A resilience-focused conceptual framework for working with school-related problems

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A resilience-focused paradigm based on the research evidence on positive social and academic adjustment is delineated as an alternative to the psychobiological paradigm currently guiding DSM and Special Education practices. This alternative conceptual framework is intended to assist counselors in working collaboratively with parents and school professionals so as to promote positive psychosocial, behavioral, and learning outcomes. The model is applicable in both family counseling and school based counseling and consultation settings.

The dominant paradigm's emphasis on diagnostic labeling and subsequent symptom reduction or control is replaced by the resilience paradigm's focus on success and wellbeing promotion. The resilience-focused counseling and consultation process offers an optimistic, developmental, and wellness-promoting approach for assessment and intervention with school related problems. The model seeks to empower parents, teachers, and children alike so as to promote resilience and wellbeing rather than label children as possessing psycho-educational disorders. The underlying assumption of the resilience paradigm is that positive growth and development can only occur in healthy, nurturing social environments. Utilizing the resilience-focused approach, counselors seek to identify counter-productive patterns in the family and classroom, and then offer strategies that promote wellbeing and positive growth and adjustment by improving social-emotional competencies, family and school supportiveness, and growth mindsets.

Keywords: Resilience, family development, mindsets, social-emotional, family tasks, school counseling, family counseling.

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Introduction
The School-Based Family Counseling (SBFC) model is rooted in the early 1920's work of Alfred Adler in the schools of Vienna (Gerrard, 2008). A fundamental component of Adler's Individual Psychology is the emphasis on increasing mental health rather than eliminating or decreasing psychopathology, "*The patient must be guided away from himself, toward productivity for others; he must be educated toward social interest*" (Ansbacher & Ansbacher, 1979, p. 200). Adler further suggested that the honest and ethical therapist is bound to social advocacy and the striving to change those conditions which adversely impact on the healthy social-emotional development of the individual (Ansbacher, 1992). This emphasis on a wellness promoting, humanistic, systemic-based and developmental paradigm led logically to his efforts to establish preventive services in mental health, focusing on parents and teachers. Alfred Adler, and later Rudolf Dreikurs, began establishing Education Counseling Centers in schools and Child Guidance Centers in the communities of Austria and the United States. The goal was to prevent or provide early intervention for children's learning and behavioral difficulties by developing more positive, supportive home and school environments.

The SBFC model has continually sought to extend the early work of Adler by offering, as noted by Gerrard (2008), a broad based, systemic meta-model that conceptualizes children's problems within the context of his or her social network of family, peer group, classroom, school, and community settings. An extensive body of research has now emerged affirming the importance of the SBFC meta-model. Adverse Childhood Experiences (ACE's) in the home and community have been found to be associated with significantly higher rates of learning difficulties, mental disorders, and personal or behavioral adjustment problems for both children and adults (Anda et. al., 2006). Living in high stress family and community environments appears to result, over time, in an adverse impact on the executive functioning processes of the brain (learning, memory, problem solving, etc.), and leads to social-emotional and behavioral adjustment difficulties. Fortunately, the same research also indicates that with the provision of safe, supportive environments and training in emotional self-regulation, (e.g. social-emotional competencies) this process can be effectively reversed.

The SBFC model has long noted that the vast majority of children referred for school problems are found to also have significant problems at home (Gerrard, 2008). The common practice of referring children and families out to receive counseling in community agencies simply does not work. An early study by Conti (1971) noted that only 31% of school referred families actually contacted the agency and only 8% continued beyond two sessions. The SBFC model has consistently called for integrating school and family counseling to address this problem (Crespi & Hughes, 2004; Crespi, Gustafson & Borges, 2006; Friesen, 1976; Hinkle, 1993; Hinkle & Wells, 1995; Nicoll, 1984a, 1992, 2002; Stinchfield, 2004). Yet, despite the research supporting the SBFC model, both the school counseling and family counseling fields continue to resist any movement toward this integrative and more systemic paradigm. What accounts for this resistance to SBFC?

