Handbook for WORKING *With* CHILDREN *and* YOUTH

Pathways to Resilience Across Cultures and Contexts

EDITOR
MICHAEL UNGAR
Dalhousie University

Hawker Brownlow
EDUCATION

CONTENTS

Introduction: Resilience Across Cultures and Contexts

Michael Ungar

Like all works on resilience, this one too is a cultural artifact, the result of a shared set of beliefs, values, and ideologies found among a group of academics, child advocates, clinicians, and other specialists who share an interest in children's unique ways of protecting themselves when growing up amid adversity. Although I share with contributors to this volume the common goal of better understanding children, our multiple standpoints make me reticent to assert that there is any one pathway to health common to children globally. Instead, I must be satisfied with a collage of competing truths, each a vibrant local account of what we have come to think we know about children's well-being. The more we dialogue across social, cultural, and linguistic barriers, the more convinced I am of a plurality of possible ways to account for children's resilience.

The best place to begin this exploration of pathways to resilience is close to home. I live on the East Coast of Canada. I am a white, heterosexual male. I earn a good income. I am able-bodied. The risks my family and I confront in our daily lives are negligible compared with those of many other families and their children living less than a mile from my home. Of course, the latchkey children across the street who come home after school to an empty house, who spend hours with video games, suffer their own risks that come with being emotionally neglected. Fortunately, as a community we have provided services and structures to, at the very least, meet these children's needs. There are schools they can attend, guidance counselors who check in on them, government-funded social workers to investigate claims of neglect against their parents. There are also community programs, perennially underfunded, but nevertheless available. There are police, doctors, and emergency services close at hand.

Farther from my home, there are children who face far different challenges. They still confront the same acute risks of my neighbors, experiencing episodes of abuse or the disruption of divorce. But their worlds provide more chronic stressors as well. For example, the African Nova Scotian communities a little north of where I live and across the harbor have experienced systematic discrimination and underservicing that have been an unfortunate part of their deep-rooted history. Their schools have historically been underfunded more than those in my neighborhood. Their access to health care is compromised by the poverty that results from prejudice. They are more likely to be the target of police checks and incarceration. These same prejudices led to the outright dislocation of the African Nova Scotian community in the 1960s to make way for a bridge over the harbor. Combined, these intrusions have taken their toll.

Of course, I could widen the circle further. I could speak about street children in other parts of my community, youth who couch surf, drift between shelters, or when weather permits, populate the streets of every major city and small town in Canada. I could go further and paint simplistic pictures from my travels in Aboriginal communities in Canada and describe the challenges they face: the legacy of residential

schools that were a cultural genocide that has contributed to epidemics of substance abuse and suicide. I could move beyond my national borders and look to the United States with its structural inequities, the multiple risks of biological, psychological, emotional, and social factors confounding children's development. But why stop there? I could look overseas to the Middle East, Asia, South America, Africa, and even Eastern and Western Europe where the politics of hatred and prejudice, war, poverty, disability, and marginalization due to gender, sexual orientation, race, and ethnicity all combine to disadvantage children. I could easily paint a picture of a world of children at risk.

This monochromatic view of children and families presents us with a singular and "thin" description of children's lives. Seldom do we hear accounts from children themselves. This is unfortunate because a quieter, less articulated version of children's lives speaks of resilience. It is a much more hopeful vision, one embraced by the authors of the chapters in this volume. If we look, we can find within each population of at-risk children aspects of healthy functioning that may or may not have been overlooked.

Discovering Resilience

In the middle to late 1900s, a growing number of researchers such as Werner and Smith (1982), Rutter (Rutter, Maughan, Mortimore, & Ouston, 1979), Garmezy (1976), and Murphy and Moriarty (1976) began to structure longitudinal studies in Western contexts that found that an inconsistent and unpredictable number of children from at-risk populations presented with remarkably good mental and physical health outcomes despite the multiple disadvantages of structural, familial, and individual stressors.

