Resilience Theory: A Literature Review

with special chapters on deployment resilience in military families & resilience theory in social work

by

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Resilience theory, although it has been evolving over the past 70-80 years, has enjoyed a renaissance in the past two or three decades. What started as an enquiry into the childhood roots of resilience has grown into a broad, dynamic and exciting field of study. Resilience theory currently addresses individuals (both children and adults), families, communities, workplaces and policies. There are few domains of life that have not been touched in one or other way by resilience theory, including the military community.

This document serves to review the wealth of literature on resilience and to provide a consolidated summary of this literature. Close to 500 sources are cited in this document, published between 1945 and 2001, and drawing from books, academic journals, masters and doctoral dissertations, released government and military reports, training and family manuals, popular magazines and unreleased research reports. The comprehensive review addresses:

- Individual resilience (including resilience in children, salutogenesis, sense of coherence, thriving, hardiness, learned resourcefulness, self-efficacy, locus of control, potency, stamina and personal causation),

- Family resilience (including family stress research, Hill’s ABCX model of family stress, family strengths research and the various models of family resilience developed by McCubbin and associates – Double ABCX Model, FAAR Model, T-Double ABCX Model and the most recent Resiliency Model of Family Adjustment and Adaptation),

- Community resilience (including social support systems and a number of cutting edge writings in this newly evolving field),

- Resilience-based policy (again with the latest thinking on the integration of resilience theory into policy formulation, and with a detailed section on work-life or work-family policies as an example of resilience-based policy),

- Resilience theory in social work (including an historical review of social work’s inconsistent alliance with resilience theory, the newly evolving strengths perspective and the narrative and solution-focused therapies of Michael White and Steve DeShazer),
Cross-cultural perspectives on resilience, and

Deployment resilience (including a detailed review of literature pointing towards families developing the resilience to resist the stress of military separations).

This review does not aim to provide a synthesis of these various fields of study, but rather to bring together in one place a range of writings and perspectives on resilience and strength that have not previously been seen together in one document.
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CHAPTER ONE: INTRODUCTION TO RESILIENCE THEORY

Resilience theory is a multifaceted field of study that has been addressed by social workers, psychologists, sociologists, educators and many others over the past few decades. In short, resilience theory addresses the strengths that people and systems demonstrate that enable them to rise above adversity.

The emergence of resilience theory is associated with a reduction in emphasis on pathology and an increase in emphasis on strengths (Rak & Patterson, 1996). O’Leary (1998) notes:

Psychologists have recently called for a move away from vulnerability/deficit models to focus instead on triumphs in the face of adversity ... This call for a focus on strengths parallels that of a number of other investigators in child development..., medical sociology..., and education... The potential theoretical, empirical and policy significance of the proposed paradigm shift from illness to health, from vulnerability to thriving, from deficit to protection and beyond ought not be underestimated. The precedent for this paradigm shift is growing in the scientific literature. (p. 426)

Hawley and De Haan (1996) also note a similar trend in family therapy:

In recent years there has been a movement in the family field toward strengths-based and away from deficit-based models. For example, in family therapy the solution-focused and narrative models assume that clients possess resources that will allow them to resolve their difficulties... An emphasis on resilience in clients has often accompanied this focus on strengths. (p. 283)

McCubbin and McCubbin (1992, p. 150) have identified five major developments in the field of family social work during the 1970s and 1980s, the fourth of which is most relevant here:

- There has been ongoing evaluation of the efficacy of interventions targeted at the family system.
- The revival of family stress theory has highlighted important dimensions of family functioning for intervention.
- Various family typologies have been developed to guide family assessment and intervention.
- Theory and research have been advanced to promote family strengths and capabilities, which have enhanced intervention.
Family assessment and measurement tools have been developed for use in family research, clinical assessment and programme evaluation.

Pearlin and Schooler (1982) note that researchers have historically tended to confine their attention to pathology and problems. The advance of our knowledge of how people survive, cope and even thrive has been left largely to clinicians in the field. This has had four main effects:

- Firstly, it has created the impression that coping in the face of adversity is an idiosyncratic phenomenon rather than widespread or even normative (see also Antonovsky, 1979).

- Secondly, it has tended to locate such coping within unique individuals, thereby overlooking the possibility of “institutionalised solutions to common life tasks” (Pearlin & Schooler, 1982, p. 110; see also Saleebey, 1997b).

- Thirdly, it has elevated pathology into the high realm of ‘Science’, and relegated coping to the homely world of folklore (see also Goldstein, 1997).

- Fourthly, it has led clinicians, including social workers, to resist acknowledging the validity and presence of strengths in their clients. Barnard (1994, p. 136) refers to this as the Law of the Hammer, which “suggests that if you give young children a hammer, everything they come in contact with will need pounding. One of the primary ‘hammers’ of the human services fields has been psychopathology, and related nomenclature.”

There is, of course, the danger of turning the notion of resilience into a kind of rugged, rigid, “just-shake-it-off”, “don’t-look-back”, “Teflon-coated” resilience, which has renders the individual or system "brittle” and vulnerable to stress (Schwartz, 1997). What is advocated in the resilience literature is a kind of resilience that is compassionate, flexible and in-touch-with-life and which promotes the ability-to-bounce-back (ibid.).

The field of resilience is broad and diverse. In some aspects it is well developed and explored. In others it is still nascent. This document purposes to provide the reader with a broad overview of the entire field of resilience theory. Many notions are being drawn together here in a way that has not been done before. When a theory provided additional understanding of resilience, it was incorporated, whether or not that theory was considered to be part of resilience theory.
This review begins at micro level and historically with the individual. Resilience theory has its roots in the study of children who proved resilient despite adverse childhood environments. Antonovsky’s seminal work on salutogenesis and sense of coherence is outlined. Various other individually oriented theories that have been associated with salutogenesis are then mentioned, including thriving, hardiness, locus of control and learned resourcefulness.

Secondly, the field of family resilience, which is the main focus of this document, will be detailed. Family resilience began with family stress research in the 1930’s and these roots are explored. The family strengths literature that has been popular for the past thirty years is summarised. McCubbin’s detailed models, theories and research on family resilience are then discussed in some depth.

The emerging field of community resilience is introduced, including the importance of social support systems, followed by a discussion on the similarly emerging field of resilience policy. Particular attention is given to policies addressing the work-life interface, which, it is argued, illustrate the application of resilience theory to the field of policy.

The place of resilience theory in social work is then explored. The historical tension in social work between pathogenesis and salutogenesis is highlighted. The recently emerging strengths perspective is outlined as well as the solution focused models to family therapy.

Penultimately, the implications of resilience theory for cross cultural research and practice are briefly addressed.

Lastly, the notion of deployment resilience in military families is explored in depth. Deployment resilience is an application of resilience theory and work-life theory in the population of military families, and addresses the question of how military families can resist the stress of work related deployments or separations.

It is perhaps important to note three issues which probably influence the content, style and emphases of this document:

- Firstly, I am a social worker. There are, consequently several references to social work in this document, including a whole chapter devoted to the place of resilience in the social work profession. In addition, I write with the paradigm of a social worker – two of the results of this are a constant search for the practice or clinical value of theory and models, and an emphasis on families and communities. I cannot...
apologise for this bias since I believe in the social work paradigm. Nevertheless, I have not written this document for the sole use of social workers.

- Secondly, I live in South Africa. I have, therefore, tried to make is clear when I am referring to USA or South African literature. I have also tried to incorporate literature from other countries, such as Sweden, Europe and the UK. There is not a great deal of literature on resilience theory in South Africa, apart from the excellent work of D.J.W. Strümpfer, which concentrates on individual resilience from a salutogenic perspective and with an interest in the links between salutogenesis and work.

