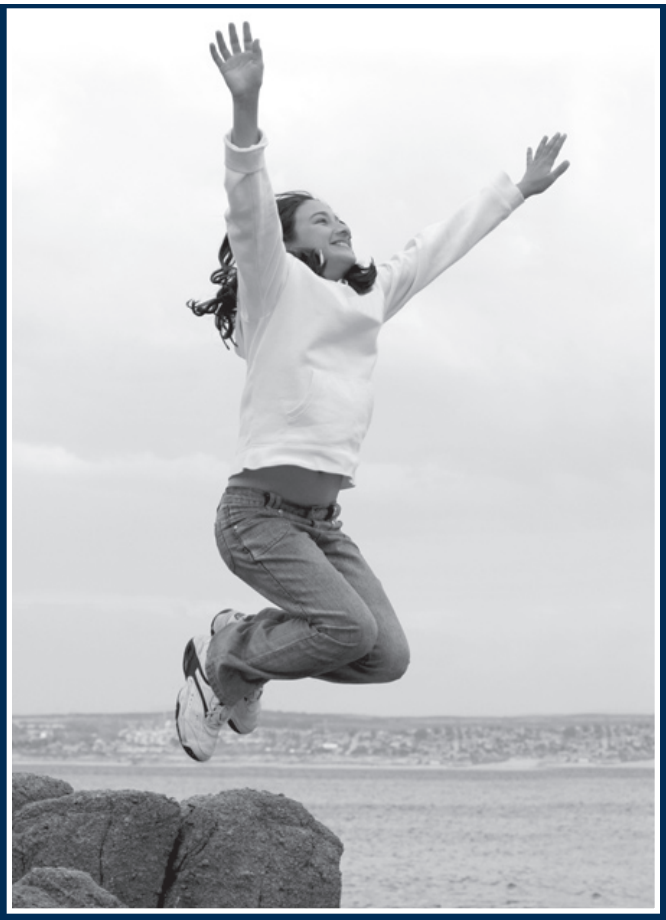
FOCAL POiNT

Research, Policy, and Practice in Children's Mental Health

Resilience and Recovery



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WRITE FOR FOCAL POiNT: SOCIAL SUPPORT

We are currently inviting proposals for articles for the Winter 2006 issue of **FOCAL POiNT**, which will focus on the theme of Social Support. What is the role of social support in achieving positive outcomes for children and families? How can social support be measured? Can social support be built around people who lack it?

We invite research reviews, program descriptions, policy discussions, and personal essays. For information about how to propose an article, contact Janet S. Walker, **FOCAL POiNT** editor, at janetw@pdx.edu or 503.725.8236.

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Resilience and Recovery

The final report of the President's New Freedom Commission on Mental Health describes the need for fundamental transformation of mental health care in America. According to the report, successful transformation would result in mental health care that focuses on *facilitating recovery* and *building resilience.* Efforts to transform children's mental health care have been underway for over twenty years; however these efforts have been largely based on the *system of care principles,* which make no direct mention of either recovery or resilience. Understandably, this has led to some confusion about the relationship between a resilience-and-recovery framework on the one hand, and systems of care principles on the other. Are they compatible, or do they represent two distinct visions of transformation?

This issue of *Focal Point* explores the concepts of resilience and recovery and what they mean in the context of mental health care for children and adolescents. From the articles, it emerges that the *terminology* associated with recovery and resilience (particularly the word *recovery* itself) can be confusing and even off-putting to stakeholders in children's mental health. On the other hand, the larger underlying *concepts* of recovery and resilience are appealing to stakeholders, and are also highly compatible with system of care values. This point is explored explicitly in the articles by Barbara Friesen and Charles Huffine, but the same implication appears throughout other contributions as well.

Beyond merely being compatible with system of care values, a resilience-and-recovery perspective highlights new ideas and strategies for transforming mental health care for children and adolescents. For example, Friesen found that young people and their families were most excited by the focus on hope and optimism that figures prominently in both recovery and resilience. Terre Garner similarly reports that young people and families see hope as the cornerstone of effective mental health care. Hal Shorey and C. R. Snyder argue that hope is a crucial element in successful maturation and development, particularly during the transition from childhood to adulthood. What is more, Shorey and Snyder describe a system they have developed for teaching hopeful thinking to adolescents.

Similarly, a resilience-and-recovery framework draws attention to the importance of connectedness as a developmental asset for all youth, including youth who are at-risk, troubled, or struggling with emotional or behavioral difficulties. For younger children, connections to caregivers are central, while for older children and adolescents, other connections become increasingly important: connections to peers and individuals, organizations, and institutions in the wider community. Through these kinds of connections, young people gain emotional support and access opportunities to discover and develop skills, talents, and vision. Young people thrive when their communities are rich in the kinds of opportunities that draw out their assets. This interplay of individual and community assets is explored in detail by Christina Theokis, Richard Lerner, and Erin Phelps, using Search Institute data

from a large and diverse sample of teens.

Hope and connectedness are intertwined in a resilience-and-recovery perspective. Using longitudinal data from her Kauai study, Emmy Werner argues that positive development is promoted when young people acquire the conviction that they can overcome problems by their own actions. This type of hopeful outlook is more likely to develop when young people have emotional support available, and when they have access to opportunities to learn and to acquire skills. In Werner's study, this was true not only for at-risk children who proved resilient, but also for troubled teenagers who recovered as young adults.

On a more personal level, this is the same message delivered by Melanie Green and Angela Nelson. Both young women have developed a hopeful, empowered stance that has enabled them to move ahead in their lives despite considerable adversity. Formal services may help, as they did for Green, or they may contribute to difficulties, as they did for Nelson. Ultimately, however, what these young women seek is a place in the community and the opportunity to develop their skills and talents.

When young people have hope, connectedness, and opportunities, they are more likely to be able to "bounce back" from adversity. A resilience-and-recovery framework helps us expand our thinking about how to provide interpersonal and community environments that help struggling young people acquire these crucial assets and return to a positive developmental path.

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Barbara J. Friesen is Director of the Research and Training Center on Family Support and Children's Mental Health.

RTC Projects 2004 - 2009

Beginning in October 2004, the Research and Training Center on Family Support and Children's Mental Health was funded for five years to undertake six major research projects described below. For more information, visit www.rtc.pdx.edu.

Voices of Youth and Families: Community Integration of Transition-Age Youth is designed to gain understanding of community integration from the perspectives of transition-age youth, young adults, and caregivers, and examine links between the concepts of community integration, youth and family participation in individualized planning, empowerment, the effects of stigma, and recovery and resilience.

Transforming Futures: Research on Expanding the Career Aspirations of Youth with Mental and Emotional Disorders addresses the under-researched area of transition supports and services for youth who are preparing for adulthood, with a specific focus on employment. This project features a web-based intervention connecting youth with adult mentors who have struggled with mental illness and have successful employment outcomes.

Partnerships in Individualized Planning will develop instruments to assess youth empowerment, youth participation in planning, and perceptions of the utility and feasibility of youth participation in planning. The project will also develop and evaluate an intervention to increase the participation of youth and family members in the individualized planning and service process.

Work-Life Integration directly addresses the issue of community integration for the adult caregivers of children and youth with emotional disorders, specifically with regard to their ability to maintain employment. This project is designed to influence the knowledge, attitudes, and practices of human resource professionals, with a view to reducing stigma and increasing the family friendliness of their organizations.

Transforming Transitions to Kindergarten focuses on the families' experiences of the shift from pre-school to kindergarten when children have emotional/behavioral challenges. The project will develop and test a training intervention to increase the capacity of early childhood and kindergarten settings to meet the needs of these children, and a family-driven team-based transition intervention to promote the success of children and their families as they move from pre-school to kindergarten. The project will also include a review of evidence-based practice in the field of mental health consultation.

Practice-Based Evidence: Building Effectiveness from the Ground Up will conduct a case study in partnership with a Native American youth organization and the National Indian Child Welfare Association. The project addresses the need to conduct effectiveness studies of practices that are believed to be helpful, but for which little evidence exists.

Additionally, the Center will continue to undertake a range of dissemination, training, and technical assistance activities. These include our *Building on Family Strengths Conference*, **FOCAL POiNT**, our award-winning website, and our two listservs, *Data Trends* and *rtcUpdates*.

The Concept of Recovery: "Value Added" for the Children's Mental Health Field?

What can the concept of *recovery* add to system of care principles and the emphasis on promoting resilience already operating in the children's mental health field? One answer to this question is "an increased focus on hope, optimism, and a positive orientation to the future." These features of the concept of recovery have been identified as "value added" by many youth, family members, and service providers in the children's mental health field. Others, however, are uncomfortable using *recovery* with children and youth, expressing their belief that the term is confusing, that it implies a medical-illness orientation to mental health treatment, and that it lacks a developmental perspective. Both groups agree that the concept of recovery, as developed within the adult mental health field, cannot be imported "as is" into the children's mental health field.

Background

In September 2004, staff here at the RTC on Family Support and Children's Mental Health were asked to address the question, "What can the concept of recovery add to current thinking and practice in the field of children's mental health?" This information was requested by the Child, Adolescent, and Family Branch, which is part of the Center for Mental Health Services (CMHS), which, in turn, is part of the Substance Abuse and Mental Heath Administration (SAMHSA), the primary federal funder of programs to improve mental health care nationwide.

This interest in recovery was motivated in large part by the 2003 report of the President's New Freedom Commission on Mental Health, which recommended fundamentally transforming how mental health care is delivered in America. According to the report, "Recovery is the goal of a transformed system." The report also states that, "Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience…"

Federal agencies, including SAMHSA, have been asked to align their work with the recommendations of the New Freedom report. In the field of children's mental health, we are accustomed to talking about resilience; however, not much attention had previously been paid to the question of how recovery might apply to children and youth. RTC staff thus set out to help SAMHSA answer two related questions: first, What exactly does recovery mean in the context of children's mental health? and second, How do recovery and resilience mesh with the system of care values that underpin current transformation efforts for children's mental health?

During the fall and winter 2004-05, we sought feedback on these questions through a series of telephone and in-person discussions with families and youth, as well as with service providers, researchers, and state and local agency administrators. Additionally, in December 2004, we hosted a two-day meeting at SAMHSA sponsored by the Child, Adolescent, and Family Branch, during which representatives from these same stakeholder groups and SAMHSA staff held extended discussions on this topic.

