RECULTURING SYSTEMS WITH RESILIENCE/HEALTH REALIZATION

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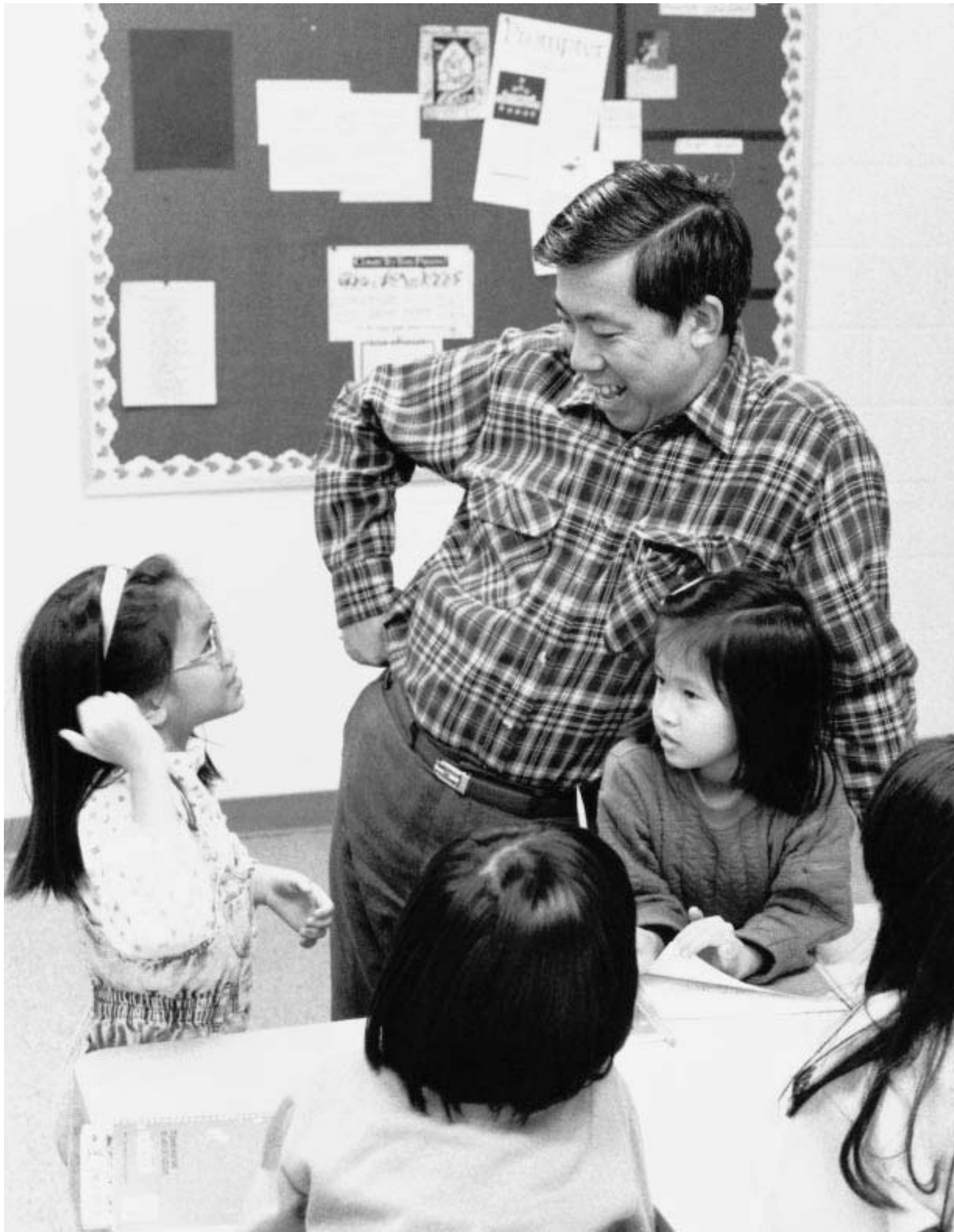
Services are customized to meet the needs of schools, community-based organizations, collaboratives, and other entities. Often work begins with a pilot group. Interest can be keen and staff and community response positive; additional groups usually need to be included in a more comprehensive plan. This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

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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 Garmezy'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

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*   For more information on resilience research, see the references list beginning on page 57. Specific references to resilience are marked with an asterisk.
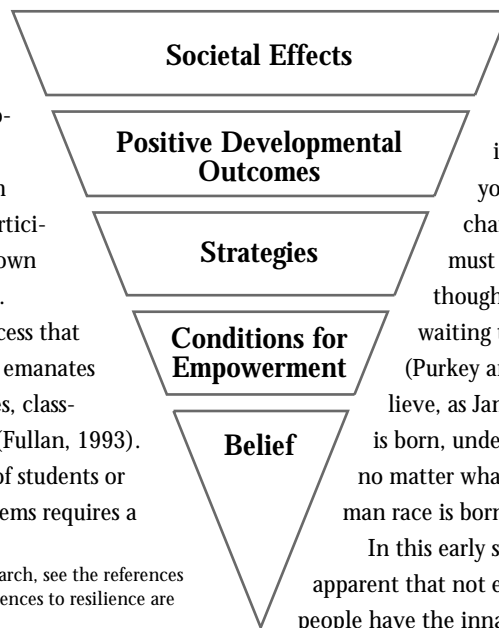
shift in how we plan and provide services. Most critically, it means we shift from a focus on fixing individuals to creating healthy systems (Gibbs, 1995). We use our research-based *Planning Framework for Tapping Resilience* (Benard and Marshall, 1997) to train school and community teams implementing 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

Societal Effects

Positive Developmental Outcomes

Strategies

Conditions for Empowerment

Belief

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-

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

"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"

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

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

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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.

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.

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

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,

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 participants 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 then 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 unmeasureable 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,

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.

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."

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