PUBLICATION SERIES

PA CASSP Training and Technical Assistance Institute

FOSTERING RESILIENCE

A Strengths-Based Approach to Mental Health

By J. Douglas Coatsworth, Ph.D. and Larissa Duncan, B.S.

a CASSP discussion paper

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PUBLICATION SERIES

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Introduction

Over the past few decades the psychological sciences have seen a tremendous growth in the number of research studies focusing on resilience. During this time we have learned a great deal about the personal, social, and societal factors that help individuals succeed despite being exposed to adversity. This information has been used to guide new approaches to interventions with children and adolescents who have developed, or are at risk for developing, serious emotional disorders. This paper traces some of the historical roots of resilience research, describes some of the main lessons learned from resilience research, and illustrates how this framework has been adopted to influence the practice of prevention and treatment.

What is Resilience?

Among the concepts that have been introduced into the clinical psychology, social work, or mental health treatment fields over the past several decades, few have been greeted with the hope and promise of "resilience." Resilience refers to "a class of phenomena that is characterized by good outcomes despite serious threats to adaptation or development" (Masten, 2001, p. 228). Resilience is the process of adapting well in the face of adversity, tragedy, or high levels of stress. It has been used to mean the processes by which children, youth, and adults *withstand* those sources of challenge and also the patterns of *bouncing back* or *recovering* from such conditions.

Although resilience is a relatively new concept in the mental health field, it is not new to those who have observed and chronicled human nature. Throughout history, biographers, ethnographers, and authors of all kinds have told the stories of successful people who emerged from poor environmental conditions such as poverty, who overcame far less than optimal home situations, or who surmounted early handicaps, school or peer difficulties to achieve prominence (Goertzel , 1962). Also plentiful are stories of individuals who maintained positive social functioning while confronting the symptoms of their physical or mental illness, or bounced back after a period of relative decline.

Resilience research is the scientific study of these lives. It is the effort to understand the lifestories of these individuals in a scientific way, to understand how they overcame the difficulties to live productive and fulfilling lives, and to apply the lessons learned toward improving prevention and treatment interventions for all people.

Resilience may be most aptly defined as a "category" or "classification" of individuals that is based on two judgments: (1) that they are experiencing relatively competent social and emotional functioning, and (2) that they have been exposed to some serious adversity or risk that would lead most to believe that their adaptation would be impaired for some period of time. When individuals show a pattern of good adaptation despite risk, they are classified as showing resilience. One critically important point here is that resilience is a broad concept and does not imply a fixed trait of the individual. That is, resilience is not a single characteristic of the individual such as eye color or height, or some trait that individuals may possess

more or less of, such as intelligence or thoughtfulness. This kind of conceptualization of resilience is an inappropriate labeling of the person that attributes too much to the person and not enough to the person's social environment, in much the same way that the opposite label of "at-risk youth" does. It also implies a more permanent view of resilience than is warranted, suggesting that once a person is "resilient" he or she will always be resilient.

The concept of resilience is more dynamic, and suggests that people may show resilience at one point in their lives, but show poor adaptation at another. Take, for instance, a youth who is raised in a poor urban environment with very little social support from family and friends. If this youth shows positive adaptation during adolescence, such as school success, good peer relations, or low levels of internal or external symptoms, then he may be classified as resilient. If that youth enters the Army in his early 20s and is directly exposed to the horrors of war, he may develop symptoms of Post-Traumatic Stress Disorder and his social functioning may decline. If his psychiatric symptoms are severe enough and/or his social functioning is poor enough, then he might *not* be classified as resilient at that time in his life. Yet, if he rebounds well from PTSD, the symptoms diminish, and he returns to a level of social functioning that is comparable, or almost comparable, to his level prior to his war exposure, then again he may be classified as resilient. The breadth and dynamic nature of the construct of resilience is critical to our understanding because it implies that the phenomenon requires that we attend to a wide range of psychological and behavioral outcomes over time (Luthar & Cicchetti, 2000; Masten, 2001; Masten & Coatsworth, 1998).