That body of work has become the basis for a burgeoning field of research into resilience among children and adults. It has provided clinicians, policymakers, child advocates, and researchers a different way of thinking about populations at risk. It has shown that some individuals do survive incredible hardship and that the uniqueness of their solutions may be invisible to outsiders to those lives. However, even as we have come to notice the health to be found among at-risk individuals, our definition of this resilience has tended to assume a minority-world bias, that of the small, privileged part of our world that lives in relative affluence in Western democracies. In particular, most resilience literature comes from the Western-trained psychological and social service community.

Within this narrow community, resilience has come to mean the individual capacities, behaviors, and protective processes associated with health outcomes despite exposure to a significant number of risks. Without risk, there is no resilience, only health of a different order. Although a good start, and a paradigmatic shift from a focus on the etiology of disease to the "etiology" of health, we have ignored the bias inherent in what we assume to be health indicators. A volume such as this, that places side by side so many different understandings of children's well-being, is a challenge to this homogenizing health discourse. This broadening of our perspective is analogous to what the theory of resilience has done to psychopathologizing discourses of well-intentioned professionals who nonetheless stigmatize at-risk populations with labels of dysfunction. This volume seeks to open to debate what is and is not a sign of health, the variety in the pathways children travel to well-being, and the theoretical and methodological challenges accounting for this plurality of perspectives internationally. This new ground can be charted, however, only because of the debt we owe to the resilience pioneers who shook us up with their vision of health hidden amid danger.

Caution is needed when speaking of resilience. The discourse of resilience can be (has been?) co-opted by proponents of a neoconservative agenda that argue if one person can survive and thrive, then shouldn't the responsibility for success be on all individuals within populations at risk to do likewise? Are services really needed, or should people themselves be expected to follow the lead of the "invulnerables" and surmount their difficult life circumstances? It is a familiar twist on the "anyone can be president" myth. It denies the very real structural constraints on children's lives. Not all children have the constellation of capacities to succeed. Much less would there be the capacity of our society as it is structured to provide places for all children if they were to succeed. After all there is only one president every four years.

More invisibly, resilience research and interventions based on a resilience framework have presented models of successful growth and adaptation that are biased toward Western conceptions of healthy functioning, ignoring the arbitrariness in their selection of outcome variables. The bulk of the resilience literature is based on a Eurocentric view of the world. This view is a product of a philosophical enlightenment that has taken place over the last 400 years during which the world became a *knowable, measurable,* and *predictable* place. Arguably, the complexity of resilience, the myriad ways individuals, families, and communities overcome adversity, cannot be so simplified as to generate a single set of principles generalizable from one contextually specific study to the next. This is not to say we cannot embrace the tools of scientific inquiry in different contexts, seeking the gold standard of external validity for each population under study. We can assert, "For this one group of people, sharing these qualities, what our research shows is likely to be true." But to go further, to speak globally, when we are bound to act only locally, requires that we overstep the bounds of reasonableness. If we learn anything from working cross-culturally, it is that to speculate on the commonality of people's experiences is to tumble into an abyss of uncertainty. Claims of external validity are now being challenged by those formerly marginalized by the process of research (minority groups, women, people with disabilities or illness). They are calling for authenticity, relevance, and the *re-presentation* of people's localized truths.

Although I might be fairly certain that what I know about health may be relevant to the neglected children who live next to me, I am less certain of the veracity of what I know about what makes a child resilient when I encounter communities further afield, such as those of Canada's First Nations or those in countries that are less economically developed, although with cultural traditions and indigenous health practices far more ancient than my own.

At a time when we are increasingly open to critical engagement between those marginalized and the elites who hold power over them, there is a need when studying resilience to understand the multiple pathways that children, their caregivers, and communities travel toward health. This book is intended to broaden our understanding of how children, youth, and the adults who care for them sustain resilience in diverse cultures and contexts. In the process, it challenges the individualizing discourse of health, showing that resilience is embedded not only in psychological factors but also in the structures that support children's access to the resources they need to sustain well-being.

