

*A CONSTRUCTIONIST DISCOURSE
ON RESILIENCE
Multiple Contexts, Multiple Realities
Among At-Risk Children and Youth*

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An ecological approach to the study of resilience, informed by Systems Theory and emphasizing predictable relationships between risk and protective factors, circular causality, and transactional processes, is inadequate to account for the diversity of people's experiences of resilience. In contrast, a constructionist interpretation of resilience reflects a postmodern understanding of the construct that better accounts for cultural and contextual differences in how resilience is expressed by individuals, families, and communities. Research supporting this approach has demonstrated a nonsystemic, nonhierarchical relationship between risk and protective factors that is characteristically chaotic, complex, relative, and contextual. This article critically reviews research findings that support an ecological perspective and explores the emerging literature that informs a constructionist approach to the study of resilience. It will show that an alternate constructionist discourse on resilience greatly enhances our understanding of resilience-related phenomena and our approach to interventions with at-risk youth populations.

Keywords: *resilience; social construction; ecological paradigm; health discourses; research methods*

In Grade 7, a teacher of mine told my classmates and me how upset she had been watching a man on a busy downtown street beat angrily on a payphone that hadn't returned his quarter. She told us that, being the extrovert, she had knocked on the glass and then, hips swinging,

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sang "I'm a little teapot, short and stout . . ." until the man, in utter disbelief, walked away. Her story left me wondering who passerbys would have judged to be the one least mentally stable—her or the man in the phone booth? The lesson my teacher taught me that day has never been lost: With enough confidence, we can exercise some say over what is defined as appropriate and healthy behavior relative to the context in which it appears. This is not unlike a postmodern sensibility that is increasingly present in our discourse on health (Gergen, Hoffman, & Anderson, 1996; Madsen, 1999; Ungar, 2001a). Postmodernism, as discussed by critical psychologists like Kenneth Gergen (1994, 2001), explains social realities as constructed through interaction and highly dependent on the language we have to describe our experiences. Building on French philosopher Michel Foucault's work, postmodernists like Gergen who describe themselves more specifically as constructionists, argue that those with the most power to control social discourse influence our definition of what is health and what is illness.

My purpose here is to explore a constructionist understanding of resilience, one that challenges the dominant ecological view which underpins the bulk of resilience research done to date. Ecological approaches to the study of risk and resilience are informed by Systems Theory and emphasize predictable relationships between risk and protective factors, circular causality and transactional processes that foster resilience. Within an ecological paradigm, resilience has been defined as health despite adversity (see Masten, 2001). In contrast, a constructionist approach to resilience reflects a postmodern interpretation of the construct and defines resilience as the outcome from negotiations between individuals and their environments for the resources to define themselves as healthy amidst conditions collectively viewed as adverse (Ungar, in press). Unlike ecological interpretations of resilience that are plagued by cultural hegemony, research that supports resilience as a social construction has found a nonsystemic, nonhierarchical relationship between risk and protective factors, describing the relationships between factors across global cultures and diverse social and political settings as chaotic, complex, relative, and contextual (e.g., see Boyden, 2001).

Regardless of which understanding researchers of resilience adhere to, researchers of resilience continue to conduct studies in the

hope of revealing ways to inoculate children against personal, familial, and environmental acute and chronic stressors. The intent of this article, however, is to explore an alternate constructionist interpretation of resilience that addresses the limitations of conventional ecological models. Like other reviews of resilience that have captured the complexity inherent in its study (Gilgun, 1996a; Glantz & Sloboda, 1999; Kaplan, 1999; Kirby & Fraser, 1997; Masten, 2001; Rutter, 2001) this review and articulation of an alternate constructionist discourse is intended to draw attention to the problems of studying resilience that conventional researchers themselves have identified but left unresolved. Adopting an explicitly constructionist orientation to resilience provides clues to innovative ways to produce findings meaningful to research participants. Table 1 summarizes the contrasting elements of an ecological model of resilience and an alternate constructionist interpretation, both to be discussed at length hereafter.