- Lastly, I work for the South African National Defence Force as a social work researcher. This document serves as the background theoretical framework for the development of a resilience-based social work assessment technique in the military community. Consequently, there is a fair amount of attention paid, including an entire chapter, to the notion of deployment resilience – an application of resilience theory to one of the stressors of the military community. I have also incorporated some of the results of my own research into this subject over the past several years.

The scope of this review is, however, broad, and should provide material of interest to any professional working in the field of mental or holistic health.
CHAPTER TWO: INDIVIDUAL RESILIENCE

2.1 INTRODUCTION TO INDIVIDUAL RESILIENCE

Resilience is the capacity to maintain competent functioning in the face of major life stressors. (Kaplan, Turner, Norman, & Stillson, 1996, p. 158)

George Vaillant (1993) defines resilience as the “self-righting tendencies” of the person, “both the capacity to be bent without breaking and the capacity, once bent, to spring back” (p. 248). (Goldstein, 1997, p. 30)

Resilience means the skills, abilities, knowledge, and insight that accumulate over time as people struggle to surmount adversity and meet challenges. It is an ongoing and developing fund of energy and skill that can be used in current struggles. (Garmezy, 1994 in Saleebey, 1996, p. 298)

[Resilience is] the capacity for successful adaptation, positive functioning or competence ... despite high-risk status, chronic stress, or following prolonged or severe trauma. (Egeland, Carlson, & Sroufe, 1993, in Sonn & Fisher, 1998, p. 458)

Resilience is primarily defined in terms of the “presence of protective factors (personal, social, familial, and institutional safety nets)” which enable individuals to resist life stress (Kaplan et al., 1996, p. 158). An important component of resilience, however, is the hazardous, adverse and threatening life circumstances that result in individual vulnerability (ibid.). An individual’s resilience at any moment is calculated by the ratio between the presence of protective factors and the presence of hazardous circumstances.

Polk (1997) has synthesised four patterns of resilience from the individual resilience literature:

- **Dispositional Pattern.** The dispositional pattern relates to physical and ego-related psychosocial attributes that promote resilience. These entail those aspects of an individual that promote a resilient disposition towards life stressors, and can include a sense of autonomy or self-reliance, a sense of basic self-worth, good physical health and good physical appearance.

- **Relational Pattern.** The relational pattern concerns an individual's roles in society and his/her relationships with others. These roles and relationships can range from close and intimate relationships to those with the broader societal system.
**Situational Pattern.** The situational pattern addresses those aspects involving a linking between an individual and a stressful situation. This can include an individual’s problem solving ability, the ability to evaluate situations and responses, and the capacity to take action in response to a situation.

**Philosophical Pattern.** The philosophical pattern refers to an individual’s worldview or life paradigm. This can include various beliefs that promote resilience, such as the belief that positive meaning can be found in all experiences, the belief that self-development is important, the belief that life is purposeful.

Barnard (1994, pp. 139-140) identified nine individual phenomena that the literature repeatedly has shown to correlate with resiliency:

- “Being perceived as more cuddly and affectionate in infancy and beyond.
- “Having no sibling born within 20-24 months of one’s own birth.
- “A higher level of intelligence.
- “Capacity and skills for developing intimate relationships.
- “Achievement orientation in and outside of school.
- “The capacity to construct productive meanings for events in their world that enhances their understanding of these events.
- “Being able to selectively disengage from the home and engage with those outside, and then to reengage.
- “Being internally oriented and having an internal locus of control.
- “The absence of serious illness during adolescence.”

The capacity of an individual to cope during difficulty is central to their resilience. Pearlin and Schooler (1982, p. 109) define coping as “the thing that people do to avoid being harmed by lifestrain.” These authors conducted 2300 interviews in the urbanized Chicago area and through content analysis of these interviews identified three main types of coping that serve distinct functions, viz:

- “Responses that change the situation out of which strainful experience arises” (Pearlin & Schooler, 1982, p. 115). Interestingly, their research found that this type of coping was not widely used. Several reasons are offered to explain this.
People must first recognize the situation which is causing the stress; something which is not always possible. People may not know how to change the situation directly. Acting on a situation to change it may result in even further stressors, which in turn inhibits further action. Some situations are not amenable to change efforts.

- It is interesting to note that much of resilience theory and research has revolved around situations which are impervious to change efforts, such as being in a concentration camp, having a terminal illness, being in a war, growing up in poverty, etc. In such circumstances, little can be done to directly change the situation causing the stress. Rather, other forms of coping are required.

- “Responses that control the meaning of the strainful experience after it occurs but before the emergence of stress” (Pearlin & Schooler, 1982, p. 115). Pearlin and Schooler found this to be the most common coping type. This coping can entail making positive comparisons which reduce the perceived severity of the stressful situation, selectively ignoring parts of the situation so as to concentrate on some less stressful aspect of the situation, and reducing the relative importance of the stress situation in relation to one’s overall life situation.

- “Responses that function more for the control of the stress itself after it has emerged” (Pearlin & Schooler, 1982, p. 115). This coping type does not attack the situation itself, either directly or through meaning or perception. Rather, the focus of the coping is on the resultant stress itself and entails basic stress management responses. “Out of the beliefs and values in the culture people are able to create a strategy for manageable suffering, a strategy that can convert the endurance of unavoidable hardships into a moral virtue” (ibid., p. 117).

An intervention was conducted in an occupational setting to enhance the coping of employed mothers (Kline & Snow, 1994). The group-based intervention was based on Pearlin and Schooler’s “model of coping and adaptive behavior: attacking the problem, rethinking the problem, and managing the stress” (ibid., p. 109). In comparison with a control group, “at 6-month follow-up, intervention participants reported significantly lower work-family and work environment stress, higher social support from work sources, less avoidance coping, and lower psychological symptomatology” (ibid., p. 105).

This intervention demonstrates the practical and clinical value of resilience theories. By promoting positive, constructive coping skills, the investigators were able to make significant changes to the problems experienced by the participants, even though these
problems were not specifically addressed. Furthermore, the intervention operationalises the theory of coping developed by Pearlin and Schooler (1982), creating the links between theory, practice and research.

The individual approach to resilience has tended to emphasise resilience as an internal phenomenon, an emphasis that is only challenged later, and with difficulty, by family resilience researchers. Walsh (1996, pp. 262-263), for example, states, “Resilience is commonly thought of as inborn, as if resilient persons grew themselves up: either they had the ‘right stuff’ all along – a biological hardiness – or they acquired it by their own initiative and good fortune.” Similarly, Goldstein (1997, p. 32) states, “Jordan gives greatest weight to resilience as a state of mind. This means that basic principles of helping begin with a primary focus on – or better, a commitment to – how clients perceive their world.” This perspective will be apparent throughout this section on individual resilience. Indeed, a great contribution of resilience theory has been to help us understand how an individual’s perspective on life difficulties fundamentally affects the individual’s experience of and response to the difficulty.

Individual resilience theory began with studies of children who rose above adverse childhood conditions. This research highlighted factors and models to explain how children develop resilience. Antonovskys’s salutogenic theory addressed the question of health in adults. Various other models have been advanced over the years to explain how people stay healthy and happy, even in difficult times. These themes will be addressed in the following sections.

2.2 Resilience in Children

Longitudinal studies on children who were born into adverse conditions have formed the foundation of much of our current understanding of resiliency in adults and families. These studies tracked children who, according to various indicators, were considered to be children at risk. Over a number of decades, researchers have become increasingly able to identify those features that are associated with the children who rose above their circumstances.

