

PROMOTING POSITIVE
AND
HEALTHY BEHAVIORS
IN CHILDREN

Fourteenth Annual
Rosalynn Carter Symposium on Mental Health Policy
November 18 and 19, 1998

THE CARTER CENTER





PROMOTING POSITIVE AND HEALTHY BEHAVIORS IN CHILDREN

Rosalynn Carter



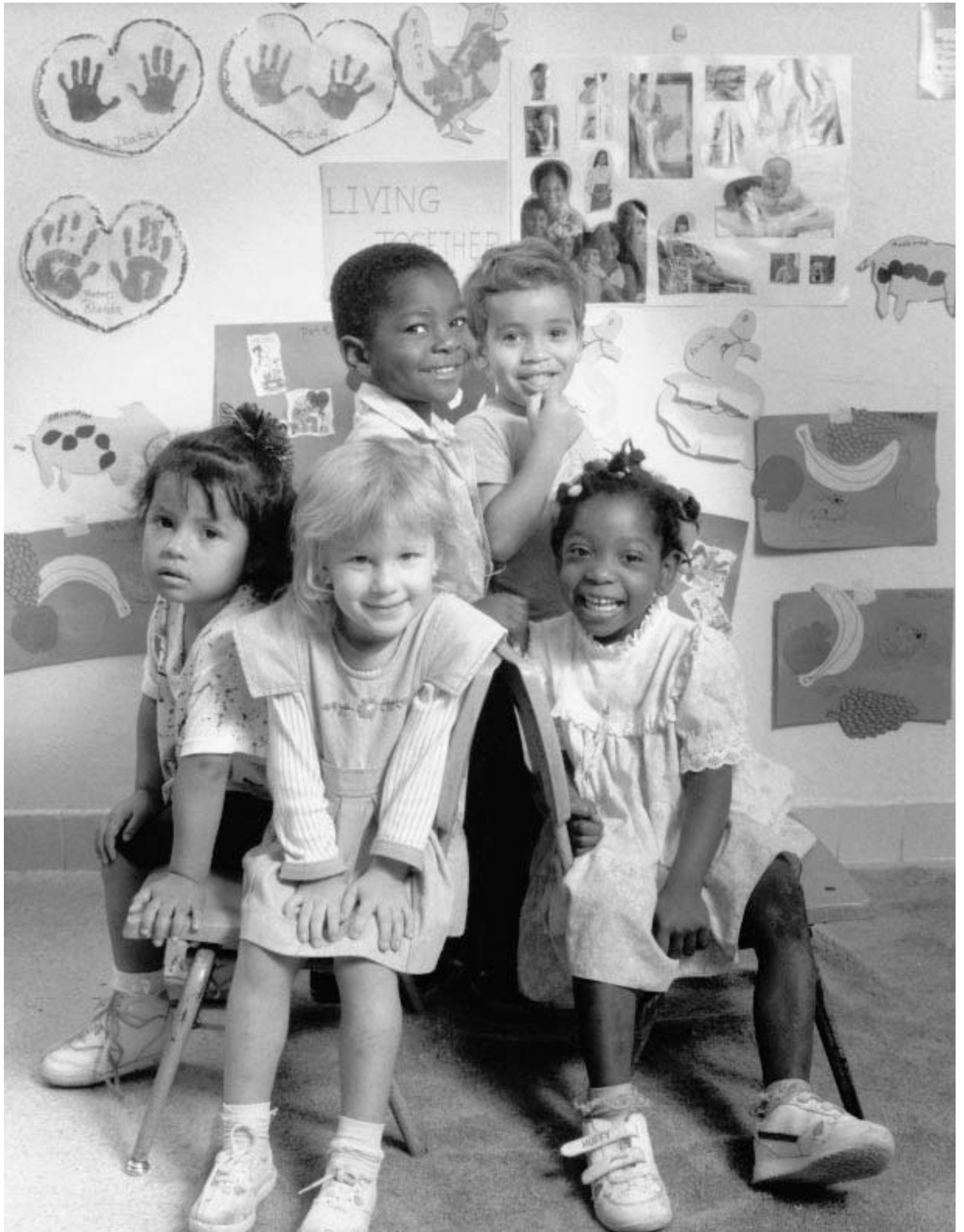
ROSALYNN CARTER

The 1998 topic for our symposium is a bit different from previous symposia. This year, we decided to focus on something positive that addressed children, so our topic is *Promoting Positive and Healthy Behaviors in Children*. Our intent is to direct attention to the need for fostering positive and healthy behaviors in children, which then can increase the likelihood of their developing into well-adjusted young people and decrease the chances of problem behaviors later in life.

All of us in the mental health field recognize that if we give children a good start in life, they have a much better chance of growing up healthy, both physically and mentally. Today, there is great concern about the healthy development of children. With so many unfortunate, often severe, incidents involving children, we are beginning to think more about not only trying to prevent and treat problems, but about promoting behaviors, skills, and characteristics that equip children to cope more effectively with life's challenges.

Why do some young people emerge from high-risk situations with their self-esteem intact, blessed with the capacity to work well, play well, love well, and respect well? I have heard that these so-called resilient children have somehow been "immunized," making them more resistant to the ill effects of life's stresses and risks.

We are going to look at children in their total environment — in their homes, schools, and communities. Of course, we will not be able to cover all of the problems nor all of the possibilities, but this symposium will hopefully serve as a first step toward devoting more of our attention and resources to what is *right* with children.





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PROMOTING POSITIVE AND HEALTHY BEHAVIORS IN CHILDREN

Produced by the Mental Health Program of The Carter Center

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The articles in this publication are adapted from addresses delivered at the Fourteenth Annual Rosalynn Carter Symposium on Mental Health Policy, November 18 and 19, 1998.

The Fourteenth Annual Rosalynn Carter Symposium on Mental Health Policy is made possible by funding from:

- The Annie E. Casey Foundation
- Dai-Ichi Kangyo Bank
- Gannett Communities Fund, WXIA-TV, 11 Alive
- The Robert Wood Johnson Foundation
- The John D. and Catherine T. MacArthur Foundation
- National Institute of Child Health and Human Development, National Institutes of Health



1998 SYMPOSIUM CONTRIBUTORS

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As president and chief executive officer of Search Institute in Minneapolis, Dr. Benson leads a staff of 70 social scientists and change agents dedicated to promoting the health and well-being of America's children and adolescents. His work on developmental assets and healthy communities provides the intellectual foundations for a national movement involving more than 300 communities. He is the author of nine books. His most recent, *All Kids Are Our Kids* (Jossey-Bass), provides a pioneering look at the intersection of community and human development. Dr. Benson lectures widely, serves as a consultant to federal agencies and foundations, and is an adjunct professor of Educational Policy at the University of Minnesota.

Dr. Benson holds memberships on many nonprofit and national advisory boards. He has authored many scientific papers in the area of child and adolescent development, community development, social psychology, education, and the psychology of religion.

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Dr. Bornstein is senior investigator and head of Child and Family Research at the National Institute of Child Health and Human Development, where he received a Research Career Development Award. A J.S. Guggenheim Foundation Fellow, he has received numerous awards including the C.S. Ford Cross-Cultural Research

Award from the Human Relations Area Files, the B.R. McCandless Young Scientist Award from the American Psychological Association, and the U.S. Public Health Service Superior Service Award from the National Institutes of Health. Dr. Bornstein has held faculty positions at Princeton University and New York University, as well as academic appointments at international institutions.

Dr. Bornstein sits on the editorial boards of several professional journals, is a member of scholarly societies in a variety of disciplines, and consults for governments, foundations, universities, publishers, scientific journals, the media, and UNICEF. He is editor of *Child Development*, and has contributed scientific papers in the areas of human experimental, methodological, comparative, developmental, cross-cultural, pediatric, and aesthetic psychology.

**WILLIAM
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Dr. Foege is a professor in the Department of International Health in Emory University's Rollins School of Public Health. He served as director of the U.S. Centers for Disease Control and Prevention from 1977 to 1983, and was executive director of The Carter Center from 1987 to 1992. Since 1992, he has been a Fellow for Health Policy at The Carter Center.

In 1984, Dr. Foege and several colleagues formed The Task Force for Child Survival and Development.



Sponsored by the World Health Organization, UNICEF, the World Bank, the United Nations Development Programme, The Rockefeller Foundation, and the United Nations Population Fund, The Task Force focuses on a broad range of issues to improve the quality of life for children worldwide.

TAMARA HALLE, PH.D.



Dr. Halle is a research associate with Child Trends, Inc. She is compiling indicators of child well-being related to education and achievement for its publication, *Trends in the Well-Being of America's Children and Youth: 1998*. She also is evaluating new measures of parenting and racial/ethnic socialization for their applicability across racial/ethnic groups.

Dr. Halle is a developmental psychologist whose research has focused on the social influences on children's cognitive development. She is collaborating on projects related to the influence of early childhood experiences on later academic achievement.

DAVID HAMBURG, M.D.



Dr. Hamburg is the retired president of Carnegie Corporation of New York. He serves on the board of The Carter Center. Dr. Hamburg has received the American Psychiatric Association's Distinguished Service Award and the Presidential Medal of Freedom at the White House.

Dr. Hamburg has been concerned with the conjunction of biomedical and behavioral sciences — first in the context of building an interdisciplinary scientific approach to psychiatric problems, then in research on the links of

behavior and health as a major component in the contemporary burden of illness. In recent years, he has concentrated on child and adolescent development.

Dr. Hamburg is the author of *Today's Children: Creating a Future for a Generation in Crisis* (1992). He was chairman of the Carnegie Council on Adolescent Development, which completed a decade-long study with a report, *Great Transitions: Preparing Adolescents for a New Century*.

TAMMY MANN, PH.D.



Dr. Mann is the director of the Early Head Start National Resource Center at Zero to Three. She also holds an adjunct appointment at Howard University in the Department of Human Development and Psycho-educational Studies. Before joining the staff at Zero to Three, Dr. Mann served as a Public Policy Fellow at the American Psychological Association. Her professional interests continue to focus on translating research into practice as it relates to promoting the importance of the first three years of life for later development.

KATHY MARSHALL



Ms. Marshall is the executive director of the National Resilience Resource Center at the University of Minnesota School of Public Health. For more than 25 years, she has directed systems-changing prevention and education programs in school, community, and public policy arenas.

She previously served as assistant to the director for the University of Minnesota Center for Applied Research and Educational Improvement. She also has



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MARTIN SELIGMAN, PH.D.



Dr. Seligman is president of the American Psychological Association. He is also professor of psychology in the Department of Psychology at the University of Pennsylvania. A leading authority on learned helplessness, depression, optimism, and pessimism, he has written 13 books and 140 articles on motivation and personality, including *Learned Optimism* (Knopf, 1991), *Learned Helplessness* (Knopf, 1993), and *The Optimistic Child* (Houghton Mifflin, 1995). He is the only person to receive both the William James Fellow Award for contributions to basic science and the James McKeen Cattell Award for the application of knowledge from the American Psychological Society. His research on preventing depression received the Merit Award of the National Institute of Mental Health in 1991.

DAVID WEIKART, PH.D.



Dr. Weikart is chairman of the High/Scope Foundation Board and president of the High/Scope Educational Research Foundation. He is also coordinator of the International Association for the Evaluation of Educational Achievement (IEA) Preprimary Study, headquartered in The Netherlands. A recipient of the Lela Rowland Award, Dr. Weikart is a member of several boards, including the High/Scope Institute U.K., the National Center for Fam-

ily Literacy, and Michigan's Children. He is also the founder and director of High/Scope Camp, now High/Scope Institute for IDEAS, an international, multicultural summer program for youth.

ROGER WEISSBERG, PH.D.



Dr. Weissberg is professor and director of Graduate Studies for the Psychology Department at the University of Illinois at Chicago. At UIC, he is a faculty member in the Division of Community and Prevention Research, the Division of Clinical Psychology, the College of Education, and the Center for Urban Educational Research and Development.

Professor Weissberg is executive director of the Collaborative for the Advancement of Social and Emotional Learning (CASEL), a national organization committed to supporting the development and dissemination of effective school-based programs that enhance the positive social, emotional, academic, moral, and healthy development of young people.

Professor Weissberg has been the president of the American Psychological Association's Society for Community Research and Action. He is a recipient of the William T. Grant Foundation's five-year Faculty Scholars Award in Children's Mental Health and the National Mental Health Association's Lela Rowland Prevention Award.



THE VALUE OF POSITIVE OUTCOMES

William H. Foege, M.D.

Task Force for Child Survival and Development

We miss Hod Ogden, for many years the creative director of health education at the Centers for Disease Control and Prevention (CDC). After his death, his friends published two small books of his maxims — such things as, “He who lives by bread alone ... needs sex education.” Two years ago Hod was on his death bed. Being very organized, he said his goodbyes, asked a colleague to write his obituary, and slipped into a coma. To the surprise of everyone, he began to recover, resumed conversations, and got out of bed. He said it was a great thrill to edit his own obituary.

We edit our obituaries every day, and we do not realize that in our actions, we are also editing the obituaries of many other people.

Today we edit our obituaries by asking, “Can we take our experiences, our knowledge, our own suffering, and focus it for a better life for others? Specifically, how could we enhance positive outcomes in our children?”

A NEW LOOK

Editing is always helped by taking a new look. The great physicist, Richard Feynman — looking in the mirror one day — realized that the explanation physicists gave for why left and right were reversed in the mirror could not be right, or top and bottom also would be reversed. It caused him to come up with a new explanation.

David, my oldest son, once said to me, “I wish I could see you for the first time.” I was puzzled and asked, “What do you mean?” He said, “My friends say you are so tall and I

do not notice. But I wish I could see you for the first time.”

What I would like to do is to take a new look at positive outcomes by asking what have we learned from health care delivery and public health, and how that might inform our approach.

If a new look is useful to improving what we do, so also is the concept we all learned in science: how to use a microscope. We started by using the low-power lens that gave the broadest possible look at the object. Then we moved to a higher power lens, and finally an oil immersion lens to enlarge a specific piece of the field. We focused eventually on the details, but only after seeing the context. We need specialists — we absolutely need them — but also we need the generalists who see the bigger picture.

More than that, we all need to be generalists.

The theologian Pelikan from Yale has said that the difference between average and good scholarship is often found in the academic program of study. But the difference between good and great scholarship is found in how much one knows beyond his or her field of expertise. Being a generalist helps to avoid polar approaches, where one thing is considered correct and everything else is wrong.

With perspective, we find that the question is not family versus society, it is family *and* society. It is not science versus religion, but science *and* religion; not traditional versus modern, but using the best from tradition with the best of the new age. A perspective says the pathological perspective is important, but it is not the only one. What if we could take a perspective that keeps in mind, at all times, the positive outcomes that we want.

Gary Wills, in his book on the Gettysberg Address,



says Lincoln’s speech was not a casual talk sketched on the back of an envelope. This was Lincoln’s whole life, his “positive outcome” that invaded every dark moment of the Civil War. For, as Gary Wills says, that two-minute talk changed the United States from a plural noun to a singular noun. That was the positive outcome that drove Lincoln.

I recall in my training the magic of fluorescence in microscopy. By adding a tagged antibody to a slide, it would attach to the antigen or organism I was seeking. The slide would retain all of its characteristics, but in addition would glow at the place where the antigen was.

What if we could do the same with positive outcomes? Where we still see the whole problem, the normal, the pathology, the problems, but the positive outcomes are tagged with fluorescence so we never lose sight of where we are going.

HEALTH CARE DELIVERY SYSTEM

What have we learned from the health care delivery system? For starters, there seems to be something wrong when we can spend over \$1 trillion a year on the health care system and still have 40 million Americans uninsured, and, in the area of mental health, much larger numbers inadequately insured.

This doesn’t happen by accident. One reason involves our very human tendency to procrastinate. We do not focus on prevention. The system puts a much higher value on treating lung cancer than in helping people stop smoking. In President Jimmy Carter’s new book, *The Virtues of Aging*, he says that for every \$12 spent on people over 65, the federal government spends only \$1 on children under 18. For all our rhetoric on prevention and children, we do not put our money there.

We always have had problems with our health care delivery system, but those problems increased when we

introduced the profit motive into the equation. Two things resulted:

First, health decisions are now made on the basis of returns expected for a stockholder rather than returns expected for a patient.

Second, the person with the most money always wins the competition for services. I do not want the marketplace solving my problem if I need a new kidney, because I know I cannot compete.

But in my clearest moments, I say to myself that no matter how much I protest, this will not change. Therefore, is there a way to beat the market system?

Maybe.

What would happen if we could re-determine the outcomes for which the market system will pay?

Large companies buying health insurance wanted a report card to measure what they were getting. The HEDIS system developed measures — certain agreed-upon items — to see if the premium is a bargain. Most of the items measure process rather than health *per se*. These include, for example, immunization coverage, the percentage of women given pap smears or mammography, etc. What if we could define the positive health outcomes we want and get the market system to compete in delivering those?

For example, a health maintenance organization (HMO) in Minnesota made the decision to do the best quality job it could in treating patients with heart attacks, but it also was going to set an objective of reducing heart attacks by 25 percent in five years. This meant offering smoke-enders clinics, diet programs, aerobic programs, better control of blood pressure — in short, all of the public health and preventive programs. If the health outcomes could be defined, we could change the basis for competition in health care delivery to our advantage.

Defining positive outcomes is difficult but necessary if

The question is not family versus society, it is family and society. It is not science versus religion, but science and religion; not traditional versus modern, but using the best from tradition with the best of the new age. . . . What if we could take a perspective that keeps in mind, at all times, the positive outcomes that we want?



we are to wrest control from a system that has gone badly awry. Could we, in like manner, define the positive outcomes we want in childhood and increase the resources society will invest for those outcomes? And could we get society to do this for *all* children?

There are also lessons from public health.

PUBLIC HEALTH EXAMPLES

It was a big step in health to move from care to prevention. It was also a big — and recent — step to shift from personal health to public health. The modern public health era started 202 years ago when Edward Jenner gave the first smallpox vaccination to James Phipps. We are just beginning our third century of public health.

It was also a big step to go from disease prevention to health promotion. With disease prevention, we focused on pathology, asking, “How can we reduce the extent of a problem or the deaths from a pathogen?” With health promotion, both the target and the philosophy changed. The object was not just to bring some adverse event down to zero; the object became to change the scale and go to a positive perspective.

It means not being a fatalist. It means believing we can change society and the future and our own health destiny. It means determining what can be changed and what cannot.

Health promotion helped us shift our thinking from reducing smoking not just to reduce lung cancer rates, but also to enhance the lives of people not compromised by reduced lung capacity; where one can enjoy racquetball or hiking the Grand Canyon. It is not just the absence of disease, it is the enhancement of life.

Health promotion is getting hooked on racquetball or tennis or golf or hiking and going to bed in anticipation of getting up early to compete, to enjoy, and to then feel the glow left by that exercise as you go through your day. To

feel that is to know the difference between health promotion and disease prevention.

PROMOTING CHILDREN’S HEALTH

And what do we learn from the attempt to protect children?

In 1962, C. Henry Kempe coined the phrase “battered child syndrome.” We know there are some genetic influences on our mental health, but we need to know also about the influences of our environment and how they shape our upbringing. This year the CDC and Kaiser published a study on the footprints of child abuse that can still

be seen in adult life. We know, of course, about the cycle of abuse from generation to generation, but this looked specifically at the health of adults if they had suffered abuse as children.

The study looked at physical, psychological, and sexual abuse; witnessing a mother being beaten; and a person in the family using drugs or going to jail. While not surprising, this was the first time it was documented that smoking and drinking, the use of drugs, depression, suicide attempts, and being overweight were all elevated in people who had experienced such adverse events in childhood.

We have known for more than a decade that it is possible at birth to identify children at increased risk of being abused. And we have known for more than a decade, thanks to the work of David Olds, that it is possible to reduce the risk significantly with a visiting nurse program during the first two years of life — *prevention*.

But we, as a society, do not fund such activities.

Instead, we allow the battered child syndrome to lead to the battered adult syndrome. Many people in our society grow up with post-traumatic stress syndrome, not because of war, but because of their preschool years.

Still, we invest in repair rather than prevention.





ENVISION IT

Again, we know that genetics has an influence, but within those parameters, what could we do to promote positive outcomes?

Jonas Salk used to emphasize that “evolution will be what we want it to be.” He said that if we can envision it, we can achieve it. Thus, creating that future starts with the ability to envision it.

What would our vision be? We are often wrong in predicting the stock market, or an election. Likewise, there is no formula that can predict the trajectory of each child. But there are some things that are true in the aggregate.

We have been greatly aided by a literature on successful aging that shows the importance of education, physical activity, the feeling of some control, the importance of one or more close relationships, and the feeling of purpose. Now it appears that these are also indicators of successful living and perhaps even successful childhood.

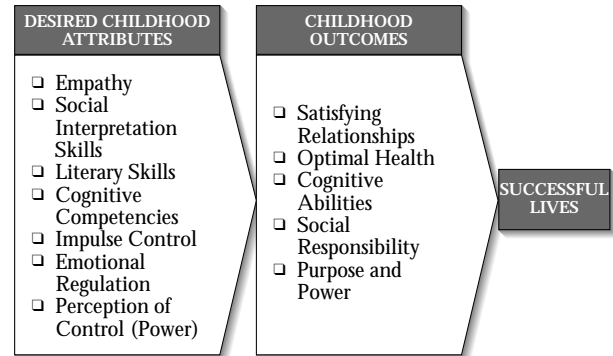
LESSONS FOR MENTAL HEALTH

Starting with this belief that people have more satisfying lives if certain traits are present, it is possible to ask what could we do to increase the chances that that happens. For example, researchers at the CDC have attempted to find agreement on some of the most important outcomes. It is a start. What are these outcomes?

- SATISFYING RELATIONSHIPS — *e.g., with a spouse or other person.*
- OPTIMAL HEALTH
- COGNITIVE ABILITIES — *e.g., intellectual skills, problem-solving abilities, etc.*
- SOCIAL RESPONSIBILITY — *helping, whether another person, a cause, a better environment, or society as a whole, is associated with a feeling of successful living.*
- PURPOSE IN LIFE — *for many, this comes from identifying with a faith group, and the feeling that one has some power to influence health or events.*

Those outcomes, we can safely predict, will lead to successful lives. And we know that we increase the chances that children will have those outcomes if they develop certain attributes. These same researchers, especially Camille

Smith with The Task Force for Child Survival and Development and the CDC, have assembled what is known about attributes that increase the chances of these outcomes.



Then it is possible to ask, “What parental attributes are most helpful in assuring these attributes in children?” Gandhi said that people often become what they believe themselves to be, and children often become what their parents believe them to be. *Desired parental attributes* are:

- NURTURING CAPACITY
- VERBAL & COGNITIVE STIMULATION
- BEHAVIORAL REGULATION
- GOOD MENTAL HEALTH
- ADEQUATE EDUCATION AND LITERACY
- NETWORK OF POSITIVE SOCIAL SUPPORT

Finally, we ask, “What attributes in society help parents be what they want to be?” Those *desired social attributes* include:

- SOCIETY COMMITTED TO FAMILY AND PARENTHOOD
- SOCIETY COMMITTED TO EQUITY
- SOCIAL STANDARDS
- ADEQUATE EDUCATION SYSTEM
- ADEQUATE CHILD CARE SYSTEM
- ECONOMIC STABILITY

The point is, we could be more purposeful in trying to influence the chain of causation that leads to successful and satisfying adult lives.

If evolution is to be what we want it to be, we would organize ourselves to enhance the chances that things would happen as we want them to happen. We would pro-



vide social support for every parent and we would fund parenting programs and educational trust funds. Our society would benefit if every child could pursue education to the extent of her or his capacity.

Why do children in the United States do worse on math and science tests than children in many other countries, but still end up being creative? Perhaps it is because we are a country of infinite second chances. While religion is often seen as a harsh master, it is the epitome of second chances — characterized by forgiveness, a chance to start over, confession, and redemption. So our religions and our national history promote the idea of *another chance*.

