WORKING WITH CHILDREN AND YOUTH WITH COMPLEX NEEDS

20 SKILLS TO BUILD RESILIENCE

Working with Children and Youth with Complex Needs provides a detailed description of techniques and rich stories of how social workers, psychologists, counselors, and child and youth care workers can help young people become more resilient. With ample case studies and fascinating explanations of research, Dr. Ungar shows why we need to work just as hard changing the environments that surround children as we do changing children themselves. Building on lessons learned from clinical, community, and residential settings, Dr. Ungar discusses 20 skills that can enhance the effectiveness of frontline mental health services. Along with descriptions of the skills necessary to talk with clients about the factors that put their mental health at risk, *Working with Children and Youth with Complex Needs* also presents systemic practices clinicians can use in their everyday work. Engaging with children's extended family, addressing issues of community violence, racism, and homophobia, and helping parents and teachers understand children's maladaptive coping strategies as sometimes necessary are among the many practical strategies that are discussed which clinicians can use to enhance and sustain the therapeutic value of their work.

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Disclaimer: The Children and Their Families

In order to protect the privacy of all the individuals with whom I have had the privilege to work, the stories I share in these pages are based on the lived experiences of actual young people and their families but details have been changed significantly. The lives of multiple individuals have been combined and identifying information fictionalized to preserve people's confidentiality.

CONTENTS

CHAPTER 1

A SOCIAL ECOLOGICAL APPROACH TO CLINICAL WORK

Monday Morning, 9:20 A.M. (Part 1)

Michelle arrived twenty minutes late for her weekly appointment at the mental health and addictions treatment center where I worked. For months I'd been seeing this 17-year-old, impulsive, white, adolescent, whose purple hair and pierced bottom lip made her look far tougher than she really was. Though Michelle eventually eased herself into her seat, a Styrofoam cup of coffee clasped in both hands, I knew these scheduled counseling sessions had done little except make Michelle much smarter about the consequences of her heroin use. It was remarkable, and a stroke of luck, that Michelle's group home staff hadn't kicked her out even though she continued to abuse drugs. Every time her 20-year-old boyfriend relapsed, she did too. Michelle insisted that he was the only person who really cared about her. He may also have been the only person she could rely on to be there when she turned 18 years old. When that happened, she would be forced to leave permanent foster care.

"I've had another fight with staff," Michelle told me. She had been late for curfew and high when she did return. The group home staff had threatened to revoke phone privileges and Michelle had slammed her door so hard the handle broke. I'd spoken with the staff many times before. They knew Michelle was at risk of ending up homeless or dead immediately after her 18th birthday. But what more could they do to help? She refused to engage in any work to create a smooth transition into adult independent living. In truth, they were just as stuck as everyone else who were trying to work with Michelle to convince her to transform her life into something better.

"What are you going to do after you age out of foster care?" I asked, realizing that any talk of drugs and drinking were going to go nowhere that day.

"I've got my boyfriend and his grandmother. He'll be out of jail before my next birthday and I can live with them. I would let the group home staff set me up in my own apartment, but my transition worker said my boyfriend couldn't live with me." Michelle rolled her eyes and stared into her coffee cup. "F—- them. They've got no right to tell me who I can live with once I'm 18," she said, then slumped down in her chair.

While most people saw Michelle as an angry young woman with serious problems, I came to know her as a lonely child with unmet psychological and material needs, living in a world that had badly neglected her for years. After a horrible start in a home where she witnessed frequent domestic violence, Michelle's mother eventually threw Michelle out when she was 14 years old because of Michelle's increasing drug use, violence in the home, and sexualized behavior toward her mother's boyfriends. None of these behaviors surprised her caseworkers.

To make matters worse, Michelle had had an awful relationship with the police for the last three years. They'd been investigating her experience of sexual abuse by an online pedophile who had made contact with her and a dozen of her classmates through Facebook. Michelle's case still hadn't reached trial and might never. Not surprising, Michelle had refused trauma counseling. "I've been through worse," is all she'd say about the incident.

I believed her. When she was 16 years old and had suffered through four foster placements in two years, Michelle asked to return to her mother's home. She was told that if she did her younger sister would have to be removed and placed in care. Her mother did what Michelle expected and refused to take her back or advocate for her right to come home.

Unsure what I could do to help that Monday morning, I paused a long time before saying to Michelle, "Maybe you can tell me what else we should be talking about today."

Michelle raised her eyes and for a moment I thought I could see the wet shine of tears. "I just want them to listen to me. Can you do that for me? Get them to stop talking at me and just listen to what I want?"

I nodded and reassured Michelle that I would try, though secretly I wasn't sure I had the power to get anyone to do anything that Michelle wanted them to do. Mustering my courage, and with a deep breath that seemed to bring with it the faintest promise of hope, I looked straight at Michelle and asked her, "So, what exactly would you tell everyone if you could get them to listen?"

Changing Social Ecologies: Three Problems

Meeting Michelle, I was entranced by her persistence, as well as the efforts of her professional caregivers to provide her with as much security as they could within the limits of their agency's resources and mandates. Later in this chapter, I'll revisit the work I did with Michelle to show the skills I used to help her. My work with Michelle is just one of many examples in this book of a *social ecological approach* to treatment designed for use by counselors, therapists, and other mental health care providers from diverse professional backgrounds.

I use the phrase "social ecological" to make clear that I mean an intervention that addresses all aspects of an individual's interactions with her environment: social and educational services, extended family, school, community, and economic and political structures. The phrase, however, refers to more than just interactions with the people in each setting. It is also about the built environment, though one can't forget that the shape of that environment reflects people's values (for example, the location of child welfare offices, the positioning of wheelchair ramps, the physical layout of subsidizing housing units). Earlier models of ecological clinical practice (Belsky, 1980; Germain & Gitterman, 1980; Kemp, Whittaker & Tracy, 1997) have certainly shaped my thinking, but a social ecological approach relies on a somewhat different and more up-to-date understanding of ecology (where our description of ecological relationships has dramatically changed over the last thirty years, becoming less causal and hierarchical, and with greater emphasis on the equal contribution made by all elements of an ecosystem from the smallest microbe to the largest multicellular organism), epigenetics (with its less fatalistic emphasis on how environments trigger gene expression), resilience, postmodernism, and integrated models of service delivery.

After all, whatever services Michelle was being offered reflected a set of beliefs about what young people like her need and the social and political systems that decide who gets which services delivered in what ways. Policies, practices, and funding are always provided in a manner that

reminds us what society as a whole says is important. This social ecological perspective will become much clearer, and much more concrete, as I describe the work Michelle and I did together that helped her cope individually while also dramatically changing her access to the resources that she needed to stay safe and heal.

While a systems-based, ecological approach to clinical work is not new, there has been very little research that shows it is effective. This book is meant to change that. Other notable efforts to describe an ecological practice that builds on our understanding of resilience include Resilient Therapy, a community-oriented model of therapy popular in the United Kingdom (Hart, Blincow & Thomas, 2007). It is one model that acknowledges the need to pay attention to social justice factors and is intended to take "resilience and turn it into set of actions and working practices, mechanisms designed to generate better outcomes than would be expected" (p. 15). Likewise, the model of community psychology promoted by Isaac Prilleltensky (2012) also focuses on aspects of inequality and the broader social determinants of health that shape well-being. These models and others have influenced the social ecological practices, principles, and skills that are described in the following chapters. This approach also builds on a decade of research with children and youth exposed to extremely adverse living conditions, family stressors, and individual challenges. I used the results of my own research in 20 countries, and that of my many colleagues, to develop a social ecological model of intervention. This model gives clinicians a toolbox to help the people with whom they work (typically referred to as clients or patients) develop the protective factors associated with well-being in contexts of adversity. That research has shown that for children exposed to higher levels of stress (the focus of my work), their resilience has much *less* to do with individual factors than it does with the way the child's environment provides the child with the resources necessary for well-being. No surprise, then, that when I thought about what my research could mean to my clinical work with children I was forced to think ecologically rather than about individuals separate from the complex environments that make it more or less likely they thrive under stress.

The problem with implementing a social ecological practice, however, is threefold. First, there is a *problem of competence*. Most clinicians are not community developers or professional advocates. Nor do they spend their day helping young people fight systemic oppression (racism, homophobia, bullying, etc.), find stable housing, make schools safe, or effect change to the many other environmental factors that create and sustain well-being (these are often called the social determinants of health). No matter what their discipline, very few clinicians have the training or skills necessary to be effective case managers and community workers.

Second, there is a *problem of resources*. Programs that have tried to turn clinicians into ecologically-minded therapists have usually required specialized programing, lots of staff resources, and extra money. While other approaches that are resource-heavy have been proven effective (for example, Multisystemic Therapy [Swenson et al., 2000] and The Penn Resiliency Program [Gillham et al., 2007]), it can seem that an ecological practice is something done by someone other than the clinician mandated to see clients in direct practice. Intensive in-home support programs, group work in schools, inter-agency treatment teams for complex cases, clinical reflecting teams, and many other important ecological interventions may be effective, but they don't meet the immediate needs of the majority of counselors who work in settings that emphasize direct clinical practice with an individual or the individual's closest family members. For these clinicians, an ecological practice may seem unwieldy and lacking specific clinical techniques that can be used when resources are scarce and clients' problems and social ecologies extremely complicated. While I cannot make this work simpler than it is, in the pages that follow I have provided descriptions of

skills that can be used by mental health care providers who want to broaden their focus from individual therapy to helping individuals change the worlds that disadvantage them.

However, there is a *problem of evidence* when working ecologically. This is the third big challenge to implementation. It is difficult for family therapists, residential workers, child welfare workers, school guidance counselors, public health nurses, community psychologists, child and youth care workers, hospital social workers, and dozens of other professionals to justify the time they devote to an ecological practice when there is so little evidence that working to change a child's broader social ecology is time well spent and cost-effective. In the absence of evidence that ecological models work, most clinicians ignore what they intuitively know: that time devoted to addressing the social determinants of well-being, exploring a child's marginalization, and including in treatment the child's natural supports are more helpful than another session alone with an individual, or a child and her caregiver.

Too often, we assume individuals who are exposed to problems beyond their control can make meaningful changes in behavior while still living in social environments that remain toxic. Will an anxious child stop being anxious as long as there is still gun violence in his housing project, or bullies who call him stupid at school? Can we reasonably expect a child to stop running away from a home where domestic violence flares every Saturday night? Can an adolescent with a physical disability thrive if his local recreation center is inaccessible because of a flight of stairs? If that same child is in foster care, will his foster parents receive enough financial support to adequately meet their child's needs? Research with the most vulnerable children shows very clearly that they heal best when we shape their environments (Jaffee et al., 2007; Prilleltensky, 2012). In the following chapters I'll describe practice principles and skills that make a social ecological approach effective.