Why Did the Study of Resilience Develop?

The resilience paradigm has emerged both from the findings within a research agenda of investigating risk for psychopathology and a political agenda of discontent with the prevailing deficit models in psychology in general and in clinical psychology specifically. Several important historical factors converged to direct clinical psychologists and social workers toward deficit models and treating psychopathology. At the beginning of the 20th century, psychology was not attached to the study of mental disorder, but focused on children who had learning or school problems (Routh, 2000). Soon, however, the influence of Freud's models of psychopathology and treatment were felt strongly in the United States, and following World War II, clinical psychology was linked with psychiatric treatment of soldiers returning from war in the Veterans Administration Hospitals. When the National Institute of Mental Health was founded in 1947, thousands of people discovered that they could make a living by treating mental illness (Seligman & Czikszentmihalyi, 2000). Pathology became the central focus of psychology and the uncritical acceptance of the medical model was the prevailing view (Albee, 2000).

Some therapists—for example, Freud's daughter Anna, Heinz Hartmann, and Erik Erikson—diverged from the Freudian models of psychoanalysis to propose more positive view of ego functioning as "adaptive." Among the leaders in the movement away from an exclusive focus on problems toward a more positive approach to psychology and therapy was Lois Murphy of the Menninger Clinic, who wrote in her 1962 book, *The Widening World of Childhood*:

> It is something of a paradox that a nation which has exulted in its rapid expansion and its scientific-technological achievements should have developed in its studies of childhood so vast a problem literature. (p. 2)

Clearly therapists had begun to note that the exclusive focus on psychopathology and problems was neglecting the positive and adaptive aspects of functioning that are inherent to human nature.

At about the same time, in the 1960s and 1970s, a group of researchers were charting a program of study on risk for schizophrenia (Garmezy, 1974).

The researchers adopted the high-risk paradigm and began to identify those characteristics of individuals and environments that increased risk for psychopathology. While studying the development of children identified to be at-risk for disorder, the investigators observed that many of the participants did not show signs of deficits and poor development; rather they showed signs of manifest competence, well-being, and positive adaptation (Garmezy, 1985). The investigators labeled these individuals "stress-resistant" or "resilient" and initiated programs of research to understand what factors in the lives of these kids helped to counteract the risks that they were exposed to. Over the next 20 years or so, programs of "resilience" research led by pioneers in the field such as Emmy Werner, Norman Garmezy, and Michael Rutter, contributed a great deal to our understanding of the natural phenomena of resilience.

Overview of Findings from Resilience Research

Results from a wide variety of studies of resilience are remarkably consistent in pointing to characteristics of the child and the environment that are associated with resilient outcomes. These characteristics are often called "protective factors" because they tend to protect the child from threats to development brought on by exposure to risk or adversity. These factors include such individual characteristics as: good intellectual functioning, an appealing and sociable personality, high self-esteem and social confidence, spirituality/faith, and talents that are recognized by self and others (Masten & Reed, 2002). Families and communities are also strong sources of protective factors. When family members share beliefs and values that are positive and optimistic, when they convey a sense of purpose for the family, they tend to protect kids and promote resilience (Walsh, 1998).

Other protective factors in the family include high levels of organization and stability, cohesion among family members, and clear open channels of communication. Protective factors also extend beyond the family to community factors such as providing resources that support families and give youth opportunities to be involved in meaningful activities, and a sense of social cohesion among community members (Masten & Reed, 2002).

