Protective Factors for Populations Served by the Administration on Children, Youth, and Families

Appendix 2

Population Crosswalks

Crosswalk of Constructs: Homeless and Runaway Youth

Homeless and Runaway Youth Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Positive self-image	• Self-esteem • Self-worth • Self-concept • Desirable personal identity • Cultural knowledge	14-24 yrs. 18 to 25 yrs. 14 to 24 yrs. Mean ages of 16.2, 18.8 and 19.1 yrs. 14-21 yrs.	Emerging Evidence	**Positive self-image** identified by youth as surviving and having meaningful life on streets (Kidd & Davidson, 2007). **Learning to love oneself** identified by youth as important to moving from streets to successful transition to adulthood (Lindsey et al., 2000). **Self-esteem** plays a protective role for homeless youth, predicting levels of loneliness, feeling trapped and suicide ideation and buffering vs deleterious effect of fearful attachment on loneliness (Kidd & Shahar, 2008). **Self-improvement** (enacting healthier behaviors, gaining emotional maturity, mastering skills for the future) allows homeless youth to be safer on the streets and meet their basic survival needs (Rew & Horner, 2003). **Self-esteem** associated with lower levels of unprotected sex for homeless girls (Tevendale et al., 2009).	
Sense of purpose	• Motivation • Goals • Spirituality • Religion • Commitment	14-24 yrs.	Emerging Evidence	**Motivation** and not wanting the help of others identified as important steps in survival for homeless youths; also motivation to make positive changes in their lives **Spirituality** identified as important to street youths, helping them define, understand, and value themselves (Kidd & Davidson, 2007).	

Homeless and Runaway Youth Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
		18 to 25 yrs. 18-24 yrs. 18-25 yrs.	Emerging Evidence	**Personal goals, spirituality** identified by youth as important to moving from streets to successful transition to adulthood (Lindsey et al., 2000). **Spirituality** helped homeless youth navigate environment (Bender et al., 2007). **Spirituality** helped homeless youths cope with adversity, including a belief in divine intervention; having a personal relationship with a nonjudgmental higher power; use of prayer; participation in traditional and nontraditional religious practices; and finding purpose in life (Williams, 2004).	
Sense of optimism	• Positive future orientation • Future expectations and aspirations • Trust • Hope	14-24 yrs. 18-24 yrs. Mean ages of 16.2, 18.8 and 19.1 yrs. 14-21 yrs. Avg age 19.9 yrs.	Emerging Evidence	**Positive future orientation** or “Belief in a better future” linked to lower risk of suicide ideation among homeless youths (Kidd & Carroll, 2007). **Positive attitude** helped homeless youth navigate environment (Bender et al., 2007). **Internal motivators for self-improvement** allows homeless youth to be safer on the streets and meet their basic survival needs (Rew & Horner, 2003). **Positive expectations for the future** were associated with lower levels of risky sexual behavior for homeless youth (Tevendale et al., 2009). **Optimism.** Quality support staff help develop newly-developed sense of optimism about the future among homeless urban adolescent mothers (Kennedy et al., 2010).	

Homeless and Runaway Youth Table 1. Protective Factor Crosswalk—Individual Level					
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		18-25 yrs.		Effective ways to get along with family, **learning to trust** and accept help from others, helping others identified by youth as important to moving from streets to successful transition to adulthood (Lindsey et al., 2000).	
Agency (self-efficacy)	• Self-efficacy • Confidence • Sense of power • Sense of control • Internal locus of control • Help-seeking behavior	14-24 yrs. 18 to 25 yrs. Mean ages of 16.2, 18.8 and 19.1 yrs. Avg age 19.9 yrs. n/a	Emerging Evidence	**Self-efficacy** and independence linked with homeless youths "finding pride in being survivors" (Kidd & Davidson 2007). **Self-love, self-confidence, ability to take care of oneself** identified by youth as important to moving from streets to successful transition to adulthood (Lindsey et al., 2000). **Becoming overly self-reliant, being independent and able to take care of one's self in spite of a lack of social support** identified as a key factor in resilience among homeless adolescents (Rew et al., 2001). **Self-efficacy.** Quality support staff help develop newly-developed sense of optimism about the future among homeless urban adolescent mothers (Kennedy et al., 2010).	**Self-sufficiency.** Systematic review of evidence suggests that interventions to promote independent living have shown promising results for homeless youth, but based on a "poor quality" intervention study (Altena et al., 2010).

Skills and Developmental Tasks					
Self-regulation skills (emotional, behavioral)	• Self-mastery • Anger management • *Fatalismo* • Character • Temperament • Emotional intelligence • Long term self-control	14-24 yrs. 18 to 25 yrs. 14-21 yrs. n/a	Emerging Evidence	**Character**. Problem-focused coping associated with lower risk of suicide ideation among homeless youths (as opposed to avoidant coping) (Kidd & Carroll, 2007). **Personal strength** was framed as crucial in the struggle to survive (Kidd & Davidson, 2007). **Responsibility for one's own actions, thinking about consequences** identified by youth as important to moving from streets to successful transition to adulthood (Lindsey et al., 2000). **Decision-making skills** were associated with lower levels of risky sexual behavior for homeless youth (Tevendale et al., 2009).	**Self-mastery.** Systematic review of evidence suggests that interventions applying cognitive-behavioral components have shown promising results for homeless youth in increased self-efficacy (Altena et al., 2010).
Awareness of environment	• Street smarts • Risk management • Safety planning	18-24 yrs. 14-24 yrs. 18 to 25 yrs.	Emerging Evidence	Qualitative study of homeless street youth: survival linked with developing **street smarts**, existence of personal strengths and informal resources. **Developing "street smarts"** helps homeless youth navigate environment (Bender et al., 2007). **Street smarts.** Development of contextual instincts and intelligence were identified as a key component in survival for homeless youths (Kidd & Davidson, 2007). **Better judge of others** identified by youth as important to moving from streets to successful transition to adulthood (Lindsey et al., 2000).	

		Mean ages of 16.2, 18.8 and 19.1 yrs.	Emerging Evidence	**Knowledge of environment** allows homeless to be safer on the streets and meet their basic survival needs (Rew & Horner, 2003).	
Problem-solving skills	• Decision making • Planning • Competence • Task-oriented coping • Problem-solving self-efficacy	12-17 yrs. 18 to 24 yrs. 14 to 22 yrs.	Emerging Evidence	**Task-oriented coping skills** associated with fewer depressive symptoms for runaways (Erdem & Slesnick, 2010). **Coping/problem solving skills** helped homeless youth navigate environment (Bender et al., 2007). **Higher task-oriented coping** associated with fewer reported delinquent behaviors among substance abusing homeless youths (Dashora, 2011).	
Relational skills	• Ability to form positive bonds and connections • Positive attachments • Relationships • Connection • Caring • Empathy • Permanent lifetime connections • Communication skills • Negotiation • Verbal • Conflict resolution • Verbal competence	14-24 yrs. 18 to 25 yrs. 18 to 24 yrs. 14 to 24 yrs. Mean ages of 16.2, 18.8 and 19.1 yrs.	Emerging Evidence	**Connection.** Strong need for understanding, connection, and support from others (Kidd & Davidson, 2007). **Effective ways to get along with family, learning to trust and accept help from others, helping others** identified by youth as important to moving from streets to successful transition to adulthood (Lindsey et al., 2000). **Social/interpersonal skills: Pets** helped homeless youth navigate environment (Bender et al., 2007). **Social involvement** plays a protective role for homeless youth against loneliness but positively associated with substance use (Kidd & Shahar, 2008). **Connectedness** is a significant predictor of resilience in homeless youth (Rew et al., 2001).	

Homeless and Runaway Youth Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Parenting competencies	• Mutually responsive orientation • Sensitive parenting • Maternal and/or paternal closeness • Stable home • Emotional commitment to child • Clear standards • Parental monitoring • Discipline • Consistency • Knowledge of child development • Ability to seek help • Parenting self-efficacy • Open communication with child about health and safety Setting developmentally appropriate limits	12-17 yrs.	Emerging Evidence	**Family systems with moderate (versus severe) levels of parental verbal aggression,** parental depression and **family conflict** associated with decreased likelihood of runaways suffering depression – risk not necessarily “negative” (Erdem & Slesnick, 2010).	

Parent or caregiver well-being	• Maternal functioning • Maternal adjustment and coping • Competent parents • Positive parental norms	12-17 yrs.	Emerging evidence	Family systems with moderate (versus severe) levels of parental verbal aggression, **parental depression** and family conflict associated with decreased likelihood of runaways suffering depression – risk not necessarily "negative" (Erdem & Slesnick, 2010).	
Family strengthening	• Treatment of problems "unique" to family, e.g., substance use • Help to mom or caregiver	12-17 yrs.	Emerging Evidence	**Family cohesion** associated with lower levels of depressive symptoms for runaway girls. Study supported challenge model of risk exposure, where moderate levels of risk exposure associated with lower depressive symptoms for boys and girls (Erdem & Slesnick, 2010).	
Positive peers	• Positive peer norms • Social support by friends • Friendship • Peer networks	18-24 yrs. 6-17 yrs. Mean ages of 16.2, 18.8 and 19.1 yrs. n/a	Limited Evidence	**Peer networks** helped homeless youth navigate environment (Bender et al., 2007). **Perceived support from friends** negatively associated with depressive symptoms in runaway/homeless adolescents (note: affiliation with deviant peers positively associated with perceived friend support and positively associated with depressive symptoms) (Bao et al., 2000). **Community of peers** allows homeless to be safer on the streets and meet their basic survival needs (Rew & Horner, 2003).	Systematic review of evidence suggests that interventions providing **peer-oriented interventions** have shown promising results for homeless youth (Altena et al., 2010).

Caring adult(s)	• Mentor • *Familismo* • Prosocial models • Engagement of all adults who are important, living in home and neighborhoods, extended kin • Support from home visitors, community center staff, and other non-kin adults	18-24 yrs 14-21 yrs. Avg age 19.9 yrs.	Emerging Evidence	**Charity/Assistance from strangers** helped homeless youth navigate environment (Bender et al., 2007). **Having a natural mentor** may reduce likelihood of unprotected sex for homeless girls (Tevendale et al., 2009). **Positive experiences with shelter staff** shown to facilitate resilience among homeless urban adolescent mothers by providing **nurturing, warm relationships** and material support (Kennedy et al., 2010).	

Homeless and Runaway Youth Table 3. Protective Factor Crosswalk—Community Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Community Characteristics					
Positive community environment	• Community vigilance • Community efficacy • Caring community • Safety • Social trust • Neighborhood cohesion • Positive community norms	18-24 yrs Mean ages of 16.2, 18.8 and 19.1 yrs.	Emerging Evidence	**Charity/Assistance from strangers** helped homeless youth navigate environment (Bender et al., 2007). **Community of peers** allows homeless to be safer on the streets and meet their basic survival needs (Rew & Horner, 2003).	
Access to support services and resources	• Staff training • Culturally appropriate staff • Use of effective counseling services (e.g., CBT) • Liaison with school, teachers • Mental health and substance use treatment • Through caseworker, connection with services • Drop in center • Referrals to education, employment, housing and other opportunities and	18-24 yrs. Avg age 19.9 yrs. n/a	Limited Evidence	Qualitative study of homeless street youth: survival linked with developing street smarts, existence of personal strengths and **informal resources** (Bender et al., 2007). **Positive experiences with shelter staff** shown to facilitate resilience among homeless urban adolescent mothers by providing **nurturing, warm relationships and material support** (Kennedy et al., 2010).	**Counseling services.** Systematic review of evidence suggests that interventions applying cognitive-behavioral components and brief motivational interventions have shown promising results for homeless youth. **Case management.** Systematic review of evidence suggests that interventions applying intensive case management have shown promising results for homeless youth. **Supportive housing.** Systematic review of evidence suggests that interventions providing supportive housing have shown promising results for homeless youth (Altena et al., 2010).

Homeless and Runaway Youth Table 3. Protective Factor Crosswalk—Community Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
	resources				
Availability of shelter	• Adequate housing • Good housing quality	16-19 yrs. (Time 1); 18-21 (Time 2) 11-23 yrs. n/a	Moderate Evidence	**Housing stability.** Longer duration of rehousing (more stable housing) for homeless youth associated with greater school participation (Hyman et al., 2011).	Systematic review indicates that **runaway shelters** show some short term benefits to youth (reduced days on the run, reduced school and employment problems, and reduced behavioral and emotional problems), but long-term benefits have not been demonstrated (Slesnick et al., 2009). Systematic review of evidence suggests that interventions providing **supportive housing** have shown promising results for homeless youth (Altena et al., 2010).
Economic opportunities	• Economic supports • Employment opportunities • Promote economic self-sufficiency • Presence of concrete support services (such as food stamps) • Socioeconomic status (SES)	14-21 yrs. n/a Families with dependents <17 yrs.	Limited Evidence	**Being employed** or in school may play a protective role with respect to number of sex partners (Tevendale et al., 2009). **Primary Tenant**, **Receiving AFDC** or **housing voucher** reduced chance of family homelessness in adulthood (Bassuk et al., 1997).	**Promotion of economic self-sufficiency.** Systematic review of evidence suggests that **interventions providing living skills/vocational training** have shown promising results for homeless youth (Altena et al., 2010).

Rating Instrument for Summative Ratings

Emerging Evidence: Preponderance of findings generated by cross-sectional studies, case studies, or qualitative investigations with non-representative samples.

Limited Evidence: Preponderance of findings generated by a single longitudinal study (significant findings with small, medium, or large effect sizes).

Moderate Evidence: Consistent findings that are generated by two or more longitudinal studies (significant findings with small, medium, or large effect sizes).

Strong Evidence: Findings generated from one or more experimental or well conducted quasi-experimental studies that demonstrate a significant effect on a protective factor and an outcome (e.g., findings demonstrate that the experimental effect on an outcome is mediated by the effect of a protective factor).

Crosswalk of Constructs: Youth Exposed to Domestic Violence

Youth Exposed to Domestic Violence Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Characteristics					
Sense of purpose	• Motivation • Goals • Spirituality • Religion • Commitment	13-16 yrs. 12-15 yrs.	Emerging Evidence	Qualitative study: **Spirituality** identified as a protective factor for adolescents exposed to domestic violence, including four emerging themes: **Learning from experiences**, **self-expression**, **beliefs**, and **feelings** (Benavides, 2012). Qualitative study: **Spirituality** ("a desire to look beyond themselves and their material world") identified as protective factor for youths exposed to domestic violence (Collis, 2009).	
Sense of optimism	• Positive future orientation • Future expectations and aspirations • Trust • Hope	12-15 yrs. 1-5 yrs. 18 mo.-14 yrs.	Emerging Evidence	Qualitative study: **Hopefulness** identified as protective factor for youths exposed to domestic violence; takes a spiritual/emotional approach to resilience (Collis, 2009). Qualitative study of responses of mothers involved in DV emphasized importance of instilling **hope** in their children after violent episode (Haight et al., 2007). **Peer trust** moderated effect of exposure to IPV on running away, depression. It did not moderate effect of IPV exposure on violence, pregnancy, dropout or victimization (Tajima et al., 2011).	

Skills and Developmental Tasks					
Self-regulation skills (emotional, behavioral)	• Self-mastery • Anger management • *Fatalismo* • Character • Temperament • Emotional intelligence • Long term self-control	2-4 yrs. 5-11 yrs. Grades 8-9 7-14 yrs. Grade 6	Moderate Evidence	Resilient DV-exposed children characterized by those who maintained **positive adaptation** and **easy temperament** (Martinez-Torteya et al., 2009) **Emotional awareness** mediated the relationship between DV and friendship closeness and internalizing problems (Katz, Hessler, & Annest, 2007).	Safe Dates is a school-based prevention program for middle and high school students designed to stop or prevent the initiation of dating violence victimization and perpetration, (focuses on decision-making exercises; role-playing to practice skills; skills for effective communication; **anger management training**); study indicated program's impact on reduced psychological and sexual abuse (Foshee et al., 2005). RCT for IPV-exposed children using community-provided **trauma-focused CBT (TF-CBT)** (compared to the usually community treatment). Program components include psycho-education about trauma, **developing individualized relaxation skills to manage stress, expressing and modulating upsetting feelings, cognitive coping skills**, developing a narrative about the child's IPV experiences and correcting maladaptive cognitions expressed during this narrative, in vivo mastery of trauma reminders, joint child-parent sessions during which the child is encouraged to share IPV experiences directly with the mother, and enhancing safety. As the sessions progress, children are encouraged to confront increasingly detailed, distressing, and personal IPV-related reminders and events. TF-CBT completers experienced significantly greater PTSD diagnostic remission and had significantly fewer serious adverse events; TF-CBT improved IPV-related PTSD and anxiety symptoms (anxiety, depression, cognitive functioning and total behavior problems), driven by decreases in hyperarousal and avoidance symptoms (Cohen, Mannarino & Iyengar, 2011). RCT of CBITS (Cognitive Behavioral Intervention for Trauma in Schools) for youth exposed to violence (witness or victim) with clinical levels of PTSD symptoms; program included **relaxation training; coping strategies; replacing negative thoughts**; social problem solving. Evidence showed that CBITs lowered scores of

		Grades 3-8			self-reported PTSD symptoms and depressive symptoms, and psychosocial dysfunction. (no difference in school conduct between the treatment and control groups) (Stein et al., 2003). RCT of CBITS (Cognitive Behavioral Intervention for Trauma in Schools) found that compared to the control group, the treatment group experienced significant decreases in depressive symptoms and PTSD scores (Kataoka et al., 2003).
Problem-solving skills	• Decision making • Planning • Competence • Task-oriented coping • Problem-solving self-efficacy	Grades 8-9 Grade 6 Grades 3-8	Moderate Evidence		Safe Dates is a school-based prevention program for middle and high school students designed to stop or prevent the initiation of dating violence victimization and perpetration, (focuses on **decision-making exercises;** role-playing to practice skills; skills for effective communication; anger management training); study indicated program's impact on reduced psychological and sexual abuse (Foshee et al., 2005). RCT of CBITS (Cognitive Behavioral Intervention for Trauma in Schools) for youth exposed to violence (witness or victim) with clinical levels of PTSD symptoms; program included relaxation training; coping strategies; replacing negative thoughts; **social problem solving**. Evidence showed that CBITs lowered scores of self-reported PTSD symptoms and depressive symptoms, and psychosocial dysfunction. (no difference in school conduct between the treatment and control groups) (Stein et al., 2003). RCT of CBITS (Cognitive Behavioral Intervention for Trauma in Schools) found that compared to the control group, the treatment group experienced significant decreases in depressive symptoms and PTSD scores (Kataoka et al., 2003).

Relational skills	• Ability to form positive bonds and connections • Positive attachments • Relationships • Connection • Caring • Empathy • Permanent lifetime connections • Communication skills • Negotiation • Conflict resolution • Verbal competence	Grades 8-9	Limited evidence		Safe Dates is a school-based prevention program for middle and high school students designed to stop or prevent the initiation of dating violence victimization and perpetration, (focuses on **decision-making exercises;** role-playing to practice skills; **skills for effective communication;** anger management training); study indicated program's impact on reduced psychological and sexual abuse (Foshee et al., 2005).