Self-assessment

Before you read further, look at the quick self-assessment tool which is on page 17 at the end of the chapter. You can also find an online copy of the tool on my website, www.michaelungar.com. You may be pleasantly surprised to see how many ecological practice principles and skills are already a part of your work with young people or get clues to which areas of practice need to be part of your growing edge. The numbered descriptions from 0 to 3 (half points are fine too) offer a way to assess fidelity (adherence) to what I'll show later are best practices. If you consistently rate your work with clients a 3 then it is very much in keeping with the principles of a social ecological approach to counseling.

You may want to score yourself now, before you read the following chapters, then again after you've had a chance to integrate more social ecological principles and skills into your practice. Without having read the descriptions of each principle and skill, however, some of the items in the self-assessment may seem vague. Feel free to skip over any questions you don't fully understand and come back to them later after reading the more detailed explanation.

If you have the ability to video record or audio record sessions with a client, you'll be able to see the extent to which your practice reflects these principles now and how your work changes over time. Keep in mind that a single session may not show all of the aspects of the model that I will discuss in the following chapters. Over several sessions, however, all these elements of good practice should be observable.

The Need for an Expanded Set of Clinical Skills

Anyone trained in techniques to enhance mindfulness (Miller, Rathus & Linehan, 2007), who does cognitive behavioral therapy (Feldman, 2007), or treats addictions (Leschied et al., 2004) can pick up a manual and read step-by-step instructions for what one does to help clients change and the research that proves it works. How, though, do we ensure that treatment pays attention to the root causes of marginalization that our clients experience rather than turning real world issues like racism into an individual's personal challenge (for example, providing anger management training to a child who attacks people when they make racist comments)? How do we ensure that the changes a child makes during counseling are sustainable when the supports and services the child needs are either unavailable or inaccessible at home (for example, a child who is incarcerated may have access to a caring worker but be placed on a 12-month wait-list for services after discharge)? Without good answers to these kinds of questions, the strengths of an individual like Michelle will remain hidden or misunderstood as maladaptive coping strategies, when they are very sensible solutions in dangerous, emotionally toxic social ecologies.

While my clinical work with Michelle takes place in what looks like a fairly traditional office-based setting, an ecological practice is useful in many different settings where mental health care providers work. It's an excellent approach for family therapists to expand the scope of their practice, residential workers to develop case plans that will continue after a client leaves treatment (I worked for many years in children's group homes, young offender facilities, and mental health treatment centers), in-home support workers who need to think about both psychological and social stressors, teen health center nurses who must provide care to young people without angering parents, and social workers, psychologists, psychotherapists, and psychiatrists who are tired of diagnosing problems that have more to do with their patients' social ecologies than psychopathology. An ecological practice can be (and has been) adapted to these settings.

Conversations that take place, like the one I described earlier with Michelle, are just as likely to occur on a residential unit, driving to a doctor's appointment, or in a secure treatment setting. They can occur over a kitchen table in a child's home or at a child's school with the child's teacher looking on. I've even done this work in coffee shops and under trees in a park when my office was too formal or too scary for a child who wasn't ready for that level of one-on-one intense clinical work. Regardless of the setting, the techniques I used to work with Michelle are effective because they focus attention on the child's social ecology and changes that others close to the child need to make rather than putting all the responsibility for change on the child herself.

Before tipping my hand and discussing in detail the techniques I used when working with Michelle, it's crucial that we agree that like most young people, Michelle showed plenty of potential to do well on her own. I would even describe her as having "hidden resilience" (Ungar, 2004). She wanted people in her life. She could control her drug abuse, at least for a time. She was thinking about her future, even if that included living independently with a boyfriend who was almost certain to continue to abuse drugs and steal.

Change the opportunities available to Michelle and she might make different choices. That's the magic of understanding resilience as more than an individual's ability to cope with adversity. Resilience is just as much about the way a child's social ecology opens new opportunities to overcome problems, or helps a child avoid exposure to risk in the first place.

Clearly, we have an internal capacity to thrive but that capacity to overcome adversity must be nurtured and supported (Seccombe, 2002). Counselors can play an important role here; for example, Nancy Scheper-Hughes (2008) argues that a focus on post-traumatic stress and the disorder that

follows over-emphasizes our fragility. Though we mustn't ignore the marginalization and exploitation that many children like Michelle experience, our assumptions of vulnerability and frailty overlook what individuals are capable of achieving when the people and institutions in their lives (their social ecologies) provide them with opportunities to excel (Cyrulnik, 2011).

An Unconventional Approach to Practice

As a guidebook for clinical practice with children, youth, and their families, this one is going to take an unconventional position and show that helping young people change is as much about changing the people and institutions with which they interact as it is about changing individuals themselves. The more complex the challenges an individual like Michelle faces, the more important it is to change the environment *first* before we try to change individual thoughts, feelings, or behaviors. The principles and skills associated with this social ecological model of practice align well with many of the core competencies required of social workers, marriage and family therapists, child and youth care workers, psychologists, guidance counselors, and other allied mental health professionals. As I'll show in Chapter 3, we, as professionals, have long recognized the need to think and work ecologically, integrating our work with the principles reflected in our codes of ethics and the core competencies that translate them into practice. What we have lacked, however, is detailed practice-informed and research-based interventions that can help us to work more effectively with people in ways that are sensitive to the complexity of the problems they face. We have had no shortage of great advice, but very little evidence to support us when we advocate for clients, promote contextual sensitivity, reflect on our power and privilege as therapists, or focus our work on changing social ecologies rather than changing people. As Madsen and Gillespie (2014) explain with regard to their work with families involved with child protection services, "Helping people to take a larger view of their lives can be a profoundly empowering to them. We want to acknowledge that we live in a socio-cultural context in which historically some people have come to matter less than others." If we are going to meet our obligations as professionals, however, we need a substantial model of ecological practice that we can be confident is effective.

Any clinician who has worked in community settings with people who are extremely marginalized, exposed to high levels of violence, or suffering from severe disabilities or mental health challenges already knows that changing the environment jumpstarts individual processes of growth. Most of the evidence-based practices, those that are used to treat problems as different as post-traumatic stress, conduct disorder, and learning challenges, focus most on helping individuals develop the cognitive skills and adaptive behaviors believed to contribute to well-being (see, for example, Feldman, 2007; Manassis, 2012). There is an odd ideological fervor to some of these interventions since we know that *change is unsustainable without access to an environment that supports the client's process of growth*. However, it is timely that several of the best-known cognitive psychologists have recognized that without social change individual change is impossible in contexts where there are significant social, economic, and political challenges (Bandura, 1998; Cicchetti, 2010).

As clinicians we understand this, but in the absence of models of ecological practice that have an evidence base to prove they are effective, we tend to focus solely on what we can easily control during the time we spend with our clients: that's clients themselves. Unfortunately, this leads to an evaluation paradox. Some interventions are far more amenable to measurement of outcomes than others because what they are trying to change is relatively simple and narrowly defined (like

expressions of anger, rates of substance use, or experiences of anxiety). How do we prove that for children like Michelle with very complex needs living in very complex environments a combination of individual, family, and community interventions offers the most effective treatment? The answer is that we must begin with what we have learned from practice, what we call "practice-based evidence" (Lebow, 2006).

Practice-based Evidence and Social Ecological Interventions

Many clinicians leave their offices to attend case conferences at children's schools, invite parents into family sessions, advocate for clients to access better financial aid, testify on behalf of clients in court when children are being removed by Child Welfare authorities, and work as staff members of treatment teams in community and institutional settings like group homes for young people with persistent mental illnesses. These are examples of what I mean by social ecological interventions. While anecdotally we know that these efforts to shape a client's experience of the world have a positive impact on a client's psychological and social adjustment, there is very little scientific proof that this systems-oriented clinical work can be as or more effective than individually-oriented practice. Herein lies a serious challenge. Clinicians are forced to squeeze these ecological interventions into their clinical practice and hope nobody will notice enough to complain.

In this regard, working to adapt systems to meet people's needs can be somewhat political. As counselors, we may have to question our job descriptions, confront the reluctance of our colleagues to see their roles more broadly, force our institution to share human and financial resources, and sell funders on the idea that clinicians who are compensated for changing a client's social ecology will be more effective at helping clients themselves change.

Here is an example: A child who is failing at school because of a complex array of problems that include a learning disorder, social exclusion, and parental neglect is going to require someone to provide good individual support along with interventions that address broader ecological barriers to successful coping. In practice, the counselor who uses an ecological approach is unlikely to ask this child "What do *you* need to do to succeed at school?" and then focus on changing the child's study habits or self-esteem. The counselor will instead say to the child, "What does *your school* need to do to help you succeed? What do *your parents* need to do? And what can *I,* as your counselor, do that will help you come to school more often?" This second set of questions obligates the therapist to work ecologically, changing systems while still supporting a child's adaptation under stress. In my practice, that has meant advocating for a child to change schools (when his school exposes him to violence and exclusion), organizing meetings of multiple service providers, and finding funding to cover the child's added costs of transportation. As if that's not enough, it also meant convincing my supervisor that if I helped address these contextual risks, the child would be much more likely to work with me on his behavioral problems and accept help from a teacher's aide. My supervisor, in turn, had to deal with a bureaucracy that had rules about which interventions I could bill for. Meetings with school principals and time spent on the phone finding transportation dollars were not typically seen as clinical interventions. The good news is that where these efforts are made, my experience and that of my colleagues tells me we become more effective clinicians. We help the most vulnerable of children engage successfully with their service providers. Other community-oriented practitioners who are focused on enhancing resilience, like Hart, Blincow and Thomas (2007), have termed this pattern of intervention "resilient moves."

An Intentional Model of Practice

As the last example shows, an ecological practice focuses attention as much on the social determinants of well-being (like safety in one's family and community, a sustainable attachment to caregivers, and access to education) as it does individual psychological factors related to biology and personality. It works because it reflects what we have learned from the following areas of research and practice:

1. Adaptation of systems theory that reminds us to include families and communities in treatment (Imber-Black, 1988; Lourie, Stroul & Friedman, 1998; Madsen, 1999, 2009; Prilleltensky, 2012).
2. Appreciation for the analyses of power and co-construction of meaning that are a part of post-structuralist (Dickerson & Zimmerman, 1996) and feminist models of therapy (Dominelli & McLeod, 1989; Weedon, 1997).
3. Bronfenbrenner's (1979, 2005) theory of the social ecology of human development that provides a multisystemic lens with which to think about individual growth and development in different contexts.
4. Research on resilience with marginalized populations of children which has shown that many protective factors predict which children will do well despite adversity (Bonanno, Westphal & Mancini, 2011; Cyrulnik, 2011; Masten, Monn & Supkoff, 2011; Ungar, 2011, 2012; Werner & Smith, 2001).
5. The study of natural ecologies where relationships between elements are now understood to be less linear, causal, or hierarchical than we thought previously (Naess, 1989; Wackernagel & Rees, 1996).