A Popular Theory

A burgeoning interest in the study of resilience has resulted in a fascination with lives lived well despite adversity. Television talk shows and bookstore shelves are full of tales of those who have survived well. They provide a picture of individuals who encounter any of a host of challenges and then marshal personal and social resources to overcome them. Eric Weihenmayer (2001), for example, in his biography of his life as a visually impaired mountain climber, demonstrates incredible resourcefulness and determination as he learns to conquer more and more difficult peaks, eventually reaching the summit of Mt. Everest, a metaphoric as much as a physical accomplishment. In a different vein, *The Girl in the Picture: The Kim Phuc Story* (Chong, 2000), documents the life of a 9-year-old girl badly burned during a napalm attack in Vietnam in 1974. A newspaper photo of Phuc shortly after the attack not only helped to end the war by raising awareness of what was happening but also brought her much-needed medical attention even as she was being exploited as a tool for government propaganda. Her story, too, is one of survival.

To understand these lives lived well, one cannot, however, overlook the cultural, social, and structural forces at play. Each was provided with very real resources that contributed to survival. Each had access to opportunities. Each also had the intelligence and temperament to exploit those opportunities.

A broad developmental perspective on resilience that can fully account for how children become resilient in multiple contexts and across cultures has yet to be fully articulated. A number of works from Western authors, such as

Combrinck-Graham's (1995) *Children in Families at Risk*, Walsh's (1998) *Strengthening Family Resilience*, Luthar's (2003) *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities,* and Greene's (2003) *Resiliency,* have alluded to the trajectories of at-risk children's growth and the protective factors that promote resilience. Each has contributed to our thinking about what creates healthy individuals and families. However, as helpful as these works have been, they have not demonstrated the plurality of pathways and the *cultural embeddedness* of how health is realized by children and families growing up under adversity. We need to take an approach more typical of McCubbin (McCubbin, Fleming, et al., 1998; McCubbin, Thompson, Thompson, & Fromer, 1998; McCubbin, Thompson, Thompson, & Futrell, 1999), Werner and Smith (1992, 2001), Glantz and Johnson (1999), and Johnson-Powell and Yamamoto (1997), all of whom have made more explicit the need for contextual and cultural specificity when studying, intervening, or theorizing resilience as a developmental process in at-risk populations.

The Local and the Universal

There are many branches to this unwieldy tree that makes up the field of resilience research. Fields as diverse as developmental psychology, international development, refugee studies, criminology, and child and youth care, among others, have shown an acceptance of the concept of resilience and produced bodies of literature congruent with its usage. We are now coming to understand perilous development in cultures under stress (Johnson-Powell & Yamamoto, 1997), just as we are the neurological markers of children who cope better with stress (Denenberg, 1999; Shonkoff & Phillips, 2000). However, this knowledge is seldom sufficiently contextualized to make it relevant to those whose worlds it purports to represent. Recipients of interventions based on theories unquestioningly embedded in a dominant Western psychological discourse of disease and psychopathology are routinely suspicious of concepts and interventions created by those well-intentioned "others" beyond their borders (temporal, geographic, and sociocultural) (Swartz, 1998). As Rapoport (1997) explains,

> In the smaller scale societies in developing [sic] countries, the impingement of modern values has produced a spectrum of responses from reaction against what they perceive as alien to enthusiastic acceptance of what they perceive as modern and advantageous. There is still little known about how and why families respond in the way they do. Even less is known about the process of reconciling local traditional values with global values. (p. 75)

A construct as complicated as resilience requires a critical deconstruction, with special emphasis placed on the social locations of those who hold the theory to be true. What then is the value of this thing we call resilience? If it is a product of discourse, a socially and contextually specific idea that is open for interpretation by those who use it around the world, then what can it offer health professionals and researchers? How can we say anything meaningful about children's pathways through adversity that will resonate with "truth" for everyone globally if resilience remains a concept controlled by Western professionals?

These questions are answerable. In fact, if we turn to philosophers such as Hacking (1999), who has sought to understand how ideas such as health become accepted as true, we see that realities are fixed through their simple day-to-day ritualization, the everyday way in which lives are lived. Hacking illustrates his point with a critical examination of what are termed "paper crime waves," the excessive focus on a public event that exceeds the relative importance of the phenomenon to most people's lives. This media hyperbole leads people to exaggerate the occurrence of the event and gives rise to panic. In North America, we see this occurring with youth crime, which continues to decrease despite public perceptions to the contrary. Hacking cautions us, however, from treating such panics as simply social constructions. Such a simplistic and dismissive understanding, he says, overlooks the complexity of the relationships involved and the intricate power plays between individuals and institutions that sustain the definition of the problem.

