Transitions in Youth Development:

From Deficiency to Resiliency

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INTRODUCTION

The National Youth Development Information Center (Center, 1999) defines youth development as "a process which prepares young people to meet the challenges of adolescence and adulthood through a coordinated, progressive series of activities and experiences which help them to become socially, morally, emotionally, physically, and cognitively competent." Initially youth development centered on preventing high risk behaviors that were linked with negative outcomes. Deficiency-based models evolved into resiliency models that targeted the antecedents of high-risk behaviors and therefore were much more proactive in their approach. More recently, attention is being given to the idea that an absence of high-risk behaviors may not be enough to proclaim healthy youth development. The positive youth development grew from the question of what is healthy development and how do we promote healthy development in our children and adolescents. This paper reviews the evolution in thinking about youth development from the deficiency-based and resiliency-based approaches to current ideas about positive youth development.

Why is youth development a concern? From an economic standpoint, there are concerns about the transition of youth into the labor force. Dryfoos (1990) projected that one-quarter of future labor force requirements will not be met because of the growing number of high-risk youth that will not have the skills to meet the demands of the jobs. From a social perspective, troubled youth are also not prepared for committed family relationships or friendships, nor are they prepared for participation in democratic society. The Carnegie report Turning Points, (1989) estimates one in four adolescents are extremely vulnerable to multiple high-risk behaviors, including school failure. Another quarter of our adolescents are in a moderate risk category and as many as one half of our adolescents are in a moderate to high-risk category for diminishing their future life opportunities through behaviors destructive to themselves and others. Dryfoos (1990) contends that a new class of "untouchables" is arising from the group of troubled youth.

MEDICAL MODEL

The first interventions addressing youth development were based on risk-focused models in human medicine. Namely, programs focused on preventing behaviors closely tied to heart and lung disease (Hawkins, Catalano, & Miller, 1992). Educating people about the risks for heart disease (e.g., smoking, lack of exercise, high fat diets) resulted in reductions in the incidence of heart disease. Therefore, because of the success in reducing negative health behaviors, the idea of reducing or eliminating risk was also applied to youth problem behaviors. The theory (figure 1) underlying the risk model was that identifying the factors that contribute to the behavior and then eliminating them can prevent problems. For example, if alcohol is identified as a contributing factor to teenage pregnancy, eliminating access to alcohol should reduce teenage pregnancy rates. However, like heart disease, human development trajectories are influenced by multiple risk factors, not just one. Cowen (Cowen, 1986) uses the analogy of lead poisoning to explain the effect of accumulation of multiple risks on human development. It's the accumulation of lead, not one time exposure that affects physiological development.

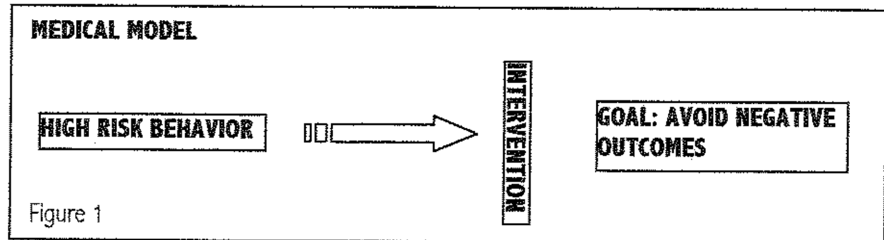


Figure 1

Limitations of the Medical Model

The initial prevention/intervention programs focused on high-risk behaviors after they occurred rather than before, thus earning term deficiency based programs. From an epidemiological standpoint, problem behaviors are a disease; therefore, as with a disease the possibility of a cure lies within the individual. Thus, interventions should take place at the individual level.

The medical based interventions had several factors in common that limited their effectiveness. (Dryfoos, 1990). For one, their primary goal was not to change the quality of life of a child, but to eliminate the problem symptoms such as drug abuse, teenage pregnancy, crime, etc... Two, the programs

were outcome oriented with little interest in predisposing factors to the problem behavior. Three, specific groups at risk were not identified and targeted in the interventions. Also, the approach was limited by not considering the context surrounding the individual as a contributing factor to the problem behavior. In general, the intervention programs didn't create change in individuals or in the social institutions responsible for creating the ecological environments that incubate problem behaviors.