While we know that a child's social ecology influences developmental outcomes, we remain uncertain how to adapt research findings and theoretical models to the clinical interventions and systemic changes that are necessary to help children and their families succeed. Tragically, what doesn't get recognized as good practice doesn't get funded by service providers. The evidence, however, is clear: changes to children's social ecologies can have a greater impact on psychological and behavioral outcomes than focused interventions on children themselves, especially for children who face more severe challenges (Prilleltensky, 2012).

Resilience as Navigation and Negotiation

To repeat a well-known observation of Kurt Lewin, the grandfather of social psychology, "There is nothing so practical as a good theory" (1951, p. 169). Research on resilience, especially that of more ecologically-minded researchers, is producing a detailed description of how children, youth, and families overcome adversity (Bottrell, 2009; Harvey, 2007; Hobfoll, 2011; Ungar, 2005, 2008). That research, often with people who live lives as stressful as Michelle's, is proving that resilience is *not* an individual's capacity to overcome adversity. The metaphor of people being like metal springs that bounce back after being squished is nothing more than a polite way of blaming people who don't succeed (who don't bounce back) for their being unable to change conditions beyond their control. To see resilience as a quality of the individual reflects an ideology of rugged

individualism that has convinced us that because one individual "beats the odds" every other individual in similar circumstances should be able to do the same. This detestable idea is challenged by research with people who live in challenging contexts around the world, in both high-income nations like the United States, Canada, and the UK, and those from low- and middle-income countries like Cambodia and Brazil (Bell, 2011; Panter-Brick & Eggerman, 2012; Ungar, 2007; Weine et al., 2012). For many, success is beyond people's reach until someone (a therapist, teacher, family member, friend, politician, or significant other) makes mental health resources available and accessible.

To illustrate, Kimberly DuMont and her colleagues (DuMont, Ehrhard-Dietzel & Kirkland, 2012) showed that among a group of mothers who have characteristics that put them at risk of child abuse or neglect (for example, living in vulnerable communities with high rates of poverty, infant mortality, and teen pregnancy), many protective factors distinguished parents who harmed their children from those who did not. Almost all of these factors are not individual qualities that the mothers themselves control. Social supports that provide stressed parents with respite care, educational opportunities, employment, and family income, combined with appropriate expectations of children's developmental progress (reinforced by the mother's cultural beliefs) and empathy for children's feelings, create a rich collection of protective factors.

Furthermore, there were marked differences between ethnoracial groups in DuMont et al.'s study. Hispanic mothers were more likely than African American and non-Hispanic mothers to avoid abusive behaviors. Accordingly, very little of the overall difference between the parents could be accounted for by individual qualities of the parents themselves, but instead seemed to reflect broader social processes like access to social support and culturally related experiences that helped mothers be better parents. Preventing child abuse, it seems, is best done by changing a mother's social ecology rather than changing the mother herself.

Such findings help us to see that while we have remarkable capacity *individually* to cope well with stressors, and many of us do just that, the greater the stress load, the less likely it is that individuals will be resilient. Stevan Hobfoll (2011), based on years of research in Israel with both Jews and Arabs, wryly observes, "We must be careful not to romanticize this striving, as our research already shows that the initial optimism about how many people are resilient in the face of major stress . . . is greatly exaggerated in circumstances where stressors are more massive or chronic" (p. 128).

It appears that people who cope well and overcome adversity succeed at two processes: navigation and negotiation (Ungar, 2005). Resilient individuals (families or communities) are those who are able to *navigate* their way to the resources they require. These navigations, however, can only succeed if the resources people need are *available* and *accessible*. Practically speaking, an individual must exercise enough personal agency (motivation and personal power) to seek the resources she needs while her social ecology must have the capacity to put those resources where individuals can make use of them. For example, a health care system can be flush with mental health professionals (in other words, they are available) but these human resources are not accessible to the most marginalized without such things as subsidized service fees, cultural sensitivity by clinicians, public transportation, and out of hours service.

So far, so good. However, making resources available and accessible is only going to impact well-being if what is provided is *meaningful* to individuals who need the service. As my work with Michelle showed, it is important that clients know they can *negotiate* for what is important to them and successfully make their goals the focus for therapy. Bringing all these ideas together, resilience can be defined as follows:

> In the context of exposure to significant adversity, resilience is both the capacity of individuals to *navigate* their way to the psychological, social, cultural, and physical resources that sustain their well-being and their capacity individually and collectively to *negotiate* for these resources to be provided and experienced in culturally meaningful ways.
>
> (Ungar, 2008, p. 225)

An ecological practice makes it possible for young people and their families to navigate and negotiate for resources that are meaningful to them.

Of course, that doesn't mean we should completely neglect individual factors either. A growing number of studies of resilience are pointing to genetic factors (and their environmental triggers), neurological processes (and the neuroplasticity that results from a facilitative environment) and personality types as all contributing to a child's well-being under stress (Folkman, 2011; Luthar, 2006). For example, if we look at resilience to traumatic events, we know that characteristics like the ability to show some restraint and self-regulation of emotions, a touch of extroversion to solicit support from others after exposure to traumatic events, the capacity to be calm in new situations, cheerfulness, enthusiasm, and the capacity to take pleasure in life, are all personality traits that distinguish those who cope well from those who are likely to suffer from Post-Traumatic Stress Disorder (PTSD; Miller & Harrington, 2011). However, it is a good environment that puts the resources people need to do well in front of them. Personal potential in a toxic social environment may never be realized.

Three Ways to Intervene

There are many ways that Michelle's team of professional supports could have helped her realize such potential for growth and avoid the debilitating effects of trauma. Here are three aspects of what should be part of every mental health practitioner's job description:

- *Direct Clinical Practice:* Direct practice with individuals and families is still the most common form of mental health intervention. It is typically focused on changing thoughts, feelings, and behaviors (Ivey & Ivey, 2007). The emphasis is on the relationship between the counselor and the client that has been shown to be the one aspect of clinical work that contributes to change more than any other (Duncan, Miller & Sparks, 2004; Orlinsky, Rønnestad & Willutzki, 2004).
- *Case Management:* When patients with mental and physical disabilities were deinstitutionalized and hospitals closed, clinical staff were forced to develop new ways of helping people develop the life skills necessary to live independently. Case management grew as an approach to helping individuals develop the networks of support and the life skills they need to survive. It extended the mandate of therapists to include the brokering of access to resources like housing and support groups. In the process, it turned clinicians into advocates for the rights of vulnerable populations (Heinonen & Spearman, 2006).
- *Community Work:* Sometimes, counselors must shift their focus from individual and family interventions to work with groups experiencing a common challenge, or the wider community. For example, in contexts where there has been a natural disaster or political violence, therapists may become community developers, intervening to address collective experiences

of trauma and the broader social determinants of health like racism and inequality (Almeida, Vecchio & Parker, 2008; Hart, Blincow & Thomas, 2007; Gewirtz, Forgatch & Wieling, 2008; Pancer et al., 2012). As a model for intervention, an ecological approach to practice does not require mental health professionals to stop working with individuals and families. It does, however, emphasize a continuum of service that places importance on collaboration between mental health counselors (those who help individuals change) and community developers (those who help communities meet people's needs).

All three approaches help children, youth, and families find new ways to cope under stress. They help young people succeed at two important tasks: (1) *navigate* to the personal and social resources they need to experience well-being and (2) *negotiate* for resources to be provided in ways that are meaningful to children and youth from diverse contexts and cultures.

Monday Morning, 9:20 A.M. (Part 2)

Helping Michelle navigate and negotiate was not easy. As her counselor, I thought Michelle would do well to talk about her experience of sexual abuse and her response to traumatic events, to reconnect with school, put in place a harm reduction strategy to decrease her drug abuse and control the influence of the boyfriend, and accept help from her transition worker. Michelle, meanwhile, had learned that authority figures could not be trusted even if she knew she needed their help. For her, the future was a foggy uncertainty and she was unlikely to let go of the one person, her boyfriend, whom she believed was there for her, no strings attached.

Compounding Michelle's problems was the fact that even if Michelle told her workers, "I need my own apartment," they were compelled by outdated policies to place barriers in front of her that prevented her from achieving the housing, safety, attachments, and support she required to manage her drug use. Housing First initiatives teach us that people change when they feel physically secure (Tsemberis et al., 2003). Psychological interventions are more effective the less the client is exposed to factors that threaten well-being, which means mental health is sometimes more dependent on the quality of the client's environment than the quality of the client's cognitions. With this in mind, I had to ask myself:

- Could Michelle exercise some say over who she lives with in her independent housing unit? Could her workers respect her choice of sexual partner and support her as the relationship runs its course?
- Could Michelle insist that her group home workers be the ones who help her transition out of care rather than being forced to start a new relationship with another social worker?
- Could Michelle's contact with her family be supported without it resulting in the removal of her younger sister from the home?
- Could Michelle's need to bring her court case to a conclusion be respected and the process expedited?
- Could Michelle's need to use drugs to maintain a peer group be understood? Could she be taught the harm reduction techniques she needed to reduce the consequences of her risky behaviors without jeopardizing the few relationships she had?

Thinking ecologically means engaging in a relational therapeutic approach to counseling that intentionally combines the best of what we know about clinical practice, case management, and the community work that helps us advocate for clients like Michelle.

My Clinical Practice with Michelle

"So, what exactly would you tell everyone if you could get them to listen?" I asked Michelle. She thought about my question for a moment, then told me she didn't want to be alone and she was actually happy to remain connected to people who had been her workers for the past several years. She was anxious about turning 18 years old and being on her own. If she couldn't get an apartment and share it with her boyfriend, she would rather move in with him and his mother. Unfortunately that would distance her even further from her support staff, something that neither Michelle nor her workers wanted to see happen.

On one level our conversation was about how I could advocate with the child welfare agency mandated to care for Michelle; on another, we were talking about insecure emotional attachments, abandonment, and the way drugs helped Michelle self-soothe. We decided that Michelle was not a bad kid, but a good kid in a bad situation that could be changed.

