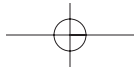
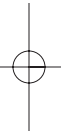
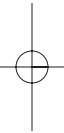
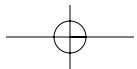
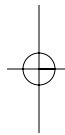
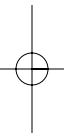
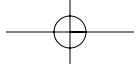


PART I

Introduction





Chapter 1

PREVENTION AND RESILIENCE

CATHERINE N. DULMUS AND LISA A. RAPP-PAGLICCI

Children and adolescents are being diagnosed earlier and more often with an array of serious and debilitating disorders ranging from mental illness to obesity and diabetes. Add to this teen pregnancy, substance abuse, and school violence, and it becomes clear that our youth are at risk for numerous emotional, health, and social problems.

The personal consequences of these problems can include developmental delays, school dropout, future unemployment and poverty, imprisonment, and even premature death. On a societal level, financial costs, loss of competent citizens, ineffective parents, and a future cycle of more problems may be the aftereffects of childhood and adolescent disorders and problems (Dulmus & Rapp-Paglicci, 2000).

The case can easily be made for a preventative approach to such disorders and problems that would be far more fruitful financially and personally than treating the problems once they occur. In the United States during the latter half of the twentieth century, the dominant approach to prevention was the public health model (Institute of Medicine, 1994). The original classification system of disease was proposed by the Commission on Chronic Illness (1957) and consisted of three types of prevention intervention: primary, secondary, and tertiary. The primary level seeks to prevent a disorder or problem. The secondary level addresses treatment of the disorder or problem once it occurs, and the tertiary level focuses on rehabilitation. This approach to prevention started out as an effort to prevent infectious disease. Because of its success, it was later extended for use with noninfectious diseases and physical illnesses (Institute of Medicine, 1994). The public health model of prevention, although a good beginning, does not focus all efforts on preventing a disorder or problem (Dulmus & Wodarski, 1997).

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PREVENTION RECONSTRUCTION

The Institute of Medicine (1994) defines *prevention* as those interventions that occur before the initial onset of the disorder, with preventive research and interventions being limited to the processes that occur before there is a diagnosable disorder or problem. The treatment of such disorders is defined as *maintenance*. We support this approach because, unlike the public health model, this approach focuses on interventions to prevent the onset of a disorder or problem. Gordon's model addresses prevention from this perspective (Gordon, 1983, 1987). Its interventions are broken down into three areas: universal, selective, and indicated:

1. *Universal preventive interventions* are defined as interventions for disorders or problems that are targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
2. *Selective preventive interventions* are interventions that are targeted to individuals or a subgroup of the population at high risk of developing a specific disorder or problem at some point in their lifetime.
3. *Indicated preventive interventions* are defined as interventions that are targeted to high-risk individuals who do not meet the specific criteria for a mental or medical disorder, but who otherwise are identified as having minimal but detectable signs or symptoms of a specific disorder or who have a biological marker indicating predisposition for the disorder (Institute of Medicine, 1994).

Thus, a risk reduction model to prevention complements Gordon's approach to prevention.

RISK REDUCTION MODEL

A risk reduction model is a promising approach to prevention, whereby risk factors are identified and matched to empirically tested interventions (Institute of Medicine, 1994). Risk factors are characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected from the general population, will develop a particular disorder (Werner & Smith, 1982). Risk groups could be identified on the basis of biological, psychological, or social risk factors that are known to be associated with the onset of a specific disorder. Once identified, individuals or subgroups of the population at risk for developing a particular disorder could be targeted with selective preventive interventions (Institute of Medicine, 1994).

It is likely that both biogenetic factors and social conditions jointly operate to heighten the risk status of children (Garmezy, 1993). The manifestations of problematic development in vulnerable children are as varied as the risk factors to which they are exposed (Hauser, Vieyra, Jacobson, & Wertlieb, 1985). Psychosocial development from early childhood through adolescence and into adulthood is shaped by myriad specific events, ongoing circumstances, and inherent strengths and vulnerabilities of the individual (Hauser et al., 1985). Certain events and circumstances are especially likely to adversely affect this development. Cowen and Work (1988, p. 591) state: "Negative psychological effects of multiple stressful life events and circumstances cumulate like lead poisoning." These situations vary widely, but if risk factors can be decreased or in some way altered and/or if protective factors can be enhanced, the likelihood of at-risk individuals eventually developing a specific disorder or problem would decrease (Dulmus & Rapp-Paglicci, 2000).