Werner and Smith’s (1992) study in Kauai, Hawaii, which began in 1955, is probably the most well known study of this nature. By age 18, one third of the participants, who were assessed at birth to be ‘at risk,’ had developed into “competent and confident young adults” (Saleebey, 1996, p. 299). By age 32, two thirds of the remaining
participants “had turned into caring and efficacious adults” (ibid., p. 300). This research demonstrates firstly that certain factors protect vulnerable children from dysfunction, and secondly that a vulnerable person’s life course can change at any time and is not completely determined in early childhood (ibid.).

Cederblad and her colleagues (Cederblad, Dahlin, Hagnell, & Hansson, 1994) conducted a similar study in Sweden, starting in 1947. Children who were exposed to three or more factors that are associated with later mental illness were included in the study (Dahlin, Cederblad, Antonovsky, & Hagnell, 1990, p. 229). A follow-up of these participants in 1988, when they were in their 40’s and 50’s indicated that “almost half the sample succeeded in creating a reasonably successful and at least moderately healthy life despite the severe handicaps in their childhoods! … It can be argued that at least half the sample has manifested considerable resilience” (Dahlin et al., 1990, p. 231).

Research such as this has challenged three intransigent ideas that have been and probably still are prevalent in social work and psychology:

- “There are fixed, inevitable, critical, and universal stages of development;
- “Childhood trauma inevitably leads to adult psychopathology…; and
- “There are social conditions, interpersonal relationships, and institutional arrangements that are so toxic they inevitably lead to decrements or problems in the everyday functioning of children and adults, families, and communities” (Saleebey, 1996, p. 299).

Beliefs such as these, which are indicative of pathogenic thinking, are shattered by the discovery that the majority (around 50%) of children who should not develop into well-adjusted adults do in fact just that. While it is true that childhood adversity does increase the likelihood of psychopathology in later life (Cederblad, Dahlin, Hagnell, & Hansson, 1995, p. 322), this adversity is also moderated by a set of identifiable protective factors, such as “a high sense of coherence, high mastery, [and] an inner locus of control” (ibid.).

Children who are able to overcome these odds are called resilient. “Resiliency in children is the capacity of those of who are exposed to identifiable risk factors to overcome those risks and avoid negative outcomes such as delinquency and behavioral problems, psychological maladjustment, academic difficulties, and physical complications” (Rak & Patterson, 1996, p. 368).
Research has shown that the following factors are present in resilient children (Benard & Marshall, 1997; Bogenschneider, 1996; Butler, 1997; Cederblad et al., 1994; Hawley & De Haan, 1996; Parker, Cowen, Work, & Wyman, 1990; Rutter, 1979; Werner, 1984, 1990):

- They had an outgoing, socially open, cooperative, engaging, likeable personality. They were able, from infancy on, to gain other people’s positive attention. Their behaviour was open, kind and calm.

- The children had good early bonding with their mothers or some other caregiver (e.g. a grandmother, older sister or another relative).

- They had a variety of alternative caregivers who played important roles as positive identification models.

- Their mothers had steady employment outside the home.

- They were required to participate in household chores and activities, i.e. ‘required helpfulness’.

- There were clearly defined boundaries between subsystems within the family.

- They weren’t colicky.

- They were active, cuddly and good-natured.

- They had at least average intelligence.

- They were more likely to be girls.

- They experienced no separations from their primary caregiver during the first year of life.

- They were more likely to be the oldest child.

- They did not have another sibling born before they turned two.

- They attended good schools that set appropriately high standards, that provided teacher feedback to students, that praised students for good work, that gave students positions of trust and responsibility, that provided extramural activities, and where teachers were good behaviour models.
They had a high self-esteem.

They had strict parental supervision.

They had good positive coping skills. They had an active, evocative approach towards solving life’s problems, enabling them to negotiate successfully emotionally hazardous experiences. They had flexible coping skills that could respond to the changing environment and their own changing development.

They perceived themselves to be competent.

They tended to perceive their experiences constructively, even if the experiences caused pain or suffering.

They had better interpersonal skills.

They had an internal locus of control.

They had good impulse control.

They had high energy and were active.

They enjoyed school.

They had a strong ability to use faith to maintain a positive view of a meaningful life. Their faith provided them with a sense of rootedness and coherence, a conviction that their lives had meaning and a belief that things would work out in the end despite unfavourable odds.

They were autonomous and independent.

They had special interests and hobbies.

They were able to ask for support when they needed it.

Clearly, children are not defenceless against stressful life conditions. There are many factors which can assist to ‘buffer’ (Rutter, 1985) children against stress, and which assist them in growing up to be well-adjusted and happy adults, who work well, play well, love well and expect well (Werner in Dahlin et al., 1990, p. 228). These resilience studies stand in contrast to “the overwhelming bulk of developmental research [which] has been devoted to exploring the pathogenic hypothesis, ie that risk factors in the
perinatal period, infancy and early childhood are predictive of disturbances in later childhood and adulthood” (ibid.).

The theory that has most strongly drawn together studies such as those described so far is the theory of salutogenesis, developed by Antonovsky.

### 2.3 Salutogenesis

Aaron Antonovsky, a medical sociologist, coined the term ‘salutogenesis’ in 1978 (Antonovsky, 1998a, p. 5). Salutogenesis “emphasizes the origins of health, or wellness, [and comes from the Latin]: *salus* = health, Greek: *genesis* = origins” (Strümpfer, 1990, p. 263). Literally translated salutogenesis means the ‘*origins of health*’. Salutogenesis offers a paradigm for thinking about resilience, illness and health, that stands in contrast to the dominant pathogenic paradigm.

#### 2.3.1 Pathogenesis

Pathogenesis, the ‘*origins of disease*’, has been and largely continues to be the dominant model of health and medicine. According to the pathogenic paradigm, “people remain healthy unless some special bug or combination of bugs ‘is caught’” (Antonovsky, 1998a, p. 5). Pathogenic research and practice is aimed at determining why people become sick and why certain people develop particular diseases (Strümpfer, 1990). Pathogenesis assumes that people normally function in a state of homeostasis and order (Antonovsky, 1984), “which may vary somewhat but is maintained by various complexly interacting regulatory mechanisms” (Strümpfer, 1990, p. 264). When these mechanisms are inadequate to resist the attacks of “microbiological, physical, chemical, and/or psychosocial stressors, vectors or agents”, disease results (Antonovsky, 1984, p. 114). Consequently, these ‘bugs’, be they germs, chemicals or psychosocial stressors, must be ‘bad’ and should be eradicated or avoided.

The central pathogenic question is, “How do stressors eventuate in undesirable illness outcomes?” (Antonovsky & Bernstein, 1986, p. 53). In pathogenic research, the outcome variable is always illness of some kind. “Mediating or coping variables” may be introduced as illness “buffers”, increasing the validity of the study, but the outcome variable is always illness (ibid.).
The pathogenic paradigm has had six primary consequences for research and clinical practice (Antonovsky, 1984):

- **Health versus Disease.** “We have come to think dichotomously about people, classifying them as either healthy or diseased” (Antonovsky, 1984, p. 115). The majority of people are assumed to be in the healthy category, and a minority of people, the “deviants” or “abnormals”, are in the diseased category (Antonovsky, 1979, p. 48).

- **Specific Focus on Pathogen.** “Thinking pathogenically, we have almost inevitably taken as our focus of concern a specific pathologic entity: heart disease, or cancer, or schizophrenia” (Antonovsky, 1984, p. 115). The researcher or practitioner focuses exclusively on that disease and only that disease (Antonovsky & Bernstein, 1986). Only phenomena that are thought to contribute directly to that disease are considered. Other phenomena, which may be common to various diseases, either as causes or solutions, tend to be ignored due to the high level of specialisation of the practitioner (Antonovsky, 1984).