Discussions began with an introduction of the values associated with the recovery concept. We asked participants to consider whether these values, along with lessons from the resilience field, would add new ideas or dimensions for transformation in children's mental health. Some participants suggested that *recovery* should apply only to adults, and *resilience* should be reserved for children. We thought it was important to fully explore what both concepts could offer children's mental health.

Definitions and History

We approached the complex process of thinking about how system of care values and principles, recovery concepts, and resilience knowledge might fit together by looking first at the definitions and main elements of each set of ideas. We developed a "crosswalk" table as a way of looking at where the ideas were similar, and where they were unique (Table 1).

Table 1. Crosswalk: System of Care, Resiliency, and Recovery

Resilience Core Concepts	SOC Principles	Recovery Elements
	1. Comprehensiveness	Holistic (C)
Specification of elements: (V) Reducing risk Enhancing protective factors	2. Individualized services	Individualized and person centered (C) Strengths-based (C)
	3. Community based	(Assumed)
Racial socialization (V) Healing historical trauma (V)	4. Culturally and linguistically competent	Healing historical trauma (V)
Solid basic and applied research base for prevention and early intervention (V)	5. Early intervention	
	6. Family and youth participation Family driven Youth guided, directed	Empowerment Self direction (C)
	7. Service coordination	
	8. Interagency coordination	
	9. Protection of rights	Respect, stigma reduction (V)
	10. Support for transition	Life planning (V)
Future orientation (V) Optimism (V)		Hope, optimism (V)

System of care. A system of care is "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children [with emotional and behavioral disorders] and their families." The system of care values and principles (Stroul & Friedman, 1986) specify that the care provided should be comprehensive, coordinated, community-based, individualized, culturally competent, child centered, and family focused.

Recovery. As defined in the New Freedom report, recovery is "The process in which people are able to live, work, learn, and participate fully in their communities." For some, recovery may mean the complete remission of symptoms. For others, it may mean the ability to live a fulfilling and productive life despite the challenges of an ongoing condition. The concept of recovery was developed in the adult mental health field to describe a process whereby people with serious mental illnesses build fulfilling, self-directed lives in the community. These ideas developed as it became apparent that the life stories of people with positive outcomes contradicted the prevailing pessimistic view of serious mental illness as resulting in inevitable decline over time (Houghton, 1982; Harding, et al., 1987).

Resilience. Concepts of resilience (literally, the ability to "bounce back") have been developed through years of research examining how some individuals do well in many areas of their lives despite severe challenges and/or deprivations (Luthar, Cicchetti, & Becker, 2000). Researchers have identified individual, family, and community characteristics that are associated with resilience. For **individuals**, these include good intellectual functioning, easy-going disposition, self-efficacy, high self-esteem, talents, and faith. **Within the family**, having a close relationship to a caring parent figure, authoritative parenting (characterized by warmth, structure, and high expectations), socioeconomic advantage, and connections to extended family networks have all been shown to be important. **Outside of the family**, factors associated with resilience include bonds to prosocial adults who can serve as good role models, connections to positive community organizations, and attending effective schools (Masten & Coatsworth, 1998). It's important to note that thinking about resilience has changed from focusing extensively on the characteristics of individuals to include the importance of family, neighborhood, and community factors in promoting resilience (Masten & Coatsworth, 1998).

Compatibility of Ideas and Value Added

The crosswalk in Table I allows us to examine how resilience, recovery, and system of care concepts complement each other, and to identify their unique contributions or *value added*. In the following paragraphs, key concepts related to recovery and resilience are examined along with system of care principles.

1. Comprehensiveness. This system of care principle calls for addressing all of the important life domains of developing children and youth—their physical, emotional, social, and educational needs. The recovery element *holistic* represents a very similar idea, including all aspects of the person's mind, body,

spirit, and community, as well as needs such as housing, employment, education, mental health and health care services, addictions treatment, spirituality, and others. The resilience literature does not directly address the concept of comprehensiveness.

2. Individualized services. The language related to this system of care principle, and two recovery elements, *individualized* and *person-centered*, and *strengths-based*, are very similar. They recognize the unique needs of each individual and the importance of building on their strengths and assets. The resilience literature makes a unique contribution with its emphasis on reducing risk (e.g., poverty, exposure to toxic substances, and neighborhood or family violence) and enhancing protective factors (e.g., through building competence and coping in individuals, promoting excellent parenting, and increasing community assets such as caring adults, prosocial organizations, and opportunities for youth to contribute positively to the community).

3. Community based. The principle that children should live at home and in their communities is implicit in the concept of recovery, often with an emphasis on "non-institutional" living situations and full participation in community life.

4. Culturally competent. This value is aligned with the principle of non-discrimination and responsiveness to cultural differences and special needs. The principle focuses on the knowledge and behavior of individual service providers, as well as the appropriateness of services and the process of service delivery. Both the resilience literature and the recovery movement underscore the importance of trauma that may have preceded the emotional or mental illness as well as the traumatic effects of being ill and of receiving treatment in an imperfect and sometimes oppressive system. In addition, the resilience literature contains many examples of racial socialization, a process that parents use to help their children develop pride in their heritage, and to anticipate and prepare for discrimination and prejudice (Coard, Wallace, Stevenson, & Brotman, 2004). An emphasis on healing historical trauma, as well as building increased competence and targeted coping mechanisms in children of color, constitute *value added* from both resilience and recovery.

5. Early intervention. This principle underlines the importance of dealing proactively with problems or challenges rather than letting them become entrenched and more difficult to address. The concept of early intervention is not explicitly discussed in the recovery literature; however, knowledge about resilience building provides valuable information about strategies that can be used to provide early and effective services. For example, as we understand more about the ways in which poverty increases risk of poor outcomes for children (e.g., increasing parents' stress, interfering with parents' ability to provide stable, predictable caregiving, and so on) we can act to counteract these effects (Yates, Egeland, & Sroufe, 2003).

The aspects of recovery that sparked the most interest and excitement were the hope, optimism, and positive orientation to the future that characterize the recovery process…

6. Full family participation in planning, implementing, and evaluating services is a core system of care principle that is also emphasized in the New Freedom report. The idea of involvement and participation has recently been updated to "family driven and youth guided" to communicate that families should provide leadership in decisions about services, and that youth can be effective self-advocates and managers of their own lives. Recovery concepts of consumer empowerment and self-direction parallel concepts of family-driven and youth-guided services.

7. Service coordination is emphasized in the system of care principles because families with complex needs may need a broker, or guide, to help navigate the complicated system of services in their communities and gain access to needed services. Neither resilience nor recovery principles directly addresses service coordination.

8. Interagency coordination is emphasized as a system of care principle to reduce service fragmentation so that children and families with complex needs can be better served.

9. Protection of rights is included as a system of care principle to directly address problems related to coercion, exclusion from decision-making, and other violations. Key elements of recovery, *respect* and *stigma reduction*, are compatible with system of care values, but have not been sufficiently emphasized in the children's mental health field. Attention to building societal acceptance of difference and helping young people gain self-acceptance are *value added* strategies.

10. Support for transitions, although a principle of systems of care, is an area that young people and families identify as needing further development and support. Neither resilience nor recovery explicitly addresses transition planning as a service, although life transitions are identified as presenting challenges to individuals in the resilience literature.

Other elements of recovery that are not emphasized in system of care principles include the notion that progress may be non-linear

(i.e., that setbacks may occur), the notion of personal responsibility, and a heavy emphasis on peer support and peer-run programs.

The aspects of recovery that sparked the most interest and excitement on the part of young people and their families were the concepts of hope and optimism and a positive orientation to the future that characterize the recovery process. In our discussions, family members and youth recalled their frustration and sorrow when they received pessimistic messages about their futures. They also expressed concerns that services are often narrowly focused (not comprehensive) and take a very short-term view. The prospect of having support for life planning, an emphasis on self-management and personal responsibility, and having quality of life seen as a legitimate outcome are all possible contributions of the recovery movement to children's mental health.

On the other hand, an exclusive focus on *recovery* is problematic for many individuals and organizations. We suggest the use of the phrase, *resilience and recovery*, rather than recovery alone, to describe transformation goals, processes, and funding opportunities. This supports the adaptation of important contributions from both the recovery movement and from knowledge about resilience building, and sidesteps objections and confusion related to the term recovery.

Using a resilience and recovery framework, together with system of care principles, has numerous implications for how the transformation of mental health systems should occur. Those implications include the following:

- The outcomes that are important under a resilience and recovery framework are different from those often measured to evaluate either treatment or system effectiveness. For example, outcomes such as optimism or quality of life are rarely measured. Families and youth should be fully engaged in defining resilience- and recovery-oriented outcomes, both for their own individualized plans and for service systems as a whole.
- Protective factors—including community-level strengths and assets—should receive greater attention in treatment planning. There is a need to expand knowledge about how to create treatment plans that effectively build on strengths and assets.
- Transformation work must also be concerned with reducing community risks (e.g., poverty, neighborhood crime, violence, or biohazards). Although the mental health system cannot tackle these problems alone, collaboration with other systems could do much to bring these issues to public awareness, and to make the conceptual connection between community problems and the physical and mental health of all citizens.
- Stigma reduction deserves increased attention. Youth and family experiences of stigma should be used as a basis for developing strategies to reduce stigma.
- Expanded national and local support should be provided for peer-run, mutual support groups and organizations for youth and families.

Although many of the concepts and principles reviewed here are familiar to the children's mental health field, the value that we found through a review of resilience knowledge and in key elements of recovery suggests that these ideas should have a more central place in our work to transform the mental health system across the life span. The effect, we think, should be to move them out of the background and into the spotlight.