What if parents, no matter how poor and regardless of their education, could be given a second chance? For example, if they were willing to participate in a curriculum on parenting — covering conception to school entry, and including group work with other parents, sessions with experts on parenting, joint activities for parents and children — parents could earn an educational trust fund for their child. Think of what this could do for their self-image and how children would regard their parents, knowing they had done that for them.

What if there was even a third chance (a second, second chance), so that children would know they could earn, or add to, an educational trust fund by participating in such outside activities as Scouts, sports, learning a musical instrument or a second language, or community service.

And what if there was even a fourth chance, because some children are “late bloomers” — in a program

similar to the Hope Scholarships in Georgia, in which students could get college tuition by keeping a B average in high school.

These are investments in the future. Congressman Charles Rangel once said that when he died, he wanted to be buried in Chicago so that he could remain politically active. By making these investments we remain politically and socially active forever. To achieve a social change that rewards promoting mental health, we need creative activism with the involvement of everyone, not just official leaders.

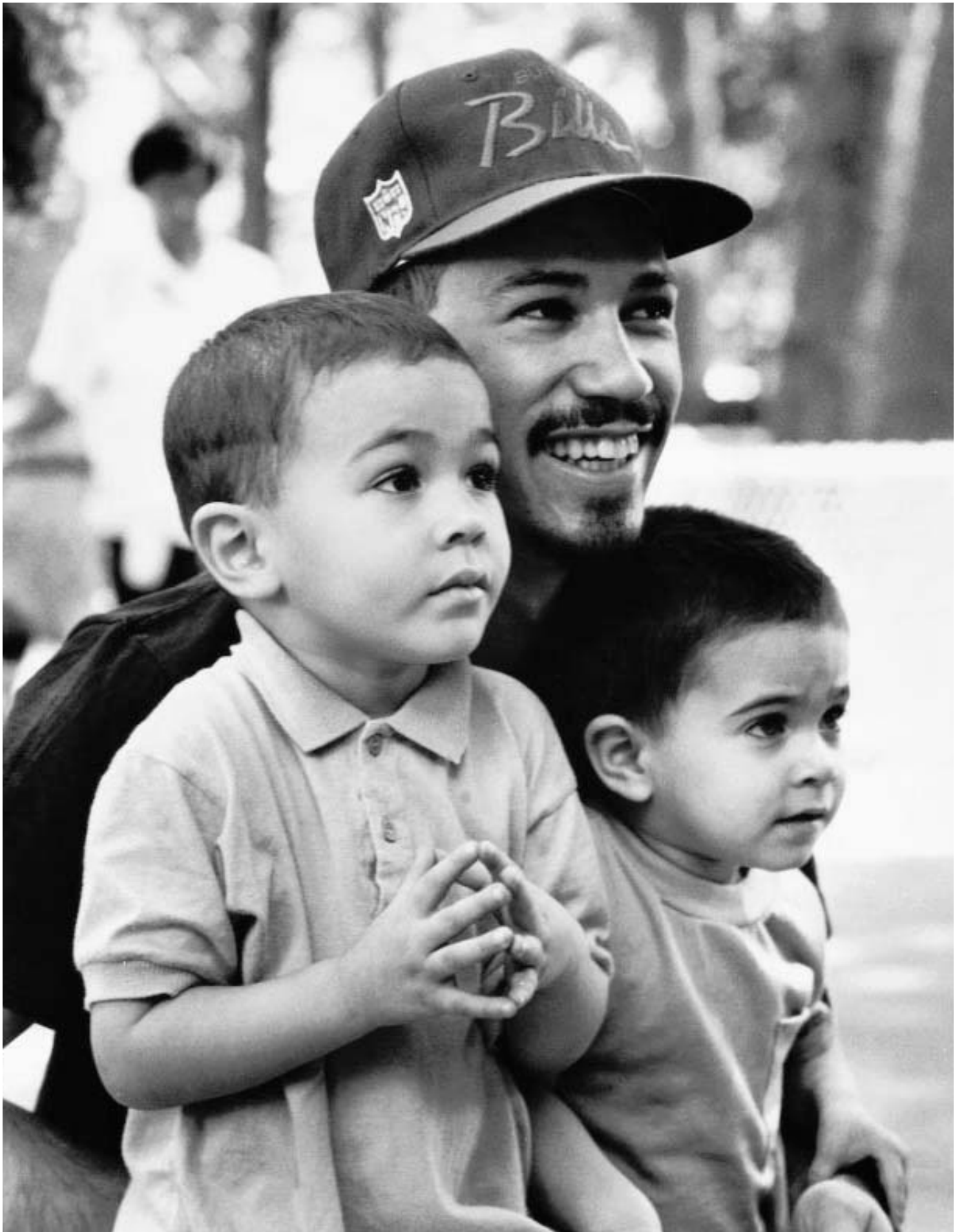
Understanding the positive outcomes — the attributes involved, what is malleable, the roles of parents, families, and society — is an important part of changing our approach. We need to organize our resources, our experience, our new science, our ingenuity, and our sense of community with new approaches to education; we need to do what needs to be done, so that we have early intervention and prevention, all leading to positive outcomes.

As Jim Grant, former head of UNICEF, said in his last speech to the UN General Assembly, “The vital vulnerable years of childhood should be given a first call on societies’ concerns and capacities. There will always be something more immediate; there will never be anything more important.”

Paul Frame has said that an ounce of prevention is a ton of work. Developing a new focus on positive outcomes will be hard work. But as Jonas Salk said, if we do these things, we will have been good ancestors.

We need to organize our resources, our experience, our new science, our ingenuity, and our sense of community with new approaches to education; we need to do what needs to be done, so that we have early intervention and prevention, all leading to positive outcomes.







A DEVELOPMENTAL STRATEGY FOR LIFELONG BENEFIT

David A. Hamburg, M.D.

President Emeritus, Carnegie Corporation of New York

What are the essential requirements for healthy development, and what are the principal opportunities for meeting these requirements? In what ways can families be strengthened to meet the developmental needs of children and youth? What extra-familial influences can help to meet them?

Finally, what information, skills, and professional services can be brought to bear in ensuring healthy development under contemporary American conditions?

THE CHANGING AMERICAN FAMILY

From time immemorial, the family has been the fundamental unit responsible for the health, education, and general well-being of children; indeed, the family has been the central organizing principle of societies everywhere. But in the United States, the structure and function of families have undergone profound changes in just the past 30 years. Some of the changes represent new opportunities and tangible benefits. Others place the well-being of children in such jeopardy as to pose a major problem for the entire society.

Stable, close-knit communities where people know each other well and maintain a strong ethic of mutual aid are not as common as they once were. Young people having children are less experienced caring for their offspring than were those of predecessor generations. Many start new families without the knowledge, skills, or confidence to carry out the enduring responsibilities of competent parenthood.

For growing children, the intellectual and social tasks they must master are far more complex than they

were in the small, simple societies of their ancestors.

In this time of accelerated change, family life has been subjected to severe strains. With such dramatic shifts in the nature of family life, it is not surprising that surveys indicate that American parents across all social classes are troubled about raising their children. Two-thirds of them report they are less willing than their own parents were to make sacrifices for the next generation.

A major consequence of this metamorphosis has been that children are becoming a responsibility shared by members of the family with other individuals and institutions.

Just as the economic functions of the family moved out of the home early in the Industrial Revolution, so is child care to a large extent moving outside the home. A child's development is less and less under parents' and grandparents' direct supervision and increasingly in the hands of near strangers. The people who can meet the fundamental developmental needs of children and adolescents are usually available within the young person's immediate family, often augmented by relatives. But other adults — health care providers, teachers, community and church workers, even business leaders — now must help provide the necessary conditions for healthy development.

CONDITIONS FOR FOSTERING HEALTHY DEVELOPMENT

A good start is the beginning of hope. A poor start can leave an enduring legacy of impairment, and the high costs may show up in the various systems of health care, education, and juvenile justice. We call these impairments by many names: disease, disability, ignorance, incompetence, hatred, violence. By whatever name, such outcomes entail



severe economic and social penalties for the entire society.

During their earliest years of growth and development, children need dependable attachment to parents or other adult caregivers; they need protection, guidance, stimulation, nurturance, and skills to cope with adversity. Infants, in particular, need caregivers who can promote attachment and thereby instill the fundamentals of decent human relationships throughout the child's life. Young adolescents, too, need to connect with people who can guide their momentous transition to adulthood with sensitivity and understanding.

In an ideal world, all children grow up in an intact, cohesive, nuclear family that is dependable in every crunch. They flourish in a multifaceted parent-child relationship with at least one parent who is consistently nurturing, loving, and able to enjoy child rearing, teaching, and coping. They inhabit a reasonably predictable adult environment that fosters gradual preparation for adult life. They have supportive, extended family members who are available to lend a hand. They are part of a supportive community, whether it be a neighborhood, religious, ethnic or political group, but some larger group beyond the family that is helpful.

Conditions such as these greatly enhance the odds that a young person will pursue lifelong learning, acquire constructive skills, have good health, and develop valued human attributes, including pro-social behavior. They provide a tangible basis for envisioning an attractive future and for taking advantage of opportunities.

Approximating these optimal conditions is an immense task for the parents or other caregiver in any family. For single parents struggling alone, the challenge is exceedingly difficult. Child raising takes time and care, protection and guidance, experimentation, and learning from experience. Above all, it is an enduring commitment — one that

is fundamentally rewarding if often frustrating.

The institutions beyond the family that have the greatest influence on child and adolescent development are the schools, community organizations (including religious ones), health care institutions, and the media.

Are there a few essential requirements for healthy development that most families can meet with the support of these pivotal institutions?

Within the scientific and professional communities, an important consensus has emerged on ways that parents and others can cooperate in coping with the developmental needs of children and young adolescents. Evidence is accumulating that a range of preventive interventions can set a young person on the path toward healthy, constructive adulthood. Beginning with early and comprehensive prenatal care, these measures include:

- well-baby medical care, with an emphasis on disease prevention and health promotion;
- home visits by human service professionals, especially in homes with very young children;
- parental education to strengthen competence and build close parent-child relationships;
- parent support networks that foster health and education for their children and themselves;
- child care of high quality outside the home, especially in day care centers;
- preschool education, modeled on Head Start, that combines parental involvement with disease prevention and the stimulation of cognitive as well as social skills; and
- enhanced elementary education and middle-grade education that is developmentally appropriate, fosters fundamental skills, and encourages good health practices.

A child's development is less and less under parents' and grandparents' direct supervision and increasingly in the hands of near strangers. ... Health care providers, teachers, community and church workers, even business leaders now must help provide the necessary conditions for healthy development.



Altogether, such opportunities have strong potential to prevent damage of many kinds as reflected in indices of health and education.

FOSTERING HEALTHY DEVELOPMENT IN THE EARLIEST YEARS

PRENATAL CARE. Now weak or absent from at least a quarter of pregnant American women, prenatal care has a powerful capacity to prevent damage, including brain damage, that can lead to so many tragic outcomes. At its best, prenatal care is a two-generation intervention that serves both children and parents, provides social supports, and incorporates vigorous outreach efforts to bring young women into prenatal care early.

In addition to medical care of the mother and the developing fetus, an essential component of good-quality prenatal care is education of the parents. Prenatal education makes use of the distinctive motivation of the pregnant mother as well as the young father to strengthen their knowledge and skill in caring for themselves and their prospective baby. In combination with social support services, which can link clients to job training and formal schooling, among other benefits, prenatal education can substantially improve prospects for the future of the young family.

Especially in poor communities, young parents need a dependable person to provide social support for health and education through the months of pregnancy and beyond. This can be organized in a systematic intervention, drawing upon women who are from the community and have relevant experiences in child rearing. When provided with a modicum of training and supervision, they can give support and practical guidance to poor young mothers.

CHILD CARE. As child rearing moves beyond the home, the quality of outside care becomes crucial. The vast

majority of responsible parents are eager to ensure that such care facilitates their child's healthy development. The crucial factor in quality of care is the nature and behavior of the caregiver. Just as parents want a competent doctor, so do they desire a capable caregiver who can understand and meet their child's developmental needs. But such a person is difficult to find, even for affluent parents.

With the surge in demand for child care, those trying to provide it have eagerly sought to develop competent caregivers. Even with the best of intentions, this field has been characterized by low pay, low respect, minimal training, minimal supervision, and extremely variable

quality. Although most child care workers try very hard to do a decent job, the plain fact is that many of them do not stay in their positions very long, and this in itself puts a child's development in jeopardy. Especially for young children, for whom dependable long-term caretaking relationships are crucial, such staff turnover is all too common.

In 1994, the Carnegie Corporation task force report, *Starting Points*, spelled out the importance of four basic approaches in meeting the needs of the youngest children:

- preparation for responsible parenthood;
- preventive health care;
- the strengthened quality and availability of child care, for example, through cooperative networks and professional training; and
- stronger community supports for families.

The report suggests ways of mobilizing communities for children. The achievement of intersectoral cooperation toward the well-being of children is difficult but not impossible. Agents of change include family-child resource centers: federal, state, and local councils for children that include educational institutions, relevant professions, business, and media.





Together, they can assess specific needs and formulate ways of meeting them, as well as seeking ways to integrate services, for example, by linking educational, health, and social services in community schools.

EARLY ADOLESCENCE: A TIME OF OPPORTUNITY AND RISK

Early adolescence is one of the most striking developmental experiences in the entire life span. What does this transition mean? It means going beyond childhood toward the distant goal of becoming an adult. There is a chasm between these two great phases of life, and it takes a mighty leap to get across. How do our children learn to make the leap? What help do they need in making it? Who helps — or fails to help — in this risky process? Why do so many fall into the chasm, never making it to healthy, constructive, productive adult life?

The Carnegie Council on Adolescent Development, formed in 1986, illuminated this sadly neglected but fateful phase of life, sounding a powerful alarm for the nation in its concluding report, *Great Transitions*. Most of the report describes and illustrates practical measures that can usefully and feasibly be taken to prevent the damage now crippling so many lives.

The problems adolescents face are occurring across all of the youth population; no part of the society is exempt from the casualties. Among the more disquieting signs is the emergence in younger adolescents of very high-risk behaviors that were once associated with older groups: early smoking, early alcohol use, early sex, early alienation from school, even early involvement with deadly weapons.

Early adolescence is a time of profound biological transformation and social transition characterized by exploratory behavior, much of it adaptive and expected. But carried to extremes — especially if they become habitual — such behaviors can have lifelong consequences. Danger-

ous patterns, in fact, often emerge during these years.

Initially, adolescents explore these new possibilities tentatively, with the experimental attitude that is typical of adolescence. Before damaging behavior is firmly established, therefore, there is a unique opportunity to prevent lifelong casualties.

What does it take to become a healthy, problem-solving, constructive adult? Young adolescents on an effective developmental path must:

- Find a valued place in a constructive group;
- Learn how to form close, durable human relationships;
- Earn a sense of worth as a person;
- Achieve a reliable basis for making informed choices;
- Express constructive curiosity and exploratory behavior;
- Find ways of being useful to others;
- Believe in a promising future with real opportunities;
- Cultivate the inquiring and problem-solving habits of the mind necessary for lifelong learning and adaptability.
- Learn to respect democratic values and responsible citizenship; and
- Build a healthy lifestyle.

Early adolescence is a time of profound biological transformation and social transition characterized by exploratory behavior, much of it adaptive and expected. But carried to extremes — especially if they become habitual — such behaviors can have lifelong consequences.

The work of the Carnegie Council consistently addressed ways in which these requirements can be met by a conjunction of front-line institutions that powerfully shape adolescent development, for better and worse. They begin with the family but include schools, the health sector, community organizations, and the media. How can we move the balance of these influences from worse to better? The Council's recommendations for each of these institutions are not utopian or hypothetical. Working models can be observed in some communities, a few of which have been scrutinized by evaluative research. The challenge is to expand them to meet the nation's needs.



STRENGTHENING FAMILIES FOR ADOLESCENT DEVELOPMENT

Parental involvement in school activities declines steadily as children progress to middle school and later to high school. School personnel often discourage such involvement, and, after a child reaches middle-school age, parents think it is inappropriate or do not make the time.

Schools should regard the families of students as allies and cultivate their support. Together with other community institutions, they can create parent support groups, parent education programs, and education for prospective parents. Parents, for their part, must recognize the need to remain actively engaged in their adolescents' education.

Additionally, employers, both public and private, can pursue more family-friendly policies for parents with young adolescents. Health professionals, moreover, should be more active in helping parents understand ways of renegotiating their relationship with their developing adolescent, so that they remain deeply interested and supportive while moving toward more adult-to-adult modes.

CREATING DEVELOPMENTALLY APPROPRIATE SCHOOLS

Research has shown the value of developmentally appropriate education for children and young adolescents, which means that the content and process of learning should mesh with the interests and capacities of the child. Specifically, this means the creation of schools of small units, or schools within schools, which can offer sustained individual attention to the developing adolescent in the context of a supportive group.

In such schools, students learn decent human relations through the techniques of cooperative learning and super-

vised community service. Curiosity and thinking skills are stimulated through study of the life sciences. Education and health are linked, each nourishing the other.

The life sciences, emphasizing a distinctively human biology, can provide a salient organizing principle for middle-grade education. These sciences can tap into the natural curiosity of young adolescents, who have good reason to be interested in development since they are experiencing the early adolescent growth spurt. A curriculum focused on human biology should naturally include the scientific study of behavior, particularly behavior that bears strongly on health throughout the life span.

Connected to life-skills training and social supports, courses in the life sciences can diminish the likelihood that a young person will engage in health-damaging behaviors.

SCHOOLS AS HEALTH-PROMOTING ENVIRONMENTS

Middle-grade schools should provide clear examples of health-promoting behavior, means of social reinforcement

for such behavior, and encouragement of healthful habits. They should clarify the nature of good nutrition in the classroom and serve nutritious food in the cafeteria. They should be smoke free and offer programs to help students and adults quit smoking. Demonstrating the effects of alcohol and illicit drugs on the brain and other organs should be an integral part of education and school practices.

Physical fitness should be a matter of pride for all in the school community. Opportunities for exercise and athletics should not be limited to varsity competition. Schools should join with parks and recreation departments to provide a variety of physical activities, so that every student can participate.

Schools must be safe places. Stopping violence, drug dealing, and the carrying of weapons in and around schools





is an urgent challenge. Nonviolent conflict resolution should become a vital part of curriculum and school practices. Indeed, the curriculum and school practices should be closely allied over the whole range of health-relevant behavior.

ENSURING ACCESS TO HEALTH SERVICES

There is a serious unmet need for accessible health care among young adolescents. Health clinics — established at or near schools — should be clearly recognizable to middle-grade students and be “user friendly.” Local option is important in order to recognize and respect the diversity that exists among American communities. Although sexual behavior is controversial, reproductive health is a modest but significant part of adolescent health. This cannot be avoided in the era of AIDS and adolescent pregnancy.

It is essential to give health and education professionals a thorough understanding of the developmental needs and behavior-related problems of adolescents. Historically, the relevant professions have been skimpy in preparing for the specific needs and opportunities of this crucially formative phase.

LIFE-SKILLS TRAINING

Middle-grade schools can provide their students with knowledge and skills to help them make informed, deliberate decisions. Such information, combined with training in interpersonal skills and decision making, can help students:

- Resist pressure from peers or from the media;
- Relieve distress without dangerous activity;
- Learn how to make friends if they are isolated; and
- Develop and use conflict resolution skills to avoid violence, yet assert themselves effectively.

Such life skills are pertinent to a wide range of health-

relevant behavior and especially to the prevention of smoking and other substance abuse in early adolescence.

SOCIAL SUPPORTS IN EARLY ADOLESCENCE

A variety of organizations and institutions can provide supplements or surrogates for parents, older siblings, and an extended family. Across the country, there are many examples of such interventions. Some are based in churches, such as the initiatives of the Congress of National Black Churches; some are based in community organizations, like the Girls Clubs. Others involve youth service, like the

Campus Compact based in colleges and universities; still others are based in minority organizations.

The central point is that churches, schools, community organizations, and businesses can build constructive social support networks that attract disadvantaged youngsters. These networks can foster health, education, and the capacity to be accepted rather than rejected by the mainstream society, and they can offer young people healthy alternatives to substance abuse and gang membership.

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OPPORTUNITIES IN THE NONSCHOOL HOURS

Communities must provide attractive, safe, growth-promoting settings for young adolescents during the out-of-school hours — times of high risk when parents often are not available to supervise their children.

More than 17,000 national and local youth organizations, including those sponsored by religious groups, now operate in the United States, but they do not adequately provide opportunities for this age group. These organizations must work to expand their reach, providing attractive and enjoyable opportunities for youth, offering more activities that convey information about life chances, careers, and places beyond the neighborhood, and engaging them in



community service and other constructive activities that foster education and health.

CONSTRUCTIVE POTENTIAL OF THE MEDIA

The undeniable power of the media could be used far more constructively than it is in the lives of young adolescents. Families, schools, and community organizations can help young people become “media literate” so they can examine media messages thoughtfully and critically. Public and professional organizations can work with media organizations in developing health-promoting programming and media campaigns for youth. Such organizations can support social actions that discourage the media from glamorizing violence and sex, as well as drinking, smoking, and other drug use. Independent experts in child and adolescent development, health, and education can link up with news and entertainment leaders, striving for the accurate, informative, and constructive portrayal of youth in the media.

CONCLUDING COMMENTS

Those institutions that have a major shaping influence on the young — family, school, the health sector, community organizations, and the media

— must join forces in adapting to the transforming requirements of the late 20th century. Much could be achieved in this vast, heterogeneous nation of ours if we thought of our entire population as a large extended family, tied by history to a shared destiny and therefore requiring a strong ethic of mutual aid. The central question is: Can we do better than we are doing now?

In the long run, the vitality of any society and its prospects for the future depend on the quality of its people — on their knowledge and skill, health and vigor, and the decency of their human relations. Preventing much of the damage now occurring would therefore have powerfully

beneficial social and economic impacts, including a more effective work force, higher productivity, lowered health costs, lowered prison costs, and much relief of human suffering.

In an era when there is well-founded concern about losing a vital sense of community, the initiatives sketched here can have the profound collateral benefits of building national solidarity, a mutual-aid ethic, and a reasonable basis for hope among people of all ages.

What can bring us together better than our children?

If there were any mission more important, what would it be?

Preventing much of the damage now occurring would therefore have powerfully beneficial social and economic impacts.





ZERO TO THREE

Tammy L. Mann, Ph.D.

Early Head Start National Resource Center

The goal of Early Head Start is not very different from the goal of Head Start when it was established more than 30 years ago. Under this new initiative, there continues to be a commitment to providing services from a comprehensive, holistic perspective — Early Head Start, like Head Start, seeks to meet the needs of the “whole child” in the context of the family. Its aim is to enhance the overall development of infants and toddlers who are growing up in poverty-stricken communities across the country.

THE GENESIS OF EARLY HEAD START

There are a number of scientific developments that led to the establishment of the initiative, only a few of which will be highlighted here.

Developments in the field of maternal and child health have been especially important in illuminating how experiences during the prenatal period impact later development. For example, poor or absent prenatal care, exposure to teratogens, malnutrition, and stress during pregnancy are associated with low birth weight and birth defects for children. Low birth weight is in turn associated with infant mortality, illness, disability, child abuse, relationship difficulties, and problems in learning.

We also know that socioemotional experiences in infancy influence adaptability in later development. Much of the evidence documenting this finding is grounded in attachment literature generated over the past 30 years. During infancy, in the context of relationships, the infant’s sense of self and trust evolves. These early experiences provide the building blocks from which social skills such as empathy, emotional regulation, self-control, and coopera-

tion emerge. We also have known for quite some time, though documented more recently due to advances in technology, that the interplay between nature and nurture is a critical force in shaping brain development that takes place during the first two years of life.

