Families at risk and the role of the care system

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Chapter 1

Introduction

This thesis focuses on the role of the family, especially parents, in the development of adolescents – both adaptive and maladaptive. First, the relevant theories of adolescent development are introduced. Next, the role of the family as a potential facilitator of and barrier to the development of adolescents is discussed. Thereafter, we focus on theories describing and explaining how the family, more specifically family-related adversities, can affect the development of adolescents. As adolescents with an adverse family background often enter the psychosocial care system, in the next part we focus on the description of this system, first in general and then specifically in Slovakia. We then address the role played by the family, particularly by parents, in the system of psychosocial care. Finally, we briefly describe the main professionals working in the system of psychosocial care for adolescents.

1.1 Psychosocial development in adolescence

Adolescence is a period of various significant psychosocial changes within human development. It is a crucial period for adopting health-related behaviour in areas such as substance use, sexual behaviour, healthy eating, exercising, and management of chronic diseases (Viner et al., 2012). Moreover, adolescence is a stage in life when various emotional and behavioural problems start to occur (Ormel et al., 2015), namely social and generalised anxieties, major depression and eating disorders (Rapee et al., 2019). As all humans develop in different contexts, it is important to understand how these contexts contribute and affect psychosocial development. In line with the aim of this thesis, in the following sections we introduce relevant theories explaining psychosocial development in adolescence.

1.1.1 Relational developmental system theories

Relational developmental system theories (RDST) emphasise that mutual influencing processes between developing individuals and different levels of their environment represent the basis of human development. These bidirectional interactions between an individual and the environment are the core unit of the human development analysis from the RDST perspective (Geldhof et al., 2014). RDST includes various models and theories of development, including positive youth development (PYD)

(discussed in the next section). These have several common characteristics (Lerner, 2007): a.) rejection of a split between components of the ecology of human development; the reductionist division is replaced by systemic syntheses and integration; b.) integration of levels of organisation (from biological and physiological through cultural and historical); c.) the assumption that regulation of development occurs among all levels of developmental systems; d.) the assumption of bidirectional relations between an individual and his/her context are the basic unit of analysis within human development; e.) an important feature of human development is its potential for systematic change, called plasticity; f.) plasticity at the individual and contextual levels is the fundamental strength of human development, but it is not limitless and depends on developmental regulations that may facilitate or constrain opportunities for change; g.) due to the combination of variables across levels of organisation, the developmental process may vary across individuals and groups; a study of diversity is fundamental for the description, explanation and optimalisation of human development; h.) an optimistic perception of human development and search for characteristics in individuals and their context that can be arrayed to promote positive human development; i.) a developmental system involving various levels of organisation requires cooperation between scholars from multiple disciplines and change-sensitive methodologies. To sum up, RDST understand the development of the individual as an interaction between various contexts – from the biological to the societal one. Development is not just a process taking place in the individual, but it is affected by many different factors on all levels of the environment.

1.1.2 Positive youth development theory

The theory of Positive youth development (PYD) is based on the relational developmental system theory (RDST), which considers plasticity as a key principle and the essential strength of development during the whole life (Overton, 2011; Lerner & Overton, 2008). One of the main ideas of PYD is that all young people have a capacity for positive development and that the trajectory of PYD is activated when adolescents are involved in relationships, contexts and environments that facilitate their development (Benson et al., 2006). This idea was supported by Kwong & Hayes (2017), who showed that even children who experienced three or more adverse experiences can flourish when they are involved in other beneficial relationships outside of their family.

The important part of PYD is the identification of developmental assets that are derived from an ecological perspective on human development (e.g., Benson, 1997; Scales et al., 2000). These are strengths in the individual and the environmental resources needed for successful development. The Search Institute in Minneapolis (1997) divided them

into external (support, empowerment, boundaries and expectations, constructive use of time) and internal (commitment to learning, positive values, social competencies, positive identity) assets. Next, Lerner, a prominent researcher in the area of PYD, brought in the concept of 5C (e.g., Lerner et al., 2005), which stands for the five domains of PYD: competence, confidence, connection, character and caring. *Competence* covers interpersonal skills (social competence), cognitive abilities (cognitive competence), school performance (academic competence), work habits and career choice (vocational competence); *confidence* means an internal sense of self-worth and self-efficacy; *connection* involves positive relationships with other people and institutions; *character* covers accepting rules, morality and integrity, and finally, *caring* represents empathy for other people (Lerner, 2004; Roth & Brooks-Gunn, 2003). Developments in all these domains result in the thriving of an adolescent. When the adolescent is well-developed in all these domains, the sixth 'C' – *contribution* – occurs (Geldof et al., 2014). Moreover, research has shown that thriving in adolescents is negatively correlated with risky health-related or delinquent behaviour (Lerner et al., 2010).