RESILIENCY MODELS

The concept of resiliency revolutionized thinking about efforts to support youth in their development by moving away from the approach that problem behaviors are diseases that can be cured. Resiliency research shifted the focus from targeting high-risk behaviors to identifying and targeting the antecedents of high-risk behavior. Rutter (1987) and Garmezy et al. (1991) found that more than half the youth living in disadvantaged situations did not continue to live in disadvantaged situations when they were adults. Resilient children manage to avoid maladaptive responses to risk and therefore do not suffer the potential negative consequences (Zimmerman & Arunkumar, 1994). These children are not, however, invulnerable to stress. They merely have the capacity to face the stress without being debilitated by it; this does not mean they never experience distress (Werner & Smith, 1992). Garmezy and Masten (1991) define resilience as "a process of, or capacity for, or the out come of successful adaptation despite challenging and threatening circumstances" (p. 459).

Common terms used in resiliency research are risk factors, protective factors and outcomes. Examples of negative outcomes or problem behaviors commonly found in the literature include school dropout, delinquency, substance abuse and teenage pregnancy (Dryfoos, 1990; Hawkins et al., 1992; Jessor, Van Den Bos, Vanderryn, Costa, & Turbin, 1997). Risk factors are variables associated with a greater likelihood of negative or undesirable outcomes (Jessor et al., 1997). Risk factors can be found the community, school, family, peer group and the individual. Pollard (1999) summarized risk factors found

by researchers in the multiple domains. Community risk factors include normative expectations of behavior and characteristics of the neighborhood such as high levels of poverty. In schools, academic failure and a lack of commitment to school predict crime and drug use. Crime or substance abuse in the family history, poor parenting skills and high levels of family conflict also predict problem behavior as well as peer drug use and delinquency. Individual factors linked to delinquency and substance abuse include early exposure to toxins, sensation seeking, poor impulse control, early aggressive behavior and early substance abuse. The definition of protective factors will be addressed as a part of the discussion on resiliency models.

Compensatory Model

What are the mechanisms of resiliency? Garmezy et al. (1984) proposed three models to describe how stress and resiliency affect adaptation. The compensatory model (figure 2) suggests positive attributes, such as self-esteem, compensate for the risk or stress variable. Risk factors are variables associated with a greater likelihood of negative or undesirable outcomes. Risk factors can be found the community, school, family, peer group and the individual. Examples of negative outcomes or problem behaviors associated with risk factors include school dropout, delinquency, drinking and drug use. Pollard (1999) summarized risk factors found by researchers in the multiple domains. Community risk factors include normative expectations of behavior and characteristics of the neighborhood such as high levels of poverty. In schools, academic failure and a lack of commitment to school predict crime and drug use. Crime or substance abuse in the family history, poor parenting skills and high levels of family conflict also predict problem behavior as well as peer drug use and delinquency. Individual factors linked to delinquency and substance abuse include early exposure to toxins, sensation seeking, poor impulse control, early aggressive behavior and early substance abuse. Both risk and compensating variables have a direct independent effect on the outcome and do not interact. The model would predict that if a child were

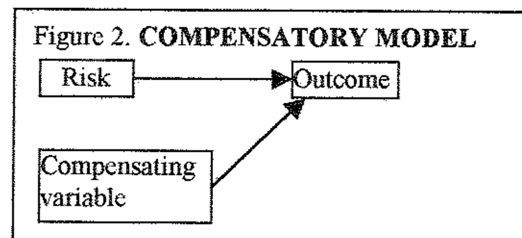
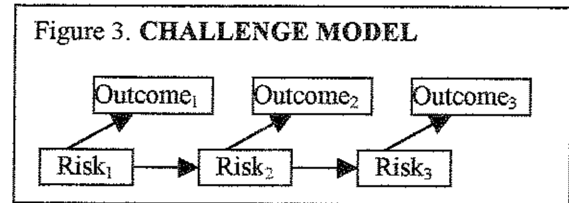


Figure 2. **COMPENSATORY MODEL**

exposed to constant levels of conflict between parents, a risk factor, increasing a compensating factor such as self-esteem would predict better outcomes.