These many studies of resilience have also taught us that protective factors do not occur in isolation, rather they are part of the social ecology (Bronfenbrenner, 1979), a broader network of social factors and influences that we are all a part of. When social ecologies are rich with protective factors and the connections between different parts of the network (e.g., individual, family, community) are strong and plentiful, then they promote healthy youth development (Garbarino & Abramowitz, 1992). Most ecologies contain some risk, yet when there are sufficient protective factors that youth and families can make use of, resilience can occur. The assumption here is that resilience arises from the many dynamic interactions that occur between the individual and aspects of the social ecology over time. It is also assumed that when the basic social processes operating within the social ecology are operating well and in harmony, they serve to promote basic systems of human adaptation that keep development on track or facilitate recovery from exposure to severe adversity (Garbarino & Abramowitz, 1992; Masten, 2001).

Ann Masten (2001) proposes that resilience is not something extraordinary, but is the result of efficient functioning of the fundamental human adaptational systems in the context of adversity. In her view, some of these adaptational systems are aspects of the person, others are aspects of the individual in relation to their immediate social ecology, and still others are broader human social systems. As examples, these basic systems include such things as: 1) attachment systems that provide social connections between people, 2) the Central Nervous System that provides for cognitive development and learning, 3) family systems, and 4) community organizations. One important implication of this broader contextual model of resilience as effective adaptational systems is that there are a variety of targets for intervention. Promoting resilience does not necessarily mean that an intervention must focus on the individual. In fact,

the strongest interventions with the most durable effects will target multiple systems and change patterns of interactions within and across systems. These interventions build protective families and communities to foster resilience in their youth.

Implications of Resilience Research for Intervention

Just as the scholarly interest in the concept has surged, so has the general professional interest and excitement about application of the resilience concept to treatment and prevention (Masten & Coatsworth, 1998). Research on the phenomena of resilience has changed the way that service providers conceptualize their interventions. It brought badly needed hope to the fields of prevention and treatment. While the empirical findings were important to the overall goal of influencing intervention, the message of possibility, optimism, and hope was equally important for transforming practice. Practitioners who worked with youth with serious problems and their families needed this message to alter the ways they thought about their clients and how they worked with them. The change in frameworks and models from solely deficit-oriented to strengths-based has meant that practitioners have altered the way they conceptualize the goals, assessment, and intervention strategies for prevention and treatment (Cicchetti, Rappaport, Sandler, & Weissberg, 2000; Masten, 2001). Adopting a resilience perspective toward intervention means extending the focus beyond the individuals being treated to their social ecology and the systems that treat them. To truly have an effect, resilience research must influence the attitudes and beliefs of human service personnel, as well as the way that service systems operate.

One model of how to apply a resilience framework to intervention has been created by Bonnie Benard and Kathy Marshall (see Marshall, 1998). They have developed a framework for transforming social service systems from risk- to resilience-based frameworks. In doing so, they suggest that the linchpin of their work is altering the core beliefs of all staff in the organization. They suggest that only when staff view all children as capable of transformation and change, and believe that all youth possess natural strengths and the capacity for resilience, will organizations be able to create the kind of environment required to nurture resilient outcomes in youth. Their model starts with the beliefs of the practitioners and administrators, moves to the structures and conditions of the organization that must empower clients, and then reaches the levels of specific strategies that are predicated on these beliefs and conditions. Benard and Marshall propose that only then will we see the effects in the individual and social outcomes that define resilience.

Prevention

Preventive interventions are a natural extension of resilience research. They build upon the resilience philosophy that it is much better to increase capacities to do well despite adversity than it is to treat individuals after maladjustment has crystallized (Albee & Gullotta, 1997; Cowen, 2000; Masten & Coatsworth, 1998). Although prevention historically focused exclusively on reducing risk factors for disorder (c.f. Mrazek & Haggerty, 1994), more recent studies have shown that the most powerful effects tend to come from reducing risks ***and*** increasing protection (Pollard, Hawkins, & Arthur, 1999). Mounting evidence in the field of prevention shows that building individual strengths and competencies, developing healthy family functioning and strong parenting skills, and building strong community infrastructures to support youth development can dramatically reduce the levels of problem behaviors and mental health problems in youth (Durlak & Wells, 1997, 1998; Greenberg, Domitrovich & Bumbarger, 1999). Exemplary programs such as the Nurse Family Partnership (Olds, Mihalic, & O'Brien, 1998) and PATHS (Greenberg, Kusché, & Mihalic, 1998) demonstrate the power of building family and individual strengths as a means for promoting resilient outcomes in youth exposed to adversity.