1.2 The role of the family in the psychosocial development of adolescents

1.2.1 Family as a facilitator of or barrier to healthy development

Within the PYD theory parents are considered to be among the major ecological assets. Research has supported this idea, e.g., Bowers et al. (2011) and Theokas & Lerner (2006) showed that family assets (mother's education, household income, family dinners and number of adults) were the most important factor contributing to the positive development of adolescents. Next, Youngblade et al. (2017) revealed that positive family characteristics (family engagement and family closeness) were related to adolescent social competence and self-esteem, and family communication, rules, and parents' own healthy behaviour were related to adolescent health-promoting behaviour. Moreover, parents had a crucial role in the application of life skills (e.g., goal setting, seeking from help from others, managing emotions etc.) learned in a sports-based life skills programme (Hodge et al., 2017). The family plays a significant role in many other aspects of psychosocial development of adolescents, e.g., building a sense of competence (Schunk & Meece 2006) and social competence (McDowell & Parke, 2009), building relationships (Christensen & Brooks, 2001; Crockett & Randall, 2006; Seiffge-Krenke et al., 2001), development of values (Smetana, 1999) and pro-environmental behaviours (Jia & Hui, 2021).

1.2.2 Family-related adversities and their consequences on adolescent development

Besides the facilitating role of the family on development, the family can also endanger an adolescent's healthy development. Various factors in the family may be considered as obstacles to the healthy psychosocial development of an adolescent, such as low socioeconomic status and living in poverty (e.g., Leventhal & Brook-Gunn, 2000; Santiago et al., 2011) or living in foster care (e.g., Bruskas, 2008), but in this thesis we discuss specifically the effect of family-related adversities on the psychosocial development of adolescents. The more frequent and more general term (than family-related adversities) that can be found in the literature is adverse childhood experiences (ACE), which represent events potentially traumatic for further development and with negative and lasting effects on health and well-being (Boullier & Blair, 2018). Probably the most extensive study on such adverse experiences was the CDC-Kaiser ACE Study (for further information, please see Felitti et al., 1998), which showed that ACE are common in the population, as almost two-thirds of respondents reported at least one adverse event in their life. Moreover, the study proposed a mechanism for how these events affect further development (Figure 1.1). This figure describes how ACE have a detrimental effect on neurodevelopment and how this results in social, emotional and cognitive impairment. Due to this impairment, the adoption of health risk behaviour in children experiencing adverse experiences is more probable. Health risk behaviour can then result in disease, disability or other social problems, and in the final stage, early death can occur.

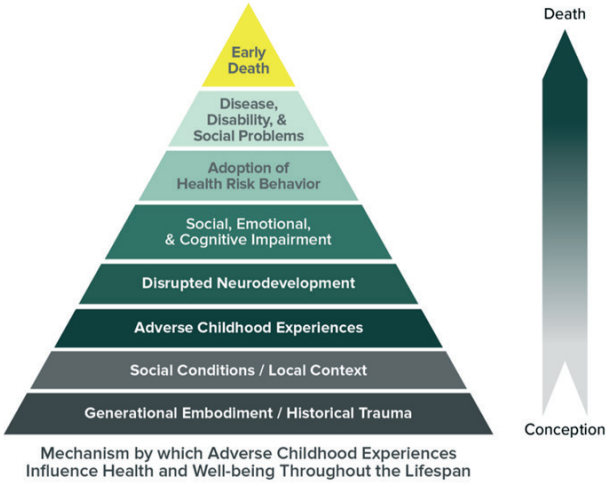

Figure 1.1 The ACE Pyramid: The mechanism by which ACE influence health and well-being throughout the lifespan. (CDC-Kaiser ACE Study, 1995-1997)

