towards states of vulnerability by reducing exposure to mental health risk factors, favouring, on the one hand, protective factors with regards to their functional development. According to Constantine et al. (1999), recognition of the relevance of resilience implies recognition of the importance of the features offered by the social environment to promote healthy development.

To reinforce the importance of resilience to psychosocial equilibrium, authors like Flach (1997, cited in Basso, Rock & Esqueda, 2008), characterise resilient individuals as having a strong and flexible sense of self-esteem; being independent in thought and action, without fear or reluctance of depending on others; with an ability to give and receive in interpersonal relationships, and with a stable group of friends, including one or more confidants; very self-disciplined and responsible; recognising and developing their own talents; open and receptive to new ideas; and willing to dream; feeding a wide variety of interests; with a keen sense of humour; capacity for introspection and perception of the feelings of others as well as the ability to communicate feelings appropriately themselves, and to tolerate suffering; concentration and strong commitment to life, in which personal experiences are interpreted with meaning and hope, even in the most difficult moments.
2. Problem Statement

The construct of resilience is closely linked to the concepts of risk and protective factors, and these are present throughout the entire process of human development (Pesce, Assis, Santos & Oliveira, 2004). Adverse situations will cause psychological changes whose impact depends on the individual’s stage of development as well as support from the external environment.

Adolescents who are in institutions are considered a population at risk, but who have adaptive traits in relation to situations and contexts. In this sense, adapting to a new, unfamiliar context determines their developmental path (Mota & Matos, 2010), and more accurately their life choices.

Protective resilience factors come from adolescent resources that enable them to respond to or deal with adverse or potentially stressful situations in an adaptive manner and include self-esteem, self-concept and social skills (Smith, 2009; Cavaco, 2010).

3. Research Questions

Scientific evidence indicates that protective resilience factors will reduce potential dysfunctions resulting from stressful life experiences (Haggerty et al., 2000; Melillo, A. et al., 2005). Resilient adolescents use their positive resources to face adversity and adapt to daily life. “Resilience is associated with protective factors which predict positive consequences in children at risk” (Masten & Coastworth, 1995). Based on these assumptions, this study was designed to answer the question: “What are the individual protective resilience factors in Portuguese institutionalised adolescents?” Identifying these protective factors enable intervention for a positive development, promoting the mental health of the adolescents involved.

4. Purpose of the Study

To describe the socio-demographic characteristics and determining the expression of resilience and self-esteem, self-concept and social competence of institutionalised adolescents. To identify the determinant variables of resilience in institutionalised adolescents.

5. Research Methods

The data collection instrument comprises: a socio-demographic form; Resilience Scale; Self-Perception Profile for Adolescents, Social Behaviour Scale

The socio-demographic characterisation comprises the following variables: age, gender, existence of siblings and their institutionalisation, education, the host institution and length of institutionalisation.

The Resilience Scale was developed and made available by Wagnild and Young in 1993 and adapted by Felgueiras (2008) for Portuguese adolescents aged between 10 and 16. It consists of 24 items and five components: Perseverance (an attitude of persistence when facing negative life events, denoting a willingness to pursue one’s life – items 1, 2, 9, 10, 23 and 24); Self-confidence (belief in one’s own skills to the extent that it is possible to depend on oneself while recognising one’s limitations – items 14, 15, 17, 18, 19, 20 and 22); Serenity (a balanced perspective in response to adverse events – items 4, 6, 12 and 16); Meaning of life (understanding one’s life has a purpose, has meaning – items 8, 11, 13, 21 and 25); Self-reliance (the ability to define one’s own path, facing some experiences alone – items 3 and 7) (Felgueiras, Festas & Vieira, 2010; Wagnild  & Young, 1993). It is a Likert-type scale in which items are scored positively from 1 (“strongly disagree”) to 7 (“strongly agree”), with a total score range between 24 and 168 (the higher the score, the higher the resilience) and good internal consistency with a Cronbach's alpha value of 0.82.