RESILIENT CHILDREN

Of interest to researchers are children who are exposed to risk factors associated with development of particular disorders, yet maintain their mental and/or physical health. These children are referred to in the literature as "resilient," "invulnerable," or "ego-resistant" children. *Resilience* is defined as "the tendency to rebound or recoil," "to return to a prior state," "to spring back," and "the power of recovery." Garmezy (1993) defines a *competence item* as one that measures successes and achievement in meeting the major adaptational expectations or requirements of people of the age of the subject. Rutter (1981, p. 323) defines *resilience* as a phenomenon, "as shown by the young people who 'do well' in some sense in spite of having experienced a form of 'stress', which in the population as a whole is known to carry a substantial risk of an adverse outcome."

Arnold (1990) reports that the way children respond to stress may either promote growth and a sense of efficacy or cause behavioral, social, academic, or psychosomatic problems. Children exposed to stress that increases the risk of an adverse outcome are said to be "vulnerable" to that outcome; therefore, their resilience is defined in terms of two concepts—vulnerability and competence: Children who are vulnerable to an adverse outcome yet achieve competence are "resilient." Cowen and Work (1988) state:

Knowledge about the effects of multiple, chronic stressful life events and circumstances on children and in vivo factors that shield them against serious psychological problems are key building blocks that undergird efforts to understand

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the nature and determinants of invulnerability and develop preventive interventions to promote wellness in profoundly stressed children. (p. 596)

Fortunately, the majority of children exposed to various forms of adversity grow up to enjoy productive, normal lives (Hauser et al., 1985). Only a minority of children at risk experience serious difficulties in their personality and physical development (Garmezy, 1981).

Resilient children may hold the key that can change a professional's present focus on pathology to one of health and wellness. Cowen and Work (1988) report the primary goal of intervention is to provide the adjustment-enhancing skills and conditions that many profoundly stressed children fail to acquire in their natural life experiences and, thus, to disrupt the inevitable maladaptive spiral in which they are caught. Garmezy (1993) states:

Once we have identified the biological, psychological, and sociocultural mechanisms that activate resilient behavior and the developmental processes that are integral to the operation of these mechanisms, we will then be in a better position to generate scientifically sturdy programs for intervention that may enable us to develop methods for enhancing resilient behavior in children disadvantaged by status and stress. (p. 133)

These intervention programs would need to use empirical measures so outcomes could be tracked for evaluation purposes.

PROMOTING RESILIENCY

Garmezy (1993, p. 129) states: "The central element in the study of resilience lies in the power of recovery and in the ability to return once again to those patterns of adaptation and competence that characterized the individual prior to the pre-stress period." Practitioners, policymakers, and researchers must look for protective factors that promote health and resiliency and presumably compensate for risk elements that are inherent in the lives and in the environments of many underprivileged children. Focus on those elements in person, family, and community that may be conducive in the development of adaptive or maladaptive behaviors.

How then do we promote resilient outcomes? There is no comprehensive intervention at a single time that accomplishes comprehensive goals of prevention for a lifetime. The ultimate goal to achieve optimal prevention should be to build the principles of prevention that enhance development into the ordinary activities of

everyday life and into the community structures over the entire life span. Risk factors that occur in multiple domains—home, school, peer group, neighborhood, or work site—require interventions in all of these domains. Children benefit from a variety of different programs, including those that focus directly on the child and those that provide parent education and support (Bradley et al., 1994).

The more that is known about etiology, the more it becomes possible to target preventive interventions that intervene in causal chains. The Institute of Medicine (1994) reports:

Because it appears that most risk and protective factors are not specific to a single disorder, the most fruitful approach for preventive interventions at this time may be to use a risk reduction model that includes the enhancement of protective factors and to aim at clusters or constellations of populations, but the interventions will be aimed at those causal and malleable risk factors that appear to have a role in the expression of several mental disorders. Identification of relative and attributable risks associated with various clusters could greatly facilitate prevention intervention research. (p. 128)

FURTHER RESEARCH

Further research on the process of adaptation will lead to a better understanding of normal and pathological development and will have direct relevance for refining existing intervention and prevention programs. Understanding the processes by which some individuals remain confident and develop supportive relationships in the midst of adversity is crucial to the development of effective prevention and intervention strategies (Rutter, 1990).

As researchers, it is imperative that we continue to build on the literature. Cicchetti and Garnezy (1993) state:

Currently the popularity of resilience as a construct has exceeded the research output associated with it. As such, resilience is at risk for being viewed as a popularized trend that has not been verified through research and thereby in danger of losing credibility within the scientific community. To prevent this it is imperative that theorists in the area of resilience devote equal effort to advancing the construct empirically. (p. 499)

There is an urgent need to develop standardized and validated measures of resiliency. Researchers must continue to do empirical research in the area of childhood resiliency and assist practitioners in the development and implementation of resiliency enhancement programs for both children and families.