We began with a plan for secure housing. While I could do little more than make phone calls and attend case conferences, I did manage to coach Michelle how to better advocate for herself. We contacted an organization for children in care, and through their support explored Michelle's rights. Eventually, Michelle negotiated a compromise with social services: they would set her up in a small independent living unit and her boyfriend could visit as often as he liked as long as he maintained a separate domicile and he refrained from bringing drugs into the home. If the couple were going to use drugs, it was expected that they would do so at the boyfriend's residence.

With that settled, it was my turn to suggest some treatment goals that I was pretty confident reflected Michelle's other priorities. First, I asked Michelle to consider talking about her relationship with her mother and what it meant to her. Second, I invited her to talk about the sexual abuse and her frustration with the lack of progress prosecuting her abuser.

Drug abuse was not our focus for some time, mostly because Michelle wanted nothing to do with that conversation beyond occasional advice regarding harm reduction strategies. We eventually talked about these strategies at length, but only after Michelle was confident I'd heard her thoughts on her mother, her time in care, and the online predator who had tricked her into meeting him.

We worked together for nine months before Michelle decided she was ready to be on her own. There were setbacks, of course. Her boyfriend physically assaulted her while on probation and she forgave him despite needing a visit to the emergency department for stitches. Two months later she was temporarily discharged from her group home after she was caught using drugs in her room. That incident almost destroyed the longer-term plan for independent living. Within seven days, though, Michelle was allowed back into the group home as long as she promised to see me more often. Everyone, including Michelle, was relieved.

There were also sessions with Michelle and her mother, who agreed to come to see me on the condition that the focus was on helping Michelle transition to independent living safely and not the problems she'd experienced parenting her daughter. There was even one session with Michelle and her boyfriend before he abused her. Having met him and watched them together, it was much

easier to understand what he meant to Michelle and why she went back to him. He was a reckless, impulsive young man who when high could be dangerous, but straight and sober he made Michelle feel like a princess (at least that's how Michelle described her experience).

Finally, we brought into our sessions a member of Michelle's support staff at the shelter and used that time together to talk about both the group home's commitment to Michelle and their worries about her future. Though the work may sound confusing, it actually flowed easily, talking about how Michelle could navigate to the resources she needed to sustain well-being while negotiating for those resources to be provided in ways that made sense to her.

Common Factors that Predict Good Outcomes

The processes that protected Michelle psychologically and physically are remarkably similar to those of other children and families living in challenging contexts around the world. Street children in Colombia, migrant youth in China, and Inuit students in Canada's Arctic show common coping strategies like relying on adult mentors, distancing themselves from toxic home environments, making the most out of personality traits that are culturally appropriate and valued by others, or resisting the cultural stereotypes that threaten self-worth (Ungar, 2011).

For populations with complex needs who face significant levels of adversity, there are seven common protective factors that appear repeatedly in my research (Table 1.1). Though all seven have been shown to contribute in ways large and small to the successful coping of children who are stressed or marginalized, they are particularly helpful when a child's environment is full of risk and her life has been a complex series of decisions with few opportunities to make good choices.

Table 1.1 Seven factors associated with resilience (Ungar et al., 2007)

Resource Category	*Explanation*
1. Relationships	Relationships with significant others, peers, mentors, and family members within one's home and community.
2. Identity	A personal and collective sense of who one is that fuels feelings of satisfaction and/or pride; sense of purpose to one's life; self-appraisal of strengths and weaknesses; aspirations; beliefs and values; spiritual and religious identification.
3. Power and control	Experiences of being able to care for oneself and others; personal and political efficacy; the ability to effect change in one's social and physical environment in order to access resources; political power.
4. Social justice	Experiences related to finding a meaningful role in one's community; social equality; the right to participate; opportunities to make a contribution.
5. Access to material resources	Availability of financial and educational resources; medical services; employment opportunities; access to food, clothing, and shelter.

Table 1.1 continued

Resource Category	*Explanation*
6. Cohesion	Balancing one's personal interests with a sense of responsibility to the greater good; feeling as if one is a part of something larger than oneself socially and spiritually; one's life has meaning.
7. Cultural adherence	Adherence to everyday culture-based practices; assertion of one's values and beliefs that have been transmitted between members of different generations or between members of one generation; participation in family and community cultural practices.

Making Practice Socially Just

In my experience, most graduates of social work, psychology, nursing, medicine, and child and youth care programs are introduced to the reasons why each of these seven factors are important. Many also receive instruction in the politics of disadvantage and marginalization, and understand *conceptually* the need to put principles of social justice into practice. The problem is that in our actual clinical work these principles are, as Isaac Prilleltensky observes, "conspicuously absent" (2012, p. 2). Read the literature on child welfare practice, for example, and one is hard pressed to find a verbatim transcript of a meeting between a parent and a social worker or psychologist that occurs during a crisis that reflects in any practical way principles of social justice (for an exception, see Hart, Blincow & Thomas, 2007; Ungar, 2011). While the problem is stubborn and entrenched in an earlier view of the therapist as detached, the likelihood of "countertransference" minimized by the impersonal separation of the one counseling and the one being counseled, there are many who see instead potential for better practice when issues of social justice are front and center. Angie Hart and her colleagues have promoted teaching health care professionals to develop an "inequalities imagination" (Hart, Hall & Henwood, 2003, p. 481) that positions within therapy a thorough understanding of social justice issues at the heart of practice. It is a practical strategy. After all, inequality and social exclusion leak into clinical processes, overwhelming people's capacity to cope and placing real world limits on their opportunities to change.

What, then, does a practice that attends to issues of racism, sexism, homophobia, and other forms of exclusion look like, especially when these issues are not the reasons why clients come to counseling? How do we resolve being solution-focused, strengths-based, and client-centered while at the same time introducing a social justice perspective to those with whom we're working? When is it acceptable to lead, and when should we follow? As Prilleltensky (2012), in his discussion of well-being, suggests, "What I am arguing for is that it is equally valid to assess the wellness of the organization or community independently from the experience of a person in such a system. In other words, I would like to argue that to complement persons' assessments of their own experience in a setting, it is useful to identify characteristics of the setting that are empowering, liberating, and health-giving" (p. 3). Clinically, that means asking clients to consider how their families, schools, service providers, and communities are either making them mentally ill or creating the conditions to overcome mental health challenges like eating disorders, anxiety, and addictions.

A Focus on Delinquency

While a social ecological model of practice can be used with problems as diverse as elder abuse of a senior who is isolated from her extended family or a delinquent youth, I've chosen in this book to focus on the clients I am most familiar with, children and youth who exhibit serious antisocial behavior and their families. It is much easier to illustrate the principles and skills of an ecological practice by discussing all the phases of intervention in relation to just one type of problem.

Serious antisocial behavior includes a range of behaviors that result in referral to mental health services (i.e., conduct disorder, depression), youth justice services (i.e., criminal behavior, violence), child welfare agencies (i.e., running away from home, involvement in the sex trade), school counselors (i.e., truancy), public health professionals (i.e., high-risk sexual behaviors), and addictions services (i.e., substance use). While the problems young people experience are often interrelated, there is little rationale for why a youth is referred to one system or the other when he presents with a complex array of concurrent disorders and comorbidities (Henggeller & Sheidow, 2012). A shortage of services tends to result in more intrusive and restrictive treatments for delinquent youth than might be necessary. Mental health services for children and youth are particularly problematic because of the level of unmet need among young people (Kirby & Keon, 2006; U.S. Dept. of Health and Human Services, 1999) and because conduct disorder is associated with adult criminality, marital problems, combative employee–employer relations, unemployment, and poor physical health later in life. Conduct disorder also predicts educational underachievement, substance use and dependency, anxiety, depression, and suicide (Jané-Llopis & Anderson, 2005). While it is never too late to intervene, early intervention has been shown to always be the better option.

The problem with individually-oriented treatment for this population is that it can overlook the complexity of the multiple systems that become involved with young people with serious antisocial behavior. The youth most in trouble with the law are often found to be in the greatest need of mental health services and responsive foster care providers (Conger & Armstrong, 2002; Loeber et al., 1998; Murphy, 2002). Similarly, homeless youths and children in care require intensive case management and mental health supports (Cauce et al. 1998; Litrownik et al. 1999). Juvenile justice programs require stronger connections with public schools to achieve effective re-integration when discharging youth to their communities (Hellriegel & Yates, 1999). Child welfare clients are often shown to be in need of mental health care and have higher rates of service utilization (Arcelus, Bellberby & Vostanis, 1999; Haapasalo, 2000; Kroll et al., 2002; Webb & Harden, 2003) as well as needing access to a myriad of other support services such as special schools and responsive court systems (Dohrn, 2002; Sagatun-Edwards & Saylor, 2000; Saathoff & Stoffel, 1999; Wilson & Melton, 2002).

Given these intersecting systems and the complex needs of young people with serious antisocial behavior, there is a growing case to be made for an ecological conceptualization of why young people misbehave and how to intervene. Several comprehensive reviews (for example, Liberman, 2007; Loeber, Burke & Pardini, 2009) have summarized findings across studies that identify a relatively consistent array of individual, family, peer, school, and neighborhood risk factors for antisocial behavior. Within each, there are patterns that repeat. Parenting practices such as how children are disciplined and supervised, especially after school, have been shown to put youth at risk of delinquency (Pettit et al., 2001). Other caregiver factors like drug use and mental health are also related to the development of antisocial behavior (Cohen, Hien & Batchelder, 2008), with aspects of individual functioning such as cognition and biological processes like autonomic arousal triggered by factors found in a youth's environment. Outside of a youth's household, factors such

as a lack of prosocial activities, low academic functioning, and deviant peer involvement also influence the development of antisocial behavior (Dishion, 2000; Mikami & Hinshaw, 2006; Shin, Daly & Vera, 2007). A good intervention with this population needs to think about all these ecological factors even if the referral is meant to provide the individual with personal therapy for behavioral problems.

Summary

An ecologically trained clinician asks clients to consider substitute coping strategies that are meaningful and that bring with them long-term success (resilience). Training in the skills necessary to influence both individual psychological factors and the social determinants of well-being gives mental health care providers a toolbox of skills they can use intentionally to broaden therapeutic interventions beyond those focused on individuals or immediate family members.

As this introductory chapter has shown, many clinicians are already case managers, advocates, and system changers. Those aspects of their work, however, go largely unnoticed. While positive thinking and "grit" might predict better psychological outcomes for the general population, we can help more children with complex needs faster when we change their environments first. In the chapters that follow, we'll explore ways to help children, youth, and families with complex needs living in challenging contexts navigate and negotiate effectively.

