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Resilience Interventions for Youth in Diverse Populations

Foreword by
Sam Goldstein

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Resilience Interventions for Youth in Diverse Populations

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ISSN 1572-5642
ISBN 978-1-4939-0541-6 ISBN 978-1-4939-0542-3 (eBook)
DOI 10.1007/978-1-4939-0542-3
Springer New York Heidelberg Dordrecht London

Library of Congress Control Number: 2014935181

Printed on acid-free paper

Springer is part of Springer Science+Business Media (www.springer.com)

Foreword

Life can only be understood backwards, but it must be lived forwards.

Soren Kierkegaard

What are the risk and protective forces that buffer each of us, pushing us along on a unique journey through childhood into our adult years? Why is it that some of us thrive, often in the face of adversity, while others are overwhelmed? In my work with Bob Brooks (Brooks & Goldstein, 2001, 2004, 2007; Goldstein & Brooks, 2005, 2007, 2012), we have written that "it would not be an oversimplification to conclude that realization of our parental goals requires that our children possess the inner strength to deal competently and successfully day after day with the challenges and demands they encounter. We call this capacity to cope and feel competent resilience" (p. 1, 2001). An increasing body of scientific evidence suggests that children facing great adversity in their lives can and do endure. Resilience explains why some children overcome seemingly overwhelming obstacles while others become victims of their early experiences and environments.

Though we now appreciate the role of families, communities, and schools in fostering a resilient mindset we must continue to create opportunities in all corners of our society to enhance and strengthen resilience in our children. No child is immune to the pressures of our culture and society. In our fast-paced, stress-filled world, it appears that the number of children facing adversity, the number of adversities they face, and the number of challenges to good coping continue to increase. Even children fortunate to not face significant adversity or trauma or to be burdened by intense stress or anxiety experience the pressures around them and the expectations placed upon them. The need to develop a resilient mindset is even more critical for youth at risk.

A number of longitudinal studies over the past decades have sought to develop an understanding of the complex qualities within individuals, families, and the environment that interact and contribute to the processes of risk and protection. One goal has been to develop an applied model of this knowledge in clinical

practice (Donnellan, Coner, McAdams, & Neppl, 2009; Garmezy, Masten, & Tellegren, 1984; Luthar, 1991; Rutter & Quinton, 1994; Werner & Smith, 1982, 1992, 2001). These and other studies identified resources across children's lives that predict successful adjustment despite exposure to adversity. These longitudinal studies have also begun the process of clarifying models of how such protective factors promote good adaptation (Wyman, Sandler, Wolchik, & Nelson, 2000).

Whether these processes can be applied to all youth regardless of the level of adversity they experience remains to be thoroughly demonstrated (Goldstein & Brooks, 2012; Ungar, 2008). Ann Masten suggested that positive outcome for many children adopted from high risk areas such as Romania confirms that resilient processes can be applied in a clinical setting (Masten, 2001). Many of these children made significant developmental growth catching up cognitively and physically (Rutter and the English and Romania Adoptee Study Team, 1998).

The process of creating an applied and practice-focused psychology of resilience begins with an understanding of the relevant variables necessary to create a working model and appreciation of the biopsychosocial nature of human development. As Sroufe (1997) and Sameroff (1995) state, such a process must take into account a broad range of biological, psychological, and social factors. This process must begin with a foundation of an appreciation of wellness (Cowen, 1991). A wellness framework assumes the development of healthy personal environmental systems leading to the promotion of well-being and the reduction of dysfunction. A wellness framework emphasizes the interaction of the children with their immediate and extended environment. Meta-analytic studies of the effectiveness of preventive intervention have generated increasing evidence that in clinical as well as community-based samples, emotional, behavioral, and psychiatric problems can be diminished and/or prevented. Such programs emphasize a science of prevention (Coie et al., 1993).

The concept of resilience is straightforward if one accepts the possibility of developing an understanding of the means by which children develop well emotionally, behaviorally, academically, and interpersonally in the face of risk and adversity. Such a model offers valuable insight into the qualities that likely insulate and protect children experiencing a broad range of challenges, including medical problems (Brown & Harris, 1989), family risks (Hammen, 1997), psychological problems (Hauser, Allen, & Golden, 2006; Sandler, Tein, & West, 1994), and parental loss (Lutzke, Ayers, Sandler, & Barr, 1999) to just name a few areas of challenge. Competent, appropriate parenting combined with parental availability and support serves as powerful protective factor extending a broad, positive impact in reducing the probability that children will develop mental health problems (Dubow, Edwards, & Ippolito, 1997; Masten, 1999). It appears to be the case that youth functioning well in adulthood, regardless of whether they faced adversity or not in childhood, may share many of the same characteristics of stress hardiness, communication skills, problem solving, self-discipline, and connections to others. Though the earliest studies of resilience suggested the role of exceptional characteristics within the child that led to invulnerability (Garmezy & Nuechterlin, 1972), it appears more likely that resilience reflects ordinary developmental processes capable of

explaining good adaptation (Masten, 2001). It is likely that there is a complex, multidimensional interaction between risk factors, biological functioning, environmental and familial issues, and protective factors that combine in a unique idiosyncratic way in each child in the course of life transition (Kim-Cohen & Gold, 2009).