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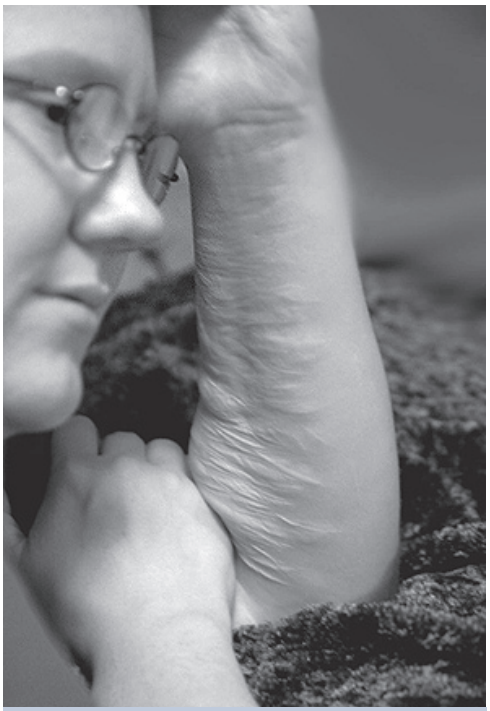
My Path to Recovery

When my alarm goes off on a typical weekday, I reluctantly roll out of bed and jump into the shower. I hurry through breakfast and race off to school. After class, I grab some coffee or a sandwich and then hurry to work. I return phone calls and emails and juggle through the tasks at hand. I stress over prioritizing my responsibilities and figuring out how I will get it all done. When the day is done, I return home to face my homework, put in some time on the treadmill, and eventually collapse into bed.

Sometimes things are pretty overwhelming. I convince myself that there is no way to manage everything that's going on and that I simply can't handle it. But then I stop and think. I think of what I've gone through and what I've achieved. I laugh at myself for stressing so much over work and school. I think of how thankful I am to be working and pursuing my education. And I think about the days when I was simply fighting for my life.

A mere three years ago I lived in a completely different world. I was depressed, anxious, obsessive-compulsive, and mildly psychotic. My emotions were so torturously intense at times that it took all my strength just to live in my own skin. I had no goals and no plans for the future. I wasn't entirely convinced there would even be a future. Self-injury became my primary coping mechanism—as well as my identity.

For several years I was intensely involved with the mental health system. I was hospitalized once per month on average, both in local and state hospitals. I was once described by a psychiatrist as "the number one utilizer of crisis services in the county." With a diagnosis of Borderline Personality Disorder, I was often misjudged by professionals with a lack of understanding of my disorder and of self-injury. I was accused of "just doing it for attention," and told that I was "taking up time and resources that could be used to treat real patients." It was difficult and confusing to be repeatedly put down when I needed help the most.



"An arm full of memories" The scars on Melanie Green's arm remind her not only of what she's been through, but of what she's overcome as well. Photo by Kaarin Peters.

Fortunately, there were people who did understand what I was going through. After meeting with several therapists for various amounts of time, I met one at a local mental health center that I truly connected with. She was trained and experienced in the area of Borderline Personality Disorder and was able to look past my illness and truly appreciate who I was as a person. I slowly gained support and learned new ways to cope with things that were difficult. After long periods of being "drugged-up" on medications like Thorazine, I began to work with an excellent nurse practitioner. Together we found a medication regimen that helped manage my symptoms and, at the same time, permitted me to function. However, even though I was receiving excellent care and support, I continued to struggle. Life was still tumultuous, and I didn't think I could tame it.

It wasn't until an early morning in the emergency room that things started to change. I was in a seclusion room waiting for a psychiatric consultation, having been transferred from a medical bed after overdosing the night before. My stomach ached with regret and I started to cry. "I don't want to do this anymore," I thought. I didn't want to continue living from one cut to the next. I didn't want to spend half my life in hospitals and emergency rooms. I didn't want to *be* my illness anymore.

It took years for my mental illness to develop to such substantial

proportions, and it would take a significant amount of time for me to regain control of my life. But I was finally ready. I was determined to make it happen. Appointments with my therapist changed from being a way to kill some time to being a way to learn new skills. We talked a lot about why I felt the way I did and about the difference between how things sometimes feel emotionally and how they are in reality. I began to understand my emotions, and I gained the power to regulate them rather than be controlled by them. I was fortunate to be working with a therapist who understood and supported me. For every bad feeling I had about myself, she could point out something good. She helped me understand that my life wasn't over. All the skills and attributes I had before my bout with mental illness were still there, there was just other stuff in the way.

I was fortunate to have a mentor as well. By chance, I met a woman who had gone through many of the things I was experiencing. Although her story was different from mine, she recognized enough of what I was going through to convince her to make a commitment to me. She told me she would be there for me and that we'd "get through this together." We spent a lot of time together—sometimes just hanging out, sometimes in serious crisis. The point is, she was there. She still is.

My family also played a significant role in my recovery. My mother relentlessly researched everything connected with my mental illness. Her wealth of acquired knowledge included the details of each diagnosis I received and every medication I took. The rest of my family did everything they could to stand by me and to encourage me to grow strong again. I never understood the value of family until I saw what they all went through for me.

Things didn't get better immediately. It took a lot of time and a lot of hard work. Sometimes I fell back into old patterns. Sometimes I'd give up—but just for a day or two. Every time things got intense, I was able to poke my head out of the chaos just long enough to get a look at the big picture. I started thinking about what I wanted to do with my life and began working on accomplishing it. I started slowly, adding one thing at a time. I went back to school and took one class per quarter. I gradually increased my schedule to two classes, then three. I began volunteering at Consumer Voices Are Born, a local consumer-run agency that provides a drop-in center and "warm line" to adults dealing with mental illness.

As my responsibilities increased, so did my confidence. I began to develop an identity. Rather than a mental illness with a little person inside, I was becoming a person with a little mental illness inside. My efforts were initially slight but quickly gained momentum. Once things started rolling, they never stopped.

In the spring of 2003, I was given the opportunity to help conduct some focus groups in preparation for a new mental health grant that had been awarded to Clark County, Washington. I was flattered by the offer and eager to participate. It never occurred to me that the offer would mark the start of a new beginning. The focus group project led to an invitation to join the steering committee for Clark County's Partnerships for Youth Transition. Later that year I was asked to travel to Washington, D.C. with the program for a cross-site meeting. Within a few months of the trip, I was offered a job as the Youth Coordinator for the program.

Now, with a little over a year of employment with Clark County, I have to take a moment from time to time to reflect on what I've accomplished. Sometimes I still feel like I'm stuck in my old world and that I'll never get out. I remember the way things used to be and wish that I could just erase it all from my life. These are the times when I give myself a pat on the back. I think about the youth I work with and the fact that I'm on the other side now. I think about the people I sit in meetings with—people from the same agencies that used to provide me with services. I think about the numerous presentations I've given at national conferences and the people who come up to me afterwards with compliments and to ask for more information. They're asking *me*—professionals in the mental health field are coming up and asking me for advice. It's amazing. I've been able to take the worst part of my life and turn it into something positive for other people.

I think about the things people tell me and the compliments I receive. They're the same kinds of compliments I received when I was younger, when I knew I was worth something. I went for so long without feeling any value. It is amazing to listen to people and to truly believe that I mean something again. People value me and the contributions I make. I've come back to life.

Recovery is a remarkable thing. For me it has meant gaining my life back. For others it may look different. But it is a possibility for everyone. There is no person alive who can't have things at least just a little bit better—and to me, that's recovery. Recovery is a process. It doesn't necessarily mean that everything will be better and problems will cease to exist. It may mean being able to cook dinner, manage medication, or simply control emotions. It's still important though. Individuals brought down by the weight of mental illness need to be reminded that there is more to their life. They deserve the opportunity to discover who they really are.

Melanie Green is a college student as well as the Youth Coordinator for the Options program in Clark County, Washington, which assists local youth with mental health issues make a successful transition from adolescence to adulthood.

Resilience and Recovery: Findings from the Kauai Longitudinal Study

For many years mental health professionals tended to focus almost exclusively on the negative effects of biological and psychosocial risk factors by reconstructing the life histories of individuals with persistent behavior disorders or serious emotional problems. This retrospective approach created the impression that a poor developmental outcome is inevitable if a child is exposed to trauma, parental mental illness, alcoholism, or chronic family discord, since it examined only the lives of the "casualties," not the lives of the successful "survivors."

During the last two decades of the 20th century, our perspective has begun to change. Longitudinal studies that have followed individuals from infancy to adulthood have consistently shown that even among children exposed to multiple stressors, only a minority develop serious emotional disturbances or persistent behavior problems. Their findings challenge us to consider the phenomenon of *resilience*, a dynamic process that leads to positive adaptation, even with a context of adversity (Luthar, 2003).

Only about a dozen longitudinal studies have examined this phenomenon over extended periods of time—from infancy to adulthood. The Kauai Longitudinal Study is the only study to date that has examined development from birth to midlife. The study explores the impact of a variety of biological and psychosocial risk factors, stressful life events, and protective factors on a multi-racial cohort of 698 children born in 1955 on the Hawaiian island of Kauai, the westernmost county in the U.S.A.

In the Kauai study, a team of mental health workers, pediatricians, public health nurses, and social workers monitored the development of all children born on the island at ages 1, 2, 10, 18, 32, and 40 years. We chose these ages because they represent stages in the life cycle that are critical for the development of trust, autonomy, industry, identity, intimacy, and generativity (Werner & Smith, 1982; 1992; 2001).

Some 30% of the survivors (n=210) in our study population were born and raised in poverty, had experienced pre- or perinatal complications; lived in families troubled by chronic discord, divorce, or parental psychopathology; and were reared by mothers with less than 8 grades of education. Two-thirds of the children who had experienced four or more of such risk factors by age two developed learning or behavior problems by age 10 or had delinquency records and/or mental health problems by age 18.

However, one out of three of these children grew into competent, confident and caring adults. They did not develop any behavior or learning problems during childhood or adolescence. They succeeded in school, managed home and social life well, and set realistic education-

al and vocational goals and expectations for themselves. By the time they reached age 40, not one of these individuals was unemployed, none had been in trouble with the law, and none had to rely on social services. Their divorce rates, mortality rates and rates of chronic health problems were significantly lower at midlife than those of their same sex peers. Their educational and vocational accomplishment were equal to or even exceeded those of children who had grown up in more economically secure and stable home environments. Their very existence challenges the myth that a child who is a member of a so-called "high-risk" group is fated to become one of life's losers.

Resilience in the Formative Years

Three clusters of protective factors differentiated the resilient boys and girls who had successfully overcome the odds from their high-risk peers who developed serious coping problems in childhood or adolescence.