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The need for preventative strategies is imperative. For example, in relation to mental disorders, preventive interventions to assist families in developing strategies that over time will prevent the emergence of a mental disorder in their youngsters and substantially enhance their resiliency are essential (Beardslee & MacMillan, 1993). Although there has been progress in treating childhood depression, few programs focus on the prevention of this disorder in youngsters (Beardslee & MacMillan, 1993). Cognitive therapy principles can be applied as a form of prevention because cognitive skills and styles are consistently reported as associated with stress-resistant outcomes (Hauser et al., 1985). Shure and Spivack (1978) suggest that primary prevention intervention with children be based on interpersonal cognitive problem-solving training. Dubow and Tisak (1989) found that social support and social problem-solving skills enhanced children's functioning by buffering the negative effects of stressful life events. Behavioral strategies can be taught to patients who have anxieties associated with life crises, and stress management can help the patient gain a sense of mastery and thereby increase self-esteem (Kiely & McPherson, 1986; Teare-Skinner, 1984).

Osborn (1990) states:

The most powerful explanation for resilience in children might be resilience in parents who successfully cope with life's problems despite economic hardships, inadequate housing and other stressors. Although the inner character of resilient children is of much interest, it is the enabling external and environmental factors which foster and support resilience that are of special consequence since this is the domain in which intervention is potentially feasible. (p. 41)

PREVENTION INTERVENTION

A more rewarding approach to prevention, given current knowledge of etiology, lies in the identification of risk factors and the design of interventions aimed at reducing these risks in vulnerable individuals (Fraser & Galinsky, 1997). The economic as well as the clinical and sociomedical arguments for primary mental health care prevention are growing (Murray, 1992). The lack of educational campaigns aimed at prevention from the mental health sector reflects the absence of consensus on etiology of the more prevalent minor affective disorders and the wide range of biological, personality, educational, social, and behavioral factors that influence susceptibility (Murray, 1992).

In relation to prevention of mental disorders in children, the Institute of Medicine's Committee on Prevention of Mental Disorders (1994, p. 467) strongly recommended that the nation mount a significant program to prevent mental

disorders, stating: "Much greater effort than ever before needs to be directed to prevention. Opportunities now exist to effectively exploit existing knowledge to launch a promising research agenda on the prevention of mental disorders." The committee found the need for prevention of mental disorders so compelling and the current opportunities for success so abundant that it recommended an increased investment across all federal agencies over a five-year period (1995 to 1999) to facilitate the development of the following three major areas of the research agenda:

1. Building the infrastructure to coordinate research and service programs and to train and support new investigators
2. Expanding the knowledge base for preventive intervention
3. Conducting well-evaluated preventive interventions

The committee viewed research training as an immediate and critical need in preventive intervention research to develop researchers' expertise in preventative research techniques so that expansion of the knowledge base for preventive interventions would and could continue.

Although these recommendations are timely and critical, it is imperative to formulate preventive interventions not only for the individual and the family, but also for the community. Social issues such as poverty, inadequate housing and health care, and violence negatively affect children and their families. Rappaport (1992) states:

We find it more attractive to blame people, rather than social institutions for problems in living. . . . In the United States, the National Institute of Mental Health has been forced to deal with the government's individual responsibility social agenda that since 1980 has forced prevention policies to become less concerned with social conditions and more focused on specific disorders." (p. 97) This is because prevention defined as interventions to prevent diagnosable mental disorders by searching for causal agents in individuals will always be supported by governments.

It is crucial to have preventionists who also have an interest in preventive social change and a focus on a community mental health perspective that addresses the social factors putatively underlying individuals' emotional distress (Baker, 1982). Albee (1982) states: "Efforts at prevention require the ideological decision to line up with the humanists who believe in social change, in the effectiveness of consultation, in education, in the primary prevention of human physical and emotional misery and in the maximization of individual competence."

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OVERVIEW OF BOOK

It is time to promote a purely preventative approach to children's physical and mental health. The *Handbook of Preventive Interventions for Children and Adolescents* brings together outstanding scholars to summarize the empirical literature related to a variety of disorders and to provide guidelines for preventive interventions relative to each level of Gordon's model. This handbook assists practitioners and policymakers in best meeting the preventive needs of our youth.

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