Youth Exposed to Domestic Violence Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Supportive Adults					
Parenting Competencies	• Mutually responsive orientation • Sensitive parenting • Maternal/paternal closeness • Emotional commitment to child • Stable home • Clear standards • Parental monitoring • Discipline • Consistency • Knowledge of child development • Ability to seek help • Open communication with child about health and safety • Setting developmentally appropriate limits • Parenting self-efficacy • [Absence of abuser's undermining of victim's parenting (DV)]	18 mo.-adolescence 18-38 yrs. 3-5 yrs. 18 mo. – 6 yrs. 1-5 yrs. 3-5 yrs.	Strong Evidence	**Parental acceptance/responsiveness** moderated effect of exposure to IPV on running away and teenage pregnancy. It did not moderate effect of IPV exposure on depression, violence, high school dropout or victimization (Tajima et al., 2011). A study interviewing adults about their childhood experiences found that **maternal warmth** was positively associated with self-esteem in witnesses of domestic violence (Harper, Arias, & House, 2003). Sample of 30 preschool-age children whose mothers were physically abused by a partner, found that **maternal attunement** DID NOT mediate the relationship between marital conflict and children's behavior problems (Johnson & Lieberman, 2007). **Stronger bonds of attachment to parents** predicted lower risk of antisocial behavior in adolescence (felony assault, minor assault, delinquency, and status offenses) (Sousa et al., 2011). Qualitative study of responses of mothers involved in DV emphasized importance of providing children with **emotional support,** including reassurance and feelings of safety (Haight et al., 2007).	RCT of Child-Parent Psychotherapy (CPP), an intervention targeting preschoolers exposed to marital violence, **which focuses on the attachment system as main organizer of children's responses to danger and safety in early life**. Goal of treatment is to promote an emotional partnership in which the child's regulation and integration of affect, interpersonal skills, readiness to learn, and accurate reality testing are supported by the **parent's increased**

Youth Exposed to Domestic Violence Table 2. Protective Factor Crosswalk—Relationship Level					
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		3-5 yrs. 4-9 yrs. 4-9 yrs. 6-12 yrs.	Strong Evidence		**ability to provide a secure base to meet the child's developmental and individual needs**. Results indicated that CPP children exhibited significant decreases in total behavior problems and decreased Traumatic Stress Disorder (TSD) symptoms versus children who received treatment as usual. CPP children were also significantly less likely to be diagnosed with TSD after treatment. In addition, mothers receiving CPP showed significantly fewer PTSD avoidance symptoms (Lieberman, van Horn, Ippen, 2005). 6 month follow-up of CPP (Lieberman, van Horn, Ippen 2005), found that improvements in children's behavior problems and maternal symptoms as the results of CPP continued at 6 month follow up, confirming the hypothesis that a **clinical focus on the child-mother relationship** as the mechanism of change will lead to longer duration of effects (Lieberman, Ippen, van Horn, 2006) Study of Project Support (provides emotional support to the mother and teaches her **child management and nurturing strategies to reduce misconduct in her child**) found that treatment children were less likely to exhibit clinical levels of conduct problems, were happier and had better social relationships. Mothers in the Project Support group were less likely to use aggressive child-management strategies and also reported improvement in parenting skills (McDonald, Jouriles, & Skopp, 2006). The Project Support intervention, which involves (a) **teaching mothers child management skills** and (b) providing instrumental and emotional support to mothers, resulted in greater reductions in conduct problems (as compared to the control group). Mothers in the Project Support group displayed greater reductions in inconsistent and harsh parenting behaviors and psychiatric symptoms (Jouriles et al., 2009). Study of Kids Club (which targets children's knowledge about family violence, attitudes and beliefs, emotional adjustment, social behavior; managing emotions, conflict resolution, and

Youth Exposed to Domestic Violence Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
					strengthening family relationships; parenting competence, parenting and disciplinary skills) found that treatment children showed improvement over time in externalizing problems, decreases in internalizing problems, and a decrease in mean Attitudes About Family Violence (AAFV) scores over the course of the study, meaning that the children in these groups became less accepting of violence (Graham–Bermann et al., 2007).
Parent of caregiver well-being	• Maternal functioning • Maternal adjustment and coping • Competent parents • Positive parental norms	2-4 yrs. 14-16 yrs. 6-12 yrs. 4-9 yrs.	Moderate evidence	Resilient DV-exposed children characterized by **nondepressed mothers** (Martinez-Torteya, et al., 2009). Positive **maternal psychological functioning** was found to be a significant moderator of the relation between DV and adolescent mental health outcomes (associated with lower symptoms of depression and trauma) (Levendosky, Huth–Bocks, & Semel, 2002).	Intervention to **improve mother's mental health** (psychoeducational element of the program designed to normalize women's experience of distress, to help reduce their stress, and to provide support and problem solving around parenting challenges; designed to improve children's externalizing and internalizing behaviors) found to improve **mother's adjustment and coping** with IPV, which in turn improved child well-being **(**mediating effect of improved parenting skills/maternal well-being) (Graham-Bermann et al., 2011). Study of Project Support (**provides emotional support to the mother** and teaches her child management and nurturing strategies to reduce misconduct in her child) found that treatment children were less likely to exhibit clinical levels of conduct problems, were happier and had better social relationships.

Youth Exposed to Domestic Violence Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
		4-9 yrs.			Mothers in the Project Support group were less likely to use aggressive child-management strategies and also reported improvement in parenting skills (McDonald, Jouriles, & Skopp, 2006). The Project Support intervention, which involves (a) teaching mothers child management skills and (b) **providing instrumental and emotional support to mothers**, resulted in greater reductions in conduct problems (as compared to the control group). Mothers in the Project Support group displayed greater reductions in inconsistent and harsh parenting behaviors and psychiatric symptoms (Jouriles et al., 2009).
Positive peers	• Positive peer norms • Social support by friends • Friendship • Peer networks	18 mo.-14 yrs. 14-16 yrs. 10-18 yrs.	Emerging Evidence	**Peer communication** moderated effect of exposure to IPV on running away, depression and dropout. It did not moderate effect of IPV exposure on violence, pregnancy or victimization**.** **Peer trust** moderated effect of exposure to IPV on running away, depression. It did not moderate effect of IPV exposure on violence, pregnancy, dropout or victimization (Tajima et al., 2011). **Social support** from peers found to be a significant moderator of the relation between DV and peer relations – associated with increases in best friend satisfaction and dating partner satisfaction (Levendosky, Huth–Bocks, & Semel, 2002). **Receiving prosocial behaviors** buffers against the effects of IPV exposure on internalizing problem behaviors; Demonstrates **social support** as moderator between exposure to IPV and child adjustment (Camacho, Ehrensaft, & Cohen, 2012).	

Youth Exposed to Domestic Violence Table 3. Protective Factor Crosswalk—Community Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Community Characteristics					
Positive school environment	• Perceived safety at school • Prosocial relationships with teachers • Positive school environment • Effective classroom management • High levels of school engagement • Effective, specialized programming in school	Grade 6 Grades 3-8 Grades 8-9	Moderate Evidence		RCT of CBITS (**Cognitive Behavioral Intervention for Trauma in Schools**) for youth exposed to violence (witness or victim) with clinical levels of PTSD symptoms; program included relaxation training; coping strategies; replacing negative thoughts; social problem solving. Evidence showed that CBITs lowered scores of self-reported PTSD symptoms and depressive symptoms, and psychosocial dysfunction. (no difference in school conduct between the treatment and control groups) (Stein et al., 2003). RCT of CBITS (**Cognitive Behavioral Intervention for Trauma in Schools**) found that compared to the control group, the treatment group experienced significant decreases in depressive symptoms and PTSD scores (Kataoka et al., 2003). **Safe Dates is a school-based prevention program** for middle and high school students designed to stop or prevent the initiation of dating violence victimization and perpetration, (focuses on decision-making exercises**;** role-playing to practice skills; skills for effective communication; anger management training); study indicated program's impact on reduced psychological and sexual abuse (Foshee et al., 2005).

Rating Instrument for Summative Ratings

Emerging Evidence: Preponderance of findings generated by cross-sectional studies, case studies, or qualitative investigations with non-representative samples.

Limited Evidence: Preponderance of findings generated by a single longitudinal study (significant findings with small, medium, or large effect sizes).

Moderate Evidence: Consistent findings that are generated by two or more longitudinal studies (significant findings with small, medium, or large effect sizes).

Strong Evidence: Findings generated from one or more experimental or well conducted quasi-experimental studies that demonstrate a significant effect on a protective factor and an outcome (e.g., findings demonstrate that the experimental effect on an outcome is mediated by the effect of a protective factor).

Crosswalk of Constructs: Youth in or Transitioning out of Foster Care

Youth in or Transitioning out of Foster Care Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Characteristics					
Sense of purpose	• Motivation • Goals • Spirituality • Religion • Commitment	Teen mothers Older youth, average age 17	Emerging Evidence	**Spirituality** and a **positive value placed on children and motherhood** may support resilience among African American teen mothers in foster care according to this longitudinal qualitative study (Haight et al., 2009). **Greater religious beliefs** were associated with a reduction in odds of foster youth's use of alcohol in the past 6 months and current use of cigarettes. **Religious service attendance** was associated with reduced odds of youth's engagement in sexual behavior in the past 2 months and current use of cigarettes. Results also indicated that church/religious service attendance had a moderate inverse association with marijuana use (Scott et al., 2006).	
Sense of optimism	• Positive future orientation • Future expectations and aspirations • Trust • Hope	15-18 yrs.	Emerging Evidence	A stronger or more positive **future orientation** was significantly associated with safer HIV-related attitudes, higher HIV/AIDS knowledge, fewer intentions to engage in risky behaviors, and specific risky sexual behaviors (i.e., age of first intercourse and number of sexual intercourse partners) among adolescent in foster care (Cabrera, Auslander & Polgar, 2009).	
Agency (self-efficacy)	• Self-efficacy • Confidence • Sense of power • Sense of control • Internal locus of control • Help-seeking behavior	14-17 yrs. Teen mothers Youth in	Emerging Evidence	Qualitative study of adolescents in foster care. **Increase in perceived self-efficacy** identified as key component to promote resilience (Drapeau, et al., 2007). Having an **oppositional gaze** (resistance to messages that limit and oppress) may support resilience among African American teen mothers in foster care according to this longitudinal qualitative study (Haight et al., 2009). The children who do best in Treatment Foster Care are those who	

Youth in or Transitioning out of Foster Care Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
		treatment foster care Youth transitioning out of foster care into adulthood	Emerging Evidence	have: (1) fewer emotional and behavioral problems, (2) fewer prior placements and less time spent in institutions before their first foster placement, (3), fewer prior negative placement outcomes, (4) good relationships with their foster family, and (5) **a degree of control over the frequency and type of visitation with their biological family** (Redding, Fried & Britner, 2000). Qualitative study (focus groups). Many foster care youth emphasized the importance of **young people taking part and having a say in the important decisions that impact their lives while in care**. Many child welfare professionals explicitly agreed that **giving youth more opportunities to take responsibility and ownership for their lives** is key to successful transition. Generally foster parents agreed with youth and caseworkers that young people in care need more **opportunities to control and direct their own lives** (Geenen & Powers, 2007).	
Cognitive ability (intelligence)	• IQ • Reading and/or math skills • Curiosity • Intellectual mastery • Verbal competence • Executive functioning	Adolescent mothers 14-18 yrs. 17-24 yrs. 16-20 yrs.	Limited Evidence	**Higher academic achievement** (as measured by **educational skills in reading & arithmetic**) was associated with lower child abuse potential scores (as measured by the CAP Inventory Abuse Scale) among adolescent mothers in foster care (Budd, Heilman, & Kane, 2000). Foster youths' **reading level** is associated with odds of employment. Youth scoring above grade 6 were 40 to 70% more likely than youth scoring below grade 6 to be employed at least 20 h per week. Furthermore employed youth scoring at the post high school level at age 17 earned 7% higher wages (Hook & Courtney, 2011). The group of foster care youth with **no risk factors or low risk** in the areas of mental health problems, delinquency issues, teen parenting, and **cognitive impairment** were significantly more likely to be employed and more likely to have successfully completed high school and live independently than medium and high-risk	

Youth in or Transitioning out of Foster Care Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
				clients (Mares & Kroner, 2011).	
Skills and Developmental Tasks					
Self-regulation skills (emotional, behavioral)	• Self-mastery • Anger management • *Fatalismo* • Character • Temperament • Emotional intelligence • Long term self-control	Youths in treatment foster care 16-20 yrs. 75% were 0-10 yrs., 25% were 11 yrs. & older[1]	Strong Evidence	The children who do best in Treatment Foster Care are those who have: (1) **fewer emotional and behavioral problems**, (2) fewer prior placements and less time spent in institutions before their first foster placement, (3), fewer prior negative placement outcomes, (4) good relationships with their foster family, and (5) a degree of control over the frequency and type of visitation with their biological family. Foster children who exhibit **normal attachment behaviors**, **good school conduct**, who are **better socialized and non-aggressive**, and have experienced acute (rather than chronic) family problems precipitating their removal from the home, are more likely to have treatment foster care placements that lasted at least 60 days and did not disrupt unexpectedly thereafter (Redding, Fried & Britner, 2000). The group of foster care youth with **no risk factors or low risk** in the areas of mental health problems, **delinquency issues**, teen parenting, and cognitive impairment were significantly more likely to be employed and more likely to have successfully completed high school and live independently than medium and high-risk clients (Mares & Kroner, 2011).	**Intensive family preservation services** (IFPS) significantly reduced the rate of out-of-home placement among youths and families involved in the child welfare, juvenile justice, and mental health system. IFPS services included motivational interviewing, behavioral parent training, cognitive–behavior therapy strategies, and relapse prevention. Therapists teach family members a variety of skills, including child behavior management, effective discipline, positive behavioral support, communication skills, problem-solving skills, **resisting peer pressure**, **mood management skills**, safety

[1] At time of referral.

Youth in or Transitioning out of Foster Care Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
		3.6-39.4 mo.			planning, and establishing daily routines (Kirk and Griffith, 2003). RCT of "Attachment and Biobehavioral Catch-Up" for infants and toddlers in foster care targeting **child regulatory capabilities**; intervention effects included lower cortisol levels and fewer parent-reported behavioral problems for older vs. younger children (Dozier, et al., 2006).
Academic skills	• Persistence • Grades • GPA Help-seeking behavior • Study skills • Time management • Coaching • Academic self-efficacy • Degrees or accomplishments	Adolescent mothers 14-18 yrs. 17-21 yrs. 17-24 yrs. Youth in treatment foster care	Moderate Evidence	**Educational status** was strongly related to concurrent parenting stress among adolescent mothers in foster care (Budd, Holdsworth, & HoganBruen, 2006). **Educational attainment** (e.g., having completed a GED, having obtained a high school diploma, having obtained some college education, or having completed an Associate's or two-year degree) among foster care youth was predictive of future earnings (Naccarato, Brophy & Courtney, 2010). **Educational attainment** is strongly associated with employment and wages. Youth with a high school diploma or GED are twice as likely to be employed as youth who did not complete high school. Youth with some college attendance or an Associate's degree are nearly four times as likely to be employed. At age 24, 20% of youth did not complete high school, 46% had a diploma, GED, or equivalency, 28% had attended some college, and 6% had an Associate's degree (Hook & Courtney, 2011). Foster children who exhibit normal attachment behaviors, **good school conduct**, who are better socialized and non-aggressive, and have experienced acute (rather than chronic) family problems precipitating their removal from the home, are more likely to have treatment foster care placements that lasted at least 60 days and did not disrupt unexpectedly thereafter (Redding, Fried & Britner, 2000).	

Problem-solving skills	• Decision making • Planning • Competence • Task-oriented coping • Problem-solving self-efficacy	75% were 0-10 yrs., 25% were 11 yrs. & older	Limited Evidence		**Intensive family preservation services** (IFPS) significantly reduced the rate of out-of-home placement among youths and families involved in the child welfare, juvenile justice, and mental health system. IFPS services included motivational interviewing, behavioral parent training, cognitive–behavior therapy strategies, and relapse prevention. Therapists teach family members a variety of skills, including child behavior management, effective discipline, positive behavioral support, communication skills, **problem-solving skills**, resisting peer pressure, mood management skills, **safety planning**, and establishing daily routines (Kirk & Griffith, 2003).
Relational skills	• Ability to form positive bonds and connections • Positive attachments • Relationships • Connection • Caring • Empathy • Permanent lifetime connections • Communication skills • Negotiation • Conflict resolution • Verbal competence	Youth in treatment foster care 13-16 yrs. 31–54 mo. 75% were 0-10 yrs., 25% were 11 yrs. & older	Strong Evidence	Foster children who exhibit **normal attachment behaviors**, good school conduct, who are **better socialized and non-aggressive**, and have experienced acute (rather than chronic) family problems precipitating their removal from the home, are more likely to have treatment foster care placements that lasted at least 60 days and did not disrupt unexpectedly thereafter. Also, children who **felt close to their foster family** were more satisfied with their foster care experience, and the family's warmth played a large role. (Redding, Fried & Britner, 2000). Adolescents who reported the **highest feelings of closeness to their caregivers** had the lowest delinquency scores (Farineau & McWey, 2011).	RCT of Bucharest Early Intervention Project (BEIP), a foster care intervention for institutionalized children focusing on **normative emotional development**; intervention found to improve secure attachment and lower levels of social/disinhibited reactive attachment disorder in foster children (Bos et al., 2011). **Intensive family preservation services** (IFPS) significantly reduced the rate of out-of-home placement among youths and families involved in the child welfare, juvenile justice, and mental health system. IFPS services included motivational interviewing, behavioral parent training, cognitive–behavior therapy strategies, and relapse prevention. Therapists teach family members a variety of skills, including child behavior management, effective discipline, positive behavioral support, **communication skills**, problem-solving skills, resisting peer pressure, mood management skills, safety planning, and establishing daily routines (Kirk & Griffith,

					2003).
Involvement in positive activities (engagement)	• Engaging in school • Engaging in community • Pro-social involvement • Recreational involvement • Faith-based involvement • Engagement self-efficacy • Employment	Older youth average age 17 13-16 yrs. Youth who aged out of foster care	Limited Evidence	**Religious service attendance** was associated with reduced odds of youth's engagement in sexual behavior in the past 2 months and current use of cigarettes. Results also indicated that church/religious service attendance had a moderate inverse association with marijuana use (Scott et al., 2006). Increased **involvement in extracurricular activities** was associated with higher delinquency scores for adolescents (Farineau & McWey, 2011). **Employment prior to age 18** is associated with positive employment outcomes at age 24 (Urban Institute, 2008).	