In our study we focus on traumatic events that are rooted in the family environment and that in particular are connected to parents as the primary caregivers. We understand family-related adversities as a cumulative risk due to negative events in the family, such as parental divorce, parental addiction, residential moves and parental illness, which undermine the stability of family life (Forman & Davies, 2003). Research has shown that family adversities such as violence, substances abuse, divorce or separation were found to be connected with a wide range of adverse outcomes. Examples could be experiencing anger, hostility, irritability, anxiety and depression (Reddy, 2009; Wolff & Baglivio, 2017), symptoms of psychological distress (Boyes, Hasking & Martin, 2016) and hopelessness (Haatainen et al., 2003), risk-taking behaviour (Alati et al., 2014; Bair-Merrit et al., 2006) and emotional and behavioural problems (Bakker et al., 2011; Theunissen et al., 2017). Moreover, research has shown that experiencing these adversities is deleterious for developing in areas discussed within PYD theory, such as self-esteem (Rangarajan & Kelly, 2006; Matsuura, Hashimoto & Toichi, 2009; Reddy, 2009; Yen et al., 2013), social competence (Hussong et al., 2005) and social skills (Neher & Short, 1998). Other research has confirmed the detrimental effects of adverse experiences in childhood and adolescence persisting into adulthood, e.g., the effect of maternal drinking on an offspring's alcohol use disorders (Pirkola et al., 2005), binge drinking in women (Timko et al., 2008), obsessive-compulsive disorder, generalised anxiety disorder and somatoform disorder (Park et al., 2014) or bipolar disorder (Park et al., 2020).

Considering the wide range of negative effects mentioned above, it is not surprising that living in an environment affected by adverse events also has consequences for different types of care utilisation. Research on this topic is scarce, but the few reports published show that experiencing ACE was associated with economic issues, higher adult health care utilisation (Chartier et al., 2010) and higher annual health care use and costs (Bonomi et al., 2008). Regarding children and adolescents and their use of health care services, research has shown that children and adolescents experiencing adversity had higher odds of receiving non-mental health specialist care, but also a higher unmet need of specialist care (Bloom et al., 2019). Regarding the use of psychosocial care in adolescents coming from an adverse family environment, research is even scarcer. We can find some overlap between ACE (especially these connected to family environment) and multi-problem families. Some evidence derived from research on multi-problem families shows that these families have problems in several areas of life, including poverty and psychosocial problems (Tausenfreund et al., 2014). Children and parents coming from such families are usually multi-users of psychosocial care (Goerge et al., 2010; Pannebakker et al., 2018). We will discuss the psychosocial care for adolescents in the section 1.3 of Introduction in more detail.

1.2.3 Selected theories explaining the influence of the family on adolescents' psychosocial development

Various theories have tried to explain the mechanism of the influence of family on the development of children or adolescents. One of them, the Social learning theory (Bandura & Walters, 1977) and its revision known as the Social cognitive theory (Bandura, 1986), claims that parents serve as role models for different types of behaviour and via observational learning, behavioural modelling and reinforcement children learn how to behave in various situations from their parents. The Social learning theory was mostly discussed in the context of the learning of violent behaviour in children (e.g., Bandura, 1978) but also in the context of other developmental outcomes, such as alcohol use by adolescents (Trujillo et al., 2015).

Observational learning is also one of the ways that children learn about emotional regulation from their parents in the Tripartite model of the impact of the family on children's emotional regulation and adjustment (Morris et al., 2007, see Figure 1.2). Morris et al. (2007) concluded that family affects emotional regulation (and in turn adjustment of children) in three important ways. The first is the process of observational learning; through this process children learn how their parents express and communicate their emotions, which emotions are allowed and which are denied, etc. The second is parenting practices and behaviours of parents related to the socialisation of emotion. The third factor is the emotional climate in the family represented by the quality of parent-child relationship, parenting styles, expressiveness and the emotional quality of relationship between parents. Although according to this model these family factors have direct effects on children's adjustment, these effects are mostly mediated by children's emotional regulation, as explained by other research (Eisenberg et al., 2003). All of these relationships are bidirectional, which means that parents and their children mutually influence each other. Additionally, the parents' and children's own characteristics (such as reactivity, mental health) also play an important role.