- **Disease Causation.** “The pathogenic paradigm has constrained us to search for the cause or, if enlightened by the concept of multifactorial causation, the causes of disease X” (Antonovsky, 1984, p. 115). Since the pathogenic paradigm assumes that people function in a state of homeostasis, it comes as a surprise to find pathogens and all energy is devoted to the study of these pathogens. Practitioners who think pathogenically are unaware that stress and pathogens are ubiquitous. Consequently, they focus on how these stressors function, rather than on how people cope with them. Stated differently, “When one’s focus is on an undesirable dependent variable, one’s thinking tends to be oriented to studying undesirable independent variables” (Antonovsky & Bernstein, 1986, p. 64).

- **Stressors are Bad.** “Stressors, by definition, are viewed as pathogenic” (Antonovsky & Bernstein, 1986, p. 64). The goal of pathogenically oriented practice is to eradicate all stressors, since stress is believed to inevitably lead to disease. “Our goal has become the creation of a sterile environment,” free of all stressors and pathogens (Antonovsky, 1984, p. 115).

- **Illusion of Health.** “The pathogenic paradigm underlies the ambience that Dubos (1960) has so cogently warned against, ‘the mirage of health’” (Antonovsky, 1984, p. 115). Wars are waged against various diseases, with the assurances that the diseases can and have been conquered. This results in a false belief that disease and
its biological causes can be eradicated. The behavioural components involved in disease prevention and health promotion are of little consideration and receive minimal funding. Nevertheless, despite enormous efforts to eradicate disease, unhealth remains.

- Group Statistics. “Pathogenesis has given overwhelming priority to the case or, in considering prevention, to the high-risk group. It tends to ignore what methodologists call deviant cases” (Antonovsky, 1984, p. 116). Researchers’ emphasis on group statistics results in satisfaction once “we have established that we can account for so and so much of the variance”, even though only a portion of the variance is actually explained (Antonovsky & Bernstein, 1986, p. 65). Group statistics prevent an examination of the “successful coper” or “deviant case” who, despite the prediction of disease, resists disease. “Children of schizophrenic parents who do not become schizophrenic do not interest us, because we are tuned in to the specific disease. They may all have been killed in traffic accidents, but that is not our turf. Because we do not study the deviants, however, we generate neither hypotheses nor methodologies to help us understand the full gamut of human health” (Antonovsky, 1984, p. 116).

2.3.2 THE SALUTOGENIC QUESTION

“Salutogenesis makes a fundamentally different philosophical assertion about the world than does pathogenesis” (Antonovsky, 1998a, p. 5). Salutogenesis asks a question that is unheard of in pathogenic circles. In a 1971 study on concentration camp survivors, Antonovsky and his colleagues (cited in Antonovsky & Bernstein, 1986) write:

Our data are very consistent in showing that middle-aged Israeli women of central European origin who were concentration camp survivors are, as a group, more poorly adapted ... than are the women in a control group. ... What is, however, of greater fascination and of human and scientific import ... is the fact that a not-inconsiderable number of concentration camp survivors were found to be well-adapted. ... What, we must ask, has given these women the strength, despite their experience, to maintain what would seem to be the capacity not only to function well, but even to be happy [italics added]. (p. 52)

Where the pathogenic paradigm asks, “Why do people get ill?” the salutogenic paradigm asks, “Why, when people are exposed to the same stress which causes some to become ill, do some remain healthy?” (see Antonovsky, 1979, p. 56; Antonovsky, 1984, p. 117; Strümpfer, 1990, p. 267)
The salutogenic paradigm has six primary consequences for research and clinical practice (Antonovsky, 1984):

- **Health as a Continuum.** “Salutogenesis open the way for a continuum conceptualization of what I have called health ease-dis-ease” (Antonovsky, 1984, p. 116). Rather than categorising people as either healthy or diseased, salutogenesis posits that people fall on a continuum somewhere between these two poles, which can be termed ease and dis-ease. Although people towards the dis-ease end of the continuum will require more intensive biopsychosocial intervention, the salutogenic questions asks, “Why does this person – wherever he or she is located on the continuum – move toward the healthy pole?” (Antonovsky, 1984)

- **Broad Focus on Health.** We no longer focus exclusively on one or other specific disease entity. Rather, the salutogenic paradigm requires researchers and practitioners to focus broadly on a variety of general factors that promote movement towards health, irrespective of the specific dis-ease being experienced by an individual (Antonovsky, 1984).

- **Health Causation.** In contrast with the emphasis on how specific diseases are caused, salutogenesis focuses on the causes or origins of wellness (Antonovsky, 1984):

  Assuming that stressors are ubiquitous, we turn our attention away from the potential pathogen and from the specific answer to a given pathogen and become concerned, in research and in practice, with the resources that are valuable in coping with a wide range of pathogens and stressors. (p. 116)

- **“Only by focusing on health can we make advances in developing a broad-range theory of successful coping that derives from familiarity with a wide range of studies on different diseases and health outcomes”** (Antonovsky & Bernstein, 1986, p. 64).

- **Stressors can be Good.** Stress, while undeniably having some negative consequences, can also have salutary consequences: “A stressor may be a challenge, giving rise to successful coping precisely because it makes unanticipated demands” (Antonovsky & Bernstein, 1986, p. 64). Stress is part of our human existence and must be dealt accordingly (Antonovsky, 1984):

  We avoid hysteria about stressors and the gimmicks and instant cures that often accompany such hysteria. The question becomes not “How can we eradicate this or that stressor?” but “How can we learn to live, and live well, with stressors, and possibly even turn their existence to our advantage?” (p. 116)
Struggle for Adaptation. “Recognition of the limited utility of wars against
diseases X, Y, and Z, of the search for utopia, leads us to focus on the overall
problem of adaptation, of the perpetual struggle for sources of adaptation”
(Antonovsky, 1984, p. 117). This raises the study of health and the clinical practice
of development and growth to the same status as the study of disease and the
practice of disease prevention. The combination of these two forces will assist in the
movement towards the health end of the ease-dis-ease continuum.

Deviant Cases. “The salutogenic paradigm continually focuses on the deviants, on
those who make it against the high odds that human existence poses. It posits that
we all, by virtue of being human, are in a high-risk group” (Antonovsky, 1984, p.
117). By studying these few deviant cases (although in some instances they may be
in the majority), which pathogenic research overlooks, we all learn how to become
more resilient.

Antonovsky and Bernstein (1986) are, however, quick to point out that the salutogenic
paradigm is not intended to replace the pathogenic one:

A friend once remarked, “When I have cancer, I want to be treated for cancer, not
for the sense of coherence.” Our thesis is that she should also be treated for the
sense of coherence – or whatever salutogenic variable turns out to be a powerful
predictor of health. Nor is it enough to ask, "Who doesn't get disease X?" For, as we
have noted, one may get disease Y, which may be as serious as disease X. The
salutogenic alternative is intended to add the study of health to the study of
diseases. (p. 64)

Antonovsky’s work focused specifically on the issue of physical health (Antonovsky,
1979):

My point is that by defining health as coextensive with the many other dimensions of
well-being, one makes the concept of health meaningless an impossible to study. It
is, of course, folly to deny the interaction between health well-being and other
dimensions. ... But the nature of this relationship is one that must be subjected to
theoretical clarification and empirical investigation. Health well-being must be
measured separately. (p. 68)

Yet despite such assertions, in the same book he adopts Dubos’ definition of health
(Antonovsky, 1979, p. 53), “A modus vivendi enabling imperfect men to achieve a
rewarding and not too painful existence while they cope with an imperfect world.”