Challenge Model

The challenge model (figure 3) proposes that stressors, if not excessive, can enhance successful adaptation. Too little stress means the child is not being challenged enough. When a child overcomes a stress or challenge, they are better prepared to face the next challenge. Rutter (1985) refers to the benefit of overcoming challenges in facing the next challenge as "steeling" or "inoculation." If the stresses are so great that the child fails to meet the challenge repeatedly, helplessness results and the child becomes increasing vulnerable to risk.



Protective Factor Model

Definition

The protective factor model predicts an interaction between risk and protective factors in how they affect outcomes rather than looking at main effects as in the other models. The definition of a protective factor has not as clear as the definition of a risk factor. Protection has often been thought of as an absence of risk or at the opposite end of the continuum of the risk scale (Jessor et al., 1997). Rutter (1987) was one of the first to reject the idea of risk and protection being a single dimension and instead argued the two factors are distinct. Thus in the protective factor model, protective factors are considered independent variables that can have their own effects on behavior and can also moderate the effect of exposure to risk factors, resulting in reduced incidence of problem behaviors. Protective factors may affect outcomes without the presence of a stressor, but the effect will be much stronger if a stressor is present. Protective factors can be divided into three basic categories: individual characteristics, social bonding and healthy beliefs that include clear standards for behavior (Hawkins et al., 1992, Werner & Smith, 1992). Individual characteristics include a positive social orientation, high intelligence and a resilient temperament. Social bonding includes warm, nurturing relationships and commitment to conventional behavior and can take place in the community, family, school and peer domains. Garmezy

divides protective factors into three categories based on proximity to the person (1985): (1)individual or dispositional attributes, such as a resilient temperament and high self-efficacy; (2) family attributes, including parental support and nurturing interactions; (3) extrafamilial circumstances, such as support from adults outside the family and strong community bonds.

How protection works.

Two mechanisms (figure 5) have been proposed to explain how protective factors affect outcomes (Brook, Brook, Gordon, Whiteman, & et al., 1990). In the risk/protective model, the protective factor moderates the negative effects of the risk factor. For example, Brook, Nomure, and Cohen (1989) found that assertiveness and high self-esteem protected adolescent girls from the detrimental influence of parental conflict, a known risk factor, on the girl's depressive moods. They also found that a harmonious and organized school environment (protective factor) interacted with peer substance abuse (risk factor) to curb the adolescent use of alcohol, cigarettes and marijuana. In the protective/protective model, protective factors boost the protective effects of variables linked to decreases in negative outcomes. For example, the time female college students spent with their father (protective factor) increased the female's responsibility, assertiveness and parental identification, which predicted low levels of depression (Brook, Whiteman, Gordon, & Cohen, 1986). Also, in a study of Native American youth, cultural identity enhanced the self-esteem and predicted lower alcohol and other substance abuse (Zimmerman, Ramirez, Washienko, Walter, & Dyer, 1998).

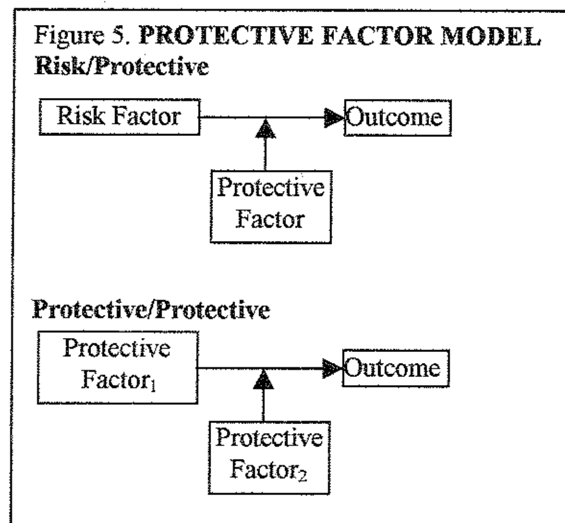


Figure 5. **PROTECTIVE FACTOR MODEL**

Rutter (1979) advocates a more precise definition of a protective factor (figure 5a). It isn't enough for a protective factor to be "good" for development;

