



Social-emotional well-being among youth living in out-of-home care[☆]

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ABSTRACT

The current study examined the use of socio-emotional well-being measures among a sample of 57 children and youth living in a congregate care type setting such as a group home or shelter. One or two measures were administered depending on the age of the child/youth, the Behavioral and Emotional Rating Scale-2 for children ages 5–18 years and the Youth Quality of Life-Short Form for youth ages 13–18 years. In addition to the measures completed by the children/youth, caregivers also completed measures assessing the social-emotional well-being of the child in her/his care. Results suggest differences between child/youth assessments of their own well-being and adult caregiver assessments. Important considerations for future measurement of socio-emotional well-being and implications for practice and future research were discussed.

1. Introduction

The well-being of children exposed to trauma has been of interest to a number of researchers (Osofsky, 2004). The specific type of trauma associated with removal from the family home and placement in a new environment can be particularly troubling for a child or youth's sense of well-being (Greeson et al., 2011; Kisiel, Fehrenbach, Small, & Lyons, 2009). The social-emotional domain of well-being is an area of particular interest since many youth placed in out-of-home care have experienced a number of disruptions to the relationships in their lives. The current study examined social-emotional well-being among youth living in congregate care settings to inform caregivers and child welfare specialists of the status of the child (Lou, Anthony, Stone, Vu, & Austin, 2008).

The child welfare system is concerned with the safety, well-being and permanency of children. From a family's initial point of contact with the public child welfare system and until children exit the system through permanency, the well-being of system-involved children will invariably change. Viewed as an important outcome that should be measured at different points in time in the child welfare case and different developmental stages, well-being has been surprisingly difficult to define and measure at the individual child level (Amerijckx & Humblet, 2013). The ability to measure child well-being, however, may have the potential to more effectively inform assessment practices, referrals and case planning, and contribute to child/youth engagement

(Anthony & Booth, 2017).

2. Defining child well-being

Despite the proliferation and popularity of using the term “child well-being,” researchers find well-being remains inconsistently defined and measured (Pollard & Lee, 2003). In a review of the well-being literature, Amerijckx and Humblet (2013) further suggest the poorly defined double-sided notion of child well-being is primarily investigated through “an oddly pathogenic approach to child well-being and a scarcity of papers still discussing a poorly defined notion” in which most studies examined the negative manifestations of well-being (Amerijckx & Humblet, 2013, p. 404). Scholmerick, Agache, & Leyendecker (2015) similarly suggest it is easier to indicate what child well being is *not* (i.e., risky sexual behavior, negative family relationships, etc.) than to define child well-being. To guide the current study, we defined general child well-being as a *positive and healthy state of being* (Cowen, 1991, 1994).

Well-being among children and youth can be measured different ways, using both subjective and objective approaches. Researchers turn to “indicators” and “domains” of child well-being to deal with the thorny definitional issues with child well-being (Brown, 2008). The Administration for Children and Families (ACF), (2012) outlined child well-being domains to include cognitive functioning, language, physical health and development, behavioral/emotional functioning, and social

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functioning. Intermediate outcome domains include environmental supports such as family income and personal characteristics such as temperament (ACF, 2012). The primacy of different domains of well-being assessment (language, cognition, physical, and socio-emotional) changes as young people develop.

Understanding children's perceptions of their quality of life offers a promising approach to assessing and monitoring the well-being of children and youth involved in public child welfare systems. The addition of well-being measurement provides a more holistic approach to assessing a young person and may identify distinct opportunities for the child welfare system to intervene on that child's behalf. Case workers and other administrators obtain diagnostic measures for young people in care and the addition of a positive development assessment may help the professional view the child in a different way and identify new avenues for intervention (Lou et al., 2008). Capturing the multi-dimensional construct of well-being is complicated, however especially important, given the considerable physical and mental health burdens experienced by maltreated children (ACF, 2012).

3. Measuring social-emotional well-being

The use of standardized well-being instruments with strong psychometric properties in child welfare practice allows for collection of valid and consistent data to identify needs, inform case planning, monitor change over time, and evaluate the impact of interventions and placements on children residing in out-of-home care settings. Of particular importance in the study of standardized instrumentation in public child welfare systems is the examination of content and face validity, as instruments that are developed with practitioner input using strength-based and system sensitive language have the potential to increase practitioner buy-in and facilitate rapport building with children and their caretakers (Helmstadter, 1964). Moreover, instrumentation with evidence of strong inter-rater reliability in studies examining their implementation among child welfare populations improves practice by promoting informed and consistent decision-making, as incongruent alignment between expertise and practitioner skill sets creates difficulty with implementation and interpretation. For instrumentation used with child welfare involved children, inclusion of multiple informants to examine well-being is important, as it allows for the ability to triangulate responses, and comprehensively identify strengths and challenges experienced throughout a child's life course that contribute to their overall well-being.

