CHAPTER III

RISK, RESILIENCE AND WELLNESS FOR TRANSITION AGE YOUTH

"One thing life has taught me: if you are interested, you never have to look for new interests. They come to you. When you are genuinely interested in one thing, it will always lead to something else."

— ELEANOR ROOSEVELT

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One way to think about the services we provide is that, to be successful, they should be designed to promote wellness and minimize or reduce the risk factors that make people vulnerable to the onset or re-emergence of Emotional and Behavioral Disorders (EBD) (Masten, 2001). Promoting wellness requires a focus on strengthening "protective factors" such as individual, family and community strengths, social supports, competence, etc. These concepts are especially pertinent to the Transition Age Youth (TAY) group, since as a result of developmental and systemic factors, they are at a threshold in their lives when there are increased opportunities for either recovery or decreased functioning. This section will explore the concepts of risk, resilience, and protective factors, and the role they play in developing interventions that support the achievement of wellness for TAY.

WHAT IS "RESILIENCE"?

Resilience has to do with an individual's ability to maintain stable functioning in the face of adversity. Stable functioning should be defined in the terms of the individual's developmental context. Emerging adulthood (the period from the late teens to the late twenties) is characterized by exploring identity and new life-course possibilities (Arnett, 2004). This exploration typically co-exists with unstable aspects of lifestyle (such as frequent residence changes) and relationships to others characterized as "in-between" adolescence and adulthood. For TAY, stable functioning may mean the ability to proceed with the developmental tasks of emerging adulthood, even if not fully accomplishing society's expectations of having residential stability, obtaining stable employment, completing school, or establishing a family. In this regard, for TAY with EBD the term "discovery" (Clark, 2002) is a better summary of these developmental tasks rather than "recovery," which is defined as the ongoing "process in which people are able to live, work, learn, and participate fully in their communities" (New Freedom Commission on Mental Health, 2003, pg. 5). Given the developmental tasks of exploring opportunities for housing, employment, school, and social relationships, the process of discovering interests, dreams, strengths and values is the key to establishing an adult identity and making life-course decisions (Clark, 2003).

There are three distinct populations of TAY who will face different types of adversity in the transition to our adult service systems. The first population consists of adolescents being served in the children's systems of care. These youths are entering adulthood already burdened with an illness that will most likely continue, such as those diagnosed with schizophrenia, co-occurring substance use and mental disorders, and severe and persistent affective disorders, among others. These youths will require continuous service through the transition into adulthood in the domains described throughout this TAY Resource Guide. The objective of recovery would apply to this group as they mature into adulthood.

The second population consists of adolescents with emotional disorders that may reflect child, adolescent and family adjustment issues such as less severe conduct disorders, adjustment disorders, and, for some children, Post-Traumatic Stress Disorders (PTSD).[1] These children and adolescents, while not completely free of recurring problems under adverse circumstances, will

[1] For others, PTSD may have lifelong sequelae and result in later disorders that meet target population criteria for adult systems of care.

most likely not develop more serious mental disorders. However, to the extent resources are available, they still need appropriate services to prevent the onset of more serious problems, and help them move on in their developmental tasks.

The third population consists of individuals who develop new disorders in late adolescence and early adulthood (or disorders that have not been assessed previously). The onset of some disorders (such as psychoses, bipolar disorder, and addictive disorders) are known to have their first onset in late adolescence and early adulthood, and thus come to the attention of mental health professionals (Kessler et al., 1996). (See, for example, the chapter on Early Psychosis). We do not yet have the tools to predict which children and adolescents will develop these disorders later in life, although there are some research findings of the correlates for later disorders, such as the likelihood of children diagnosed with conduct disorders or ADHD to develop later co-occurring disorders (Costello, Armstrong, & Erkanli, 2000).

Risk factors that predict a person's response to adversity or stress have been categorized as risk traits (e.g. genetic predisposition; neurological impairments) and environmental effects (i.e. exposure to violence; chronic poverty; family support). Researchers agree that there is significant interaction between traits and the environment (Fraser, Kirby, & Smokowski, 2004). For example, a genetic marker for a disorder does not guarantee that the disorder will eventually surface. The environmental context is highly influential and can shape risk factors (i.e. prenatal and early age stressors have effects on brain development in childhood (Dawson, Ashman, & Carver, 2000) and they can moderate risk factors during later development beyond childhood and adolescence.[2] Some risk factors rise to the top of the priority list since they elevate chances for negative outcomes. Suicidal thoughts, substance abuse, and risk-taking behavior, among other high risk factors, imply the need to muster all available supports and strengths in the environment in order to reduce the immediate risks. Where and how to intervene in these various kinds of risks requires an understanding of how much control the individual has over them and what factors the individual, family and community can muster to overcome them.