Rethinking our paradigm
One of the primary obstacles confronting advocacy for the SBFC approach continues to be the reliance of the mental health and education fields upon the dominant DSM paradigm (Gerrard, 2008). Over these past several decades, both fields have moved increasingly toward this psychobiological paradigm for explaining child and adolescent learning and behavioral adjustment

difficulties. This paradigm assumes that the etiology of presenting behavioral or learning difficulties lies in some nebulous, neurological deficit, disorder, or dysfunction within the child. This has become the dominant explanatory paradigm guiding education and mental health practice. Yet, there does not exist sufficient empirical research evidence supporting the validity of such diagnoses and existence of any biological or neurological pathogen. The rush to diagnose, or over-diagnose, disorders and disabilities in youth has potentially disastrous consequences. As noted recently by Dr. Allen Frances (2014), chair of the DSM-IV-TR task force, in his article, "No Child Left Undiagnosed", it is estimated that, using the current DSM-V criteria, 81% of youth qualify for a diagnosis for a mental or learning disorder by the age of twenty-one.

By implying that the cause of the problem(s), or disorders, lies within the child, the psychobiological paradigm essentially ignores a multitude of social environmental factors, social interaction patterns, and developmental processes that contribute to the development and maintenance of children's learning and behavioral difficulties. Consequently, all children and adolescents presenting with similar symptomatic concerns are given the same diagnostic label and treatment intervention. Accordingly, intervention or treatment plans focus only upon symptom reduction and symptom control strategies; primarily involving the prescribing of psychopharmacological medications, and/or the application of behavioral psychology-based methods.

Perhaps of even greater concern is that the psychobiological paradigm leaves the child, parents, and teachers all believing there is some permanent, neurological dysfunction, deficit, or disorder causing the difficulties. Thus, a pessimistic, self-fulfilling "fixed mindset" perspective is formed with regard to the child's potential for success. The resilience-focused paradigm offers an alternative developmental perspective, an optimistic approach that seeks to promote improvement via the development of positive psychosocial adjustment, learning motivation, and overall wellbeing of the child as well as the family and classroom systems.

The emerging resilience-focused paradigm
In recent years, this dominant, psychobiological paradigm has been increasingly called into question. Many authors have raised concerns due to the lack of solid empirical support for the tacit assumptions underlying the paradigm and the diagnostic reliability and validity of many child and adolescent disorders. Additionally, the efficacy of current behavioral and pharmacological treatment protocols are being questioned (Breggin, 2001; Deci, Koestner & Ryan, 2001; Montcrief, 2009; Waber, 2011; Whitaker, 2011). Indeed, a countermovement is clearly building in response to the dominant, pathology based, psychobiological paradigm for learning difficulties and emotional and behavioral disorders, i.e. the resilience-focused paradigm.

Based on a rapidly growing body of research on resilience and positive child development, the resilience-focused paradigm offers a positive, optimistic, and developmental alternative for the assessment of, and intervention with, learning and behavioral adjustment difficulties. Examples of this alternative perspective can be seen in the work on emotional intelligence (Salovey & Mayer, 1993; Elias & Arnold, 2006), positive psychology (Carr, 2011; Seligman, 2002; Seligman & Csikszentmihalyi, 2000), social-emotional learning (Elias et al., 1997; Zins et al., 2004) as well as other resilience or strengths-based models in counseling and education.

The resilience-focused paradigm offers a more affirming and optimistic perspective by viewing children's learning and social-behavioral difficulties as arising out of a cascade of difficulties or obstacles in their psychosocial development (Benard, 2004). Presenting learning, social-emotional, or behavioral concerns are thus understood as symptoms (i.e. developmental adjustment or coping strategies) which arise out of perceived adverse social environmental contexts and/or problem maintaining interactional processes (Anda et al., 2006; Waber, 2011). Similarly, in the medical field, physical symptoms are understood as being the body's adaptive response to some underlying problem. Symptoms are viewed not as the problem per se, but rather, as the body's attempted solutions to cope with, or rectify, an underlying biological problem. A cough (symptom), for example, is the body's attempt to free up and resolve the underlying problem of an obstruction in the trachea. So, too, a child's presenting school-related problem can be understood as his/her adaptive response (symptom) to an underlying developmental problem within the child's social environment(s). The strong association between adverse childhood experiences and subsequent child, adolescent and adult disorders offers considerable support for this alternate, resilience-focused paradigm.