1. Protective factors within the individual. Even in infancy, resilient children displayed temperamental characteristics that elicited positive responses from their caregivers. At age one, their mothers tended to characterize them as active, affectionate, cuddly, good-natured, and easy to deal with; at age two, independent observers described the resilient toddlers as agreeable, cheerful, friendly, responsive, and sociable. They were more advanced in their language and motor development, and in self-help skills than their peers who later developed problems.

By age 10, the children who succeeded against the odds had higher scores on tests of practical problem-solving skills and were better readers than those who developed behavior or learning problems. They also had a special talent that gave them a sense of pride, and they willingly assisted others who needed help. By late adolescence, they had developed a belief in their own effectiveness and a conviction that the problems they confronted could be overcome by their own actions. They had more realistic education and vocational plans, and higher expectations for their future than did their peers with coping problems.

2. Protective factors in the family. Children who succeeded against the odds had the opportunity to establish, early on, a close bond with at least one competent, emotionally stable person who was sensitive to their needs. Much of this nurturing came from substitute caregivers, such as grandparents, older siblings, aunts, and uncles. Resilient children seemed to be especially adept at "recruiting" such surrogate parents.

Resilient boys tended to come from households with structure and rules, where a male served as a model of identification, and where there was encouragement of emotional expressiveness. Resilient girls tended to come from families that combined an emphasis on independence with reliable support from a female caregiver. The families of these children tended to hold religious beliefs that provided some stability and meaning in their lives.

3. Protective factors in the community. Resilient youngsters tended to rely on elders and peers in their community for emotional support and sought them out for counsel in times of crisis. A favorite teacher was often a positive role model, so were caring neighbors, elder mentors, parents of boy- or girlfriends, youth leaders, ministers, and members of church groups.

Recovery in Adulthood

One of the most striking findings in our follow-up studies done in adulthood (at ages 32 and 40) was that most of the youth who had developed serious coping problems in adolescence had staged a recovery by the time they reached midlife. This was true for the majority of the "troubled teens," but more so for the females than the males.

Overall, the "troubled" teenagers had slightly higher mortality rates by age forty (4.4%) than their resilient peers (3.3%) and the "low-risk" members of the same birth cohort (2.8%), with more fatalities due to accidents and AIDS. The majority of the survivors, however, had no serious coping problems by the time they reached midlife. They were in stable marriages and jobs, were satisfied with their relationships with their spouses and children, and were responsible citizens in their community.

Several turning points led to lasting positive shift in the life trajectories among the high-risk men and women in our cohort who had been troubled teenagers. These changes took place after they had left high school and without the benefit of planned intervention by professional "experts." One of the most import lessons we learned from our follow-up in adulthood was that the *opening of opportunities* in the third and fourth decade of life led to enduring positive changes among the majority of teenage mothers, the delinquent boys, and the individuals who had struggled with mental health problems in their teens.

Among the most potent forces for positive change for these youth in adulthood were continuing education at community colleges and adult high schools, educational and vocational skills acquired during service in the armed forces, marriage to a stable partner, conversion to a religion that demanded active participation in a "community of faith," recovery from a life-threatening illness or accident, and, to a much lesser extent, psychotherapy.

Attendance at community colleges and enlistment in the armed forces provided "troubled" teenagers with the opportunity to obtain educational, vocational, and social skills that made it possible for them to move out of welfare dependence

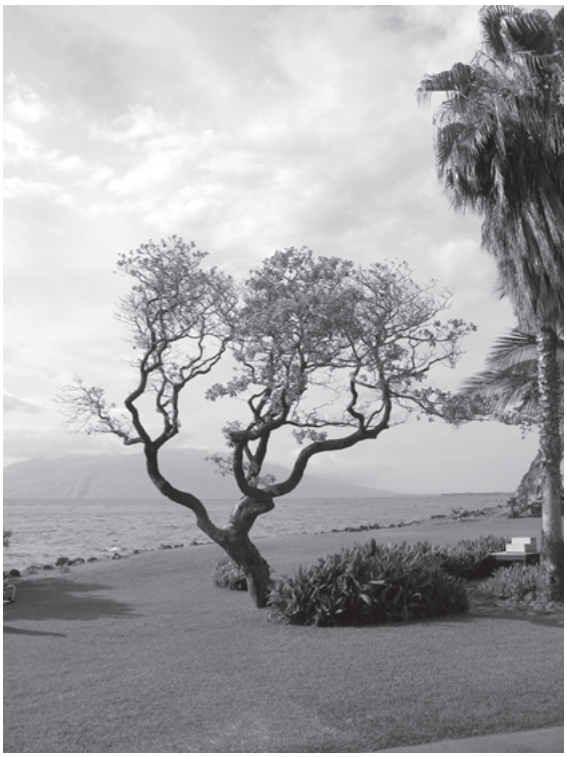
into a competitive job market. Such effects also carried forward to their children. Both the teenage mothers and the former delinquents who had made use of educational opportunities that were available to them in adulthood were eager to see their own sons and daughters succeed in school.

Marriage to a stable partner, whom they considered a close friend, was another positive turning point. Often it was a happy second marriage, after a hastily or impulsively contracted first marriage had ended in divorce. Such a marriage provided the once-troubled partners with a steady source of emotional support, and with the opportunity to share their concerns with a caring person who bolstered their self-esteem.

Conversion to a religious faith that provided structure, a sense of community, and the assurance of salvation was an important turning point in the lives of many troubled teenagers. Most of them were sons and daughters of alcoholics who had been abused as children, and who had struggled with substance abuse problems of their own.

Some individuals who had struggled with mental health problems in their teens encountered a different kind of epiphany that turned their lives around as they approached age 40. They had experienced a prolonged and painful bout with a life-threatening illness or an accident. A close encounter with death forced them to examine the lives they had lived and to consider the opportunities for positive change they would seize when they recovered.

Formal psychotherapy had worked with only a few troubled individuals (some 5%) who tended to be better educated and were of a more introspective bent. The majority in this group relied on medication that relieved anxiety or depression rather than on "talk therapy" that provided insight. The majority of the men and women consistently ranked the effectiveness of mental health professionals (whether psychiatrists, psychologists, or social workers) much lower than the counsel and advice given by spouses, friends, members of the extended family, teachers, mentors, co-workers, members of church groups, or ministers. Their low opinion of the effectiveness of professional help by mental health specialists did not improve from the second to the third and to the fourth decade of life.



Factors Contributing to the Recovery of Troubled Teens

The "troubled" individuals who made use of informal opportunities in their twenties and thirties, and whose lives subsequently took a positive turn, differed in significant ways from those who did not make use of such options. They were active and sociable, had better problem-solving and reading skills, and had been exposed to more positive interactions with caregivers in infancy and early childhood. In general, the outlook in adulthood for individuals who had been shy or lacked self-confidence as children or adolescents was more positive than for those who had displayed frequent anti-social behavior, and for youths whose parents had chronic mental health and/or alcohol abuse problems.

When we examined the links between individual dispositions and external sources of support in the family and community, we discovered that the resilient men and women were not passively reacting to the constraints of negative circumstances. Instead, they actively sought out the people and opportunities that led to a positive turnaround in their lives. The youth who made a successful adaptation in adulthood despite adversity relied on sources of support within their family and community that increased their competencies and self-efficacy, decreased the number of stressful life events they subsequently encountered, and opened up new opportunities for them.

Future Directions

Most of our findings have since been replicated in a number of longitudinal studies around the world—on the mainland in the U.S.A., and in Australia, New Zealand, Denmark, Sweden, Great Britain, and Germany (Werner, 2005). In all of these studies, one can discern a common core of individual dispositions and sources of social support that contribute to resilience. These protective buffers appear to make a more significant impact on the life course of individuals who thrive despite adversity than do specific risk factors and stressful life events, and they transcend ethnic and social class boundaries. Many of the protective factors that fostered resilience among those ex-

posed to multiple risk factors were also beneficial to those who lived in more favorable environments, but they did have a stronger predictive power for positive developmental outcomes for individuals especially challenged by adversity (Masten & Coatsworth, 1998).

Despite this accumulating evidence, the study of resilience across the life span is still relatively uncharted territory. We urgently need to explore the "reserve capacity" of older people who are an increasing segment of our population—their potential for change and continued growth in later life. Future research on resilience also needs to focus more explicitly on gender differences in response to adversity. We have consistently noted that a higher proportion of females than males managed to cope effectively with adversity in childhood and adulthood. They relied more frequently on informal sources of social support than the men. We suspect that these same gender differences may also apply to coping with old age.

We need more evidence from twin, adoptee, and family studies about the mediating effect of genetic influences that lead to positive adaptation in the context of adversity. Future research on risk and resilience also needs to acquire a cross-cultural perspective that focuses on the children from developing countries who enter our country in ever increasing numbers as migrants and refugees from war-torn countries in Africa, Asia, and Latin America.

Last, but not least, we need to carefully evaluate intervention programs that aim to foster resilience. Throughout our study, we observed large individual differences among "high-risk" individuals in their responses to adversity as well as to the opening up of naturally occurring opportunities. Our findings suggest that educational, rehabilitation, or therapeutic programs deliberately designed to improve the lives of at-risk children and youth will also have variable effects, depending on the dispositions and competencies of the participants. Thus, we should exercise some caution in advocating a particular treatment unless its effectiveness has been independently evaluated.

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Building Hope for Adolescents: The Importance of a Secure Social Base

Adolescence is a time when young people naturally work at transferring primary relational bonds from their parents to peers and romantic partners. The successful resolution of this process is critical for transitioning from childhood dependency to productive and independent adult roles. In this process, most parents strive to instill commonly accepted values and norms in their children, knowing that these standards are important for their children's future successes. These transitions are deemed successful from a societal standpoint when young people continue to be guided by these values as they enter early adulthood.

For many adolescents, however, transitions into adult roles are difficult. The frustrations and setbacks that they experience during the transition process can produce profound emotional pain. Such difficulties may be pronounced for young people with behavioral or mental health challenges. Striving to cope with mental health issues simultaneously with normal developmental tasks can make navigating social situations particularly daunting.

In this article, we show how building and maintaining hope may be particularly important for young people with emotional and behavioral challenges, because hope is a key part of both resilience and recovery. People who work with adolescents can benefit from understanding the role that hope can play, and how hopefulness can be increased, during this crucial time of transition to adulthood.