The challenge of measuring resilience in different contexts, problems discerning valid definitions of positive outcomes, and difficulty developing effective interventions which are congruent with the experiences of marginalized populations are all weaknesses of ecologically based approaches to researching and enhancing resilience (Gilgun, 1999; Ungar, in press). Support for an unconventional constructionist discourse as detailed in Table 1 is to be found hidden among the null findings and confounding variables of quantitative research and among the extended narratives of qualitative studies. Though the literature on resilience has documented a wide range of ecological factors that correlate with healthy functioning in high-risk children and families (Anthony, 1987; Combrinck-Graham, 1995; Gilgun, 1996a; Glantz & Johnson, 1999; Hauser, 1999; McCubbin, Thompson, Thompson, & Fromer, 1998; Richman & Fraser, 2001; Sharma & Sharma, 1999), that body of knowledge (impressive as it is) cannot help in prediction of which specific high-risk child will survive and/or thrive and which will experience developmental and behavioral problems. We only know that resilient children and youth are characterized by individual, social, and environmental qualities that we have come to associate with resilience, leaving the construct open to criticisms that it is nothing more than a tautology (see Tarter & Vanyukov, 1999).

TABLE 1
Two Discourses on Resilience

	<i>Ecological Model</i>	<i>Constructionist Interpretation</i>
Definition	Resilience is health despite adversity	Resilience is an outcome from negotiation with environment for resources to define one's self as healthy amidst adversity
Theory	Informed by Systems Theory; predictable relationships between risk and protective factors; circular causality; transactional processes	Nonsystemic, nonhierarchical relationship between risk and protective factors; relationships between factors are chaotic, complex, relative, contextual
Research methods	Investigations can be qualitative or quantitative but knowledge is empirical, generalizable	Investigations can be quantitative but tend to be qualitative or employ mixed designs; interpretation is dialogical, relativistic, constructed
Risk factors	Risk factors are contextually sensitive; risk impact is cumulative, factors combine exponentially; attributions and belief systems are preconditions of risk; effect of risk factors may also be neutral or protective	Risk factors are contextually specific, constructed, and indefinite across populations
Resilience factors	Resilience factors are compensatory (individual or environmental characteristics that neutralize risk), challenging (stressors that inoculate individuals against future stress), protective (multidimensional factors and processes that reduce potential for negative outcomes and predispose child towards normative developmental paths)	Resilience factors are multidimensional, unique to each context, and predict health outcomes as defined by individuals and their social reference group; characteristics identified by individuals as compensating for self-defined risks; challenges that build capacity for survival relative to the lived experience of individuals; protection against threats to well-being through the exploitation of available health resources
Definition of health	Health outcomes are predetermined	Health is constructed with a plurality of behaviors and signifiers

A constructionist approach to resilience, reflecting postmodern interpretations of the construct in both research and practice contexts, provides alternate accounts of resilience-related phenomena that deepen our understanding of how at-risk populations discover and nurture resilience in ways often invisible to health care providers (Braverman, 1999; Cross, 1998; Dryden, Johnson, Howard, & Mcguire, 1998; Felsman, 1989; Gilgun, 1996b; Ladner, 1971; Martineau, 1999; Michell, 1997; Ungar, 2001a, 2001b; Yellin, Quinn, & Hoffman, 1998). These alternate understandings should not, however, be reified as the correct way to view resilience, either. It would be conceptually wrong to understand the constructionist interpretation of resilience articulated here as the only way to interpret the research on children's well-being. A constructionist interpretation explicitly tolerates diversity in the way resilience is nurtured and maintained. The ecological model, based on positivist modes of inquiry and emphasizing causal linkages and predetermination of health outcomes, is simply unable to accommodate the plurality of meanings individuals negotiate in their self-constructions as resilient. Framed within a positivist paradigm, proponents of an ecological model must necessarily choose arbitrary distinctions of what are to be accepted as evidences of healthy functioning. Such arbitrariness is more the result of ethnocentrism than cross-cultural study that questions the hegemony of Western middle-class norms. A constructionist interpretation encourages openness to a plurality of different contextually relevant definitions of health, offering a critical deconstruction of the power different health discourses carry. Each localized discourse that defines a group's concept of resilience is privileged, more or less depending on the power of those who articulate it. This understanding of resilience, based on discursive power rather than objective measures of health, has implications for the way researchers study resilience and intervene to promote health in at-risk populations. Before exploring these themes further, I will critically examine conventional knowledge in regard to resilience.