Youth in or Transitioning out of Foster Care Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Supportive Adults					
Parenting Competencies	• Mutually responsive orientation • Sensitive parenting • Maternal and/or paternal closeness • Stable home • Emotional commitment to child • Clear standards • Parental monitoring • Discipline • Consistency • Knowledge of child development • Ability to seek help • Parenting self-efficacy • Open communication with child about health and safety • Setting developmentally appropriate limits	7 yrs and older Youth in treatment foster care 4-11 yrs. 75% were 0-10 yrs., 25% were 11 yrs. & older 0-21 yrs.	Strong evidence	Kinship placement, **mother visiting while child is in foster care placement, satisfaction of the foster parent with the child,** and social support all helped to explain the variability in child self-concept (Metzger, 2008). Effective foster parents are relatively stable emotionally, particularly the mothers, and are realistic and hardy while **sensitive and responsive to the child's needs**. They are often motivated to be foster parents out of a desire to parent a child or as a result of their own childhood experiences. As disciplinarians, they tend to be **authoritative** (rather than authoritarian or permissive), and **provide a variety of ample amounts of stimulation for the child**. In addition, adults with effective social supports (from friends as well as from the agency) tend to do better as foster parents (Redding, Fried & Britner 2000). Longitudinal study of long-term foster care found that **sensitive parenting by caregivers** contributed to a secure base for children and enhanced their adaptability and resilience (Schofield & Beek, 2005).	**Intensive family preservation services** (IFPS) significantly reduced the rate of out-of-home placement among youths and families involved in the child welfare, juvenile justice, and mental health system. IFPS services included motivational interviewing, **behavioral parent training**, cognitive–behavior therapy strategies, and relapse prevention. Therapists teach family members a variety of skills, including **child behavior management, effective discipline, positive behavioral support**, communication skills, problem-solving skills, resisting peer pressure, mood management skills, safety planning, and **establishing daily routines** (Kirk & Griffith, 2003). Systematic review of Treatment Foster Care, which utilizes **foster**

Youth in or Transitioning out of Foster Care Table 2. Protective Factor Crosswalk—Relationship Level					
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					parent training, found large program effects for increasing placement permanency, social skills; and medium program effects for reducing behavior problems, improving psychological adjustment, and reducing restrictiveness of post-discharge placement (Reddy & Pfeiffer, 1997).
		5-12 yrs.			RCT of Keeping Foster Parents Trained and Support (KEEP), parenting training for foster parents that utilizes **positive reinforcement and discipline skills**; intervention found to be effective in reducing child behavior problems (Chamberlain et al., 2008).
		n/a			The goal of the **Comprehensive Relative Enhancement Support and Training Project (CREST)** was to provide support and promote safety, permanency, and the well-being of children through care by relatives. Three primary services to relative caregivers: **eight-week formal group training**, individualized case management, and limited financial assistance. The training consisted of a curriculum-based format and social support. Individualized case management to maintain direct contact with the relative caregivers. Case management—provided through telephone calls, home visits, and attendance at meetings (court, school, etc.)—included services such as ongoing emotional support, referrals, securing social services, and crisis management. Evaluation of CREST found that the program enhanced functioning of relative caregivers and reduces the cost of care. The kin foster parents were overwhelmingly positive about the group, both in terms of knowledge gained and social support received. Foster parents stated that all three services (training, case management, and financial assistance) were equally effective. Additionally, the presence of CREST increased the confidence of the case workers to recommend (and the supervisor to approve) a placement with a relative when a placement might otherwise have been deemed too risky (Hawkins & Bland, 2002).
		n/a			Participation in the Jackson County (Ore.) Community Family Court (CFC), which is a **family drug court program for parents with**

Youth in or Transitioning out of Foster Care Table 2. Protective Factor Crosswalk—Relationship Level					
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		3.6-39.4 months			**admitted substance abuse allegations whose children are wards**, resulted in the following outcomes:1) children of CFC parents spent significantly less time in foster care in the 4 years after their parents entered the program; 2) children of CFC parents were returned significantly sooner than children of parents in the comparison group; and 3) children of CFC parents were significantly more likely to be reunited with their parents and experienced significantly fewer adoptions and termination of parent rights (compared to children of non–CFC parents). There were no significant differences in placement stability. All CFC participants are required to attend outpatient individual treatment sessions, outpatient group treatment sessions, self-help meetings, and **parenting classes**. Participants are expected to work toward specific goals, such as job training (if they're unemployed), securing safe and stable housing, accessing transportation, and identifying community service resources. Some participants may also be required to attend mental health counseling, residential treatment, psychiatric services, prenatal/perinatal programs, a batterers intervention program, employment assistance, family relations counseling, and General Educational Development (or GED)/education assistance). Additional services that are provided include detoxification, gender-specific treatment, language- or cultural-specific programming, health care, and dental care (Carey et al., 2010). RCT of "Attachment and Biobehavioral Catch-Up" for infants and toddlers in foster care targeting child regulatory capabilities. Intervention targets dysregulation directly by **helping foster parents create an environment that enhances regulatory capabilities**. The first subcomponent **helps caregivers learn to follow the child's lead**, which has been associated with children's ability to regulate behavior and emotions. The second subcomponent **helps caregivers appreciate the value of touching, cuddling, and hugging their child,** which has been associated with behavioral and biobehavioral regulation. Finally, the third subcomponent helps caregivers **create conditions that allow their children to express emotions, and to learn to recognize**

Youth in or Transitioning out of Foster Care Table 2. Protective Factor Crosswalk—Relationship Level					
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					and understand emotions. The intervention also indirectly targets regulatory capabilities by **helping foster parents provide nurturing care to their foster children**. Intervention effects included lower cortisol levels and fewer parent-reported behavioral problems for older vs. younger children (Dozier, et al., 2006).
Caregiver well-being	• Maternal functioning • Maternal adjustment and coping • Competent parents • Positive parental norms	Youth in treatment foster care n/a	Limited evidence Limited evidence	**Effective foster parents are relatively stable emotionally**, particularly the mothers, and are **realistic and hardy** while sensitive and responsive to the child's needs. They are often motivated to be foster parents out of a desire to parent a child or as a result of their own childhood experiences. In addition, **adults with effective social supports** (from friends as well as from the agency) tend to do better as foster parents (Redding, Fried & Britner 2000).	The goal of the **Comprehensive Relative Enhancement Support and Training Project (CREST)** was to provide support and promote safety, permanency, and the well-being of children through care by relatives. Three primary services to relative caregivers: eight-week formal group training, individualized case management, and limited financial assistance. The training consisted of a curriculum-based format and **social support**. Individualized case management to maintain direct contact with the relative caregivers. Case management—provided through telephone calls, home visits, and attendance at meetings (court, school, etc.)—included services such as **ongoing emotional support**, referrals, securing social services, and crisis management. Evaluation of CREST found that the program enhanced functioning of relative caregivers and reduces the cost of care. The kin foster parents were overwhelmingly positive about the group, both in terms of knowledge gained and social support received. Foster parents stated that all three services (training, case management, and financial assistance) were equally effective. Additionally, the presence of CREST increased the confidence of the case workers

Youth in or Transitioning out of Foster Care Table 2. Protective Factor Crosswalk—Relationship Level					
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		n/a			to recommend (and the supervisor to approve) a placement with a relative when a placement might otherwise have been deemed too risky (Hawkins & Bland, 2002). Participation in the Jackson County (Ore.) Community Family Court (CFC), which is a **family drug court program for parents with admitted substance abuse allegations whose children are wards**, resulted in the following outcomes:1) children of CFC parents spent significantly less time in foster care in the 4 years after their parents entered the program; 2) children of CFC parents were returned significantly sooner than children of parents in the comparison group; and 3) children of CFC parents were significantly more likely to be reunited with their parents and experienced significantly fewer adoptions and termination of parent rights (compared to children of non–CFC parents). There were no significant differences in placement stability. All CFC participants are required to attend **outpatient individual treatment sessions, outpatient group treatment sessions, self-help meetings, and parenting classes**. Participants are expected to work toward specific goals, such as job training (if they're unemployed), securing safe and stable housing, accessing transportation, and identifying community service resources. Some participants may also be required to attend mental health counseling, residential treatment, psychiatric services, prenatal/perinatal programs, a batterers intervention program, employment assistance, family relations counseling, and General Educational Development (or GED)/education assistance). Additional services that are provided include detoxification, gender-specific treatment, language- or cultural-specific programming, health care, and dental care (Carey et al., 2010).
Other Supports					
Caring adult(s)	• Mentor • *Familismo* • Prosocial models	14-17 yrs.		Qualitative study of adolescents in foster care. **Development of a positive relation with an adult** identified as a "turning point" towards resilience for foster youth (Drapeau et al., 2007)	

Youth in or Transitioning out of Foster Care Table 2. Protective Factor Crosswalk—Relationship Level					
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	• Providing rules, parameters, monitoring, safe space • Support from home visitors, community center staff, and other non-kin adults	Teen mothers 14-18 yrs. 17-19 yrs. Youths who had aged out of foster care Youth transitioning out of foster care into adulthood 13-16 yrs. 15 yrs. and	Moderate Evidence Moderate Evidence	Having **"other mothers" (who guide younger members of the community, often acting as surrogate parents and mentors)** and various sources of community support may support resilience among African American teen mothers in foster care according to this longitudinal qualitative study (Haight et al., 2009). Foster care youth in **natural mentoring relationships** were more likely to report favorable overall health and were less likely to report suicidal ideation, having received a diagnosis of a sexually transmitted infection, and having hurt someone in a fight in the past year than non-mentored youth. There was also a borderline significant trend toward more participation in higher education among mentored youth. On the summary measure, mentored youth had, on average, a significantly greater number of positive outcomes than non-mentored youth (Ahrens et al., 2008). Compared to those youth that did not nominate a mentor, youth in **long term natural mentoring relationships** reported less stress and were less likely to have been arrested at age 19 (Munson & McMillen, 2009). **Closeness to an adult mentor** was associated with an increase in the likelihood of having worked in the past year and a large reduction in the odds of recent homelessness (Courtney & Lyons, 2009). Qualitative study (focus groups). Youth aging out of foster care, foster parents, and professional stressed the importance of youth having a **caring, long-term relationship with someone** as they move into adulthood (Geenen & Powers, 2007). Adolescents who reported the **highest feelings of closeness to their caregivers** had the lowest delinquency scores (Farineau & McWey, 2011).	Qualitative evaluation of evaluation of the 'Advocates to Successful Transition to Independence' mentoring program: Overall, youth

Youth in or Transitioning out of Foster Care Table 2. Protective Factor Crosswalk—Relationship Level					
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		older Youth in high school transitioning out of foster care 5-17 yrs.			described their **relationship with their advocates** as helpful and supportive and reported that the best aspects of having an advocate were related to the support and encouragement advocates provided, as well as their dependency and consistency. All youth felt that their lives had improved since working with their advocate and reported an increase in their independent living skills since seeing their advocate. Youth felt that since working with their advocates, they have tended to be more open with their feelings, have understood their own emotions better and have been less angry (Osterling & Hines, 2006). A short, three-day residential campus-based learning program for transitioning foster youth still in high school can help contribute toward a perceived increase in knowledge and information about college life, funding, and admissions procedures. Consequently, this program contributed to the resilience of those who attended and potentially helped build steps from care to higher education. The camp program was held on a college campus and involved peer support, role modeling, **mentoring** and active learning sessions led by the faculty and students who were often foster care alumni themselves. It offered social, personal and informational support within a learning campus environment to promote resilience, and prepare youth for transition from high school to college (Kirk & Day, 2011). **Advocacy by an education liaison** led to positive results in terms of school performance of foster youth, including improvements in math and reading test scores. The education liaison worked alongside child welfare agency workers, and as workers identified school problems for individual cases, the education liaison sought to secure appropriate and effective educational programs and services from the child's school district. Social workers made referrals to the education liaison when confronted with an educational problem for a child that they were unable to resolve (Zeltin, Weinberg & Kimm, 2004).

Youth in or Transitioning out of Foster Care Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Positive peers	• Positive peer norms • Social support by friends • Friendship • Peer networks	Youth in high school transitioning out of foster care	Emerging Evidence		A short, three-day residential campus-based learning program for transitioning foster youth still in high school can help contribute toward a perceived increase in knowledge and information about college life, funding, and admissions procedures. Consequently, this program contributed to the resilience of those who attended and potentially helped build steps from care to higher education. The camp program was held on a college campus and involved **peer support**, role modeling, mentoring and active learning sessions led by the faculty and students who were often foster care alumni themselves. It offered **social, personal and informational suppor**t within a learning campus environment to promote resilience, and prepare youth for transition from high school to college (Kirk & Day, 2011).

Living with immediate family, extended family, or other kin	• Placement in a kinship foster home. • Maintaining children in the extended family network	7 yrs. and older 13-16 yrs. Children in kinship care and regular foster care	Strong Evidence	**Kinship-placed** children and youth had significantly more robust self-concept, performance, and personal attribute scores (compared to children and youth placed in family foster care) (Metzger, 2008). Adolescents in **kinship settings** had the lowest delinquency scores (compared to adolescents in group homes or traditional foster care) (Farineau & McWey, 2011). .	Children in **kinship care** had significantly fewer placements than did children in foster care, and they were less likely to still be in care, have a new allegation of institutional abuse or neglect, be involved with the juvenile justice system, and achieve reunification (Winokur et al., 2008).

Youth in or Transitioning out of Foster Care Table 3. Protective Factor Crosswalk—Community Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Community Characteristics					
Positive school environment	• Perceived safety at school • Prosocial relationships with teachers • Positive school environment • Effective classroom management • High levels of school engagement • Effective, specialized programming in school	Former foster care youth in college	Moderate evidence	Former foster care youth reported that they valued **college campus support programs** in one exploratory study. **P**rograms were designed to provide financial, academic, and other types of supports to students who had aged out of foster care. Specifically, respondents reported the following program components as being important or very important: financial aid, housing assistance, **help in choosing courses and choosing a major**, **a sense of family gained through participation,** and **contact with program staff**. What mattered most about the program for participants**: always having someone there to help or to turn to for support, feeling understood** and **having someone who believed in them** (Dworsky & Perez, 2010).	
		Youth in high school transitioning out of foster care			A short, three-day **residential campus-based learning program** for transitioning foster youth still in high school can help contribute toward a perceived increase in knowledge and information about college life, funding, and admissions procedures. Consequently, this program contributed to the resilience of those who attended and potentially helped build steps from care to higher education. The camp **program was held on a college campus and involved peer support, role modeling, mentoring and active learning sessions led by the faculty and students who were often foster care alumni themselv**es. It offered **social, personal and informational support** within a learning campus environment to promote resilience, and prepare youth for transition from high school to college (Kirk & Day, 2011).
		5-17 yrs.			**Advocacy by an education liaison** led to positive results in terms of school performance of foster youth, including improvements in math and reading test scores. The education liaison worked alongside child welfare agency workers, and as workers identified school problems for individual cases, the education liaison sought to secure appropriate and effective educational programs and services from the child's school district. Social workers made

Youth in or Transitioning out of Foster Care Table 3. Protective Factor Crosswalk—Community Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
					referrals to the education liaison when confronted with an educational problem for a child that they were unable to resolve (Zeltin, Weinberg & Kimm, 2004).
Positive community environment	• Collective efficacy • Caring community • Informal social control • Faith/spiritual organizations • Shared perception of safe, continuous community • Safe spaces and activities • Recreational opportunities • Neighborhood cohesion • Positive community norms	Older youth in foster care, average age 17 Teen mothers	Emerging evidence	**Religious service attendance** was associated with reduced odds of youth's engagement in sexual behavior in the past 2 months and current use of cigarettes. Results also indicated that church/religious service attendance had a moderate inverse association with marijuana use (Scott et al., 2006) Having **"other mothers" (who guide younger members of the community, often acting as surrogate parents and mentors)** and various sources of community support may support resilience among African American teen mothers in foster care according to this longitudinal qualitative study (Haight et al., 2009).	
Independent living support	• Availability of independent living programs • Independent living case managers	14-17 yrs. Youth transitioning out of foster care	Moderate evidence	Qualitative study (focus groups): A few foster care youth were assigned **Independent Living Program case managers**, and they described this one-on-one assistance as helpful (Geenen & Powers, 2007). Some **Independent Living Programs** may have protective effects for youth leaving the public care system. These trends were observed for outcomes related to educational attainment, employment, housing, health, and other life skills (Montgomery, Donkoh & Underhill, 2006).	

Youth in or Transitioning out of Foster Care Table 3. Protective Factor Crosswalk—Community Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
		16-24 yrs.[2]	Moderate evidence		One to three years after discharge from care, youth who had **participated in an independent living program** in North Carolina were more likely to be living independently or paying all of their housing expenses while living with others than were the nonparticipants. Program participants also reported a higher level of educational attainment and aspirations (Lindsey & Ahmed, 1999).
Stable living situation	• Permanency • Placement stability • Staying in foster care longer instead of aging out	16-24 yrs. Youth in foster care 4-11 yrs.	Moderate evidence	Youth who **age out of foster care later** are more likely to achieve four quarters of consecutive earnings by age 24 (Urban Institute, 2008). **Pursuing permanency** (ongoing coaching, training and support); **providing strengths-based assessment and educational support**; and **treating mental health problems** all identified as predictors of success for alumni of foster care (Pecora, 2012). Longitudinal study of long-term foster care found that **placement stability** contributed to enhanced adaptability of children (Schofield & Beek, 2005).	
Access to support services and resources	• Staff training • Culturally appropriate staff • Use of effective counseling services (e.g., CBT) • Assessing and recruiting foster parents and caregivers in a	Youth in treatment foster care Youth in foster care	Limited evidence	There are numerous **foster care agency characteristics and functions** that can help to improve outcomes for youth in treatment foster care. Characteristics include: strong bonds between foster care agency and foster parents and high energy expended by caseworker. Function areas include: effective foster parent recruitment, selection and training, proper service delivery, and empowering families and children (Redding, Fried & Britner, 2000).	Children served by **agencies using Structured Decision Making (SDM)** achieved permanency rates at a significantly higher rate than children in the comparison counties (68.6 percent versus 61

[2] Age at time of survey

Youth in or Transitioning out of Foster Care Table 3. Protective Factor Crosswalk—Community Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
	more comprehensive way • Support, monitoring, nurturing families • Formal and informal community resources • Supportive childcare	42-54 months			percent). Children in the pilot counties were more likely to be returned home, adopted, or placed for adoption than children in comparison counties (Johnson & Wagner, 2005). RCT of Bucharest Early Intervention Project (BEIP): Children **placed in foster care** saw higher intellectual performance and higher gains in cognitive function in comparison to children who remained in institutional setting (Nelson et al., 2007).
Economic opportunities	• Economic supports • Employment opportunities • Promote economic self-sufficiency • Presence of concrete support services (such as food stamps) • Socioeconomic status (SES)	Former foster care youth in college 4-16 yrs. n/a	Limited Evidence	Former foster care youth reported that the valued **college campus support programs** in one exploratory study. **P**rograms were designed to provide financial, academic, and other types of supports to students who had aged out of foster care. Specifically, respondents reported the following program components as being important or very important: **financial aid, housing assistance**, help in choosing courses and choosing a major, a sense of family gained through participation, and contact with program staff. What mattered most about the program for participants: always having someone there to help or to turn to for support, feeling understood and having someone who believed in them (Dworsky & Perez, 2010). Families who moved less, had **higher socioeconomic status**, with no health problems and fewer risk factors were most likely to successfully complete the Shared Parenting Project program (intended to help foster families work as a team with natural parents to promote parenting skills) and have children return home (Landy & Munro, 1998).	The goal of the **Comprehensive Relative Enhancement Support and Training Project (CREST)** was to provide support and promote safety, permanency, and the well-being of children through

Youth in or Transitioning out of Foster Care Table 3. Protective Factor Crosswalk—Community Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
		Youth who had aged out of foster care		**Employment prior to age 18** is associated with positive employment outcomes at age 24 (Urban Institute, 2008).	care by relatives. Three primary services to relative caregivers: eight-week formal group training, individualized case management, and **limited financial assistance**. The training consisted of a curriculum-based format and social support. Individualized case management to maintain direct contact with the relative caregivers. Case management—provided through telephone calls, home visits, and attendance at meetings (court, school, etc.)—included services such as ongoing emotional support, referrals, securing social services, and crisis management. Evaluation of CREST found that the program enhanced functioning of relative caregivers and reduces the cost of care. The kin foster parents were overwhelmingly positive about the group, both in terms of knowledge gained and social support received. Foster parents stated that all three services (training, case management, and financial assistance) were equally effective. Additionally, the presence of CREST increased the confidence of the case workers to recommend (and the supervisor to approve) a placement with a relative when a placement might otherwise have been deemed too risky (Hawkins & Bland, 2002).

Rating Instrument for Summative Ratings

Emerging Evidence: Preponderance of findings generated by cross-sectional studies, case studies, or qualitative investigations with non-representative samples.

Limited Evidence: Preponderance of findings generated by a single longitudinal study (significant findings with small, medium, or large effect sizes).

Moderate Evidence: Consistent findings that are generated by two or more longitudinal studies (significant findings with small, medium, or large effect sizes).

Strong Evidence: Findings generated from one or more experimental or well conducted quasi-experimental studies that demonstrate a significant effect on a protective factor and an outcome (e.g., findings demonstrate that the experimental effect on an outcome is mediated by the effect of a protective factor).