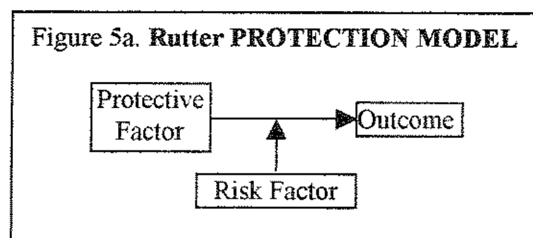
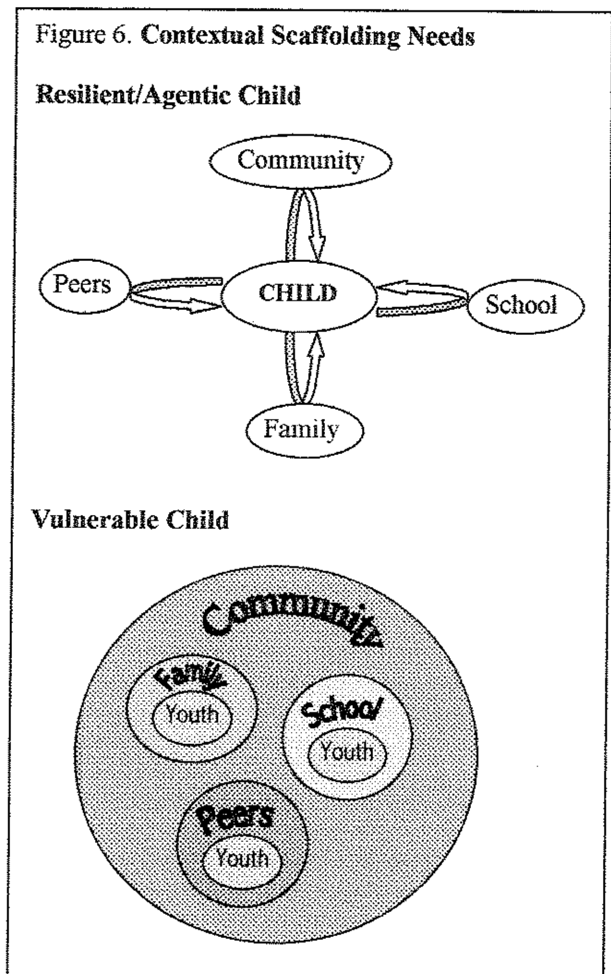


Figure 5a. **Rutter PROTECTION MODEL**

protective factors only truly exist in the presence of risk because risk is required to trigger or activate the potential of the protective factor. A protective factor is like a small pox immunization, if the immunized person is never exposed to small pox, the risk factor, the immunization does not serve a protective function.

The Rochester Child Resilience Project (Cowen, Work, & Wyman, 1997) is an example of research based on the protective factor model. RCRP is a longitudinal study of poor and good adjustment of children confronted with major life stresses in an urban setting. Children included in the study were experiencing an average of eight to nine major stresses. Examples of the life events or circumstances ranged from the death of a parent to lack of food. The most sensitive predictors based on parent responses were positive parental views of the child, open-ended estimates of the child's future, sum of the caregiver's negative attitudes, parent's childhood influences on care giving practices, discipline style, preschool parent-child relationship and child temperament. The RCRP project focused on young children and it is no surprise that parents or caretakers play an important role in how well their children adapt. From my perspective, the project demonstrates the primary importance of the child's temperament in the early years of life. Children born with resilient temperaments have more agency in interacting with their world (Figure 6). They are more capable of extracting elements necessary for healthy development from environments with meager resources. Less agentic, or vulnerable children, must be embedded in a healthy context in order for healthy development to occur.