Opening up the concept of resilience to a similar critique helps us to avoid simplistic explanations that all expressions of children's survival are social constructions and therefore

equally valid pathways to health. Promoting such social relativism is not the intention here. A population of children at some risk may sustain health in many different ways that reflect their access to the resources they need to create health. But the views of the dominant culture, frequently that found in the minority Western world, cannot be so easily dismissed as a paper tiger. Instead, we need to move beyond the dualism, a view of resilience as all about local context or all about grand metatheories that reflect the bias of their expert proponents.

It is this same middle path that has been well charted by others such as Swartz (1998), who has examined mental health in the context of Southern Africa. To Swartz, the contextualization of mental health phenomena is essential because biomedical explanations of disorder alone are inadequate to account for people's experiences of illness worldwide. Mental health must be understood as more than an intrapsychic or psychiatric phenomenon. The difficulty will always be balancing the emic and etic perspectives of those who experience illness and those who diagnose and treat it. As Swartz observes, creating an antiracist psychiatry requires that we see beyond the empiricism of psychological theory. We need a new language that more than translates ideas across cultures but that relays differing constructions of what health means and how it is expressed. Specific to the problem of translation (in particular its failure), Swartz explains,

> If we hold the *empiricist* view, the task of translating is simply finding the appropriate words in different languages for feeling states. If on the other hand we hold the *hermeneutic/constructionist* view, the task of translating is more complex: we have to consider the extent to which the act of translation implies the construction of a particular reality. (p. 29)

None of this, however, opens the door to a complete relativism or an overprivileging of indigenous medicine. According to Swartz (1998), mental illness does exist in developing countries, is recognized by people's communities as a sign of illness, leads to stigmatization, and cannot always be cured through the use of indigenous methods. Naïveté under the guise of cultural sensitivity simply re-creates the dualism between the minority and majority worlds, without appreciating any shared realities whatsoever. A better balance is required.

In the chapters that follow, we move back and forth between the specific and the universal, between local knowledge and pan-global understandings. This dialogue is meant to draw a line in the sand, to find the ever-shifting place where local truths compete with global truths in a healthy dialectic. When it comes to children's survival, we need to understand their accounts of their experiences while aggregating what we know collectively to offer others at risk some signposts on an effective pathway to health. The challenge is to provide these signposts without privileging a Eurocentric understanding of resilience as universal.

Of course, some aspects of resilience are so ubiquitous as to appear universal: We agree in most cultures and contexts not to do violence to one another (except in ways justified by the need for self-defense); we agree to share food with loved ones; we form attachments; we seek power over our lives and a position of recognition in our communities. These are all essential elements of resilience that appear in global studies on health. We can assert with confidence such truths as "universal by consent" (see Leonard, 1997). We can also simultaneously strive to show tolerance for a polyocular view of the world, encouraging transcultural exchanges that help us to see the varying degrees of relevance of many of our commonly held beliefs about what makes people healthy when exposed to risk. The juxtaposition in this book of differing theories, definitions, and interventions concerned with resilience demonstrates this ambivalence between the cold certitude of the enlightenment and the free-for-all of the postmodern. If we are to understand resilience better, we must open to scrutiny what we know and how we practice based on that knowledge.

Health data are never neutral. One would, for example, hardly know that teenagers are acting more responsible sexually now than in any time since statistics have been gathered. The teen birth rate in the United States has dropped to 42.9 births per 1,000 women aged 15 to 19 (Childtrends, 2003). The drop has been seen in all racial and ethnic groups and in all regions of

the United States. Furthermore, teens' self-reports of sexual activity have also declined slightly. Strange, then, that there is still a moral panic about teenagers and sexuality. Stranger still is that the rate of teen births during the 1950s and 1960s was twice what it is today, given perceptions that sexuality was more controlled during both those decades. What we fail to understand in a media awash with worry is that interventions and a widening social safety net are having the effect we anticipated. Clearly, in the context of where I live, we have the technologies required to help children grow up safer and to prevent their exposure to risk.