Crosswalk of Constructs: Child Abuse and Neglect

Child Abuse and Neglect Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Characteristics					
Positive self-image	• Self-esteem • Self-worth • Self-concept • Desirable personal identity • Cultural knowledge	6-11 yrs. 16-24 yrs. (8.7 % 25 and older)	Emerging evidence	Ego resilience, ego overcontrol and **positive self esteem** accounted for 69% of the variance in 3 year adaptive function for maltreated children. For non-maltreated children (at risk), relationship factors and ego resilience prominent predictors of adaptive functioning (Cicchetti & Rogosch, 1997). **Attachment security (defined as positive view of self**) strongly predicted lower levels of psychopathology in a sample of maltreated and nonmaltreated young adults. No interaction effects between attachment and social support (McLewi & Muller, 2006).	
Sense of purpose	• Motivation • Goals • Spirituality • Religion • Commitment	Wave 1: 18 mo-6 yrs.; wave 3: 18 yrs. Adolescence 12-17 yrs. 6-12 yrs. Grades 7-12	Moderate Evidence	**Religion** is a statistically significant protective factor against violence and delinquency among physically abused children (Herrenkohl et al., 2005). For physically abused adolescents**, religiosity** a protective factor against alcohol use, tobacco use, drug use, sexual activity, antisocial behavior, and for helping others (Perkins & Jones, 2004). Child reports of **the importance of faith** were related to lower levels of internalizing symptomatology among maltreated girls (but not non-maltreated girls or among boys). Child reports of **attendance at religious services** were associated with lower levels of externalizing symptomatology among nonmaltreated boys (but not among maltx boys or among girls) (Kim, 2008). Respondents' **self-perception as a religious or**	

Child Abuse and Neglect Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
				spiritual person contributed to resiliency (measures: average performance in school, no suicide risk, positive body image, no history of marijuana use, infrequent or no alcohol use) for teenagers with a history of sexual abuse or alcohol parents (Chandy et al., 1996).	
Sense of optimism	• Positive future orientation • Future expectations and aspirations • Trust • Hope	11-16 yrs. female college freshman (mean age 18.1) Students (18-63 yrs.) 11-17 yrs. 7-13 yrs. (Deblinger et al., 1996) 3-6 yrs. (Cohen & Mannarino, 1996) 8-15 yrs. (Cohen et al.,	Limited Evidence	For sexually abused adolescents, **hope and expectancy** associated with lower levels of general problem behaviors (Williams & Nelson-Gardell, 2012). In a sample of college freshman, resilience associated with positive illusions (= exaggerated perceptions of internal control and **unrealistic optimism about the future**) for both women with a history of child sexual abuse and other women (Himelein & McElrath, 1996). In this study of students (aged 18–63 years), **dispositional optimism** partially mediated distress among individuals who had experienced child physical abuse and child emotional abuse; participants with higher levels of optimism had lower levels of distress (Brodhagen & Wise, 2008). In a sample of 86 sexually abused adolescents, those with resilient profiles exhibited **more interpersonal trust** and a greater sense of empowerment (Daigneault et al., 2007).	In 3 studies of Trauma-Focused Cognitive Behavioral Therapy: for young people who have developed significant emotional or behavioral difficulties following exposure to a traumatic event (tested on sexually abused children). These aim to provide the parents and children with the skills to better manage and resolve distressing thoughts,

Child Abuse and Neglect Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
		2004)			emotions, and reactions related to traumatic life events; improve the safety, comfort, **trust,** and growth in the child; and develop parenting skills and family communication. Found to reduce PTSD symptoms (re-experience, hyperarousal and avoidance), externalizing behaviors, internalizing behaviors, sexualized behaviors, problematic behaviors, and child and parent depression and increase effective parenting (Deblinger et al 1996; Cohen and Mannarino 1996; Cohen et al. 2004).
Agency (Self-efficacy)	• Self-efficacy • Confidence • Sense of power • Sense of control • Internal locus of control • Help-seeking behavior	8-14 yrs. 5.6-11.5 yrs. 11-17 yrs. female college freshman (mean age 18.1)	Moderate Evidence	**Internal locus of control** moderates the effect of maltreatment on children's internalizing problems (Bolger & Patterson, 2001). Significant interaction effect for child maltreatment and **self-efficacy** in conflict situation for younger children's internalizing behaviors. For younger maltreated children (<8), self-efficacy (conflict) had a significant negative impact on internalizing behaviors (but not for nonmaltreated children). For older children (both maltreated and non maltreated, 8 and older), higher levels of self efficacy in conflict situation were related to lower levels of internalizing behaviors (Kim & Cicchetti, 2003). In a sample of 86 sexually abused adolescents, those with resilient profiles exhibited more interpersonal trust and a **greater sense of empowerment** (Daigneault et al., 2007). In a sample of college freshman, resilience associated with positive illusions (= exaggerated **perceptions of internal control** and unrealistic optimism about the future) for both women with a history of child sexual abuse and other women (Himelein & McElrath, 1996).	
Cognitive Ability	• IQ				

Child Abuse and Neglect Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
(Intelligence)	• Curiosity • Verbal Competence • Intellectual mastery • Executive functioning	5 and 7 yrs. 18mnths-6 yrs. (wave 1) thru elem school (wave 2) thru ages 15-21 (wave 3) 6-10 yrs.	Limited Evidence	*For boys*, **high IQ** increased relative risk of being resilient vs. non-resilient in maltreated children; for girls, no association with resilience (Jaffee et al. 2007). Protective influences associated with maintenance of at least a minimum standard of success in school include stability of home situation, clear parental expectations of academic performance, a home atmosphere in which abuse in not a chronic and pervasive theme, and **at least average intellectual ability** of the child (Herrenkohl et al., 1994). In a sample of 702 maltreated children, **higher intelligence scores** positively influenced math and reading scores in the chronically maltreated subgroup (Coohey et al., 2011).	

Healthy biological functioning	• Genetic buffers	Thru 15 yrs. 6-31 mo; followed thru 54 mo. post-placement	Limited Evidence	In a sample of Romanian youth having experienced severe institutional deprivation, youth carrying **the l/l allele of the 5HTT promoter polymorphism** had the lowest overall levels of emotional problem scores (Kumsta et al., 2010). **COMT genotype** protective for lower rates of depressive symptoms (by 108% and 60% for various alleles) in children with greatest exposure to institutional care (deprivation), but not for children placed in foster care (Bos et al., 2011).	
Low stress		K to 8th grade	Emerging Evidence	For a community sample of physically abused youth followed longitudinally for 9 years, **lower levels of early stress** and **lower levels of adolescent stress** are protective of internalizing outcomes (Lansford et al., 2006).	
Skills and Developmental Tasks					
Self-regulation skills (emotional, behavioral)	• Self-mastery • Anger management • *Fatalismo* • Character • Temperament • Emotional intelligence • Long term self-control	3-5 yrs and 1st-6th grades 6-12 yrs. 6-11 yrs. Avg age 8.68 yrs. 6-18 yrs.	Strong Evidence	**Strong ego control** and ego resiliency, high morning cortisol and low DHEA are related to higher resilient functioning (Cicchetti & Rogosch, 2007). **Ego resilience, ego overcontrol** and positive self esteem accounted for 69% of the variance in 3 year adaptive function for maltreated children. For non-maltreated children (at risk), relationship factors and ego resilience prominent predictors of adaptive functioning (Cicchetti & Rogosch, 1997). **Ego resiliency** and **moderate ego-control to slight ego-overcontrol** predicted resilience in a sample of maltreated and nonmaltreated Latino children (Flores, Cicchetti, & Rogosch, 2005). The absence of **dysregulated emotion regulation patterns** was related to academic resilience in a sample of maltreated children removed from their	

				homes; it was the strongest predictor after race (Schelble et al., 2010).	
		6-10 yrs.	Strong Evidence	**Behavior problems** were protective for chronically maltreated youth in terms of math scores at wave 3, though not at waves 1 and 2; chronically maltreated youth scored as well as non-chronically maltreated youth on math scores (Coohey et al., 2011).	
		6-10 yrs.		In a study of maltreated and non-maltreated low-income youth, maltreated children in **the increasing ego resiliency trajectory** group exhibited better adjustment functioning as indicated by their relatively low levels of externalizing and internalizing symptomatology (Kim et al., 2009).	
		6-12 yrs.		In a sample of maltreated and high risk/low SES children, **higher self regulation scores** were associated with greater likelihood of resilience (Curtis & Cicchetti, 2007).	
		6-12 yrs.		Maltreated children more susceptible to emotion dysregulation, which increases chance for peer rejection. However, this study found that **higher emotion regulation** was predictive of higher peer acceptance over time, which was related to lower internalizing symptomatology. Results emphasize the important role of emotion regulation as a risk or a protective mechanism in the link between earlier child maltreatment and later psychopathology through its influences on peer relations (Kim & Cicchetti, 2010).	
		6-13 yrs.			In an evaluation of **Alternatives for Families:** assessed with maltreated children, 6-13. Cognitive Behavioral Therapy group: (for kids) **coping and self control skills training**; interpersonal effectiveness skills to enhance social competence; (for parents) parental views on violence/physical punishment, attributional style and expectations, self-control (anger control, cognitive coping), contingency management. Family Therapy group: enhance cooperation and motivation of family members by promoting an understanding of

		7-18 yrs. 10-17 yrs. (average age 13.9)	Strong Evidence		coercive behavior, positive communication skills, solve problems together. Kolko (1996) found : FT associated with less child-reported parent to child violence, and both CBT and FT with less parent-reported child to parent violence. Positive impact of both on child abuse potential, individualized problems, externalizing behavior, general parental distress, family cohesion and conflict. No statistically significant difference between groups on child reabuse. Limited change in social competence and overall aggression or hostility (Kolko, 1996). In an evaluation of **Child and Family Traumatic Stress Intervention (CFTSI):** For children aged 7–18 years, together with their parent or caregiver, after the child has experienced a potentially traumatic event (PTE) (e.g., sexual and physical abuse, domestic violence, community violence, rape, assault, and motor vehicle accidents). Targets increase communication skills, improved caregiver emotional support, thought replacement, breathing retraining, behavioral activation for depression and avoidance, relaxation techniques, **coping strategies**, reduce concrete external stressors (e.g. housing issues, systems negotiation, safety planning, etc.). Berkowitz, Stover, and Marans (2010) found that had significantly lower posttraumatic and anxiety scores then comparison youth. CFTSI reduced the overall odds of partial or full PTSD by 73 percent. There were significant differences between groups in reexperiencing (85 percent comparison versus 57 percent CFTSI) and avoidance (37 percent comparison versus 17 percent CFTSI) but not in hyperarousal. In an evaluation of MST – Child Abuse and Neglect: For physically abused and neglected children and their families. Tx targets **anger management**, CBT treatments for the impact of trauma or posttraumatic stress disorder on adults and children, reinforcement-based therapy for adult substance abuse, behavioral family therapy for communication and problem-solving issues, functional analysis for

		7-13 yrs. (Deblinger et al., 1996) 3-6 yrs. (Cohen & Mannarino, 1996) 8-15 yrs. (Cohen et al., 2004)	Strong Evidence		family conflict and the use of force in parenting, and abuse clarification. Safety planning and abuse clarification are used in all cases. Participants in MST-CAN presented significantly greater improvement than the Enhanced Outpatient Treatment (EOT) in internalizing, posttraumatic stress disorder, child-reported dissociative symptoms, and total symptoms and experienced reductions in out-of-home placement (or to change placement). Parents in MST–CAN reported significantly greater improvements in psychiatric distress and increases in external social support. Reduced child- and parent-reported neglect, psychological aggression, and minor and severe assault. However, while the MST–CAN group had fewer referred incidents of abuse, there were no significant differences between both treatment groups over the 16 months post baseline (Swenson et al., 2010). In 3 studies of Trauma-Focused Cognitive Behavioral Therapy: for young people who have developed significant emotional or behavioral difficulties following exposure to a traumatic event (tested on sexually abused children). These aim to provide the parents and children with the **skills to better manage and resolve distressing thoughts, emotions, and reactions related to traumatic life events**; improve the safety, comfort, trust**,** and growth in the child; and develop parenting skills and family communication. Found to reduce PTSD symptoms (re-experience, hyperarousal and avoidance), externalizing behaviors, internalizing behaviors, sexualized behaviors, problematic behaviors, and child and parent depression and increase effective parenting (Deblinger et al 1996; Cohen and Mannarino 1996; Cohen et al. 2004).

Academic skills	• Persistence • Grades • GPA • Help-seeking behavior • Study skills • Time management • Coaching • Academic self-efficacy • Degrees or accomplishments	mid-adolescence .	Emerging Evidence	**School GPA** protects maltreated youth from perpetration of partner violence as young adults (Smith et al., 2012).	
Problem-solving skills	• Decision making • Planning • Competence • Task-oriented coping • Problem-solving self-efficacy	6-10 yrs. 0-14 yrs. 5.6-11.5 yrs. 7-18 yrs.	Strong Evidence	In a sample of maltreated children, **higher daily living scores** positively influenced math and reading scores in the chronically maltreated subgroup (Coohey et al., 2011). In a sample of children investigated for maltreatment, for 1 SD above in **adaptive functioning skills**, had increased odds of normal range for externalizing and higher odds of being in the normal range for reading (Schultz et al., 2009). Significant interaction effect for child maltreatment and **self-efficacy in conflict situation** for younger children's internalizing behaviors. For younger maltreated children (<8), self-efficacy (conflict) had a significant negative impact on internalizing behaviors (but not for nonmaltreated children). For older children (both maltreated and non maltreated, 8 and older), higher levels of self efficacy in conflict situation were related to lower levels of internalizing behaviors (Kim & Cicchetti, 2003).	In an evaluation of **Child and Family Traumatic Stress Intervention (CFTSI):** For children aged 7–18 years, together with their parent or caregiver, after the child has experienced a potentially traumatic event (PTE) (e.g., sexual and physical

		10-17 yrs.	Strong Evidence		abuse, domestic violence, community violence, rape, assault, and motor vehicle accidents). Targets increase **communication skills**, improved caregiver emotional support, thought replacement, breathing retraining, behavioral activation for depression and avoidance, **relaxation techniques, coping strategies**, reduce concrete external stressors (e.g. housing issues, systems negotiation, safety planning, etc.). Berkowitz, Stover, and Marans (2010) found that had significantly lower posttraumatic and anxiety scores then comparison youth. CFTSI reduced the overall odds of partial or full PTSD by 73 percent. There were significant differences between groups in reexperiencing (85 percent comparison versus 57 percent CFTSI) and avoidance (37 percent comparison versus 17 percent CFTSI) but not in hyperarousal. In an evaluation of **MST – Child Abuse and Neglect:** For physically abused and neglected children and their families. Tx targets anger management, CBT treatments for the impact of trauma or posttraumatic stress disorder on adults and children, reinforcement-based therapy for adult substance abuse, behavioral family therapy for communication and **problem-solving issues**, functional analysis for family conflict and the use of force in parenting, and abuse clarification. Safety planning and abuse clarification are used in all cases. Participants in MST-CAN presented significantly greater improvement than the Enhanced Outpatient Treatment (EOT) in internalizing, posttraumatic stress disorder, child-reported dissociative symptoms, and total symptoms and experienced reductions in out-of-home placement (or to change placement). Parents in MST–CAN reported significantly greater improvements in psychiatric distress and increases in external social support. Reduced child- and parent-reported neglect, psychological aggression, and minor and severe assault. However, while the MST–CAN group had fewer referred incidents of abuse, there were no significant differences

					between both treatment groups over the 16 months post baseline (Swenson et al., 2010).
Relational skills	• Ability to form positive bonds and connections • Positive attachments • Relationships • Connection • Caring • Empathy • Permanent lifetime connections • Communication skills • Negotiation • Verbal • Conflict resolution • Verbal competence	Grades 2-4 (ages 8, 9, 10) followed for 1986-89 16-24 yrs. (8.7 % 25 and older) Kindergarten thru grade 8 0-14 yrs. 5.6-11.5 yrs.	Strong Evidence	Having a **good quality friendship** was associated with a greater increase over time in self-esteem among children who experienced chronic maltreatment than among non-mal children. Among physically abused children/chronically maltreated children, those who had a **reciprocated best friend** showed a greater increase over time in self-esteem than those who did not (Bolger, Patterson & Kupersmidt, 1998). **Attachment security (defined as positive view of other**) predicted lower levels of psychopathology in a sample of maltreated and nonmaltreated young adults. Social support a small predictor of lower levels of psychopathology in a sample of maltreated and nonmaltreated young adults. No interaction effects between attachment and social support (McLewin & Muller, 2006). In a community sample of youth followed longitudinally for 9 years, abused children **high in early hostile attributions** showed fewer internalizing problems (but not fewer externalizing problems) than those low in hostile attribution (this effect disappeared by Grade 8) (Lansford et al., 2006). In children investigated for maltreatment: For **social competence,** children with scores 1 SD higher had greater odds of being in the normal range for externalizing behavior and higher odds of being in normal range for internalizing behaviors (Schultz et al., 2009). Significant interaction effect for child maltreatment and **self-efficacy in conflict situation** for younger children's internalizing behaviors. For younger maltreated children (<8), self-efficacy (conflict) had a significant negative impact on internalizing	

				behaviors (but not for nonmaltreated children). For older children (both maltreated and non maltreated, 8 and older), higher levels of self efficacy in conflict situation were related to lower levels of internalizing behaviors (Kim & Cicchetti, 2003).	
		7-18 yrs			In an evaluation of **Child and Family Traumatic Stress Intervention (CFTSI):** For children aged 7–18 years, together with their parent or caregiver, after the child has experienced a potentially traumatic event (PTE) (e.g., sexual and physical abuse, domestic violence, community violence, rape, assault, and motor vehicle accidents). Targets **increase communication skills**, improved caregiver emotional support, thought replacement, breathing retraining, behavioral activation for depression and avoidance, relaxation techniques, coping strategies, reduce concrete external stressors (e.g. housing issues, systems negotiation, safety planning, etc.). Berkowitz, Stover, and Marans (2010) found that had significantly lower posttraumatic and anxiety scores then comparison youth. CFTSI reduced the overall odds of partial or full PTSD by 73 percent. There were significant differences between groups in reexperiencing (85 percent comparison versus 57 percent CFTSI) and avoidance (37 percent comparison versus 17 percent CFTSI) but not in hyperarousal.
		6-13 yrs.			In an evaluation of **Alternatives for Families:** assessed with maltreated children, 6-13. Cognitive Behavioral Therapy group: (for kids) coping and self control skills training**; interpersonal effectiveness skills to enhance social competence**; (for parents) parental views on violence/physical punishment, attributional style and expectations, self-control (anger control, cognitive coping), contingency management. Family Therapy group: enhance cooperation and motivation of family members by promoting an understanding of coercive behavior, positive communication skills, solve problems together. FT associated with less child-reported parent to child violence, and both

		10-17 yrs.			CBT and FT with less parent-reported child to parent violence. Positive impact of both on child abuse potential, individualized problems, externalizing behavior, general parental distress, family cohesion and conflict. No statistically significant difference between groups on child reabuse. Limited change in social competence and overall aggression or hostility (Kolko, 1996). In an evaluation of **MST – Child Abuse and Neglect:** For physically abused and neglected children and their families. Tx targets anger management, CBT treatments for the impact of trauma or posttraumatic stress disorder on adults and children, reinforcement-based therapy for adult substance abuse, behavioral family therapy for **communication** and **problem-solving issues**, functional analysis for family conflict and the use of force in parenting, and abuse clarification. Safety planning and abuse clarification are used in all cases. Participants in MST-CAN presented significantly greater improvement than the Enhanced Outpatient Treatment (EOT) in internalizing, posttraumatic stress disorder, child-reported dissociative symptoms, and total symptoms and experienced reductions in out-of-home placement (or to change placement). Parents in MST–CAN reported significantly greater improvements in psychiatric distress and increases in external social support. Reduced child- and parent-reported neglect, psychological aggression, and minor and severe assault. However, while the MST–CAN group had fewer referred incidents of abuse, there were no significant differences between both treatment groups over the 16 months post baseline (Swenson et al., 2010).