Figure 6. **Contextual Scaffolding Needs**



This theoretical distinction is important because one of the debates in the field is whether resiliency resides inside the person or is a product of the person-environment interaction. The implications for prevention efforts includes whether focus should be on adaptive change in individuals or whether the focus should be on creating healthy contexts for development. If resilient children are adept at extracting resources from depleted contexts, was the resiliency present at birth or was it created through a developmental process of interacting with the environmental context. Given the limitations of being effective in intervening at the genetic level, it seems that the best strategy for enhancing resiliency would focus creating healthy contexts for all children and therefore assist them in becoming more agentic in meeting their needs.

RESILIENCY BASED PREVENTION

Risk and protective factors explain much of the variance in positive and negative outcomes. Much of the research in this area has been survey research with the goal of understanding the antecedents of problem behavior in order to identify and help at risk youth before serious problems arise. Many researchers believe various adolescent problem behaviors originate from a general deviance syndrome (Jessor & Jessor, 1977) meaning adolescents tend to engage in several problem behaviors not just one. The early warning signs can be traced to early childhood antisocial behavior that intensifies and diversifies as they approach adolescence. Also, the more risk factors a child is exposed too, the greater the chances of problem behaviors.

Resiliency/Risk Intervention Model

The resiliency/risk model (figure 7), with it's focus on the interaction between risk and protective factors in predicting outcomes, helped shifted the field of prevention away from high risk behavior approaches to identifying the precursors of high

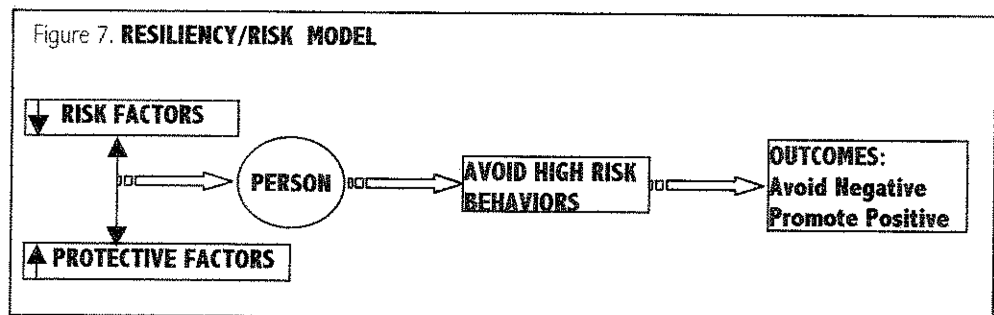


Figure 7. **RESILIENCY/RISK MODEL**

risk behaviors. Focusing on resiliency in unfavorable contexts allowed researchers to make recommendations to policy makers about programs that would be useful in assisting youth in coping with disadvantaged environments. This new way of thinking about preventions targets risk factors or antecedents of the high-risk behaviors rather than the behaviors themselves. Researchers studying risk and resiliency were able to explain more variance in outcomes when considering the number of risk factors in the child's life (Rutter, 1979). Counting the number of risk factors could then identify youth at risk and target them for intervention efforts.

Prevention researchers found that many problem behaviors have common antecedents or risk factors. Risk factors (Dryfoos, 1990) categorized the antecedents for the high-risk behaviors leading to delinquency, substance abuse, teenage pregnancy and school dropout into four main categories: demographics, personal, family and community. In this model, prevention strategies would be designed to influence each of the four categories of antecedents simultaneously. Programs would address unchangeable antecedent demographic variables, namely age and sex, by being designed appropriately for each variable. Jessor (1977) reframed the thinking on clustering adolescent high-risk behaviors and reframing them as adolescent lifestyles shaped future research in this direction.

Increase Protection or Decrease Risk?