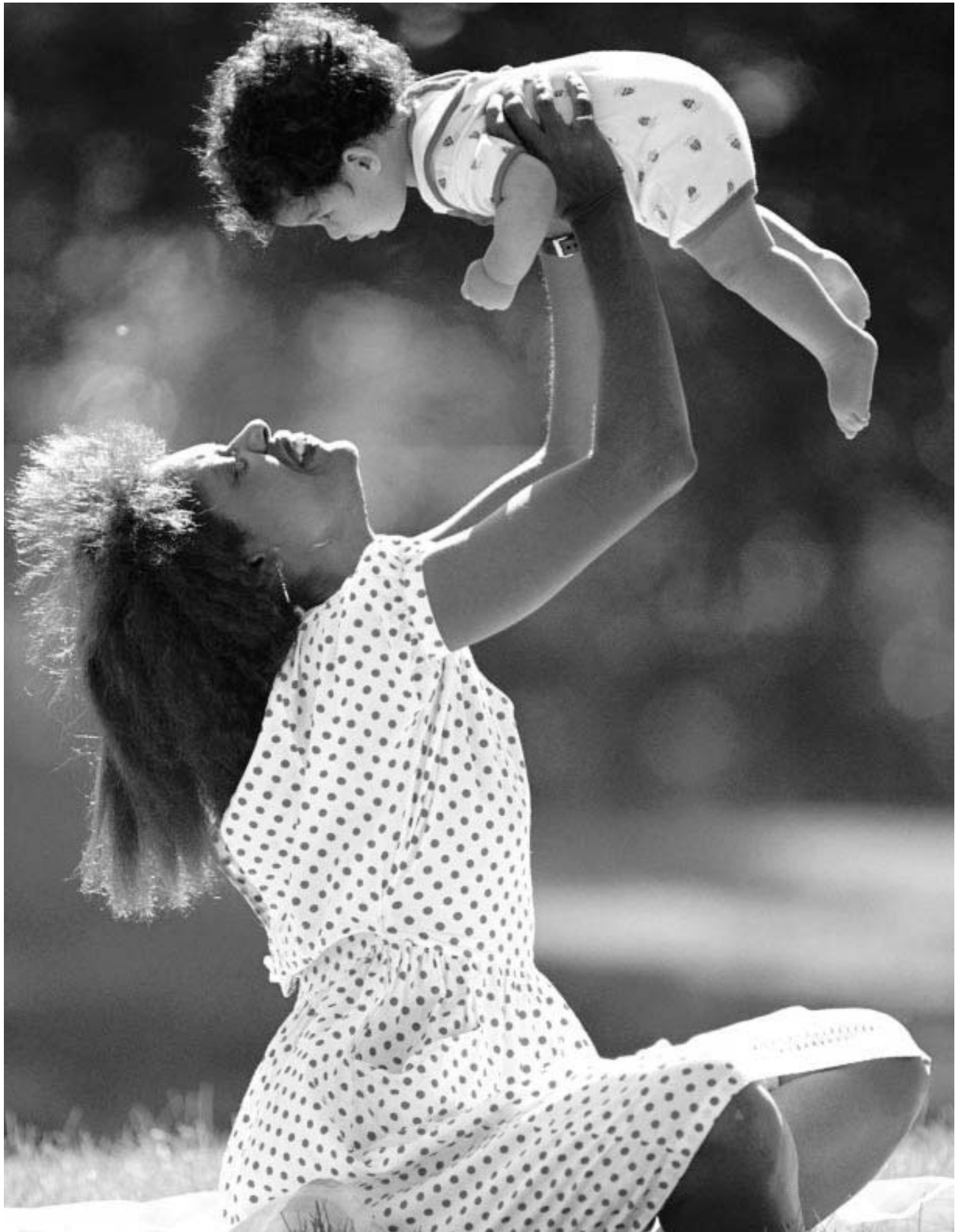
Beyond these scientific developments, recommendations set forth in the *Final Report of the Advisory Committee on Head Start Quality and Expansion* were also important factors leading to the creation of this important initiative.

The Committee released a report in 1993 identifying three key recommendations that focused on:

- the need to reaffirm and bolster Head Start’s commitment to quality and excellence in service, if the program was to be successful in impacting meaningful outcomes for children;
- the need for Head Start programs to be able to respond flexibly to the needs of families; and
- the need to build external partnerships at community, state, and national levels to support its continued growth and development into the next century.

While articulating the second recommendation, the Committee addressed the need and importance of comprehensive child development services for infants and toddlers. Data on families being served by the Head Start program suggested that many families had younger children who needed services, but were unable to access special programs in their communities. Consequently, the committee recommended that Head Start expand services to meet the growing needs of families requiring access to comprehensive child development services for infants and toddlers.

Taken together, these developments provide the backdrop against which Early Head Start was born.





LEARNING THE LESSONS OF PRACTICE

When the Head Start Act was re-authorized in 1994, it incorporated language that charged the secretary of Health and Human Services with establishing an Advisory Committee to guide the development of the Early Head Start program — its philosophy and approach to service delivery. Early Head Start was created with the purpose of providing high quality, comprehensive services — available 12 months a year — to low-income pregnant women and families with infants and toddlers.

While Early Head Start came “online” as a new initiative, it was not the first experience that the Head Start Bureau, the agency responsible for administering the Head Start program, had in providing services to infants and toddlers. Migrant Head Start programs had been providing such services for a number of years, as had Parent Child Centers, which was a demonstration effort funded for nearly 27 years. There were also lessons learned from the Comprehensive Child Development Project that shaped the thinking behind the approaches used in Early Head Start.

The Advisory Committee articulated nine principles as the foundation upon which the program was to operate:

- High Quality
- Prevention and Promotion
- Positive Relationships and Continuity
- Parent Involvement
- Inclusion
- Culture
- Comprehensiveness, Flexibility, Responsiveness, and Intensity
- Transition
- Collaboration

These principles were designed to serve as the “lens” through which the provision of all services should be pro-

jected. The Advisory Committee also developed four cornerstones that described the scope of services these programs would provide to families. The cornerstones include a commitment to comprehensive child development services, family development services, community building efforts, and staff development.

The cornerstone focusing on staff development addressed the importance of ensuring that Early Head Start staff had the requisite skills and support necessary to ensure the provision of high-quality services.

In addition to setting the course for the approach and philosophy of Early Head Start, the Advisory Committee addressed the importance of research and evaluation, training and technical assistance, and program monitoring.

At the program’s inception, a rigorous national evaluation was funded — and currently is being conducted by Mathematica Policy Research Inc., in Princeton, N.J. This will examine the impact of services across 17 Early Head Start sites from the initial pool of programs funded in the fall of 1995.

In addition, 17 locally designed research studies are being carried out by a consortium of researchers to explore the unique characteristics and impacts observed within individual

programs.

The Head Start Bureau collaborates with a regional network of training and technical assistance providers to ensure that Early Head Start program providers have access to information and resources that support them in their efforts to deliver high-quality services.

A NATIONAL-LOCAL FRAMEWORK

Services offered by the Early Head Start National Resource Center (EHS NRC) at ZERO TO THREE demonstrate the Head Start Bureau’s commitment to ensure that EHS workers have access to training and technical assistance as they implement the programs.

The Bureau collaborates with a regional network of training and technical assistance providers to ensure that Early Head Start program providers have access to information and resources that support them in their efforts to deliver high-quality services. Furthermore, every three



years, Early Head Start programs are monitored by the Head Start Bureau to assure compliance with performance standards.

Currently, 436 Early Head Start programs are funded across the United States. The first round of programs began in the fall of 1995. By early 1998, there were more than 22,000 infants and toddlers being served.

Funding for Early Head Start services is taken from a percentage of the overall Head Start Budget, in excess of \$4 billion for fiscal year 1999. Provisions outlined in the recent reauthorization of the Head Start Act pave the way for continued growth in this program. Pending the availability and nature of results associated with the national evaluation, Early Head Start will grow to 10 percent of the overall Head Start budget by 2003.

PERFORMANCE STANDARDS

Early Head Start programs are required to adhere to performance standards as a condition of funding. A new set of standards, which began in 1998, represents the first major revisions since the standards were initially created by the Head Start Bureau in the mid-1970s. Important differences distinguish the current regulations from the previous version.

The revised *Standards* reflect a commitment by the Bureau to provide grantees with increased flexibility to determine *how* they meet regulations as they design services. In other words, the revised *Standards* set the parameters that define the scope of services, but local grantees determine the manner in which these services will be designed and offered. Thus, increased flexibility provides programs with the opportunity to establish creative partnerships and strategies to ensure that needs of families in their community are addressed.

The revised *Standards* also include regulatory language

that describes critical elements of management systems that all programs must have to provide the infrastructure to support effective programming.

The section on child development services explicitly requires Early Head Start programs to promote continuity of care — a direct reflection of the important role that relationships play in shaping development during infancy.

The standards also encourage services that promote the development of trust and emotional security — experiences that are critical to the health and wellness of young children. The regulatory language emphasizes socioemotional development and the quality of the caregiving

experience as critical to promoting healthy development in infancy.

Thus, Early Head Start is, by design, a program that seeks to promote wellness in very young children. Recognizing importance of the early years of life for later development, the Early Head Start programs will certainly provide a fertile ground for understanding benefits that can be reaped as vulnerable infants and toddlers, and their families, are served by this important initiative.

CHALLENGES

Two challenges merit attention:

1. Although there have been many advances made in science, only limited tools are available for reliably

assessing various aspects of socioemotional development in infancy. In an era of “fiscal accountability,” the need for measurement tools that aid program managers in documenting the impact of their services, particularly on social and emotional development, cannot be emphasized enough. Our understanding and ability to reliably assess indicators of cognitive development in young children continue to exceed our ability to understand how we might measure and assess dimensions of socioemotional development. Progress on this front is overdue and sorely needed.





2. Many communities are finding it difficult to locate clinicians and practitioners trained in infant development to “staff” programs and provide the needed clinical consultation when treatment issues emerge. Past experience — particularly in the Head Start context — suggests that mental health services are often not adequately available to meet the needs of families and children served in many agencies.

Training in infant development, as an area of focus in undergraduate and even graduate programs, is not widely available across this country. The need to consider how mental health practi-

tioners can gain access to programs/training experiences that provide the necessary understanding of infant mental health and infant development must be addressed.

If our efforts in Early Head Start and other health

prevention and promotion programs are to be fully realized, we must have access to individuals that understand how to promote health and wellness in very young children, as well as individuals who can provide clinical consultation and treatment services when such services are required.

Past experience — particularly in the Head Start context — suggests that mental health services are often not adequately available to meet the needs of families and children served in many agencies.





THE CASE FOR EARLY EDUCATION

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High/Scope Educational Research Foundation

For many reasons, preschool education is a particularly appealing intervention. The preschool aspect is attractive because most people see it as a beginning, a time of promise, a period when good traits can be encouraged and solid intellectual and social foundations formed. Then, too, the education aspect is attractive because education is the traditional means by which people have improved their prospects for productive and satisfying lives.

IMPROVING POOR CHILDREN'S START IN SCHOOL AND IN LIFE

Many poor children are handicapped when they enter school because they have not had the chance to develop the skills, habits, and attitudes expected of children in kindergarten and first grade. This lack of development is manifested in low scores on tests of intellectual or scholastic ability. And while poor children may be developmentally advanced in other respects, their lack of preparedness for school also can lead to their unnecessary (*i.e.*, preventable) placement in special education classes, to being held back a grade, to repeated scholastic failure, and to dropping out of high school.

Given the chance to attend high-quality preschool programs, poor children can learn the skills, habits, and attitudes expected of them in kindergarten and first grade. Thus, they get a better start toward success in school and in life.

This idea of giving poor children a "head start" took hold with educators and social scientists in the 1960s. As many pilot preschool child development programs were mounted, a limited number of scientific evaluations of these programs were made. As might be expected, most

studies assessed the short-term effects of such programs; only a handful have been able to examine their effectiveness 10 years or more after the programs' end.

The most carefully drawn studies of preschool child development programs suggest a pattern of cause and effect that stretches from early childhood into the adult years.

The weight of the evidence of all the studies suggests:

- Poor children who attend a high-quality early childhood development program are better prepared for school, intellectually and socially.
- This better start probably helps them achieve greater success in school. Far fewer poor children who have attended good preschool programs need special education classes, have to repeat a grade, or experience major behavior problems.
- Their greater success in school tends to lead to greater success in adolescence and adulthood. Their rates of delinquency, teen-age pregnancy, and welfare usage are lower; and their rates of high school completion and subsequent employment are higher. Thus both their economic and social performances are greatly improved.

HIGH/SCOPE PERRY PRESCHOOL STUDY

Compelling evidence on the value of early childhood education comes from a long-term study of the High/Scope Perry Preschool Project in Ypsilanti, Michigan, conducted by the nonprofit High/Scope Educational Research Foundation (Schweinhart, Barnes, & Weikart, 1993). The purpose of the study was to explore whether participation in a high-quality early childhood education program would have long-term effects.



The High/Scope Perry Preschool Project is a longitudinal study begun in 1962 of 123 disadvantaged African-American youths from a single school district. At ages three and four, these youths were randomly divided into two groups — an experimental program group that received a high-quality preschool education and a control no-program group that received no preschool training.

The two groups were studied on an annual basis from ages 3 to 11; again at ages 14, 15, and 19; and at age 28. Funding was awarded in 1999 for the study to be undertaken at age 40.

Among the hundreds of variables considered were the children's abilities, attitudes, and scholastic accomplishments, and, as adults, their involvement in delinquent and criminal behavior, their use of welfare assistance, and their employment patterns.

The study's results indicate that good preschool programs can lead to consistent improvement in poor children's achievement throughout their school years, a reduced delinquency and arrest rate, a reduced teen-age pregnancy rate through age 19, and a decreased rate of dependency on welfare. Among statistically significant results through age 28 were:

- SOCIAL RESPONSIBILITY: By age 27, only one-fifth as many program group members as no-program group members were arrested five or more times (7% vs. 35%), and only one-third as many were ever arrested for drug dealing (7% vs. 25%).
- EARNINGS AND ECONOMIC STATUS: At age 27, four times as many program group members as no-program group members earned \$2,000 or more per month (29% vs. 7%). Almost three times as many owned their own homes (36% vs. 13%); and more than twice as many owned two cars (30% vs. 13%). Three-fourths as many received welfare assistance

or other social services at some time as adults (59% vs. 80%).

- COMMITMENT TO MARRIAGE: Five times as many program females as no-program females were married at the age-27 (40% vs. 8%). Program females had only about two-thirds as many out-of-wedlock births as did no-program females (57% of births vs. 83% of births).

The High/Scope Perry Preschool Project has become a standard reference for those who argue in favor of early education. Its acceptance is widespread. The American Psychological Association (Price, Cowen, Lorion, &

Ramos-McKay, 1988) selected it as one of 12 diverse validated methods for reducing social problems of adolescence. This endorsement occurred after a committee of scientists carefully reviewed research from 900 intervention programs. The Committee on Economic Development (1985), after reviewing the High/Scope Perry Preschool Project economic study, labeled early education a major investment opportunity for the business community.

A study of disadvantaged African-American youth indicates a good preschool program can lead to consistent improvement in poor children's achievement throughout their school years, a reduced delinquency and arrest rate, a reduced teen-age pregnancy rate, and a decreased rate of dependency on welfare — at a savings to taxpayers.

COST-BENEFIT ANALYSIS

The High/Scope Perry Preschool study includes the most complete cost-benefit analysis of early childhood education yet undertaken. A first, rudimentary effort made in 1971 looked at scholastic placement from a cost-savings viewpoint. A second, major effort was carried out under the direction of an economist using data collected from the schools through 1973. The most recent report presents a new economic analysis based on data collected through 1993 from schools, police and courts, and social services (Barnett, 1996).

The cost-benefit analysis, covering 25 years of follow-up data, indicates that this type of program can be a good investment for taxpayers. The major cost (in constant 1992



dollars, discounted at three percent annually) is the initial investment of about \$12,356 per participant per program year. This cost includes items of school operation that are usually overlooked, such as building depreciation, clothing, volunteers, and so on. The major benefits to taxpayers were savings per participant of \$6,287 for special education programs, \$12,796 for crime, \$2,918 for administration of welfare assistance, and \$57,585 in crime victim costs. Participants were expected to pay \$8,847 more in taxes because of increased lifetime earnings (predicted from their improved educational attainment).

The total benefits to taxpayers amount to about \$88,433 per participant, which is more than seven times the initial cost of the two-year program, or \$7.16 per \$1 invested in program services.

The return is large enough that even a two-year program only half as effective as the full program would still yield a positive return on investment. The savings from special education alone are equivalent to the cost of a one-year program.

The High/Scope Perry data indicate the great importance of high-quality educational experiences during the transition from infancy to elementary school years, at ages three, four, five, and six. It is likely this finding can be generalized to any youngster, poor or middle class. Although the educational, social, and economic results for middle-class children might not be as dramatic as those for disadvantaged children (because middle-class children tend to have more advantages to begin with), the preschool years are clearly crucial for all children.

THE CURRICULUM

The High/Scope Perry Preschool Project developed the High/Scope Curriculum (Hohmann & Weikart, 1995). In its first year, the curriculum was centered loosely around traditional nursery school activities.

After the first year, the theories of psychologist Jean Piaget became influential and the curriculum was reorganized accordingly. The fundamental premise of the High/Scope Curriculum is that children are active learners and construct their own knowledge from activities they plan

and carry out with the support of adults. This concept of active, self-generated learning affects all aspects of the curriculum from teacher training through classroom practice to parent involvement.

Such an approach implies a consistent daily routine, because the children have to be able to follow up on their plans and ideas. The adherence to routine gives children control of their time, which helps them develop a sense of responsibility and independence. The daily routine includes a “plan-do-review” sequence and incorporates cleanup as well as small- and large-group activities. The cycle permits children to make choices about their activities and engages the teacher in the whole process.

Planning gives children consistent opportunities to express their ideas and intentions to adults and to see themselves as individuals who can make decisions and act on them. The children experience the power of independence and the joy of working with attentive adults and peers.

Since the children are responsible for executing their plans, adults do not lead work-time activities. The adult's role during work time is to observe how children gather information, interact with peers, and solve problems. Adults then join the children in play activities to encourage them and to help them set up problem-solving situations.

The final phase of the plan-do-review cycle gives children an opportunity to represent their experiences in a variety of developmentally appropriate ways. They can draw pictures or make models of what they did, review their plan, or describe the activities they undertook. This opportunity for reflection gives the child a sense of personal control and success; it encourages the use of memory, which develops a broad awareness of context.

The curriculum is organized around “key experiences” that underlie the development of thought — based in part on Piaget's theory of cognitive development and also drawn from child development research.

The key experiences — 10 main categories subdivided into creative representation, language and literacy, initiative and social relations, movement, music, classification,



seriation, number, space, and time — create a frame of reference that helps teachers assess the children’s progress so that they can work with the children at each stage of their development and structure their own (adult) interactions with the children. They are not a framework of instructions delivered by a teacher to a child.

Although the High/Scope Curriculum is based on a particular theoretical perspective, it is an open framework approach. This means that people can use it in many disparate situations with many different kinds of children. It is now widely used throughout the United States and in many other countries. Training institutes are located in the United Kingdom, Mexico, Netherlands, and Singapore. Others are developing in Ireland, Turkey, Chile, Taiwan, and South Africa.

FACTORS THAT CONTRIBUTE TO SUCCESSFUL PRESCHOOL PROGRAMS

Successful preschool programs are the result of numerous variables. Some are known; others are still being discovered. High/Scope has studied the effects of three different preschool curriculum models on the subsequent lives of 68 children through the age of 23 in the High/Scope Curriculum Comparison study (Schweinhart & Weikart, 1997). At the ages of three and four, 68 preschoolers in Ypsilanti, Michigan, were randomly assigned to one of three curriculum groups.

The three curricular approaches differ mainly in the degree of initiative required of teacher and child — whether the primary role of each is to initiate or respond.

The first approach, inspired by the psychological theories of B.F. Skinner and other behaviorists, may be called the *programmed learning* or *direct instruction approach*. In this approach, the teacher initiates clearly defined, structured activities and the child responds and receives positive reinforcement.

The second, an *open framework approach*, is based

largely on the cognitive development theories of Jean Piaget and is represented by the High/Scope Curriculum as described above. Its activities, generated by children and supported by adults, involve specific “key experiences” that promote intellectual and social development.

The third, a *child-centered approach*, consists of elements of traditional nursery school programs. Based on Freudian psychoanalytic theory, this type of curriculum allows the child to express needs and interests, while the teacher responds and encourages free play. This approach is typical of traditional play group preschools.

Although elementary school level reports from the study found no significant differences in results from any of the three different approaches, the adolescent and young adult findings have raised serious questions about direct instruction or behaviorist programs, at least for disadvantaged children at the preschool age. These results also refocus attention on the importance of the surrounding environmental events that permit general social and behavioral learning rather than simply on the content knowledge itself.

High/Scope’s latest report (Schweinhart & Weikart, 1997) shows that at age 23, the High/Scope and Nursery School groups had 10 significant advantages over the Direct Instruction group, the High/Scope group alone had another six advantages, and the Nursery School group alone had two additional advantages. However, the High/Scope and Nursery School groups, after controlling for gender makeup, did not differ significantly from each other on any outcome variable.

By age 23, the High/Scope and Nursery School groups both had two significant advantages over the Direct Instruction group:

- Only 6% of either group needed treatment for emotional impairment or disturbance during their schooling, as compared to 47% of the Direct Instruction group.

Although the educational, social, and economic results for middle-class children might not be as dramatic as those for disadvantaged children, the preschool years are clearly crucial for all children.



- 43% of the High/Scope group and 44% of the Nursery School group had done volunteer work, as compared to 11% of the Direct Instruction group.
- The High/Scope group had six additional, significant advantages over the Direct Instruction group:
- Only 10% had ever been arrested for a felony, as compared to 39% of the Direct Instruction group.
 - None had ever been arrested for a property crime, as compared to 38% of the Direct Instruction group.
 - 23% reported at age 15 that they had engaged in 10 or more acts of misconduct, as compared to 56% of the Direct Instruction group.
 - 36% said that various kinds of people gave them a hard time, as compared to 69% of the Direct Instruction group.
 - 31% of the group had married and were living with their spouses, as compared to none of the Direct Instruction group.
 - 70% planned to graduate from college, as compared to 36% of the Direct Instruction group.
- The Nursery School group had two additional significant advantages over the Direct Instruction group:
- Only 9% had been arrested for a felony at ages 22 — 23, as compared to 34% of the Direct Instruction group.
 - None of them had ever been suspended from work, as compared to 27% of the Direct Instruction group.

These findings, based on one study with a small sample, are by no means definitive no matter how well designed the study; but two earlier studies have raised some of the same questions (Karnes, Schwedel, & Williams, 1983; Miller & Bizzell, 1983), as well as two recent studies in Washington, D.C. (Marcon, 1992, 1994), and Portugal (Nabuco & Sylva, as cited by K. Sylva in Schweinhart & Weikart, 1997). Each of these studies, with widely different samples and from different geographic areas, also has found similar problems in the performance of children who were placed in teacher-directed instruction settings. The Washington, D.C., study is of special importance both because it

used classroom observation to classify the mode of instruction in establishing the study groups and because of its sample size.

SUMMARY

Since the early 1960s, well-designed research projects have explored the issues in early childhood growth and development that lead to high-quality care and educational programs for all children. The essential ingredients of high-quality educational programs are known. The challenge is to apply these principles in programs throughout the country to improve the lives of children and families.

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HEALTHY CHILDREN 2010: NEXT STEPS?

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In the past, mental health efforts, because of the health-illness model of individual treatment, have been largely restricted to illness-oriented interventions. We believe, most urgently, that effective primary prevention efforts will be more social and educational than rehabilitative in nature.