The last theory important to mention is the Complex trauma theory. Complex trauma in children or adolescents is a result of repetitive exposure to severe stressors in the caregiving system – from persons who should be sources of security, protection and stability. Moreover, as complex trauma often occurs within the caregiver system, the consequence is a disruption of the sense of self, an experiencing of anxiety and the expectation that the world is unsafe and chaotic. The latter can in turn lead to the violation of relationships with others (Courtois & Ford, 2009; Cook et al., 2017). Complex trauma events include physical, sexual and the emotional abuse of children, as well as neglect, witnessing domestic violence, exposure to community violence, and medical trauma

(Kliethermes et al., 2014). Symptoms of complex trauma include affective and behavioural dysregulation, but also disturbances of attention, cognition, and information processing and interpersonal relationships (Kliethermes et al., 2014). Moreover, many of children or adolescents who experienced complex trauma are included in the Child welfare system (Kisiel et al., 2009).

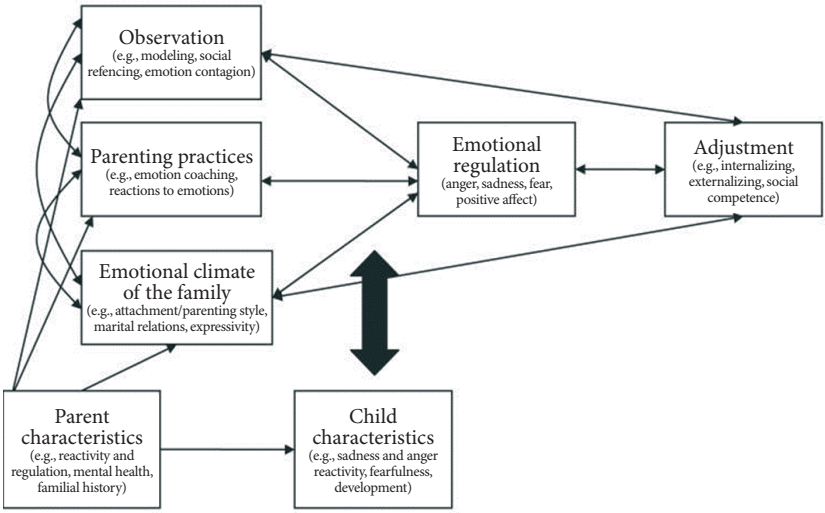

Figure 1.2 Tripartite model of the impact of the family on children's emotional regulation and adjustment (Morris et al., 2007)

1.3 The system of psychosocial care for adolescents

The system of psychosocial care for adolescents in Europe differs somewhat across countries; however, in this section we would like to describe its general common characteristics. For the purpose of this section and for clearer and easier understanding of this system, we divided it into a child and adolescent mental health care system and a child and adolescent social care system.

1.3.1 System of mental health care for children and adolescents in European countries

The organisation of child and adolescent mental health care is heterogeneous in various aspects across European countries. The review by Remschmidt & Belfler (2005) attempted to provide an overview of this system. They concluded that child and adolescent mental health care systems in Europe relate to the development of child and adolescent

psychiatry as a medical specialty and that its roots can be found first in several medical disciplines, such as neurology, psychiatry and paediatrics, and second, in psychology. They also identified four types of mental health care services available in most European countries (Table 1.1).

Table 1.1 Types of mental health care services for children and adolescents available in most European countries, and services offered per type (Remschmidt & Befler, 2005)

Type of service	*Services offered*
Outpatient services	Child and adolescent psychiatrists in private practice Analytical child and adolescent psychotherapists in private practice Outpatient departments at hospitals Child psychiatric services at public health agencies Child guidance clinics and family counselling services Early intervention centres, social paediatric services
Day patient services	Day patient clinics Night clinic treatment facilities
Inpatient services	Inpatient services at university hospitals Inpatient services at psychiatric state hospitals Inpatient services at general community hospitals or paediatric hospitals
Complementary services	Rehabilitation services for special groups Different types of residences Residential groups for adolescents

1.3.2 Social services for children and adolescents in Europe

Like mental health care services, social services differ across European countries. Munday (2003) discussed four different models of social services occurring in European countries. The first of them, *the Scandinavian model of public services*, brings services for vulnerable groups, children at risk included, that are paid from general taxation. In the planning and production of these, local government plays a key role, with limited contributions of non-governmental organisations and for-profit organisations. An advantage of this model is a good range and quantity of services, sensitivity to gender issues and paying attention to clients' rights. Second is *the Family care model*, which is characterised by limited state provision of services and an emphasis on the Catholic tradition, where the family – especially women – is responsible for the care of its members. A well-established non-governmental organisation provides social services, and wealthy people use commercial services. Third, *the Beveridge model*, is characterised by state's retreat from its traditional role of direct service provision and targeting services on the most dependent clients. Non-governmental organisations and for-profit services play an important role in this model. Last, *the Northern European subsidiarity model (the Bismarck model)*, is characterised by the provision of social services by non-governmental organisations that are financed by the state.