Involvement in positive activities (Engagement)	• Engaging in school • Engaging in community • Pro-social involvement • Recreational involvement • Faith-based involvement • Engagement self-efficacy • Employment	11-16 yrs. Wave 1: 18 mo-6 yrs; wave 3: 18yrs. 5-17 yrs. mid-adolescence	Moderate Evidence	For sexually abused adolescents, **higher school engagement** associated with lower levels of general problem behaviors. **Involvement in extracurricular activities** protective against tobacco use, purging, and protective for school success and helping others—but also positively correlated with antisocial behavior (Williams & Nelson-Gardell, 2012). **School commitment and importance** a pf for antisocial behavior (violence, delinquency, status offenses) for abused youth and for comparison youth (Herrenkohl et al., 2005). Authors present a conceptual model, that is a three-stage process in which child maltreatment affects school performance which affects delinquency. Examines the mediating role of **school achievement and participation** on delinquency for maltreated children; found that higher grade point average, **lower absenteeism**, and lower elementary school behavior problems reduce the effects of maltreatment on delinquency (Zingraff & Leiter, 1995). **School performance or connectedness** is not a very powerful or consistent mediator of the relationship between maltreatment and negative behavioral outcomes (arrest, perpetration of partner violence, general and violence crime) in early adulthood. Also, no moderating effect (Smith et al., 2012).	

Note: some studies provide evidence for a cumulative PF model. For instance, Herrenkohl et al (2005) found that the more PFs an abused/nonabused individual has, the stronger the negative correlation with antisocial behavior. The variable explained an additional 4% to 9% of the variance for 3 antisocial outcomes (violence, delinquency, status offenses) after controlling for age, gender, and early antisocial behavior. Conversely, Jaffee et al (2007) proposes a cumulative stressors model suggesting that individual strengths of youth distinguished resilient from non-resilient children under conditions of low, but not high, family and neighborhood stress.

Child Abuse and Neglect Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Parenting competencies	• Mutually responsive orientation/sensitive parenting • Maternal and/or paternal closeness • Stable home • Paternal functioning • Emotional commitment to child • Clear standards • Parental monitoring • Discipline • Consistency • Knowledge of child development • Ability to seek help • Setting developmentally appropriate limits • Open communication with child about health and safety • Parenting self-efficacy	K-8th grades 18mnths-6 yrs. (wave 1) thru elem school (wave 2) thru ages 15-21 (wave 3) Adolescence thru adulthood 8th graders 12-17 yrs. Presch to 1st grade	Strong Evidence	For a community sample of physically abused youth followed longitudinally for 9 years, **lower levels of unilateral parental decision** making are protective of externalizing outcomes (Lansford et al., 2006). Protective influences associated with maintenance of at least a minimum standard of success in school include stability of home situation, **clear parental expectations of academic performance**, a home atmosphere in which abuse in not a chronic and pervasive theme, and at least average intellectual ability of the child (Herrenkohl et al., 1994). In a community sample, for the individuals reporting physical or sexual abuse in childhood, predictors of resilience included **perceived parental care**, adolescent normal peer relationships and quality adult friendships, and the quality of adult love relationships (Collishaw et al., 2007). 14% of variance in perceived competence associated with **sense of family coherence** in a group of maltreated Israeli 8th graders (Sagy &, Dotan, 2001). For physically abused adolescents, **family support** protective against alcohol use, tobacco use, suicide, purging. Not associated with thriving behaviors (school success, helping others) (Perkins & Jones, 2004). For physically abused children, **positive parenting** ameliorates the effects of low self-regulation on externalizing symptomatology, although the role of positive parenting changed over developmental	

Child Abuse and Neglect Table 2. Protective Factor Crosswalk—Relationship Level					
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				period (no effect in preschool, interactive protective effect in kindergarten, direct, "exacerbating additive" effect in 1st grade (Kim-Spoon et al., 2012).	
		Adols mothers 14-19 yrs. (avg age 17.4 yrs.) and infants 4 mo. old		Pregnant adolescents' **positive evaluation of their relationship with their primary caretaker** and **feelings associated with impending motherhood** mediated the relationship between maltreatment history and early difficulty in mother-infant relationship (Milan et al., 2004).	
		Wave 1: 18 mo-6 yrs.; wave 3: 18yrs.		**Parenting and peer disapproval of antisocial behavior** is a protective factor for delinquency for abused youth and for comparison youth (Herrenkohl et al., 2005).	
		0-12 yrs.	Strong Evidence		**Basic caregiving structure**, **parenting routines** targeted in SafeCare intervention for neglecting and maltreating parents. Significant main effects in favor of SC vs. TAU in reduced CPS recidivism. Larger effects were found in subpopulation meeting usual criteria for inclusion in SC. Coaching condition for SC and TAU had most significant effect for cases falling outside the usual criteria (Chaffin, et al., 2012).
		Prenatal to 3 yrs.			In a meta-analysis of **early family support** (prenatal thru 3 yrs) programs, a significant overall positive effect was found; study demonstrated a decrease in abusive and neglectful acts and in risk reduction of child functioning, parent-child interaction, parent functioning, family functioning, and contextual characteristics. 17 of the 40 studies from the Healthy Families America home visitation programs (Geeraert et al., 2004).
		6-31 mo;			**Foster placement** of young institutionalized

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		followed thru 54 mo. post-placement			Romanian youth (through the Bucharest Early Intervention Project) resulted in improved attachment patterns, reduced signs of emotionally withdrawn/inhibited reactive attachment disorder, improved measures of positive affect, reduced prevalence of internalizing disorders (Bos et al., 2011).
		n/a			A meta analysis found that **Parent training** was moderately effective in promoting desirable and reducing undesirable child-rearing behaviors and child-rearing attitudes; and somewhat effective in promoting parental emotional adjustment (Lundahl, Nimer & Parsons, 2006).
		Parents 18+ living with children < 17	Strong Evidence		This meta analysis found that parental training programs using **home visitors** had a substantial positive impact on parents for attitudes linked to abuse and child-rearing behaviors (Lundahl et al., 2006).
		3-9 yrs. (intervention); 10-17 yrs. (follow-up)			Study of Parents Anonymous, a program that promotes **nonviolent discipline tactics** (parental resilience, social connections, knowledge of parenting and child development, and concrete supports in times of need) led to increased overall family functioning, but not statistically significant (Polinsky et al., 2010).
		7-13 yrs. (Deblinger et al., 1996) 3-6 yrs. (Cohen & Mannarino, 1996) 8-15 yrs.			In 3 studies of Trauma-Focused Cognitive Behavioral Therapy: for young people who have developed significant emotional or behavioral difficulties following exposure to a traumatic event (tested on sexually abused children). These aim to provide the parents and children with the skills to better manage and resolve distressing thoughts, emotions, and reactions related to traumatic life

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		(Cohen et al., 2004) Families Families with school age children	Strong Evidence		events; improve the safety, comfort, trust, and growth in the child; and **develop parenting skills and family communication**. Found to reduce PTSD symptoms (re-experience, hyperarousal and avoidance), externalizing behaviors, internalizing behaviors, sexualized behaviors, problematic behaviors, and child and parent depression and increase effective parenting (Deblinger et al., 1996, Cohen and Mannarino, 1996; Cohen et al., 2004). In an evaluation of **Triple P Positive Parenting Program:** For universal and targeted populations of families, this program offers **positive and supportive parenting**. The first step is getting past the stigma that some parents need help and training in how to be effective parents. The second step is giving them the proper tools and knowledge to raise healthy children. Prinz et al. (2009) found that Triple P System had a *large effect* in reducing child maltreatment in the counties in which it was implemented. A positive effect for the child maltreatment investigation rate was also found with a medium effect size. In a study of **Parent-Child Interaction Therapy: t**ested on physically abused children and parent, parents taught to build **positive relationship with their child**; also parents learn how to give specific commands and discipline practices. The PCIT treatment led to less than half the reoccurrence rate for physical abuse, and parents presented significantly reduced parent negative behavior scores from baseline, which was mediated by reductions in negative parent-child interactions; no effect was found for changes in positive parent behaviors. The PCIT treatment was effective in

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		Infants (1 yr.) and moms	Strong Evidence		improving negative aspects of parenting that had been present in the sample before the intervention (Chaffin et al., 2004). In an evaluation of **Infant-Parent Psychotherapy:** For infants from maltreating families. Targeted attachment by altering the influence of negative maternal representational models on parent-child interaction. Compared with the CS group, the IPP group had significantly higher rates of secure attachment at the follow-up period. The rates of secure attachment increased from 3.1 percent to 60.7 percent for the IPP group, and there was virtually no change in secure attachment in the CS group (the rate increased from 0 to 1.9 percent). The IPP group also had significantly lower rates of disorganized attachment compared with the CS group. At the follow-up, disorganized attachment was prominent in the CS group (77.8 percent), while IPP group displayed much lower rates (32.1 percent) (Cicchetti, Rogosch, and Toth 2006).
		Families with young children (up to 7 yrs.)			A seven-year longitudinal randomized controlled trial to evaluate the effectiveness of the Healthy Families America (HFA) model in New York (HFNY) for women who had at least one substantiated Child Protective Services report found that the women who participated in HFA had significantly lower rates of initiating preventative, protective, and placement services (as compared to control group). They also had lower rates of confirmed Child Protective Services reports for any abuse or neglect as well as physical abuse, although not significant. HFA is a voluntary home visitation program providing a variety of services, including child development,

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		6-13 yrs. 7-18 yrs.	Strong Evidence		access to health care, and **parent education** (Dumont et al., 2010). In an evaluation of **Alternatives for Families.**. Cognitive Behavioral Therapy group: (for kids) coping and self control skills training**;** interpersonal effectiveness skills to enhance social competence; **(for parents) parental views on violence/physical punishment, attributional style and expectations, self-control (anger control, cognitive coping), contingency management**. Family Therapy group: enhance cooperation and motivation of family members by promoting an understanding of coercive behavior, positive communication skills, solve problems together. FT associated with less child-reported parent to child violence, and both CBT and FT with less parent-reported child to parent violence. Positive impact of both on child abuse potential, individualized problems, externalizing behavior, general parental distress, family cohesion and conflict. No statistically significant difference between groups on child reabuse. Limited change in social competence and overall aggression or hostility (Kolko, 1996). In an evaluation of Child and Family Traumatic Stress Intervention (CFTSI): For children together with their parent or caregiver, after the child has experienced a potentially traumatic event (PTE) (e.g., sexual and physical abuse, domestic violence, community violence, rape, assault, and motor vehicle accidents). CFTI targets communication between the affected child and his caregivers about feelings, symptoms and behaviors with the goal of increasing the caregivers' support of the child; improved caregiver emotional support; and specific behavioral

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			Strong Evidence		skills that are taught both to the caregiver and child to assist in coping with symptoms such as thought replacement, breathing retraining, behavioral activation for depression and avoidance, relaxation techniques, coping strategies, reduce concrete external stressors (e.g. housing issues, systems negotiation, safety planning, etc.). CFTSI youth had significantly lower posttraumatic and anxiety scores then comparison youth. CFTSI reduced the overall odds of partial or full PTSD. There were significant differences between groups in re-experiencing and avoidance but not in hyperarousal (Berkowitz, Stover, and Marans, 2010).
Parent or caregiver well-being	• Maternal functioning • Maternal adjustment and coping • Competent parents • Positive parental norms	18mnths-6 yrs. (wave 1) thru elem school (wave 2) thru ages 15-21 (wave 3) 8 to 15 yrs. 11-16 yrs.	Strong evidence	Protective influences associated with maintenance of at least a minimum standard of success in school include stability of home situation, clear parental expectations of academic performance, **a home atmosphere in which abuse in not a chronic and pervasive theme**, and at least average intellectual ability of the child (Herrenkohl et al., 1994). Better youth-rated (but not parent- or teacher-rated) adjustment (=less depression, PTSD, and behavior problems, better self-esteem) was related to **caregiver support** in a sample of 147 sexually abused youth (depression; self-esteem; they also reported more sexual anxiety). More satisfaction with initial caregiver support at time 1 predicted better parent- and teacher-rated adjustment 1 year later, after controlling for initial adjustment. (Rosenthal et al., 2003). For sexually abused adolescents, **caregiver social**	

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		infants 7-18 yrs		**support** associated with lower levels of general problem behaviors (Williams & Nelson-Gardell 2012). **Parenting stress** significantly mediated the relation between history of maltreatment and maternal sensitivity (Pereira et al., 2012).	In an evaluation of Child and Family Traumatic Stress Intervention (CFTSI): For children together with their parent or caregiver, after the child has experienced a potentially traumatic event (PTE) (e.g., sexual and physical abuse, domestic violence, community violence, rape, assault, and motor vehicle accidents). CFTI targets communication between the affected child and his caregivers about feelings, symptoms and behaviors with the goal of increasing the caregivers' support of the child; improved caregiver emotional support; and specific behavioral skills that are taught both to the caregiver and child to assist in coping with symptoms such as thought replacement, breathing retraining, behavioral activation for depression and avoidance, relaxation techniques, coping strategies, reduce concrete external stressors (e.g. housing issues, systems negotiation, safety planning, etc.). CFTSI youth had significantly lower posttraumatic and anxiety scores then comparison youth. CFTSI reduced the overall odds of partial or full PTSD. There were significant differences between groups in re-experiencing and avoidance but not in hyperarousal (Berkowitz, Stover, and Marans, 2010).
Positive peers	• Positive peer norms	12-17 yrs.		For physically abused adolescents**, positive peer group characteristics** (e.g., don't drink, use drugs,	

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	• Social support by friends • Friendship • Peer networks		Strong Evidence	etc) protective against alcohol use, tobacco use, drug use, sexual activity, antisocial behavior, suicide, purging, and for school success and helping others (Perkins & Jones, 2004). More satisfaction with **support from friends** predicted lower self-esteem but less sexual anxiety in a sample of 147 sexually abused youth (Rosenthal et al., 2003). In a sample of children investigated for maltreatment, for 1 SD high for **peer relationship** score, 1.6 time greater odds for being in normal externalizing range (Schultz et al., 2009). **Parenting and peer disapproval of antisocial behavior** a pf for delinquency for abused youth and for comparison youth (Herrenkohl et al., 2005). In a community sample, for the individuals reporting physical or sexual abuse in childhood, predictors of resilience included perceived parental care, **adolescent normal peer relationships** and quality adult friendships, and the quality of adult love relationships (Collishaw et al., 2007). Having a **good quality friendship** was associated with a greater increase over time in self-esteem among children who experienced chronic maltreatment than among non-mal children. Among physically abused children/chronically maltreated children, those who had a **reciprocated best friend** showed a greater increase over time in self-esteem than those who did not (Bolger, Patterson & Kupersmidt 1998).	
		8-15 yrs. 0-14 yrs. Wave 1: 18 mo-6 yrs.; wave 3: 18 yrs. Adoles. to adulthood Grades 2-4 (ages 8, 9, 10) followed for 1986-89			

Other Family Supports					
Caring adult(s)	• Mentor • *Familismo* • Prosocial models • Networks • Support for caregivers • Support from home visitors, community center staff, and other non-kin adults	Avg age 8.68 yrs. 12-17 yrs.	Emerging evidence	Regardless of maltreatment status in sample of Latino youth, overall **quality of the relationship with the head camp counselor** significantly predicted higher resilient functioning, contributing to 50.6% of variance in resilient functioning score (Flores et al., 2005). Abused adolescents **having support from other adults** were 1.5 time more likely to engage in alcohol use, 1.4 times more likely to use drugs; also associated with higher tobacco use, more sexually active , more likely to have considered suicide, and less likely to do well in school. But protective factor for helping others (Perkins & Jones, 2004).	

Child Abuse and Neglect Table 3. Protective Factor Crosswalk—Community Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Community Characteristics					
Positive school environment	• Perceived safety at school • Prosocial relationships with teachers • Positive school environment • Effective classroom management • High levels of school engagement • Effective, specialized programming in school	12-17 yrs. 9th-11th grades	Moderate Evidence	For physically abused adolescents, **positive school climate** protective against alcohol use, tobacco use, drug use, sexual activity, antisocial behavior, suicide and supportive of school success (Perkins & Jones, 2004).	The risk of violent delinquency associated with cumulative types of child maltreatment was lower in **schools with a universal violence prevention program (Fourth R)** compared to control schools. For a child in the control group, each additional form of child maltreatment yields a 46% higher chance of engaging in violent delinquency. The effect of an increase on delinquency for a child in intervention school is negligible delinquency (reduce risk by 3%) (Crooks et al., 2011).
Positive community environment	• Community vigilance • Community efficacy • Caring community • Safety • Social trust	< 11 yrs.; interviewed about 22 yrs. later (mean age 29.1 yrs.) 5 and 7 yrs.	Moderate Evidence	**Neighborhood advantage** moderated the relationship between household stability and resilience in adolescence. Youth in relatively advantaged neighborhood with a single parent significantly less likely to be resilient in adolescence than those who had a short first placement. Respondents in less advantaged neighborhood with single parent significantly more likely to be resilient in adolescence than those from same type of neighborhood with short first placement outside the home (DuMont et al., 2007). **Social cohesion, informal social control** associated with increased relative risk of being resilient vs. non-resilient in maltreated children (Jaffee et al., 2007).	

Child Abuse and Neglect Table 3. Protective Factor Crosswalk—Community Level					
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Stable living situation	• Stable home situation • Placement stability • Permanency	< 11 yrs.; interviewed about 22 yrs. later (mean age 29.1 yrs.) 6-31 mo; followed thru 54 mo. post-placement 18mnths to 6 yrs. (wave 1) thru elem school (wave 2) thru ages 15-21 (wave 3) 0-42 months; followed at ages 6 and 11 yrs.	Strong Evidence	**Stable living situation** (2 parents or long placement) increased likelihood of resilience in adolescence, but not in young adulthood, in sample of abused and neglected children (DuMont et al., 2007). Protective influences associated with maintenance of at least a minimum standard of success in school include **stability of home situation**, clear parental expectations of academic performance, a home atmosphere in which abuse in not a chronic and pervasive theme, and at least average intellectual ability of the child (Herrenkohl et al., 1994). After **placement in adoptive families**, very few effects of institutional deprivation on language and cognitive abilities if infants exposed less than 6 months. No linear effect for those exposed 6 to 42 months. For children over 18 months, minimal language acquisition prior to arrival was strong beneficial prognostic factor for language and cognitive outcomes (Croft et al., 2007).	**Foster placement** of young institutionalized Romanian youth (through the Bucharest Early Intervention Project) resulted in improved attachment patterns, reduced signs of emotionally withdrawn/inhibited reactive attachment disorder, improved measures of positive affect, reduced prevalence of internalizing disorders (Bos et al., 2011).

Economic opportunities	• Economic supports • Employment opportunities • Promote economic self-sufficiency • Presence of concrete support services (such as food stamps) • Socioeconomic status (SES)	11-16 yrs. 6-31 mo; followed thru 54 mo. post-placement	Emerging evidence	For sexually abused adolescents, **middle (vs. low) SES** associated with lower levels of general problem behaviors (Williams & Nelson-Gardell 2012).	**Foster placement** of young institutionalized Romanian youth (through the Bucharest Early Intervention Project) resulted in improved attachment patterns, reduced signs of emotionally withdrawn/inhibited reactive attachment disorder, improved measures of positive affect, reduced prevalence of internalizing disorders (Bos et al., 2011).