This resilience-focused paradigm represents, in many ways, a Copernican Shift in counseling and education. Rather than asking the question, "*What is wrong with this child or adolescent*?", or "*What psychobiological disorder does he or she suffer from?",* the more appropriate and useful question posed is that of, "*What factors that contribute to the healthy social and academic development of youth and that lead them to become responsible, cooperative, productive, useful, well-adjusted and contributing members of society are missing in this child's primary social environments?"* Intervention can then focus upon infusing such wellness associated factors into the child's life experience. The resilience paradigm moves us toward the promotion of health, wellbeing, and positive psychosocial development in youth. Positive growth and development is sought rather than mere symptom control or reduction, through the facilitation of positive social-emotional and academic competencies within positive, supportive and empowering family and school environments.

By examining the characteristics of resilient, well-functioning youth along with the characteristics of consistently high functioning families, classrooms and schools, we have begun to understand the conditions necessary for both optimal learning and optimal social-emotional development to occur. The resilience-focused paradigm advocates for identifying where these positive factors are missing or lacking in the lives of those youth experiencing conflict, failure, and social-behavioral adjustment concerns. A more affirming, positive, and optimistic approach to intervention is thus offered. Instead of seeking to control or decrease problem behaviors, one seeks instead to find ways of infusing positive, growth oriented processes into the lives of at-risk youth. Everts (2008) has earlier described the application of such a supportive, resilience-based approach in SBFC for working with immigrant families to facilitate positive child and family adjustment and transition. The foundational assumption of the resilience-focused perspective is that the health and well-being of all living organisms requires, first and foremost, the presence of healthy, supportive environments!

Resilience research review
Over the past three decades, there has been a rapid growth of empirical research on, and interest in, the resilience paradigm. Resilience is defined here as the ability to set a positive, productive,

fulfilling and goal-oriented direction in life, while also being equipped to handle adversity, stress, difficulties, trauma, failures and setbacks in one's stride. It enables one to have the ability to 'bounce back' from such setbacks and adversity to continue moving forward in that positive direction. The concept of resilience offers what might be termed both a "social vaccine" immunizing youth from social adjustment difficulties and a "social-emotional antidote" for learning and behavioral symptoms already manifested in the lives of at-risk youth. Promoting resilience in youth has been found to not only lead to improved child/adolescent adjustment but also to be an effective method for preventing later life problems (Durlak, 2000; Masten & Coatsworth, 1998, Resnick et. al., 1997; Wyman et al, 1999). Research evidence now indicates that the development of resilient, successful youth appears to involve the presence of three primary and inter-related factors: firstly, the development of essential social-emotional competencies (Benard, 2004; Elias et. al., 1997; Elias & Arnold, 2006; Merrell & Gueldner, 2010); secondly, the presence of positive, protective and supportive social environments in the home, school and community (Benard, 2004; Tough, 2012) and thirdly, adult-child communication patterns which promote the development of a 'growth mindset' in children (Dweck, 2006; Larson, 2000).

Social-emotional competencies.
Social-emotional competencies such as compassion, responsiveness to others, empathy, communication, caring, and altruism have been consistently found to be important indicators of overall positive adjustment and psychosocial wellness (Englander-Golden et al., 2002; Luthar & Burak, 2000; Masten & Coatworth, 1998; Rein, McCraty & Atkinson, 1995; Werner & Smith, 1992, 2001). In a longitudinal study, Vaillant (2000) found altruism to be the highest form of social competence. Measures of adolescent problem solving skills, self-understanding and responsibility have been linked to resilience and better psychological and social adjustment in adulthood (Beardslee, 1997; Heppner & Lee, 2002; Luthar & Zigler, 1992; Schweinhart & Weikart, 1997; Watt et al., 1995).

Further studies have found individual responsibility, autonomy, humor, self-understanding and problem solving skills to be social-emotional competencies associated with positive personality development, resilience, and mental health (Heppner & Lee, 2002; McBroom, 2002; Higgins, 1994; Kumpfer, 1999; Vaillant, 2000). Studies also indicate that a sense of compassion for others and attitudes of hope and optimism are associated with mental, physical, social, emotional and spiritual well-being and, in addition, positively impact on one's immune system (Rein et al., 1995; Benson, 1996; Carver & Scheier, 2002; Peterson & Steen, 2002; Seligman, 2002; Snyder et al., 2002; Werner & Smith, 2001).