4. Challenges to measurement of social-emotional well-being

Social-emotional well-being can be conceptualized as the way young people feel about themselves, how they relate to others close to them (including caregivers, teachers, and peers), and how they behave (Isakson, Davidson, Higgins, & Cooper, 2009). One of the challenges to the ability to measure social-emotional well-being has been the difficulty obtaining both youths' and caregivers' perspectives (Authors, 2017). Standardized instruments of behavior tend to focus on diagnostic criteria and clinical cutoff scores that reveal more about problems than strengths. Purely qualitative measures, on the other hand, are subjective and make it difficult to provide comparative information. For the purposes of the current study, we employed non-diagnostic quantitative measures to assess social-emotional well-being among youth living in out-of-home care. Our objective was to study youth; the use of caregiver measures was intended to provide an additional perspective on the well-being of young people, particularly for the younger participants in the study.

4.1. Theoretical perspectives

The outcome of well-being has been conceptualized through shifts from deficit-based theoretical approaches to more adaptive perspectives

such as positive psychology, learned optimism, and resilience (Lopez & Snyder, 2003; Luthar, 2003; Seligman, 1998a; Seligman, 1998b; Rutter, 1987; Werner & Smith, 2001). When applied to youth living in out-of-home care, this shift from deficit-based perspectives is particularly pertinent given the number of risks these young people face. For the purposes of this study, the eco-interactive-developmental perspective (Richman, Bowen & Woolley, 2004) provides a helpful lens to view well-being measurement. This perspective emphasizes risk and protective factors across ecological systems, the interaction between the child and others, and the role of development. The measures selected for the study employ this adaptive, strength-based perspective on well-being measurement.

4.2. Research questions

The research questions guiding this study were: 1) How do youth living in out-of-home care assess their social emotional well-being? and 2) How do caregivers of children/youth living in out-of-home care assess social-emotional well-being among the children/youth in their care?

5. Method

5.1. Participants

Children and youth living in group home or shelter settings and their caregivers (57 children/youth and 57 caregivers) were selected from the list of eligible participants provided by the child welfare agency. The participants were part of a demonstration project designed to reduce the number of children living in congregate care. Random sampling was not possible due to the staggered enrollment of participants. Therefore, we interviewed eligible and willing participants from the list provided by the agency, resulting in our sample of 57. Eligibility requirements included: 1) living in either a group home or shelter at the initial point of contact, and 2) up to age 18 years at the initial point of contact. The caregivers were typically group home staff members or supervisors. The research assistants requested the measure be completed by the staff member in the home who works with the child the most and knows him or her the best. The length of time the caregiver knew the child and the length of time the children were in care varied. Caregiver measures were completed independently. For the children/youth, the graduate research assistant read the questions and response options and completed the instrument. This was done both to ensure complete data and to address any literacy or cognitive limitations among the children. Several visuals were created to help the child/youth understand the concept of well-being and the response set (e.g., cards with happy faces replaced the Likert scale for young children).

5.2. Measures and procedure

The standardized measures administered included the Behavioral and Emotional Rating Scale (BERS-2) (Epstein, Mooney, Ryser, & Pierce, 2004) for youth ages 5–18 years and the Youth Quality of Life Short Form Instrument- Short Form (YQOL-SF) (Patrick, Edwards, & Topolski, 2002) for youth ages 13–18 years. These measures were selected for their psychometric properties and prior (or potential use) with the child welfare population. Both measures are standardized for use with child and youth populations. Additionally, the measures were selected for their ease of use and focus on strengths and needs rather than diagnostic criteria. We piloted the tools with several youth prior to the start of the study to ensure ease of use and administration. Youth ages 13–18 years completed both measures, offering a more comprehensive picture of their social-emotional well-being. Caregivers completed only the BERS-2 since they YQOL-SF is only intended for youth administration and does not have a caregiver version.

The Behavioral and Emotional Rating Scale, 2nd edition (BERS-2) is

Table 1
Comparison of youth and caregiver ratings on the behavioral and emotional rating scale-2nd edition (BERS-2) (n = 57).