— Report of the Task Panel on Prevention
President's Commission on Mental Health (1978)

Founded in 1994 by Eileen Rockefeller Growald and Tim Shriver, the Collaborative for the Advancement of Social and Emotional Learning (CASEL) has an overall mission to support the development of schools that foster knowledgeable, responsible, and caring students. We have the following primary goals:

- Identify and enhance the scientific and theoretical foundation for social and emotional education.
- Foster the international dissemination of scientifically sound SEL educational practices.
- Increase training opportunities for educators to foster implementation of high-quality SEL programs and practices.
- Encourage collaboration and communication among scientists, practitioners, and advocacy groups in their efforts to promote effective SEL programs and practices.
- Increase the awareness of educators, policy-makers, funders, and the public regarding the need for and effects of quality SEL programming.

CASEL currently supports two active work groups comprised of SEL experts from around the world. Each

group collaborates on projects to advance the quality of school-based efforts to enhance children's healthy development. The Research and Guidelines Work Group (co-chaired by Mark Greenberg of Pennsylvania State University and Joe Zins from the University of Cincinnati) conducts original research and synthesizes current SEL research to provide a firm empirical foundation for future research, practice, and policy.

For example, work group members recently co-authored *Promoting Social and Emotional Learning: Guidelines for Educators* (Elias *et al.*, 1997), which has been distributed to 100,000 educators by the Association for Supervision and Curriculum Development. With funding from the U.S. Department of Education, work group members are currently conducting a systematic review of nationally available drug prevention, violence prevention, and health education curricula with the intent of creating a consumer's guide for educators. Also, in collaboration with the Center for the Advancement of Health, we are examining empirical studies on relations between children's social-emotional competence and health outcomes in order to articulate the implications of this research for the practice of health care providers and educators.

The Educator Preparation Work Group focuses its efforts on preparing the educational community to integrate SEL programming into the standard preschool through high school educational curriculum. Two current initiatives include (a) writing a new book for educators describing the best SEL practices, and (b) developing pre-service and in-service courses for educators that emphasize scientifically based approaches for implementing SEL programs and practices.



Current updates about CASEL's research, training, and advocacy efforts are continuously posted on our web site: www.casel.org.

SCHOOL-BASED SEL AND HEALTH-PROMOTION PROGRAMS

There is widespread concern that too many children engage in risky behaviors that interfere with their academic performance and development as responsible, productive, healthy citizens. Approximately 25 percent of American youth are vulnerable to the negative consequences of engaging in multiple high-risk behaviors such as school dropout, substance use, violence, and early unprotected intercourse. Another 25 percent experiment with some risky behaviors. The remaining 50 percent, who currently do not participate in such behavior, nonetheless require effective education and strong, consistent support to avoid such involvement.

One could cite many statistics to highlight concerns about the social and health status of our youth. For example, Dryfoos (1997) reviewed national data sources for 14- to 17-year olds and reported the following:

- 30% engaged in binge drinking (5 or more drinks on one occasion) during the past 30 days.
- 30.5% were smokers.
- 25% had engaged in sexual intercourse without a condom.
- 7.9% acknowledged carrying a gun during the past 30 days.
- 8.6% had attempted suicide.
- 25% were one year behind in school and another 5% were two years behind.

Many social, emotional, and physical health problems among America's young people are caused and/or exacerbated by significant changes that have taken place during the past few decades in families, schools, neighborhoods,

and the media (Weissberg, Kuster, & Walberg, 1999). One major change in American families has been the dramatic increase in dual-earner and one-parent homes. For example, percentages of children with mothers in the labor force rose from 10 percent in 1940 to 68 percent in 1995 (Hernandez, 1999). These factors, in combination with the breakdown of traditional neighborhoods and extended family networks, have reduced the amount of supportive contact and guidance provided to young people by positive adult role models.

Changing societal circumstances and the high prevalence of adolescent problem behaviors have prompted widespread calls for innovative school, family, and community programming to address children's social, emotional, and health needs. Takanishi (1993, p. 87) challenges us: "As members of U.S. society, we stand at the crossroads: We can make a commitment to support the full development of adolescents into productive adults or we can continue to waste the lives of significant numbers in the youth cohort." Unfortunately, the majority of well-intentioned efforts to prevent students' social and health problems are short term and categorical (e.g., dropout prevention, health education, sex education, violence prevention).

Although such prevention programs are well-intentioned, one unintended negative consequence is that schools have become inundated with brief, categorical programs that are introduced in independent, isolated ways rather than through systematic, coordinated programming. Introducing these programs in a piecemeal fashion results in disjointed programs that can be confusing to students and overwhelming to teachers.

In addition, schools typically lack organizational structures and resources to support short-term prevention programs. When implementing categorical efforts, schools are less likely to: provide high-quality training and on-site coaching to teachers who introduce programs; monitor the

"As members of U.S. society, we stand at the crossroads: We can make a commitment to support the full development of adolescents into productive adults or we can continue to waste the lives of significant numbers in the youth cohort."



integrity of program implementation; evaluate program effects on children's skills, attitudes, and practices; and modify and improve programs based on student, teacher, and parent reactions. Lacking an adequate infrastructure to support ongoing implementation, most categorical prevention programs are not given sufficient priority in school- or district-level planning. As a result, they are not allotted sufficient instructional time to affect student social and health behaviors, nor do teachers who implement the programs receive adequate training. Without systems-level supports, these programs have little opportunity of becoming institutionalized efforts that evolve and strengthen over time.

In recent years, investigators have begun to integrate the strengths of currently available prevention programs into coordinated school-family-community partnerships to promote positive academic, social, emotional, and health behaviors. CASEL is committed to helping educators effectively implement scientifically based, multi-year SEL programs that educate students so that they:

- (a) are motivated to learn and achieve academically;
- (b) engage in positive, safe, health practices;
- (c) are socially skilled and have positive relationships with peers and adults;
- (d) contribute responsibly and ethically to their peer group, family, school, and community; and
- (e) acquire a basic set of skills, work habits, and values as a foundation for a lifetime of meaningful work.

Research indicates that it is possible to teach children a variety of SEL competencies that mediate positive academic performance, health, and citizenship. Such competencies include:

- knowing one's emotions: self-awareness or the ability to monitor feelings from moment to moment;
- managing one's emotions: emotional regulation



- skills such as self-control and stress management;
- self-efficacy: confidence in one's ability to handle situations effectively;
- perspective taking: accurate perceptions of situational demands and the feelings and perspectives of the people involved;
- prosocial goal setting: attitudes and motivation to establish adaptive goals;
- problem solving: capacity to access/generate goal-directed alternatives and link them with realistic consequences;
- decision making: choosing responsible, effective solutions;
- means-end planning: developing elaborated implementation plans that anticipate potential obstacles;
- communication and social skills: carrying out chosen solutions with behavioral skill;
- self-monitoring: observing behavioral impact with the capacity to abandon ineffective plans, try backup strategies, and reformulate goals as needed; and
- emotion-focused coping or self-reward: engaging in emotion-focused coping when a desired goal cannot be reached, or providing self-reinforcement for successful goal attainment.

Researchers have developed and evaluated a variety of SEL programs designed to address diverse social and health problems. For example, in Weissberg, Barton, and Shriver's (1998) social-competence promotion program for young adolescents, teachers train students to employ a six-step social-information processing framework for solving a wide range of real-life problems. A traffic-light poster is used to display the following, sequential six-step process:

1. Stop, calm down, and think before you act.
2. Say the problem and how you feel.



3. Set a positive goal.
4. Think of lots of solutions.
5. Think ahead to the consequences.
6. Go ahead and try the best plan.

Through explicit instruction in the six steps, teachers, parents, and students learn a common language and framework for communicating about problems. Furthermore, the traffic-light poster is a visual reminder to prompt students to apply problem solving throughout the school and at home.

The best school-based SEL programs involve multi-year, multicomponent intervention approaches that:

- (a) enhance the capacities of children and adolescents to coordinate cognition, affect, and behavior so that they may adaptively handle developmentally relevant social tasks; and
- (b) create environmental settings and resources that support using adaptive behavior and achieving good developmental outcomes (Weissberg & Greenberg, 1998).

An exemplary district-wide comprehensive social development effort has been established by the New Haven Public Schools (Weissberg, Shriver, Bose, & DeFalco, 1998). At the core of the New Haven Social Development Project, kindergarten through high school teachers provide 25 to 50 hours of planned, ongoing, and systematic classroom-based SEL instruction at each grade level. Instruction focuses on self-management, problem solving, communication skills, and prosocial attitudes and values about self, others, and tasks. Students learn to apply SEL skills to health concerns, relationships, and constructive participation in classroom, school, and community activities. Classroom-based SEL education is coordinated with school, family, and community initiatives that reinforce children's positive social and health behavior.

Comprehensive, multi-year SEL programs, such as the

New Haven Social Development Program, have produced positive effects on children's problem-solving skills, academic performance, social behavior, and health (Weissberg, Gullotta, Hampton, Ryan, & Adams, 1997). They also have positive impact on teachers who have reported that their own problem solving in their personal life improved, their ability to communicate with students improved, and their capacity to deal with stress in their own lives improved.

There is a growing consensus regarding the following perspectives on effective SEL programs:

- SEL programs that involve school-family-community partnerships produce more positive effects than initiatives that include only school-based programming.
- One-year SEL programs do not permanently inoculate children, especially from high-risk environments. Multiyear programs have had more impact.
- Many high-risk behaviors co-occur and result from common protective and risk factors, so in the long run, it may actually be more cost effective and beneficial for SEL programs to target multiple rather than single

Comprehensive, multi-year SEL programs have produced positive effects on children's problem-solving skills, academic performance, social behavior, and health. They also have positive impact on teachers who have reported improvements in problem solving, handling stress and communicating with students.

categorical outcomes.

- Program designers often start by designing and evaluating short-term approaches that address a specific problem behavior, like substance use or violent behavior. However, with experience over time, they begin to think of more holistic, multicomponent approaches that target multiple behaviors.
- Programs that promote positive academic, social, and health behavior in the context of the same coordinated effort will be best received by schools and are more likely to be institutionalized. Thus, the goals of drug or violence prevention programs must



go beyond affecting those categorical outcomes and also emphasize ways that SEL skills can promote positive academic performance.

- The quality of training and support for people who implement SEL programs and the personal skills and characteristics of program implementers are vital to the success of SEL programs.
- Collaborative, interdisciplinary research — involving researchers, program designers, practitioners, and participants — is critical for the creation of coordinated, comprehensive SEL efforts.

- management and coordination by an education professional who is trained to implement the program;
- instruction from teachers who are trained to teach the subject;
- involvement of parents, health professionals, and other concerned community members; and
- periodic evaluation, updating, and improvement.

CASEL applauds Objective 8.4 from Healthy People 2000, and believes it is an appropriate goal to which researchers, educators, and policy makers should aspire. A critical question then involves how close the nation is to achieving this objective. Unfortunately, *Healthy People*

2000 Review, 1995-96 estimated that only 2.3 percent of schools actually provided all recommended components of quality health education (National Center for Health Statistics, 1996). Given the gap between state-of-the-art programming proposed by Objective 8.4 and state-of-practice across the nation, it is appropriate to ask how this objective should be revised in Healthy People 2010.

HEALTHY CHILDREN 2000 AND 2010

The research on school-based SEL and prevention programming (Weissberg & Greenberg, 1998; Weissberg et al., 1997) supports Objective 8.4 from Healthy People 2000 which proposed to increase to at least 75 percent the proportion of the nation's elementary and secondary schools that provide planned and sequential kindergarten through 12th grade quality school health education.

The Centers for Disease Control Division of Adolescent and School Health defined comprehensive school health education in a way that complements the perspectives and findings discussed in this overview. They identify the following key elements of comprehensive school health education:

- a documented, planned, and sequential K to 12 program;
- a curriculum that integrates education about a range of categorical health issues at developmentally appropriate ages;
- activities that help young people develop health-promotion and health-protective skills, not just acquire information;
- instruction is provided for a prescribed amount time at each grade level;

Providing only one year of health education contradicts the research evidence, which suggests that more systemic approaches and multi-year approaches are needed.

According to *Healthy People 2010 Objectives: Draft for Public Comment* (September 15, 1998), Objective 4.2 — the proposed revision for 8.4 — offered the following recommendation: “Increase to at least 30 percent the proportion of the nation's middle/junior high and senior high schools that require one school year of health education.”

The difference between the two is stunning. While the new objective appears to encourage our nation to strive for a more achievable objective, research suggests the intensity of programming recommended by Objective 4.2 is insufficient to enhance children's behavior. Although it may be realistic to reduce the proportion of schools from 75 percent to 30 percent, it is troubling to read the proposed revision which suggests requiring one year of instruction at the middle/junior and high school level in contrast to offering “planned and sequential kindergarten through 12th grade quality (emphasis added) school health education.” Provid-



ing only one year of health education contradicts the research evidence, which suggests that more systemic approaches and multiyear approaches are needed.

In addition, it is clearly important to begin such instruction with children before they enter middle/junior high school.

Fortunately, the development of Healthy People objectives is an inclusive, iterative process. Many advocates for quality school-based prevention programming have shared our perspectives on ways that the new objective should be modified, and Objective 4.2 has since been revised based on public comments. The current version now recommends the following: "Increase to at least (figure to be determined) the proportion of the nation's elementary, middle/junior, and senior high schools that require health education on at least the following six categories of priority health risk behaviors: behaviors that contribute to unintentional and intentional injuries; tobacco use; alcohol and other drug use; avoiding unintended pregnancies, HIV infection, and other sexually transmitted diseases; dietary behaviors and nutrition; and physical activity and fitness."

This objective will be subjected to continued scrutiny and revision up until the time Healthy People 2010 goes to press for release in January 2000. There are improvements in this latest revision. For example, it adds "elementary schools" and no longer recommends providing "one school year" of health education for each school level. However, analyses of the best research and practice suggest that it is planned and sequential K to 12 SEL and health education that is most likely to result in institutionalized school programming and to enhance children's social, emotional, and health practices. Scientists, educators, policy-makers, and the public should support the implementation of K to 12, quality SEL and health education — both as an objective

for Healthy People 2010 and ultimately for 100 percent of our nation's schools.

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THE EPIDEMIC OF DEPRESSION AMONG AMERICAN YOUTH

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I had an encounter with CNN the other day. The news network asked me to assess the state of the field of prevention in mental illness. “But,” the reporter said, “this is CNN — you only get a sound bite.”

I said, “Oh, OK. How many words do I have?”

He said, “One.”

The cameras rolled. “Dr. Seligman, what is the state of prevention of mental illness?”

“Good.”

“No, that will not do. Look, we’ll give you a longer sound bite. That’s just not sufficient.”

I said, “Well, how many words do I get this time?”

He said, “You get two.”

Cameras rolled. “Dr. Seligman, what is the state of prevention of mental illness?”

“Not good.”

“This just will not do. We will give you a real sound bite this time. You are going to get three words.”

Cameras rolled. “Dr. Seligman, what is the state of prevention of mental illness?”

“Not good enough.”

THE PARADOX OF YOUTHFUL DEPRESSION

Two remarkable things have happened to depression in the United States over the past 40 years. Both were discovered during a massive set of studies launched by former President Jimmy and Rosalynn Carter in the late 1970s. We found out in the course of assessing how much mental illness existed, that depression was 10 times as common as it was 50 years ago. That was the first thing that happened.

The second was that, 50 years ago, the mean age for the first incidence of depression was 29.5 years old. It was essentially a disorder of middle-aged housewives. Now the mean age is 14.5 years old. It has become much younger. This is not only a paradox, but also the only tenfold increase of anything in the area of psychology.

We often think of depression as being about bad lives. But every statistic we have that should give us insight into the well-being of young Americans and American children is positive: the hands on the nuclear clock are farther away from midnight than ever before, there are fewer soldiers dying on the battlefield than any time since the Boer War 100 years ago; there is more purchasing power, more education, more music. But at the same time, as every objective statistic is going north, every statistic we have on the morale of our youth is going south.

DEPRESSION AND PROBLEMS

When we talk about an epidemic of depression, particularly in our next generation, we also must discuss the relationship of depression to other problems. Depression is related in lockstep with productivity, absenteeism, and poor achievement. Thus, this is a serious national problem not solely related to mental health. It is not a biological phenomenon. Nor is it an ecological phenomenon, or a phenomenon about bad events.

Three things have happened in the past 40 years that have produced the epidemic of depression, a disorder in which the individual is thwarted, or feels thwarted, about her or his most important goals. The first is that the “I-We” balance has changed. We now have a larger “I” than ever before, and a smaller “we.” The spiritual furniture that



buffered our parents and our grandparents when they failed in life — relationship to God, relationship to nation, patriotism, community, extended family — all of the spiritual furniture has become shopworn.

The second thing that has changed is the development of a movement that praises unwarranted self-esteem: We value feeling good as opposed to doing well in the world. This movement is not about *warranted* self-esteem.

The third thing is that we have adopted a victimology. Our young people believe when things go wrong, it is someone else's fault. This is a formula for passivity and depression.

SOLUTIONS

As people interested in mental health and mental illness, there are things you can do to curtail this epidemic. None of them involves handing out Prozac. We are not going to solve this problem with Prozac, for two essential reasons:

- First, according to 11 of 13 outcome studies, Prozac doesn't work on children before they reach puberty. Despite the fact that it now comes in orange and peppermint flavors, Prozac is not an effective drug for children. There are also moral/ethical problems about medicating an entire generation of young people to help their productivity and their good cheer.
- Second, even though I find myself president of the largest mental health labor union in the world, there are not enough therapists to go around. We have something of tidal proportions here.

But what we can do is encourage the fostering of positive traits. This is prevention by building strength rather than repairing weakness.

LEARNED OPTIMISM

Where I work, we teach children optimistic thinking: first to recognize the catastrophic thoughts they have when bad events strike (*e.g.*, "I have lost my best friend," or, "No

one is ever going to love me") and then to dispute them. This is the essence of learned optimism. We teach this to kids who are 10 to 12 years old and we teach it to freshmen at the University of Pennsylvania. Over the past decade, we have found that by teaching young people the skill of recognizing catastrophic thoughts and disputing them, they do not sink into the same depressed states as those who have not learned this technique. Through learned optimism, we may halve the rate of depressive episodes and depressive symptoms in participants over the next several years. In learned optimism, we are not repairing something broken. We are taking human strengths — hope and optimism — and nurturing them.

Before World War II, my profession of psychology had three missions. The first was to cure mental illness. The second was to make the lives of all people better, more fulfilling, and more productive. The third great mission of psychology was to identify and nurture genius, or high talent. Something very important happened right after World War II to change the mission. In 1946,

the Veterans' Administration System was founded and suddenly you could make a living curing mental illness.

In 1947, the National Institute of Mental Health was founded and academics discovered they could get grants if they were working on a cure for mental illness. There have been two great victories from that approach, which turned psychology and psychiatry almost solely into healing professions. The first great victory was that 15 major mental illnesses that were untreatable 50 years ago are now either curable or greatly relievable by medication or by various specific psychotherapies.

The other great victory of this movement was that we developed a science of mental illness. We were able to take things that people said were unmeasurable, such as depression, schizophrenia, anger, and alcoholism, and quantify, rigorously measure, look at the causal chain, and, best of all, look at how to undo them and how to assess whether what we tried has worked.

We have adopted a victimology. Our young people believe when things go wrong, it is someone else's fault. This is a formula for passivity and depression.



But there also have been two serious losses. The first is that we forgot our other two tasks. We forgot that our professions are also about making the lives of all people better, more productive, and more fulfilling. We forgot about high talent, and its assessment and nurturance. The second was that by working in the disease model, by working on human weaknesses, we forget about human strengths.

I recently read a biography of Eleanor Roosevelt in Doris Kearns Goodwin's *No Ordinary Times*. When explaining why Mrs. Roosevelt spent her life helping black people, poor people, and disabled people, Goodwin says that she was compensating for her mother's narcissism and her father's alcoholism. She never considers the possibility that Eleanor Roosevelt was pursuing virtue. The reason she does not is that there is an underlying belief that the positive things in life, the great motivations, are inauthentic and derivative, and that the real motivations are the negative things.

There is not a shred of scientific evidence that this is so. The investigation and nurturing of the best things in life, like the investigation and undoing of the worse things in life, are independent and different endeavors. They are part of what we are about and they are a particularly important part of the future of prevention. I have spent the past 15 years of my life working on prevention and am going to suggest something radical to you: What we have learned about the neurochemistry of schizophrenia, of depression, of drug abuse, and what we have learned about psychotherapy for these problems, does not tell us anything about how to prevent them. In fact, the great preventatives come from another model, and that model is called human strength.



A BUFFERING MODEL OF PREVENTION

If you are interested in preventing depression in kids who are genetically vulnerable to depression, if you are interested in preventing substance abuse in young people who, because of where they live, are vulnerable to substance abuse, it is the human strengths that are the buffers — courage, optimism, interpersonal skill, honesty, future-mindedness, the capacity for hope, faith, work ethic, self-understanding. These are our great preventatives. That is the evidence we have.

I had a personal epiphany about this. It happened two summers ago when my daughter Nicki was five years old. It changed my mind about psychology and psychiatry, about child rearing, and also about my mission. A few weeks after her birthday, we were working in the garden, and I have to confess that even though I write books about children, I am really not very good with them.

When I am weeding in the garden, I'm trying to get rid of the weeds. Nicki meanwhile, is throwing weeds into the air and running around, dancing and singing. I yelled at her, and she looked at me and walked away.

She came back and said, "Daddy, I want to talk to you."

"Yes, Nicki."

"Daddy, do you remember from the time I was three, I was a whiner. I whined every day. Every day! And when I turned five, I decided I wasn't going to whine any more and that was the hardest thing I have ever done. And if I can stop whining, you can stop being such a grouch."

There were several messages there. One was personal and that is that, even though I write about optimism, I was born a pessimist, and only a pessimist can write serious stuff about optimism. I also learned that I was raised in a model in which child development was about repairing things, correcting what had gone wrong.



What I learned from Nicki was that raising her was not about changing whining or about correcting it. She was going to do that herself. It was about taking this skill, this positive strength of “seeing into the soul,” and helping Nicki build her life around it, nurturing it, and letting it be the buffer against the ills that will ensue.

What we have coming at the millennium are a positive psychology, a positive psychiatry, and a positive social science. A science in a practice that asks, “What are the best things in life? What are the strengths? What are the virtues?” This process will complement our 50 years of work repairing the worst things in life.

This approach may seem politically impossible, but it is not. When nations are at war, when nations are in social turmoil, when nations are poor, it is natural that the science, the arts, the novels they write are about defense and damage, about the worst things in life.

But when nations are in surplus, when nations are at peace, when nations are not in social turmoil, human history tells us that some extraordinary things have happened. Those are the times when nations have lifted their eyes up from the worst things in life, from selfish things, to the heavens. One of the best examples can be seen in Florence, Italy, in the 15th century. Florence had become immensely

wealthy from its wool trade and its banking. It had the opportunity to become the strongest military power in Europe. But it decided not to do that. Instead, it decided to invest its surplus in beauty.

Our nation now stands at a similar historical moment. We are at peace, we are in surplus, we are not, compared to the rest of the world, in social turmoil. We can ask ourselves, “What are the best things in life? What are the human strengths? What makes life worth living?”

To answer, we must create a science, a taxonomy. We must use the same science that we used to ask about depression and schizophrenia to ask about courage, faith,

interpersonal skills, and future-mindedness. Taxonomy — assessment of what causes it and how to build it.

This will have as a side effect, the prevention of the major mental illnesses. But it will also have, as its main effect, the scientific study and the practice of human strength and of civic virtue.

And for those of us who are mental health workers, it will be an opportunity to explore more than mental illness, which is what we have done for the past 50 years; rather we may finally address *mental health* itself. I hope this will lead to the answer of the question we have asked for thousands of years: What is the good life and how can we achieve it?

We are at peace, we are in surplus, we are not, compared to the rest of the world, in social turmoil. We can ask ourselves, “What are the best things in life? What are the human strengths? What makes life worth living?”





UNITING COMMUNITIES TO PROMOTE CHILD AND ADOLESCENT DEVELOPMENT

Peter L. Benson, Ph.D.