1.3.3 The Slovak system of psychosocial care: preventive counselling, social and mental health care

The system of social services in Slovakia can to some extent be described as a Family care model of social services. There are no specific institutions aimed only at adolescents facing mental health problems, but these adolescents can receive care from various institutions, depending on various factors, such as the seriousness of the problem, which person recognised the problem in the adolescent, which professional is easy to reach and trusted by the parents, and whether the family is willing to cooperate or not, etc. The Slovak system of psychosocial care has been explored in the Care4Youth study by Dankulincova et al. (2020), and the description below is based on the findings of this study. The system of psychosocial care for adolescents in Slovakia consists of different institutions and professionals that can be divided into three groups: preventive–counselling care, social care and mental health care. These three categories are described in more detail in the following paragraphs.

Preventive–counselling care is organised predominantly by the Ministry of Education, Science, Research and Sport. This type of care primarily solves problems in adolescents that are associated with the school environment, and these problems are usually a stimulus for entry into the psychosocial care system. The following institutions are included in this type of the care. First, schools, where teachers, school psychologists, educational counsellors and in some school pedagogists for children with special needs have special competencies to help children with their problems; they are usually the first people who can notice the problem and solve it or send an adolescent to another professional or institution. Second, centres of pedagogical-psychological counselling and prevention, where complex care, including psychological care, diagnostics, educational, counselling care and pedagogical care for children with learning disabilities, should be provided. Third, centres of special pedagogical counselling, where complex care, including special-pedagogical, psychological, counselling care and diagnostics, rehabilitation and prevention, should be provided for children with disabilities, including developmental disorders. Another institution included in this type of care is the therapeutic-educational sanatorium, which provides psychological and therapeutic care and education for children and adolescents with learning disabilities and activity and attention disorders. A last type of institution that provides this type of care is the re-educational centre, which is an institution providing education and re-educational programmes for children and adolescents with the aim of reintegrating them into their original social environment. The last two mentioned centres provide only inpatient care, and adolescents may be placed in them at the request of parents or on the basis of a court decision.

The second type, *social care*, is predominantly organised by the Ministry of Labour, Social Affairs and Family, but it also includes non-profit organisations that are used to collaborating with state institutions. First, the Office of social and legal protection of children and the Office of social curator are involved in this type of care. These offices are decentralised parts of the Office of Labour, Social Affairs and Family. As defined by law, they are supposed to prevent crisis in families, protect the rights and interests of children, and prevent a deepening and repeating of disorders of healthy development, including mental, physical and social areas of development. Next, professionals from the national project of deinstitutionalisation can provide care for adolescents. Professionals in this project are closely linked to the Office of Labour, Social Affairs and Family and they work with families sent by the Office. These professionals are social workers and psychologists who provide services of the outpatient care for children and adolescents and also work with families. The main aim of their work is to support the family environment and prevent removal of a child from the family. The last type of institutions in this social care system are non-profit organisations working with families. These institutions provide a broad range of services depending on the accreditation they received. These services usually include social counselling, social work with families in difficult situations (such as low-income families, families in divorce, families with children with different problems, such as EBP, etc.). These non-profit organisations are also used to work with families on the request of the Office of Labour, Social Affairs and Family.

The third type of providers, *mental health care*, is predominantly organised by the Ministry of Health. This type of care includes outpatient clinics of clinical psychologists for children which provide diagnostics, therapy, counselling and prevention. Further, it includes child psychiatrists whose services involve outpatient care for children and adolescents, including pharmacotherapy and treatment of psychological difficulties and disorders. Third, psychiatric hospitals, which are primarily used to treat acute conditions, and psychiatric sanatoriums, where long-term inpatient care is provided, belong to this type of care. The last institution in this type of care is a psychosocial centre, which provides a broad spectre of services, such as social counselling, psychological counselling, therapy and psychiatric care for children and adults. This type of centre also provides outpatient care.