Is Resilience Research Flawed?

If we are to make the study of resilience a legitimate and fundable endeavor, one that can offer a counterpoint to the study of disease and psychopathology, we will need to address its shortcomings. Critics contend that the concept of resilience may be nothing more than a tautology, a simplistic way of saying that whatever makes you stronger must necessarily be good. There is also the danger of identifying resilience in individuals we have already arbitrarily designated as successful by the design of our inquiry into their lives. If, for example, a child remains in school despite population-wide risks associated with dropping out, then we might argue the child is resilient. But what does such a distinction, the laying on of the label *resilient*, add to our understanding about children and health? We already, after all, have ample theories to explain why some children drop out and why others do not.

With all the problems discussed above, it is not surprising to find some researchers abandoning the construct of resilience altogether. Tarter and Vanyukov (1999) characterize resilience as lacking heuristic value or practical usefulness because of its nonlinearity and failure to predict epigenetic trajectories through life. Their argument is ecological: "Successful or poor adjustment does not ultimately reside in some abstruse property of the person such as resilience but instead emanates from the interaction between the person's phenotype and environment" (p. 99).

Arguably, what the study of resilience as an overarching concept adds is the possibility to weave a tapestry of health-related phenomena that offers a paradigmatically different position from which to examine children at risk. Resilience researchers and clinicians look to those who succeed for clues to successful development rather than focusing on those who succumb to risk. When we investigate what makes someone strong instead of what causes weakness, we are more likely to identify that which bolsters health. Alleviating illness gets us only halfway to resilience. We might interrupt the course of a disease, but we fail to understand how individuals sustain health. This shift in focus is imperative if we are to study health rather than disorder. As Glantz and Sloboda (1999) explain, despite criticisms of resilience research, "It should not be discarded because it encourages an important focus on a real and important phenomenon" (p. 113). In our pursuit of the etiology of health, we encounter the multiple forces at play in the lives of those who survive and thrive. For example, in Canada, it is noteworthy that some children don't drop out of school when facing the combined threats of decreased job prospects or the systemic prejudice encountered by visible minorities, most notably Aboriginal and African Canadian youth. However, it is even more remarkable that children don't drop out when they must dodge bullets to get to school or resist the pull into street gangs and the money and status they bring when growing up in the poorest communities of Medellín, Colombia. Shifting our focus to health, we are given culturally embedded clues to survival strategies. Collectively, these strategies can help us understand where best to invest our limited social and financial capital.

Because good interventions and policies tend to be built on enlightened science, it has fallen to researchers to demonstrate what resilience is and how it is nurtured. The problems of arbitrariness in what is measured and what is used as health outcomes and the difficulties of accounting for social and cultural variability are all aspects of resilience research that are not insurmountable. Even the skeptics are encouraging a much-needed debate. I would agree with Glantz and Sloboda (1999) who write the following:

> Unfortunately, the concept of resilience is heavily laden with subjective often unarticulated assumptions and it is fraught with major logical, measurement, and pragmatic problems. . . . We share many of these concerns. We find there is great diversity in the use of the concept; it is used variously as a quality, a trait, a process, or an outcome. We have identified few attempts to assess resilience in which measurement problems do not cloud or eclipse the findings. There is no consensus on the referent of the term, standards for its application, or agreement on its role in explanations, models, and theories. In sum, the problems and inconsistencies in measurements, findings, and interpretations in the published literature raise serious questions about the utility and heuristic value of the concept of resilience. (pp. 110–111)

These are not necessarily arguments for abandoning the term, which, as Glantz and Sloboda (1999) note, is still much needed. They do, however, push us to find a heuristically useful understanding of resilience that is helpful for comprehending the way children live their lives day-to-day.