Rating Instrument for Summative Ratings

Emerging Evidence: Preponderance of findings generated by cross-sectional studies, case studies, or qualitative investigations with non-representative samples.

Limited Evidence: Preponderance of findings generated by a single longitudinal study (significant findings with small, medium, or large effect sizes).

Moderate Evidence: Consistent findings that are generated by two or more longitudinal studies (significant findings with small, medium, or large effect sizes).

Strong Evidence: Findings generated from one or more experimental or well conducted quasi-experimental studies that demonstrate a significant effect on a protective factor and an outcome (e.g., findings demonstrate that the experimental effect on an outcome is mediated by the effect of a protective factor).

Crosswalk of Constructs: Pregnant and Parenting Teens

Pregnant and Parenting Teens Table 1. Protective Factor Crosswalk—Individual Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Characteristics					
Positive self-image	• Self-esteem • Self-worth • Self-concept • Desirable personal identity • Cultural knowledge	All articles refer to pregnant and parenting adolescents and/or their children.	Limited Evidence	**Self-esteem** levels did NOT predict repeat pregnancy among teen mothers (Raneri & Wiemann, 2007). Mothers who were **well adjusted socioemotionally** during pregnancy were well-adjusted when their firstborn child was 10 years old (i.e., they had higher self- esteem, less trait anxiety, and lower depression) (Noria, 2005). Teen mother's **self-esteem** was NOT related to cognitive competence of the teen mother's child at 54 months (Luster et al, 2000). Adolescent mothers with higher levels of **self-esteem** at baseline felt more satisfied as parents at 6 months compared to teen mothers with lower levels of self esteem, but were not more likely to be more nurturant caregivers (Hess, Papas & Black, 2002). A moderate positive correlation was found between **resilience** (as measured by personal competence and **acceptance of self and life**) and family health work of the mothers who had given birth as teens. Also, a moderate positive correlation was observed between mother's resilience and health promoting lifestyle practices (Black & Ford-Gilboe, 2004). For **African American** pregnant and parenting teens, there was a significant negative relationship between **ethnic identity** and internalizing behavior problems and significant positive relationships between ethnic identity and self-esteem and between ethnic identity and social support. For **Hispanic American** pregnant and parenting adolescents, there was a significant negative relationship between ethnic identity and internalizing behavior problems and a significant positive relationship between	

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		All articles refer to pregnant and parenting adolescents and/or their children.	Limited Evidence	ethnic identity and self-esteem. For **Caucasian** pregnant and parenting teens, there was a significant negative relationship between ethnic identity and internalizing behavior problems and between ethnic identity and externalizing behavior problems (Sieger & Renk, 2007). **Self-esteem** (measured before becoming a teen parent) was NOT related to depression in early adulthood (Kalil & Kunz, 2002). **Lower levels of maternal depressive symptoms** for teen mothers while child was in preschool significantly predicted positive academic adjustment for child in third grade and positive adjustment for child at home (Rhule et al., 2006). One qualitative study found that individual factors associated with resilience during early adulthood included: motivation and responsibility; goals and aspirations; **a strong sense of identity**; a wider sense of purpose; **pride in achievements**; and insight (Collins, 2010).	
Sense of purpose	• Motivation • Goals • Spirituality • Religion • Commitment	All articles refer to pregnant and parenting adolescents and/or their children.	Limited Evidence	**Participation in a religious organization at school** was NOT associated with a statistically significant decrease in probability of second teen pregnancy or second pregnancy within 24 months for teen mothers (Manlove, Mariner, et al., 2000). **Post-secondary education plans** in 8th grade were NOT associated with a statistically significant decrease in probability of second teen pregnancy or second pregnancy within 24 months for teen mothers (Manlove, Mariner, et al., 2000). Teen mothers who had **no plans to have another baby** within five years were less likely to have a second pregnancy than teen mothers who did have such plans (Raneri & Wiemann, 2007).	A cognitive-behavioral group intervention based on the use of a five-step problem-solving process to **identify goals and carry out specific tasks toward each goal** resulted in better outcomes (compared to the control group), including improvements in problem-focused coping behavior, rational social problem-solving skills, school attendance and GPA (Harris & Franklin, 2003).

Pregnant and Parenting Teens Table 1. Protective Factor Crosswalk—Individual Level					
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		All articles refer to pregnant and parenting adolescents and/or their children.	Limited Evidence	**Spirituality** and a **positive value placed on children and motherhood** may support resilience among African American teen mothers in foster care (Haight, 2009). According to this qualitative study, mentors, family and partner support, **spirituality,** optimism, and economic opportunity were factors that increased the chance of a young mother to achieve financial independence and academic prestige (as measured by achieving a master's or doctoral degree) in the future (Perrin & Dorman, 2003). **Lower levels of maternal depressive symptoms** for teen mothers while child was in preschool significantly predicted positive academic adjustment for child in third grade and positive adjustment for child at home (Rhule et al., 2006). A qualitative study of urban adolescent mothers living with violence conceptualized that the following factors contributed to resilience: 1) Ability to connect with others for support; 2) Problem-solving ability and planfulness as opposed to impulsivity; 3**) A strong goal orientation coupled with motivation to succeed**; 4) Insightfulness (i.e., the ability to be introspective, interpersonally intelligent, and articulate); 5) Independent, action-oriented, and determined to stand up for herself (Kennedy, 2005). One qualitative study found that individual factors associated with resilience in early adulthood included: **motivation** and responsibility; **goals and aspirations**; a strong sense of identity; **a wider sense of purpose**; pride in achievements; and insight (Collins, 2010).	

Sense of optimism	• Positive future orientation • Future expectations and aspirations • Trust • Hope	All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	**Educational aspirations** after first birth and **occupational aspirations** after first birth were NOT associated with a statistically significant decrease in probability of second teen pregnancy or second pregnancy within 24 months for teen mothers (Manlove, Mariner, et al., 2000). Teen mothers who had **no plans to have another baby** within five years were less likely to have a second pregnancy than teen mothers who did have such plans (Raneri & Wiemann, 2007). Virtually all participants in one hermeneutic phenomenology study of rural pregnant and parenting Hispanic teens agreed that their **education aspirations to stay in school and graduate** were key components towards their success in high school (Estrada, 2012). 54-month old children (of teen mothers) with high cognitive competence were more likely to have mothers who were **more trusting of other people** (than the mothers of the least successful children) (Luster et al., 2000). Having **higher educational expectations** reduced a woman's odds of having a second teenage pregnancy (Shearer et al., 2002) According to this qualitative study, mentors, family and partner support, spirituality, **optimism,** and economic opportunity were factors that increased the chance of a young mother to achieve financial independence and academic prestige (as measured by achieving a master's or doctoral degree) in the future (Perrin & Dorman, 2003). Pregnant and parenting teens in an alternative school with **higher levels of desired education** more highly valued someone to help directly with educational and childcare support (whereas participants with lower levels of education goals more highly valued someone to have fun with and loan them money) (Brosh, Weigel & Evans, 2007). Whether a teen mother **expected to go to college** (measured before becoming a teen parent) was NOT related to depression in early adulthood (Kalil & Kunz, 2002).	

				Lower levels of maternal depressive symptoms for teen mothers while child was in preschool significantly predicted positive academic adjustment for child in third grade and positive adjustment for child at home (Rhule et al., 2006).	
Agency (self-efficacy)	• Self-efficacy • Confidence • Sense of power • Sense of control • Internal locus of control • Help-seeking behavior	All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	Among young mothers who reported negative childhood family contexts, greater resilience in parenting (as measured by lack of substantiated child maltreatment) was associated with **less caregiving and emotional support from their mothers while parenting, and living separately from their families of origin** (Easterbrooks et al., 2010). Having an **oppositional gaze** (resistance to messages that limit and oppress) may support resilience among African American teen mothers in foster care (Haight, 2009). Thinking that attending college was important and thinking that job training was important were both positively correlated with level of **self-efficacy**. However, the importance of marriage and graduating from high school did not vary by level of self-efficacy (Turney et al., 2011). **Higher levels of mastery** (i.e., the extent to which one regards one's life chances as being under one's own control in contrast to being fatalistically ruled) after becoming pregnant was related to decreases in depressive symptoms seven years later (Turner et al., 2000). A moderate positive correlation was found between resilience (as measured by **personal competence** and acceptance of self and life) and family health work. Also, a moderate positive correlation was observed between mother's resilience and health promoting lifestyle practices (Black & Ford-Gilboe, 2004). Levels of **maternal self-efficacy** predicted levels of postpartum depression among teen mothers (Birkeland et al., 2005). **Locus of control** was a predictor of early subsequent pregnancy and birth as mothers with more internal locus of control were less likely to become pregnant or have another baby within 24 months (Sims & Luster, 2002).	Adolescent mothers who participated in a culturally sensitive mentorship model of home visits and videotape programming to develop skills in interpreting infants' cues, nonfood methods of managing infant behavior, and **mother–grandmother negotiations** were more likely to follow the guidelines that they received from WIC and from their pediatricians on waiting to give babies solid food until they were 4-6 months old (Black et al., 2001). Graduates from the NCAPP program, which supports the positive development of teen parents by **helping them become self-sufficient and better able to support themselves and their children** [through activities designed to help the teens (a) delay a subsequent pregnancy until beyond adolescence; (b) graduate from high school or pass the GED tests; (c) successfully transition to adulthood through achievements such as enrolling in postsecondary education, receiving vocational training, being employed at a livable wage, and living in safe and stable housing environment; and (d) increase the incidence of appropriate discipline, nurturing behavior, and assurance that the children are well cared for] were on a more positive life course (compared to nonparticipants) in terms of greater primary responsibility for housing and utilities, greater higher education enrollment, more job stability, and greater focus on career goals (Gruber, 2012).

		All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	Pregnant adolescents with **higher levels of self-care agency** (i.e., adolescents' perceptions of their agency or capabilities to care for their own health) had better birth weight outcomes for their babies (Renker, 1999). Compared to "low functioning" dyads, "average functioning" dyads, and "average parenting/disengaged infant" dyads, "high-functioning" infant-mother dyads were **less likely to have maternal grandmothers as regular caregivers** at time 1 and **less living to have maternal grandmothers involved in caregiving of infants** at times 1 and 2 (Easterbrooks et al., 2005). Although **mastery** (e.g., the extent to which one regards one's life-chances as being under one's own control) was not a significant predictor of depression in the 36 month regression model, it was negatively correlated with both 14 and 36 month depression. Further analysis reveals that depression at 14 months mediates the relationship between mastery and 36 month depression. This suggests that mastery may still show promise as an intervention strategy (Eshbaugh, 2006). **Self-efficacy** (measured before becoming a teen parent) was NOT related to depression in early adulthood (Kalil & Kunz, 2002). A qualitative study of among urban, adolescent mothers living with violence conceptualized that the following factors contributed to resilience: 1) **Ability to connect with others for support**; 2) Problem-solving ability and planfulness as opposed to impulsivity; 3) A strong goal orientation coupled with motivation to succeed; 4) Insightfulness (i.e., the ability to be introspective, interpersonally intelligent, and articulate); 5) **Independent, action-oriented, and determined to stand up for herself** (Kennedy, 2005).	

Cognitive ability (intelligence)	• IQ • Reading and/or math skills • Curiosity • Intellectual mastery • Verbal competence • Executive functioning	All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	Having an additional pregnancy within ten years of a teenage pregnancy was NOT related to **IQ**, **GPA, being at grade level**, or **cognitive readiness for parenting**. However, expectant mothers with **more cognitive resources** exhibited better socioemotional adjustment, higher socioeconomic status, and lower child abuse potential 10 years after the teen birth. Also, mothers with **greater prenatal cognitive resources** and **school involvement and success** were also more resilient 5 years after becoming a mother (Noria, 2005). Higher levels of **cognitive ability** (as measured by arithmetic reasoning, math knowledge, word knowledge, and paragraph comprehension) reduced likelihood of a rapid repeat pregnancy among teen (Shearer et al., 2002). At the time of their pregnancy, adolescent mother who had completed more schooling, were relatively younger, had more perceived support from friends, had more perceived support from siblings, more empathic parenting attitudes, and somewhat **lower verbal intelligence** were more likely to be resilient (as measured by social and psychosocial outcomes) five year (Weed, Keogh, & Borkowski, 2000). Mothers with **higher arithmetic achievement** had lower parenting stress about two years later (Budd et al., 2006) **Higher academic achievement** (as measured by educational skills in reading & arithmetic) was associated with lower child abuse potential scores among adolescent mothers who were wards of the state (Budd et al., 2000). Teen mothers' **IQ** and **reading ability** (measured when child was age 3) were associated with reductions in school dropout, unemployment, early parenthood, and violent offending among their children when their children became young adults (Jaffee et al., 2001). Academic achievement, as measured by **verbal and math skills** before teen birth, was related to decreases in depression when the teen mother was in young adulthood (Kalil & Kunz, 2002).	

		All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	A qualitative study conceptualized that the following factors contributed to resilience among urban, adolescent mothers living with violence: 1) Ability to connect with others for support; 2) Problem-solving ability and planfulness as opposed to impulsivity; 3) A strong goal orientation coupled with motivation to succeed; 4) **Insightfulness (i.e., the ability to be introspective, interpersonally intelligent, and articulate);** 5) Independent, action-oriented, and determined to stand up for herself (Kennedy, 2005).	
Knowledge and endorsement of safe sexual practices (utilization of long-acting contraception)	• Knowledge of sexual issues, pregnancy, and methods of prevention • Use of long-term contraception	All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	Teen mothers who were given a **long-acting contraceptive** within three months of delivery were less likely to have a rapid repeat pregnancy than those teen mothers who were not given long-acting contraceptives (Raneri & Wiemann, 2007). Use of **long-acting contraceptives** was associated with reduced odds of rapid repeat pregnancy among teen mothers (Lewis et al., 2010). Teen mothers who were **early adopters of contraceptive implants** were much less likely to become pregnant again compared to mothers who used other methods or no methods within one year or two years (Stevens-Simon, Kelly & Singer, 1999). 54-month old children (of teen mothers) with high cognitive competence were more likely to have mothers who had **no other subsequent children** (Luster et al, 2000). **Long acting contraceptive use** prevented rapid repeat pregnancy. Norplant inserted during the puerperium was the strongest predictor of repeat pregnancy during the first 2 postpartum years. By the end of the first postpartum year, 0%, 11%, 25%, and 38%, respectively, for those who began using Norplant, Depo-Provera, birth control pills, and no birth control during puerperium had become pregnant (Stevens-Simon, Kelly & Kulick, 2001).	**Participation in a sexuality education course** was NOT related to probability of a second pregnancy among teen mothers (Shearer et al., 2002).

Parenting attitudes (of adolescent mother)	• Empathetic parenting attitudes (of teen mother) • Breastfeeding attitudes (of teen mother) • Maternal self-efficacy (of teen mother)	All articles refer to pregnant and parenting adolescents and/or their children.	Limited Evidence	Levels of **maternal self-efficacy** predicted levels of postpartum depression among teen mothers (Birkeland et al., 2005). At the time of their pregnancy, adolescent mothers who had completed more schooling, were relatively younger, had more perceived support from friends, had more perceived support from siblings, more **empathic parenting attitudes**, and somewhat lower verbal intelligence were more likely to be resilient (as measured by social and psychosocial outcomes) five year later (Weed, Keogh, & Borkowski, 2000). A review of studies on adolescent mothers found that by possessing **positive attitudes or ascribing benefits to breastfeeding**, adolescents who intended to or actually chose breastfeeding were often differentiated from those who intended to or chose to bottle feed (Wambach & Cole, 2000).	
Skills and Developmental Tasks					
Self-regulation skills (emotional, behavioral)	• Self-mastery • Anger management • *Fatalismo* • Character • Temperament • Emotional intelligence • Long term self-control	All articles refer to pregnant and parenting adolescents and/or their children.	Emerging Evidence	Adolescent mothers who did not have a rapid repeat pregnancy were **more confident in their ability to settle differences without the use of physical force** and **less likely to agree that people must use physical force to show importance** (as compared to adolescent mothers who did have a rapid repeat pregnancy) (Crittenden et al., 2009).	
Academic skills	• Persistence • Grades • GPA Help-seeking behavior • Study skills • Time management • Coaching • Academic self-efficacy • Degrees or accomplishments	All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	Teen mothers who **received a GED or high school diploma** had a reduced risk of second teen birth compared to teen mothers who received neither (Manlove, Mariner, et al., 2000). 8th grade math and reading **test scores** were NOT a statistically significant factor associated with a second pregnancy among teen mothers (Manlove, Mariner, et al., 2000). Being **enrolled in a gifted class** in 8th grade reduced the likelihood that a teen mother will have a second teen birth (Manlove, Mariner, et al., 2000).	

		All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	Children with higher cognitive competence at 54 months of age were more likely to have mothers who were **high school graduates**. However, mothers in the two groups did not differ on **self-reported GPA** (Luster et al., 2000). Mothers who **had completed more schooling** were more likely to report higher levels of parenting satisfaction and were more nurturant caregivers in play interactions with their children (Hess, Papas & Black, 2002). **Education level** of adolescent mothers was NOT related to whether or not they followed the guidelines that they received from WIC and from their pediatricians on waiting to give babies solid food until they were 4-6 months old (Black et al., 2001). Having **13 to 15 years of education** (compared with less than 9 years) was the greatest positive predictor of breastfeeding initiation for teen mothers receiving WIC. It was the strongest predictor of breastfeeding for white teen mothers and the second strongest predictor for black teen mothers (Park et al., 2003). At the time of their pregnancy, adolescent mother who were **at grade level** (defined by grade completion and age), had more perceived support from friends, had more perceived support from siblings, more empathic parenting attitudes, and somewhat lower verbal intelligence were more likely to be resilient (as measured by social and psychosocial outcomes) five year later (Weed, Keogh, & Borkowski, 2000). **Mother's education level** was a protective factor against depression 36 months after the birth of the child (but not statistically significantly related14 months after the birth of the child). However, for teen mothers with lower levels of self-perceived resources, more educated mothers were more depressed than less educated mothers at 36 months. For teen mothers with higher levels of self-perceived resources, more educated mothers were less depressed than less educated mothers, as expected (Eshbaugh et al., 2006) **Educational status** was strongly related to concurrent parenting stress among teen parents in foster care (Budd et al., 2006).	