1.3.4 Main discourses shaping the care for children and adolescents

To understand which roles, positions and practices professionals in their practice adapt to, it is important to gain insight into the discourses that shape the psychosocial care for adolescents. By discourse we mean the sets of statements constructing objects (in this case psychosocial care)

and arraying the subject position (of these who speak about objects) that facilitate or limit what can be said, by whom and when (Parker, 1992; Parker 1994). In other words, how professionals, academics and researchers think, talk and write about psychosocial problems and the care aimed at treating them shape how society perceive them and which practices or approaches are established within psychosocial care. Therefore, it is expected that discourses about psychosocial care for adolescents affect the daily practice of professionals working with these adolescents.

The most important discourse shaping mental health care is the biomedical discourse (Jørgensen et al., 2020; Zeeman & Simons, 2011). This discourse allows professionals to adopt a position of power (Kent et al., 2020) and authority with the ability to make decisions about patients, and it relates to phenomena such as objectification of patients (Ziółkowska, 2012). In addition to the strict biomedical discourse, we can find the biopsychosocial discourse based on the model of Engel (1977), which considers biological, psychological and social factors that are interrelated and affect mental health of the individual. Moreover, the psychotherapeutic discourse, highlighting the importance of psychotherapeutic relationship between professional and client (Shirk et al., 2011; Karver et al., 2008), also occurs in mental health care.

In social care we can observe a discourse of neo-liberalism, holding clients responsible – that is, the responsibility for the client's well-being is placed on the individual. Moreover, the motivation to change or the reluctance to change are attributed to the clients, while little or no responsibility is attributed to social services (Liebenberg et al., 2015). Moreover, especially in social care services, a discourse of the protection of the child exists (e.g., Hanson, 2012); this appears to decrease the participation of child in the care system (e.g., van Bijleveld et al., 2015). This points to another important discourse shaping the care for adolescents – children rights – which are not always properly included in social care. For example, Heimer et al. (2018) found that providers of social services tend to listen more to the parents and make therapeutical alliance with them more than with children. They concluded that there is a need to perceive the child as a bearer of rights and, in line with this perspective, invite and support the child to participate in his/her own care.

Incorporating children's rights into care brought us to another important rising discourse – the discourse of patient-centred care for children and adolescents – which has been has recognised (Kongerslev & Storebø, 2017) and the positive outcomes of which have been revealed (Kapp et al., 2017). From the adolescents' perspective, being listened to by a professional is the most important factor for adolescents in health care (Bernsted et al., 2015), and research has shown that the involvement of adolescents in the decision-making process was a significant factor for positive care outcomes (Day, 2008). However, children and adolescents

experience poor engagement and involvement in the design of mental health services (Fusar-Poli, 2019) and therefore the training in shared-decision making is highly recommended for professionals working with adolescents (Coppens et al., 2015).

1.4 The role of the family in the psychosocial care of adolescents

As adolescents cannot make decisions about their health on their own until they are legally responsible for themselves, parents play a crucial role in the whole process of providing psychosocial care to their children. The provision of care starts with the ability of parents to recognise problems and access the care system, through the willingness to cooperate and adhere to the treatment until the outcomes of the care. In this section we will describe the role of parents in different steps of the care process.

1.4.1 The role of parents in help-seeking behaviour

Parents have an important role in recognising the problems of their children (Glascoe & Dworkin, 1995) and their uncertainty or inability to recognise the seriousness of the problem has been considered to be a key barrier to assessing professional help (Oh & Bayer, 2015). Although adolescents facing problems seek help from different sources (such as peers, friends, or teachers), Wahlin & Deane (2012) found that parents are the most influential factor in the help-seeking behaviour in the case of adolescents; Radovic et al. (2015) confirmed that parents play a crucial role in accessing mental health care services. Logan & King (2006) proposed a model of a parent-mediated pathway to mental health services for adolescents, where parents go through the five following stages: 1. Parents gain the initial awareness of the adolescent's distress, 2. Parents recognise that the problem is severe and requires attention, 3. Parents consider options for helping their children, 4. Parents develop an intention to seek mental health services and 5. Parents attempt to seek appropriate mental health services. After these steps, the adolescent finally obtains care. However, various factors can affect parental help-seeking behaviour; on the one hand it has been shown that parents' own psychological problems were associated with the increased ability to recognise the need for professional help for adolescents (Jansen et al., 2013). On the other hand, research has shown that parents who have psychological problems themselves were barriers to adolescents' mental health care utilisation (Cornelius et al., 2001); moreover, economic disadvantage, parental psychopathology and parental belief that adolescent would reject professional help were associated with unmet needs for mental health services (Flisher et al., 1997).