EXERCISE 1.1

A Social Ecological Approach to Counseling: Self-Assessment Tool

Name: _____ **Date:** _____

Section A: Total Score _____

Section B: Total Score _____

Thinking about your practice, how would you rate yourself on each of the following principles and skills? How much is each evident in your work?

You can use this self-assessment to think about your work in general, or you may want to consider what you did with a particular client during one contact or session. If you prefer, it may be easier to think about the entire course of intervention you and your client have engaged in together. After all, no single session is likely to show all these principles and practices in action, though a good ecological approach to counseling will show many being applied over time.

You can also include comments in the spaces provided if they are needed to help explain your answers.

SECTION A:

There are principles of practice that, when reflected in our work as clinicians, help to ensure that the focus of intervention is not just on individuals, but also on changing the social ecologies that either cause problems or help to make people more resilient.

20 Principles of Practice

1. The counselor discusses strategies with the client to make use of the resources that are available and accessible.

I discuss what I know, and what the client knows, regarding how to access different individual, social and physical resources. Together, we identify any challenges to accessing resources and make plans to overcome these challenges. There are clear strategies developed to help the client access resources.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

2. The counselor explores with the client the client's definition of problems and possible solutions.

I explore with the client what she/he/they identify as the reason counseling is needed, and how problems and possible solutions affect the client and other people close to the client.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

3. The counselor discusses what the client hears about his or her problems and solutions.

I explore a range of messages (positive and negative) that the client hears about her/his/their problems and the solutions that have been tried (past and present).

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

4. The counselor explores with the client which resources are the most meaningful.

I discuss with the client which individual, social, and physical resources are the most meaningful, reflecting on the client's culture and context to determine the resources that are likely the best fit to help the client.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

5. The counselor integrates different phases of the intervention.

The focus of my work with the client changes as I get to know the client better and trust builds (engagement). Our collaborative assessment provides new information about individual and contextual risks and strengths, the informal supports and formal services that are available to the client, and possible solutions to the problems the client experiences. There is evidence during the intervention that new information is used to refocus the work (change the contract), update expectations for change and how we work together, and plan for the client to succeed after the clinical work ends (transition out of counseling). Each part of the work informs the other as we move along.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

6. The counselor shows awareness of use of self.

I pay attention to my own beliefs regarding what the client needs to do. I am careful not to assume I know the solution to the client's problem.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

7. The counselor shows the intentional application of theory to practice.

My work shows the intentional use of social ecological principles. The questions that I ask and activities that are done are intended to help the client navigate to the resources she/he/they need and negotiate for the services and supports she/he/they feel are most meaningful. While other approaches to counseling may be evident, the client experiences a coherent flow to the work.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

8. The counselor shows awareness of diversity.

I show sensitivity to the unconventional (atypical) solutions that the client uses to solve problems. Context and culture are discussed when solutions are expored.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

9. The counselor assesses the client's strengths, identifying coping strategies that the client has used in the past, along with the social and physical resources that were required for these strategies to succeed.

I explore examples of the client's coping strategies from the past and present, discussing both what the client did as well as what services the client accessed, who in her/his/their personal network and community helped, and the capacity of the client's environment to help make change possible.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

10. The counselor creates a clear contract, either written or verbal, with well-described goals for the period of intervention. The counselor negotiates goals for the intervention with the client.

I work with the client to negotiate an understanding of the problems and how that understanding impacts the client's life. I set priorities and timelines with the client, and agree on how we will follow-up to ensure a plan is implemented.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

11. The counselor focuses a portion every session on reviewing or renewing the contract for service.

I review near the beginning of each session the contract, and during each session, I acknowledge new issues that the client mentions, reminding the client of the contract she/he/they have agreed to for counseling. When necessary, I ask the client if she/he/they would like to re-contract.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

12. The counselor is willing to challenge the client's problematic patterns of coping and motivate change. The counselor negotiates with the client the coping skills that will be worked on during the session.

I skillfully discuss with the client which coping skills are effective and the long-term consequences of not making changes. New skills are discussed and those that are most meaningful practiced during the session.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

13. The counselor is effective at showing genuine concern. The counselor sustains a positive relationship with the client.

I display optimal levels of warmth, concern, and genuineness, encouraging the client to engage in discussions she/he/they are ready to have.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

14. Threats to the client's safety and the safety of others are addressed and strategies put in place to protect everyone from risks.

I engage the client in discussions about her/his/their safety and the safety of others close to the client. When safety is threatened, plans to address safety concerns are developed and implemented.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

15. The counselor acknowledges that changing social structures is as important as changing individuals. The counselor explores solutions that are multisystemic and complex.

I explore the many different factors contributing to the client's problems and contract to work on multiple solutions that address both individual and contextual challenges.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

16. The counselor explores the client's internal and external barriers to growth.

I help the client identify a range of both internal and external barriers that prevent them from achieving her/his/their goals. I explore examples of how these barriers have had an impact, positive and negative, on the client's life.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

17. The counselor anticipates and prepares for the client's transition back into relationships with informal supports or other formal service providers after the intervention ends.

I do whatever I can to include during the intervention (either in person, or through periodic contact outside of scheduled meetings) individuals and services that can support the client during and after the intervention.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

18. The counselor advocates with, or on behalf of, the client, or shows the client how to advocate independently.

I spend time discussing strategies to advocate with, or on behalf of, the client, or show the client how to advocate for herself/himself/themselves.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

19. The counselor does not convince the client to comply with rules and regulations.

I briefly point out the consequences of problem behaviors but spend most of my time with the client exploring why the client's current behavior is experienced by the client as adaptive. I appreciate that resistance to rules and regulations may be a coping strategy the client finds useful when other strategies seem less effective.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

20. The counselor redirects questions about unconscious determinants of behavior to social ecological factors.

I acknowledge any questions or concerns about intrapsychic determinants of behavior (like personality traits, unconscious motivations, and early childhood trauma) but redirect the client to focus on identifying the social ecological factors that are necessary to solve problems.

This statement describes my work:

Not at all	A little	Quite a bit	A lot	Does not apply to the type of work I do
0	1	2	3	n/a

Comments . . .

SECTION B:

Putting these principles described in Section A into practice takes special skills. Here are 20 skills observed in video recordings of counselors whose work shows evidence of a social ecological model of intervention.

Navigation Skills

	This statement describes my work:				**Does not apply to the type of work I do**
	Not at all	**A little**	**Quite a bit**	**A lot**	
1. Make resources available. I help the client identify the internal and external resources that are available.	**0**	**1**	**2**	**3**	**n/a**
2. Make resources accessible. I discuss how the client can access the resources that are available.	**0**	**1**	**2**	**3**	**n/a**

	This statement describes my work:				Does not apply to the type of work I do
	Not at all	A little	Quite a bit	A lot	
3. Explore barriers to change. I discuss the barriers to change the client experiences, and which resources are most likely needed to address which barriers.	**0**	**1**	**2**	**3**	**n/a**
4. Build bridges to new services and supports. I discuss with the client the services and supports that I am familiar with and my role as a bridge builder to help make new resources available and accessible.	**0**	**1**	**2**	**3**	**n/a**
5. Ask what is meaningful. I explore with the client which resources are the most meaningful given the client's context and culture.	**0**	**1**	**2**	**3**	**n/a**
6. Keep solutions as complex as the problems they solve. I explore solutions that are as complex (multisystemic) as the problems they address.	**0**	**1**	**2**	**3**	**n/a**
7. Find allies. I explore possible allies who can help the client access resources and put new ways of coping into practice.	**0**	**1**	**2**	**3**	**n/a**
8. Ask whether coping strategies are adaptive or maladaptive. I help the client explore whether the solutions she/he/they are using to cope in challenging contexts are adaptive or maladaptive, and the consequences to the choices the client makes.	**0**	**1**	**2**	**3**	**n/a**
9. Explore the client's level of motivation. I discuss with the client her/his/their level of motivation to implement new preferred solutions.	**0**	**1**	**2**	**3**	**n/a**

	This statement describes my work:				Does not apply to the type of work I do
	Not at all	A little	Quite a bit	A lot	
10. Advocate. I advocate with, or on behalf of, the client, or show the client how to advocate independently, to make resources more available and accessible.	**0**	**1**	**2**	**3**	**n/a**

Negotiation Skills

	This statement describes my work:				Does not apply to the type of work I do
	Not at all	A little	Quite a bit	A lot	
1. Thoughts and Feelings I explore with the client thoughts and feelings about the problem that brought the client to counseling.	**0**	**1**	**2**	**3**	**n/a**
2. Context The client and I explore the context in which the client's problems occur, and the conditions that sustain them.	**0**	**1**	**2**	**3**	**n/a**
3. Responsibility The client and I discuss who has responsibility to change patterns of coping that are causing problems for the client, and/or for others in the client's life.	**0**	**1**	**2**	**3**	**n/a**
4. Voice I help the client's voice be heard when she/he/they name the people and resources necessary to solve problems in challenging contexts.	**0**	**1**	**2**	**3**	**n/a**

	This statement describes my work:				Does not apply to the type of work I do
	Not at all	A little	Quite a bit	A lot	
5. New Name When appropriate, I offer different names for a problem, and explore what these new descriptions mean for how the client and I will work together.	**0**	**1**	**2**	**3**	**n/a**
6. Fit I invite the client to choose one (or more) new description(s) of the problem that fit with how she/he/they see the world.	**0**	**1**	**2**	**3**	**n/a**
7. Resources The client and I work together to find the internal and external resources the client needs to put new solutions into practice.	**0**	**1**	**2**	**3**	**n/a**
8. Possibilities I help the client see that she/he/they have more possibilities for change, and a larger number of coping strategies than she/he/they believed possible.	**0**	**1**	**2**	**3**	**n/a**
9. Performance I help the client identify ways to perform for others her/his/their new coping strategies.	**0**	**1**	**2**	**3**	**n/a**
10. Perception I help the client to convince others that she/he/they have changed, or are doing better than expected.	**0**	**1**	**2**	**3**	**n/a**

CHAPTER 2

WHY A SOCIAL ECOLOGICAL PRACTICE WORKS

The most difficult times clinically are those when we feel lost, overwhelmed by another's problems, or naively believe we have the solutions to fix someone's life but fail miserably. Without an organizing set of rules (a theory of change) we risk floundering, following people's problem-saturated stories without any hope of helping them find solutions that are meaningful for them. Counseling with a theory of change in mind provides us with a roadmap that helps us know where to start, how to proceed, and when to encourage a transition to something new. It makes our clinical practice intentional. The roadmap we use needn't be overly prescriptive, spelling out the specifics of every word we say. The best theories inform a practice that is flexible, allowing us to apply theory to practice in ways that are sensitive to people's contexts and cultures.