The Nurse Family Partnership is an intervention for first-time mothers living in poverty. This

preventive intervention works to nurture and build the natural attachment relationship between mother and infant, works with mothers to build their own beliefs in their capacity to change the course of their lives, and build the mother's sense of efficacy. The intervention is designed to be relatively intensive, working with these mothers during pregnancy and up to two years post delivery. The effects are dramatic, both for the mothers' health and well-being and for the developmental outcomes of their children. These positive effects have been sustained 15 years after the intervention was delivered. Mothers show healthier pregnancies and deliveries, more sensitive parenting, have developed closer relationships with their children, and demonstrate overall more workforce participation. Youth also show better long-term developmental outcomes, including reduced rates of delinquency at age 15. The intervention appears to have facilitated the adaptive systems of these families producing a long-term benefit for their youth.

The PATHS intervention is an elementary school-based intervention to promote social/emotional competence through cognitive skill-building. It emphasizes teaching students to identify, understand, and regulate their emotions. The intervention has produced significant improvements in children's social problem solving, emotional understanding, self-report of conduct problems, teacher ratings of adaptive behavior, and cognitive abilities related to social planning and impulsivity (Greenberg, Kusché, & Mihalic, 1998; Greenberg, Kusché, Cook, & Quamma, 1995). These improvements were maintained at one-year followup and, more importantly, additional significant reductions in teacher and student reports of conduct problems appeared two years after the intervention was given.

Treatment

Resilience frameworks can be as powerful in treatment as they are in prevention. The frameworks of resilience (Luthar & Cicchetti, 2000; Masten, 2001), positive psychology (Seligman & Csikszentmihalyi, 2000), and the strengths-based approach in social work (Saleebey, 1996) have all converged to begin to reshape the ways that assessment/diagnosis, treatment planning, and treatment are done. Current models of assessment and diagnosis are built on the DSM classification system, which focuses on problems almost to the exclusion of positive and adaptive behaviors. It classifies people based on an illness model of clusters of problems and symptoms alone and this can lead to additional problems of a fundamental negative bias and dehumanization (Wright & Lopez, 2002). If a person is viewed solely as a constellation of symptoms and problems, the natural strengths and adaptive capacities of the person are frequently ignored. The resilience literature and the protective factors literature have provided us with sufficient information about the positive individual and environmental assets that can have a powerful ameliorating effect. The list of protective assets could be used to create a classification system of psychological and social strengths, comparable to the symptom clusters currently used in the DSM. This classification of strengths could be integrated into future versions of the DSM. This integration of competence with psychopathology provides a more complete framework from which to assess a person's functioning (Masten & Curtis, 2000).

Simply, a few bits of positive information about a youth can alter the fundamental negative bias of diagnosis (Wright & Lopez, 2002), and also change the prognosis and treatment planning. For example if I tell you that I have a male client who is 15 years old and meets the DSM-IV diagnostic criteria for Conduct Disorder, you have one view of this youth. If I give you more information and say that he likes school, has a very caring mother with whom he shares a close and loving relationship, and has an IQ of 130, your assessment of this young man will change dramatically. He clearly has some strengths around which one could build a treatment. Clinicians who take a strengths-based approach to assessment and treatment planning have a more complete picture of the client and perhaps greater leverage for therapeutic change.