ECOLOGICAL UNDERSTANDINGS OF RESILIENCE

A large and varied empirical literature addresses the etiology of problem behaviors and the factors thought to contribute to resilience

in at-risk populations from an ecological perspective. For example, it is commonly believed that in Western countries populated by peoples of European descent, where the bulk of these studies have been conducted, the greatest risks to the health of high-risk youth originate from delinquent behaviors such as drug and alcohol abuse, dangerous driving, and self-injurious behaviors (suicide, high-risk sexual activity) or social factors that include intrafamilial and extrafamilial violence, school failure, poor parenting, divorce or separation, and threats to family economic stability (Jaffe & Baker, 1999; Johnson, 1993; King, Boyce, & King, 1999; Lane & Murakami, 1987; Madigan, 2000; Prilleltensky & Nelson, 2000; Robinson, 1994; Vanier Institute of the Family, 2000). Though this list is comprehensive, leaders in the field of risk and resilience research acknowledge their inability to narrow down the causal or "keystone" (Fraser & Galinsky, 1997) factors that predict unhealthy and healthy outcomes among at-risk individuals or those factors that protect and divert children and youth from these problem behaviors (Kaplan, 1999; Loeber & Farrington, 2000; Masten, 2001).

Despite this shortcoming, a greater focus on resilience-enhancing variables and processes in developmental studies has resulted in attention being paid to children and youth who resemble their problem peers on measures of risk but demonstrate qualities associated with normative definitions of health. Such individuals are described as resilient. Ann Masten (2001) defined resilience as a "class of phenomena characterized by *good outcomes in spite of serious threats to adaptation or development*" (p. 228). Resilience may refer to either the state of well-being achieved by an at-risk individual (as in "he or she *is resilient*") or to the characteristics and mechanisms by which that well-being is achieved (as in "he or she *shows resilience to a particular risk*"). As Jane Gilgun (1999) has observed, the resilience construct has come to mean both a set of behaviors and internalized capacities. The combined effect of this focus on resilience has been to engage us increasingly in a salutogenic discourse (Antonovsky, 1987; Cowley & Billings, 1999). In a salutogenic discourse, in contrast to our more typically pathogenic one, we look for signs of healthy functioning irrespective of the presence or absence of a diagnosable disease.

According to Stuart Hauser (1999), within this conventional literature, studies of resilience cluster into three categories. The first are *ep-*

idemiological and are found in case-specific narratives or large, longitudinal studies that examine the way individuals within an at-risk population achieve better-than-expected health outcomes (Cairns & Cairns, 1994; Hagan & McCarthy, 1997; Moffitt, Caspi, Rutter, & Silva, 2001; Rutter, 2001). An analysis of the constellation of variables at play in subjects' lives identifies protective and vulnerability factors. A second set of studies focus on *life course development* and changes in level of functioning through the study of patterns of adaptation and coping following sequences of stressful events such as the divorce of parents, the onset of mental illness in a family member, chronic illness, dislocations, or a change in economic status (Klebens & Roca, 1999; Sampson & Laub, 1997; Stouthamer-Loeber, Loeber, Wei, Farrington, & Wikstrom, 2002). In these studies, the focus is not solely on risk factors but equally on the way negative (or positive) life events combine with biopsychosocial risks to produce desirable or undesirable outcomes. Over the past 20 years, these studies have changed their focus from the examination of antecedents and pathways to illness to investigations of the protective factors at play in lives lived successfully under adversity. A third category of resilience research is concerned only with *recovery after instances of trauma*, either natural or human in design (Beardslee, 1989; Garmezy, 1991). In these studies, which share much in common with the work on life events, the emphasis is on developmental pathways after the trauma occurs and predisposing behaviors and attitudes that buffer the effects of the trauma.

In all three types of studies, researchers have largely avoided the thorny issue of definitional ambiguity in the resilience construct. When designing studies, they must decide if resilience is to be normative levels of coping in exceptionally difficult circumstances, above average coping when there are normative levels of stress, or exceptional levels of functional adaptation in circumstances of heightened risk exposure. All three understandings of outcomes are reflected in the literature with little comment as to which definition is the most congruent with resilience. As will be shown below, definitional variability does not pose the same problem to constructionist resilience researchers.

Resilience-related factors, which have been identified through largely quantitative ecological approaches to research, have been

routinely categorized as compensatory, challenging, or protective (Garmezy, Masten, & Tellegen, 1984; O'Leary, 1998).

Compensatory factors are those aspects of an individual or environment that neutralize exposure to risk in the first place (Garmezy et al., 1984; Luthar & Ziglar, 1991). Such things as faith, a positive disposition toward life, an evoking personality, and an internal locus of control have all been shown to contribute to positive outcomes in children and youth when growing up under adverse circumstances (Murphy & Moriarty, 1976; Werner & Smith, 1982; Zimmerman, Ramirez-Valles, & Maton, 1999).

Challenge factors are risk factors that serve the functions of enhancing resilience when the risk is manageable for the individual and of enhancing the individual's adaptive capacity over time. Such challenges, in the form of an illness, significant loss, or family disruption, act as an inoculation against future stress during crises (Cairns & Cairns, 1994; Chong, 2000; Rutter, 1987).