Being "resilient" has to do with how well a person is protected from risk factors and adversities. The concept of personal resilience applies not only to those facing impossible odds, such as survivors of extreme violence or disasters, but also includes basic competencies that are very amenable to intervention for most people, even under moderate or severe levels of stress (Masten, 2001). The characteristics that help individuals maintain stable functioning through adversity are "protective factors." These include individual factors (e.g. an easygoing disposition, competence in school or other activity, high self esteem); family factors (e.g. parental warmth and availability or other caring adult relationship); and community factors (e.g. availability of resources in a neighborhood). Some of these factors were established in early childhood (such as parental warmth) and continue to benefit the individual throughout adulthood (Masten & Coatsworth, 1998); others represent an ongoing process of interaction between the individual and environment.

The research into resilience and protective factors has resulted in a heightened awareness of the importance of competencies, strengths, and assets in the prevention of such negative outcomes as teen pregnancy, sexually transmitted disease, substance use, adolescent and adult antisocial behavior, and PTSD. This shift in thinking away from the one-sided deficit approach of psychopathology was an important precursor to strengths-based models for systems of care. Practitioners know that a focus on symptoms and problems alone cannot support recovery,

[2] Brain imaging studies have also shown evidence of brain development in older adolescence that can be directly compromised by environmental stressors, such as exposure to violence and alcohol use (Paus et al., 1999).

without the mobilization of personal, family and community resources. Helping a person strengthen and maximize protective factors is probably the most important and long-lasting outcome that can be achieved. These factors can continue to provide benefit long after the intervention ends.

WHAT IS "WELLNESS"?

Because an EBD can affect so many aspects of a person's life, it makes sense to think about the overall goal of our interventions as *maintaining or increasing our clients' wellness*. The wellness approach is a holistic framework that is congruent with the recovery movement. There are five "pathways to wellness" as proposed by Emory Cowen, a founder of prevention and early intervention (Cowen, 1994):

1. Forming wholesome early attachments;
2. Acquiring age-appropriate competencies;
3. Exposure to settings that favor wellness outcomes;
4. Having the empowering sense of being in control of one's fate; and
5. Coping effectively with stress.

Originally developed to support early interventions for very young children and families, these pathways can easily be adapted to services for transition age youth. In addition to the effects of wholesome early attachments, ongoing wellness for adolescents and transition age youth requires meaningful and continuous relationships with caring adults. Age-appropriate competencies for TAY include such things as work and study skills, skills in social relationships, etc. TAY need exposure to settings that support their developmental tasks and strengths (such as supportive group housing), and some TAY need extra help avoiding negative settings (such as a drug-using peer group). Like all people who benefit from feeling in control of their lives, TAY do better when they are in charge of decisions about their treatment, living situation, and personal goals. TAY with emotional disorders needs extra help coping with the normal stresses of becoming independent, made even more difficult by the burdens of their EBD.

Within a wellness framework, for example, the goal "reduction of symptoms", if it is truly congruent with the client's own goal, would contribute to the achievement of wellness via the pathways of increased ability to cope with stress and an increased sense of competence. Similarly, relapse prevention involves skill building (learning to identify early symptoms and managing them effectively) as well as the utilization of internal and external resources for support (Walling & Marsh, 2000). In another example, providing assistance to a TAY in completing college financial aid forms similarly contributes to overall wellness by allowing the individual to develop competencies useful in adult life (self-advocacy, writing, and money management, among others).

The wellness framework allows for a multi-factor approach in justifying and designing interventions. It assumes that the strengthening of one pathway to wellness will influence others, and that success in one outcome will have long-lasting effects in later development and with multiple outcomes. Facilitating a young person's entry into, and completion of, college classes has the short term effects of increasing coping abilities and building competencies, and the potential long term effect of building personal resilience factors that will be needed to participate in the labor force throughout adult life.

