

## **Resilience in a Life Course Perspective: Reflections on research and life**

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Thank you very much. I cannot express how deeply thankful and grateful I am for this professional recognition. My thanks in particular to Hani Atrash for nominating me, as well as other colleagues such as Sara Rosenbaum and Jaime Resnick, and past MME awardees Debbie Klein Walker and Milt Kotelchuck, for their moving letters of nomination.

As I accept this award, in the time allowed today, I'd like to talk to you about a life course perspective on risk and resilience. What I am going to share is based on both my own trajectory and 40 years of research on these topics.

Over the past thirty years of professional life, my personal narrative has been simplified, fine-tuned in presentation to various audiences. My own story has motivated me to advocate for poor, vulnerable, and at-risk children, and it has served as a powerful illustration of why investment in every child is important to our society. My family was poor, living below 50% of the poverty level, and my family had been poor over generations in the South, with my parents moving north from the Ozarks in the late 1930s to pick fruit in Michigan.

I am the only one of my mother's five children to graduate from high school and the only one who was not a teen parent. As I will show you, my adverse childhood experiences (or ACE) score is high (5), which is today true for in estimated one in 8 adults. By the time I graduated from college, I wondered why I was a survivor, why I had succeeded academically. The easy answer from most of my middle-class friends and colleagues was that I was "smarter," but this explanation did not

fit with my experience of my siblings. The answer was, I am now convinced, resilience and the interplay of risk and protective factors that helped me to succeed.

Resilience refers to a dynamic process encompassing positive adaptation in the context of significant adversity. Implicit within the concept of resilience are two critical conditions: 1) exposure to significant threat or severe adversity; and 2) the achievement of positive adaptation despite major assaults on the developmental process. As eloquently described by Almedom and Glandon, “resilience is not the absence of PTSD any more than health is the absence of disease.”

Design of longitudinal studies of resilience may have started around 1953, the year I was born. The children of Kauai studied by Werner were born in 1955. By the 1970s, other researchers were documenting the role of resilience in helping vulnerable children be more invincible to risk factors. As a graduate student, I read and then met and listened to lectures by Michael Rutter. I read and reread the work of Werner and her colleagues. The work of Sameroff and Garmezy added to my understanding.

The literature has grown since that time. During recent years, the focus of research has shifted away from identifying the personal qualities of “resilient children” toward understanding how protective and risk processes are operating in an ecological context, particularly at the level of the community and social supports, the family, and the child. More recent studies also tell us that boys and children of color face greater hurdles. As research on resilience has evolved, it has become clear that positive adaptation in the face of significant adversity involves a developmental progression over the life course. This more extensive literature gave me a basis for understanding how the combination of me, my family, and the environment, with critical support from public programs shaped my trajectory.

So let me show and tell you more about my own trajectory. I've created graphs that actually score and plot my developmental trajectory. This first slide summarizes my trajectory over my life. As you can see, a variety of risk and protective factors led to a varied trend but ultimately to an upward outcome.

## **Early childhood**

- In my early childhood years, I experienced multiple risks and traumas. While born healthy, my mother's depression and reactions to her own childhood traumas affected me from the start. Brain cancer led to the death of my father by the time I was three. During his illness, I lived for months with a stable and well-functioning family who would provide a long-term set of protective experiences. My siblings were 10-17 years older than me, so they were able and willing to provide nurturing support, including making me an early reader. A Kindergarten experience with 12 substitute teachers in a rat-infested school was not, however, an optimal start to my formal education.
- With the exception of income support from Social Security Survivor benefits, few public policy and program supports were available in my 1950s early childhood in the rust belt of Indiana. I've listed programs and policies I believe might have helped me. Thanks to federal policy action many of these are available to children today. But with state and community variations, there are gaps. Notably, quality child care, adequate wages, home visiting, and early childhood mental health services are not routinely available to young children living in my hometown today.

## **Middle childhood**

- In my middle childhood years, new risks, traumas and protective factors emerged. A step-father who was an effective and nurturing parent came into my life for a few years. We moved to a good neighborhood, and I attended a high quality elementary school. Recognizing my interests, my mother made sure books were available. Neighbors, family friends, and others made sure I was able to attend Girl Scouts and church while my mother worked as a waitress. But, baby bottle tooth decay without adequate treatment led to loss of my front teeth by age 9. Sexual abuse began shortly thereafter. These, in turn, led to obesity and bullying in late elementary school. A move to New Mexico for 6 months to live with an adult sister again brought me into a nurturing and organized family setting. With exercise and diet changes there, I was able to enter adolescence at a healthy weight, with a lifetime commitment to exercise. Despite my resistance and without parental intervention, a remarkable middle -school principal insisted that I be moved into a college prep track. I did not want to be in classes with wealthy and smart kids, preferring to stay with those familiar from my home context, but it was a critical positive turn in my life.
- From a program and policy perspective, access to health, mental health, and dental care would have made an enormous difference. Afterschool care, school lunch, and a more accessible library would have been positive additions.

## Adolescence

- As shown in various studies, the multiple risks and traumas of early years began to be reflected in adverse outcomes by the time I reached adolescence. In my teen years, I was depressed and engaged in multiple high risk behaviors. (As I once said in a speech to the Society for Adolescent Medicine – think of all the typical risks and you would have those on my list). My siblings again contributed, making sure that I was using contraception to avoid the experiences they'd had as teen parents. In 11<sup>th</sup> grade, a high school teacher, Mr. Delos Lonzo, saved me from being expelled due to too many absences and mentored me toward college applications, SATs, and attendance at a small, supportive college. No one else in my family / community life was in a position to do that, and it would not have happened without him. In college, I thrived in an environment of the late 1970s where many rejected social class boundaries and social activism was valued. I also had an opportunity to spend my junior year in France, where my experience of the world widened.
- Yet again there were unmet program and policy needs. The routine health care and community supports I needed were not available, particularly in Indiana which implemented Medicaid and its child health benefit EPSDT long after other states. Also, for first-in-family college attendees, we now know how critical it is to have mentoring and supports both in high school and during college. I was lucky, but this should not be left to chance.