Social-emotional competence develops within the family, school and community environments. These competencies are taught via modeling by adults as well as via specific, conscious instruction by parents and teachers. Research further indicates that the long-term social and emotional adaptation, academic success and cognitive development of youth can be enhanced by opportunities for developing and strengthening their social-emotional competence (Diekstra & Gravesteijn, 2008; Payton et al., 2008). Nicoll (2011) has suggested five primary social-emotional competencies necessary for resilience and positive social and academic adjustment: understanding and respecting self and others, empathy, positive/constructive communication, cooperation, and social responsibility. Enhancing children's social-emotional competence has been demonstrated to significantly increase academic achievement and pro-social behavior.

Supportive family and classroom environments.
When plants or wildlife fail to thrive, we immediately look for the solution by investigating what toxins are present in, or what nutrients are missing from, their environment. Unfortunately, with children, we often ignore this environmental perspective. The dominant DSM and special education perspective is to immediately seek to offer some psychobiological explanation. In so doing, one effectively blames the victim. Attributing the problem to a presumed, pseudo-scientific and neurologically based disorder, dysfunction or disability, implies that the child "has" or "possesses" a biological disorder which in turn causes the learning or behavioral difficulty. Parents and teachers, therefore, have no responsibility for the etiology, maintenance, or reversal of the child's difficulties. However, much to the contrary, research evidence provides a clear indication that such school problems are often symptoms of developmental and social environment factors (Anda et. al, 2006; Waber, 2011). Children who succeed, and those who thrive despite other adversities in their lives, appear to do so largely due to their degree of personal resilience (Benard, 2004).

The development of resilience in youth is associated with certain characteristics of the social environments in which their lives are embedded. The most significant social environments for youth are those of family, school, classroom, and community (Benard, 2004). The National Research Council and the Institute of Medicine (Eccles & Gootman, 2002) concluded that supportive social relationships appear to serve as "critical mediums" of development providing the opportunity for the healthy physical, intellectual, psychological and social growth of youth. In addition, the parenting styles research has linked the authoritative/democratic parenting style with its focus on warmth/connection, guidance/regulation, psychological autonomy and responsibility as leading to the best developmental outcomes in terms of both academic and social-emotional development (Dornbusch et. al., 1987; Nicoll, 2002; Paulsen, Marchant & Rothlisberg, 1997).

The significance of family environment factors on children's academic achievement was highlighted in Good and Brophy's (1986) review of the literature on school effects. They summarized the research on factors associated with student achievement, by concluding that family factors account for more of the variance in student achievement than do all the curricular and instructional variables combined. Parenting styles have been consistently identified as significantly impacting on student success, both academically and socially. The authoritative parenting style has consistently been associated with higher achievement, better grades, higher aspirations, and better relationships with peers and authority figures, as well as decreased rates of behavioral adjustment problems such as substance abuse, mental disorders, and behavior difficulties (Dornbusch et al., 1987; Cohen & Rice, 1997; Herman et al., 1997; Shek, 1997).

The other three common parenting styles of permissive-indulgent, permissive-disengaged, and autocratic, have similarly been linked to poorer outcomes such as lower academic achievement and increased behavioral problems including bullying, delinquency, truancy and dropping-out. Finally, research evidence indicates that when schools actively promote parent-school collaboration the outcomes include higher grades, higher student achievement, improved teacher morale, better student attitudes toward school, fewer special education placements, higher graduation rates, and higher post-secondary enrollments (Henderson & Berla, 1995).