1.4.2 The role of parents in adherence to treatment

The role of the parents does not end after a child enters psychosocial care. Most research has paid attention to parental factors playing an important role in medical treatment adherence, such as Hoza et al. (2006), who found that parental awareness of treatment risk and benefits was associated with children's adherence. Moreover, parental decision self-efficacy was positively correlated with adolescents' adherence to pharmacotherapy (O´Brien et al., 2013). Parents should be also involved in the psychotherapy of their children; as the meta-analytical review of Dowell & Ogles (2010) and a meta-analysis of Sun et al. (2019) showed, including parents in the treatment of their children brought an additional benefit of this treatment. Nock & Ferriter (2005) in their review concluded that attendance and adherence to psychotherapy are the most important necessities for treatment delivery, and parents have the main responsibility for managing these necessities. Halvorsen & Heyerdahl (2007) pointed out the importance of parental trust in the intervention. Research has also brought some evidence on parental factors that are barriers in delivering psychosocial care to adolescents. Gordon et al. (2010) identified maternal depression as a factor related to missed appointments; the fathers' level of self-reported somatisation was associated with worse outcome of a child's anxiety treatment (Crawford & Manassis, 2001), or lower expectancies from treatment of parents were associated with higher barriers to treatment (Nock & Kazdin, 2001). Therefore, we can conclude that it is very important to establish good cooperation and form a relationship between professionals and parents.

1.5 The role of care providers in psychosocial care for adolescents

Besides the important role of parents in psychosocial care for adolescents, there is also a need to explore the role of professionals working with adolescents. The work and practices of these professionals are shaped by discourses they have adapted (as was discussed in section 1.3.4 of the Introduction). Although the primary clients of professionals are usually adolescents, as we have shown in section 1.4 of the Introduction, parents are also an important part of the care process. Therefore, the issue of cooperation between parents and professionals to achieve successful treatment is also raised. In this section we introduce the main professionals working within the psychosocial care system for adolescents.

1.5.1 The main professionals working in child and adolescent psychosocial care

In child and adolescent psychosocial care, the main professionals differ per subtype. A report on child and adolescent mental health care services

(CAMHS) in Europe (Braddick et al., 2009) reports that professionals working within CAMHS mostly have training as a psychologist or psychiatrist. This report highlighted the issue, that primary care doctors, paediatric and primary care nurses are considered as significant professionals who play an important role in the early detection of mental health problems, but in some countries still lack training in this area. Similarly, a lack of training has been recognised in teachers, social workers and the staff of juvenile detention centres. Moreover, research on adolescent mental health care in Europe (ADOCARE) (Coppens et al., 2015) has shown that the profession of adolescent psychiatrist is recognised only in some European countries, such as Finland, Germany, Hungary, Italy and Lithuania, and the profession of adolescent psychologist was not recognised anywhere.

According to the European Union Agency for Fundamental Rights (FRA, 2015), requirements for professionals working in child protection services vary across EU Member States. Some states, namely Belgium, Estonia, Germany, Greece, Luxembourg, Malta, Romania, Spain and Sweden, require an accredited diploma in social work, but no specific training for professionals. A certification procedure for social workers in some countries, namely France, Ireland, Lithuania and Poland, includes training requirements, and certified social workers have to complete a required number of training hours. Other countries, including Czech Republic, Hungary, Latvia, Slovakia and Slovenia, have no accreditation procedures for social workers. However, in these countries the mandatory training of professionals at specific positions do exist, such as child protection officers, family or social assistants and child carers. Adding to the varying level of training within EU countries, the Children's Right and Social Services report by Fernandes Guerreiro & Sedletzki (2016) summarised that professionals working with children and families in social services often lack training in applying children's rights, guidelines and protocols for their work.