Hope as we define it (see Snyder, 2002) is a future-oriented pattern of thinking that involves the abilities to: (a) set clear and challenging "stretch goals," (b) develop the strategies or pathways to those goals, and (c) muster the necessary motivation to use those pathways to pursue objectives. All three hope components are necessary in order to successfully attain goals. Success in this context does not simply mean "getting what one wants," but rather getting what one wants in such a way that mental health benefits are maximized.

When each of the hope components is present in sufficient magnitude, people will expect to succeed. Even when they do not succeed, however, high- as compared to low-hope people are better able to cope with their failure experiences. When low-hope people fail to achieve goals, they typically cannot create alternate pathways to go around obstacles. Accordingly, these individuals with low hope are prone to give up, to criticize their own abilities, and to experience strong negative emotions. On the other hand, when individuals with high hope fail to attain goals, they simply acknowledge that they did not try hard enough or that they did not have access to the most useful pathways. Instead of becoming stuck in criticizing themselves, the high hopers get busy in finding solutions. As a result, any negative emotions experienced by high-hope people are not likely to incapacitate them. On this point, we have found that high- relative to low-hope people try harder and persevere longer after failure experiences precisely because of their abilities to retain their positive emotions.

Researchers consistently have found that high- compared to low-hope people achieve superior outcomes across a range of performance and mental health indices (see Snyder 2002, for a review). For this reason, we have suggested that having hope is vital for the successful transition from adolescence to satisfying adult roles (Shorey, Snyder, Yang, & Lewin, 2003). We also have proposed that intentionally instilling hope in young people should be a societal priority. To understand how hope can be instilled, however, we first will need to look at how hope develops naturally in the course of childhood development.

Hopeful Development

Hopeful development begins in early childhood through ongoing interactions with consistently available and responsive caregivers (Shorey et al., 2003; Snyder, 1994). Children learn that they can engage freely in exploring their environments when parents provide what attachment researchers have termed *secure bases* (See Bowlby, 1969/1982). The secure base is a safe haven to which a child can return for comfort, support, and guidance when she becomes fearful because of the obstacles that she encounters. Over time, children with secure bases will internalize beliefs in the availability of other people, in themselves as being lovable, and in the world as being a safe and predictable place. Parenting can thus support *secure attachment styles* in children. In contrast, *insecure attachment styles* can result when this type of parenting is not available. Permissive, authoritarian, and rejecting parenting styles are linked to insecure attachment. Other variables including negative life events (e.g., loss of a parent, life-threatening illness in a parent or the child, or parental psychological disorders) and wider social contexts (e.g., economic patterns necessitating parents working long hours and thereby being less available and/or less responsive) can take away children's secure bases and lead to insecure attachment.

Adolescents with insecure attachment styles are predisposed to experiencing setbacks in establishing satisfying peer and romantic relationships. For example, adolescents with "preoccupied" attachment styles are likely to place an exaggerated premium on relationship importance. When they experience relational setbacks these young people often have exaggerated negative emotional reactions. Moreover, because they are hypervigilant for potential signs of rejection, they are likely to perceive interpersonal threats even when such threats are negligible or nonexistent. Given their high levels of emotionality, they then may lash out angrily, or they may urgently seek reassurances from others. Other people, however, are likely to perceive such behaviors as aversive and withdraw their support. In this way, preoccupied individuals contribute to their experiencing that which they fear the most—rejection.

With increased perceptions of being distanced or rejected, anxiety for these preoccupied persons is likely to rise dramatically. Efforts to regulate these negative emotions and to reestablish some semblance of interpersonal security may include the preemptive rejection of others or the desperate seeking of approval in order to bolster floundering self-esteems. Such approval seeking may take the form of delinquent behaviors, sexual promiscuity, or drug or alcohol abuse.

Of course, difficulties forming social relationships can arise in children and adolescents whose parents are warm, available, and responsive. Despite available parental support, children with emotional and behavioral problems often have difficulties with interpersonal relationships. Social anxiety, depression, impulsivity, and difficulty decoding emotional cues all may impede the development of relationships, and can result in decreasing hopefulness. Furthermore, children and adolescents with emotional and behavioral difficulties may spend much of their time coping with and managing the effects of their disorders. As a result, they may miss out on a range of opportunities to build hope or to reach important developmental milestones.

As hope for achieving commonly accepted social goals begins to wane, other goals may take precedence for children and adolescents who are struggling. Goals of belonging gradually may be replaced by goals of escaping feelings of distress and negative emotionality. Goals of gaining entry into valued peer groups may be replaced by goals of gaining entry into any peer group in which acceptance and security can be attained.

Teaching Hopeful Thinking

It is important to be mindful that adolescents who experience such rough transition phases may perceive society's representatives (e.g., parents, teachers, or school administrators) as being out of touch with the goals that are most important to them—their social goals. In this respect, contemporary psychology researchers have consistently documented the primacy of social goals and over achievement-oriented goals. This is not to say that adolescents do not understand the practical significance of being skilled in the arts of reading, writing, and arithmetic. The application of achievement-oriented academic skills, however, may seem abstract and unimportant to adolescents if they are in emotional pain because their current needs for security and belonging are not being met. For this reason, lessening adolescents' emotional pain by helping them to learn how to attain social goals may enhance their academic achievements. In this regard, interventions that increase social competence also significantly increase academic competence (Watson, et al., 1989).

We have found evidence in our own laboratory about the primacy of social goals. Among college-aged students, for example, the hope of achieving social goals (relating to friends, family, or romance) had a direct impact on positive mental health, whereas hope for achieving performance-oriented goals (relating to work or academics) did not. This and other research has convinced us that adolescents' social goals cannot be ignored if we expect them to pursue socially valued goals related to academic and career achievements. In this regard, we have developed a curriculum that is specifically tailored to raising hope among at-risk adolescents.

Our approach has been to teach hopeful thinking in a framework that emphasizes the importance of having a secure social base. We also teach adolescents to attend to their basic needs of security and affiliation as they move toward pursuing higher order goals (e.g., goals involving college educations that are wants rather than basic needs). Thus, the system of hopeful thinking that we teach is applied to the goals that adolescents view as being personally important. For example, if a young person is lonely, we work on helping him or her to develop the strategies, resources, and motivation to pursue friendships. We do not think that it would be advisable to ignore this young person's loneliness and to ask him or her to concentrate on the goals that we think are important (e.g., academics success). Experiencing success in their own personally important life areas, however, should have the effect of bolstering the drives and motivations of young people to succeed in other socially valued life areas.

Artwork by William Chen (age 11) of New Jersey
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Of course, children will be willing to try new strategies and behaviors to the extent that they have secure bases to retreat to for comfort, support, and guidance when they stumble or encounter impediments. In this regard, every child should have a consistently available adult mentor. When parents are not available, young people can rely on a caring neighbor, teacher, or other "coach" to fill this mentor role. Research has indicated that the key characteristic of resilient children is that they find their own mentors in the community (Masten, 2001). Therefore, coaching teens in social skills is important in helping them make these adaptive interpersonal connections. Moreover, adults need to be particularly attentive to the affiliative bids made by young people whom they encounter. Young people who need the most guidance may be the same children who have parents who are least able to provide it. A supportive and available "coach" can help break the mold of previous relationships and failure experiences and help teens build new roadmaps for their futures.

With mentoring and social support in place, teens can be free to focus on learning how to create and construct "adaptive" goals. Many goals that adolescents initially verbalize in our hope intervention groups are constructed in such a way that they set the teen up for failure. For example, open-ended goals (e.g., to become rich or to become a better person) are not measurable and do not have specific time frames within which they can be reached. Accordingly, the pursuer cannot know when the objective has been reached, nor can he or she experience the positive emotions associated with successful goal attainment. One of the first things that we do in our groups, therefore, is to help adolescents to frame their goals so that they are (a) measurable, (b) set in distinct time frames, (c) single goals (to get a job and make lots of

money is two goals), (d) consistent with longer-term life objectives, and (e) cause no harm to self or others.

Once goals are framed so as to facilitate success, we and other mentors are in the position to begin teaching ways to problem solve—helping teens anticipate roadblocks, develop alternative routes to go around impediments, and find new resources. Finally, supported by trusted mentors and armed with adaptive goals and strategies, teens can learn ways to bolster their own positive emotions and motivations.

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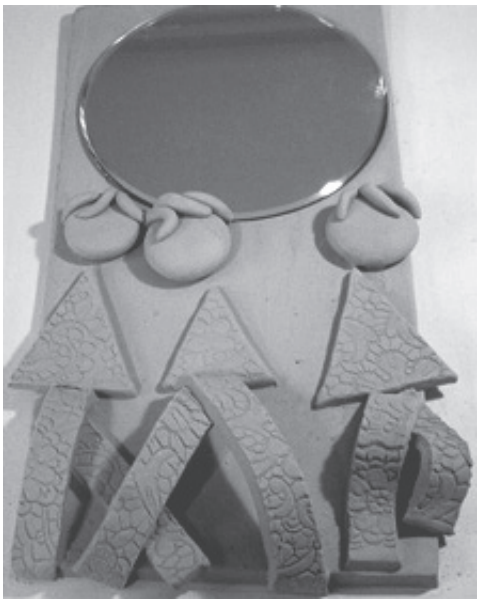
Surviving the System

My name is Angela Nelson, and this is the story of my survival. I grew up in the child welfare system in Illinois, spending most of eleven years in psychiatric institutions and group homes. I can honestly say that the system did not help me recover from any of the problems I came in with; in fact, it created additional difficulty. The system focused on controlling my behavior with little regard to the issues that brought me into the system in the first place. In particular, I received very little education and there was no effort to keep my family unit together. Despite the lack of regard for my future, I still maintained hope and I am living independently today. I know reaching my goals will be difficult, especially since there are few resources and little support available to me now.

My mother had me the month after her 14th birthday. My father was 19. My mother's father told her to have an abortion, but she decided that she wanted to keep me, and ran away to Memphis to live with her mother. My mother left me with my grandmother until I turned six. My mother had turned 20, and decided that she could take care of a child. She fought for custody, and I came back to Chicago to live with her and my stepfather. About seven months after I came to live with her, my stepfather left. Although I didn't know it at the time, they had had an arrangement to suit both of their needs. She needed to show she had a stable home and he needed to obtain citizenship.