More recently, new research on the relationship between adverse childhood experiences (ACEs) and subsequent learning, behavioral, and mental disorders has called into question many of the neurological-based hypotheses for behavioral adjustment and learning problems. Anda et al. (2006) found that the greater the number and type of ACEs in one's early family life, the more likely the development of both learning and behavioral disorders in children and adolescents. A study by Burke et al. (2011) indicated that of those children with no ACEs (as measured by the ACE Questionnaire) only 3% displayed any indications of learning or behavior problems. However, 21% of those with ACE scores of 1 – 3 had been so diagnosed and of those with 4 or more ACEs, 51% had learning or behavior problems in school. Similarly, studies have found that the greater the number and type of ACEs in one's life the higher the probability of experiencing one or more mental or emotional disorders in adulthood (Lucenko et al., 2002; Danese et al., 2009). Identifying the presence of stress factors, maltreatment and trauma in the etiology of children and adolescents is thus essential in developing effective interventions.

Consistent with the family and parenting research findings, the school variable found to impact most on student success, is that of the teacher's classroom management or relationship style (Heck, 2007; Rivkin, Hanushek & Kain, 2005; Sanders & Horn, 1998). A large, multidisciplinary body of research has clearly established that positive, supportive student-teacher relationships are strongly associated with academic and social development outcomes (Wallace & Chhoun, 2014). The teacher's interpersonal relationship style determines the classroom climate which, in turn, has a profound impact upon student learning motivation, academic success, and social adjustment.

Teachers viewed by students as empathic, warm, friendly and having a genuine concern for the students as individuals have been associated with such student outcomes as better academic performance, higher learning motivation, more positive attitudes toward school and decreased behavior problems (Paulson, Marchant & Rothlisberg, 1997). Effective classroom teachers are found to employ a classroom leadership style consistent with the authoritative parenting approach. Such teachers create a classroom climate that focuses upon high caring with high expectations (i.e. belief in the student's ability to succeed), warmth-connection, guidance-regulation, and autonomy-responsibility (Benard, 2004). A teacher's interpersonal relationship style of caring, encouragement, and supportiveness is found to be predictive of student engagement in school, learning motivation, and academic achievement as well as positive social development (Goodenow, 1993; Jennings & Greenberg, 2009; McHugh et al., 2013; Murray-Harvey, 2010; Piant & Stuhlman, 2004). Adopting a broader, developmental and resilience-promoting paradigm in the assessment of, and intervention with, school-related problems invites a greater awareness of the role of family and classroom social environment factors in the child's presenting school problem.

Family and classroom environments as task performance groups.
We can view the family, classroom, and school social environments as task performance groups. The goal, or task, being to develop youth equipped with both the academic/occupational and the social-emotional competencies required to successfully fulfill their full complement of adult roles. The resilience paradigm utilizes an adaptation of Aldous' family developmental task criteria for assessing effective task performance groups (1978). Family and classroom functioning may be assessed along five dimensions necessary for optimal social-environment functioning. These are designated as the five maintenance tasks consisting of: physical and safety maintenance, life skills

maintenance, cohesion maintenance, behavioral maintenance, and boundary maintenance. Just as an automobile, household, lawn or garden requires consistent maintenance, so do families, classrooms, and school social environments need attending to on a daily basis. Well-functioning families, classrooms and schools will be found to address all five tasks in an effective and balanced manner. Those experiencing chronic conflict, stress, poor performance, and relational difficulties, on the other hand, will tend to be found to underperform, or improperly perform, on one or more of these five maintenance tasks.

Safety and physical maintenance

The safety and physical maintenance task refers to the need to provide for the basic physical needs of children such as food, clothing, and shelter. In addition, the safety of family members must also be considered; all children must feel they are physically, emotionally, psychologically, verbally and sexually safe in the home, in the classroom, and in the school. Protecting the safety of all children from abuse or maltreatment of any kind (e.g., physical, sexual, bullying, verbal abuse, threat, marginalization, or humiliation) is absolutely essential and must be of the utmost priority for the counselor in terms of both assessment and intervention.

Life skills maintenacne

The life skills maintenance task refers not only to teaching academic skills but also to the importance of training children in the social-emotional competencies necessary for successful functioning in all aspects of their lives (Nicoll, 2011). In high functioning families and classrooms these skills are not only directly taught but modeled as well by the behavior of parents and teachers. While the imparting of essential academic skills such as reading, mathematics, physical and social sciences, arts, and so forth are important, research now also indicates that social-emotional competencies are equally, if not even more, important for optimal development and life success. The resilience-focused conceptual framework focuses upon five essential social-emotional competencies: understanding and respecting self and others, empathy, positive/constructive communication, cooperation and responsibility contribution skills (Elias & Arnold, 2006; Nicoll, 2006, 2011; Zins et al, 2004). When parents and teachers fail to adequately train children in these social-emotional competencies or, as in some cases, actually model the opposite behaviors, academic and social adjustment difficulties and conflicts are likely to develop.