Resilience research does not translate directly into a specific kind of therapy, nor does it suggest that one kind of therapeutic approach will be superior to another. Instead, it suggests more general practices that are useful across different therapeutic approaches. Seligman (2002) has proposed that common tactics used by experienced and competent clinicians, such as building rapport, trust, opening up, and naming the problem, all serve to produce positive therapeutic outcomes. He also recommends another class of techniques, "deep strategies," that are commonly used by effective therapists and include such things as instilling hope and building buffering strengths. The buffering strengths, such things as optimism, interpersonal skills, future-mindedness, and finding a purpose, all reflect a resilience, or strengths-based approach to treatment. Clinicians can use the existing foundations of these strengths to build new and equally protective assets.

One exemplary, resilience-based treatment intervention that has adopted this strategy is the Relational Psychotherapy Mothers Group designed by Luthar and colleagues (Luthar & Suchman, 2000). The intervention draws directly from the literature on resilience in mothers who abuse substances. It focuses on the mothers' strengths, including their capacity to acknowledge past mistakes, their concern for the welfare of their children, and the potential benefit of positive influences in their lives. Working with clients who frequently are viewed as possessing no positive qualities, this intervention has taken a resilience view and helped to change the lifecourses of some mothers and their children.

Another treatment approach that directly reflects resilience research is that of helping clients to cognitively and affectively process life events in a way that builds on the positive, does not deny the negative, and allows them to incorporate the reality of these experiences into their own self concept (Rutter, 1999). This method is seen very clearly in the general clinical strategy of ***reframing*** in which clinicians "accentuate the positive" in the situation so that the client sees it in a slightly more adaptive way, thereby helping to reduces stress and negative affect. Reframing is a common technique in family therapy and is comparable in some respects to the technique of positive cognitive restructuring used in cognitive behavioral therapy. One example of how this approach can be integrated more fully into a treatment approach is in Toddler-Parent Psychotherapy, designed by Cicchetti and colleagues (Cicchetti, Rogosh & Toth, 2000). This treatment intervention works to build a secure attachment between mother and toddler, while also addressing mothers' possible insecure representations of their own attachment figures. Again the focus is on the mothers' strengths and her abilities to overcome some earlier adversities.

Conclusions

The theoretical, empirical, and applied underpinnings of resilience have provided an excellent foundation for wide ranging systems change in how we approach the prevention and treatment of mental health problems throughout the lifespan. It leads directly to a strengths-based approach to interventions with the main goals of fostering development by assuring that all social ecologies are filled with supportive resources and protective factors that nurture inherent human adaptive systems. We believe that a resilience perspective, or a strengths-based approach to intervention, resonates with the humanistic approach of the PA CASSP core principles. A resilience approach reminds us to focus on the positive when working with children and adolescents at risk for developing, or currently experiencing, severe emotional disorders. In our view, it could be considered the seventh core principle for effective services.

This principle is reflected in several important lessons that we have learned over the years (Masten, 2001). First, resilience is fundamental to human nature and it is built into our naturally occurring developmental systems that tend to channel us toward health and positive adaptation. The challenge to society is to build the kinds of individual, family, and community supports that can

help ensure that the systems are operating well. Second, adults must be aware that they play a central role in the development of all protective systems for children and youth, but that as children grow, they have a more active role in their own resilience. Third, systems of preventive and treatment interventions are important aspects of promoting youth, families, and communities that are resilient. Finally, as noted by Ann Masten "resilience is ordinary magic" and is a reachable goal (Masten, 2001).

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References

Albee, G.W. (2000). The Boulder Model's fatal flaw. *American Psychologist, 55*, 247-248.

Albee, G. W., & Gullotta, T. P. (1997). Primary prevention's evolution. In G.W. Albee and T.P. Gullotta (Eds.), *Primary Prevention Works (pp. 3-22)*. Thousand Oaks, CA: Sage.

Cowen, E. L. (2000). Psychological wellness: Some hopes for the future. In D. Cicchetti, J. Rappaport, I. N. Sandler, & R. P. Weissberg (Eds.), *The promotion of wellness in children and adolescents* (pp. 477-503). Washington, DC: Child Welfare League of America Press.