After my stepfather left, things went downhill rapidly. I went from



one relative's home to another and occasionally I lived with my mother. When I lived with her, she beat me and left me at home by myself. There were times when I told the public defender that I didn't want to be at home with my mother because she was beating me. He said he couldn't just take a child away from her home because she didn't want to be there. But I kept telling him it was because she was beating me. I definitely had been involved with the system before I came into the system. But the system kept sending me back to her.

At the age of ten, almost eleven, things seemed somewhat normal. Then my uncle came to live with us. He started sexually abusing me and I told my teachers about it. He was removed from my house. The system didn't offer us any support. About a month later, my mother asked me to clean my uncle's room. I turned over the mattress and I saw a *Playboy* magazine and some matches. I lit the matches and put them on the bed. I went into the system after I set my house on fire. I never understood why I set my house on fire until years later, when I realized my mother probably would have eventually killed me if I had stayed at home. I think deep down inside, I realized that was my way out.

Little did I know that once I came into the system my problems had not even begun. Coming into the system with a label such as a fire setter sometimes prevents people from seeing who you really are. They really can't see past that label. I really think I was a decent kid and years later, my mother said I was a pretty good kid. Damn right—I *was* a good kid.

I got into the system and the first place I landed was a psychiatric institution. I spent 11 months there. From the medication to the seclusion to the restraints, how was I supposed to adjust? I was surrounded by people I didn't know:

nurses, doctors, psychiatrists, and other children who also had behavior problems. It was an unrealistic adjustment I was supposed to make. Needless to say, I didn't do too well adapting. Of course, more labels followed. I rarely saw anybody from my family. I saw my mother once or twice. My teachers came to visit me once. My grandparents came to see me once. I saw none of my cousins, aunts, or uncles. To this day, I just cannot comprehend how I survived my world being flipped upside down like that. But of course since I didn't handle it well, I was the one who suffered.

I got out of the first institution and I went to a group home. More strangers. I stayed there for three months. I believe I had so many unresolved issues that, before I could be anyplace successfully, the issues that brought me into the system would have to be addressed outside of a pill bottle. But that's clearly not what my treatment plan was. Therefore, since I desperately needed to be in control of my own existence, we battled. And they always won because they had the ability to give me shots, pills, restraints, and seclusions anytime I resisted, questioned, or disobeyed their nonsense.

After leaving the group home, I went back to the hospital for three months. That was just more of the same old nonsense of them controlling my existence. I left there and went to another group home for three weeks. Still, nothing had been resolved and I was 13 at this time. The issues that got me into the system were no longer the issues at hand. I was faced with a whole new set of issues. The system wanted to control me, and I resisted.

I left the group home and I went back to the hospital. My father's mother tried to get custody of me. Needless to say, she was not a winner. Let's just put it like this–it wasn't a good match. But at least I wasn't in the hospital. One day I got into a fight at school. The school called my grandmother, but she was not at home. Since she was not at home, they called my social worker. She came to the school with another social worker. On the way to my grandmother's house, I told her that I wanted to get out of the car because I could go home by myself. She disagreed, and we fought. This fight with my caseworker at 14 years of age landed me a 4-year stay in a state hospital. Needless to say, the restraints and the seclusion and the medication that I experienced earlier in life do not compare to the seven days in restraints and another three days in restraints and the endless amount of medication and the countless hours in seclusion. If I could do it all over again, I would have stayed at my mother's house and let her continue to beat me and let my uncle continue to sexually abuse me. By the time I got out of this institution, I can assure you if I didn't have mental health issues before I went in, I had them now.

When I was discharged from the hospital, I went to a group home in Denver. Of course, that didn't last very long. I returned to Chicago to the adult hospital. We all know that's a different ball game. I was thrown right into the mix of people there, many with serious mental illness. Thank goodness I had found a psychiatrist who was actually willing to listen to me. When I told him I didn't need medication, he said OK. He told me that if a staff member asked me to go to my room and I didn't get out of control, they wouldn't put me on medication. I haven't taken a pill since. Of course, since I had such a stellar record, programs in Chicago weren't exactly eager to take me. So I spent six months in the adult psychiatric institution. Not because I needed to but because I had no place to go.

Once the Department of Children and Family Services did find a place for me, they expected me to live alone and to basically take care of myself. Thank goodness for me there actually wasn't too much wrong with me. I have always thought I got caught up in the system. I got labeled because of my behavior, and I never had a chance after that. Unfortunately for me, I was just as uneducated when I came out of the system as I was when I went in. So I didn't have many skills or any money. I ended up on social security, yet again a financial burden to the system.

In all of this, I did come out with a wonderful gift for the arts. I was able to recognize an opportunity when I saw one. I was walking down the street one day and I saw a sign that stated, "Do you want to learn how to make tiles for free?" Being interested in the arts and not having money for materials, this was an opportunity to be creative at somebody else's expense. It was a great success. It gave me hope that I actually could do something meaningful with my life. Today I feel much better about studying for the GED because I have succeeded in something in another part of my life. I am good at art and it gives me a good sense of myself. Although there have been a lot of ups and

downs in my life, I knew I could shape my own world and I have done so with the help of my creativity. I have been able to supplement my Social Security money with the sales of my artwork. Of course, making a living that way is hard, so I have been working toward my GED so that I will have more employment options. I failed the GED three times, but I am hoping to pass it this June. I am also working on a book that I plan to finish this year.

I would like to close by saying this: if people in the system could have looked to the future and could have seen both me and my mother as productive members of society, they could have given my mother some parenting classes, helped her get some kind of skill or trade, and helped to educate me. We could be productive members of this society. Instead, she's on Social Security and she receives food stamps. I, too, am on Social Security and I receive food stamps. We are both still uneducated.

The system has to meet real needs in order for people to truly function in this society, especially if they already have challenges. If you take a child from a mother and do nothing with the child, what is the point? If I had gotten some of the right kind of help at the beginning, much of what I suffered could have been avoided. So if you're trying to help children and families, look towards their futures to see what it is you can do to help them be successful when the system has left their lives five or ten years from now.

Angela Nelson lives in Chicago. Her artwork can be viewed at www.geocities.com/angelasceramics/tiles.

Supporting Recovery for Older Children and Adolescents

For children and adolescents, recovery is best understood as a process that enables the young person and his or her significant adults to understand and manage the realities of an emotional disorder, so that the young person can return to a positive developmental path. Recovery starts from the idea that young people have within them capacities that will, if unleashed, propel them on a constructive developmental course. Recovery-oriented therapeutic services facilitate the efforts of children and youth to connect with their strengths and capacities as drivers of positive development. Recovery-oriented services also focus on providing opportunities for children to participate, free of stigma, in activities alongside peers and adults who comprise their community. An essential part of this work is empowering parents—and other significant adults in the youths' lives—in their roles as the primary facilitators of the recovery process.

A functioning system of care and a high fidelity wraparound process provide the ideal context for supporting recovery. The system of care values and principles—with their focus on individualization, cultural competence, family empowerment, and strengths—are inherently in tune with a recovery approach. For individual children and their families, the wraparound process addresses the challenges of working around limitations from an illness or disorder and getting on with the process of growing up. Within this context, strengths-based, culturally competent, individualized treatment can thrive and conform to the core values of recovery.

The Experience of Recovery

Older children and youth rarely embrace the role of "mental health patient" as they enter treatment. They are more comfortable playing, or talking about their social world; and they have neither the vocabulary nor the inclination to discuss the concept of recovery. It is a therapist's task—in consultation with parents, their child and, if available, a wraparound team—to find ways to help the child *experience* the recovery process. Consider this example:

Ted, an unhappy 10 year-old boy, avoided all talk of his feelings and of his family circumstances. His father was in prison. Ted missed the good times he had with his father fishing in the lake near their home. Although those times were precious few, the boy was full of stories of catching the biggest and best fish. Ted's therapist had him bring his fishing gear to his office and worked with the boy to untangle lines and get ready for a fishing trip. His mother, with a wraparound team's support, had connected her son with a peer group that took monthly outings with a youth recreational worker. Ted and his mom had suggested a fishing trip as an activity and the "therapy" was understood by the boy as preparing for that trip. While untangling fishing line prior to the trip, Ted had important conversations with his therapist about school, about his mom and siblings, and occasionally, about his dad. The therapist allowed the boy to avoid emotionally overwhelming topics and kept emphasizing the boy's capabilities in organizing fishing tackle. With support from the youth leader, Ted had a great experience. On the trip he gained status among the other boys as a fishing expert, and this left

him confident as a leader. When he returned, his mother was impressed with her son's swagger and confidence, as well as with the fish he brought home. Fishing stories became a way for him to enjoy being in school. He gladly adopted the nickname "Fish" with his friends.

Ted never once heard the terms *recovery*, *resilience* or *protective factors*. He would have been bored and put off by any such talk. Yet he was in a position to teach all the adults in his life what a strength-based approach can do for a withdrawn and depressed boy. He found a way to reconnect to a developmental process, identifying with positive aspects of his father, incorporating such attributes into his growing personal identity, and earning respect for his capability. Ted was also placed on an antidepressant medication and monitored by a doctor who knew about the boy's love of fishing. That doctor enabled Ted to see that the medication had a positive effect on his patience, which in turn increased his fishing success. A doctor can be perceived as an ally when offering a medication that further diminishes the implications of a mental health problem and enables a youth to engage more fully in developmentally appropriate activities.

Risk and Recovery in Adolescence

The developmental tasks of adolescence are primarily social, as young people change the focus of their lives from family to community and from parents to peers. The presence of a mental illness in adolescence often distorts this social-developmental process. On the one hand, it can lead to a youth being more dependent on parents than is age appropriate. Alternately, it can lead to a teen being defiant to parents in a way that increases risk for further social and mental health difficulties. It is often a central therapeutic task to help the young person and his or her family to navigate between these extremes, as in this example:

Erin, an unhappy girl who was failing in school, had recently been diagnosed with bipolar disorder. Her drinking in peer situations had gotten out of control. She began to act in a more and more outrageous and disrespectful manner toward her mother, defying the curfew her mother had set for her and sneaking out of her window at night to be with friends. Erin was very aware of her irritable mood, which was painful to her as she recalled the good-natured, fun kid she had been before. Though terrified she was "going crazy," she refused to acknowledge any problem to anyone. Her means for coping with excess energy had been sports, and she held her life together during basketball season by playing and exercising regularly. After basketball season, she began going to raves, taking ecstasy and dancing with enormous energy.