There are many different hypotheses about what sustains resilience. Frequently, they are not well articulated, hidden beneath the fog of a dominant discourse that is more concerned with illness than health. For example, Loeber and Farrington (2000) note in their review of the factors contributing to juvenile delinquency:

> Some children engage in minor delinquent acts for excitement, adventure, or other emotions common among children. For these children, offending may be considered as part of the context of child development in which youngsters learn prosocial behaviors by trial and error. (p. 742)

Although it is certain that for some of these children, these early offenses are "stepping stones in pathways to serious, violent, and chronic offending" (p. 743), for many others, these events do not predict future negative outcomes. It is intriguing that Loeber and Farrington find such problematic behaviors to be part of normative development in some contexts. The problem, as they explain, is that "currently we have few tools to distinguish between those young children who will continue with their problem behavior and those who will not" (p. 746). What is refreshing is that Loeber and Farrington can at least see the complex negotiations for health of the subjects in their study. If we are to understand healthy coping among children at risk of becoming delinquents, then we must look for patterns of health-seeking behavior that co-occur with their problems. Thus, we can see what Glantz and Sloboda (1999) mean in concrete terms when they invite us to "postulate the interaction of positive and negative influences leading to variable outcomes" (p. 114). In the case of children who act like delinquents, it is a difficult distinction to make between those who are engaged in risk-taking behaviors as a way to further their positive growth and those whose delinquency puts them on a course to more serious problems. To categorically say that risk-taking socially deviant behaviors are all bad, or all good, overlooks the variability in children's pathways to health.

An example such as this enters us into the realm of Saussure's (1978) signs and signifiers: We can no longer be entirely certain that any set of behaviors signifies either health or illness. Empiricism does not necessarily become obsolete, however. Instead, our attention is called to the contextual specificity and need to account better for the meaning those being investigated hold for the phenomena under study. The more complex and mixed method our designs, the more likely we are to achieve a theory that accounts for the multiplicity of competing understandings of health (and illness).

As Massey, Cameron, Ouellette, and Fine (1998) note in their studies with youth, at least three problems face resilience researchers: values, context, and trajectory.

> Resilience researchers have suggested that resilience can be conceptualized as increased self-esteem, decreased depression, and improvements in one's social competence, sense of coherence, or sense of empowerment. These multiple indicators of wellbeing complicate a simple conceptualization of thriving. *In many cases the values implied by these indicators suggest outcomes harmonious with the lived experience of our participants, although in other cases there may be disagreement between the values of researcher and those of the researched* [italics added]. (p. 339)

In practice, one can see how these research problems get expressed in instances where children are resistant to interventions or behave in ways that challenge cultural norms. A remarkably diverse collection of studies have found that resistance is not all bad, and in fact, the children and families who challenge authority are often those who maintain health better than the passive victims of structurally exploitive educational and social welfare systems (see Ungar, 2004). Resisting hegemony has its value, although one is less likely to be seen as resilient. There is a fine balance observable in the lives of at-risk children and youth between conformity and resistance, each contributing to the definitional ceremony of becoming known as resilient to one's peers, caregivers, and community (see Bowman, 2001, for an example of how Palestinian families strengthen their collective identity through acts of resistance and personal sacrifice). Studies of lives lived well, such as those provided in this volume, highlight this tension, providing a caution to our nomothetic tendencies to categorize children without attention to the contexts in which labels are worn.

Culture and Context

The construct of resilience has relevance globally, although pathways to health must be understood as contextually specific. Take, for example, instances where children experience substantial social upheaval. In 1996, a post-Soviet Russia adopted a new set of laws to govern families that have significantly changed the relationship between children and parents and families and State institutions. In this world of ambiguity and shifting norms, there have been unforeseen challenges as both bureaucrats and professionals are reluctant to pass to parents the State powers they enjoyed before perestroika. Not surprisingly, contemporary Russian parents are also not prepared to rear their children independent of the State's sharing responsibility and authority over children (Butler & Kuraeva, 2001). From my standpoint, where the boundaries between State and family are more clearly defined, I find it difficult to understand the Russian family's dilemma. This blinder to my Russian counterpart's more collectivist orientation would, of course, bias any research I design from my cultural standpoint that might overemphasize individualism.