Cohesion maintenance

The third family and classroom maintenance task, cohesion maintenance, is of particular importance. The research on high functioning families, classrooms and schools has consistently found the variable of cohesion (i.e. belonging, engagement and connectedness) to be the most powerful predictor of positive outcomes (Otto, 1963; Fisher, Giblin & Hoopes, 1982; Stinnett, 1983; Nicoll, 1984b; Lam, 1997). Positive, supportive, and encouraging communication between and among all members is a dominant feature in supportive social environments (Dornbusch et al, 1987; Paulsen, Marchant & Rothlisberg, 1992; Niebuhr & Niebuhr, 1999; Weishen & Peng, 1993). It is only to the extent that parents and teachers adequately address this task that their ability to successfully function on the fourth task, behavioral maintenance (i.e., discipline), is possible. Most typically, however, parents and teachers will seek counseling assistance when they are already over-focused on behavior control strategies and have all but abandoned functioning on the cohesion maintenance task. Evidence suggests a minimal ratio of 5:1 between positive and negative parent-child or teacher-student interactions is required for minimal stability and

functionality of the family or classroom. The lower the ration the greater the problems (Fredrickson, 2009; Gottman, 1994, 2002).

Behavioral maintenance
Behavioral maintenance refers to the fact that in any family or classroom instances of inappropriate behaviors (misbehavior) will occur. Therefore, parents and teachers need to possess appropriate behavior management competencies or skills (aka: discipline) for correcting and re-directing problematic behavior. Unfortunately, neither parents nor teachers are typically trained in positive, effective behavior maintenance skills. In well-functioning families and classrooms, behavioral expectations are clearly established and behavior expectations maintained in a firm, fair, respectful and appropriate manner. Discipline is understood as involving an educational, not punitive, process with the use of logical consequences and choices to teach responsible, cooperative behavior (Albert, 2012; Hoy & Weinstein, 2006; Nelsen, 2013). While parents and teachers will typically enter counseling seeking assistance in this area, the counselor must keep in mind that strengthening family or classroom functioning in the cohesion maintenance task is a pre-requisite for initiating improved performance in the behavioral maintenance task. Only with improvement in the cohesion maintenance task can improved behavior management and social-emotional competencies be taught to both parents and teachers as needed.

Boundary maintenance
The fifth family and classroom maintenance task is that of boundary maintenance. Overly rigid or overly diffuse individual and subsystem boundaries frequently lead to problematic interaction patterns (Minuchin, 1974; 1992; Minuchin & Fishman, 1981; Walsh, 1993). It is essential that the individual privacy, autonomy and interests of all, adults and children/students alike, are respected (Aldous, 1978). Subsystem boundaries must be recognized and properly maintained, with parents, teachers and students each understanding their appropriate roles and responsibilities. Inappropriate subsystem boundaries (e.g. enmeshed/diffuse or rigid/controlling) often need to be addressed and re-aligned. Examples would include such dynamics as that of a parent aligning with a child against the other parent, parents blaming teachers, parents over-controlling or indulging ("doing-for") the child, or teachers assigning instructional or behavior control responsibility to the parents.

Mindsets: growth versus fixed
As noted by Benard (2004), Walsh (1998) and others, changing the life trajectories of youth to resilience and success begins with changing the beliefs and behaviors of the significant entourage of adults surrounding their lives. This involves first of all, changing the mindsets of parents and teachers. Carol Dweck's (2006) research regarding the effect of teacher and student mindsets on learning outcomes lends further support to this perspective. Dweck differentiates between two primary types of mindsets, the "fixed mindset" and the "growth mindset". The latter is associated with personal resilience and optimal academic success and social-emotional development.