Finally, protective factors interact with risk factors to reduce the potential for negative outcomes. Whereas compensatory factors are characteristics of individuals and environments, protective factors actively target specific risks and are thus better thought of as processes or mechanisms for growth. Families that provide stable homes, individual coping strategies, better parenting practices, and safer communities all mitigate risk (Gilgun, 1999; McCubbin et al., 1998; Recklitis & Noam, 1999). Michael Rutter (1987), through his numerous studies of school children and children with mental health problems, identified four specific types of protective experiences that were especially salient in this regard: reduction of risk impact, reduction of negative chain reactions, establishment and maintenance of self-esteem and self-efficacy, and opening of opportunities.

Only large longitudinal studies have managed to account for a large number of compensatory, challenge, and protective factors in the same study (e.g., see Cairns & Cairns, 1994; Magnus, Cowen, Wyman, Fagen, & Work, 1999; Werner & Smith, 1982). More typically, researchers have focused on one or two narrowly defined sets of factors, identifying characteristics synonymous with resilient individuals. For example, Karol Kumpfer and Rodney Hopkin (1993) reexamined research on efforts to prevent use/abuse of alcohol and other drugs, and they noted seven self (compensatory) factors and seven

transactional (protective) factors which are identified in the literature. Self factors included optimism, empathy, insight, intellectual competence, self-esteem, direction or mission, and determination and perseverance. The transactional factors were emotional management skills, interpersonal social skills, intrapersonal reflective skills, academic and job skills, ability to restore self-esteem, planning skills, life skills, and problem-solving ability.

Although efforts to identify the characteristics of resilient individuals have been popular, other researchers have investigated pathways to resilience, with resilience being defined as successful growth and a positive life trajectory. Robert and Beverley Cairns (1994), for example, used semistructured interviews in multiple waves with the same large sample of youth over 10 years. Combining these interviews with file reviews, they found that changes in expected life course from negative to positive could be accounted for by novelty in development (as when a child shows unexpected talents), measurement errors caused by aggregating data (making people's lives appear to be more stable, and therefore more at risk, than they really are), and real changes in development resulting from a significant change in circumstances and access to health resources (as when a child's school, neighborhood, or family structure changes for the better).

This attention to protective factors over time is typical of a shift in focus among many conventional resilience researchers from the study of characteristics of individuals to investigations of developmental processes associated with healthy outcomes. Researchers' understanding of protective factors and mechanisms has broadened over the years and is increasingly ecological, providing better predictions of health. The very best of this work has attempted to account for sociopolitical factors that offer a challenge to the psychopathologizing discourse of helping professionals that has tended to locate the etiological roots of illness inside individuals. The more contextualized research has become, the better it fits with innovative constructionist interpretations of resilience. For example, a study by Marc Zimmerman, Jesus Ramirez-Valles, and Kenneth Maton (1999) employed a longitudinal design to examine the link between helplessness, a risk factor, and mental health. Analysis of findings from two interviews, spaced 6 months apart, with 172 African American male adolescents found that "sociopolitical control moderated the negative

effects of personal helplessness on mental health outcomes. . . . Psychological symptoms did not vary as levels of personal helplessness increased for youths who reported the highest levels of sociopolitical control" (Discussion, para. 1). Zimmerman et al. noted that we know much more about what causes pathology in this population than why or how some of these youth become well-functioning citizens. This is a common refrain among resilience investigators, especially those concerned with marginalized populations whose psychopathology has been overestimated because of a lack of cultural and racial sensitivity (Batey, 1999; Cross, 1998; Klevens & Roca, 1999; Sharma & Sharma, 1999; Tyler, Tyler, Tomassello, & Connolly, 1992).

PROBLEMS WITH AN ECOLOGICAL MODEL OF RESILIENCE

Despite some successful efforts to identify clusters of resilience-related factors and processes, the study of resilience continues to be complicated by a number of measurement and sampling issues. Factors related to resilience may be relevant only to specific developmental stages, and the use of some measures but not others may identify strengths or weaknesses leading to contradictory evidence of resilience. For example, a factor that mitigates risk in one domain of life may do little or nothing in another (Kaplan, 1999). An internal locus of control may be a great advantage to a White child growing up in poverty who can anticipate future success attributable to his or her personal hardiness. This same trait has been shown to have little or no bearing on an African American child from a lower-class home who perceives little or no access to economic security or higher education (see Cross, 2003; Gooden, 1997). While there is agreement that certain factors put children at risk and others mitigate risk, there is no universal set of conditions that can be said to protect all children.