Search Institute

Iwant to describe what is becoming a rapidly expanding national movement designed to awaken and unleash the power of communities to promote positive human development for children and adolescents. A movement that engages multiple sectors of community, it is a comprehensive work, both in naming the developmental targets to be sought and in naming who the actors are in communities. The actors include the people of the city, all of the socializing systems, and the community infrastructures that inform them, including the media and local government.

HEALTHY COMMUNITIES, HEALTHY YOUTH

Under the banner of *Healthy Communities — Healthy Youth*, this national initiative actually began in 1996 although my organization, Search Institute, just hit its 40th anniversary. Many have discovered us only because of our recent work on developmental assets and community transformation. To a certain degree, our earlier history as an applied research organization was necessary to move us to the work we now champion.

Healthy Communities — Healthy Youth is designed to trigger and support communitywide attention to healthy human development. Nearly 450 cities are connected to the movement. As it evolves and grows and, to a certain extent, spreads too quickly, Search Institute seeks to be its intellectual underpinning. Our organizational challenge is to procure partners to deliver the kinds of training, consulting, and technical assistance needed to support and sustain the initiatives at a local level.

Our work is receiving corporate and foundation support. Lutheran Brotherhood, a national financial services

organization in Minneapolis, serves as the corporate sponsor, providing both long-term funding and a national network of volunteers who assist in community initiatives. National foundations such as Kellogg, Annie E. Casey, and DeWitt Wallace-Readers Digest provide additional support. And regional conversion foundations (i.e., foundations formed from the sale of hospitals) fund statewide initiatives in Colorado (The Colorado Trust) and Kansas (the Kansas Health Foundation). The work is also supported by certain arms of state government, particularly in New Mexico, Ohio, New York, and Alaska, with departments of Public Health or Education helping in many communities.

It is likely that this work is not yet on your radar screens. This may be due to a judgment we made several years ago about where the change-making process begins. In a general sense, we had to choose between launching a grassroots effort and initiating a more traditional top-down process that initially travels through institutions, bureaucracies, and systems. We opted to begin at a grassroots level, encouraging input from local people who were empowered to serve as change-agents within local institutions. Thus, the paradigms we have developed bubble up within communities and, over time, begin to capture the attention of civic leaders. In turn, local affiliates inform their national systems. And it is these national systems which eventually bring our work to the attention of policymakers.

The work is also starting to enter the scientific literature more directly.

There are three facets we feel important:

- the core theoretical assumptions that undergird Healthy Communities — Healthy Youth;



- the framework of developmental assets (the building blocks of human development we use to unify communities); and
- our model of asset-building community (what a place looks like when it becomes developmentally attentive to all the children and adolescents in its midst) and the core change-making strategies we advocate.

THEORETICAL ASSUMPTIONS

To activate the developmental capacity of communities, we place high emphasis on uniting residents and their leaders around a vision of the common good. Given the fragmentation of systems and the turf wars that dominate in most cities, we first name elements of positive human development which are important for children and adolescents regardless of race, ethnicity, family income, gender, or geography. We have defined 40 developmental assets with this unifying, bridge-building purpose in mind.

We also seek to activate multiple sources of positive developmental energy, including informal, nonprogrammatic relationships between adults and youth; traditional socializing systems such as families, neighborhoods, schools, and congregations; and the governmental, economic, and policy infrastructures that inform the work of socializing systems. By so doing, we develop a flow of developmental energy within many settings of a child's life, and at the same time, increase the probability of developmental redundancy. The goal is to activate the experiences of support, connection, boundary-setting, and competency building within many settings.

Many obstacles within American communities inhibit the flow of developmental energy. Among these are age segregation and the deep disconnect, particularly during the teen years, of young people from long-term, sustained

relationships with multiple adults. To these we can add the issue of socialization inconsistency that now describes the journey of human development in most communities. Most cities evidence a kind of dissonance in core messages to children and adolescents about boundaries, expectations, and values.

Civic disengagement, a concept often used to explain decline in voting rates, disinterest in community affairs, and declining associational memberships, also interferes with child and adolescent development. Positive human development requires, in our view, the active engagement of citizens. Child and adolescent needs for engagement,

empowerment, and connection require a citizenry that seeks relationships with children and adolescents. However, mounting adult cynicism about youth, coupled with a media-driven fear of youth, fuels a retreat from daily engagement. (As a corollary, John McKnight of Northwestern University suggests "the over-professionalization of care" — the creation of caring professions — has robbed the public of some of its natural tendency to provide care. This trend could exacerbate the disconnect between adults and youth.)

Search Institute's national research on American youth demonstrates the disconnect. One develop-

mental asset is having three or more adult relationships that last longer than a year. The idea is to have multiple sources of communication, modeling, and value transmission. But only about a third of sixth- to 12th-grade youth benefit from this developmental asset. As adult influence decreases, peer influence increases.

Our core assumption is that in all towns and cities, there is a deep rupture in the developmental infrastructure. Ultimate processes of socialization are threatened by disengagement, the isolation of families, the fragmentation of social institutions, and the demise of sustained, intergenerational connections.

In all towns and cities there is a deep rupture in the developmental infrastructure. Ultimate processes of socialization are threatened by disengagement, the isolation of families, the fragmentation of social institutions, and the demise of sustained, intergenerational connections.



To recapture some of the capacity of communities to promote necessary and essential developmental resources, opportunities, and experiences for all youth, three dynamics are crucial:

- a reawakening among community residents of their capacity to make a difference in the lives of children and adolescents;
- a reawakening of socializing systems to their power to promote healthy development; and
- a shared vision of the elements of healthy development which unite and connect citizens and systems.

Search Institute triggers these transformations by providing communities with a portrait of developmental assets of their youth. By so doing, we seek deep change in how communities think about individual and system efficacy.

THE FRAMEWORK OF DEVELOPMENTAL ASSETS

How one names these building blocks of healthy development depends on where one enters the developmental sequence and one's definition of health. The 40 developmental assets are framed around the second decade of life, roughly the middle school through high school years. This is a watershed decade, filled with choices, opportunities, and dangers significantly predictive of long-term adult outcomes and inextricably linked to developmental experiences in the first decade of life.

The developmental assets represent a conceptual model of essential socialization experiences for all young people. The naming of the developmental assets has been guided by a set of lenses, filters, and processes. Each of the assets is rooted in scientific literature, particularly in the intersection of child and adolescent development, and the applied literatures in prevention, protective factors, and resiliency.

In synthesizing this expansive and ever-growing terrain of scientific knowledge, my key interest was to locate those

developmental factors known to be causative or predictive of healthy outcomes.

The conceptualization of health integrates several dimensions. The first is resistance to health-compromising behavior, or "high-risk behavior." Many developmental assets are rooted in the extensive literature on prevention and protective factors: family, school, and community factors that help inoculate youth against acts of substance use, violence and anti-social behavior, sexual activity or teen pregnancy, driving and drinking, and quitting school.

Avoiding health-compromising or future-jeopardizing behavior, however, is only part of the fuller conceptualization of healthy development. Equally important are developmental experiences that promote thriving. Included are school success, affirmation of diversity, compassion for others, leadership, and healthy lifestyle choices (e.g., nutrition, and exercise).

These assets reflect core developmental processes, including the kinds of relationships, social experiences, social environments, and patterns of interaction that are crucial and necessary within a community and over which a community has considerable control. Therefore, the assets are more about the primary processes of socialization than about the community's economy, service, and physical structure. The developmental assets become both a research tool and a mobilization tool within communities.

As a mobilization tool, the study of developmental assets within a particular city becomes an important wake-up call. About 950 cities in America have completed our profile of assets. This survey usually involves a census of all sixth to 12th graders in a city, from public schools, parochial schools, and alternative schools.

We use the information about developmental assets to help ignite the initial spark of change in a community. Based on a sample of 99,000 students in 213 communities, we know:

- The average number of assets is 18.0. Boys average

Text continues on page 46





SEARCH INSTITUTE'S 40 DEVELOPMENTAL ASSETS

ASSET TYPE	ASSET NAME AND DEFINITION	
EXTERNAL ASSETS	<p>SUPPORT</p> <ol style="list-style-type: none"> 1. Family support — Family life provides high levels of love and support. 2. Positive family communication — Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parent(s). 3. Other adult relationships — Young person receives support from three or more nonparent adults. 4. Caring neighborhood — Young person experiences caring neighbors. 5. Caring school climate — School provides a caring, encouraging environment. 6. Parent involvement in schooling — Parent(s) are actively involved in helping young person succeed in school. 	
	<p>EMPOWERMENT</p> <ol style="list-style-type: none"> 7. Community values youth — Young person perceives that adults in the community value youth. 8. Youth as resources — Young people are given useful roles in the community. 9. Service to others — Young person serves in the community one hour or more per week. 10. Safety — Young person feels safe at home, at school, and in the neighborhood. 	
	<p>BOUNDARIES AND EXPECTATIONS</p> <ol style="list-style-type: none"> 11. Family boundaries — Family has clear rules and consequences and monitors the young person's whereabouts. 12. School boundaries — School provides clear rules and consequences. 13. Neighborhood boundaries — Neighbors take responsibility for monitoring young people's behavior. 14. Adult role models — Parent(s) and other adults model positive, responsible behavior. 15. Positive peer influence — Young person's best friends model responsible behavior. 16. High expectations — Both parent(s) and teachers encourage the young person to do well. 	
	<p>CONSTRUCTIVE USE OF TIME</p> <ol style="list-style-type: none"> 17. Creative activities — Young person spends three or more hours per week in lessons or practice in music, theater, or other arts. 18. Youth programs — Young person spends three or more hours per week in sports, clubs, or organization at school and/or in the community. 19. Religious community — Young person spends one or more hours per week in activities in a religious institution. 20. Time at home — Young person is out with friends "with nothing special to do" two or fewer nights per week. 	
	INTERNAL ASSETS	<p>COMMITMENT TO LEARNING</p> <ol style="list-style-type: none"> 21. Achievement motivation — Young person is motivated to do well in school. 22. School engagement — Young person is actively engaged in learning. 23. Homework — Young person reports doing at least one hour of homework every school day. 24. Bonding to school — Young person cares about her or his school. 25. Reading for pleasure — Young person reads for pleasure three or more hours per week.
		<p>POSITIVE VALUES</p> <ol style="list-style-type: none"> 26. Caring — Young person places high value on helping other people. 27. Equality and social justice — Young person places high value on promoting equality and reducing hunger and poverty. 28. Integrity — Young person acts on convictions and stands up for her or his beliefs.



PROMOTING POSITIVE AND HEALTHY BEHAVIORS IN CHILDREN

INTERNAL ASSETS

ASSET TYPE	ASSET NAME AND DEFINITION
SOCIAL COMPETENCIES	29. Honesty — Young person “tells the truth even when it is not easy.”
	30. Responsibility — Young person accepts and takes personal responsibility.
	31. Restraint — Young person believes it is important not to be sexually active or to use alcohol or other drugs.
	32. Planning and decision making — Young person knows how to plan and ahead and make choices.
	33. Interpersonal competence — Young person has empathy, sensitivity, and friendship skills.
	34. Cultural competence — Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
POSITIVE Identity	35. Resistance skills — Young person can resist negative peer pressure and dangerous situations.
	36. Peaceful conflict resolution — Young person seeks to resolve conflict nonviolently.
	37. Personal power — Young person feels he or she has control over “things that happen to me.”
	38. Self esteem — Young person reports having a high self-esteem.
	39. Sense of purpose — Young person reports that “my life has a purpose”
	40. Positive view of personal future — Young person is optimistic about her or his personal future.

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three developmental assets less than girls (16.5 vs. 19.5).

- The number of developmental assets are not strongly related to family income.
- Urban youth in lower-income families have about three and a half developmental assets less than those raised in higher income families.
- The average number of assets is surprisingly similar in small towns and urban centers.

Communities hear two messages when their developmental asset profile becomes part of their civic discourse (often initiated in a town meeting, some of which draw 2,000 community residents):

- First, “All youth in our city need more of these building blocks than they now have.” Typically, community profiles show that fewer than 10 percent possess more than 30 assets and that two-

thirds experience 20 or fewer of the assets.

- Second, as the number of assets rises, major reductions occur in alcohol use, tobacco use, illicit drug use, early sexual activity, violence, anti-social behavior, and gambling. A rise in the developmental assets is linked to increases in school success, the affirmation of diversity, and other thriving indicators.

There is not, we discover, a subset of four, six, eight, or 10 of these that assures positive human development. It is the combination of support, empowerment, engagement, structure, boundary, value, competency, and identity that is important for framing a life.

In examining all factors, from the community’s size and geography to race, ethnicity, family income, gender, and age, we have found the presence of these 40 developmental assets remains a powerful predictor of health.

COMMUNITY ASSET BUILDING

Fifteen targets help define the dynamics of asset-building community:

1. All residents take personal responsibility for building assets in children and adolescents.
2. The community thinks and acts intergenerationally.
3. The community builds a consensus on values and boundaries, which it seeks to articulate and model.
4. All children and teenagers frequently engage in service to others.
5. Families are supported, educated, and equipped to elevate asset building to top priority.
6. All children and teenagers receive frequent expressions of support in both informal settings and in places where youth gather.
7. Neighborhoods are places of caring, support, and safety.
8. Schools — both elementary and secondary — mobilize to promote caring, clear boundaries and sustained relationships with adults.
9. Businesses establish family-friendly policies and embrace asset-building principles for young employees.
10. Virtually all youth 10 to 18 years old are involved in one or more clubs, teams, or other youth-serving organizations that see building assets as central to their mission.
11. The media repeatedly communicate the community’s vision, support mobilization efforts, and provide forums for sharing innovative actions taken by individuals and organizations.
12. All professionals and volunteers who work with youth receive training in asset building.
13. Youth have opportunities to serve, lead, and make decisions.
14. Religious institutions mobilize their resources to build assets within their own programs and in the community.
15. The communitywide commitment to asset building is long term and sustained.



CREATING ASSET-BUILDING COMMUNITIES

As we support a growing network of 450 communities seeking to unleash asset-building power, we provide models and resources to trigger actions, with an emphasis on mobilizing a critical mass of adults and youth in all settings (e.g., families, neighborhoods, schools, congregations, youth organizations, public places, workplaces).

Asset-building communities — healthy communities for children and adolescents — have a shared commitment. They are relational and intergenerational places that emphasize support, empowerment, boundaries, opportunities, and a united goal of developing internal assets. Developmental assets become a language of the common good, and the commitment to engage citizens and systems pursuing this common good is visible, long term, and inclusive. This is a vision of a city’s developmental infrastructure. As such, there also are economic and service infrastructures that are needed to address additional concerns, such as jobs, safety, and racial and socioeconomic inequities.

Much of our work now is devoted to creating resources to support community transformations. These include the production of print and video resources and the development of systems for speaking, training, and consulting. As the movement expands, we evolve ways for communities — from Seattle, Washington, to Rochester, New York — to learn from each other. An annual Healthy Communities — Healthy Youth conference gathers 1,000-1,500 adults and youth from 40 or more states to link, learn, and celebrate.

A parallel commitment is to increase our scientific work on the processes and dynamics of sustainable community change. Via our first statewide initiative, Assets for Colorado Youth, we have launched several longitudinal

studies to document the effects of community initiatives on both developmental assets and civic life.

A CITIZENS’ MOVEMENT

A movement has been unleashed. The models of developmental assets and asset-building community spread more rapidly than Search Institute can manage or control. But movements are like that. They cannot be controlled, nor should they be.

This changes our work at Search Institute. To a certain extent, we are not the teachers of a way, but teammates with communities in discovering how to create and sustain deep change. What we are learning is that much of the wisdom about change for human development is vested in the people of communities. Our work now is more about learning what communities can teach us than teaching communities how to proceed.

If I knew the 48 steps for deep community change around human development, I would not tell anybody what they are. Because what we are seeing in towns and cities across the country is the incredible power of people to come together around a shared vision, to unite across areas of power and control, to discover their own strengths,

then to ask us in Minneapolis to provide support when they need it.

The engine needed to drive all of this is the people of our cities. Civic engagement is at the heart of transforming communities. President Jimmy Carter has said this well: “The only title in our democracy superior to that of president is citizen.”

It is a truth we embrace. And when citizens are united and empowered and engaged, the needle gauging child and adolescent health springs forward.

A movement has been unleashed. The models of developmental assets and asset-building community are spreading more rapidly than anyone can manage or control. But movements are like that. They cannot be controlled, nor should they be.



RECURTURING SYSTEMS WITH RESILIENCE/HEALTH REALIZATION

Kathy Marshall, M.A.

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The National Resilience Resource Center (NRRC), part of the University of Minnesota's Maternal and Child Health Program in the School of Public Health, opened in 1996 when federal funding for the Midwest Regional Center for Drug Free Schools and most other federal educational technical assistance centers ended. The program focuses on "reculturing" systems and operates on a fee-for-service basis.

MISSION: SEEING CHILDREN "AT PROMISE"

The Center helps school and community leaders enhance their capacity to tap the natural, innate health, or resilience of youth, families, and communities. *The goal is to view all students, residents, or clients as being "at promise" rather than "at risk."* This operating philosophy is grounded in resilience research spanning more than 50 years in a wide variety of disciplines. The primary strategy for tapping resilience has been developed from a best practice known as the health realization model. This strategy is promising because it develops the process of human thinking as a protective mechanism (Rutter, 1987). This resilience operating philosophy serves as the foundation for ongoing training and technical assistance services designed to promote full human development and well-being.

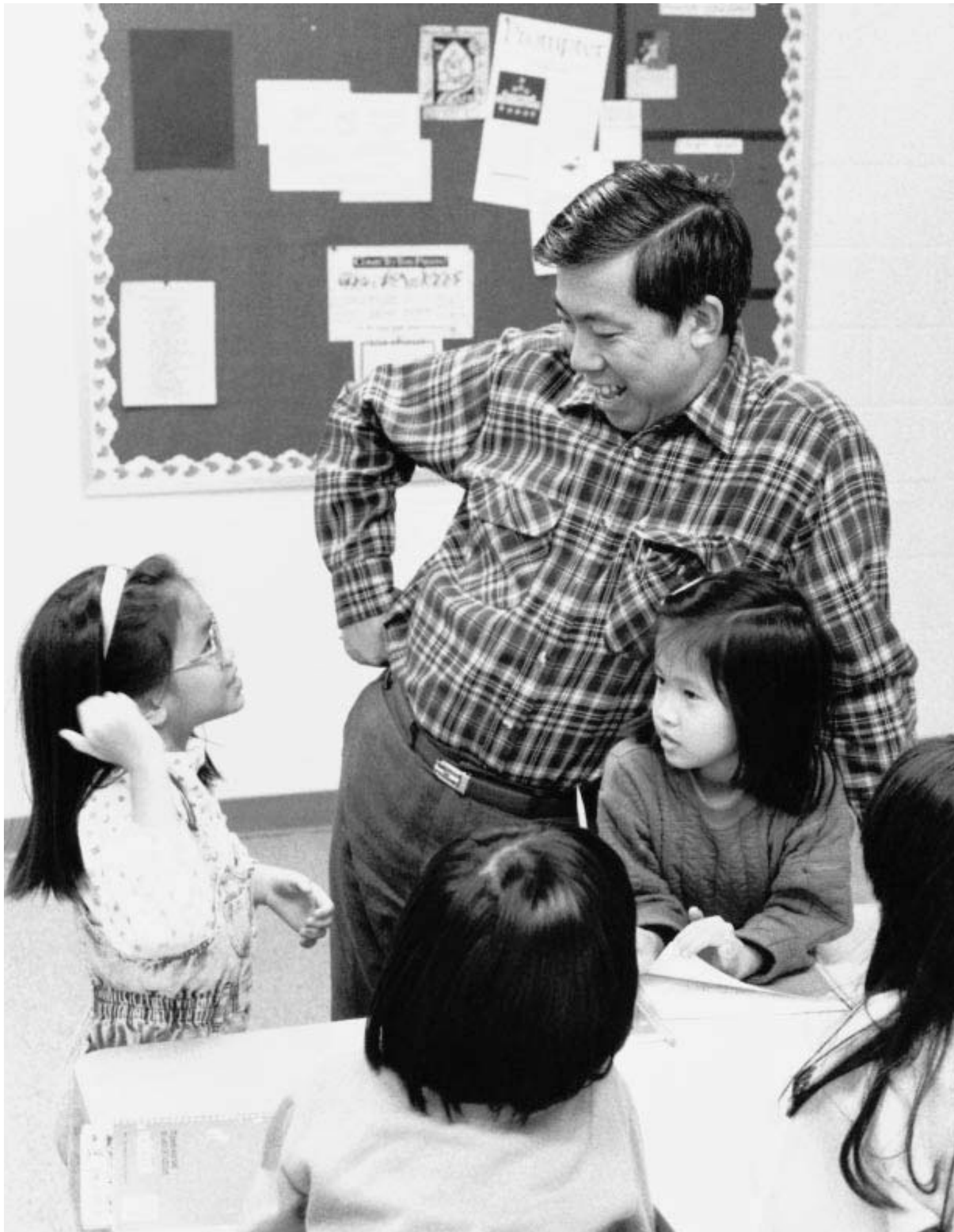
Services are customized to meet the needs of schools, community-based organizations, collaboratives, and other entities. Often work begins with a pilot group. Interest can be keen and staff and community response positive; additional groups usually need to be included in a more comprehensive plan. This natural appeal is like a magnet that pulls the resilience operating philosophy into the organiza-

tional system. This stimulates a multiyear (two- to five-year) systemic training and technical assistance plan. The service initiative has two major tracks: *ongoing training* for groups of individuals and simultaneous *technical assistance* for leadership teams.

■ **TRAINING:** 30-50 staff members are trained in ongoing resilience/health realization. Usually for teams, the training has three stages. First, personal understanding focuses on the "health of the helper" or staff member. The next phase builds confidence in communicating and using the resilience/health realization model. In the third phase, participants infuse new skills and understanding into current job responsibilities with students, clients, colleagues, parents, or community residents. Multiple groups may undergo training simultaneously in larger organizations.

■ **TECHNICAL ASSISTANCE:** A regularly convened project leadership team (district managers or key agency leaders) gives attention to management areas: needs identification, planning, policy, publicity, program coordination and scheduling, future funding, program monitoring, evaluation, and general troubleshooting. A broad spectrum of representative staff members may assist with specific tasks.

The specifics of each project are built on the insights of participants, teams, and facilitators. Project climate and personal rapport are essential ingredients. It is important to institutionalize the resilience operating philosophy in the organizational system. This maximizes the opportunity for all students (clients) or staff to be "at promise" for realizing their full capacity. For some schools, the student assistance process provides one common infrastructure for initial application of this positive approach. Student services programs, special education entities, strategic planning bodies,





community collaboratives, welfare reform and employment agencies, nonprofits, and other public agencies are also well positioned to begin this process.

The Center is new and small. Project interventions are carefully chosen. At present the Center has promising experience working in large inner-city, rural, suburban, reservation, and community agency settings. The resilience operating philosophy applies well across the board.

FRAMEWORK FOR TAPPING RESILIENCE

Resilience research* offers all who work with youth in education, youth development, children’s mental health, and human services a new paradigm for practice. This operational philosophy emanates from a fundamental belief in every person’s capacity for successful transformation and change, no matter what his or her life circumstance.

The process of resilience is the process of healthy human development, of meeting the basic human needs for caring and connectedness, for respect, challenge, and structure, and for meaningful involvement, belonging, and

power. A nurturing environment that meets these basic needs enables us to access our natural resilience. By accessing our own innate well-being, adults have the power to become, in Norman Garnezy’s words, “a protective shield” (1991) for youth by providing caring relationships, high expectations, and invitations to participate that will in turn engage their own sense of motivation and well-being.

Resilience is an inside-out process that begins with one person’s belief and emanates outward to transform whole families, classrooms, schools, and communities. (Fullan, 1993).