				Academic achievement, as measured by verbal and math skills before teen birth, was related to decreases in depression when teen mother was in young adulthood (Kalil & Kunz, 2002).	
Problem-solving skills	• Decision making • Planning • Competence • Task-oriented coping • Problem-solving self-efficacy	All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	A qualitative study conceptualized that the following factors contributed to resilience among urban, adolescent mothers living with violence: 1) Ability to connect with others for support; 2) **Problem-solving ability and planfulness as opposed to impulsivity**; 3**)** A strong goal orientation coupled with motivation to succeed; 4) Insightfulness (i.e., the ability to be introspective, interpersonally intelligent, and articulate); 5) Independent, action-oriented, and determined to stand up for herself (Kennedy, 2005). Adolescent mothers who did not have a rapid repeat pregnancy were **more confident in their ability to settle differences without the use of physical force** and less likely to agree that people must use physical force to show importance (as compared to adolescent mothers who did have a rapid repeat pregnancy) (Crittenden et al., 2009).	A cognitive-behavioral group intervention based on the use of a five-step **problem-solving** process to identify goals and carry out specific tasks toward each goal resulted in better outcomes (compared to the control group), including improvements in problem-focused coping behavior, rational social problem-solving skills, school attendance and GPA (Harris & Franklin, 2003).
Parenting skills, (of adolescent mother)	• Parenting practices • Parenting behaviors • Parenting knowledge • Maternal competency • Child nutrition skills • Positive relationship between adolescent mother and baby/child • Nurturing parenting	All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence	Children (of teen mothers) with higher cognitive competence at 54 months of age were more likely to have mothers who, at 12 months, had **stronger teaching skills (**i.e., sensitivity to cues, response to distress, social-emotional growth fostering, and cognitive growth fostering). These more successful children were also more likely to have been **read to regularly**. Additionally, their mothers had **higher parenting practices scores** (Luster et al., 2000). The **relationship and/or attachment children of adolescent mothers had with their parents (including the adolescent mother)** was the most commonly reported protective factor in helping them cope with exposure to negative life events and stressful situations (Carothers et al., 2006). **Knowledge of childrearing, infant development norms, and developmental processes** measured approximately 14 months after birth did NOT predict depression in adolescent mothers 36 months after the birth (Eshbaugh, 2006). **Secure attachment at infancy between teen mother and baby**	Adolescent mothers who **participated in a culturally sensitive mentorship model of home visits and videotape programming to develop skills in interpreting infants' cues, nonfood methods of managing infant behavior, and mother–grandmother negotiations** were more likely to follow the guidelines that they received from WIC and from their pediatricians on waiting to give babies solid food until they were 4-6 months old (Black et al., 2001). There is an increase in breastfeeding initiation among pregnant adolescents who **attend specific breastfeeding education classes** (Volpe & Bear, 2000). **Home visitation** by volunteers (which had a variety of programmatic components including a **curriculum to teach and model nurturing parenting behaviors**) resulted in a small but significant effect on better parenting outcomes for teen parents, particularly regarding expectations of the child, role reversal and dysfunctional parent-child interactions. There were no differences in

		All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence	was a marginally significant predictor for positive social adjustment for child by third grade. Additionally, **higher levels of positive parenting** significantly predicted positive adjustment at school (Rhule et al., 2006).	parenting stress or mental health (Barnet, et al., 2002). **Home visitation** with the goal of to **promoting maternal competency and nurturant parenting behavior** had NO demonstrable effect on the incidence of maltreatment and postpartum school return, or the prevalence of contraceptive use (Stevens-Simon, Nelligan & Kelly, 2001). **Participation in an early intervention program (EIP) of intense home visitation by public health nurses (PHNs) plus preparation-for-motherhood classes** resulted in fewer hospitalization episodes and fewer hospitalization days of infants and better immunization compliance for infants. There were no group differences in emergency room visits, repeat pregnancy rates, educational outcomes, depression symptoms and some other variables. Authors posited that the reduction in days of infant hospitalization in the EIP was likely to have resulted from the nursing interventions in which **young mothers were taught how to recognize signs and symptoms of infant illness and when to contact their child's health care provider** (Koniak-Griffin et al., 2002). Graduates from the NCAPP program, which supports the positive development of teen parents by **helping them become self-sufficient and better able to support themselves and their children** [through activities designed to help the teens (a) delay a subsequent pregnancy until beyond adolescence; (b) graduate from high school or pass the GED tests; (c) successfully transition to adulthood through achievements such as enrolling in postsecondary education, receiving vocational training, being employed at a livable wage, and living in safe and stable housing environment; and (d) **increase the incidence of appropriate discipline, nurturing behavior, and assurance that the children are well cared for**] were on a more positive life course (compared to nonparticipants) in terms of greater primary responsibility for housing and utilities, greater higher education enrollment, more job stability, and greater focus on career goals (Gruber, 2012). Mothers who participated in a **short-term interaction-**

		All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence		**focused parenting curriculum on maternal behaviors and child development outcomes** were significantly more responsive, less directive, and more facilitative of child language development compared with mothers in the contrast group. In addition, children of mothers who participated in the program had significantly higher developmental quotient scores than did the children of mothers in the contrast group (Deutscher et al., 2006). **Intensive home visitation** by nursing para-professionals (guided by the theory of mentorship, and **designed to improve parenting skills**, health practices, and infant outcomes within an aggregate considered to be at great risk for infant mortality, low-birth weight, and child maltreatment) resulted in a reduced likelihood of low birth weight births, reduced likelihood of infant mortality, improved age-appropriate baby immunization rates, and reduced rapid repeat pregnancy (compared to national or local data for teen mothers). Also, there were limited, favorable findings for reductions in child abuse potential scores and personal distress and personal adjustment (Flynn, 1999). **Paraprofessional home visitor services** provide only modest enhancements in the outcomes of welfare-to-work programs. However, by the end of the study period there were some striking impacts on reported rates of condom use and use of passive forms of contraception that suggest the possibility that there might be future benefits for this study sample in terms of longer spacing between births. Demonstration sought to reduce long-term welfare dependence and **strengthen parenting skills and behaviors**; home visitors assisted with: 1) strengthening teens' access to and support for education and training; 2) **better managing the stresses of parenting and working or attending school**; and 3) establishing paternity and collecting child support (Kelsey et al., 2001). Participation in 10-week **filial therapy** by adolescent mothers resulted in significant increases in empathy and acceptance of their child (compared to adolescent mothers participating in a typical parenting education model). Filial Therapy is a unique approach used by play therapists to

					train parents in basic child-centered play therapy principles and skills so that they can become therapeutic agents of change for their child. **Parents are taught skills** which include: reflective listening, recognizing and responding to the feelings of their child, building children's self-esteem, and therapeutic limit setting. Parents are required to have structured weekly play sessions with their child using selected toys. The therapist educates the parents through instruction, role-playing, small group discussion, and supervision (Sparks, 2010). **Community-based home visitation** by trained home visitors (who delivered a **parenting curriculum**, encouraged contraceptive use, connected the teen with primary care, and promoted school continuation) had a positive impact on adolescent mothers' parenting attitudes and beliefs compared to the control group. Also, more home-visited teens than control group teens returned to school and graduated by 2 years postpartum. There was a trend toward greater consistent condom use among home-visited adolescents, but no impact on use of hormonal contraception, repeat pregnancy or birth, or depressive symptoms. Finally, at the year 2 follow-up interview, 61% of home-visited adolescents vs 44% of control adolescents reported having a regular personal doctor (Barnet, et al., 2007).
Relational skills	• Ability to form positive bonds and connections • Positive attachments • Relationships • Connection • Caring • Empathy • Permanent lifetime connections • Communication skills • Negotiation • Conflict resolution	All articles refer to pregnant and parenting adolescents and/or their children.	Moderate evidence	A qualitative study conceptualized that the following factors contributed to resilience among urban, adolescent mothers living with violence: 1) **Ability to connect with others for support**; 2) Problem-solving ability and planfulness as opposed to impulsivity; 3**)** A strong goal orientation coupled with motivation to succeed; 4) Insightfulness (i.e., the ability to be introspective, **interpersonally intelligent**, and articulate); 5) Independent, action-oriented, and determined to stand up for herself (Kennedy, 2005). **English speakers** accessed services more (compared to Spanish only speakers and bilingual mothers), despite similar socioeconomic status and family structure (Nadeem et al., 2006). Adolescents who had **relationships with their mothers characterized by autonomy, mutuality, and the ability to deal**	Adolescent mothers who participated in a culturally sensitive mentorship model of home visits and videotape programming to develop skills in interpreting infants' cues, nonfood methods of managing infant behavior, and **mother–grandmother negotiations** were more likely to follow the guidelines that they received from WIC and from their pediatricians on waiting to give babies solid food until they were 4-6 months old (Black et al., 2001).

	• Verbal competence			**with conflict non-defensively (individuation),** and whose **interactions with their mothers were positive and animated** (positive affect) soon after the baby was born, exhibited more nurturant behavior with their own children 6 months after the child's birth. However, other measures of the supportive quality of the mother-grandmother relationship were not predictive (Hess, Papas & Black, 2002). Adolescent mothers who did not have a rapid repeat pregnancy were **more confident in their ability to settle differences without the use of physical force** and less likely to agree that people must use physical force to show importance (as compared to adolescent mothers who did have a rapid repeat pregnancy) (Crittenden et al., 2009). **Reciprocal exchange of support between parents and pregnant teens** was correlated with increased mastery and life satisfaction and decreased depression and anxiety (when compared to providers [i.e., teens who were high on providing but low on receiving support], receivers [teen who were low on providing but high on receiving support], and low supporters [teens who reported low levels of providing and receiving support]) (Stevenson et al., 1999).	
Involvement in positive activities (engagement)	• Engaging in school • Engaging in community • Opportunities for pro-social involvement • Recreational involvement • Faith-based involvement • Engagement self-efficacy • Employment	All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence	**Participation in a religious organization at school** was NOT associated with a statistically significant decrease in probability of second teen pregnancy or second pregnancy within 24 months for teen mothers. However, teen mothers who were **continuously engaged in school** had a reduced risk of second teen birth (compared to dropping out prior to first pregnancy and to dropping out after first pregnancy) and a second birth within 24 months (compared to dropping out prior to first pregnancy and for dropping out after first pregnancy) (Manlove, Mariner, et al., 2000). **Attending some postsecondary education** had NO STATISTICALLY SIGNIFICANT EFFECT in the multivariate analysis of second teen pregnancy or second pregnancy within 24 months for teen mothers. However, teen mothers who were **employed or enrolled in classes, in an apprenticeship or training program or in the military** after the equivalent of the 12th grade had a lower risk of either a second teen birth or a closely spaced second birth (Manlove, Marina, et al., 2000).	**Participation in the Second Chance Club high school–based intervention** for pregnant and parenting adolescents resulted in a reduction of repeat births over three years. Program components included: (a) **weekly group meetings** throughout the school year focused on parenting, career planning, adolescent issues, and group support; (b) **participation in school events such as a school club**; (c) individual case management and home visits; (d) medical care for the adolescent and infant through both a linked university-based clinic as well as the school-based clinic; and (e) **service projects** selected by the group that provided outreach to the community and to at-risk middle school girls. Although not tested empirically, authors postulated that the **close daily contact with peers in the group as well as the project coordinator was the most important factor** (Key et al., 2001).

		All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence	Teen mothers who were **enrolled in school** three months postpartum were less likely to experience a repeat pregnancy than those teen mothers not enrolled (Raneri & Wiemannn, 2007). Mothers who were **more involved and successful at school** were better adjusted, had higher SES, and less potential to abuse their children ten years after the teen birth. They were also more resilient 5 years and ten years after the birth (Noria, 2005). Children of teen mothers who were most cognitively competent at 54 months old were more likely to have **mothers who were employed** (compared to children who scored in the bottom quartile of the Peabody Picture Vocabulary Test) (Luster et al., 2000). **Postpartum school return** was NOT a significant independent predictor of subsequent conception among adolescent mothers. **Compliance with visits to the medical clinic** was NOT associated with a reduction in rapid repeat pregnancy (Stevens-Simon, Kelly & Kulick, 2001). **Employment status was** NOT a predictor variable of whether adolescent mothers would follow the guidelines they received from WIC and from their pediatricians on waiting to give babies solid food until they were 4-6 months old (Black et al., 2001). **Mothers who were employed** reported engaging in health promoting lifestyle practices more frequently than did their unemployed counterparts (Black & Ford-Gilboe, 2004). A qualitative study concluded that a **special teen parent unit in school** provided a source of support and help in gaining access to higher education. In general **education and training** helped adolescent mothers to gain useful knowledge and skills that supported their engagement with employment, allowing them to become economically self-supporting in the future (Collins, 2010).	

Pregnant and Parenting Teens Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Supportive Adults					
Parenting competencies (competencies of the parent(s) of the teen mother)	• Mutually responsive orientation • Sensitive parenting • Open communication • Maternal/ paternal closeness • Stable home • Emotional commitment to child • Clear standards • Parental monitoring • Discipline • Consistency • Knowledge of child development • Ability to seek help • Open communication with child about health and safety • Setting developmentally appropriate limits • Parenting self-efficacy • Knowledge of sexual	All articles refer to pregnant and parenting adolescents and/or their children.	Strong evidence	**Maternal nurturance** (adolescent mother's perceptions of the nurturing and parenting she received from her mother) was significantly correlated with greater empathy of a teen mother toward her child. **Paternal nurturance** was significantly correlated with greater parenting satisfaction on the part of the adolescent mother (Lewin et al., 2011). The majority of Hispanic pregnant and parenting teens in one hermeneutic phenomenology study indicated **their mother played a major role in supporting them** to remain in high school (Estrada, 2012). Teen mothers of the children with higher cognitive competence at 54 months were more likely to **identify their own mothers as positive influences in their lives** (compared to mothers of children with lower cognitive competence). Also, a **more positive home environment** at 24 and 36 months was associated with more cognitive competence (Luster et al., 2000). The link between a history of maltreatment during childhood and mother–infant relationship quality is mediated by adolescent mothers' **view of the relationship with their primary caretaker (usually the adolescents' mothers) in terms of warmth** (Milan et al., 2004). Adolescents who had **relationships with their mothers characterized by autonomy, mutuality, and the ability to deal with conflict non-defensively (individuation), and whose interactions with their mothers were positive and animated (positive affect) soon after the baby was born**, exhibited more nurturant behavior with their own children 6 months after the child's birth. However, other measures of the supportive quality of the mother-grandmother relationship were not predictive (Hess, Papas & Black, 2002). **Maternal support** (as perceived by the family advocate) was NOT a significant predictor of second pregnancies when other factors were	Adolescent mothers who participated in a culturally sensitive mentorship model of home visits and videotape programming to develop skills in interpreting infants' cues, nonfood methods of managing infant behavior, and **mother–grandmother negotiations** were more likely to follow the guidelines that they received from WIC and from their pediatricians on waiting to give babies solid food until they were 4-6 months old (Black et al., 2001).

Pregnant and Parenting Teens Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
	development • Clear standards about sexual behavior			controlled (Sims and Luster, 2002). A medium to large correlation was revealed between **social support by family** (defined as support by the partner and the **adolescent's mother**) and maternal-infant interaction (Clemmens, 2001). The **teen mother's mother** (or infant's father) were reported as being the **most influential in the decision to breastfeed** or their approval was associated with breastfeeding initiation (Wambach & Cole, 2000). **Reciprocal exchange of support between parents and pregnant teens** was correlated with increased mastery and life satisfaction and decreased depression and anxiety (when compared to providers [i.e., teens who were high on providing but low on receiving support], receivers [teen who were low on providing but high on receiving support], and low supporters [teens who reported low levels of providing and receiving support]) (Stevenson et al., 1999). Teen mothers who attended an alternative school drew on **caregiving** as the most significant influence on their transition to motherhood and on creating a positive mother identity in this qualitative study. Caregiving came from parents, siblings, or boyfriends, with most teens identifying their **mothers as most supportive** (Brubaker & Wright, 2006). Teen mother-infant dyads considered "high functioning" (compared to "low functioning," "average functioning" and "asynchronous functioning") reported the most **nurturing care from their own mothers during childhood** (Easterbrooks et al., 2005) Among young mothers who reported negative childhood family contexts, greater resilience in parenting (as measured by lack of substantiated child maltreatment) was associated with **LESS caregiving and emotional support from their mothers** while parenting, and **living separately from their families of origin** (Easterbrooks et al., 2010).	

Pregnant and Parenting Teens Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
Parent or caregiver well-being	• Maternal functioning • Maternal adjustment and coping • Competent parents • Positive parental norms	All articles refer to pregnant and parenting adolescents and/or their children.	Limited evidence	According to a longitudinal qualitative study, **t**een mothers who were continuously enrolled in school or who were later dropout had **parents who were more stable** than the teen mothers who were early dropouts. Also, i**ntergenerational traditions of school success** and the educational and vocational resources that accompany them on the part of the teen mother's parents (i.e., **competence of the parents** of the teen mothers) helped to keep the teen mother in school (SmithBattle, 2007). The **education level of the mother of the adolescent mother** was related to postpartum depressive symptoms of the adolescent mother (Secco et al., 2007).	
Other Supports					
Positive peers	• *Positive peer norms* • *Social support by friends* • *Friendship* • *Peer networks*	All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence	Teen mothers for whom **less than half of their friends were also teenage mothers** were less likely to have a rapid repeat pregnancy than teen mothers for whom more than half of their friends were teenage mothers (Raneri & Wiemann, 2007). Perceived **social support by friends** at pregnancy was related to reductions in depressive symptoms seven years later. Also, the effects of chronic stress on depressive symptoms (seven years later) were mediated through perceived social support by friends at pregnancy (Turner et al., 2000) At the time of their pregnancy, adolescent mother who had completed more schooling, were relatively younger, had **more perceived support from friends**, had **more support from siblings**, more empathic parenting attitudes, and somewhat lower verbal intelligence were more likely to be resilient (as measured by social and psychosocial outcomes) five year later (Weed, Keogh, & Borkowski, 2000). **Friend support** was related to prenatal infant care emotionality but was NOT related to post-partum depressive symptoms (Secco et al., 2007).	Participation in the Second Chance Club high school–based intervention for pregnant and parenting adolescents resulted in a reduction of repeat births over three years. Although not tested empirically, authors postulated that the **close daily contact with peers in the group** as well as the project coordinator was the most important factor (Key et al., 2001).