In part, this is because no one set of causal risk factors has been found, or is likely to exist, given the variability in the responses found among individuals to risk. A risk factor that appears as a single occurrence will not have the same impact (and may have a more acute impact) on development as one that is chronic. The loss of one significant relationship, such as when one's parent dies during one's childhood,

may or may not pose a substantial risk to a child who is older or who has other supports. This is quite different from the lifelong absence of a neglectful or abusive parent from which a child is apprehended by social services. In such cases, the loss of the parent may (or again, may not) protect the child. As risk and resilience are two sides of the same coin, with resilience present only when there is substantial exposure to risk, the problem of definitional ambiguity of risk factors further complicates researchers' understanding of resilience.

This situation becomes even more complex when one recognizes that normative definitions of health and well-being are context specific (Martineau, 1999; Ungar, 2000, in press). As Howard Kaplan (1999) discussed,

A major limitation of the concept of resilience is that it is tied to the normative judgments relating to particular outcomes. If the outcomes were not desirable, then the ability to reach the outcomes in the face of putative risk factors would not be considered resilience. Yet it is possible that the socially defined desirable outcome may be subjectively defined as undesirable, while the socially defined undesirable outcome may be subjectively defined as desirable. From the subjective point of view, the individual may be manifesting resilience, while from the social point of view the individual may be manifesting vulnerability. (pp. 31-32)

This point is particularly salient when we look across cultures. In a recent consultation by the author with resilience researchers and community informants from 10 research sites around the globe, troubling behaviors by children and youth could not be easily characterized as positive or negative. In one example, a colleague from a community in rural India challenged by sectarian violence documented the ambiguity in the message children receive in regard to appropriate choices: Some families encourage their children to join paramilitary groups, and others define successful coping as a child staying in school.

A CONSTRUCTIONIST DISCOURSE ON RESILIENCE

Instead of resilience as objective fact, results from a limited number of qualitative (and occasionally quantitative) studies and anecdotal

evidence provided through extended narrative accounts of lives suggest that researchers might better understand resilience phenomenologically. Understood this way, "resilience is the outcome of negotiations between individuals and their environments to maintain a self-definition as healthy" (Ungar, in press). Specificity of positive (and negative) outcomes is to be interpreted within the pathogenic or salutogenic discourses in which these negotiations take place. Most of the evidence provided for resilience as a distinct construct has been anchored within a pathogenic discourse that supports the view that resilient individuals demonstrate certain capacities and have specific characteristics that are unexpected, given the risks they face and their anticipated development of future problems. The false dichotomy between resilient and nonresilient individuals, to which such a perspective contributes, can be replaced with an understanding of health as residing in all individuals even when significant impairment is present. This two-factor understanding of health, in which dimensions of health like self-efficacy and self-esteem are distinct from dimensions of illness (especially a mental illness like a bipolar disorder or an addiction) (Bradburn, 1969; Jahoda, 1958; Reich & Zautra, 1988), forms one of the foundational concepts on which a less tautological constructionist interpretation of resilience is based. Resilience is successful negotiation by individuals for health resources, with success depending for its definition on the reciprocity individuals experience between themselves and the social constructions of well-being that shape their interpretations of their health status. Accounts by youth themselves tell us that even individuals labeled *delinquent* or *disordered* often maintain surprisingly good mental health (Brown, 1998; Ungar, 2002).

A careful review of the conventional resilience research shows that a number of studies raise questions about the validity of the resilience construct as it is used. By way of illustration, a simple, well-designed study by Richard Morgan (1998) examined the relationship between behavioral outcomes, as indicated by the level of privileges children attain while institutionalized, and factors associated with resilience. Based on the literature, Morgan hypothesized that children in residential treatment who demonstrate a more internal locus of control would achieve significantly higher average level scores than children in the same setting who demonstrate more externality. It is interesting that

Morgan himself predicted the possibility of a negative relationship between these variables as well:

It seems logical to suggest that, since internal locus of control is related to more successful outcomes in resiliency studies, that it may also be related to more successful, i.e. better level scores. It must be stressed that this remains only a conjecture however, since it seems possible to also imagine the opposite direction of this relationship, that an internal locus of control, since it may suggest more of a sense of empowerment, may cause these children to, in fact, question and rebel against a well-defined set of rules and expectations precisely because they see themselves as having more options, as being more capable of effecting change compared to those children who are more externally oriented vis-a-vis locus of control who may just simply go along with the structure of the program because they feel rather powerless to change or manipulate the system. (p. 44)

Given that both hypothesized causal relationships are inductively valid, it is not surprising that Morgan arrived at a null finding: "It would seem that locus of control is independent of the behavioural level score and that some other dynamic must be involved which would account for the variation of behavioral level scores" (p. 120). If Morgan had introduced greater complexity in his design or sought to understand the meaning the children themselves construct phenomenologically, he may have found patterns to the compliant or rebellious behavior among subjects that predict positive outcomes.