A key strength of the wellness framework is that it is "culturally relative"— in the context of the individual's social and cultural environment, each person can define his or her pathway. For example, the importance of "being in control of one's own fate" is culturally determined — some cultural traditions place more emphasis on the interdependence among the individual, family, community, and spiritual roots than in our mainstream culture, which places a high value on individual independence. As discussed further in this TAY Resource Guide, a wellness-oriented individualized assessment and planning process, putting the TAY and family at the center of decision-making, and a focus on strengths and resources, will ultimately result in appropriate, culturally sensitive interventions geared towards improving wellness.[3]

One more concept directly related to resilience and wellness is worth mentioning. Longitudinal studies have found that some children and youth with significant early risk factors for such outcomes as EBD and involvement with criminal justice have much better life adjustment in adulthood than expected. One important factor that these adults refer to is a "turning point" that marked a significant change in their lives. Examples of turning points from a cohort born in the mid-1950s include finding a religious or spiritual direction, marriage, parenthood, military service, and some type of vocational calling (Werner & Smith, 2001). Some of these turning points, like military service, had more impact on disadvantaged youth than on others whose families were well off. Other turning points may have become meaningful for later generations. For example, former foster youth often describe their experience with mentors as a turning point in their lives. Even traumatic events sometimes have the paradoxical long-term effect of building inner strength and maturity. Transition Age Youth are ripe for such turning points because of their developmental life stage. The adults in the Werner study stressed that turning points are important factors in their own right (this is supported by more recent research in developmental psychology), and that *opening opportunities* for youth and young adults to experience them is a requirement for our service systems.

SUPPORTING WELLNESS FOR TRANSITION AGE YOUTH

Services for a TAY that strive to address the individual's known risks, utilize and strengthen the available resources and strengths, and open opportunities for positive turning points, will most likely help TAY establish their own pathway "on the road towards wellness." Masten and Coatsworth (1998) identify three categories of service strategies based on the concept of resilience: (a) risk-focused, (b) resource-focused, and (c) process-focused strategies.

Risk-focused strategies target the identification, prioritization, and reduction of risks. Typical interventions might include those that ensure safety, minimize stressors, or prevent negative outcomes such as homelessness. Resource-focused strategies seek out and capitalize on protective factors and strengths, such as mentoring and peer-to-peer programs, opportunities for social activities, and individualized educational plans that support a student's talents. Process-focused strategies are those that affect more global characteristics, such as competence, self efficacy, and self-regulation. Interventions designed to promote success, accomplishments, and increased self-esteem would fall into this category. Obviously, many of our services cast a wide net and attempt to achieve multiple objectives among these three categories. It would be hard to implement an intervention that did not. Considering that much of the research points to the cumulative effects of risk and protective factors (rather than one or two important ones), services that incorporate as many of these objectives as possible are likely to yield positive results.

[3] Clark, Deschenes & Jones provides more comprehensive guidelines for the development and operation of quality transition age service systems.

How can we incorporate the concepts of risk, resilience and wellness into developing interventions for TAY? Fraser and Galinsky (2004, pg. 389) outline a systematic process to identify an individual's risks and protective factors in selecting and tailoring evidence-based practice strategies:

1. Define problem(s) collaboratively with client & family. What are the risk factors for the problem(s) and protective resources (i.e. strengths[4]) that can be utilized?
2. Identify the desired outcomes to be achieved (also with client & family).
3. Select appropriate resources (services, interventions, informal supports) that can be expected to reduce risks and promote protective factors, and can be linked to achieving the desired outcomes (through the best available evidence).
4. Modify or adjust the care plan to the individual's cultural and contextual environments, and client preference.
5. Implement the interventions as close as possible to existing practice guidelines while matching individualized preferences and context.
6. Evaluate progress towards reducing risks, promoting protective factors, and achieving targeted outcomes.

These guidelines were written to be used with clients of all ages and their families. We think they are particularly relevant to TAY and TAY systems of care, in conjunction with the assessment and planning guidelines in Chapters VIII and IX of the TAY Resource Guide.

The following chapters of the TAY Resource Guide make the concepts presented in this chapter "come alive" and address pathways towards wellness in the significant domains for TAY: education, employment, living situation, and community-life adjustment. The stakeholders involved in the TAY Resource Guide's development have an unwavering belief in the potential of TAY and their families to use their strengths and resources to support recovery, and in the ability of a TAY system of care to allow that to happen.

[4] "Strengths Discovery" (Clark, 2003), is an ongoing process of identifying protective factors (i.e. dreams, positive personal characteristics, personal and familial resources) while involving and empowering TAY and their families. Strengths Discovery is an integral part of identifying and implementing services that are highly individualized. This focus also ensures that any attention to risk factors will also result in promoting recovery, since their identification will lead to the mobilization of strengths and supports rather than to the potentially stigmatizing and disempowering effects of deficit-based decisions about treatment.

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