Recently some researchers have argued that (Benson, 1997) targeting risk factors places too much focus on deficits and prevention research instead should view youth as resources and focus on building assets to support them. The researchers assume that building protective factors alone will produce more positive outcomes than focusing on risk factors. Pollard et al. (1999) tested this assumption and found prevention efforts are most effective at reducing negative outcomes when risk factors are reduced in addition to promoting protective factors. Jessor and colleagues (1997) also tested the importance of protective factors and found risk factors have a stronger relationship to problem behaviors than protective factors. However, protective factors have a stronger relationship to change in problem behaviors than do risk factors. Research on risk and protective factors suggests the relationship between the two is

orthogonal rather than protection merely being on the opposite end of the risk continuum. Also, focusing solely on increasing protective factors is not adequate to reduce negative outcomes.

Issues with resiliency/risk models

One problem with resiliency/risk model is the assumption that the absence of negative outcomes, such as teenage pregnancy, substance abuse, school dropout, etc…, is equivalent to healthy development. Luthar and Zigler (1991) noted that resiliency in one life domain doesn't necessarily translate to other domains. A child may show resiliency to parental conflict in positive school outcomes, but may not be resilient in social relationship outcomes. Prevention models based on resiliency have focused on only specific negative outcomes and deemed youth that avoid the selected outcomes as having achieved healthy development. A gap exists in prevention research because of its focus on the prevention of negative outcomes rather than promoting positive outcomes. It may be protective factors exert indirect rather than direct effects on problem behaviors. In other words, increasing protective factors increases the likelihood of positive outcomes, which in turn decreases problem behaviors and outcomes. This model has not been tested in the literature, but may also be too simplistic to explain the complexity of intrapersonal and contextual influences on development. The emerging field of positive youth development presents an opportunity to link developmental theory with prevention science to explain the mechanisms of positive development and provide guidance for creating future interventions that view youth development through a resource rather than a deficiency lens. The National Youth Development Information Center (1999) states, "Positive youth development addresses the broader developmental needs of youth, in contrast to deficit-based models which focus solely on youth problems."

POSITIVE YOUTH DEVELOPMENT

The predictors of resiliency are strongly associated with aspects of psychological well-being. Ryff and Singer (1998) offer a model of well-being that moves beyond the current idea of health, whether speaking of physical or psychological health, as meaning an absence of illness. The core features in their model of human health include leading a purposeful life and having quality connections to others. Also,

Baumeister and Leary (1995) propose the need to belong is a fundamental human motivation fulfilled by long term frequent and caring interactions with others. Looking back at the RCRP project, the most sensitive predictors of resiliency in children were global self-worth, empathy, realistic control attributions, social problem-solving skills and self-esteem. One does not have to stretch too far to see a connection between the resilient child and the adult who leads a purposeful life and has quality connections to others. Certainly high global self-worth, empathy, social problem-solving skills, realistic control attributions and self-esteem are qualities that nourish quality connections to others and would help one achieve a sense of purpose in life. Resiliency and psychological well-being research can guide prevention efforts to promote positive youth development.

The importance of belonging in prevention efforts is demonstrated in prevention research. Hawkins and Weis (1985) proposed the "social development model" which states strong social bonds to others role modeling prosocial behaviors in childhood is necessary for healthy development. Based on this theory their prevention model entails three types of interventions to help children identified as high risk: 1. Create opportunities for positive family, school, community and peer interactions, 2. Help children acquire social, cognitive and behavioral skills to enhance their successful in the social groups, and 3. Provide consistent rewards to reinforce prosocial behavior. Botvin (1985) believes adolescent high-risk behaviors stem from a combination of influences, including parental, peer, media, personality characteristics and values. The goal of his prevention model is to teach adolescents coping skills to deal with the social influences. A common element in each of these theories is the important of multidimensional approaches that target family, school and community, i.e. the context of the developing individual. The focus on family, school and community could also be framed as addressing the lack of opportunity to establish belonging and purpose in life.

Youth Development Models

Youth Development was a precursor to the Positive Youth Development approach. The resiliency model focuses on youth at risk for negative outcomes because of unfavorable conditions, which create a lack of

fit between the individual and their environment. Youth development adds the philosophy of seeing youth as a resource and of seeking positive outcomes to the process of youth development. The guiding principle in the application of positive youth development in prevention research is to create environments that will assist youth in achieving positive outcomes. The youth development models place resiliency outside the individual and into the context. This view, however, gives the individual less agency in their developmental process and places resiliency outside the individual.