Pregnant and Parenting Teens Table 2. Protective Factor Crosswalk—Relationship Level					
Proposed Protective Factor (PF) Constructs	**Related PF Terms (from literature review)**	**Age Range/Dev. Stage**	**Summative Rating**	**Studies Reporting Significant Relationships Between Protective Factors and Youth/Family Outcomes**	**Intervention Studies Reporting Mediating, Moderating, or Direct Effects of Protective Factors on Youth/Family Outcomes**
				Friends who also had children, and thus understood that accommodations had to be made around social events, were an important source of support for teen mothers according to one qualitative study (Collins, 2010).	
Caring adult(s)	• Mentor • Pro-social models • Engagement of all adults who are important, living in home and neighborhoods, extended kin • Providing rules, parameters, monitoring, safe space • Presence and availability of mentors in the community • Support from home visitors, community center staff, and other non-kin adults	All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence	Having **"other mothers" (who guide younger members of the community, often acting as surrogate parents and mentors)** and various sources of community support may support resilience among African American teen mothers in foster care (Haight, 2009). Mothers who received **support from professionals (primarily public health nurses)** reported engaging in health promoting lifestyles more often than those who did not receive professional support (Black & Ford-Gilboe, 2004 According to this qualitative study of young, homeless pregnant and parenting women, **positive experiences with the shelter staff** facilitated critical protective processes, including a newly-developed sense of optimism about the future. By providing both nurturing, warm relationships and material support, the staff succeeded in reducing the impact of participants' chain of risks, while increasing their pro-social opportunities and feelings of self-efficacy. These growth-enhancing changes led to a turning point for the majority of the participants, as they chart new paths for themselves and their children (Kennedy et al., 2010). A study using phenomenological methods found that a positive therapeutic relationship between pregnant and parenting adolescents and their schools counselors had the following characteristics: **supporting emotional well being, respectful communication, friend and confidante who listens, being reliable, identifying goals and possibilities, and supporting academic achievement** (Slater et al., 2011).	**Intensive home visitation** by nursing para-professionals (guided by the theory of **mentorship**, and designed to improve parenting skills, health practices, and infant outcomes within an aggregate considered to be at great risk for infant mortality, low-birth weight, and child maltreatment) resulted in a reduced likelihood of low birth weight births, reduced likelihood of infant mortality, improved age-appropriate baby immunization rates, and reduced rapid repeat pregnancy (compared to national or local data for teen mothers). Also, there were limited, favorable findings for reductions in child abuse potential scores and personal distress and personal adjustment (Flynn, 1999). In a review of programs for pregnant and parenting teens, the author concluded that the "most important factor in preventing subsequent pregnancies may be the **strength of the relationship built between the teenage mother and the individual working with her**" and that "**close relationships between program staff and the teenage mother** seem to lead to success" (Klerman, 2004). A program model including **engagement strategies** such as **relentless outreach, transformational relationships,** and stage-based programming increases the likelihood that high-risk young mothers engage in and stay engaged in young parent program services (Chablani & Spinney, 2011). **Home visitation** by volunteers (which had a variety of

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		All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence		programmatic components including **mentoring and supportive relationships**) resulted in a small but significant effect on better parenting outcomes for teen parents, particularly regarding expectations of the child, role reversal and dysfunctional parent-child interactions. There were no differences in parenting stress or mental health (Barnet, et al., 2002). **Community-based home visitation** by trained home visitors (who delivered a parenting curriculum, encouraged contraceptive use, connected the teen with primary care, and promoted school continuation) had a positive impact on adolescent mothers' parenting attitudes and beliefs compared to the control group. Also, more home-visited teens than control group teens returned to school and graduated by 2 years postpartum. There was a trend toward greater consistent condom use among home-visited adolescents, but no impact on use of hormonal contraception, repeat pregnancy or birth, or depressive symptoms. Finally, at the year 2 follow-up interview, 61% of home-visited adolescents vs 44% of control adolescents reported having a regular personal doctor (Barnet, et al., 2007). Adolescent mothers who **participated in a culturally sensitive mentorship model of home visits and videotape programming** to develop skills in interpreting infants' cues, nonfood methods of managing infant behavior, and mother–grandmother negotiations were more likely to follow the guidelines that they received from WIC and from their pediatricians on waiting to give babies solid food until they were 4-6 months old (Black et al., 2001). Adding a **home visitor** component [which attempted to establish a **trusting relationship** with the teens and their families, provided information about services available in

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		All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence		the community (e.g., family planning) and the care of children, **provided emotional and instrumental support** (e.g., transportation), and encouraged the young mothers to pursue the goals of the program (e.g., high school completion and limiting further childbearing)] to an existing program for pregnant and parenting teens did NOT statistically significantly reduce chances of an early subsequent pregnancy or second birth (Sims & Luster, 2002). **Home visitation** (with the goal of to promoting maternal competency and nurturant parenting behavior) had NO demonstrable effect on the incidence of maltreatment and postpartum school return, or the prevalence of contraceptive use (Stevens-Simon, Nelligan & Kelly, 2001). Participation in the **Second Chance Club high school–based** intervention for pregnant and parenting adolescents resulted in a reduction of repeat births over three years. Program components included: (a) weekly group meetings throughout the school year focused on parenting, career planning, adolescent issues, and group support; (b) participation in school events such as a school club; (c) **individual case management and home visits**; (d) medical care for the adolescent and infant through both a linked university-based clinic as well as the school-based clinic; and (e) service projects selected by the group that provided outreach to the community and to at-risk middle school girls. Although not tested empirically, authors postulated that the **close daily contact with** peers in the group as well as the **project coordinator** was the most important factor (Key et al., 2001). **Paraprofessional home visitor services** provide only modest enhancements in the outcomes of welfare-to-work programs. However, by the end of the study period there

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					were some striking impacts on reported rates of condom use and use of passive forms of contraception that suggest the possibility that there might be future benefits for this study sample in terms of longer spacing between births (Kelsey et al., 2001).
Living with immediate family, extended family, or other kin	• Living with parent(s) while parenting • Living with two biological parents • Living with one or more biological parents • Number of other children in the home • Number of adults in the home	All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence	Teen mothers who **lived with at least one of their parents** after the birth of their first child (compared to living with a boyfriend, husband or other adult) were less likely to have a second teen birth. Living alone with the child was also associated with lower likelihood of having a second teen birth, but it was not statistically significant (Manlove, Mariner, et al., 2000). **Living with two biological parents** in 8th grade was NOT a statistically significantly predictor of second teen birth or second birth within 24 months for teen mothers (Manlove, Mariner, et al., 2000). Latina adolescent mothers **living with their mothers** had higher self-esteem than those who did not, regardless of language background. There was a significant interaction such that English-speaking and bilingual girls who lived with their mothers were less depressed than those who did not. For Spanish speakers only, living with one's mother was associated with higher educational attainment (Nadeem et al., 2006). Adolescent mothers were less likely to possess some form of depression if there were **two or more adults living in the home** (compared to adolescents with only one adult living in the home). Adolescent mothers were less likely to possess some form of depression if there were fewer children living in the home, compared to adolescent mothers who had more children living in their home (Lanzi et al., 2009). Among young mothers who reported negative childhood family contexts, greater resilience in parenting (as measured by lack of substantiated child maltreatment) was associated with less caregiving and emotional support from their mothers while parenting, and **living *separately* from their**	

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				families of origin (Easterbrooks et al., 2010).	
Supportive romantic (or dating) relationship	• *Age appropriate boyfriends* • *Partner's willingness to used contraception* • *Partner connectedness* • *Emotional commitment* • *Partner communication* • *Marriage*	All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	**Marriage history** was NOT a statistically significant predictor of a second teen birth or a second birth within 24 months for teen mothers (Manlove, Mariner, et al., 2000). Having a **supportive romantic relationship during pregnancy** may counteract the impact of a history of maltreatment on mother–infant relationship difficulty because such relationships are associated with less overall negative feelings about motherhood, even among those with a maltreatment history (Milan et al., 2004). **Marital status** was NOT significant in predicting depression in teen mothers when babies were 14 months and 36 months old (Eshbaugh et al., 2006). A medium to large correlation was revealed between **social support by family** (defined as **support by the partner** and the adolescent's mother) and maternal-infant interaction (Clemmens, 2001). The teen mother's mother or **infant's father** were reported as being the **most influential in the decision to breastfeed** or their approval was associated with breastfeeding initiation (Wambach & Cole, 2000). According to this qualitative study, mentors, family and **partner support**, spirituality**,** optimism, and economic opportunity were factors that increased the chance of a young mother to achieve financial independence and academic prestige (as measured by achieving a master's or doctoral degree) in the future (Perrin & Dorman, 2003). **Relationship support** was a positive indicator of school retention for all the rural, pregnant and parenting Hispanic teens in the hermeneutic qualitative study. The importance of strong, supportive relationships with the participants' family members, the **father of the baby**, and teachers were common among all 12 participants (Estrada, 2012).	

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		All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	A **high quality relationship with a significant other** was associated with increased self-esteem among pregnant teens dating the father of their child. However, the well-being of pregnant adolescents did not differ among teens dating the father of their child, dating someone other than the father, or those without a significant other (Stevenson et al., 1999). In one study of pregnant and parenting teens in an alternative school, the **sources of support** regarded as most helpful in trying to reach their educational goals were their **husband or boyfriend**, parents of the participant, teachers, babysitter or daycare, and the school nurse, in order from most helpful to less helpful (Brosh, Weigel & Evans, 2007). Compared to “low functioning” dyads, “average functioning” dyads, and “average parenting/disengaged infant” dyads, the "high-functioning" infant-mother dyad was the only one of the four groups that included **married teen mothers** (though a low percentage) (Easterbrooks et al., 2005). Being **married at the time of the teen birth** decreased likelihood of depression in early adulthood (Kalil & Kunz, 2002). One qualitative study concluded **that practical and emotional support from partners** was a source of resiliency among teen mothers (Collins, 2010). **Living with the father of the child or another male partner** was associated with more cognitive competence for the 54-month-old children of teen mothers (Luster et al., 2000).	

Social support in general (not specified by whom)	• *actual provision of financial, emotional or informational support from a network member (e.g., mother, father, other family members, boyfriend/partner/spouse, friends, and persons in community agencies)* • *social support by family, friends and significant others*	All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	The **level of support** seen by young mothers that exists in the months prior to the birth of their babies is similar to the support they will receive when their babies are in early infancy. Both when pregnant and when her baby was 6-months-old, **social support** was negatively related to stress when measured concurrently. That is, social support appears to reduce stress right away (Devereux et al., 2009). Higher measures of **social support** (as measured by a 12-item inventory that measures support by family, friends and significant other) in the third trimester or shortly after the birth was related to a reduction in child abuse potential scores at 6 months among teen mothers. However, social support scores were not statistically significantly related to other studied outcomes such as parenting stress, child developmental level quotient, and mother's school status (Whitson et al., 2011). **Social support by family, friends and significant others** (measured together) moderated the relationship between internalizing behavior problems and self esteem and between externalizing behavior problems and self-esteem (i.e., social support was found to serve as a protective factor for pregnant and parenting adolescents' self-esteem when they were experiencing behavior problems). Social support was a mediator in the relationship between ethnic identity and internalizing behavior problems and a partial mediator in the relationship between ethnic identity and self-esteem (Sieger & Renk, 2007). There was a negative relationship between depression and **social support** and between loneliness and social support. There was a positive relationship between self-esteem and social support (Hudson et al., 2000). A medium to large correlation was revealed between **social support by family** (defined as support by the partner and the adolescent's mother) and maternal interaction (Clemmens, 2001). **Family support** was significantly related to infant care emotionality and postpartum depressive symptoms (PDS) but was not a significant predictor of PDS (Secco et al., 2007) Adolescent mothers in a home visiting programs were more likely to be in compliance with the home visit schedule if they had a **relative, friend or father of the baby participate** with them (Stevens-Simon, Nelligan &	

		All articles refer to pregnant and parenting adolescents and/or their children.	Moderate Evidence	Kelly, 2001) **Social support** was strongly related to concurrent parenting stress among adolescent mothers in foster care. However, social support at time 1 was NOT related to parenting stress approximately two years later (Budd et al., 2006). **Higher levels of satisfaction with social support** was associated with lower child abuse potential scores for teen mothers who were wards of the state (Budd et al., 2000). According to this qualitative study, mentors, **family and partner support**, spirituality**,** optimism, and economic opportunity were factors that increased the chance of a young mother to achieve financial independence and academic prestige (as measured by achieving a master's or doctoral degree) in the future (Perrin & Dorman, 2003). A literature review found that despite the variety of definitions and measuring instruments, **receiving adequate social support** has been associated with a number of important outcomes for both the adolescent and her baby, including adolescent well-being, attachment to infant, complications of pregnancy, depression, length of pregnancy, birth weight, mastery and life satisfaction, maternal adjustment, prevention of child abuse, and school dropout (Logsdon, 2002). Mother's **satisfaction with support received** (from parent(s), boyfriends, professionals, and friends) was moderately related to health work (Black & Ford-Gilboe, 2004). Abused pregnant adolescents with **higher levels of social support (from family and shelter)** had better infant birth weight outcomes than abused adolescent with lower levels of social support. This interaction provides evidence that social support buffers the effects of abuse (Renker, 1999).	

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Community Characteristics					
Supportive school environment	• Perceived safety at school • Prosocial relationships with teachers • Positive school environment • Effective classroom management • High levels of school engagement • Positive school environment • Effective, specialized programming in school	All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence	Teen mothers who were **continuously engaged in school** had a reduced risk of second teen birth (compared to dropping out prior to first pregnancy and to dropping out after first pregnancy) and a second birth within 24 months (compared to dropping out prior to first pregnancy and to dropping out after first pregnancy) (Manlove, Mariner, et al., 2000). Being **enrolled in a gifted class** in 8th grade reduced the likelihood that a teen mother will have a second teen birth (Manlove, Mariner, et al., 2000). One hermeneutic phenomenology study of rural Hispanic pregnant and parenting teens found **having caring and helpful educators that encouraged the young mothers to keep going was part of their success in school** (Estrada, 2012). According to this longitudinal qualitative study, **schools** can reengage teen mothers and support their new aspirations as long as the teen mother's needs for child care, housing, and economic stability are also addressed by families or community resources (SmithBattle, 2007). Pregnant and mothering adolescents attending alternative schools generally agreed that the **alternative school staff support** is critical in helping them get their degrees according to one study. Adolescent mothers who assigned more importance to sources of support directly related to the educational system had higher educational goals than mothers who assigned more importance to sources not related to the educational system, but instead tied to the husband or boyfriend relationship (Brosh, Weigel & Evans, 2007). A qualitative study concluded that a **special teen parent unit in**	Participation in the **Second Chance Club high school–based** intervention for pregnant and parenting adolescents resulted in a reduction of repeat births over three. Program components included: (a) weekly group meetings throughout the school year focused on parenting, career planning, adolescent issues, and group support; (b) participation in school events such as a school club; (c) individual case management and home visits; (d) medical care for the adolescent and infant through both a linked university-based clinic as well as the school-based clinic; and (e) service projects selected by the group that provided outreach to the community and to at-risk middle school girls. Although not tested empirically, authors postulated that the close daily contact with peers in the group as well as the project coordinator was the most important factor (Key et al., 2001).

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				school provided a source of support and help in gaining access to higher education (Collins, 2010). Providing **programs that support adolescent mothers in the school setting** increases the chances that they will remain in school (Sparks, 2010). A study using phenomenological methods found that a **positive therapeutic relationship between pregnant and parenting adolescents and their schools counselors** had the following characteristics: **supporting emotional well being, respectful communication, friend and confidante who listens, being reliable, identifying goals and possibilities, and supporting academic achievement** (Slater et al., 2011).	
Positive community environment	• Collective efficacy • Caring community • Informal social control • Faith/spiritual organizations • Shared perception of safe, continuous community • Safe spaces and activities • Recreational opportunities • Neighborhood cohesion • Positive community norms	All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence	**Participation in a religious organization at school** was NOT associated with a statistically significant decrease in probability of second teen pregnancy or second pregnancy within 24 months for teen mothers (Manlove, Mariner, et al., 2000). **Living in a safer and higher quality neighborhood** was associated with higher cognitive competence among the 54-month children of teen mothers (the study compared children who scored in the top quartile to children who scored in the bottom quartile of the Peabody Picture Vocabulary Test) (Luster et al., 2000). Adolescents who were **exposed to more breastfeeding role models** were more likely to choose to breastfeed (Wambach & Cole, 2000). **Neighborhood quality** was reasonably good for "high functioning" infant-mother dyads (compared to "low functioning" and "average functioning") (Easterbrooks et al., 2005). Having **"other mothers" (who guide younger members of the**	

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				community, often acting as surrogate parents and mentors) and **various sources of community support** may support resilience among African American teen mothers in foster care (Haight, 2009). A meta-analysis found a medium-to-large correlation between social network support (defined as **support from a composite network of friends and community**) and maternal-infant interaction (Clemmens, 2001).	
Access to support services and resources	• Culturally appropriate staff • Use of effective counseling services (e.g., CBT) • Mental health and substance abuse treatment • Drop in center • Referrals to education, employment, housing, and other opportunities and resources • Formal and informal community resources • Access to supportive childcare • Access to health care and social	All articles refer to pregnant and parenting adolescents and/or their children.	Limited Evidence	**Child care arrangements** were NOT a statistically significant predictor of a second teen birth or a second birth within 24 months for teen mothers (Manlove, Mariner, et al., 2000). **Health care providers** were cited as **sources of encouragement**, discouragement, or influence in the decision to breastfeed among adolescent mothers, although to a lesser extent than the mother or partner (Wambach & Cole, 2000). Mothers who received **support from professionals (primarily public health nurses)** reported engaging in health promoting lifestyles as adults more often than those who did not receive professional support (Black & Ford-Gilboe, 2004). According to this qualitative study of homeless pregnant and parenting women, **homeless shelter staff** facilitated critical protective processes as they transitioned to adulthood. The development of a positive, caring relationship with staff was the foundation upon which all other work rested. **Provision of critical material supports** (e.g., GED classes and preparation books, vocational training, bus tokens, internship opportunities, clothing, Section 8 help, funds for the rental deposit, and furnishings for their first apartment) not only helps the participants by interrupting negative risk chains, but also offers their children a future with greater opportunities and fewer risks (Kennedy et al., 2010).	

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	services			Pregnant teens with **appropriate prenatal care** were more likely to have positive birth weight outcomes for their babies than teens with inappropriate prenatal care (Renker, 1999).	
Economic opportunities	• Economic supports • Employment opportunities • Promote economic self-sufficiency • Presence of concrete support services (such as food stamps) • Socioeconomic status (SES)	All articles refer to pregnant and parenting adolescents and/or their children.	Strong Evidence	Children of teen mothers who were most cognitively competent at 54 months old were more likely to have **mothers who were employed** (compared to children who scored in the bottom quartile) (Luster et al., 2000). Adolescent mothers with **higher household incomes** were more likely to follow the guidelines that they received from WIC and from their pediatricians on waiting to give babies solid food until they were 4-6 months old, although **employment status** was NOT a predictor variable (Black et al., 2001). Teen mothers who were **employed or enrolled in classes, in an apprenticeship or training program or in the military** after the equivalent of the 12th grade had a lower risk of either a second teen birth or a closely spaced second birth (Manlove, Marina, et al., 2000). **Poverty** (as measured by family poverty status) was NOT significantly associated with a subsequent birth among teen mothers (Shearer, et al., 2002). Teen mothers with a higher level of **self-perceived resources** [i.e., teen mother's perception of available resources such as money, basic needs (e.g., enough clothes for your family), time for self (e.g., time to get enough rest or sleep), and time for family (e.g., time to be with your child/children)] were less depressed than were other teen mothers when their babies were 14 and 36 months old. **Income** was unrelated to depression among teen mothers (Eshbaugh et al., 2006). According to this qualitative study, mentors, family and partner	A review of programs for adolescent mothers found that **offering modest financial incentives** to young people for avoiding pregnancy was NOT associated with a reduction in pregnancy (Klerman, 2004).

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		All articles refer to pregnant and parenting adolescents and/or their children	Strong Evidence	support, spirituality**,** optimism, and **economic opportunity** (as defined by school loans and grants, Social Security, Medicaid, AFDC, rent assistance, day care, $ from family, $ from paid work) were factors that increased the chance of a young mother to achieve financial independence and academic prestige (as measured by achieving a master's or doctoral degree) in the future (Perrin & Dorman, 2003). **Mothers who were employed** reported engaging in health promoting lifestyle practices more frequently in adulthood than did their unemployed counterparts (Black & Ford-Gilboe 2004). **Higher family SES** did was NOT associated with postponing a second birth within the teen years or with 24 months for teen mothers (Manlove, Mariner, et al. 2000). **SES** (as measured by the education of the mother of the adolescent mother) was related to postpartum depressive symptoms (Secco et al., 2007). A meta-analysis of programs for pregnant and parenting teens found that intervention programs appear to be more effective in preventing second teenage pregnancies among **high SES teens** than among low SES teens (Corcoran & Pillai, 2007).	
Social capital	• Social networks • Extended community networks	All articles refer to pregnant and parenting adolescents and/or their children.	Emerging Evidence	Among young mothers who reported high ecological risks, greater resilience in parenting was associated with **higher frequency of social contacts with their broader social networks** (Easterbrooks et al., 2010). A meta-analysis found a medium-to-large correlation between **social network support** (defined as support from a composite network of friends and community) and maternal-infant interaction (Clemmens, 2001).	

Rating Instrument for Summative Ratings

Emerging Evidence: Preponderance of findings generated by cross-sectional studies, case studies, or qualitative investigations with non-representative samples.

Limited Evidence: Preponderance of findings generated by a single longitudinal study (significant findings with small, medium, or large effect sizes).

Moderate Evidence: Consistent findings that are generated by two or more longitudinal studies (significant findings with small, medium, or large effect sizes).

Strong Evidence: Findings generated from one or more experimental or well conducted quasi-experimental studies that demonstrate a significant effect on a protective factor and an outcome (e.g., findings demonstrate that the experimental effect on an outcome is mediated by the effect of a protective factor).