Masten and Coatsworth (1988) suggested that resilience within a clinical realm requires two major judgments. The first addresses threats. Children are not considered resilient unless they have faced and overcome adversity considered to impair normal development. Second, a consensus needs to be determined as to how to assess good or adequate outcome in the face of adversity. It continues to be the case that most clinical practitioners define resilience on the basis of a child meeting the major requirements of childhood successfully, such as attending school, making friends, and functioning well within his or her families. Yet, one must also consider that a child facing multiple developmental adversities, who does not develop significant psychopathology but who may not demonstrate academic or social achievement, may be resilient as well (Conrad & Hammen, 1993).

An applied and practice-focused psychology of resilience must provide an appreciation of protective factors within the child, family, and community. Children's temperament appears to play a significant role in their capacity to handle adversity. Interactions with parents that encourage trust, autonomy, initiative, and connections to others serve as powerful protective factors. Living in a safe community and attending supportive school serve an important role as well. Thus, a psychology of resilience must incorporate an understanding of the processes that drive human development. As Lorion (2000) points out, human growth is in part driven by a need to cope, adapt, and develop homeostasis. The complexity of this process is exemplified in the studies of youth capable of overcoming a variety of unfavorable environmental phenomena while others facing similar risks do not.

In a 1988 review of successful prevention programs, Schorr suggested that effective programs for at-risk youth were centered upon the establishment of relationships with caring, respectful, and trust building adults. Ultimately, connections to people, interests, and to life itself may represent the key components in resilience processes (Polakow, 1993). Development, as Michael Rutter contends, is a question of linkages that happen within you as a person and also in the environment in which you live (Pines, 1984). Cowen (1991) argues that mental health as a discipline must expand beyond symptom-driven treatment interventions if the tide of increasing stress and mental health problems in children is to be averted. There must be an increasing focus on ways of developing an understanding of those factors within individuals, in the immediate environment and in the extended environment that insulate and prevent emotional and behavioral disorders. Understanding these phenomena is as important as developing "an understanding of the mechanisms and processes defining the etiological path by which disorders evolve and a theory of the solution, conceptual and empirically supported or supportable intervention that alters those mechanisms and processes in ways which normalize the underlying developmental trajectory" (Cowen, 1994, p. 172). Yet, 20 years later we continue to struggle as a field. Most mental health professionals continue to be trained to collect assessment data focused on symptoms of psychological "difficulty" as described in

the DSM-V (APA, 2013) or other diagnostic classifications. Such symptoms may be equated with poor adaptation, inadequate adjustment, distress and life problems, or even more significant disturbance. Emphasis on the negative equates with the perception that symptom relief will ultimately lead to positive, long-term outcome. Even the recent publication of DSM-V, the accepted nosology of the mental health system, is built on a model that reflects assessment of symptoms and severity packaged into what continues to be a weakly factor-analyzed framework. Still unavailable is a nosology and system to measure adaptation, stress hardiness, and the qualities necessary to deal successfully with and overcome adversity. Yet in the professional practice of psychology including clinical, school, and counseling, we increasingly recognize that it is these phenomena rather than relief of symptoms or the absence of certain risk factors that best predict adaptation, stress hardiness, and positive adjustment into adulthood.

This volume, *Resilience Interventions for Youth in Diverse Populations*, continues the important work of Sandra Prince-Embury and Don Saklofske in their efforts to help create a psychology of resilience. This volume serves as a companion to their 2013 work, *Resiliency in Children*, *Adolescents*, *and Adults*: *Translating Research into Practice* (Prince-Embury & Saklofske, 2013), which focuses on the definition and assessment of resilience. Prince-Embury is also the author of the *Resiliency Scales for Children and Adolescents* (*RSCA*) (Prince-Embury, 2006, 2007, 2013; Prince-Embury & Courville, 2008a, 2008b) which presents a three-factor working model for the assessment and application of resilience theory. In their current volume Prince-Embury and Saklofske advocate further for the systematic translation of resilience theory and research for practice by identifying programs that are already attempting to systematically apply principles based on solid theory and related findings.

As the Coeditor of one of the first clinical volumes addressing resilience in children, now in its second edition (Goldstein & Brooks, 2012), it is exciting to witness the ground swell of interest in applying 60 years of psychological research to develop, create, evaluate, and implement prevention and treatment programs focused on enhancing children's abilities to cope with and overcome adversity. The breadth and scope of the programs discussed in this volume authored by dedicated professionals, from multiple continents throughout the world, speak to the now universal acceptance of what up until recently was considered only an academic subject. Mahatma Gandhi wrote, "The future depends on what you do today." Today we are doing extraordinary and important work for the welfare and future of our children.

Salt Lake City, UT Sam Goldstein

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