But how much does any systemic risk such as that found in Russia compromise the health of children? Should it be considered a risk factor at all? Markowitz (2000) shows that despite the changes Russian children have experienced over the past decade and a half, remarkably *few* have noticed how different their lives are from that of their parents. Instead, amid the chaos, adolescents have taken up the challenge to design a life that works well for them, one that emphasizes "challenge and adventure" (p. 216). In a world of constant change, anything becomes possible. As the value placed on authority breaks down in school and community, as evidenced by the dissolution of organizations for children sponsored by the Communist party, the effect has been to leave a cultural vacuum that is more noticeable to adults than children. Yet despite the absence of these formal collectivist organizations, Russian teens still desire the same close connection to their families and a few close friends that were common a generation ago. One must therefore exercise caution assessing Russian children as more at risk now as a result of the socioeconomic turmoil experienced by their caregivers.

This trend toward greater understanding of health in context has been evolving for decades. More than 30 years ago, we saw novel approaches to studies of people's experiences that challenged racial bias. Ladner (1971) observed in her landmark study of 30 young black women:

> We can observe differences between racial and social class groups regarding, for instance, the time at which the female is considered to be ready to assume the duties and obligations of womanhood. Becoming a woman in the low-income Black community is somewhat different from the routes followed by the white middle-class girl. The poor Black girl reaches her status of womanhood at an earlier age because of the different prescriptions and expectations of her culture. There is no single set of criteria for becoming a woman in the Black community; each girl is conditioned by a diversity of factors depending primarily upon her opportunities, role models, psychological

> disposition and the influence of the values, customs and traditions of the Black community. (p. 11)

We know that how children address the "maturity gap" (Moffitt, 1997) between their status as children and their participation in their communities as adults is an important component of how children negotiate their way to healthy adult identities. That Ladner (1971) opens to debate the cultural bias of normative behavior in *American* culture problematizes the whole notion of what is and is not measured as risk and resilience in the West. By her work, Ladner shakes the foundations of what we assume to be healthy adolescent behavior. If teenage pregnancy needs to be reconsidered as a sign of risk, then the entire psychological enterprise of arguing what is health and illness tumbles like a house of cards. What we see in its place is the tentative negotiated agreement that defines what is a healthy pathway to resilience and what is not for each specific context.

This is similar territory to that charted by other feminist authors in the late 1970s and early 1980s. Gilligan (1982) showed us the different developmental pathways for girls' moral development, and members of the Stone Center such as Surrey (1991) and Miller (1976) challenged Erikson's stage theory of development. In both cases, these authors make the distinction that what we believe about development and, ultimately, about health is influenced by the dominant culture that has privileged male ways of classifying the world as normative or nonnormative. We no longer need to think of independence and autonomy as the signs of healthy growth. Instead, if we take the lead from these feminist theorists, we see that growth in connection is a better description of how girls develop. Interestingly, this has also been shown to be an accurate description of how healthy males develop as well. Osherson (1992) found among young men an expressed desire to find connections with their fathers and children. Perhaps we must follow Ladner's (1971) lead. As she notes,

> It is simply a question of whether or not the values, attitudes, behavior and systems of belief which govern the dominant white middle class should be the criteria by which Black people, most of whom have never been allowed to assimilate into the American mainstream, should be evaluated. (pp. 267–268)

Substitute the phrase "Black people" with any other group that does not count itself among the privileged white middle class and one quickly sees the shallowness of assuming any definitive construction of healthy functioning that can be evaluated outside the context in which it is experienced. The bulk of resilience research, although itself contesting the irony of trying to say something meaningful about health from studies of illness, has avoided looking critically at how wellness is culturally embedded and expressed.