This chapter, then, is mostly about the theory behind why a social ecological practice works rather than the specific skills that make it work. It also provides a concise introduction to some of the most important things we know about patterns of resilience and the processes that make resilience possible. For those who want to read immediately about the skills necessary to put theory into practice, you should proceed to Chapter 4. You can always come back to this chapter and the next one later.

My purpose here, then, is to show that a good model of clinical practice should help counselors make their work contextually and culturally responsive. Whatever your model of practice, it should facilitate resilience, creating the conditions for the young people with whom we work to experience positive psychological and social development even when burdened by physical and psychological disorder or the marginalization that results from living in socially disadvantaged families and neighborhoods. To do this, the counselor focuses on the two processes of navigation and negotiation. These are the engines of change used by mental health care providers who think ecologically. But what specific kinds of navigations and negotiations are likely to produce the greatest amount of change? Answering this question is the focus of this chapter.

An Example of Theory in Action: Colin

Since grade three, Colin has lived in a community where he has been exposed to violence almost daily. Children there quickly learn to survive by being aggressive and delinquent. Colin, however, is a mild-mannered, well-cared-for, white, working-class child who stands out at school as one of the brighter students. He comes to school every day with a lunch bag nicely packed by his mother who works full-time as a professional driver. Unlike his peers, Colin's problems aren't neglect. They are the bullies who torment him because he is so well looked after.

At age 16, Colin was referred to a colleague of mine, Jennifer, a child and youth care worker who is part of a team of service providers who offer families in crisis support in their homes at times convenient for them. Jennifer asked me to help her develop a better plan for the clinical work she was doing with Colin. As hard as she had tried to help Colin, she just couldn't make the bullies go away. Colin was at risk of dropping out of school because of the constant torment. At first, we were both doubtful that anything else could be done for Colin that hadn't already been tried. Our hesitancy to predict success was only reinforced when Jennifer met with both Colin and his mother, Becky, in their home early one weekday evening. Becky was very clear what she thought Colin's problem was: "He needs more self-esteem. Damn it, teach him how to stand up for himself!"

Colin wasn't convinced that was his problem. He insisted he had tried to stand up for himself and had done everything in his power to get away from the bullies. In grade school he'd avoided the bullies by walking to school rather than taking the bus. He'd purposefully found activities to do at lunchtime so he wouldn't have to be on the playground. He'd even made a few friends, though they too mostly cowered when the bullies noticed them. When Colin's lunch was stolen or he was pushed down and slapped, he told his teacher and his principal. The bullies were suspended, which only made them laugh at Colin more. "We just got three days at home playing Nintendo," they told him and spit in his face. By the time Colin reached Junior High, the bullies had begun to vandalize his home, throwing eggs at his windows, or putting dog excrement in his mailbox. Colin's mother called the police and they spoke to the boys' parents, but still nothing changed. By this point, Becky was driving her son to school every day so he wouldn't have to be alone on the street.

"If only he'd fight back," Becky said.

Colin did eventually pick a fight with one of the bullies. "I told him, 'Okay, let's go outside and do this'," Colin told Jennifer. A teacher overhead him instigating the fight and suspended Colin. It was at that point that Colin's mother had requested help and agreed to let Jennifer into her home. She hoped one more attempt at counseling might help her son.

"It's so frustrating," Jennifer told me when we met for consultation. "It's not fair what's happening to Colin. But nobody is changing it."

I agreed, and wondered if she was going to do what the mother had asked and provide Colin with therapy to increase his self-esteem. She thought about it, but it didn't feel right, she said, to be putting all the responsibility for change on Colin's shoulders. The question remained, though, what else could she do except try to change Colin's self-concept and behavior?

It's a common problem that individual and family therapists encounter, no matter what their theoretical orientation. At one time or another, we all ask ourselves, "How can I influence the social factors that surround my client?" "Do I focus just on the individual, or can I do something to change my client's environment?" Whether we work in office-based clinical settings, residential settings like group homes and hospitals, or community clinics that are less formal, we still encounter the same problem. How does one have a practice that is both individually focused and socially conscious? How do we not only help individuals beat the odds stacked against them, but also change those odds so that clients are more likely to thrive? Just as importantly, will a more ecological practice work?

"Do you think Colin's problem is a lack of self-esteem?" I asked Jennifer.

"His mother thinks so," she replied slowly, "but I think the problem is the bullies."

I thought about this for a moment. It struck me that Colin had shown a remarkable amount of self-esteem. Colin had persisted and gone to school each day. He'd told his teachers about the bullying even though it had made the bullies retaliate against him and his family. It struck me that the problem was that Colin's mother didn't see her son as coping well in an impossible situation

and that what Colin needed first was recognition for the self-esteem he'd already shown. Once we convinced Becky how competent her son really was, I wondered if we couldn't continue to work with Colin to identify solutions that made sense to him. Neither Jennifer nor I had experience living in the community where Colin was growing up, nor did either of us really know what it was like to be bullied for such a long period of time by boys who brought guns to school. We decided we'd have to trust Colin to help us find solutions that made sense to him in his world and had at least half a chance of succeeding if put into practice.

A case plan using the principles of navigation and negotiation was developed:

- Jennifer would work with Colin to review everything he'd already done to stand up to the bullies. She would ask him whether he felt he had shown self-esteem each time. Her approach would challenge 'thin' descriptions of Colin (those that lack appreciation of Colin's socio-historical context) as failing or lacking self-esteem by engaging him in a conversation that would support a view of Colin as resilient in a terribly adverse context. Colin's perception of himself would be made a little louder and given more power when his problems were being discussed.
- Colin's mother would be invited to participate in these conversations. Jennifer would help Colin convince Becky that he had actually been showing a lot of personal power in how he had protected himself. In this way, the intervention would be systemic, changing how Becky interacted with her son and her definition of his problem and its solution.
- If Colin still felt he needed help to improve his self-esteem, Jennifer would work with him to challenge faulty cognitions and change behaviors that were disempowering. Her application of techniques borrowed from Cognitive Behavioral Therapy. Those treatments could be used to develop Colin's ability to resist feeling depressed or mimicking the violence he experienced.
- Meanwhile, if Colin agreed, Jennifer would host an after-school meeting for a few of Colin's friends. She would ask them what they thought about Colin's situation, whether he had shown courage dealing with the bullies, and most importantly, what they thought he could do to keep himself safe. By making Colin's peers the experts, and listening to them describe what they were up against, Jennifer hoped to challenge Mom's perception of Colin as failing to tackle his problem and to explore the contextual challenges to Colin standing up for himself more (Would it be safe? Would others support him?).
- Though there had been many case conferences in the past, Jennifer wanted to meet with Colin's school and see if anything more could be done to keep him safe. She wanted to be Colin's case manager and advocate for Colin and coach him on how to advocate more effectively for himself.
- Finally, Jennifer needed to talk to her manager at the agency where she worked and get her support. She needed to know that the extra hours she'd be accumulating organizing case conferences and meetings alone with Colin's mother (to help her understand the process Jennifer was using) would be seen as hours fulfilling Colin's contract for service which was explicit with regard to addressing his "psychological problems and family dynamics." She worried that sessions alone with Becky might not fit her funder's idea of what individual and family work looks like.

This is, though, what an ecologically-oriented clinical intervention looks like: clinical work and case management combined into a seamless intervention that facilitates navigations and

negotiations by individuals and families who have few resources and complex needs. The approach does not require elaborate collaboration between counselors (a large group of therapists working together behind a one-way mirror is a luxury, but not a necessity), client therapy groups, or any other techniques that are often impractical outside of well-resourced clinical training centers. Any time Jennifer spends on activities that are beyond the traditional role of clinician doing individual or family therapy is justified as time spent changing the social and physical ecologies that surround Colin. Her supervisor may have balked a little at the time Jennifer was spending changing Colin's social ecology rather than working directly with Colin, but she couldn't argue with the results. Both Colin and Becky were pleased with the service they were getting and fully engaged. Furthermore, those extra hours working ecologically reduced the duration and intensity of the individual work Jennifer had to do with Colin.

A Social Ecological Approach to Clinical and Community Interventions

Colin's case plan is a good demonstration of how a social ecological practice can be combined with other approaches to counseling. Jennifer may eventually use Cognitive Behavioral Therapy to address Colin's self-concept, or borrow aspects of Narrative Therapy to change Colin's mother's perception of her son's problem. Changing individual or family therapy into an effective multisystemic therapy in contexts of adversity means helping people make changes where changes are needed most: their social ecologies. Colin didn't need to work on his self-esteem as much as he needed to get recognition for the coping strategies he had already used in a very challenging context. As was shown in Chapter 1, psychological resilience cannot be nurtured in higher risk situations until the risks a child faces are dampened.

The work with Colin adheres to six rules that make change processes effective for people who live in contexts where there are few supports and high levels of stress. The same rules, however, may not be all that effective for clinical work with people who experience less severe problems or problems that are relatively uncomplicated (for example, a child from a well-resourced, safe home is arguing with his mother about how much homework he should do after school).

Rule #1: Early is Better, but it's Never Too Late

When designing interventions, it is always preferable to provide help early, before problems become more complex and patterns of coping that cause problems grow to be deeply entrenched. Early intervention changes life trajectories. For example, at the level of biological developmental processes, we know how important it is to provide a better beginning for children. Neuroplasticity, the brain's capacity to recover from exposure to prolonged traumatic events and neglect, can be developed through positive and supportive experiences that prevent further deprivation (Luthar & Brown, 2007). In other words, environments that provide optimal conditions for human development, like soil rich in nutrients, are an investment in early prevention that makes resources more easily available and accessible to disadvantaged children. It is an "upstream" cost-effective alternative to counseling and other forms of "downstream" intervention after problems have become serious, which is especially effective when there is "constellated disadvantage" (Hart, Blincow & Thomas,

2007, p. 14), the challenge posed by a myriad of factors that come together to produce complex problems. In these difficult contexts, children survive because of changes to both external factors such as the child's social and economic status or exposure to violence, and internal factors like the subtle changes in behavior and cognition that result from a positive attachment to a caregiver.

The factors that have the potential to turn a child from vulnerable to resilient are temporal. Specifically, time influences resilience in two ways. First, developmentally, we know that people will cope with adversity with varying degrees of success at different points in their psychosocial development, depending on the number of stressors in their environment (the burden) and their capacity (the resources) to cope. Second, different historical periods demand of us different coping strategies. For example, in a period of economic boom, leaving school and moving out on one's own early may protect the self-esteem of a child with a severe learning disability if he is able to quickly find work and support himself. During a prolonged recession, however, he may have to remain in school longer and living at home if there are no opportunities for employment.