A fixed mindset involves the assumption that certain qualities, characteristics, talents or abilities are innate and biologically determined. Thus, it is assumed that each student possesses a certain innate amount of intelligence, attending ability, motivation, academic potential and personality type or character (e.g., extrovert). A fixed mindset perspective adheres to the notion that qualities such as intelligence, talent, and motivation are contained within the individual's biological makeup and can therefore be measured and predict potential for academic success.

Students who perform well in class, i.e., for whom learning tasks are readily met with quick success, are assumed to be "smart" or "gifted". While those who struggle are assumed to possess "less intelligence", "lesser natural ability" or to be suffering from some form of neurologically based deficiency, disorder, or disability (e.g., attention deficit disorder, learning disorder or disability, conduct disorder, low intelligence), or some moral or character deficit in regard to motivation or attitude.

The fixed mindset perspective is at the very foundation of the psychobiological paradigm currently guiding Special Education (Exceptional Student Education) and Mental Health practices. It is a cultural-bound bias commonly shared among educators, parents and mental health professionals in much of western society. Despite the existence of a large body of research evidence questioning the validity and effectiveness of these fixed mindset assumptions, most educators continue to adhere to the tacit assumptions and practices of the traditional, fixed mindset-based special education paradigm. However, as Waber (2011) has noted in her book, *Rethinking Learning Disabilities,* the fact is that after over five decades of researching and employing the LD paradigm, experts have yet to reach consensus on what a learning disability is, how to determine if a child has one, and what to do about it. Further, Deci, Koestner & Ryan's (1999, 2001) meta-analysis of the research on behavioral-based reward systems for improving learning motivation and achievement, indicates that the approach actually adversely impacts on learning, leading to decreased learning motivation. Similar adverse effects have been found for many commonly employed educational practices such as retention in grade and ability grouping. The common denominator amongst these methods is their grounding in the fixed mindset paradigm.

By contrast, an individual with a growth mindset starts with the assumption that basic qualities such as intelligence, talent, motivation and creativity can be cultivated and developed through effort. Though we all differ in our initial talents, aptitudes, interests or personal temperaments, we can all change, grow and develop further through effort, training and experience within supportive, optimistic social environments. Individual potential is recognized as dependent upon numerous interacting factors, many of which can be cultivated, improved and may even compensate for difficulties in other areas of development. The growth mindset perspective is fundamental to fostering resilience in youth. Counselors employing a resilience-focused approach strive to move parents, teachers, and students to the adoption of an optimistic, developmental growth mindset perspective. This, in turn, fosters a positive, encouraging communication pattern within the child/student/parent triad, fostering resilience and optimal growth and development both socially and academically.

Summary
The resilience-focused conceptual framework provided in this article offers a much needed alternative to the dominant psychobiological perspective of the DSM/ICD and special education field. In addition, the research knowledge base supporting the assumptions of the resilience paradigm is far more substantial than that of the disorder/disability/dysfunction model so widely employed today with relatively poor outcomes. Counselors working with school-related problems might better serve children, families, and schools by seeking to assess the extent to which the resilience factors are present in the child's life first. Intervention would then focus on developing those areas which are either not adequately addressed or inappropriately addressed and thus serving to maintain, rather than resolve, the presenting school related issue(s).

School-based family counseling and consultation services grounded in the application of the resilience perspective offer an optimistic, systemic, and wellness promoting approach to the assessment of, and intervention with, academic and behavioral school problems. The resilience-focused conceptual framework delineated in this article provides a template for case conceptualization. It enables counselors to direct parents and educators toward areas for collaborative interventions designed to build resilience by the development of positive social-emotional competencies and the creation of supportive social environments. Such strategies lead to improvement in academic achievement, behavior, motivation and aspirations, rather than seeking only to manage or control behaviors and remediate academic limitations.

Conceptualizing presenting school-related difficulties from this resilience-focused framework enables the counselor to reframe presenting concerns into a developmental and interactional perspective. By so doing, parents and teachers are empowered to develop collaborative strategies for improving or resolving learning and behavior adjustment concerns. Thus, a growth mindset perspective is fostered among the significant entourage of adults (parents and teachers) most impacting the child's life, replacing the fixed mindset perspective of the prevailing DSM paradigm.

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