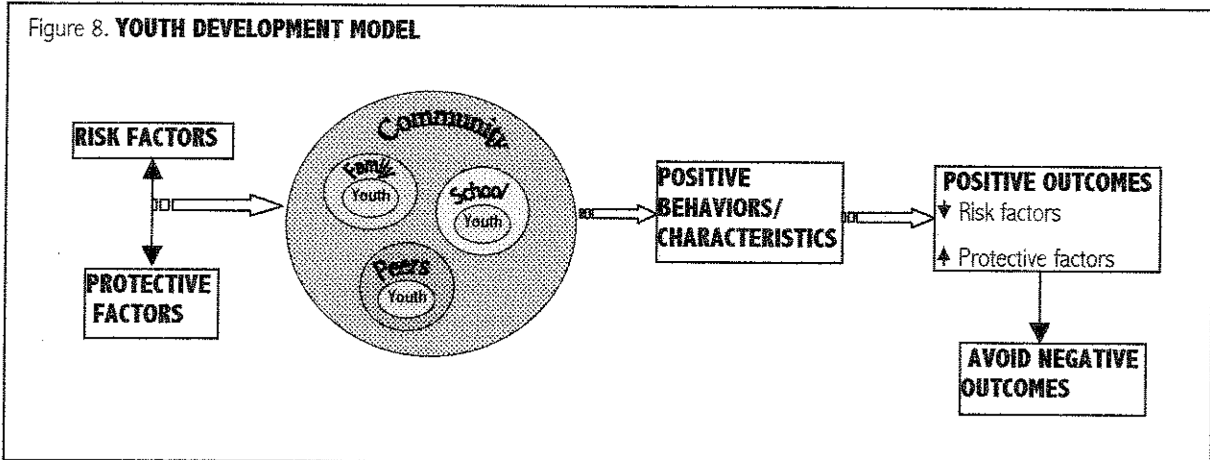
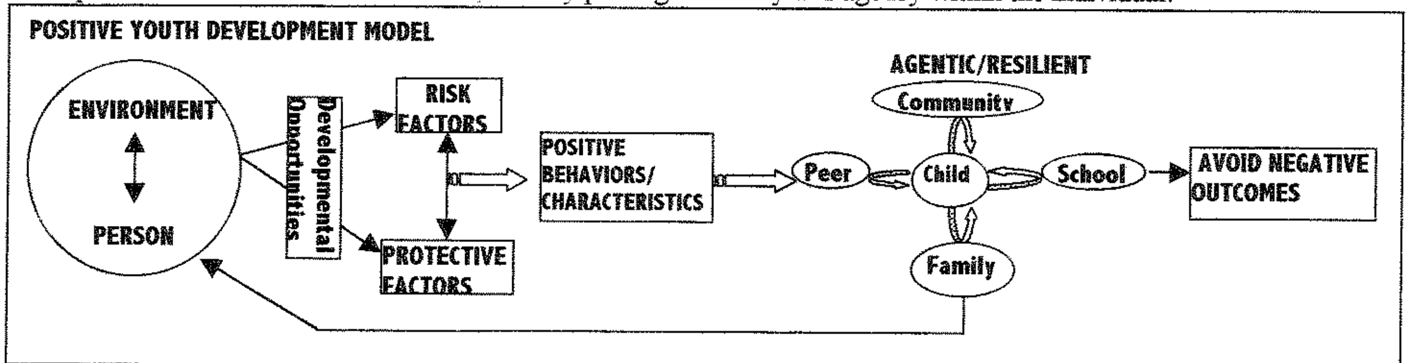


Figure 8. **YOUTH DEVELOPMENT MODEL**

Positive Youth Development

The goal of positive youth development (Figure 9) is to foster resiliency and agency that resides in the individual. With contextual support, the internal risk factors can be decreased and the internal protective factors can be increased, thereby placing resiliency and agency within the individual.