We are much more familiar with what Laub and Sampson (2003) term "cumulative continuity" (p. 51) of problem behaviors like delinquency over time: "Delinquency incrementally mortgages the future by generating negative consequences for the life chances of stigmatized and institutionalized youth" (p. 51). Delinquency, therefore, has a temporal dimension too. It weakens social bonds and leads to the necessity of adult crime. Fortunately, there are other factors that are likely to make a delinquent youth resilient as an adult, interrupting negative life trajectories. First, just becoming an adult changes a young person's level of delinquency as many status offences, crimes that only a young person can commit like under-age drinking, stop being criminal acts. Later, marriage, time in the military, and full-time employment, all predict better attachments and opportunities to change patterns of adult criminal behavior. These experiences are dependent on how well the youth's social ecology responds to the needs of the young person.

However, there is no easy way to predict with certainty that any single protective factor will permanently change problem behaviors. Each intervention is, however, "grist for the mill," adding a little more to the potential strengths an individual has to resist falling into problematic patterns of coping. There is a great deal of variability in responses, with some compensatory patterns of coping producing a steeling effect: the child compensates for exposure to traumatic events like abuse by developing coping skills that allow her to maintain a sense of equilibrium and continue to do well. Later, the adult who experienced abuse as a child is shielded from the mental health problems that are related to adversity because of the coping skills she learned earlier in her life (Feder et al., 2010; Friborg et al., 2006).

The only drawback to compensatory coping strategies is that they sometimes backfire. When researchers studied whether American soldiers returning from tours of duty in Iraq and Afghanistan were more or less likely to experience PTSD, they discovered that soldiers who had been abused as children and who as children used avoidance and withdrawal strategies to cope made great soldiers during their tours of duty. The same soldiers were the ones most likely to experience PTSD when they returned home (Bonanno & Mancini, 2012; Cacioppo, Reis & Zautra, 2011). Soldiers without a history of abuse and soldiers with histories of abuse who had used other strategies like externalizing behaviors (i.e., angry outbursts, running away, truancy) tended to report lower levels of PTSD in large part because they were better at talking about their experiences after discharge. The example is interesting as it reminds us that a coping strategy that may be very adaptive for a child when younger, allowing an abused child to continue to perform adequately outside of his home, can later become an unsustainable maladaptive strategy to cope with trauma. In the case of the soldiers with abuse experiences and histories of avoidant coping, they were less able to access

informal social supports (for example, the camaraderie of other veterans) which can be crucial to coping with the trauma related to being a combatant during war.

Rule #2: 70-20-10

From clinical practice and a review of studies of resilience, we know that approximately 70% of children will cope well with the challenges they face in adverse family, school, and community contexts *if* they are provided with the psychological and social supports they need (see, for example, Bonanno, 2013; Sroufe et al., 2005). For most children who face significant adversity, that means sustained structural supports like safer streets, good schools, attachments to peers involved in prosocial activities, a financially stable home, and freedom from violence or harsh discipline at home and at school. It also means good government policies informed by research that set as a priority the provision of services that match the needs of communities. Despite a popular belief to the contrary, children's level of motivation to achieve positive developmental milestones like high school graduation or to resist substance abuse is actually less important than the resources children are provided by their caregivers, educators, and policy makers (Ungar, 2011). When well-monitored, well-cared for and provided quality education and other supports, most children succeed even if they have low levels of motivation to excel. In contrast, motivated children in social ecologies that deprive them of caring adults, good schools, and opportunities for recreational "highs" (like sports, music, and adventure) are not as likely to succeed in as great numbers as less motivated but better resourced children.

To illustrate, an initiative called Pathways to Education (www.pathwaystoeducation.ca) is a community-based program that has been shown to be effective increasing high school completion rates among students from disadvantaged communities where rates of graduation can be as low as 25%. Staff work with adults in the community to identify one public housing project or neighborhood school where the majority of children are exposed to factors associated with early school leaving such as poverty, parents who left school early, community violence, or high rates of teenage pregnancy. Because the sample is purposeful, every child in the catchment area is offered extra help beginning in grade nine. The intervention includes one-on-one support and advocacy, group mentoring with caring adults, academic tutoring that children are expected to attend after school with trained educators, and financial support (money is put into a trust account each year the child attends high school) which, by the time the child graduates, is enough to pay for the first few years of college, university or a vocational program. By changing the environment around the child and making it more supportive, high school completion rates more than doubled and rates of absenteeism dropped as much as 52% in the first year. Students who participated showed rates of engagement in post-secondary education higher than the national average, and were much more likely to complete their degrees than post-secondary students. These positive outcomes can be attributed to the changes in the availability and accessibility of the supports children needed to succeed at school. Individual motivation to change was not the primary focus of Pathways to Education.

Sadly, longitudinal studies also show that approximately 30% of children who experience significant adversity require more than just good homes, schools, or community centers to overcome the trauma resulting from abuse, marginalization, relocation, individual mental disorders, or the disordered behavior of their caregivers (Moffitt et al., 2001; Werner & Smith, 1992). In those cases, approximately two thirds of the children who do not respond to structural changes in their

families, schools, or communities (or 20% of the total at-risk child population) respond well to tertiary level mental health interventions that help change complex, harmful reactions to past victimization and current psychological problems. This number is arrived at by estimating the typical level of effectiveness reported for most therapeutic interventions (about two thirds of clients of mental health services show improved functioning after counseling) (Lebow, 2006). Together, the combination of structural supports, effective clinical interventions and case management can ensure that at least 90% (70% plus 20%) of young people in adverse contexts enter adulthood relatively well-functioning.

What happens to the remaining 10% of children who experience significant levels of adversity? Despite the advantages of safe supportive environments and therapeutic help, many are still likely to move into their adult years with troubling patterns of problem behavior (Moffitt et al., 2001). The good news, though, is that many of these individuals do, in time, heal the wounds inflicted on them by adverse early childhood experiences (Laub & Sampson, 2003). Their success will be partly the result of their growing capacity to think more clearly about their actions and anticipate the consequences. Their pattern of growth will also be related to the opportunities they have for employment, intimate relationships, and a sense of belonging and purpose in their communities.

The 70-20-10 rule highlights a pattern in the research and evidence from the clinical practice literature that suggests that not all individuals who face significant challenges need individual or family therapy, though many do, especially when structural changes to the individual's environment are not enough to change their problem behavior. Unfortunately, even with extra clinical help, we can expect that 10% of all individuals with complex needs will not show much short-term improvement in their behavior. For these individuals interventions are, to quote Earla Vickers, one of my clinical mentors, "money in the bank" that can pay dividends much later in life.

Rule #3: Protective Processes Work

We misspeak when we describe someone as "resilient," as if there is one final state they can achieve, like a cake that is fully baked and ready to be taken from the oven. We are also mistaken when we say a child shows resilience, as research clearly shows that the capacity to recover from stress is not a static quality of the child, but the result of processes that make growth possible (Masten & Obradović, 2006). Factors associated with resilience are the fuel that makes protective processes effective. For example, a good relationship with one's parent and the capacity of that parent to monitor her child are both factors that facilitate the process of healthy child–parent interactions that make the child more likely to be resilient.

To illustrate, Reid is a 12-year-old child with above average intelligence and a talent for sports, but living in subsidized housing with his mother who has been diagnosed with Borderline Personality Disorder. Over the years she has struggled to attach to her son but her abusive behavior has never been severe enough to warrant Reid's removal. Much of Reid's success is attributable to a supportive school, though the school can only do so much to keep Reid safe. It was his school Principal who noticed that Reid was reluctant to go home and helped the boy get involved in a number of school activities. She also called child protection services to ensure that Reid was being properly monitored by authorities. Arguably, if Reid hadn't been engaged in the protective processes that resulted from healthy interactions at school and with service providers, it is likely that he would have fallen into patterns of behavior such as delinquency or depression.

With regard to clinical and community interventions, this focus on process is particularly important. It is far easier to change the environment around an individual in ways that open opportunities for new resources than it is to fortify an individual to make him strong enough to cope in an environment that fails to adequately provide him with what he needs to do well.

Rule #4: Cumulative Resilience

The more protective processes individuals engage in that enhance their capacity to cope, the more likely they are to show good developmental outcomes. Studies of strengths show the same pattern. Across a population, prosocial behaviors like school attendance and attachments to peers are related to a long list of internal and external factors (Benson, 2003; Donnon & Hammond, 2007). In general, the more these factors are available to the individual, the better the individual weathers stressful life events.

The relationship between the number of protective factors, protective processes and positive outcomes is curvilinear. This is important for counselors to understand when developing case plans. One positive health-enhancing factor in a child's life, like a non-delinquent peer group, is good. That peer group and an opportunity to get extra help at school is even better, doubling the chances the young person will do well. Add to this list a parent who communicates with his child's teachers, a violence-free home, a community that values education, the transmission of cultural traditions to the child, access to recreational facilities, and the young person is likely to be engaged in multiple processes that ensure long term developmental benefits. Research shows that these factors combine in ways that make them more than just the sum of their individual influence. Their influence grows exponentially, one increasing the positive impact of all the others.

For counselors this means we need to think about case plans as a complex and interrelated set of possible solutions to problems that occur at different systemic levels (individual, family, school, community). The more positive processes we help clients engage in, the more impact each process will have. Changing behavior, then, is a matter of providing access to enough protective processes to help people cope effectively in threatening environments.

Rule #5: Differential Impact

One of the most distinguishing aspects of the study of resilience is that it always pays attention to the amount of risk a child is exposed to. Change the amount of risk and the long-term impact a protective process will have changes too. In other words, protective processes exert different amounts of influence on developmental outcomes depending on the amount of adversity individuals experience (Ungar, 2013).

Factors that are protective when there is exposure to a great deal of stress may have no benefit at lower levels of stress, or could even cause an individual harm. For example, adoption is usually seen as an advantage for an abandoned child but is experienced by a child with a secure attachment to an adult as a terrible and life-disrupting traumatic event. The rule of differential impact explains this pattern. Furthermore, the amount of benefit a protective process brings to a child also varies by how richly resourced the child's world is. Comparing two orphans, we know that for orphans

who suffered severe early neglect before they were adopted, a secure attachment to an adoptive family will result in a disproportionately greater amount of positive influence on the neglected child when compared to an adopted child who did not suffer early neglect (Beckett et al., 2006). In other words, adoption benefits the most badly treated children the most.