Strümpfer (1995, p. 81) notes “that Antonovsky struggled with a much more
encompassing problem [than merely physical health], namely that of the sources of
strength in general.” In response to this, Strümpfer proposes the term ‘fortigenesis’
(ibid.):
The term “fortigenesis”, from Latin: *fortis* (= strong), seems to be more descriptive of the paradigm than the term ‘salutogenesis’. The English words, *fortify* (= to impart physical strength, vigour or endurance, or to strengthen mentally or morally), *fort* (= a fortified place), and *fortitude* (= strength and courage in adversity or pain), all have the same root. Introducing the construct is not to deny the need to search for the origins of health; it is merely to say that, in the process of doing so, Antonovsky could not help but point to the closely related origins of the strength needed to be effective at other end-points of human functioning too. This total endeavour should be acknowledged: “fortigenesis” is more embracing, more holistic, than “salutogenesis”. (p. 82)

Owing to the long history of the term ‘salutogenesis’ and in light of the broad way in which the term has been used by psychologists, medical practitioners, nurses, educationalists and social workers, I have opted to retain the term ‘salutogenesis’. Despite both Antonovsky’s reservations and Strümpfer’s astute observations, ‘salutogenesis’ has come to mean the ‘origins of health’, where health is broadly defined as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (World Health Organization, cited in Antonovsky, 1979, p. 52).

### 2.3.3 The Salutogenic Model of Health

Antonovsky’s studies concerning the origins of health led him to propose the Salutogenic Model of Health (Figure 2.1). This model illustrates how various components work together leading to a prediction of an individual’s position along the ease-dis-ease continuum. The following discussion, which clarifies the important components of the model, is summarised from Chapter 7 of Antonovsky’s Health, Stress, and Coping (1979, pp. 182-197).

- **Sense of Coherence.** Antonovsky’s notion of ‘Sense of Coherence’ is the central tenet of his salutogenic paradigm and will be discussed in greater depth in the following section. He says (Antonovsky, 1979):

  I start the discussion from the sense of coherence. This is, after all, the core of my answer to the problem of salutogenesis. The sense of coherence is measurable; each of us is located at some point on the sense-of-coherence continuum, which can be seen as an ordinal scale. (p. 183)

- **Life Experiences.** Arrow A in Figure 2.1 indicates the importance of life experiences in the development of a sense of coherence. “The more these experiences are characterized by consistency, participation in shaping outcome, and an underload-
Life experiences shape the sense of coherence.

Stressors affect the generalized resistance resources at one's disposal.

By definition, a GRR provides one with sets of meaningful, coherent life experiences.

A strong sense of coherence mobilizes the GRRs and SRRs at one's disposal.

Childrearing patterns, social role complexes, idiosyncratic factors, and chance build up GRRs.

The sources of GRRs also create stressors.

Traumatic physical and biochemical stressors affect health status directly; health status affects extent of exposure to psychosocial stressors.

Stressors interact with endogenic pathogens and 'weak links' and with stress to affect health status.

Public and private health measures avoid or neutralize stressors.

A strong sense of coherence, mobilizing GRRs and SRRs, avoids stressors.

A strong sense of coherence, mobilizing GRRs and SRRs, defines stimuli as nonstressors.

Ubiquitous stressors create a state of tension.

The mobilized GRRs (and SRRs) interact with the state of tension and manage a holding action and the overcoming of stressors.

Successful tension management strengthens the sense of coherence.

Successful tension management maintains one's place on the health ease/dis-ease continuum.

Interaction between the state of stress and pathogens and 'weak links' negatively affects health status.

Stress is a general precursor that interacts with the existing potential endogenic and exogenic pathogens and 'weak links'.

Good health status facilitates the acquisition of other GRRs.

The statements and arrows in bold are the core of the salutogenic model.
overload balance of stimuli, the more we begin to see the world as being coherent and predictable” (Antonovsky, 1979, p. 187). The foundations of the sense of coherence are laid in childhood, during one’s formative life experience, but can change throughout life in response to significant cataclysmic life events or through personal development and growth.

- **Generalised Resistance Resources.** Generalised Resistance Resources (GRRs) are the factors that give life experiences the qualities of “consistency, participation in shaping outcome and neither underload nor overload” (Antonovsky, 1979, p. 189). GRRs, by definition, provide a person with life experiences that are meaningful and coherent. The relationship between life experiences and GRRs is not causal, hence Line C in Figure 2.1 is a line and not an arrow. GRRs are the ingredients that mix together with life experiences to influence one’s sense of coherence.

- **Sources of GRRs.** As indicated by Arrow E, GRRs are rooted in still earlier experiences that are located within a sociocultural and historical context. One’s position in society affords one certain opportunities and conditions – some better, some worse. These conditions affect the repertoire of and the type of GRRs that can develop. In particular, they influence child rearing patterns and social-role complexes. There are other factors, however, which are not subject to context: idiosyncratic factors such as an individual’s personality, appearance, intelligence, etc as well as chance factors influence the development of GRRs. While people who are poor or isolated from participating in society have fewer opportunities to develop GRRs, they are not completely without opportunity.

- **Stressors.** Although the sense of coherence occupies the central position of the Salutogenic Model, stressors occupy the most ‘busy’ position. Arrow F indicates that the sources of GRRs (as discussed in the previous paragraph) influence the kinds of stressors present in an individual’s experience. Arrow B indicates that stressors can profoundly influence one’s GRRs by introducing unexpected experiences that promote or shake one’s GRRs. Arrow G indicates that traumatic physical or biochemical stressors (such as poison, a bullet or a car) affect one’s position on the health continuum directly. Arrow H indicates that prolonged exposure to physical and biochemical stressors can indirectly affect one’s health through interaction with potential pathogens and one’s state of stress. Arrow L indicates that the stressors place one in a state of tension.
**Management of Tension.** Arrow I indicates that advances in preventive and remedial medicine have increased society’s capacity to reduce, restrict or remove some of the stressors. Of course, “the bugs ... are smarter” (Antonovsky, 1979, p. 193) making such measures inadequate to ensure health. Arrow D indicates how sense of coherence enables the management of tension that arises from the stressors by mobilising the GRRs and also other Specific Resistance Resources (SRRs). The mobilised GRRs can then be used in three main ways. Firstly, as can be seen by Line J, one can avoid the stressors completely. Secondly, Line K indicates that certain stressors can be redefined “as innocuous or even as welcome” (ibid.). Thirdly, as Arrow M indicates, the GRRs enable one to manage one’s state of tension by holding the stress or by overcoming the stressor (see the previous discussion on Pearlin and Schooler’s (1982) three types of coping which are relevant here). Successful efforts to manage the state of tension contribute to one’s sense of coherence (Arrow N), by enabling one to “learn that existence is neither shattering nor meaningless” (Antonovsky, 1979, p. 194).

**Stress.** The successful management of stress contributes to one’s sense of coherence (Arrow N) and also maintains one’s position along the health continuum (Arrow O). Unsuccessful management of tension contributes to a state of stress, which, together with the indirect work of stressors and the activation of potential pathogens, leads to illness (Arrow P). Arrow Q indicates that the pathogens that ‘cause’ illness do so only in interaction with a state of stress. This suggests that, “other than the massive traumata that leave none unscathed (Arrow G), all diseases are usefully understood as psychosomatic. In other words, almost all breakdown involves stress. Stress, however, does not determine the particular expression of the breakdown” (Antonovsky, 1979, p. 196).

**Health.** One’s position on the health or ease/dis-ease continuum is the final stage of the Salutogenic Model. One’s health status acts on one’s life experiences in three main ways. Firstly, Arrow G indicates that one’s health status influences the kinds of stressors one is exposed to. Secondly, Arrow R indicates that “good health is in itself a significant generalized resistance resource by the definition of a GRR as a factor that fosters meaningful and sensible life experiences” (Antonovsky, 1979, p. 197). Thirdly, being healthy “can facilitate the acquisition of other GRRs” (ibid.).