Durlak, J. A., & Wells, A. M. (1997). Primary prevention mental health programs for children and adolescents: A meta-analytic review. *American Journal of Community Psychology, 25*, 115-151.

Durlak, J.A., & Wells, A.M. (1998). Evaluation of indicated preventive intervention (secondary prevention) mental health programs for children and adolescents. *American Journal of Community Psychology, 26,* 775-802.

Garbarino , J., & Abramowitz, R.H. (1992) Sociocultural risk and opportunity. In J. Garbarino (Ed.) *Children and Families in the Social Environment* (2nd Edition) (pp. 35-48). New York: Aldine De Gruyter.

Garmezy, N. (with Streitman, S.) (1974). Children at risk: The search for the antecedents of schizophrenia. Part I: Conceptual models and research methods. *Schizophrenia Bulletin, 8,* 14-90.

Garmezy, N. (1985). Competence and adaptation in adult schizophrenia patients and children at risk. In R. Cancro, & S.R. Dean (Eds.), *Research in the schizophrenic disorders: The Stanley R. Dean Award Lectures* (Vol. 2). New York; Spectrum Publications.

Goertzel V., & Goertzel, M.G. (1962). *Cradles of eminence*. Boston: Little, Brown, & Company.

Greenberg, M.T., Domitrovich, C., & Bumbarger, B. (1999). Preventing mental disorder in school-age children: A review of the effectiveness of prevention programs. Report submitted to The Center for Mental Health

Services (SAMHSA), Prevention Research Center, Pennsylvania State University (obtainable at http://www.psu.edu/dept/prevention/).

Greenberg, M.T., Kusché, C., & Mihalic, S.F. (1998). *Blueprints for Violence Prevention, Book Ten: Promoting Alternative Thinking Strategies (PATHS).* Boulder, CO: Center for the Study and Prevention of Violence.

Greenberg, M.T., Kusché, C.A., Cook, E.T., & Quamma, J.P. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS curriculum. *Development and Psychopathology, 7,* 117-136.

Marshall, K. (1998). Reculturing systems with resilience/health realization. *Promoting Positive and Healthy Behaviors in Children: Fourteenth Annual Rosalynn Carter Symposium on Mental Health Policy.* Atlanta, GA: The Carter Center. pp. 48-58.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56*, 227-238.

Masten, A. S., & Coatsworth, J. D. (1998) The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist, 53*, 205-220.

Masten A.S. & Curtis, W.J. (2000). Integrating competence and psychopathology: Pathways toward a comprehensive science of adaptation in development. *Development and Psychopathology, 12*, 529-550.

Masten, A.S., & Reed, M.G. (2002). Resilience in Development. In C.R. Snyder & S.J. Lopez (Eds.), *Handbook of Positive Psychology*. New York: Oxford University Press.

Mrazek, P. J., & Haggerty, R. J. (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research* (Chapters 1 & 2: pp 3 - 29). Washington, D.C.: National Academy Press.

Olds, D., Hill, P., Mihalic, S., & O'Brien, R. (1998). *Blueprints for Violence Prevention, Book Seven: Prenatal and Infancy Home Visitation by Nurses.* Boulder, CO: Center for the Study and Prevention of Violence.

Pollard, J.A., Hawkins, J.D., & Arthur, M.W. (1999). Risk and protection: Are both necessary to understand diverse behavioral outcomes in adolescence? *Social Work Research, 23*, 145-158.

Routh, D.K. (2000) Clinical Psychology Training: A history of ideas and practices prior to 1946. *American Psychologist, 55*, 236-240.

Seligman, M.E.P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55,* 5-14

Walsh, F. (1998). *Strengthening Family Resilience*. New York: The Guilford Press.

About the Institute

The PA CASSP Training and Technical Assistance Institute addresses the human resource development needs in clinical best practice for serving children and adolescents with mental health needs and their families. As the training arm for children's mental health services of the state Office of Mental Health and Substance Abuse Services, the Institute's programs include the following:

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