Subscales	Participant	Frequency by category						Agreement (%)
		Poor	Below Average	Average	Above Average	Superior	Very Superior	
		n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	
Interpersonal strength (IS)	Youth	5 (8.8)	7 (12.3)	23 (40.4)	13 (22.8)	5 (8.7)	4 (7.0)	(38.6)
	Caregiver	11 (19.3)	17 (29.8)	21 (36.8)	4 (7.0)	3 (5.3)	1 (1.8)	
Family involvement (FI)	Youth	0 (0)	6 (10.5)	37 (64.9)	7 (12.3)	5 (8.8)	2 (3.5)	(38.6)
	Caregiver	12 (21.0)	16 (28.1)	26 (45.6)	1 (1.8)	2 (3.5)	0 (0)	
Intrapersonal strength (IaS)	Youth	5 (8.8)	3 (5.3)	30 (52.6)	13 (22.8)	6 (10.5)	0 (0)	(38.6)
	Caregiver	4 (7.0)	15 (26.3)	28 (49.1)	7 (12.3)	3 (5.3)	0 (0)	
School functioning (SF)	Youth	4 (7.1)	2 (3.5)	24 (42.1)	21 (36.8)	6 (10.5)	0 (0)	(17.5)
	Caregiver	9 (15.8)	19 (33.3)	22 (38.6)	5 (8.8)	2 (3.5)	0 (0)	
Affective strength (AS)	Youth	6 (10.5)	6 (10.5)	35 (61.4)	7 (12.3)	3 (5.3)	0 (0)	(17.5)
	Caregiver	11 (19.3)	14 (24.6)	28 (49.1)	4 (7.0)	0 (0.0)	0 (0.0)	
Overall strength index	Youth	<i>(M</i> = 118.00) <i>(SD</i> = 18.98)						
	Caregiver	<i>(M</i> = 105.41) <i>(SD</i> = 28.36)						

a strengths-based measure that focuses on various aspects of well-being such as interpersonal strength (e.g., “I can express my anger in the right way”), involvement with family (e.g., “I get along well with my family”), intrapersonal strength (e.g., “I believe in myself”), school functioning, (e.g., “I complete tasks when asked”), affective strength (e.g., “I care about how others feel”), and career strength (e.g., “I can name at least one thing that I want to do in my life”). The BERS-2 consists of a youth rating scale, parent rating scale, and teacher rating scale. The BERS-2 can be completed in approximately 10 min and scored in about 15 min. The BERS-2 parent scale has established reliability coefficients at or above 0.80 and demonstrated convergent validity in several studies (Mooney, Epstein, Ryser, & Pierce, 2005). The BERS-2 youth rating scale also has established test-retest reliability and demonstrated convergent validity in three studies (Epstein et al., 2004).

The Youth Quality of Life-SF is a brief measure consisting of 16 items assessing overall quality of life in youth ages 13–18 years. The YQOL-SF includes items about social relationships (e.g., “I am happy with the friends I have”), sense of self (e.g., “I am pleased with how I look”), environment (e.g., “I feel safe when I am at school”), and general quality of life (e.g., “I feel my life has meaning”). The YQOL-SF or short form performed as well in the original sample as the YQOL-R or long form (Patrick, Edwards, & Topoloski, 2002). It takes approximately 10 min to complete and score the YQOL-SF. Internal consistency and test-retest reliability for the measure was at or above 0.80 and convergent and discriminant validity were also established (Patrick et al., 2002).

Incentives were provided to child/youth participants and adult participants to acknowledge their contribution of time and to show appreciation for their valuable perspectives. Incentives included selection of a small \$5 item (such as a sports water bottle, gift card, nail polish, or ear buds) and a food gift for the adults to share among the house members (such as a box of cookies).

Graduate research assistants with prior child welfare practice experiences who were trained in administration of the measures and consent procedures conducted the interviews in-person to support completion and accuracy of data collection. Initial contact was made by the research assistant based on information provided by the child welfare agency. Setting up the interviews was a labor-intensive endeavor typically involving multiple contacts with group home staff to establish a time that worked for the staff and the young person's school schedule. The interviews were conducted one-on-one at the group home, in a location identified by the youth to be reasonably private.

All of the children and youth in this study were in the care of the child welfare agency; therefore, consent was provided by the state agency. Youth assent was obtained at the time of the interview when the study was explained to the young person and to allow the opportunity to ask questions. For caregivers, the consent was also completed

at the time of the interview. All data collection procedures were approved by the University's IRB.