In short, childrearing patterns and social-role complexes build up generalised resistance resources (Arrow E), which provide one with sets of meaningful, coherent life experiences (Line C) which shape an individual’s sense of coherence (Arrow A). When
one is exposed to life stress, one enters a state of tension (Arrow L). A strong sense of coherence mobilises one’s available GRRs (Arrow D), which interact with the state of tension to hold the stress and overcome the stressor (Arrow M). Successful management of the tension boosts one’s sense of coherence (Arrow N) and maintains one’s position towards the health end of the ease/dis-ease continuum (Arrow O).

### 2.4 Sense of Coherence

#### 2.4.1 Introduction to SOC

As the previous section will have made clear, ‘Sense of Coherence’ (SOC) is the central contribution of Antonovsky’s salutogenic theorising. Antonovsky’s research investigated the source of resilience and found the GRRs. Further research indicated that GRRs were mobilised by another construct, namely SOC (Antonovsky, 1998b). Ongoing research provided ample evidence to support the notion that people’s SOC contributed substantially to their resilience and health.

Before unpacking what SOC is, it is important to clarify what it is not. It is not a specific coping style or method or resource. It is rather a general approach to life that enables the mobilisation of specific coping resources (Antonovsky, 1998a):

Much as salutogenesis is a very broad construct, seeking to understand health rather than any given diagnostic category of disease, so the SOC is, in two senses, broader than the coping resources that have been studied. First, it is most emphatically not a coping style or a substantive resource. The crucial idea is that, since people confront such a wide variety of bugs, no specific style or resource is ever appropriate all the time. The person with a strong SOC, believing that she or he understands the problem and sees it as a challenge, will select what is believed to be the most appropriate tool for the task at hand. Second, the SOC distills the core of specific coping or resistance resources (money, social support, mastery, a confidant, a belief in God, and so on), and expresses what they have in common: they enhance one’s sense of comprehensibility, manageability, and meaningfulness. In this way, the SOC offers an explanation of how these resources may contribute to health. (p. 8)

SOC was originally defined as follows (Antonovsky, 1979):

The sense of coherence is a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one’s internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected. (p. 123)
Ongoing research led Antonovsky to identify three main components of SOC, viz: comprehensibility, manageability and meaningfulness. This resulted in a reformulation of the original definition (1987, cited in Antonovsky, 1998b):

A global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one’s internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement (Antonovsky, 1987, p. 19). (p. 22)

These three components can be discussed in more detail:

- **Comprehensibility.** The comprehensibility component of SOC is what was most strongly emphasised by the original 1979 definition of SOC, viz “the extent to which individuals perceive the stimuli that confront them as making cognitive sense, as information that is ordered, consistent, structured, and clear – and, hence, regarding the future, as predictable – rather than as noisy, chaotic, disordered, random, accidental, and unpredictable” (Antonovsky, 1984, p. 118). Comprehensibility is primarily a cognitive dimension, referring to how the individual thinks about or makes sense of a set of internal or external stimuli or situations. It implies that life, which is currently comprehensible, is expected to comprehensible in the future. It also implies that, although one may undergo great difficulties, challenges and complex situations, there is a fundamental conviction that these situations will make sense.

- **Manageability.** Manageability is “the extent of the belief that not only did one understand the problem, but that the requisite resources to cope with the problem successfully were at one’s disposal” (Antonovsky, 1998a, p. 7). It may appear that manageability refers to the sense that life is ‘under my control’ and that it is thus equivalent to Rotter’s Locus of Control (to be discussed further in a later section). However, Antonovsky (1984) argues that Locus of Control and Manageability are quite different constructs:

  “At one’s disposal” may refer to resources under one’s own control – the ... Rotter understanding – but it may also refer to resources controlled by legitimate others – friends, colleagues, God, history – upon whom one can count. No implication exists that untoward things do not happen in life. They do; but when people are high on manageability, they have the sense that, aided by their own resources or by those of legitimate others, they will be able to cope and not grieve endlessly. Moreover, there will be no sense of being victimized by events or of being treated unfairly by life. (p. 119)
The concept of ‘legitimate others’ introduces the notion that being tied into a meaningful social network promotes one’s resilience, a subject that will be addressed in greater depth later. Strümpfer (1990, p. 269) notes “that the mere perception that help is available may operate [to enhance resilience], without any actual support being provided.”

Meaningfulness. Meaningfulness is the emotional face of comprehensibility (Antonovsky, 1984). While comprehensibility means that life makes cognitive sense, meaningfulness means that life is emotionally worthwhile and sensible. In this way, meaningfulness accounts for an individual’s motivation to engage in a difficult life situation (Antonovsky, 1998a). To say that life is meaningful is to say that one cares (Antonovsky, 1984). When a difficult situation is perceived as meaningful, one chooses to invest emotional energy in dealing with it, one sees the difficulty as a challenge in which it is worth investing energy and commitment, rather than as a burden (ibid.).

An individual who had a weak Sense of Coherence would thus (Strümpfer, 1990):

Perceive internal and external stimuli as noise, not information, as inexplicable disorder and chaos, and as unpredictable in future; (s)he would experience the events of life as unfortunate things that happen to her/him and victimize her/him unfairly; and (s)he would feel that nothing in life mattered much, or worse, are unwelcome demands and wearisome burdens. (p. 269)

By contrast, the person with a strong SOC (Cederblad et al., 1994):

Confronting stressors, is capable of clarifying and structuring the nature of the stressor, believes that the appropriate resources are available and can be mobilized to deal successfully with the challenge, and is motivated to deal with it. Such an orientation to life … allows the selection of appropriate coping strategies and provides a solid base for maintenance and strengthening of health and well being. (pp. 2-3)

2.4.2 DETAILS CONCERNING SOC

In his various writings, Antonovsky unpacks a number of important details concerning Sense of Coherence:
2.4.2.1 SOC is a Paradigm

SOC is a personal paradigm. Inasmuch as salutogenesis is a paradigm, a “set of fundamental beliefs inaccessible to empirical validation” (Strümpfer, 1990, p. 263), SOC is a personal paradigm that indicates an individual’s global outlook on life (Antonovsky, 1979):

The sense of coherence explicitly and unequivocally is a generalized, long-lasting way of seeing the world and one’s life in it. It is perceptual, with both cognitive and affective components. Its referent is not this or that area of life, this or that problem or situation, this or that time, or, in our terms, this or that stressor. It is, I suggest, a crucial element in the basic personality structure of an individual and in the ambiance of a subculture, culture, or historical period. (p. 124)

2.4.2.2 SOC is Dynamic

Antonovsky assumes that SOC is established by about age 30 and thereafter remains stable (Antonovsky, 1984, p. 118). A person who enters adulthood with a strong SOC will tend to generate life experiences that reinforce, even promote, their SOC. Even catastrophic life events will, most likely, be survived with SOC remaining intact. On the other hand, a person whose life experiences during the first 30 years are marked by chaos will enter adulthood with a weak SOC. It is unlikely that even regular SOC enhancing life experiences will fundamentally alter their SOC. “By and large … the person with a weak SOC in adulthood will manifest a cyclical pattern of deteriorating health and a weakening SOC” (Antonovsky, 1998a, p. 15). Antonovsky is arguing that people with high SOC get more SOC, while people with low SOC get less.

However, Antonovsky points out that his position is theoretical not empirical, and that he has no evidence to substantiate his argument (Antonovsky, 1998a). He also argues that SOC is dynamic and can change during an individual’s life course. “I certainly am not committed to understanding the sense of coherence as being determined forever and anon by genes or early childhood experience. It is shaped and tested, reinforced and modified not only in childhood but throughout one’s life” (Antonovsky, 1979, p. 125). He suggests that “change, even significant change, can occur if people can be enabled to alter their lives significantly, encouraging SOC-enhancing experiences to occur with greater frequency over a sustained period” (Flick & Homan, 1998, p. 109).