In Slovakia, the main professionals working in psychosocial care in the preventive – counselling sector are psychologists working at school or in centres of preventive-counselling care, social workers, teachers, educational counsellors and pedagogues for children with special needs. In social care, psychologists and social workers are included. Mental health care is provided by child psychiatrists, clinical psychologists and psychologists without specialisation in clinical psychology (Dankulincova et al., 2020). Similarly, as mentioned above (Coppens et al., 2015), in Slovakia an adolescent psychiatrist or adolescent psychologist are not recognised as professions.

1.6 Aim of the study and research questions

The aim of this thesis is to explore the role of the family in the psychosocial development of adolescents. Second, it aims to understand the role of the family in the psychosocial care of adolescents. Last, this thesis aims to explore how mental health care providers of care for adolescents perceive their roles. To achieve the aim of the thesis, we formulated the following research questions, which are also graphically represented in Figure 1.3:

Research question 1:
Does family functioning mediate the association of family-related adversity with positive youth development? (Chapter 3)

Research question 2:
Does negative emotionality mediate the association of family-related adversity with positive youth development? (Chapter 4)

Research question 3:
Does hopelessness mediate the association of family-related adversity with fighting? (Chapter 5)

Research question 4:
How do providers of psychosocial care for adolescents perceive the role of parents in psychosocial care for these adolescents? (Chapter 6)

Research question 5:
How do providers of care perceive their professional roles in the care for adolescents? (Chapter 7)

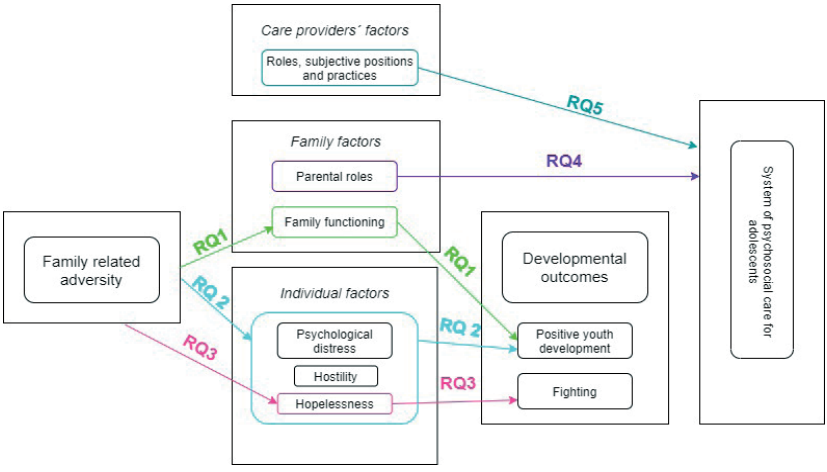

Figure 1.3 Model of the research questions examined in the thesis

1.6 Outline of the thesis

Chapter 1 provides the theoretical background, discussing the most relevant theories of adolescents' development and focusing on the role that family and parents play in both adaptive and maladaptive development of adolescents. Next, it brings insight into the general functioning of the psychosocial care system for adolescents facing problems. Last, it presents current knowledge on the role of parents and care providers in the care for adolescents. *Chapter 2* introduces information on the methodology of this thesis. It describes the designs of the studies, their samples and measures and the methods used to analyse data. *Chapters 3*, *4* and *5* explore how family-related adversities are associated with developmental outcomes of adolescents. Specifically, *Chapter 3* examines the association of family-related adversities with positive youth development and the mediating role of family functioning in this association. *Chapter 4* explores the association of family-related adversities with positive youth development and the mediating role of experienced psychological distress, hostility and hopelessness in this association. *Chapter 5* explores the association of family-related adversities with fighting among adolescents and the mediating role of hopelessness in this association. In *Chapters 6* and *7* we move to the point when family is no longer able to cope with an adolescent's problems on its own and enter the care system. In Chapter 6 we take a closer look at how psychosocial care providers perceive the role of parents in the care for their children facing emotional and behavioural problems. In *Chapter 7* we then discuss how professionals working in mental health care for adolescents perceive their own roles. Finally, *Chapter 8* summarises and discusses the main findings of this thesis. Moreover, it addresses its implications for practice, policy and future research.

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