6. Results

Of the 57 children/youth, all 57 completed the BERS-2. Another 43 also completed the YQOL-SF. The average age of youth participants was 13 years ($SD = 3.38$); the youngest child was 5 years of age and the oldest youth was 18 years. There were more males ($n = 35$; 61.4%) than females ($n = 22$; 38.6%). This higher number of males is consistent with national norms reported by the Children's Bureau for children in congregate care, 67.7% (males) to 37.3% (females) (United States Department of Health and Human Services (USDHHS), 2016).

A raw score, scaled score, and strengths index were calculated for the BERS-2. The scaled score is derived from the raw scores of normative samples. These are particularly useful for looking clinically at an individual child's profile. Finally, the BERS-2 Strength Index is based on a mean of 100 and a standard deviation of 15.

The quantitative results can be interpreted relative to the criteria established by the authors of the BERS-2. The BERS-2 manual provides general guidelines for interpreting the scores (Epstein et al., 2004). Scaled scores on the subscales ranging from 4 to 5 correspond to “poor;” 6–7 corresponds to “below average;” 8–12 corresponds to “average;” 13–14 corresponds to “above average;” 15–16 corresponds to “superior;” and 17–20 corresponds to “very superior.”

For the overall strength index, scores greater than 130 equate to “very superior;” 121–130 equate to “superior;” 111–120 corresponds to “above average;” 90–110 corresponds to “average;” 80–89 corresponds to “below average;” and 70–79 corresponds to “poor.” The lower the overall strength index score, the greater the probability that the child has an emotional or behavior disorder (EBD) (Epstein et al., 2004).

Table 1 presents the frequency and percentage associated with each category on the five BERS-2 subscales, as well as the overall strength index average scores across the adult caregiver and youth samples. Per the criteria established by the authors of the BERS-2, the majority of youth in our sample fell within the category of average or above for each of the subscales, as well as for the strengths index. Fewer of the adult caregivers, in contrast, rated the youth as average and in many instances their scores fell into the below average and poor categories. The caregiver overall strength index score was in the average range. The youth overall strength index score was above average. Table 1 also shows the percentage of agreement among adult and child/youth dyads. The highest level of agreement was 38.6% for three of the five subscales (interpersonal strength, family involvement, and intrapersonal strength), whereas the percentage agreement was only 17.5% for the subscales pertaining to school functioning and affective strength.

Table 2
Paired sample t-test comparing youth and caregiver raw scores (BERS-2) (n = 57).

Subscales	Youth	Caregiver	t-Value	df	p value	Cohen's d
	Mean (SD)	Mean (SD)				
Interpersonal strength (IS)	33.14 (8.01)	24.70 (10.13)	5.94	56	0.000	0.92
Family involvement (FI)	22.95 (4.09)	19.49 (5.58)	4.30	56	0.000	0.71
Intrapersonal strength (IaS)	28.25 (4.43)	23.35 (5.64)	5.45	56	0.000	0.97
School functioning (SF)	20.86 (5.18)	16.63 (5.89)	4.73	56	0.000	0.76
Affective strength (AS)	14.70 (4.03)	13.21 (4.37)	1.91	56	0.062	0.35
Overall BERS-2 score	118.00 (18.98)	105.41 (28.36)	3.06	55	0.003	0.52

Table 2 shows paired t-tests comparing the youth and caregiver scores on each of the subscales and the overall strengths index. On each of the subscales, the youth scored themselves more positively than the caregivers scored the youth. Differences were statistically significant for all subscales but one, affective strength. There was a statistically significant difference in the overall strengths index scores for youth ($M = 118.00$, $SD = 18.98$) versus caregivers ($M = 105.41$, $SD = 28.36$); $t(55) = 3.06$, $p = .003$.

The YQOL-SF includes items that measure generic quality of life with response scales ranging from 0 “not at all” to 10 “a great deal or completely.” The scores are transformed to a 0 to 100 scale with higher scores representing a high quality and lower scores representing low quality. The YQOL-SF also provides a standardized list of items that youth can select from to represent areas of well-being that they perceive most important in their lives, as well as areas that they would like to change.