A study by Irene Cirillo (2000) did just this. Using both qualitative and quantitative methods, Cirillo examined the constructive use of aggression among a sample of 32 adults abused as children. She demonstrated that an "oppositional stance rather than passive victimage" is associated with better mental health outcomes. Contrary to popular belief, an oppositional or defiant stance in those previously victimized can become a useful personal resource to sustain well-being. An appreciation for an alternate and highly localized construction of aggression (that of adult survivors of abuse) was built into the design of Cirillo's study, which was empirical even in its qualitative aspects.

Work by Michael Ungar and Eli Teram (2000) identified a generic pattern of resilience-enhancing behaviors among healthy and disordered and delinquent youth. In a naturalistic study of 41 high-risk ado-

lescents, sampling selection based on authoritative discrimination between resilient and vulnerable youth failed to distinguish one group from the other when between-group comparisons were carried out. These findings reflect results from other studies which have shown more similarities than differences in the health and behavior of problem youth and their nonsymptomatic peers (Hutchison, Tess, Gleckman, & Spence, 1992; Michell, 1997; Tyler et al., 1992). In Ungar and Teram's study, youth labeled *resilient* and *vulnerable* demonstrated similar engagement in protective processes which they reported as health enhancing. The distinguishing characteristic between the two groups was the availability of the resources to sustain their well-being and their resulting self-constructions as healthy. Interestingly and counter-intuitively, the most vulnerable youth in that study found through their delinquent and disordered behaviors the same health resources (self-esteem, competence, meaningful involvement with their communities, and attachments to others) as their more stereotypically resilient peers.

Similar patterns were noted more than 30 years ago in Joyce Ladner's (1971) study of Black girls coming of age in a high-risk urban environment. She found among those youth much more health than she'd been told was there.

Placing Black people in the context of the deviant perspective has been possible because Blacks have not had the necessary power to resist the labels. This power could have come only from the ability to provide the *definitions* of one's past, present and future. Since Blacks have always, until recently, been defined by the majority group, that groups' characterization was the one that was predominant. (p. 2)

Arguably, a preoccupation with deviance among certain marginalized groups, including vulnerable or at-risk youth, has made researchers blind to the normalcy which is present (Cross, 2003).

Internationally, this same variability is evident in the unique constellations of factors that appear in studies of resilience-related phenomena. For example, Neerja Sharma and Bhanumathi Sharma's (1999) review of 21 studies of at-risk youth in India found that Western notions of family and family functioning failed to account for the Indian experience. Even at-risk street youth who were expected to re-

port trauma or conflict with family (mirroring Western models of concurrent risk) did not demonstrate a detachment from, antagonism toward, or history of abuse by their families, this despite the vulnerability they displayed when their behavior was judged by Western standards.

What the child at risk experiences as “family” may not conform to the dominant culture’s norm of a family. The physically distant family of the street child, the single-parent family of a fatherless adolescent and a large extended family with several village-based relatives of a migrant slum girl—all provide succour to the vulnerable child. The important lesson that emerged from the research data is that the risk factors could well be moderated by resilience factors within the child’s family. (p. 413)

When researchers construct studies with greater attention to the relativistic nature of resilience, they discover a less determined or arbitrary understanding of resilience phenomena. In this regard, Gilgun’s (1999) study of young men in prison for violent offenses showed

a sense of agency is not always pro-social. [Offenders] pushed themselves forward for the sake of pro-social goals. Many of the persons whom I interviewed and who were in prison for various acts of violence also displayed strong sense of agency, but they sought to succeed in often extreme antisocial ways, such as being the most vicious, intimidating person they could be or in being the best drug addict. (p. 61)

Thus, association of agency with resilience is a valid approach to measurement, but the expression of that agency must be understood within the context in which it occurs and the health supporting resources that are both available and accessed.