The same pattern is observed in other interactions that take place in a child's wider social ecology. For example, a good relationship with one's teachers at school and the feeling of belonging that follows is very important to youth from homes and communities where there are few emotional supports, but does very little to increase a young person's engagement at school if he is already well anchored at home and has plenty of extra-curricular activities. Here again is the same pattern of differential impact (Shernoff & Schmidt, 2008). School engagement is much more important to children from disadvantaged backgrounds who do not have after-school supports than children who have lots of opportunities to show their talents and form positive relationships with caring adults outside of school (Ungar & Liebenberg, 2013).

Likewise, acculturation may be a good thing for children and adults from the dominant culture but resisting acculturation can protect the mental health of first and second generation immigrants when it prevents them from becoming alienated from their culture of origin (Berry et al., 2006; Simich et al., 2009). Acculturation can actually cause harm to populations coping with the stress of migration and integration into a community where they experience racial or ethnic prejudice.

For counselors, understanding the differential impact of protective processes helps fine-tune goals for intervention. Depending on the individual client's exposure to adversity and the complexity of the client's needs, different processes may be more or less helpful. This is a very important distinction and one that is often overlooked by both clinicians and policy makers. This differential impact is the result of both children's perceptions of the resources available to them, both real and imagined, and the opportunity structures that make it possible for them to use resources. It also reflects their differential susceptibility to risk factors related to gene expression (Belsky, Bakermans-Kranenburg & van Ijzendoorn, 2007; Belsky & Pluess, 2009a, 2009b). In other words, individual factors related to both cognitions and genetics influence whether a protective process exerts a large or small influence on a client. For counselors, this may explain why an effective intervention with one individual fails to help another.

This is the kind of complexity that an ecological practice addresses far better than clinical models that rely on explanations of human development that assume homogeneity in the way individuals from different contexts and cultures will respond to stress. When we ignore differences, we overlook how we can match interventions to individuals. For example, Fergusson and Horwood (2003) make the distinction between protective processes (those that are beneficial to those exposed to risk factors but of no benefit to those not exposed) and compensatory processes (the process associated with resilience benefits both those exposed and not exposed to adversity). They report results from a 21-year study, the Christchurch Health and Development Study, with an unselected birth cohort of 1265 children born in 1977 in Christchurch, New Zealand. Those results show that what is and is not a source of resilience depends on the context in which interactions between people and resources take place: "When externalizing and internalizing in adolescence are considered, it is apparent that each sex has what appear to be gender-specific strengths and vulnerabilities, with femaleness providing resilience to externalizing but vulnerability to internalizing. . . The results show that what may confer resilience to one outcome, may increase vulnerability to another" (p. 147). As the example suggests, even gender will decide which types of protective processes work best for which person. This is not surprising given that a child's gender exposes them to many forms of risk and dramatically changes their access to health resources.

We need, therefore, to put most of our energy into looking for the protective processes that are effective for those who are the most marginalized. This makes a social ecological model of intervention different from Positive Psychology, which has tended to focus on population-wide factors that reflect the values of the dominant culture (see, for example, Peterson et al., 2008). We could imagine, for example, a situation where dominant culture youth fail miserably when assessed for skills that minority culture youth use to thrive. To illustrate, language acquisition skills in a country like the United States are far better developed among immigrants than Americans of Anglo-European descent or those who have fully acculturated, yet we do not measure the *absence* of multilingualism as a *deficit* among American school children. We don't typically talk about children as vulnerable and lacking potential to flourish because they *only* speak English. In a country comprised mostly of English speakers, the majority of children need only one language to survive. Of course, it's not the same for cultural minorities and immigrants for whom multilingualism is a protective factor with profound influence on their life course. Generalized assessments of the protective factors that are the building blocks of Positive Psychology do not, however, focus on capacities that are most relevant to minorities. Instead, there is a bias toward aspects of behavior valued by cultural elites.

The same argument can be made with regard to the ability to resist racism, or "code switch," when transitioning between one cultural group and another. Children behave in ways that either celebrate their differentness through clothing, language, and other behaviors, or find ways of being chameleon-like conformists and fitting in. These skills are important to sustaining a positive identity and sense of coherence when one is a cultural outsider. They are typically developed, however, only by cultural minorities (we could say that cultural minorities show strengths in this area). Therefore, as these examples show, there is a need for counselors to understand how a protective factor can have a negligible effect on a population but skew developmental outcomes (and exert a differential amount of influence) on a particularly disadvantaged group of children. As one can imagine, this important observation can dramatically change what occurs in counseling and the goals that are set.

Finally, the rule of differential impact also explains why the provision of human services is so important to disadvantaged children and families, but has little impact on developmental outcomes among those who face little or no adversity (Sanders et al., 2013). Browne's (2003) work illustrates this difference. In an effort to provide lower socio-economic status (SES) children and those involved with child welfare services with access to extra-curricular activities, funds were provided to help children participate in activities after school. The program realized back the investment through decreased demand for medical services and mental health counseling. Investments in services do not, as a rule, exert a significant impact on children who face fewer risks and don't need them (Masten, 2006; Ungar, 2012).

Rule #6: Hidden Resilience (Maladaptive Coping)

Sometimes young people cope in ways that others perceive as harmful but that clients themselves argue are protective. Children adapt to their environments in ways that make sense to them given the psychological and social resources that are available. When these patterns of coping are thought by others to be unacceptable, but clients see their coping as effective, we can describe their coping as maladaptive and their resilience as hidden (Ungar, 2004).

The theory of maladaptive coping (or pathological adaptation) suggests that in contexts with few options, certain behaviors may protect the child from threats to their psychological well-being even though these behaviors bring with them problems like disapproval from caregivers, school suspensions or forced treatment (Ng-Mak et al., 2010). Problem behaviors in poorly resourced environments can simply be an individual's best "choice" (though there really is very little choice!) to make do with what little she has.

Interventions to change maladaptive coping strategies can, therefore, offer substitutes that bring with them equally effective means to achieve the same psychological benefits that dangerous, deviant, delinquent, and disordered behavior already provide. The child who is looking for a sense of belonging and security but lacks a stable home may turn to delinquent peers because he has no other way to protect himself and feel affirmed. The young woman who becomes sexually active may find through her sexual activity a way to develop a positive identity when other paths to self-esteem appear blocked. Neither strategy (joining a delinquent peer group or early sexual activity) are socially acceptable, but research shows that maladaptive coping is most likely to occur when contexts are poorly matched to the personalities and strengths of individuals (Cruz-Santiago & Ramirez-Garcia, 2011; Ebersöhn, 2007). For example, in ethnographic accounts of youth in gangs young people talk about their criminal experience as an opportunity to be entrepreneurial, to feel safe, or to feel the self-esteem that comes with belonging to a powerful group of peers (Pinnock, 1997; Totten, 2000). Likewise, marginalized young women who become sexually active early may account for their experience as a rite of passage that makes them feel adult-like in much the same way that other children experience their driver's license and high school graduation as their rites of passage (Allen et al., 2007; Taylor, Gilligan & Sullivan, 1995).

When counseling to change children's behavior, it is important to consider whether the children and their caregivers can successfully navigate and negotiate for the resources they need to thrive. When satisfying substitutes to troubling behavior are available and accessible, change is likely to occur. After all, people navigate toward problem behaviors because those behaviors become the most meaningful. For example, a family where the parents (especially the mother) haven't completed high school may create a context in which education is undervalued and children are given permission to disengage from school early. Change the resources available to the child by providing the child with an educational mentor, financial assistance for post-secondary education, and tutors to ensure academic success, and many children will choose to stay in school and graduate. In other words, the meaning of school can be changed through a comprehensive approach that involves both individually-focused interventions with the child to assess learning challenges and motivate a child to learn along with structural changes that make it easier for children to learn. It's this second prong of the intervention, the adaptation of the environment, which is as or more important as individual therapy in contexts where education is undervalued and underfunded. In those instances, individual children and their families need to be engaged in the construction of a new definition of education as a pathway to success that is available to them while lawmakers must be coaxed to understand that investing in schools is a better investment than prisons.

The argument goes even further when we consider behaviors that may be socially undesirable but which are functional for a minority. An interesting example is the tendency of youth who perform poorly at school to leave before graduation. The strategy may appear to disadvantage them except that by their own account leaving a situation where they feel their self-esteem is threatened, and where opportunities for a good job in the future are perceived as few and far between even if they have a high school leaving certificate, may be a protective strategy relevant in a particular socio-historical context (Dei et al., 1997).

Collectively, as a community of mental health professionals, we have largely overlooked differences among ethnic and racial minorities. As Pratyusha Tummala-Narra (2007) wrote recently as an introduction to a case study of a bi-racial 30-year-old American woman plagued by anxiety, "While there is empirical evidence for the effectiveness of several psychotherapeutic approaches for certain psychological problems, such as phobias and depression, empirical evidence that any of these is effective with ethnic minority populations is sorely lacking" (p. 209). The therapy that unfolded grew well beyond a cognitive treatment, exploring the woman's experience of racism, sexual abuse, and the systemic prejudice she encountered when interacting with the police. It was in that context that therapy was effective because it was done in a way that was sensitive to the client's understanding of the world and the barriers she experienced daily.

While mental health care providers are trained to help individuals, we can also practice in ways that influence an individual and family's meaning system and, on occasion, the perception of policy makers of the appropriate solutions to wickedly stubborn problems like school drop-out or non-disclosure of sexual abuse. The chapters that follow emphasize direct clinical practice, but always with attention to the need to understand the context in which our interventions take place and our multiple roles as clinicians, case managers, residential workers, and advocates for socially just services.

Chapter Summary

Whether working in an office-based service, a residential setting, or a community program, counselors need to be able to help people navigate to the resources and services they need and negotiate for resources to be provided in ways clients find meaningful. A theory of change for a social ecological clinical practice directs our attention to how young people adapt to their environments in ways that make their navigations and negotiations effective. The more effective children are as navigators and negotiators, the more resilient they will be in challenging contexts. In this chapter, I've provided six rules to explain why a social ecological practice works, linking aspects of contextualized, culturally sensitive therapy with children and families to what we already know about resilience.

As has been shown, a social ecological practice encourages us to look at young people as making the best use possible of their strengths (what they already do well). When children face multiple challenges, however, counselors must appreciate that coping strategies may not result in socially acceptable patterns of navigation and negotiation (maladaptive coping and hidden resilience). When counselors understand young people's coping patterns as adaptive, they are in a better position to help them find substitutes for problem behaviors that bring solutions every bit as good as (and likely better than) the ones they found on their own when resources were scarce.