Constructions of Risk and Resilience

First things first. There is a good news story everywhere we turn. As much as professions such as social work, psychology, and psychiatry, and the general public hooked on CNN, want to imagine the world a more dangerous place, our children more at-risk than ever before, and life in general miserable, there remains much to be hopeful about. This does not minimize the staggering impact that people globally experience from HIV-AIDS, the effect of war and community-wide epidemics of violence, or the lack of human rights for the many who are dispossessed. In each instance, however, there remains an alternate story, one that is much more full of hope. There is a fine line when studying resilience: One can simply ignore the bad or, alternately, be too realistic, embedded in an empiricism that is itself biased by the numbers it reports. Instead, we may be better off to appreciate that the construction of problems is dialogical. As Houston and Griffiths (2000) have shown, at some level, risk is socially constructed, dependent for its identification on a discursive process that names what we experience as a risk to our well-being.

Take, for example, two perspectives on violence. Michael Moore's Academy Award-winning documentary *Bowling for Columbine* is a disturbing and humorous look at the culture of fear in America today, a fear that is far out of

proportion to the risks people face. Instead, according to Moore, the fear that is seeded by the media and nurtured through people's collective beliefs makes Americans constantly afraid for their safety. Their response, a liberal access to guns, has ironically made the very people trying to protect themselves 10 times more likely to be killed by a firearm than in Canada and 50 times more likely than people living in Japan.

In contrast, we can examine a very different perspective on violence. Accounts from Bogotá, Colombia, one of the most violent places on earth, with homicide rates that have been as high as 4,000 per year in a city of 3 million, show that for most people the experience of violence is still a relatively rare event. Duque and his colleagues (Duque, Klevens, & Ramirez, 2003) have found that few people in Bogotá say they experience extreme forms of violence, despite very well-founded perceptions by outsiders that their communities are dangerous.

Which is the better account of the risks associated with violence? Whose view of their personal security, the American or Colombian, is the most accurate? Risk and resilience are never phenomena that are simply objective fact. They are entangled in the collective ideologies of people and their communities.

If we look closely at the risk and resilience literature, there are quiet discourses that tell a different story about the health status of at-risk populations and the unique mechanisms that promote well-being. For example, in the West, we are coming to understand that our efforts to mitigate all risk in children's lives might inadvertently be removing meaningful rites of passage through which children experience manageable risk. Perhaps we would do well to remember "that which doesn't kill you makes you stronger." Improving children's well-being is never as simple as removing risk from children's lives (Ungar, 2002).

We need to listen better. This volume is about providing a space for voices that are less often heard and, indeed, have been all but absent from discussions on resilience. Clearly, the contributors to the following chapters argue that resilience is not an individual characteristic alone. Nor is it only a process. Resilience occurs when the personal meets the political, when the resources we need for health are available so we can realize our potential. Resilience is as much a quality of my family, community, and culture as it is something inside me or a process I engage in. It is only because of a Western psychological discourse that we think more about the individual than the communal. Even when we acknowledge the agentic qualities of a child who thrives, we mustn't overlook the access that child experiences to health resources, including a collective discourse that defines the child's pattern of coping as resilient. We need a communitization of health, understanding health as a communal experience. A well-resourced community, a caring family, meaningful roles for individuals, rites of passage, social equality, and access to education and health care are some of the conditions necessary for the individual to experience health. Strictly speaking, these factors are independent of the individual. And yet, they also result from the actions of healthy individuals who provide for others who are more vulnerable.

To say "I" am resilient is to be mistaken. The *I* of which we speak is a cultural artifact, a perspective that is social and historical, relational and constructed. Instead, we might better say, "There is resilience in this child and his or her community, family, and culture." Resilience is simultaneously a quality of the individual and the individual's environment. To the extent that a child accesses communal health resources and finds opportunities to express individual resources, so too will resilience be experienced.

The implication of this way of thinking is that pathways to resilience must be adaptive and provide individuals with ways to negotiate for the health resources that are available. These resources can be diverse and include anything from attachments to others, self-efficacy, and a healthy sexual identity to safety and security and access to health care, food, and shelter. As this volume illustrates, children, youth, and adults globally enjoy differential access to these resources and exploit opportunities to overcome adversity in many different ways. However, the interplay between what is available and what is used is complicated. Simplistically, the provision of an opportunity that addresses risk is insufficient to change behavior unless the complexity of the problem and the construction of