The Self Perception Profile for Adolescents Scale was developed by Susan Harter (1988) and adapted to the Portuguese population by Peixoto, Alves Martins, Mata & Monteiro (1996). It evaluates self-esteem and self-concept and consists of 40 items and eight subscales: Scholastic Competence (1, 9, 17, 25 and 33); Athletic Competence (3, 11, 19, 27 and 35); Social Acceptance (2, 10, 18, 26 and 34); Behaviour (6, 14, 22, 30 and 38); Physical Appearance (4, 12, 20, 28 and 36); Self-esteem (8, 16, 24, 32 and 40); Romantic Attraction (5, 13, 21, 29 and 37) and Intimate
Friendships (7, 15, 23, 31 and 39). Each item is scored from 1 (low perceived competence) to 4 (high perceived competence). The results of each subscale result from the average of the items that comprise it. Fourteen additional items are presented to assess the importance attributed to each of the specific areas: Scholastic Competence (1 and 8); Social Acceptance (2 and 9); Athletic Competence (3 and 10), Physical Appearance (4 and 11); Romantic Attraction (5 and 12); Behaviour (6 and 13); Intimate friendships (7 and 14), with a Cronbach's alpha value of 0.89.

The Social Competence Scale was developed by Kenneth W. Merrell (2002) and validated for the Portuguese population by Raimundo, Marques-Pinto & Lima (2007). It is a Likert-type scale consisting of 17 items which refer to three dimensions: Relationship with peers (1, 4, 5, 9, 11, 12 and 15), Self-control (2, 7, 8, 10 and 18), School and institutional behaviour (3, 13, 14, 16 and 17). In assessing the frequency of positive social behaviours in the last three months, the total score ranges from 17 to 85, with a Likert-type response between 1 (never) to 5 (very often) and good internal consistency with a Cronbach's alpha value of 0.94 for the total scale.

The statistical programme SPSS (Statistical Package for Social Sciences), version 19.0 for Windows was used for information processing.

This is a quantitative, cross-sectional, descriptive-correlational study. An intentional non-probabilistic sample of 40 adolescents from two Portuguese host institutions: the Santa Isabel Home (Casa Santa Isabel - district of Leiria in central Portugal) and the CBEI – Our Lady of Sorrows Child Welfare Centre (CBEI - Centro de Bem-Estar Infantil Nossa Senhora das Dores de Mafra - district of Lisbon in southern Portugal).

Ethical and methodological principles were considered with permission for implementing the data collection instrument for institutionalised adolescents aged 12 to 17 years requested from and granted by those responsible for the participating institutions. Data collection was carried out in 2012.

6. Findings

Of the 40 institutionalised adolescents 67.5% are female and 32.5% male. Ages vary between 12 and 17 years, with a mean age of 14.33 years and a standard deviation of 1.67 years. Females have a higher mean age than males (14.33 vs 14.31). The most highly represented age group is 14 to 15 (45%) and the least represented is 16 to 17 (22.5%). In both sexes, the age group with the highest percentage is 14 to 15 years, without statistically significant differences.

Most teens (95%) reported having siblings, of which 57.90% are also institutionalised. Of these 47.40% live in the same institution as the respondents.

With regards to the host institution, 60% live in the Santa Isabel Home and 40% in CBEI – Our Lady of Sorrows Child Welfare Centre. The length of institutionalisation varies between 1 and 16 years. Males have a higher mean (6.54) compared to females (3.30). It is worth noting that 30.80% of the boys have been in the institution for over 9 years and 37% of girls between 1 and 3 years.

Regarding education 52.50% attend the 3rd cycle [between the 7th and 9th year of schooling], of which 55.60% are female and 46.20% male. It is worth highlighting that 15.00% attend secondary school and of these 14.29% are 17 years old. Of the 30% who attend the 2nd cycle [5th and 6th years of schooling], 33.33% and 16.67% are 13 and 14 years old, respectively.

Regarding resilience and respective components (Perseverance, Self-Reliance, Serenity, meaning of life and Self-Reliance) male adolescents reveal higher levels of resilience compared to females. The “Self-Reliance” and “Perseverance” components are the ones with higher values (35.08 and 28.18), while “Self-Reliance” has the lowest mean value (9.65).

Regarding self-concept and its respective dimensions (Scholastic Competence Athletic Competence, Social Acceptance, Behaviour, Physical Appearance, Self-esteem, Romantic Attraction and Intimate Friendships) male adolescents show higher levels of self-concept compared to females. Regarding the importance attributed by adolescents to each of the dimensions previously assessed, it appears that only the “behavior” dimension is rated important by the female adolescents. The “Intimate Friends”, “Scholastic Competency”, “Athletic Competence”, “Social Acceptance”, “Physical Appearance”, “Self-esteem” and “Romantic Attraction” dimensions are rated important and very important by adolescent males. Discrepancies were calculated to compare perceived skills and
the importance attributed to them. The averages showed negative values indicating low levels of self-esteem linked to all dimensions.