Table 3 presents the means and standard deviations on the raw scores for each question on the YQOL-SF. Overall, youth indicated favorable responses to the items, scoring an average of 8 or 9 on a scale of 1 to 10. Two items were rated lower, “I feel most adults treat me fairly” ($M = 6.91$; $SD = 2.52$), and I feel my parents/guardians allow me to participate in important decisions which affect me ($M = 7.23$; $SD = 2.85$). YQOL-SF scores were moderately correlated with the youth BERS-2 overall strength index values ($r(42) = 0.43$, $p = .005$).

7. Discussion

Our goal was to examine how young people assess their own social-emotional well-being and how their caregivers assess the social-

Table 3
Scores on youth quality of life-short form (n = 43).

Item	Mean (SD)*
I have enough energy to do the things I want to do	8.77 (1.90)
I am pleased with how I look	8.63 (1.97)
I feel my life has meaning	8.56 (2.09)
I feel most adults treat me fairly	6.91 (2.52)
My family encourages me to do my best	8.70 (2.21)
I feel I am getting along with my parents or guardians	8.04 (2.42)
I feel my parents /guardians allow me to participate in important decisions which affect me	7.23 (2.85)
I am happy with the friends I have	9.35 (1.41)
I feel I can take part in the same activities as others my age	8.26 (2.24)
People my age treat me with respect	8.35 (2.49)
I look forward to the future	9.05 (1.57)
I feel safe when I am at home	9.26 (1.66)
I feel I am getting a good education	9.12 (1.46)
I know how to get the information that I need	8.91 (1.36)
I enjoy learning new things	9.00 (1.86)
I feel safe when I am at school	9.09 (1.47)
Total score	137.4 (18.0)
Transformed score	85.0 (12.3)

Note. Response set on items range from 1 (Not at all) to 10 (A great deal or completely); transformed scores range from 0 to 100 with higher scores representing greater quality of life.

emotional well-being of children in their care. That young people overall rate their strengths higher than their caregivers is a mixed finding. In one way, it is encouraging that these young people, who have been through the traumatic experience of being removed from their parents among other painful experiences, consider their strengths as relative to their peers.

On the other hand, caregivers assessed the social-emotional well-being of the children in their care to be lower than the youth assessed themselves, even though ratings were overall “average.” Caregivers may feel a strong sense of responsibility for the care of the children and the need to advocate for them in decision-making. It is also possible in some cases that caregivers have limited time to get to know the child or not have a primary relationship with the child. Another potential reason for the lower caregiver scores may be that group home staff did not feel adequately incentivized to participate.

It is also an interesting finding that the BERS-2 and YQOL were positively correlated at a moderate level. This suggests that these measures are tapping into related but different aspects of socio-emotional well-being. Particularly for youth ages 13 and older, it appears that the use of both measures is advantageous to understand the multidimensional aspects of socio-emotional well-being. The use of the BERS-2 and YQOL together for those 13 and over should be explored by those in the field interested in social-emotional well-being for older youth.

In the process of interviewing, the graduate research assistants noted an ability to engage with the young people in a discussion about her/his life that was different than most conversations the young person has with professionals. For instance, completing the standardized instruments provided an opportunity for the youth to discuss their involvement in important decisions, as well as components of their lives that they felt were meaningful, and those that provided hope for their future. Overall, most youth were open and interested in sharing their perspectives on well-being and quality of life. This suggests the *process* of assessing well-being, not simply the results, may serve an important function in engagement and case planning by opening up dialogue. The use of well-being measures can be clinically beneficial in a field where assessment tasks are often outsourced to allied professionals. This may provide a distinct opportunity for professionals working directly with young people.

There are several limitations of the study to consider. One of the limitations of the study is the variability in length of time the caregivers have known the children and length of time in care. It is possible that young people responded according to social desirability, in the interest of pleasing the interviewer or wanting to portray his/her self-perception as more positive. The graduate research assistants, experienced in child welfare practice and research interview techniques, sought to minimize this potential by assuring the young person that this was not a test and we were simply interested in what the child/youth honestly thought about her/himself.

Our results suggest that these tools may serve the dual purpose of informing child welfare professionals about the status of the child and serve as sources of information for case planning/service referral, as well as engaging the child/youth in meaningful discourse about the

state of her/his life and experience. The opportunity to enhance engagement with children and youth residing in congregate care settings has the potential to lead to better identification of placement needs, and enhanced case plan development and referral to services. We recommend future research examine the status of social-emotional well-being over time, employ measures of engagement, and explore concrete ways in which measures such as the BERS-2 and YQOL-SF can be used by child welfare case managers and administrators to link to the case planning and referral process.

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