Antonovsky’s somewhat contradictory statements regarding the stability and dynamism of SOC are not well resolved. There is little research pointing to ways to enhance SOC.
There is also little research indicating the degree to which a weak SOC can be bolstered and substantially improved. In 1998, Antonovsky stated that the “developmental dynamics of the sense of coherence” was one of three important areas for ongoing research, indicating this to be an unresolved issue.

2.4.2.3 Boundaries

SOC is the view that a person has about the world around him/her. It does not follow, however, that the person must view the entire world as comprehensible, manageable and meaningful. Antonovsky’s research found that people draw boundaries within the objective world – provided those things which fall within the boundaries are considered coherent the person will have a strong SOC, irrespective of the coherence of things outside the boundaries. “Quite conceivably, people might feel that they have little interest in national government or international politics, little competence in manual (or cognitive or aesthetic) skills, little concern for local volunteer groups or trade union activity, and so on, and yet have a strong SOC” (Antonovsky, 1984, p. 119).

This is similar to Covey’s notion of circles of concern and influence (Covey, Merrill, & Merrill, 1994, p. 150). The ‘circle of concern’ refers to everything about which one is concerned. Things outside of the circle of concern are of no importance to that individual. Within the circle of concern is a smaller circle, the ‘circle of influence’, which refers to those things which concern that individual and over which that individual has some influence. Covey’s point is that being concerned about something does not give one influence over it. By focusing on the area between the two circles (ie those things which concern one but over which one has no influence) one creates SOC reducing experiences, since the situation is not manageable. In this regard, Antonovsky (1984, p. 119) asks, “First, is there at least some part of my life that does matter very much, which I care about [ie the circle of concern]? Second, within these boundaries, are stimuli meaningful, comprehensible, and manageable [ie the circle of influence]?” By focusing on issues within the circle of influence, one is assured of life experiences that are coherent, and in so doing, one can (theoretically) expand the circle of influence.

Of course, a person may have a very small circle of concern and an even smaller circle of influence, yielding a life that is very limited in scope although potentially high in SOC. Not everything can be left out of the circle of influence, however (Strümpfer, 1990):
Antonovsky (1987) maintained that there are four spheres that cannot be excluded if the person is to maintain a strong SOC, namely, his/her own feelings, immediate interpersonal relations, the major sphere of activity (work, really) and the existential issues of death, inevitable failures, shortcomings, conflict and isolation. (p. 269)

2.4.2.4 SOC and Values

It is tempting to think that people with high SOC will be principled people with humanitarian values. This, however, is not so. “A person with a strong SOC might well be a terrible person in terms of my (or your) values; … a Nazi or … a highly manipulative, unscrupulous academic, or a member of an extreme religious sect” (Antonovsky, 1984, p. 120). In this way, SOC is value neutral and is simply a world-view that tends to promote an individual's health in the face of life stressors.

2.4.2.5 SOC and Work

Given that the workplace is where most people spend a large percentage of their waking hours, the relationship between SOC and work is an area of interest. Strümpfer (1990) has studied this area extensively and says that having high SOC will result in the person:

- Making cognitive sense of the workplace, perceiving its stimulation as clear, ordered, structured, consistent and predictable information;
- Perceiving his/her work as consisting of experiences that are bearable, with which (s)he can cope, and as challenges that (s)he can meet by availing him-/herself of personal resources or resources under the control of legitimate others;
- And making emotional and motivational sense of work demands, as welcome challenges, worthy of engaging in and investing his/her energies in. (p. 270)

Antonovsky notes that work need not be intrinsically satisfying to be a SOC reinforcing experience. “People may find little joy in their work, but if they feel that the work has a meaning because it is how they support their family and keep it functioning smoothly and happily, they can still have a strong SOC” (Antonovsky, 1984, p. 120).

2.4.2.6 Coherence and Locus of Control

Locus of Control implies that that events are under control of an individual, leading to the phrase ‘sense of control’ or ‘I am in control’. “The sense of control is totally related
to the freedom of the individual to choose among available alternatives and to perceive
the outcome of the dynamic situation as completely contingent on the choice he or she
makes” (Antonovsky, 1979, p. 153). Internal locus of control (ibid.):

Locates one’s fate in one’s own hands. The tendency is most ethnocentrically
powerful to equate sense of coherence, sense of control, and internal locus of control,
using the model of the autonomous individual extolled in the litany of Western
societies since the Industrial Revolution – or, perhaps more appropriately, the
Protestant Revolution. This ideological paradigm dominates our own lives and shapes
our science. (p. 153)

Antonovsky strongly argues that the equation of manageability and control is a Western
and culturally biased practice, where the ego is placed at the centre of the universe and
where any form of control that is not ‘my control’ is greatly mistrusted. He draws a
distinction between the phrases “I am in control” and “Things are under control”
(Antonovsky, 1979, p. 155) to illustrate this difference. “I am in control” is the
dominant Western paradigm, while “Things are under control” is a dominant paradigm in
many other cultures. He goes further to state that in some cultures SOC is strongly
enhanced by the belief that things are under the control of a beneficent deity (or
powerful others) (ibid.).

The crux, argues Antonovsky, lies in the concept of ‘participation’ (Antonovsky, 1979):

If life offers one the chance of confirming one’s predestined salvation by doing the
prescribed right things, one can have a strong sense of coherence. Only when there
is no deity, no writ, but only meaningless chaos does one’s only hope lie in an
internal locus of control. There are, then, many cultural roads to a strong sense of
coherence. (p. 156)

The crucial issue is not whether power to determine such outcomes lies in our own
hands or elsewhere. What is important is that the location of power is where it is
legitimately supposed to be. This may be within oneself; it may be in the hands of
the head of the family, patriarchs, leaders, formal authorities, the party, history, or a
deity. The element of legitimacy assures one that issues will, in the long run, be
resolved by such authority in one’s own interests. Thus a strong sense of coherence
is not at all endangered by not being in control oneself. (p. 128)

2.4.2.7 Fake SOC

It is possible for a person to have a ‘fake sense of coherence’ (Antonovsky, 1979, p.
158). “The claim that everything is comprehensible and that all problems can be
managed suggests a profound underlying anxiety that this not at all the case, a fragile
covering that might easily be rent apart” (Antonovsky, 1984, p. 119). Antonovsky
continues elsewhere (1979):
When there is a contention that all problems have an answer, when challenge or doubt is intolerable, when there is no flexibility to adapt to changing circumstances, when one claims to be in control of all things or to understand everything, when there is a denial of sadness, and when there is an incapacity to admit to the uncontrollable without being overwhelmed – there is a clear indication that we are confronted by a fake sense of coherence. (p. 159)

### 2.4.2.8 Measuring SOC

In order to operationalise SOC, Antonovsky developed a 29-item scale that measures the three constructs comprising SOC. The SOC scale has been used in 14 languages, including Afrikaans and Tswana (two African languages), and has been completed by almost 10,000 people (Antonovsky, 1998b, p. 25). A short-form version of the scale, comprising 13 of the 29 questions, is also available but will not be reported on here.

The scale demonstrates good levels of reliability. Internal consistency measures (Cronbach’s Alpha) range from .82 to .95, in 26 studies using different languages and cultures (although all Western) (Antonovsky, 1998b, p. 25). Test-retest reliability coefficients (appropriate since SOC is conceptualised as a stable construct) range from .41 to .55 over a two-year interval, from .52 to .86 over a one-year interval, .80 over six months, .80 to .97 over five to six weeks, and .91 over two weeks (ibid., p. 26).