Regarding social competence male adolescents have higher values (70.08) compared to females. As for the dimensions, the “Relationship with peers” dimension has a higher average (26.28), while “Self-control” has the lowest average (18.55). When compared by gender, all dimensions have higher mean scores for males.

Inferential analysis between socio-demographic variables and the resilience of the institutionalised adolescents reveals that there are statistically significant differences between gender and total resilience (p = .001) as well as the different components: Self-confidence (p = .000), Meaning of Life (p = .001), Self-Reliance (p = .046), Serenity (p = .008) and Perseverance (p = .007). Age does not present statistically significant differences with resilience (p = .543). Schooling does not influence resilience in the total scale (t = .508, p = .619) and respective components. The host institution has significant differences with resilience, particularly with the total scale (p = .012) and the Meaning of Life (p = .003) and Self-confidence (p = .033) components.

Regarding the relationship between the dimensions of self-concept and resilience, it is found that: the scholastic competence dimension presents significant differences between the total resilience of the scale (p = .014) and the Perseverance (p = .014), Self-confidence (p = .036), Meaning of Life (p = .000) components. In the Social Acceptance dimension, there is a relationship in all resilience components, except Self-Reliance (p = .361) and Serenity (p = .054). Athletic Competence, Physical Appearance, Romantic Attraction and the General Self-esteem related to resilience reveal that only the Self-reliance component shows no statistical differences (p = .120; p = .780; p = .487 and p = .245, respectively). As for the Behaviour dimension, there is no relationship with the Serenity (p = .102) and Self-reliance (p = .354) components. Between the Intimate Friendships dimension and the resilience components, there are no statistically significant differences.

With regards to social competence, there is a relationship between Resilience (p = .004) and its components Perseverance (p = .001), Self-confidence (p = .006) and Meaning of Life (p = .016). As for the dimensions of social competence, Relationship with peers and Self-control show statistical differences with Perseverance, Self-confidence, Meaning of life and the total resilience scale. There is a highly significant difference between Self-control and Self-Reliance (p = .000). School and Institutional Behaviour only has a relationship with Perseverance (p = .035).

7. Conclusions

Currently most authors are unanimous in considering resilience the result of an interactive process between the individual and the environment, taking into account their intra-psychic characteristics and environmental conditions, as well as recognising the importance of the place the family occupies in this process. Resilience encompasses many concepts and intra-psychic and social processes in the course of human development (Martins, 2005). Social competence and self-concept are factors associated with resilience (Constantine, Bernard & Diaz, 1999).

From this study the profile of the population under study can be concluded to be teenaged girls, aged 14.33 years with siblings who are also institutionalised and in the same shelter. They attend the 3rd cycle [7th to 9th years] of schooling. As for resilience, it is adolescent males taken into CBEI – Our Lady of Sorrows Child Welfare Centre in Mafra who have higher levels of resilience, and it is the Self-confidence component that has the highest average (35.08). As for self-concept, the Behaviour dimension is given the most importance. Regarding the social component, it is the Relationship with peers dimension that holds the highest average (26.28).

The relationship between resilience and the self-concept dimensions of Scholastic Competence, Social Acceptance, Athletic Competence, Physical Appearance, Romantic Attraction, Behaviour, and Intimate Friendships reveal a relationship. Only the Intimate Friendships dimension reveals no relationship with resilience. The resilience component, Meaning of Life, is the one which most relates to the self-concept and respective dimensions. It can be concluded that self-concept and the dimensions that compose it represent a protective factor for the adolescents under study.

From the study of the relationship between social competence and respective dimensions and resilience, it can be concluded that the dimensions of social competence, Relationship with peers, Self-control and the total scale influence the resilience components of Perseverance, Self-confidence, Meaning of life and the total scale.
School and institutional behaviour dimension does not interfere with resilience; the higher the social competence, the higher the level of resilience.

In short, this study was designed with the expectation of leading to reflecting on the importance of investment in development in areas such as social competence, or self-concept and self-esteem of institutionalised adolescents for a more positive development. This investment should contribute to the perception of the importance of creating intervention programmes to enhance individual protective resilience factors, and consequently resilience itself. “Educational activity can promote resources, both to the child and the adolescent, to resolve challenges, fostering their resilience” (Matos & Sampaio, 2009).

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