Tapping the innate resilience of students or family, school, and community systems requires a

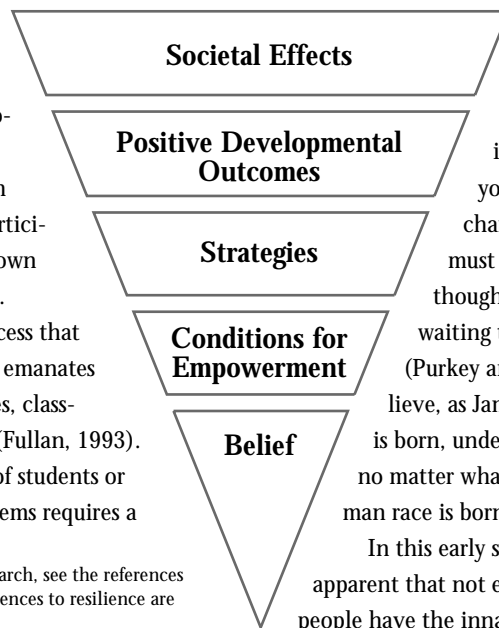
shift in how we plan and provide services. Most critically, it means we shift from a focus on fixing individuals to creating healthy systems (Gibbs, 1995). We use our research-based *Planning Framework for Tapping Resilience* (Benard and Marshall, 1997) to train school and community teams implementing the resilience paradigm. School and community change agents must see the “big picture.”

Furthermore, in a resilience-based framework, it is important to discover what staff believes. How do the beliefs about human potential and development help or hinder achieving identified goals? What advice can they gather from research and best practice? How will they know they have tapped the resilience of a student or system? In short, is there an understandable, planful way for change agents to unlock innate strength and measure results?

As presented in Figure 1, the essential planning realms examine individual and systemic beliefs, the conditions of empowerment, operational strategies, and individual and societal outcomes. Unlike most planning frameworks, which are based on problem-focused needs assessment, the

foundation for change to tap resilience begins and rests with planners’ belief in resilience.

FIGURE 1: FRAMEWORK FOR TAPPING RESILIENCY



BELIEF

For staff to create the nurturing environment that taps innate resilience, its members must believe in youth’s capacity for transformation and change (Mills, 1995; Lifton, 1993). They must believe that “human potential, though not always apparent, is always there, waiting to be discovered and invited forth” (Purkey and Stanley, 1995). They must believe, as James Agee wrote, “In every child who is born, under no matter what circumstances, and no matter what parents, the potentiality of the human race is born again” (1960).

In this early stage of planning, it usually becomes apparent that not everyone on the team believes all people have the innate capacity for well-being. Our expe-

* For more information on resilience research, see the references list beginning on page 57. Specific references to resilience are marked with an asterisk.



rience has convinced us that we must concentrate on the “health of the helper.” Using the “health realization” approach developed by community psychologist Dr. Roger Mills, we train people to see how conditioned thoughts prevent us from recognizing students’ natural strengths. By learning to tap our own resilience — our own original, healthy thinking — we can model and articulate the behavior we want to see in youth. According to both social learning theorists and cognitive scientists, it is through modeling — not direct teaching — that most human learning occurs (Bandura, 1977; Pearce, 1991; Strayhorn, 1988).

Teams planning to foster resilience may need to spend as much time discovering individual members’ beliefs about resilience and coming to consensus as they have spent in the past on linear needs assessment and problem-focused solutions. They must ask themselves: What occurred in our lives to bring out our strengths and capacities? Have we connected what we know with what we do?

America’s children need these same protective factors to realize well-being.

Looking at school district or county budgets also may reveal a system’s operating belief. Do we define children as problems at risk or resources at promise (Swadener and Lubeck, 1995)? Does the system to be changed operate from a belief that all children have the capacity for common sense, mental health, compassion, well-being, learning, strength, and wisdom? Do human beings, indeed, have a natural self-righting tendency? Are school mottoes true? Can all learners succeed? Is every child at promise?

The answers to these questions are enlightening. For example, some school principals may talk about the kids who belong in alternative programs: “Just get him out of my building.” Others design programs for “those kids” — the ones in gangs, on skateboards, just hanging out. These words indicate the system players believe there are “throw away children,” youth who do not belong in the

mainstream of school life. Unchecked, this belief will sabotage the resilience paradigm.

CREATING THE CONDITIONS OF EMPOWERMENT

The next stage of planning examines the Conditions of Empowerment. These are findings from research and best practice that document how we tap the innate resilience or capacity for healthy transformation and change in an individual, family, school, or community systems.

Findings from the traditional studies of resilience have been reinforced by ever-growing bodies of research on

issues such as effective schools, healthy families, and successful learning and learning organizations. What has become clear in all the research on human systems of any form — individual, family, group, school, organization, or community — is that successful learning and development is stimulated by the following conditions:

- caring relationships that provide love and consistent support, compassion, and trust;
- high expectations that convey respect, provide guidance, and build on the strengths of each person; and
- opportunities for participation and contribution that provide meaningful responsibilities, real decision-making power, a sense of ownership and belonging, and, ultimately, a sense of spiritual connectedness and meaning (Benard, 1996).

These systemic Conditions of Empowerment, or protective factors, cross “ethnic, social class, geographical, and historical boundaries” (Werner and Smith, 1992), because they address our common, shared humanity (Maslow, 1954).

Caring relationships convey high expectations and respect for who one is. They invite participation and welcome one’s gifts, meeting basic human needs of students and staff alike. We have inborn drives for caring and connectedness; for respect, challenge, and structure; and for

“In every child who is born, under no matter what circumstances, and no matter what parents, the potentiality of the human race is born again”



meaningful involvement, belonging, and power. When these needs are acknowledged, strength and capacity for transformation and change emerge more easily.

DEVELOPING STRATEGIES

In our training sessions, participants often ask for a recipe: “Show me how to foster resilience in the classroom.” We refer them back, first, to the Planning Framework’s foundation in belief: Are humans born with the capacity for well-being? “Discover your own resilience. We cannot teach what we do not know. When you have experienced your own ever-present resilience, then you are ready to implement strategies designed to tap resilience within students.”

The Conditions of Empowerment name the three broad areas in which to plan interventions: caring, high expectations, and opportunities for participation. In traditional planning models, a needs assessment identified problems and then team members brainstormed strategies to meet the need. At times, we simply began by creating a program we thought would address a need.

The Framework for Tapping Resilience asks planners to go much deeper. Does the strategy demonstrate a solid belief in the innate health of the student for whom it was designed? Is it apparent that a student’s risky behavior does not deter a teacher from seeing the young person’s promise? Risky behavior alone does not predict future capacity for well-being. Do planners know and use the resilience research base?

What we do to tap the young person’s resilience makes all the difference. For example, it is not enough to simply institute best-practice strategies such as mentoring, peer helping, cooperative learning, service learning, authentic assessment, multiple intelligences, community service, full-service schools, or parent involvement, etc. While these are all strategies that research has associated with positive learning and developmental outcomes in students (Hilliard, 1991; Noddings, 1992), their success depends on

the quality of the relationships surrounding them and ongoing opportunities for participation. Do the adults and children respect and care for each other? Are they equal partners? Do youth have opportunities to contribute their talents and work from their strengths and interests? Does the adult understand her own resilience? Can she aid the youngster in understanding his own thinking and thereby tapping natural inner strength?

These are only a few items that help adults examine how they are unlocking student resilience (Benard, 1996). Fostering resilience requires adults to create the Conditions for Empowerment child by child, system by system.

It is not enough to institute best-practice strategies. Their success depends on the quality of the relationships surrounding them and ongoing opportunities for participation.

INDIVIDUAL AND SOCIAL OUTCOMES

If we believe all children have innate capacity for resilience and we adhere to research as we develop our strategies, we will know success at two levels: in developmental outcomes and societal effects. Evaluation design in our planning framework addresses these measures of change.

DEVELOPMENTAL OUTCOMES: First, positive developmental outcomes indicate transformation among children and adults. The natural expression of our innate capacity — and drive — for resilience is in meeting basic needs through positive beliefs, relationships, and opportunities. The individual traits consistently found in studies of resilience are social competence (including caring, empathy, communication, and humor); identity (autonomy and self-awareness); problem solving and planning; and belief in a bright future (Benard, 1991).

Too often, however, resilience traits are erroneously used as names for prevention or youth development strategies. These traits are outcomes, not causes, of resilience. They are best used as evaluation markers or indicators, signs that we are bringing out the best in people. To label a child, family, community, or culture resilient or not resilient misses the mark. Labeling one child resilient implies



another is not and contradicts the resilience paradigm in which resilience is part of the human condition and the birthright of all human beings.

SOCIETAL EFFECTS: Successful change is apparent as well, in societal effects. When adults in the system believe in the innate resilience of their students, families, and colleagues, they can create a nurturing environment.

At the school or community level, we begin to see impacts in larger social issues: reduced problem behaviors like substance abuse, teen pregnancy, delinquency, and violence; interest and engagement in lifelong learning; and most importantly, the development of compassionate citizens (Werner and Smith, 1992; Meier, 1995; Higgins, 1994). Thus, our planning framework is circular and demonstrates a process of inside-out change (Fullan, 1993). By beginning with our own understanding of resilience, we can systematically implement strength-based prevention and education strategies for all students.

A CASE FOR DEEPER INTERVENTION

Many converging fields of study support interventions based on a deeper understanding of resilience and interventions designed to foster it. Resilience research repeatedly underscores the importance of protective factors. Mostly, the research documents manifest behaviors, skills, and competencies. Masten and Coatsworth (1998) trace the convergence of studies on competence, resilience, and interventions in both low- and high-risk environments. They outline tasks that may indicate developmental milestones and point to the importance of effective relationships and other factors.

Community survey research led by Peter Benson (1997) delineates 40 developmental assets (see Benson's article, pp. 44-45) and suggests these supports in urban, suburban, and rural communities are in short supply for America's youth. Research from the Carnegie Council on Adolescent Development (1995) supports adapting pivotal

institutions to foster healthy adolescence with generic strategies for families, schools, health promotion, communities, and the media.

Additional findings from the legendary High/Scope Educational Research Foundation's Perry Preschool Project (see article, page 25) establish the value of child-driven prevention and education programs (Berruta-Clement *et al*, 1984; Schweinhart, Weikart, and Larner, 1986; Schweinhart, Barnes, and Wiekart, 1993; Schweinhart and Weikart, 1997a, b, c). These studies document, for example, improved cognitive gains, graduation rates, relationships, employment, and reduction in violence, crime, and drug abuse for adults who were in resilience-fostering Perry Preschools.

Similarly, program evaluation research is also documenting the value of deeper level interventions. Hattie, Marsh, Neill, and Richards (1997) record the powerful effects of adventure education programs like Outward Bound. This meta-analysis reports student gains on 40 different outcomes in these "restorative environments" with facilitative leaders. Public Private

Venture's evaluations of Big Brothers/Big Sisters mentoring programs indicate developmental rather than prescriptive relationships with mentors make a difference in promoting healthy youth outcomes (Morrow and Styles, 1995; Tierney, Grossman, and Resch, 1995).

The \$25 million longitudinal study on adolescent health, funded by the National Institute of Child Health and Human Development and 18 other federal agencies, offers perhaps the most convincing evidence that a paradigm shift of the highest order will promote positive and healthy behaviors by our children. In contrast to well publicized risk-factor prevention research, Resnick *et al* (1997) report teens who feel they are understood and paid attention to by parents and teachers are less likely to use drugs, drink, alcohol, smoke, or have sex.

"Specifically, we find consistent evidence that perceived caring and connectedness to others is important in





understanding the health of young people today. While these findings are confirmatory of other studies, they are also unique because they represent the first time certain protective factors have been shown to apply across the major risk domains” (p. 830).

Perhaps child psychiatrist Robert Coles (1990) touches the heart of the matter: “Do I risk pomposity when I describe this work as phenomenological and existential rather than geared toward psychopathology, or toward the abstractions that go with ‘stage theory,’ with ‘levels’ of ‘development’? ... Others too might enjoy walking this road, one that has been somewhat neglected, even shunned.”

Resilience research has effectively measured what has happened to children — especially those who have demonstrated behaviors, characteristics, and skills useful in adapting to stress and trauma. However, it has not informed us how to teach adults to become caring and supportive, to articulate encouraging high expectations, or to create meaningful opportunities for participation.

In the void, eager practitioners have frequently identified children as resilient or not resilient. We strongly discourage such labeling. The capacity for resilience and demonstrated behaviors are not the same. In our experience, behavior does not equal capacity for well-being. Risk factors do not predict an absolute future. The deciding factor — protective mechanism — is whether an individual has the opportunity to learn and understand how to function in a psychologically healthy manner ... to tap natural resilience. In this sense, there is something deeper than behaviors, skills, and characteristics to explore as indicators of a future yet-to-be. How can the elusive capacity for resilience be measured? Should it be measured or fostered?

The ultimate systems-changing question is, “How can we intervene to prepare adults to provide protective factors ... caring and supportive relationships, high and encouraging expectations, opportunities for involvement that young people deem meaningful?” Studying indicators is not the same as intervening to foster, promote, and tap resilience.

Michael Rutter makes a compelling case for resilience and protective factors to be understood at a much deeper level. “Protection ... resides, not in the evasion of the risk, but in successful engagement with it. ... The key feature lies in the process and not in the variable. ... Protection” is found “in the ways in which people deal with life changes and in what they do about their stressful or disadvantageous circumstances” (1987, pp. 319-329). It is the individual who will make sense of the world and its events. Rutter stresses that we know very little about these protective mechanisms.

Coles (1990) also searches for reflective answers. “I

have wanted to learn from young people that exquisitely private sense of things that nurtures their spirituality.

‘My thoughts, you mean when they suddenly come to me, about God and the world and what it’s all about. ...’

We would surely learn more of what it means to be a human being [if we hear

their insights].” Fostering existential and phenomenological resilience, truly promoting the best in children, involves both internal and the external protective mechanisms. At our center, we have found a ground swell of interest in going deeper.

HEALTH REALIZATION FOR TAPPING RESILIENCE

The protective process of tapping resilience — the self-righting inner spirit that fuels our engines — may or may not be triggered by prevention education, health promotion, community collaboration, and a variety of human and mental health services. At our center, we have been pleased to discover that children and adults can be taught to tap their natural resilience. The center’s work incorporates the health realization model as a means for teaching adults to tap resilience and promote positive and healthy behaviors in children. The model (Pransky, 1998; Mills, 1995) offers principles and concepts that explain the universally protective mechanism for tapping natural resilience. This process is equally applicable in classrooms,

We have been pleased to discover that children and adults can be taught to tap their natural resilience.



boardrooms, and living rooms.

Tapping natural, innate health depends on understanding how our thinking process creates experience. The model outlines essential elements in understanding thinking. Samples include these understandings:

- Thought is the source of human experience.
- All people share an innate capacity for healthy psychological functioning.
- There are two modes of thought: one based on learned thoughts/memories; the other is fresh, original, and imbued with insight.
- Health realization interventions teach people to realize healthy psychological functioning and to recognize when their mental processes become dysfunctional.

Center trainings point people to their health and resilience by teaching the process (principles) of how thought creates experience — the interaction of mind, thought, and consciousness. Amplifying concepts include two modes of thought, separate realities, moods, feelings and emotions, levels of understanding, and healthy human functioning.

Teaching the protective mechanism of human-thought processes reconnects participants with their own ability to navigate life in a successful and healthy manner. Once students understand they are the thinker, the educational process triggers the student's own self-righting ability. The goal is to enhance the "health of the helper" — to prepare large numbers of adults to tap their own resilience and naturally provide essential protective factors for young people. Ongoing technical assistance for a leadership team attends to systemic issues and implementation.

An initial Center project evaluation by Dr. Joan Patterson includes focus group results indicating potential domains for assessing the impact of future resilience/health realization training and subsequent identification of potential questionnaires or scales for assessing each domain:

"As a result of Center training, focus group partici-

pants reported changes in knowledge, attitudes, and feelings, as well as changes in their behavior. The changes they identified suggest that new protective mechanisms were developed or existing ones were strengthened and these factors appear to contribute to their improved health and role functioning. The changes occurred in several domains of their lives, including: (a) personal functioning and well-being, (b) how they related to others in their personal life (interpersonal relationships), and (c) how they carried out their work responsibilities in relationship to co-workers and those they serve (clients, students, patients, etc.)."

These changes are summarized in Figure 2 (p. 56).

Work with the resilience/health realization model nationally has not yet been scientifically researched. At this early point, preliminary evaluation indicators suggest this best practice model may be a significant protective mechanism fostering resilience and healthy human functioning.

The health realization strategy offers a new and promising way of developing positive and healthy behaviors in children. There is hope and promise

not only for individuals, but also for whole systems to improve. Health realization/community empowerment has operated in many sites across the country. U.S. Attorney General Janet Reno brought it to two public housing projects in Miami in the late 1980s. As the project started under the direction of Dr. Roger Mills, Modello and Homestead Gardens where characterized by:

- 65% of households selling or using illegal drugs;
- 50% teen pregnancy rate;
- 50% school dropout rate;
- Epidemic child abuse and neglect;
- 80% of residents being on public assistance;
- Post office refusing to deliver mail;
- Cable television and others refusing to do business; and
- Drugs, prostitution, and criminal activities serving as major sources of household income.





FIGURE 2. PARTNERS FOCUS GROUPS REPORT, 1998

PERSONAL FUNCTIONING AND WELL-BEING

- Improved mental health: less anxiety, increased inner peace and calmness; less depression, less anger with the “systems” in which they work.
- Improved physical health: fewer headaches and illness episodes; weight reduction.
- Healthier lifestyle practices (better eating, exercise, sleeping habits, etc.).
- Increased ability to be self-reflective (regarding thoughts, feelings, and behaviors).
- Increased self-efficacy, greater awareness of having personal choices.
- Increased self-esteem; decreased

self-denigration; increased self-care.

- Improved coping with stressful situations at home and work.
- Changed world-view and perspective on what is important in life.

INTERPERSONAL RELATIONSHIPS

- Reduced reactivity and conflict; improved conflict resolution skills.
- Improved communication skills, especially improved listening and use of “I” statements.
- Increased perspective-taking ability and empathy.
- Increased awareness of strengths of others.
- Increased tolerance and acceptance of differences in thoughts and behaviors of others.

WORK PERFORMANCE AND RELATIONSHIPS

- More efforts to empower co-workers; greater awareness and acknowledgment of divergent perspectives and strengths.
- More efforts to empower service recipients; more attention to their perspectives and strengths.
- Reduction in work-related strain (burnout).
- More realistic expectations and hopeful attitudes about work processes and outcomes.
- Increased consultation requests from co-workers and service recipients.

Source: National Resilience Resource Center, St. Cloud, MN, Joan Patterson, Ph.D.

After the first year, the situation improved significantly:

- 87% better parent relationships with children;
- 60% of adults found employment;
- 20% of adult enrolled in school;
- 80% improvement in children’s school performance;
- 500% increase in parent involvement in school;
- 52% of parents joined PTA;
- 60% reduction in child abuse; and
- Students who had dropped out and dealt drugs returned to school and graduated; some went on to college when no one had done so before.

After three years, school failure dropped from 50 percent to 10 percent. Middle school teen pregnancy dropped 80 percent. No drug-related arrests, stolen cars, or burglaries were recorded for a year. Parents organized, wrote grants, and saw reduced problems with children’s alcohol and other drug use. Parents stopped hitting their children.

Children performed markedly better in school.

The number of participants studied in surveys, school records, and case file reviews is small (150 families). While this initial work cannot be considered rigorous research or statistically significant, these findings, our own experience, and personal contacts with residents and staff using this model are very promising indeed. The initiative is spreading rapidly to new locations nationally and internationally.

There is practical beginning evidence that a positive approach can, indeed, ignite innate potential for full and healthy development. Such an effort can strengthen youth and the adults who serve young people.

IMPLICATIONS FOR CHILDREN’S MENTAL HEALTH SERVICES

Interestingly the most promising protective mechanism our center has discovered for helping children and



adults tap resilience and engage in healthy and positive behaviors relies on psychological intervention. The resilience/health realization model emanated from the discipline of psychology in the past 25 years.

The paradigm shift in this model asks clinicians — and other professionals — to see all children as “at promise” rather than “at risk.” This fundamental shift means teaching rather than fixing, pointing to health rather than dysfunction, turning away from limiting labels and diagnosis to wholeness and well-being. This change in our professional thinking leads to seeing beyond behaviors, skills, and characteristics to the promise of what can be. It means seeing our clients, consumers, and students as sources of their own solutions and seeing ourselves as facilitators and teachers.

The most important first step for mental health practitioners will be to discover their own “health as a helper” and rely on the natural insights that flow from a quiet mind. This will allow the helper to access the common sense and wisdom of those served.

To successfully navigate this conceptual shift we must welcome the unknown. Today’s needs will not be met by yesterday’s understanding. We must learn to evaluate the unmeasurable and elusive nature of innate resilience. As we traverse this unlighted path, it will help to access our self-righting inner spirit, to develop a living faith in that which guides all life. If we can do this, our children will be healthier, and we can lighten up. In this state we will be free to learn to expect better client outcomes than we have known in the past. It is even likely that health care costs will reduce and more clients will seek restorative mental health services when we truly promote positive and healthy behaviors.

We must think and address systems. Successfully shifting to the resilience operating philosophy requires careful attention to systems change processes, evaluation, and appropriate research and best practices. Most importantly,

this should be undertaken over an extended period. We also highly recommend regular professional learning groups.

Resilience and health realization hold tremendous promise for all schools and communities. This change is relatively inexpensive because it involves a shift in thinking systemwide and does not require entirely new systems or programs to be created.

Finally, the promotion of children’s mental health requires us to let go of managing illness. We will need to create a health care system rather than a sickness control system. In this sense, managed care could be an adventure. Health realization psychiatrist William Pettit predicts, “We have only begun to imagine the depths of profound mental well-being.”

To see all children as “at promise” rather than “at risk” is a fundamental shift that means teaching rather than fixing, pointing to health rather than dysfunction, turning away from limiting labels and diagnosis to wholeness and well-being.

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Special thanks to Bonnie Benard and Dr. Joan Patterson

Portions of this article have been adapted with permission from: Benard, B., & Marshall, K. (1997) A framework for practice: Tapping innate resilience. Research/Practice, Spring 9-15. Excerpts from the final NRRC focus group report, prepared by Dr. Joan Patterson in June 1998 for Partners for Comprehensive Resilience Support in St. Cloud, Minn., have been included.



CREATING INDICATORS OF POSITIVE DEVELOPMENT

Tamara Halle, Ph.D. and Kristin Moore, Ph.D.

Child Trends

Many of the researchers at Child Trends are very interested in developing new indicators of child well-being that focus on positive aspects of development. We have been doing a lot of thinking about the challenges that currently exist in this area, and they are reflected in the following questions:

1. Which healthy, positive behaviors in children are currently being tracked?
2. What are our current data sources for tracking this information? For the purposes of this paper, the focus is on indicators derived from nationally representative samples. Many data files are maintained or sponsored by federal statistical data systems such as the Bureau of the Census and the National Center for Education Statistics.
3. Where are the gaps in our current data systems?
4. What are some of the implications for developing a national surveillance system that tracks positive development in children over time?

THE NATURE OF SOCIAL INDICATORS

Before addressing these questions, it is important to understand the nature of social indicators and how they are being used. There are two important characteristics of social indicators:

First, social indicators are measures of well-being that are collected on a regular basis so trends can be tracked over time — e.g., the percentage of high school graduates who attended some college from 1971 to 1997.

Second, they are gathered on a representative sample of a population, allowing for the ability to look at sub-

group differences — e.g., the total population, white non-Hispanics, black non-Hispanics, and Hispanics. (This basic, two-part definition of social indicators is found in “Creating Indicators of Positive Development,” page 60, along with a longer list of characteristics or criteria for social indicators.)

Social indicators have been used for many years to describe and monitor the state of our society. They are used, for example, to monitor fluctuations in population growth, infant mortality rates, and the number of youth who receive a college degree. They are used to set standards and to hold managers, agencies, and even governments accountable for improving the social well-being of individuals and communities.

In recent years, social indicators have become increasingly important for evaluating existing social programs and for setting new policy agendas. However, because indicators do not allow for an assessment of causality, their use in evaluations of programs should be made with caution.