After a while, Erin's problems began to spill over into her peer world. She got drunk at a party and engaged in public sexual behavior with a boy. The high school gossip mill spread word of the incident, providing her instantly with a bad reputation. Some of the cool kids shunned her, and new, more troubled boys wanted to be her friend. Erin began to sink into self-hatred, cutting herself, and imagining gruesome ways to commit suicide. Eventually Erin's mother convinced her to accept a hospitalization. The experience only increased her rage as she was given a mood stabilizer that caused her to rapidly gain weight. The only positive outcome was that she was able find a psychiatrist she could work with once discharged.

The new psychiatrist helped Erin's mother get into a parent support organization where she encountered other parents who had faced similar problems with their children. The psychiatrist wasn't shocked or judgmental about Erin's difficulties and Erin was relieved to be able to disclose her thoughts and feelings. Her particular concerns were the cruel comments boys had made to her and the loss of status she experienced with girls who had formerly been her allies. After some explanation about bipolar illness and the medications she might find useful, Erin was very open to re-trying a mood stabilizer. She was grateful to her psychiatrist for not giving her a medication that would cause her to gain weight.

Erin's medications quelled her constant irritability. She began to exercise more and feel better. She stuck close to her good friends who defended her amongst her classmates. She continued to go to parties, but friends refused to let her drink. She continued to fight with her mother, who was determined to curtail Erin's risky behavior. Erin resisted and defied her mother's attempts to ground her. Friends came to the house to talk to Erin's mother and assure her that her daughter was beginning to take care of herself. They promised her that

they would not let Erin endanger herself. Erin's mother made some compromises with her daughter as she sensed the constructive nature of her daughter's relationships with friends. Erin stuck by her agreements regarding a very liberal curfew and was supported in doing so by her good friends. As the climate of hostility began to change, Erin and her mother had a long tearful night that ended in reconciliation.

Gradually, Erin's mood improved and she began to seek some accommodations from her school so that she could salvage her spring semester. She continued to go to raves because she loved to dance, but she went with a good friend and found she could enjoy dancing without ecstasy. She became a peer mentor to others and participated in a youth group that intervened to keep other youth safe at parties. Her mother, though wary of such social events, grew to respect Erin as she proved her capacity to handle social events responsibly. Erin's mother also became active with other mothers seeking more constructive and safe social outlets for youth in their community.

With the support of the therapist, peers, friends, and family, Erin was able to re-engage with a healthy and normal (for her community) developmental process. However, Erin never really thought of herself in treatment and certainly never contemplated the concept of recovery. The mental health professional may *call* it a recovery process, but the young person *lives* a recovery process. Youth simply know when things are screwed up and when they get it together.

Treatment that Supports Recovery

Treatment that supports a recovery process for teens must be supportive of developmentally appropriate moves for more independence and privacy within their family. An effective therapist recognizes that youth are going to experiment with behavior that is normative, developmentally, even though it may carry extra risks for someone with an emotional disorder. Dating, engaging in sexual experiences, experimenting with drugs and alcohol, and experiencing the liberating feeling of being in an unsupervised group of youth edging toward out-of-control behavior—these are all experiences that are part of normal adolescence. A therapist can help the young person learn to manage the risks that are inherent in these activities and to participate in youth culture in a manner that makes sense, given the young person's particular needs. This is done through education and negotiation about the kinds of accommodations a youth must make for his or her illness. This process demands a high degree of confidentiality for the youth, but also a close alliance with parents who, understandably, have fears for their vulnerable son or daughter. An important facet of the therapist's role with an adolescent in recovery is to help the youth negotiate with parents regarding reasonable limits, and to help the parents avoid inappropriately limiting their adolescent child out of fears stemming from the illness or disorder. Parents suffer most from quandaries that arise around potential sources of risk. With good reason, they see unsupervised social activity among teens as risky, and it is a parent's job to be alert for signs of such behavior running out of control. But risk is also a part of the fabric of experiences that allow youth to grow and mature.

Professionals sensitive to the principles of recovery in youth can be invaluable allies with young people as they move toward restoration of the developmental process. To do this effectively, professionals need to be able to help young clients recognize and build on their strengths. Additionally, professionals must have the ability to support their young clients in learning to appropriately engage in the types of situations and relationships that are part of the normative developmental process. Professionals must also understand the families their youthful clients come from and recognize that young people love their families no mater how disguised that love may be. Finally, professionals must be able to help the young person and his or her significant adults work together. With these capacities, a professional can facilitate a recovery process that engages a young person's assets and allies, and promotes a return to a healthy developmental path.

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RESILIENCE *AND* RECOVERY: CHANGING PERSPECTIVES AND POLICY IN OHIO

Beginning in the mid-1990s in Ohio, adult mental health consumers began to have an increasing impact on the state's mental health policy. Leadership within the Ohio Department of Mental Health began to work with adult consumers and, at the same time, consumer advocacy networks were strengthening. Adult consumers promoted the idea that services should focus on recovery.

Advocating for children and families, the Ohio Federation for Children's Mental Health had representatives at the table when these initial discussions about recovery were taking place. Family advocates supported the recovery philosophy, but at the same time felt that the recovery concept did not draw attention to some of the issues that are particularly important for children and families. They kept pointing out that children are not just little adults, that the mental health services and systems for children and adults are very different, and that the philosophy of recovery simply did not connect with some of their central concerns.

One difficulty families had with *recovery* is that the word implies going back to what existed before. For families and children, going back to a time before the mental illness or the mental issue began to impact life is not an option. If your child has been struggling for two or three years and is now six years old, the goal is not to restart the developmental process at age three, but to recoup those years as part of the process of moving ahead. To support this kind of ongoing development—this moving ahead in the light of emotional or behavioral difficulties—mental health services and supports need to be built on the cornerstone of hope, and they need to focus on using and developing the strengths of the young person and the family so as to build a full life.

Resilience

For family members, the idea of *resilience* captures this vision best. Resilience brings attention to the strengths of the child as protective factors and as assets for the process of positive development. Resilience also draws attention to the family as the most important asset a child can have. Family advocates felt it was essential for the state to place resilience on an equal footing with recovery as a guide for mental health policy and practice. They felt that a resilience orientation would help to bring about changes that were in line with the two central elements of their vision for transforming Ohio's mental health system: the empowerment of families and youth at all

levels of the service system, and the focus on hope and strengths.

Initial attempts to get the state to recognize the importance of the concept of resilience were not particularly successful. Family advocates would use the term resiliency, and providers and policymakers would nod their heads and then just go right back to whatever they had been talking about before. But four or five years ago, things began to change with the gradual shift toward a greater voice for families and youth in various state-level planning and decision making arenas such as the Mental Health Planning Council and the Clinical Quality Council. Family advocates used those venues as opportunities to keep reminding people—adult consumers, mental health providers, and state policymakers—about the issue of resilience.

Then, with the publication of the final report from the President's New Freedom Commission, things finally began to change. The report validated what family advocates had been saying all along about the need to focus on resilience. At about the same time, the Department of Mental Health developed consumer-family partnership teams as a means to increase consumer and family voices in policy decision making. The Department of Mental Health allocated funds so that consumers and families from across the state of Ohio can get support to pay for their transportation and their hotels. This means that they can be at the table when policy is made. The goal is to have 50% consumers and family members and 50% Department people or providers at the table. While attaining this goal is still in the future, it has provided a wonderful opportunity for families to speak out and for youth to be involved. The state is working on policies that require a public arena for family input whenever there is a new initiative in the state that impacts them. These are mechanisms that promote inviting, recruiting, and supporting families and youth to give their input and opinions.

All along, the Ohio Federation for Children's Mental Health kept using its voice to promote resilience and to pressure the state to get serious about it. Two years ago family advocates developed a proposal asking the Department to fund a series of forums across the state. The forums invited young people and their families to come and talk about resiliency and to describe what had been most important in giving them hope and making their lives better. With state funding, six of these forums were held across the state. Data was compiled and given back to the Department.

What was learned during the forums was wonderful and also surprising. One might expect that folks would give most attention to the service system or the lack of services. They did comment on services, but what was surprising to the facilitators of the forums was how much of what youth and families said could have come straight out of a book on developmental assets. They were talking about the importance of having an adult just to talk to, the importance of supportive relationships in the family, and the need to feel a sense of acceptance and belonging at school and in the community.

The Resiliency Ring

Advocates were determined not to allow the state just to sit on this great information. After about a year, advocates decided they needed to do something independently to draw further attention to the issue of resiliency. To do this, family advocates organized a public relations event in Columbus and called it the *Resiliency Ring.* The event started with a rally at the capitol, with speakers including the head of the Department of Mental Health and a young woman who was a suicide survivor. Several state legislators came, as did Hope Taft, Ohio's first lady. Also present were families from all over the state and people from a number of advocacy organizations. The highlight of the rally was when attendees held hands in solidarity and formed the Resiliency Ring, encircling the capitol building. After the rally, advocates paid a personal visit to every legislator and provided him or her with a packet of resiliency-focused literature. Advocates spent time with the legislators, providing an overview of findings from resiliency studies and talking about the policies and issues that tie into a resiliency framework.

The Resiliency Ring was a huge success and received quite a bit of attention in the media. The event seems to have had a real impact too. In a budget full of cuts, one bright spot is a carveout for children's mental health that includes increased support for family advocates to work directly with families. What is more, it has become rare to see policies or administrative rules coming from the state that do not use the words resiliency and recovery together. The Federation has been working with the state to develop a definition of resiliency that is workable and that resonates with families and young people.

Of course, there is still much to do in terms of building a mental health system that knows how to foster hope and build strengths. At the same time, progress is obvious. The terminology of resiliency is becoming embedded in Ohio's mental health policies and standards. Advocates continue working to broaden people's understanding of mental health and to help them see that there are many creative ways to promote positive development and wellness.

The image at the beginning of this article is the logo for the Resiliency Ring.

This article was written by **Janet S. Walker**, based on an interview with **Terre Garner**, Director of the Ohio Federation for Children's Mental Health.