## Adulthood

- Positive shifts in life trajectories in adult life are also shown in studies of resilience and vulnerability, with opportunities in the 3<sup>rd</sup> and 4<sup>th</sup> decade of life leading to enduring positive changes. This was the case for me. A federal program permitted me to work off my small student loans. To obtain masters degrees, I was able to attend affordable public universities, saving and paying with a minimum wage job in child care. Two special public health MCH mentors helped open doors to enduring positive changes.
  - Dr. C. Arden Miller was pivotal in a process that changed my life from a minimum wage child care worker to an MCH professional and advocate. He raised his voice to overcome faculty objections to my acceptance into the UNC MCH department, seeing perhaps in me another young person who wanted, as he had, upward mobility from meager circumstances and a career that would do good. His confidence in me, in my ability to use my voice as an advocate for maternal and child health, provided the “water wings” I needed to start swimming in national policy. The year I went to Washington, in 1984, Dr. Miller received the Martha May Eliot Award from the American Public Health Association. Thirty years later, as I prepare to accept the same award, I can think of no one who deserves more credit for launching my MCH career than the late Dr. Miller.
  - Another work/life mentor, Sara Rosenbaum, equally had confidence in my potential and provided the coaching in policy, advocacy, writing, and speaking I would need to fulfill my career goals. Few in large national organizations are willing to nurture students and young staff in this way, yet Sara truly does. While I was the first to benefit from her support, Sara has mentored dozens of others from low-income backgrounds – these individuals are MCH professionals, lawyers, and public health policy leaders working across the nation.

- In my young adult years when I was uninsured, the availability of federally funded family planning clinics and federally qualified health centers made it possible for me to obtain needed primary care. Yet program and policy constraints, along with a recession at the time I graduated from college put another damper on my trajectory. For me and for millions of young adults graduating from high school and college in recent years, a major recession has been shown in economic studies to depress lifelong earnings. I also was unable to complete PhD studies due to a requirement for full-time attendance at a point when I could not afford to quit my job.

In the interest of time, let me summarize how research has identified factors associated with resilient functioning. Many of these factors appear indeed to have influenced my life, to explain my “resilience”. These factors are often described in terms of three clusters:

1. ***Protective factors within the individual***, such as:

- a. Sociable temperament, with self-regulation and coping abilities;
- b. Language, communication and problem-solving skills,
- c. Planning skills and a future orientation (linked to executive function), with motivation to be effective in the environment (i.e., self-efficacy and self-determination)
- d. Friendships and romantic attachments with prosocial and well-regulated peers

2. ***Protective factors in the family***

- a. Close relationships with competent and caring adults in the family and community, in particular having at least one person in their lives who accepted them unconditionally

3. ***Protective factors in the community***

- a. Reliance on the community for positive support
- b. Experiences of competence in a larger domain.

Studies also point to “staged recovery” in adult life, with positive shifts after high school and opportunities in the 3<sup>rd</sup> and 4<sup>th</sup> decade of life that lead to enduring positive changes. These often come in the form of advanced education, work opportunities, or marriage to a stable and nurturing partner. Research tells us, however, that interventions to support mental health recovery from ACE is crucial to making these opportunities meaningful and lasting.

### **MCH Leaders Taking Action**

For the field of maternal and child health and public health professionals I believe there are some key opportunities. First, we need to integrate the concept of resilience as we embrace the life course perspective. Measuring scores for adverse childhood events (ACEs), defining toxic stress, drawings of better or worse trajectories, and tallying disparities are ways to document the challenges; however, they do not comprise the approaches we need to implement in order to make a difference in children’s lives.

We also must avoid a “deterministic” tone in our work on life course and its trajectories. While some people, such as me, are able and willing to use our experiences as illustrations, not all affected are visible. We should pay attention to the fact that many who have overcome the odds are silently working among us and avoid “us and them” language.

Second, we need to align our work to promote resilience in the context of social determinants of health. Conceptual frameworks for social determinants and resilience have notable commonalities and can be aligned. Understanding the processes, programs, and policies that may contribute to resilience and improved developmental trajectories under conditions of adversity, including social determinants of health, may be critical to our understanding of how to improve outcomes, of what combination of interventions work. Assuring equity may require such alignment in perspectives and frameworks.

Third grounding our public policy agenda and advocacy in the knowledge I've discussed is critical. As Werner said two decades ago: "*Our findings alert us to the need for setting priorities, to choices we must make in our investment of resources and time.*" (Werner 1993, p. 512) Federal, state, and local investments in evidence-based home visiting are a step in the right direction. Insistence on quality early care and education is another. Emphasis on improving the health and well-being of women before and beyond pregnancy is another, including both health and mental health. The interest in supporting the transition from youth to adulthood for those with special health care needs and disabilities is yet another. But focused and coordinated action is needed, such as that in the project on "*Addressing Adverse Childhood Experiences*" supported by CAHMI and AcademyHealth and led by Christy Bethell.

Last but not least, we need to mentor students and young professionals from disadvantaged backgrounds, following the examples set by Arden Miller, Sara Rosenbaum, Jack Dillenberg, Mario Drummonds and others.

Maternal and child health leaders must do more to shape future policies and programs armed not only with the life course perspective, the social determinants of health framework, and an enduring commitment to equity, but equally with knowledge of the concept of resilience. The well-being of future generations depends on it.

Thank you for the honor of this award and your willingness to listen today.

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