Two publications, *Trends in the Well-Being of America's Children and Youth*, by the Department of Health and Human Services in 1998, and *America's Children: Key National Indicators of Well-Being* by the Federal Interagency Forum on Child and Family Statistics in 1997, have become important when it comes to policies and programs affecting children and families. These publications compile information on the condition of children's economic security, health, education, and social development. (Child Trends has assembled the *Trends Report* every year since 1996.)

These publications help policy-makers and others get a comprehensive understanding of the condition of our nation's children. They represent a major effort to gather indicators across government statistical systems.

Text continues on page 61



CREATING INDICATORS OF POSITIVE DEVELOPMENT

Social Indicators are measures of well-being that are gathered on a regular basis so trends can be tracked over time.

Social indicators are based on data gathered on a representative sample of the population so that different subgroups can be compared.

CRITERIA FOR INDICATORS OF CHILD WELL-BEING

- 1 Comprehensive coverage. Indicators should assess well-being across a broad array of outcomes, behavior, and processes.
- 2 Children of all ages. Age-appropriate indicators are needed at every age from birth through adolescence and covering the transition into adulthood.
- 3 Clear and comprehensible. Indicators should be easily and readily understood by the public.
- 4 Positive outcomes. Indicators should assess positive as well as negative aspects of well-being.
- 5 Depth, breadth, and duration. Indicators are needed that assess dispersion across given measures of well-being, children's duration in a status, and cumulative risk factors experienced by children.
- 6 Common interpretation. Indicators should have the same meaning in varied population subgroups.
- 7 Consistency over time. Indicators should have the same meaning across time.
- 8 Forward-looking. Indicators should be collected now that anticipate the future and provide baseline data for subsequent trends.
- 9 Rigorous methods. Coverage of the population or event being monitored should be complete or very high, and data collection procedures should be rigorous and consistent over time.
- 10 Geographically detailed. Indicators should be developed not only at the national level, but also at the state and local level.
- 11 Cost efficient. Although investments in data about U.S. children have been insufficient, strategies to expand and improve the data system need to be thoughtful, well planned, and economically efficient.
- 12 Reflective of social goals. Some indicators should allow us to track progress in meeting national, state, and local goals for child well-being.
- 13 Adjusted for demographic trends. Finally, to aid with our interpretation of indicators, indicators, or a subset of indicators, should be developed that adjust for changes in the composition of the population over time that confound our ability to track well-being. Alternatively, indicators should be available for population subgroups that are sufficiently narrow to permit conclusions within that subgroup.

— Tamara Halle, Ph.D., and Kristin Moore, Ph.D.
Child Trends

Source: Moore, K.A. (1997). Criteria for indicators of child well-being. In R.M. Hauser, B.V. Brown, & W.R. Prosser (Eds.), *Indicators of children's well-being* (pp. 36-44). New York: Russell Sage Foundation.



But many indicators of child well-being are monitoring negative rather than positive aspects of children's development: the percentage of children living in poverty; the percentage of children under 18 who report not having enough to eat; the percentage of students who have used illicit drugs in the last 30 days; the birth rate among females age 15 to 17; and so on.

Many measures of negative conditions are in indicator reports of child well-being because research suggests that reducing or eliminating negative outcomes increases an individual's chances for optimal development. Thus, downward trends in negative indicators are interpreted as increases in positive development.

But parents and society in general do not want children who just avoid serious problems and risks. They want children who are emotionally healthy, who have positive relationships with their parents and others, who are polite and honest, and who engage in positive behaviors such as exercise and volunteerism.

Clearly, positive development should not be defined as the absence of negative outcomes. Rather, indicators of positive development should encompass both the absence or diminishment of negative conditions *and* the existence or promotion of positive behaviors, attitudes, and milestones.

There are several challenges to creating indicators of positive development. One is defining *positive development* itself. Another is figuring out how best to measure positive development once it has been defined.

DEFINING POSITIVE DEVELOPMENT

While the public, policy-makers, and researchers tend to agree on what is negative, we lack agreement on a definition of positive development. Researchers focus disproportionately on problem behaviors and negative trends (Maynard, 1997; Yamaguchi & Kandel, 1987; Moore, Morrison, & Gleib, 1995).

Nevertheless, people who are involved in designing,

implementing, and evaluating programs for children and youth, especially those involved in youth development, have been moving forward to identify positive constructs and measures for their programs. Practitioners' views of positive development stress positive behaviors and achieving a certain level of competency in a skill. In this way, the practice field is leading the way in expanding the definition of positive development. Some of these markers have been targeted in program evaluations, while others identified through work with focus groups.

■ The Search Institute has developed a widely used measure of assets, including the assets of commitment to learning, positive values, and positive identity (Benson, 1993; Leffert, Benson, Scales, Sharma, Drale, & Blyth, 1998; see the article on pp. 44-45). Researchers from the Search Institute also report that self-esteem has been one of the primary outcomes assessed in youth development intervention evaluations.

■ The International Youth Foundation (1998) has developed a definition of youth development that incorporates several desirable youth outcomes. Among them: a sense of self-worth and confidence; a sense of accountability, responsibility and control; and competence in the areas of physical and emotional health, intellectual development, civic action, and employment.

■ Focus groups conducted for The Task Force for Child Survival and Development have yielded still more measures of positive development. Adults and children describing a "successful 25-year-old" included such characteristics as having self-confidence and self-esteem; learning from mistakes — both one's own and other people's; and possessing faith, spirituality, or maintaining some form of religious practice. In fact, religiosity was the one feature of a successful 25-year-old that was overwhelmingly endorsed by all age groups (Chervin, Reed, & Dawkins, 1998).

■ The Council on Civil Society (1998), as well as a poll by the nonprofit organization Public Agenda, have identified civility and good citizenship as important, posi-

Indicators of positive development should encompass both the absence of negative conditions and the existence of positive behaviors, attitudes, and milestones.



tive attributes for all youth. Many of the same constructs were identified by the Carnegie Council on Adolescent Development (1989).

All of these seem reasonable measures of positive development.

The next task is to incorporate them into national longitudinal surveys. This will not be easy. For instance, although “character” is a highly endorsed construct of positive development, researchers do not agree on how to measure it, or even if it should be included in surveys.

This leads to the other challenge in establishing indicators of positive development: How do we measure these constructs?

MEASURING POSITIVE DEVELOPMENT

We face several challenges in defining measurements of positive development. One is that measures do not exist for some of the constructs. How, for example, would one measure “social competence” or “character”?

A second complication is that, when measures do exist, they often are too long to be included in their entirety in a national survey. Because of space constraints, as well as consideration for respondents’ time, only a few questions of a national survey can be devoted to any one construct. Thus, survey constraints require researchers to make difficult decisions about which questions to ask.

Sometimes, this means that certain constructs cannot be measured at all. Unless there is a short set of questions of high quality (*i.e.*, able to stand up to statistical analysis of their ability to measure what we want them to measure) that can be administered in survey form, it is unlikely that the construct will be included in a national survey — even if the construct is considered extremely important.

CURRENT DATA SOURCES FOR POSITIVE DEVELOPMENT INDICATORS

Despite these constraints, a number of constructs of positive development have been included in several

national surveys. (See “*Social Indicators*,” page 63.)

Educational achievement is the indicator that has enjoyed the widest acceptance and the broadest data collection efforts to date. Achievement has been measured in multiple ways — for example, in years of education attained and in diplomas and degrees earned. Data also are collected on test scores and academic domain knowledge, and questions have even been designed to measure school engagement. The National Center for Education Statistics maintains or sponsors many of the national data sets that track educational achievement, but other data files measure achievement also. For instance, a new data set focused on health, called the National Longitudinal Study of Adolescent Health (“Add Health” for short) has several questions on this topic.

Add Health also contains other indicators of well-being. Because it primarily focuses on adolescent health, the survey includes questions on health promotion (targeting diet, exercise, the use of seat belts and bike helmets, use of sunscreen) and mental health (self-esteem and the

lack of depressive symptoms).

Add Health asks about parent-child relationships, sibling relationships, and friendships; spirituality; involvement in community organizations and institutions; extracurricular programs; and sexual behavior — a topic also included in the newest data set of the National Longitudinal Survey of Youth (or NLSY), collected in 1997.

Soon, two additional data sets will offer information on school readiness, among other things. The Early Childhood Longitudinal Study, Kindergarten Cohort (ECLS-K), begun in fall 1998, will track a nationally representative sample of kindergartners through the fifth grade. Another data set, the ECLS-B (Early Childhood Longitudinal Study, Birth Cohort), will begin data collection in 2000; it will track children from birth through school entry. Both will be rich sources of information on factors considered important for school success, including family and neighborhood environments, children’s cognitive and social

Text continues on page 64





SOCIAL INDICATORS

CONSTRUCTS OF POSITIVE DEVELOPMENT

NATIONALLY REPRESENTATIVE DATA BASE
INCLUDING MARKERS OF THESE CONSTRUCTS

Educational Achievement (years, degrees, test scores, knowledge, engagement)	National Longitudinal Survey of Youth, 1979; National Longitudinal Survey of Youth, 1997; National Longitudinal Study of Adolescent Health; National Education Longitudinal Study, 1988; National Evaluation of Welfare to Work Strategies
School Readiness	Early Childhood Longitudinal Study-Kindergarten Cohort; National Health and Nutrition Examination Survey
Health Promotion (diet, exercise, use of seat belts, bike helmets, sunscreen, dental hygiene)	National Longitudinal Study of Adolescent Health; National Health and Nutrition Examination Survey; Youth Risk Behavior Surveillance System; National Health Interview Survey
Mental Health (lack of depression, self-esteem)	National Longitudinal Study of Adolescent Health; National Education Longitudinal Study, 1988
Responsible Sexual Behavior	National Longitudinal Study of Adolescent Health; National Longitudinal Survey of Youth, 1997; Survey of Program Dynamics
Parent-Child Relationships	National Longitudinal Study of Adolescent Health; National Longitudinal Survey of Youth, 1997; Survey of Program Dynamics; National Education Longitudinal Study, 1988
Sibling Relationships	National Longitudinal Study of Adolescent Health
Positive Behavior	National Evaluation of Welfare to Work Strategies
Responsible Citizenship (knowledge, voting)	National Education Longitudinal Study, 1988; National Household Education Survey; Current Population Reports, Bureau of the Census
Volunteer Service	National Education Longitudinal Study, 1988
Religiosity/Spirituality/Belief or Practice	National Longitudinal Study of Adolescent Health; National Longitudinal Survey of Youth, 1997
Engagement in School/Community Institutions	National Longitudinal Study of Adolescent Health; National Education Longitudinal Study, 1988
Character	
Civility	
Participation in Cultural and Literary Activities	
Environment Life Style	



skills, and teachers' reports of children's behavior.

Add Health's data set surveys 12,105 adolescents in grades 7 to 12 in 134 schools within 80 different communities. The ECLS-K samples 23,000 children in about 1,000 kindergarten programs, both public and private. Both studies over sample for minority racial and ethnic groups, twins, and children with disabilities. In addition, Add Health includes a saturated sample within several schools to allow analyses of peer networks. Pairs of siblings are also included in the Add Health sample.

The availability of these new surveys, and the measures they contain, suggest it would be possible to begin to explore empirically the hypothesis that positive development is not just the absence of negative behaviors, but the presence of desirable characteristics, activities, and behaviors. However, the data available at present may not support development of any broad-based indices of positive development.

CREATING A NATIONAL SURVEILLANCE SYSTEM FOR POSITIVE DEVELOPMENT

A particular weakness in the current indicators system is the lack of information on mental health, particularly its positive aspects. The 1997 edition of the *America's Children Report* calls for work on developing a global indicator of mental health for children that takes into account the age and sex, and elicits valid responses from racial, ethnic, and income groups. The report notes that several efforts are under way to develop "reliable estimates of the number of children with mental, emotional, and behavioral problems," but data sources will not be available until perhaps 2000 (Federal Interagency Forum on Child and Family Statistics, p. 33).

"Mental, emotional, or behavioral problems" refers to negative indicators. What about positive indicators of mental health?

A review of the objectives for *Healthy People, 2010* (1998) indicates that collecting information on early-life

risk and protective factors is a focus for the coming years. Prevention and resiliency are represented. Nevertheless, overwhelmingly, the goals regarding mental health are couched in negative rather than positive terms. For instance, there are goals for reducing the prevalence of mental disorders and negative outcomes associated with mental disorder, such as suicide, and increasing the prevalence of screening for disorders.

The mental health community can — and should — help survey researchers think through the best ways to measure good mental health, so that they can be reflected in national surveys, and eventually in a national surveillance system.

So, how should we define "good" mental health? Does it mean having high self-esteem? All of the time? Researchers have noted problems with current measures of self-esteem, primarily because they do not seem to obtain comparable results across racial/ethnic groups. Nevertheless, this seems to be the only positive measure of mental

health currently included in national surveys.

What about defining good mental health in terms of the ability to manage stress and to achieve "emotional balance"? Focus groups for The Task Force for Child Survival and Development stressed both of these as goals of positive development — but how would we measure "balance"?

Bruce Compas, after reviewing the research on the positive mental health outcomes of adolescents, concludes that no single profile characterizes positive mental health. Instead, optimal functioning is "relative and depends on the goals and values of the interested parties, appropriate developmental norms, and one's sociocultural group" (Compas, pp. 166-167).

Other constructs that need to be developed are the more global and amorphous constructs identified by the practice community: character, civility, positive behavior, and competence. As with positive mental health, each of these constructs needs some "unpacking" so that it can be distilled into a few, carefully worded questions on surveys.

The mental health community can — and should — help survey researchers think through the best ways to measure good mental health.



A national surveillance system based on positive characteristics of child development is still a distant dream. Few databases contain a broad set of measures of positive development. Instead, measures are, for the most part, scattered throughout several of the newer data sets.

Because many of the data sources that include measures of positive development are relatively new, the long-term tracking of positive development is just beginning. This means that the ability of indicators of positive development to inform policy may be years away.

Finally, with the devolution of government on the development of national surveillance systems in general, the responsibility of maintaining data to guide program and policy decisions will be in the hands of individual states and localities, rather than in the hands of the federal government. If new data systems are developed, and we want to be able to use that data in a national surveillance system, we will need to encourage, or even demand, comparability of data collection and data maintenance across jurisdictions. This will become more difficult with time, unless all stakeholders commit to gather comparable information.

There is some reason to be hopeful here. Because positive indicators emphasize assets and success, it may be easier to enlist support for positive indicators by those who will now be responsible for the monitoring systems.

For the immediate future, it is clear the challenges we face in developing and maintaining new measures of positive development necessitate a mutually beneficial dialogue between researchers and practitioners, so indicators of positive development can be strengthened throughout our national surveillance systems.

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YOUNG CHILDREN AND POSITIVE CHARACTERISTICS

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The research: At 4 months, infant information-processing ability was assessed in the laboratory; at 1 year, the size of children's vocabulary was evaluated; at 4 years, children's intelligence was tested. At 4 months and at 1 year, mothers' didactic interactions with their children were recorded during naturalistic home observations: These included mothers encouraging children to attend to and gain a greater appreciation of objects, properties, and events in the environment by mothers pointing, labeling, showing, demonstrating, and the like.

An analysis of associations among these several measures revealed three noteworthy findings:

- First, children's cognitive performance as infants predicted the sizes of their productive vocabulary at their first birthday and their intelligence test scores as preschoolers. Specifically, infants were assessed in a laboratory "habituation" test. When a visual image first appears, a baby will normally attend to it; after all, it is new and novel. If, however, the same image is presented repeatedly, the baby's response to it — measured baby's visual attention — wanes. This decrement in attention indicates habituation. Some infants are fast, but others are slow in habituating. Children who habituate more efficiently in infancy possess more vocabulary in toddlerhood and score higher on intelligence tests in childhood.

- Second, mothers' didactics toward their children contributed to children's cognitive outcomes at both 1 year and 4 years. Mothers who encouraged their children's involvement in the world and who named objects had toddlers with larger expressive vocabularies and preschoolers who scored higher on the standardized IQ test.

- Third, infants affected their mothers' didactic activities

over time. Babies who habituated to the laboratory stimuli more efficiently had mothers who engaged them more in home didactic interactions eight months later. In short, children influenced their own development by influencing their parents. The child characteristics that influence adults may be obvious ones (age, gender, physical appearance), or they may be subtle ones (temperament or information processing capacity, such as described here).

This empirical example illustrates the three general sources of positive characteristics and values in young children: Children contribute directly to their own development; children contribute indirectly to their development by the influence they exert on their parents or caregivers; and parents and caregivers contribute directly to children's development.

HISTORY AND METHODOLOGY

Surprisingly little is known scientifically about the threads that are woven into the fabric of children's positive development. Such understanding requires longitudinal research, and longitudinal study is painstaking, expensive, and time consuming.

The discipline of developmental science is still quite young. Until the 20th century, psychology was part of philosophy, and philosophers of different stripes asserted that human development was subject to one or another influence and followed one or another path. John Locke (1632-1704): the infant mind is a "tabula rasa"; Immanuel Kant (1724-1804): no, the infant is born with innate knowledge; Thomas Hobbes (1588-1679): the life of man is "solitary, poor, nasty, brutish, and short;" J.J. Rousseau (1712-1778): no, children are "noble savages," born perfect in the state of nature.





With Charles Darwin, developmental science began formally, approximately 100 years ago. In 1877, Darwin published *Biographical Sketch of an Infant*, about his son, Dobby. In the succeeding half-century, many observational reports of children’s development were published, normally by the scientist parents. However, these “baby biographies” were unsystematic and often included less than objective components. In the words of one critic, “No one can know as well as the attentive parent the subtle and cumulative changes that take place in the world of the child ... but, on the other hand, no one can distort as convincingly as a loving parent.”

This subjective tradition was replaced with systematic experimental and observational studies of children and child development only in the middle of this century. As a consequence, the cumulative number of intellectual generations of practicing developmental scientists is only about three. All previous work in this field, since at least Plato’s *Laws*, had an anecdotal cast at worst, or was based on some principled philosophical stance at best.

MECHANISMS AND PROCESSES

Furthermore, to fathom just how characteristics or experiences of young children relate to their later functioning — that is, to identify the underlying mechanisms and processes — we need to distinguish stability in individuals from the roles of external effects.

Stability describes consistency in the relative ranks of individuals with respect to the expression of an ability or performance over time. A stable ability would be one that some infants perform relatively well when they are very young and again perform well when they are children and older. The fact that habituation in infancy predicts intelligence in childhood presumably means that infants carry

something that is stable and contributes to their development. Indeed, stability entices researchers toward the belief that endogenous mechanisms or processes are at work, that stability is in the child.

It is, however, impossible to characterize any child outcome as reflecting mechanisms or processes exclusively in the child without considering the influences of experience. Experiences vital to development can be early occurring and determinative; they can be contemporaneous (when later experiences are unique and/or override earlier ones); or they can accumulate (to be effective, some experiences may need to recur). To understand the positive characteristics and values of young children and to

fathom their sources, we need to isolate and measure stabilities in the child and differentiate among different models of experience, things that have not been done enough.

These points about history and methodology explain the complexity that faces us in the quest to identify exactly what is known about young children in relation to the development of positive characteristics and values in later life. They also stand apart from the consistently negative focus of earlier longitudinal work. Researchers and policy makers alike have been almost wholly occupied with children’s “disorders, deficits, and disabilities,” even if they have had the salutatory goals in mind to develop and effect interven-

tions, remediations, or preventions. Focusing the Rosalynn Carter Symposium on the development and promotion of positive characteristics and values in children is quite forward thinking.

POSITIVE CHARACTERISTICS AND VALUES IN YOUNG CHILDREN

Given this thumbnail history, the difficulty of disentangling, much less proving, longitudinal effects, and the

It is impossible to characterize any child outcome as reflecting mechanisms or processes exclusively in the child without considering the influences of experience. . . . To understand the positive characteristics and values of young children and to fathom their sources, we need to isolate and measure stabilities in the child and differentiate among various models of experience.



focus on negative outcomes, it is well to bear in mind just how much developmental science could conceivably have contributed to what we know empirically about young children in relation to their developing positive characteristics and values in later life. Nonetheless, we can ask what characteristics and values we would like to see develop in our children, which characteristics and values are modifiable, and just how parents and family, social context, and environment can foster those characteristics and values.

We can point to what developmental science has identified. The following list of attributes is not meant to sound overly generic, although perhaps some strike us as such.

Moreover, positive development is always “in the parental eye”: Some parents may seek control of emotionality in their children, others career success, and for still others, eye-hand coordination in batting matters most. The empirical literature offers this list, in no particular order:

- We want children who do not have health problems or any disorders, and, reciprocally, it is positive to possess desirable physical attributes.
- We want children who appear to have significant coping skills and resilience; coping implies the ability to interact with the environment positively, constructively, and adaptively, especially under conditions of stress, threat, or harm; resilience implies the ability to recover and regain equilibrium in face of negative environments and experiences.
- We want children with good social skills, including social cognition and social adjustment — understanding one’s place in the world and negotiating social interactions well.
- We want children who achieve educational success, not only in school, but also in the intrinsic motivation to want to succeed in school, on the job, or elsewhere.



- We want children who exhibit an understanding and satisfaction with one’s self in terms of the development of a constructive self-concept, possessing self-efficacy, an ability to self-regulate, and positive self-perceptions.
- We want children to have feelings of security — to have a very, very close bond with at least one caregiver in one’s life. (It has been contended that probably the worst thing for a child, with the exception of an organic problem or physical trauma, is not to have a parent or significant other who really cares.)

- We want children to possess whatever it is that intelligence tests measure, for in our world intelligence predicts school achievement and eventual social status and income. Under the same rubric, it never hurts to possess an identifiable talent — intellectual, artistic, musical, or athletic. This often means being singled out and considered in some way special, a condition that can become a positive part of one’s being.
- Finally, we want children to possess a temperament that has

a positive affect, an approach orientation, and adaptive style — having an “easy and winsome personality” in lay terms.

POSITIVE CHARACTERISTICS AND VALUES IN LATER LIFE

Although parenting is a somewhat mystifying subject — almost everyone has opinions about parenting, but few people agree — one thing is sure: It is the principal and continuing task of parents in each generation to prepare children of the next generation for the physical, economic, and psychosocial situations in which those children must survive and hopefully thrive. Many factors influence the



development of children, but parenthood is the “final common pathway” to childhood oversight and caregiving, development and stature, adjustment and success. The fit is neat because not only is the sheer amount of interaction between parent and offspring greatest in childhood, but childhood is the time when human beings are particularly susceptible to external experiences. Indeed, the opportunity for enhanced parental influence, and prolonged learning, is thought to be the evolutionary reason for the extended duration of human childhood.

It is a biological fact that human children do not — and cannot — grow up as solitary individuals; human young are totally dependent on their parents for survival. Childhood is the time when human children also first make sense of and understand objects in the world, forge their first social bonds, and first learn how to express and read basic human emotions. In childhood, individual personalities and social styles also first develop. Parents escort children through all these dramatic “firsts.” The influences of these developments then reverberate through time: in the view of many social theorists, the child’s first relationships with parents set the tone and style for the child’s later social relationships with all others.

Parenting therefore constitutes an all-encompassing ecology of a young child’s development. Mothers and fathers, as well as siblings, other family members, and even children’s nonfamilial day care providers guide the development of children via many direct and indirect means.

Direct effects are of two kinds: genetics and experience. Of course, biological parents endow a significant and pervasive genetic makeup to their children, with its beneficial or other consequences for the expression of children’s proclivities and abilities. Beside genes, however, all prominent theories of human development put experience in the world as either the principal source of individual growth or as a major contributing component. It falls to parents (and

other caregivers) to shape most, if not all, of young children’s experiences, and parents directly influence child development both by the beliefs they hold and by the behaviors they exhibit. Parenting beliefs include perceptions about, attitudes toward, and knowledge of all aspects of parenting and childhood, and each plays a telling part.