Similarly, Marc Braverman (1999) found in his look at tobacco smoking patterns among adolescents that

if adolescents initiate smoking in an attempt to signal a maturity transition, gain entry into a peer group, seek physical sensation, or cope with stress, it is reasonable to ask whether the smoking fulfilled the goals in question (as well as, perhaps, to examine the adolescents’ powers to articulate those goals). Although we recognize that these instrumental

functions are at the core of the tobacco uptake process, we do not typically investigate whether tobacco use constitutes an *effective strategy from the adolescent's point of view* [italics added]. In other words, our studies need to accommodate questions about how tobacco use may be related to successful or unsuccessful adjustment to the developmental tasks of adolescence. (p. 71)

Although not an argument for supporting smoking among young people, Braverman's emphasis on conducting investigations of substance use/abuse that include the perspective of adolescents themselves is likely to produce better results regarding the pathways children travel toward unhealthy and healthy behaviors. Most inquiries into such phenomena arrive at predetermined conclusions because they assume that one set of behaviors is maladaptive and another, more conventional set is adaptive, thereby missing the important generic functioning of protective mechanisms when resources such as power are limited.

A wide and varied cohort of authors have challenged the notion of homogeneity in healthy behaviors, arguing from behind the critical lens of culture, gender, and race that negative and troubling behaviors are in fact signs of health in specific contexts. For example, the concept of resistance, as when a youth resists interventions, dominant cultural norms, or pressures by caregivers to change antisocial behavior, has been frequently confused with vulnerability. Jill Taylor, Carol Gilligan, and Amy Sullivan (1995) discussed adolescent girls and noted,

Girls' active attempts to maintain connection with others, and with their own thoughts and feelings, are acts of resistance and courage. That these actions often result in psychological distress or land girls in trouble with authorities—or both—points not to deficiencies in girls but to the need for social and cultural changes that would support healthy development in girls and women. (p. 27)

And what about the boys? Mark Totten (2000) found, in a qualitative study of 90 marginalized male street youth in a midsized Canadian city, stereotypical interpretations of masculinity which brought these young men access to power otherwise denied them. Though far from socially acceptable, these youth argued that their misogynist,

racist, homophobic behaviors were efforts to sustain a powerful identity when other paths to health were unattainable. As one of the participants, Marty, explains of his experience as a neo-Nazi,

At the time, it was a high. A power high. It was a feeling of being king shit—no one could touch you. It was like niggers were to blame for everything and we made them pay for everything. They were the reason we had no money, no jobs, no decent place to live. Being a part of the gang [white supremacist] gave us a sense of belonging. We felt like we were accepted and someone cared for us. They told us we had an important job to do. We felt really important—because we were white—because we were guys. (p. 141)

Far from justifying these behaviors, Totten's findings help to inform interventions with these youth. To engage these young men in any change process, it would be necessary to meet their needs for power, which are strongly associated by them with feelings of health and survival under stress. Interventions that can provide alternative and safe lifestyle choices that fit with these youth's experiences and deviant constructions of health are the most likely to be adopted.

A constructionist discourse need not, however, be an excuse for absolute relativism with its implied anarchy between competing definitions of health. Not all definitions of healthy functioning, like Marty's above, will necessarily become widely accepted, but they should be understood as preferred constructions by those who adhere to them. Achieving this appreciation for alternate discourses requires a critical look at the differences in the power of those who are marginal in health discourses or who have only limited access to resources that support health. An alternate discourse on risk and resilience need not define all deviant behaviors as functionally adaptive. It does, however, need to appreciate that problem behaviors help some individuals experience themselves as resilient.

Readers are cautioned, however, to look for instances where this theoretical perspective is misapplied. Some authors have mistakenly applied the constructs of risk and resilience to populations that are neither oppressed nor disadvantaged, making victims out of oppressors and mistakenly labeling problems as vulnerabilities (i.e., see Dugan, 1989). This conceptual error was made by Christina Sommers (2000)

in her examination of what she terms “the war against boys.” Sommers’s work was an attempt to challenge the assumptions made by Gilligan and her colleagues (Taylor et al., 1995) about girls’ oppression. Although Sommers poked some holes, she assumed that because two phenomena look the same (an unequal gender split among the number of college students) the language we use to describe the phenomena can be the same. There was a postmodern distinction lacking in Sommers’s work that is important when understanding risk and resilience. Sommers failed to address the broader contextual issues of risk that create very different meanings for phenomena such as the decreasing representation of young men in higher education. Though this “exclusion” may resemble what occurred previously for young women, males are now under-represented in post-secondary education because of social factors that are different from those young women faced decades ago. Sommers talked about both experiences of exclusion as the same, as if this emerging discourse on male oppression should be given the same power as the one that describes the systemic oppression females experience, ignoring the differences in how young men and women experience their exclusion and the risk factors that contribute to it. To talk of men as being at risk ignores the qualitative and quantitative differences of what a marginalized group experiences. Though one could read Sommers’s work and come to consider men who reach college as resilient, such a construction confusing oppressors and oppressed is not what is meant by the constructionist interpretation of resilience discussed in this article.