POSITIVE YOUTH DEVELOPMENT MODEL

Great Transitions (1995), addressed positive youth development by attempting to answer the following questions. What does it take to become a healthy, problem-solving, constructive adult? What

kinds of experiences during adolescence are helpful in the transition from childhood to adulthood? The report outlined the essential requirements for positive youth development. "Ideally, all adolescents must:

- Find a valued place in a constructive group.
- Learn how to form close, durable human relationships.
- Feel a sense of worth as a person.
- Achieve a reliable basis for making informed, deliberate decisions especially on matters that have large consequences, such as educational futures.
- Know how to use available support systems.
- Find ways of being useful to others beyond the self.
- Believe in a promising future with real opportunities.
- Cultivate the inquiring and problem-solving habits of mind for lifelong learning and adaptability.
- Learn respect for democratic values and understand responsible citizenship.
- Build a healthy lifestyle. "

The report also states that no one social institution, i.e. family, school, etc… can help youth attain this list alone. Positive youth development requires "the concerted efforts of all the frontline institutions not only families, but schools, health care providers, the media, and community organizations, particularly sports and sports organizations that influence youths and the choices they make almost daily."

The Social Development Research Group at the University of Washington (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 1999) reviewed the research findings on positive youth development programs and came up with following list of constructs to define positive youth development:

- Promotes bonding
- Fosters resilience
- Promotes social, emotional, cognitive, behavioral and moral competence
- Fosters self-determination, spirituality, self-efficacy, clear and positive identity and belief in the future
- Provides recognition for positive behavior, opportunities for prosocial involvement
- Fosters prosocial norms

A list very similar list to the Great Transitions report that most people in the field can agree is important in achieving positive youth development.

Obstacles for the field of positive youth development

If most people agree with the critical elements of positive youth development, as well as the multidimensional approach required to achieve it, why aren't all prevention programs based on this model? One obvious obstacle is funding. Unfortunately, funding sources are not as interested in funding programs with positive outcomes when there is a perceived crisis in the number of adolescents with

negative outcomes. It is difficult to take the next step back, even beyond antecedents of high risk behavior, to give attention to what children and adolescents need for healthy development even if the focus on healthy development would envelop and solve the issues of unhealthy development. Grant proposals interested in positive youth development must couch their request in terms of avoiding negative outcomes and therefore continue to be locked in a deficit model of development.

Catalano and colleagues (1999) list three challenges for positive youth development. One, shared definitions of the constructs of positive youth development must be established. Two, better evaluations of programs that search to promote positive development. Finally, a theoretical framework and empirical evidence for understanding why a focus on positive development would also prevent high-risk behaviors will be necessary. The interdisciplinary assumption that a positive youth development approach will promote healthy behavior as well as prevent problem behaviors is not enough. The mechanisms underlying the assumptions must be understood to validate the claim.

Limitations and New Trends for Positive Youth Development (New Model)

While positive youth development models are a step in the right direction, the mechanisms of positive development must be better understood to more fully support the positive development of youth. The current additive model of does not explain the complex nature of the interaction between the person and the environment, nor does it explain how positive outcomes result from the developmental process. Combing the ecological developmental approach with prevention science will move the field of positive youth development forward. Furstenberg et al. 99 characterizes positive outcomes for adolescents as the "acquisition of the skills and competencies that lead to physical and mental health, social involvement, and economic self-sufficiency and productivity in adulthood. The protective factors required for positive outcomes grow out of opportunities in the environment to "(1) acquire cognitive skills and resources to become educated to highest potential; (2) accumulate psychological and social skills that foster a positive identity, including a personal sense of well-being and self-efficacy; and (3) participate in activities that foster a capacity to perform as family members, workers, and informed citizens in their communities." This perspective takes into account the interactions or fit between the individual and their environment in

understanding risk and protective factors (Bronfenbrenner, 1979; Eccles, Midgley, Wigfield, Buchanan, & et al., 1993). The goal of prevention from an ecological perspective is to provide a better fit between the individual and the environment to support the individual's developmental process.

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