First, how you see yourself vis-à-vis children can lead to expressing one or another kind of affect, thinking, or behavior in childrearing. Moreover, how you see childhood functions in the same way: Parents who believe that they can or cannot affect their child’s temperament or intelligence often modify their parenting accordingly. (Unfortunately, by one recent account, one in four parents in the U.S. today thinks that a baby is born with intelligence that cannot be increased or decreased by how those parents interact with the baby.) Finally, how you see your own children has its special consequences: Parents who regard their child as being difficult are less likely to pay attention or respond to their child’s overtures, and their inattentiveness and nonresponsiveness can then foster further temperamental difficulties.

Perhaps most salient in the phenomenology of childhood are parents’ behaviors, the tangible experiences parents provide children. Virtually all of young children’s worldly experiences stem directly from interactions they have within the family. The contents of parent-child interactions are varied; some are compulsory, and others are discretionary. A small number of central domains of caregiving have been identified, however, as a prominent universal “core” of the childcare repertoire; they are nurturant, social, didactic, and material caregiving.

■ NURTURANT CAREGIVING meets the biological, physical, and health requirements of children. Parents are responsible for promoting children’s wellness and preventing their illness. Parents in virtually all higher species nurture their young, providing sustenance, routine care, protection, supervision, grooming, and the like. Nurturance is prereq-

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quisite to children's survival and well-being.

■ **SOCIAL CAREGIVING** includes the visual, verbal, affective, and physical behaviors parents use to engage children emotionally and manage their interpersonal exchanges. Through sensitivity and responsiveness, positive feedback, openness and negotiation, listening, and emotional closeness, parents make their children feel valued, accepted, and approved of. Social caregiving also includes helping children to regulate their own affect and emotions, and influencing the communicative styles and interpersonal repertoires which children bring to form meaningful and sustained relationships with others.

■ **DIDACTIC CAREGIVING** consists of the variety of strategies parents use to stimulate children to engage and understand the environment and to enter the world of learning. Didactics means introducing, mediating, and interpreting the external world to the child; teaching, describing, and demonstrating; as well as provoking or providing opportunities to observe, to imitate, and to learn.

■ **MATERIAL CAREGIVING** includes the ways in which parents provision, organize, and arrange the child's home and local environments. Adults are responsible for the number and variety of inanimate objects (toys, books, tools) available to the child, the level of ambient stimulation, the limits on physical freedom, and the overall safety and physical dimensions of children's experiences.

Caregiving behaviors and styles constitute direct experience effects of parenting. Mothers and fathers exert indirect effects in childrearing as well. Parents can indirectly influence their children by virtue of their influence on each other, for example by marital support and communication. Women who report having supportive relationships with husbands, for example, are more attentive and sensitively responsive to their children. By contrast, quarreling

parents are likely to convey confusing messages to their children, have less time for and become less involved in their children's lives, and engage in more hostile relationships with their children. Children in the back seat of a car overhear everything parents say in the front seat.

Parental influences on children operate on two additional principles. Sorrowfully, it is not the case that overall level of parental stimulation directly affects children's overall level of functioning and compensates for selective deficiencies: Simply providing an adequate financial base, a big house, or the like does not guarantee, or even speak to, a child's development of empathic personality, verbal competence, or other desirable characteristic or value. The *specificity principle* holds that specific experiences parents provide children at specific times in development exert specific effects over specific aspects of child growth in specific ways. (This is apparently counterintuitive because nearly 90 percent of parents in the United States simplistically think that the more stimulation a baby receives, the better off the baby is.)

In fact, parents and caregivers need to carefully match the amount and kinds of stimulation they offer to the child's level of development, special interests, temperament, mood at the moment, and so forth. Often, it is not simply that positive is best, but

the fit must be good. Between temperament and environment, for example, inhibited children do less well by some social criteria, but they also get into fewer scrapes.

The *transaction principle* asserts that the experiences parents provide their children shape the characteristics and values of children through time just as the characteristics and values of children shape their experiences. As noted, children influence which experiences they will be exposed to; children also interpret similar experiences differently, and therefore ultimately how those experiences affect





them. As child and parent bring distinctive characteristics to their mutual interactions, and because child and parent change as a result of those interactions, both parent and child enter future interactions as somewhat “different” individuals.

The result of the intersection of the transaction principle and the specificity principle is a degree of uncertainty in what is predictable about the characteristics and values of children, their origins, and their outcomes.

There are many pathways to success. Some populations we expect to fail miserably (teen parents, children born to crack mothers), and those we think should have it made (the educated and affluent), almost always show a surprising amount of diversity of outcome. To detect regular relations between the antecedents of parenting, experience, and environment, and the outcomes of positive child characteristics or values, we need to find precisely the right combinations of independent and dependent variables. This is not easy.

Parents are the proximal protectors, providers, and proponents of their own progeny; parents are children’s primary advocates and their front-line defense. Parenting is not easy. From the start, parenthood is a 168-hour-a-week job. Few sentient parents want to abrogate their childrearing responsibilities; quite the opposite, virtually all want only the best for their children. Parents must be empowered to provide children with experiences and environments that optimize development.

CONTEXT AND ENVIRONMENT

The parent-child dyad is embedded in a nexus of multiple layers of contexts and environments. Context and environment contribute in equally critical ways to promote and support positive characteristics and values in children. For example, parents develop feelings of competence and satisfaction through social support, contact with advice

givers, role models, and persons who share their responsibilities. Mothers with social support (especially from husbands) feel less harried and overwhelmed, have fewer competing demands on their time, and as a consequence are more sensitive and responsive to their children. Quality day care, positive peers, appropriate stimulation, adequate schools, and community opportunities have all been shown to facilitate positive development in children.

Minimal economic security is also critical: Poverty puts children at tremendous disadvantages on all fronts.

THE PRODUCTS OF SYSTEMS

No one factor is determinative and trumps all others in promoting the development of positive characteristics and values in children, but rather, in a comprehensive systems view of human development, many factors — environment and experience, genetics and biology — influence development, and a greater understanding of the role of each improves explanatory power.

To understand the nature of positive characteristics and values, and the childhood and parent-child relationships within families that give rise to them, requires of us a multivariate and dynamic stance. Only by taking multiple factors into consideration can we appreciate individual-, dyadic-, and family-level contributions to child development, as well as reflect on the embeddedness of the family within its many relevant extrafamilial systems. So, mature characteristics most certainly possess a partly biological basis: shyness, risk taking, intelligence, criminality, and alcoholism are among them.

Unquestionably, peer dynamics influence children, and children are susceptible to influences from outside the family. But people are also influenced by the individuals they spend the most time with in their impressionable youth, their own parents.

The dynamic aspect involves the different develop-

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mental trajectories of individuals in the family. Understanding a child is akin to “hitting a moving target,” the ever-changing child developing in fits and starts at his or her own pace. To exert appropriate influence and guidance, parents must constantly and effectively adjust their interactions, cognitions, emotions, affections, and strategies to the age-graded activities, abilities, and experiences of their children. It is no wonder that children do not come with an operating manual; it would have to be as encyclopedic as life itself.

The multiple pathways and temporal dynamics of child development make for a quite messy situation, and they make everyone’s job harder. Researchers have to develop new paradigms and methodologies to accommodate this (seeming) chaos, and this perspective makes the development and implementation of effective programs and policies for children “nightmarish.” Some will fail. Yet, only by addressing this complexity can we understand more that is valid about children, parents, and families.

The good news is that, in each one of these domains — the child, parents and family, context and environment — there are many attributes that are modifiable. Indeed, we can promote not just some, but almost all of the characteristics and values we want to see in our children. For example, intelligence is inherited in part, but to be inherited does not mean to be immutable. Longitudinal studies of intelligence demonstrate that individuals change over time. Heritable traits depend on learning for their expression, and they are subject to environmental effects. Similarly, only fatalists uncritically accept the developmental contexts in which they live. Those who are not take the social and political steps to organize their children’s day care, to promote their children’s associations with positive peers, to construct environments with appropriate stimulation, to make sure their community affords adequate schooling, and to enroll their children in growth promot-

ing extracurricular activities (church or temple, Boy or Girl Scouts, Little League or soccer).

SCIENCE, POLICY, AND VALUES

Developmental science is young, and admittedly its ability to identify and measure influences is primitive, perhaps too premature to make definitive statements about how positive characteristics and values are formed, never mind about ensuring successful aging. And yes, child-rearing is complicated to say the least.

Inevitably, human development is influenced by genetic endowment, by early determination, and by the contexts in which individuals adapt. Therefore, policy sometimes needs to focus on interventions that attempt to cure the individual, but sometimes, too, to provide experiences that are valuable in their own right because they improve current conditions.

As our children mature, parenthood and citizenship ultimately mean having facilitated children’s self-confidence, capacity for intimacy, achievement motivation, pleasure in play and work, friendships with peers, and continuing academic success and fulfill-

ment. It is only through very complex interventions, however, that parent and family, context and environment can be brought to bear on the route and terminus of children’s development. That these factors challenge us does not mean that we should shrink from them. The positive characteristics and values of the next generation rest in the balance.

ACKNOWLEDGMENTS

This chapter summarizes selected aspects of my research, and portions of the text have appeared in my previous scientific publications. I thank B. Wright for assistance. Requests for reprints should be sent to Marc H. Bornstein, Child and Family Research, National Institute of Child Health and Human Development, National Institutes of Health, Building 31 — Room B2B15, 9000 Rockville Pike, Bethesda, MD 20892-2030, U.S.A. E-mail: Marc_H_Bornstein@nih.gov.





POST-SCRIPT

RECOMMENDED DEVELOPMENTAL OBJECTIVE FOR HEALTHY PEOPLE 2010

John J. Gates, Ph.D.

Previous Rosalynn Carter Symposia that addressed the needs of children have emphasized treatment, rehabilitation, and social support approaches designed to deal with the problems of children, *i.e.*, their disorders, deficits, and disabilities.

The Fourteenth Annual Rosalynn Carter Symposium was different in its emphasis upon approaches based upon the assets, strengths, and abilities of children. While there are significant differences among Early Head Start, The Search Institute, The National Resiliency Resource Center, the Collaborative for the Advancement of Social and Emotional Learning, and the High/Scope Perry Preschool Project in terms of underlying theory, targeted populations, the degree of scientific rigor and validated effectiveness and scope of application, they share in common the focus of fostering the development of certain positive characteristics of children and the various environments in which they live. These include environments shaped by their families, peers, schools, and communities.

The belief is that children with these positive characteristics will function more successfully throughout life. Thus, these approaches can be viewed not just as preventative, but also as promotive of health and optimal development and well-being.

There is not yet consensus on which characteristics (physical traits, behaviors, skills, competencies, attitudes, beliefs) to foster, nor is there a generally accepted taxonomy for well-being. The fact that there are elaborate classification systems for disorders, deficits, and disabilities is indicative of the relative inattention historically paid to positive outcomes for children. Several of the speakers and

discussion groups noted the need for additional efforts to develop more consensus around what constitutes positive outcomes and how they can be measured if there is to be a shifting of more resources, energy, and creativity toward fostering assets, strengths, and abilities. It was also noted that, while there are data relating some interventions to some positive outcomes, there is need for additional research and evaluation across developmental stages.

Several recommendations emerged from the group discussions.

The first was to encourage The Carter Center to convene additional meetings of individuals and organizations to facilitate the development of a movement promoting positive outcomes in children.

The second was for all present to consider how their agencies and organizations might foster cross-sectoral dialogue about policy, research, and applications pertinent to positive outcomes for all children.

The third was to encourage continuing study of the interactions among children and their families, peers, schools, and communities. The final and most specific recommendation was to submit an objective focused on healthy, positive behaviors to the U.S. Department of Health and Human Services (DHHS) for inclusion in Healthy People 2010.

The following developmental objective was submitted by this writer by the deadline given by DHHS. It should be noted that a developmental objective is one for which there is not currently an established working data system. Perhaps, if this objective is accepted, there may be a surveillance and data system of healthy, positive outcomes developed by 2010.



DEVELOPMENTAL OBJECTIVE

Recommended for Healthy People 2010

INTRODUCTORY COMMENTS

The literature on developmental outcomes for children now encourages the opportunity to increase disease prevention and control efforts by investing in the science and interventions that tend to produce resilient children—those with social competencies, problem-solving skills, self-regulation, and a sense of purpose that lead them to decisions for successful living.

The following proposed focus area and related developmental objectives are intended to create a focus for the knowledge, strategies, interventions, and systems that contribute to the development of assets, strengths, and abilities of children and adolescents. Currently, elements of positive assets/skills are subsumed in various other focus areas, e.g. promote healthy behaviors, healthy and safe communities, improve systems, and prevent and reduce diseases and disorders. This fragmentation, though unintended, mutes the opportunity to comprehensively address important underlying causes of behaviors leading to bad decisions regarding health and well-being.

The inclusion of this proposal in Healthy People 2010 has the potential to focus the interest of researchers, health care providers, public health officials, child care providers, education specialists and community leaders to improve the knowledge base regarding positive child development and expand the application of that knowledge for all children and their families.

A focus upon the assets, strengths, and abilities of children and an expansion of knowledge of the specific behaviors, skills, competencies, and characteristics that are the basis for those assets, strengths, and abilities, combined with an expansion of knowledge of how to foster the acquisition and maintenance of them can contribute to the pro-

motion of health and adaptive functioning and to the prevention of illness and dysfunction later in life.

The proposal is relevant to both of the overarching goals of Healthy People 2010, i.e., Increasing Quality and Years of Life and Eliminating Health Disparities. While admittedly an ambitious effort, the idea of enabling all children to acquire the skills, competencies, and abilities to achieve their maximum potential as individuals and to enable parents to choose how to help them do that makes the effort important to pursue.

The timing for this proposal has the advantage of capturing the increased interest of researchers and practitioners in mental health, pediatrics, social services, education, and child health policy who increasingly see that developing constructive behaviors, skills, competencies, and characteristics in children, youth, and families is a wise investment for the health and well-being of all children.

There are several examples of the current public and private sector efforts to improve developmental outcomes, including those of the Institute of Medicine's Committee on Integrating the Science of Early Childhood Development;

The Search Institute (youth assets for healthy communities); Cooperative Extension, USDA, (National Outcomes Work Group); and the National Institute of Child Health and Human Development, NIH.

Inclusion of this proposal in the 2010 Objectives for the nation will provide visible evidence of the renewed intent to foster child health and development in multiple ways to ensure the vision of health as stated by the World Health Organization.

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PROPOSED FOCUS AREA

(to be added to Promote Healthy Behaviors)

- Behavioral Assets, Strengths, and Abilities
- Healthy Behaviors and Adaptive Functioning



GOAL: To improve the health and functioning of children and adolescents by fostering the acquisition and maintenance of behaviors, skills, competencies and characteristics that enable them to develop the assets, strengths, and abilities to cope effectively with the stresses and challenges of daily living and which are correlated with healthy, adaptive functioning later in life.

TERMINOLOGY: Behaviors, skills, competencies, and characteristics that enable children and adolescents to cope effectively include:

- Social competencies as manifest by flexibility in dealing with others, responsiveness to social cues, empathy, good communication skills, ability to elicit positive responses from others.
- Problem-solving skills as manifest by age-appropriate development (personal care, language, socialization, etc.), literacy, education achievement, abstract thinking, reflection, ability to develop alternate solutions to problems.
- Autonomy and self-direction as manifest by goal setting, internal locus of control, impulse control, emotional self-regulation.
- Sense of purpose as manifested by goal directness, future planning, persistence, articulated educational and vocational objectives, personal expectations of success and achievement.

DEVELOPMENTAL OBJECTIVES

(Illustrative)

1. To implement a surveillance and data system of behaviors, skills, competencies, and characteristics that enable children and adolescents to develop the assets and abilities to cope effectively with the stresses and challenges of daily life, resulting in choices that promote health and optimal functioning.

2. To increase to _____ percent the proportion of health departments, school systems, and early intervention programs that collaborate in the identification and reporting of indicators of relevant behaviors, skills, competencies and characteristics.

3. To increase by _____ percent the number of researchers in the fields of early intervention, child development, children's mental health, early education, public health, pediatrics, and maternal, infant and child health who are focused upon the assets, strengths and abilities of children and adolescents rather than their disorders, deficits, and disabilities.

4. To increase to _____ percent the proportion of prospective and current parents and alternate adult caregivers who are supported to acquire the knowledge and skills that foster the acquisition and maintenance of adaptive behaviors in their children.

5. To increase to _____ percent the proportion of health care providers, health departments, preschool programs, schools, and communities that support or provide the information, services, programs, and supports that foster the acquisition and maintenance of healthy behaviors and optimum, adaptive functioning of children, adolescents, and their adult caregivers, teachers, and business, faith, media, and community leaders.

The goal for us is to improve the health and functioning of children and adolescents by fostering the acquisition and maintenance of behaviors, skills, competencies, and characteristics that enable them to develop the assets, strengths and abilities to cope effectively with the stresses and challenges of daily living.

CURRENT POTENTIAL DATA SOURCES

- National Longitudinal Study of Adolescent Health
- Current Population Reports, Bureau of the Census
- Early Childhood Longitudinal Study - Kindergarten Cohort
- National Health and Nutrition Examination Survey
- National Educational Longitudinal Study
- National Evaluation of Welfare to Work Strategies
- National Household Education Survey



- National Health Interview Survey
- National Longitudinal Survey of Youth
- Survey of Program Dynamics
- Youth Risk Behavior Surveillance System
(others to be developed as knowledge base expands)

RELATED OBJECTIVES FROM OTHER FOCUS AREAS

The focus area and related developmental objectives proposed here can be related to some of the objectives in the following categories:

- Promote Health Behaviors
 - Physical activity and fitness
 - Nutrition
 - Tobacco use

- Promote Healthy and Safe Communities
 - Educational and community-based programs
 - Injury/violence prevention
- Improve Systems for Personal and Public Health
 - Access to quality health services
 - Maternal, infancy, and child health
 - Health communication
- Prevent and Reduce Diseases and Disorders
 - HIV/AIDS
 - Mental health and mental disorders
 - Sexually transmitted diseases
 - Substance abuse





IN CLOSING

Rosalynn Carter



When The Carter Center Mental Health Task Force chose the topic of *Promoting Positive and Healthy Behaviors in Children* for our 1998 Mental Health Policy Symposium, our intent was to raise awareness of the value of attending to what is right about our children. While it is important to continue to find ways to address the deficits, disorders, and disabilities of America's children, we felt that more attention needed to be paid to their strengths, assets, and abilities.

We have been successful today in assembling a remarkable group of people who have described a variety of approaches to fostering and strengthening the competencies of youngsters from very early in life through the teen-age years. While there is some good evidence of the efficacy of these programs, it is clear that there is more research to be done. It also seems clear that the earlier we intervene with these asset-based approaches, the more effective they will be and the more likely it is that children will benefit from them.

Our hope is that all who are concerned about the welfare of children will take a closer look at these programs and consider the best features that might be applied in our different communities. Just imagine what could happen if children and their parents were to work in concert with local policy-makers and elected officials, educators, the child-caring community, the various professions, and leaders in the faith and business sectors to focus more of our energy on achieving positive, healthy outcomes. Interventions early in life have the potential to decrease the likelihood of later problems such as violence, teen-age pregnancy, school dropout, alcohol and drug abuse, and the like.

We all can begin to see the tremendous possibilities in the promotion of competencies and skills and the characteristics of resiliency that can equip children to become well-adjusted, successful young people.







1998 PANELIST ORGANIZATIONS

FOURTEENTH ANNUAL ROSALYNN CARTER SYMPOSIUM ON MENTAL HEALTH

“Promoting Positive and Healthy Behaviors in Children”

COLLABORATIVE FOR THE ADVANCEMENT OF SOCIAL AND EMOTIONAL LEARNING (CASEL)

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CASEL is an international organization committed to supporting the development and dissemination of effective school-based programs that enhance the positive social, emotional, academic, moral, and healthy development of young people. It is comprised of a network of educators, scientists, policy-makers, and concerned citizens. Its purpose is to encourage and support the creation of safe, caring learning environments that build social, cognitive, and emotional skills in students. CASEL is committed to the idea that cognitive, social, and emotional development are naturally interwoven and that optimal development is supported when social skills and emotional development are made an integral part of teaching, learning, and community life that involve children.

CHILD TRENDS, INC.

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Child Trends, Inc. is a nonprofit, nonpartisan research organization dedicated to studying children, youth, and families through research, data collection, and data analysis. Child Trends gathers data on the major indicators of

children's health and well-being, analyzes trends in these data over time, and works to develop new or improved indicators of child and family well-being. Child Trends, Inc. publications include *Indicators of Children's Well-being and Family Strengths, Family Processes and Family Functioning.*

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The High/Scope Foundation is a nonprofit research, development, training, and public advocacy organization. The Foundation's principal goals are to promote the learning and development of children worldwide from infancy through adolescence and to support parents and educators as they help children learn.

The High/Scope educational approach took shape through the High/Scope Perry Preschool Project (1962-1967) and the High/Scope Curriculum Demonstration Project (1967-1970). There is now more than 30 years of data on the initial cohort used to inform the development of their approach.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

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The National Institute of Child Health and Human Development administers a multidisciplinary program of research and research training. The section on Child and Family Research is part of the Laboratory of Comparative Ethology. It is responsible for conducting laboratory observational and clinical research on cognitive, social, personality, and language development aimed at understanding the behavior of children from birth to adulthood.

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The Center assists school and community leaders in enhancing their capacity to tap the natural, innate health or resilience of youth, families, and communities. The goal is to view all students, residents, or clients as being “at promise” rather than “at risk.” The primary strategy for tapping resilience has been developed from a best practice known as the health realization model. This resilience operating philosophy serves as the foundation for ongoing training and technical assistance services designed to promote full human development and well-being.

The increasing number of individuals, schools, and community agency leaders who are requesting to participate evidences the rapidly growing interest in their approach. Significant efforts are currently underway in a variety of locations.

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Search Institute is a nonprofit research and educational organization dedicated to advancing the well-being of children and adolescents. With a core staff of 70 social

scientists, technical consultants, writers, and trainers, Search Institute uses its research and evaluation to guide and catalyze the creation of community-wide initiatives aimed at promoting positive human development in the first two decades of life. Through its national Healthy Communities — Healthy Youth initiative, Search Institute supports more than 400 cities engaged in this national movement.

Search Institute’s research focuses on child and adolescent development, community change, social change, and the impact of socializing systems on development. Particular focus is placed on exploring and deepening the scientific foundations for its developmental assets and healthy community frameworks. Its publication unit produces both scientific and practical resources for multiple audiences, including schools, families, religious institutions, youth-serving organizations, employers, and policy makers. Its training and consulting unit assists communities and state-wide initiatives to launch and sustain long-term movements to promote child and adolescent development.

Search Institute’s work is supported by federal and state contracts and a wide range of foundations, including the Annie E. Casey Foundation, the W.K. Kellogg Foundation, the Lilly Endowment, the Ford Foundation, the DeWitt Wallace-Reader’s Digest Fund, the McKnight Foundation, Lutheran Brotherhood, The Colorado Trust, and the Kansas Health Foundation.

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Zero to Three is a national nonprofit organization dedicated solely to advancing the healthy development of babies and young children. They disseminate key developmental information, train providers, promote model approaches and standards of practice, and work to increase public awareness about the significance of the first three years of life.



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Fourteenth Annual Rosalynn Carter Symposium on Mental Health Policy

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Member, Board of Directors

Obsessive Compulsive Foundation

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The Carter Center is honored to have the following special guests in attendance:

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Jacquelyn A. Anthony
Program Director
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The Carter Center Mental Health Task Force is funded by The John D. and Catherine T. MacArthur Foundation

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Our hope is that all who are concerned about the welfare of children will take a closer look at the programs we have described, and consider how to apply their best features in our different communities. Just imagine what could happen if children and their parents were to work in concert with policy-makers and elected officials, educators, the child-caring community, the various professions, and leaders in the faith and business sectors to focus energy on achieving positive, healthy outcomes for children, so they may grow into successful, mentally healthy adults.

—ROSALYNN CARTER



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