Developmental Assets and the Promotion of Positive Development: Findings From Search Institute Data

The healthy development of youth is a value and a goal of American society. Families, schools, and communities are charged with nurturing, socializing, and educating children to be competent, happy, positively contributing members of society. However, the theory and research traditions associated with psychology—developmental psychology in particular—have historically been framed within a deficit perspective regarding youth.

G. Stanley Hall (1904) initiated this deficit perspective with his description of adolescence as a time of inevitable storm and stress. Similarly, Anna Freud viewed adolescence as a period of developmental disturbance, and Erik Erikson believed that youth identity was born of crisis. Under the influence of the deficit perspective, much of the research and theory about youth development has emphasized a medical model that focuses on the diagnosis and treatment of problems. In addition, the data collected on youth and the media's portrayal of youth have often stressed problems, risk behavior, and challenges. In response, interventions and programs for adolescents have often focused on specific problems or disorders. However, this approach detracts from viewing youth holistically, and as possessing hopes, purpose, and skills, as well as problems and challenges. Moreover, viewing youth as the target of change overlooks the importance of the multiple contexts youth inhabit. These contexts also have strengths that can be engaged to promote healthy development and recovery from adversity.

Research in the 1980s and 1990s began to focus on the study of *positive youth development* (PYD). This approach emphasizes the potential in every individual for positive, healthy growth across the life span, regardless of socioeconomic situation, past negative experience, or clinical diagnoses. Instead of trying to fix problems, the PYD approach considers ways to develop individuals *and* social contexts through strengths-based policies and programs and through the empowerment of youth and families. Research derived from this perspective seeks to align children, families, and communities with growth-supportive resources, opportunities, and experiences, leading to healthy development and thriving.

The PYD approach views adolescence as a period of the life cycle with unique opportunities for developing assets and putting young people on a positive developmental path. Youth are viewed as eager to explore the world and build competencies (Damon, 2004). From this perspective, youth who have experienced mental health issues need not only treatment, but also growth-promoting, challenging activities that help develop their identities, skills, and interpersonal relationships. Of course, developmental challenges and adversities do exist; however, they do not define the adolescent and determine all treatment and interactions.

Impact of Developmental Assets

Benson and colleagues (1998) at the Search Institute have proposed a framework of 40 developmental assets, with 20 internal assets (unique to the individual), and 20 external assets (available in youths' families, schools, and neighborhoods) that promote healthy growth among young people. Benson et al., believe that when these external assets (e.g., support, empowerment, boundaries and expectations, and constructive use of time) are integrated over time for youth with internal assets (e.g., commitment to learning, posi-

Table 1: Fourteen Developmental Asset Scales

Developmental Assets	Definition
Individual Asset Scales	
Social Conscience	Being committed to equality, social justice, and helping to make the world a better place
Personal Values	Committing to values such as honesty, responsibility, and integrity
Interpersonal Values and Skills	Caring about other people's feelings, demonstrating empathy, and being a good friend
Risk Avoidance	Making good choices when confronted with risky situations (e.g., "Being able to say no when someone wants me to do something that I know is wrong or dangerous")
Activity Participation	After-school involvement in clubs, organizations, sports, and lessons
Positive Identity	A sense of self-esteem and self-efficacy
School Engagement	Being prepared for school by completing homework and bringing books and materials to class
Ecological Asset Scales	
Connection to Family	Interactions with family members include support, communication, and love
Adult Mentors	Having relationships with caring adults whom one looks forward to spending time with
Connection to Community	Being part of a community that values what youth have to say
Parent Involvement	Parents are active participants in schooling—attending events, asking about homework, and encouraging youth to do their best
Connection to School	Having caring teachers, receiving encouragement, and caring about the school one goes to
Rules and Boundaries	Experiencing appropriate and fair boundaries at home, at school, and in the neighborhood
Contextual Safety	Perceiving that one's family, school, and neighborhood are safe and free from danger

tive values, social competencies, and positive identity), then mutually beneficial individual youth ⇔ community context relations are created, providing young people with the resources needed to build and to pursue healthy lives. The model attempts to describe what is universal and good for all youth. However, it is important to note that developmental assets may have different meaning, value, and impact for diverse youth, families, and communities.

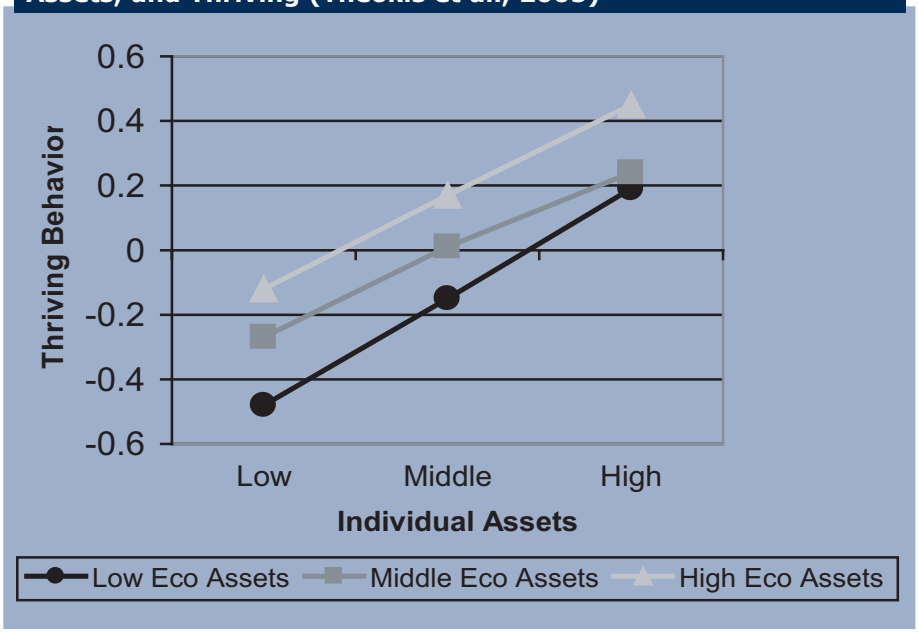
Data from the Search Institute (Benson et al., 1998; Leffert et al., 1998; Scales et al., 2000) regarding the impact of assets suggests there is an additive or cumulative effect of the total number of assets on positive outcomes. Using a sample of more than 200,000 youth in grades 6 to 12 from across the United States, the findings indicate that the more assets a young person reports experiencing, the more likely he or she is to report engaging in thriving behaviors (e.g., helping others or school success) and the less likely they are to report engaging in high-risk behaviors (e.g., delinquency or substance abuse). These relationships are consistent for youth of all socioeconomic strata and racial/ethnic groups. However, the absolute number of developmental assets and thriving risk behaviors do differ among groups, demonstrating the different needs and experiences of youth in the United States.

The Search Institute data also indicate that youth report only having about half or less of the 40 total assets (average = 18) and the total number of assets tends to be lower for high school youth as compared to middle school youth. Some assets show steeper differences than others and may represent contrasting developmental needs of youth in different grades. In addition, boys generally report having fewer assets than girls. This difference may arise from the reporting approach or may reflect different socialization practices and expectations.

The cumulative power of developmental assets for the promotion of thriving behaviors and reduction of risk behaviors is consistent with the PYD vision of how to strengthen the capacities of youth. However, it is also important to understand the unique contributions of specific assets for diverse youth. Youth after-school activity engagement (e.g., involvement in school activities, sports, or community clubs) was the most consistent predictor of positive outcomes for youth of all racial/ethnic backgrounds, when socioeconomic status, gender, and grade were controlled for in statisti-

cal analyses. These activities are hypothesized to include skill-building activities with adult mentors, which are believed to meet youths' developmental needs for competence and positive social bonds. This finding coincides with Eccles and Gootman's (2002) emphasis on the growing importance of community programs as an asset for youth, given America's changing social structure (e.g., more single-parent households) and the increasing education and training needs of youth in our progressively more complex and technological world.

Figure 1: Relationship between Individual Assets, Ecological Assets, and Thriving (Theokis et al., 2005)



Planning and decision-making skills, as well as self-esteem, were also strong predictors of many positive outcomes for diverse youth. In addition, for youth of color, family variables (e.g., provision of support) and community variables (e.g., presence of adult mentors) were significant contributors to thriving. Future research must continue to describe which attributes, of which youth, in relation to what contextual settings, promote thriving.

It is important to note that the 40 assets do not work in isolation, and that there are strong relationships among assets due to the unique cultural niches of youth. For example, school engagement by youth occurs in relation to a caring school climate and high expectations by teachers. To explore the nature of the interrelation among developmental assets, we did a reanalysis of the Search Institute developmental assets data. Theokas et al. (2005) found that the 40 developmental assets could be reduced to 14 asset scales. These scales could be grouped into two categories of seven scales each, representing individual and ecological assets, respectively (see Table 1). Each of these scales combines several assets from the original 40-asset framework, and each scale represents a major category of influence for youth development. Higher scores on each individual scale are related to higher thriving scores.

Moreover, both individual and ecological assets contribute to thriving behaviors. As can be seen in Figure 1, having high assets in either domain increases the likelihood of youth thriving and having high assets in both domains predicts the highest levels of thriving.

Building Opportunities for Thriving

The PYD approach and the construct of developmental assets associated with it are intended to replace the traditional problem-focused paradigm about adolescent development and to help communities and practitioners plan and organize different programs and policies to benefit youth and families. The asset concept orients individuals towards what is good and possible across development. This emphasis reduces the likelihood of stigmatizing youth who have experienced adversity—including mental health challenges. It also provides new avenues for fostering resilience and recovery by identifying many ways to mobilize developmental assets, not just of the individual and family, but also of the community.

The PYD approach and the assets concept use community as an organizing principle. Community ties together multiple, intersecting individuals, relationships, and institutions. Interventions that are confined to a setting (e.g., school reform) or to a problem (e.g., juvenile delinquency) are missing out on multiple opportunities to engender positive change. Multiple, positive social influences throughout an individual's life are needed to maximize motivation, learning, and healthy growth.

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MENTAL HEALTH CONSULTATION IN HEAD START: SELECTED NATIONAL FINDINGS. (Mental Health Services Survey Report). Portland, OR: Portland State University, Research and Training Center on Family Support and Children's Mental Health.

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