THE APPLICATION OF QUALITATIVE METHODS

It is no coincidence that many of the studies cited above that support a constructionist interpretation of resilience are qualitative. Qualitative methods have the potential to provide a more comprehensive picture of lives lived under adversity, but to date, their use has been limited and their integration with more mainstream programs of research less than adequate. The result is that children’s own perspective on their culturally embedded pathways to resilience have remained largely silenced. Qualitative methods in particular are ideally suited to address this shortcoming. For example, in a challenge to a Eurocentric

perspective that presupposes indicators of resilience, Joanne Klevens and Juanita Roca (1999) found in their explorations of the life histories of 46 young men from high-risk families in Bogotá, Colombia, that the common epidemiological predictors for violence were not sufficient to explain their behaviors. Instead, Klevens and Roca noted, "We chose qualitative methods for data collection and analysis to avoid imposing foreign variables and hypotheses in this new context and to allow new variables to emerge from the data" (p. 313). Their findings indicate that for young men growing up in very violent settings, the use of violence is more a coping strategy than an indication of vulnerability.

As discussed by Ungar (2003), five aspects of qualitative research make it ideally suited to studies of health and resilience in children. These include the ability of qualitative methods to discover unnamed processes, to attend to the contextual specificity of health phenomena, to increase the "volume" of marginalized voices, to produce thick enough descriptions of lives lived to allow for the transfer of findings between contexts, and to challenge researcher standpoint bias that orients findings toward an adult-centric perspective. Combined, these five aspects of qualitative studies of resilience help to make comprehensible the unique health-seeking behaviors of children.

THE NEED FOR A CONSTRUCTIONIST DISCOURSE

Although two discourses on resilience have been distinguished here, a constructionist one has not been well articulated despite the emerging evidence for it found in quantitative and more notably qualitative research. This article takes one step in this direction. The discourse, which has been characterized above as ecological, has provided us with only one way of understanding factors that harm children and those that help them interact during a child's development. The goal here has been to offer an alternative discourse on resilience, one that recognizes the contextual specificity required in all resilience- and health-related studies to demonstrate sensitivity to the level of access young people enjoy to health resources.

In particular, the implications of this constructionist interpretation make it necessary for both researchers and practitioners to ask

whether deviant and disordered behavior can be a search for health resources in specific contexts. Can resilience be achieved through alternate pathways typically thought to indicate vulnerability? Within each particular social and cultural context, what do people themselves discern as healthy functioning? How do their views compete with the dominant discourse on health as articulated (and privileged) by health care providers? Who, then, is to decide what is or is not an acceptable expression of health? By way of illustration, the young person who leaves home to avoid abuse and lives on the street has been shown to be more resilient than the youth who demonstrates passivity and continues living with abusive parents when self-esteem, competence, problem-solving, and other related factors are taken into account (Hagan & McCarthy, 1997; Tyler et al., 1992). Such findings have remained largely sidelined within an ecological discourse that favors predetermined behavioral goals even as it has broadened its analysis of contextual factors affecting the achievement of these goals.

A constructionist perspective invites us to examine how race, gender, class, ability, and other factors affect not just access to health resources but, at a more fundamental level, our definition of resilience itself. As Carol Gilligan and her colleagues have shown (Taylor et al., 1995), the foul-mouthed, conduct-disordered young girls they encounter, though arguably more at risk by conventional standards, are less stereotypically passive and view themselves (and are viewed by appreciative others like Gilligan) as healthier than their peers who express themselves in gender-appropriate ways that result in their remaining silent.

A constructionist approach to resilience also fits well with growing interest in strength-based perspectives to treatment offering empirical and phenomenological support for such work (Nylund & Corsiglia, 1996; Ungar, 2001a, 2002). Just as Alice Miller (1991) has spent her career arguing for a better understanding of children in context as their psychological drama unfolds, so too do resilience researchers seek to understand the propensity for health among at-risk populations. Adding new information to this discourse may help researchers perceive unrecognized patterns, authenticated by at-risk individuals themselves, that account for the exigencies of their health-seeking behaviors.

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