The scale has also demonstrated good validity. Evidence for content validity includes the fact that the items were carefully selected according to facet theory to cover all aspects of the SOC construct (Antonovsky, 1998b, p. 27). Various studies are presented by Antonovsky which demonstrate criterion validity by reporting appropriate correlations with theoretically expected variables (ibid., pp. 28-33). Known-groups validity studies demonstrate that “Czech cancer patients, Israeli young adults with cerebral palsy, New Zealand chronic pain patients, and older American patients in Department of Veterans Affairs (VA) clinics” have the lowest SOC scores, while “kibbutz members, American university faculty, and Israelis who have reached on-time retirement age” have the highest SOC scores (ibid., p. 34).

Although SOC comprises three components (comprehensibility, manageability and meaningfulness), these components are highly interrelated and “can really only be separated for analytic purposes. Theoretically, an individual can be high on one component and low on others, but this is inherently unstable” (Antonovsky, 1984, p. 120). For this reason, Antonovsky argues that factor analysis of the SOC scale is inappropriate (Antonovsky, 1998b). No factor analytic studies of the SOC scale have
been published, but a number of unpublished studies suggest that a single-factor solution provides the best explanation for the item variances (ibid., p. 35).

2.4.3 STUDIES OF SOC

SOC, as with many of the constructs that have been developed regarding individual resilience, was developed primarily to explain health. Many studies have thus used SOC as the independent variable and various measures of physical health as the dependent variable. Most studies, however, have introduced a broader range of dependent variables measuring strength or health more holistically defined, and have even moved out of the medical/health field completely. More recent thinking has also led to the conception of SOC at family level. Although this will be more fully discussed later, such studies are included here for the sake of completeness.

2.4.3.1 Health Narrowly Defined

Health. In a small (N=74) prospective study, SOC was effective in predicting the health status of a group of employees one year into the future, accounting for 22% to 32% of the variance in illness (Fiorentino & Pomazal, 1998, p. 98). However, when various other variables were entered into the multiple regression analyses (eg various resistance resources, health practices and stress), SOC did not enter any of the equations.

Survival of the Chronically Ill. An initial study (Time I) was conducted with 377 men who were over 55 years and who had at least one chronic condition (Coe, Romeis, & Hall, 1998). Significant correlations were found between SOC and the various measures of health status (including perceived health status, functional health status, nutritional status, mental health, etc) (ibid., p. 267). Five years later (Time II), 199 of the original sample were again interviewed. SOC (at Time I) was significantly correlated with the various measures of health status (at Time II), indicating the predictive validity of SOC regarding health (ibid., p. 270). The Time I profile of the 199 men who were interviewed at Time II was compared with the Time I profile of the 90 men who had died in the interim. SOC was not found to predict survival (ibid., p. 271); having better functional health status and living with one’s spouse and children at Time I were most effective at predicting survival at Time II (ibid.). The researchers conclude that while
SOC does not directly influence survival, it may indirectly influence survival through its direct predictive effect on health status.

**Cancer Outcome.** A study of 38 cancer patients investigated the effect of SOC and mental imagery on the immune system and cancer outcome (Post-White, 1998). Participants were randomly divided into experimental (n=22) and control (n=16) groups, the former receiving training in mental imagery. SOC scores did not differ between the two groups and over time (ibid., p. 283), although among the experimental group SOC scores correlated with various beliefs of improved health (ibid., p. 284). Baseline SOC also predicted an actual improvement in the immune system over time (ibid.). Baseline SOC predicted increased quality of life and increased hope over time (ibid., p. 285). Baseline SOC did not, however, predict actual disease state; to the contrary, greater baseline disease state predicted lower SOC scores (ibid., p. 287). The researcher concluded that “even though SOC did not directly influence disease state, a strong SOC did result in better quality of life and a more hopeful state” (ibid.).

**Immune System.** Another study (n=59, American women over 60 years) investigating the effects of SOC on the immune system yielded contradictory results (Milanesi et al., 1998). SOC correlated with the various measures of self-reported health, did not correlate with cortisol levels (a physiological measure of stress) and correlated with only one of several measures of the immune system. The authors (ibid.) conclude:

That no significant negative correlations appeared between the summed SOC scores and cortisol raises the possibility that perceived coping with perceived stress constitutes the major operating factor in the sense of coherence and that these perceived experiences do not cover all the actual stress and stress reduction processes operating at the physiological level. (p. 304)

**2.4.3.2 Health More Broadly Defined**

**Mental Health.** In the longitudinal Lundby study, 148 participants completed the 29-item SOC scale. Cronbach’s Alpha was .89 (Cederblad et al., 1994, p. 4). The scale correlated at .44 with the Locus of Control (LOC) scale (being in control of one’s life) and at .59 with the Mastery scale (being the master of one’s fate) (ibid.). The moderate correlations indicate that the three constructs are related but not identical. The SOC scale did, however, correlate highly with a number of other measures: A correlation of .76 was found with the Quality of Life (QOL) Scale which measures satisfaction with various areas of life, and a correlation of -.70 was found with the Symptom Checklist (SCL-90) which measures expressions of psychosomatic and emotional distress (Dahlin...
et al., 1990, p. 231). This study found that the more salutogenic factors present during childhood (eg positive self-esteem, successful coping, trusting relationships, intellectual capacity) the better the adult’s mental health and quality of life (Cederblad et al., 1994, p. 8). “Of the nine personal dimensions [including SOC, LOC, mastery, intelligence and ways of coping] entered into the multiple regression analyses, the SOC contributed most to the explained variance in health measures [including QOL, SCL-90, the Health-Sickness Rating Scale and rated health]” (Cederblad & Hansson, 1996, p. 198). The researchers propose a model in which the various salutogenic factors contribute to the development of high SOC which in turn contributes to better mental health (Cederblad et al., 1994, p. 10).

**Family Illness.** A study of 78 families in which one adult had a “serious illness” investigated the relationship between a family’s sense of coherence and family quality of life in the face of illness (Anderson, 1998). A multiple regression analysis indicated that 57.6% of family quality of life was accounted for by the family’s sense of coherence, “illness stress, family system balance, length of family relationship, patient full time job status and family income”, with family sense of coherence being the “largest predictor” (ibid., p. 179). The researcher concludes that family sense of coherence was “an important mediator in the impact of illness stress on the family, reducing the direct influence of the illness stress on family quality of life by half” (ibid., p. 182).

**Cystic Fibrosis.** A study of 123 adolescents with Cystic Fibrosis investigated the various factors (including SOC) that contribute to self-care, defined as “the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being” (Baker, 1998, p. 146). SOC was found to correlate significantly (p<.001) with the various ‘power components’ which which enable specific health-promoting practices, viz. eg “ego strength, valuing of health, health knowledge and decision-making capability, attention to health, energy, and the ability to talk about one’s feelings” (ibid., p. 164). SOC also correlated significantly (r=.76, p<.001) with self-care (ibid., p. 165), and also was a significant predictor of self-care in the multiple regression analyses. The researcher concludes that “having a sense of coherence is very important to the self-care of adolescents with cystic fibrosis” (ibid., p. 167).

**Single Parents of Disabled Children.** A study of 152 single mothers who had children with a variety of developmental disabilities sought to understand what factors help such mothers cope (Gottlieb, 1998). Results indicated that mothers with higher SOC scores tended to report fewer child behavioural problems, fewer recent and potentially stressful family experiences, greater family cohesion and adaptability, larger social support
networks, greater parenting satisfaction, less financial concern, less concern about meeting their disabled child’s needs, less depression, fewer health problems, greater well-being and less parenting stress (ibid.). SOC was not however related to the severity of the child’s disability nor the number of disabilities. The researcher concludes that SOC is an important variable in the way single mothers cope with the stress of raising a disabled child.

**Successful Aging.** A study of 199 American men aged 55 years and older investigated the role of SOC in ‘successful aging’, measured as a composite of psychological, social and physical well-being or health (Brooks, 1998). SOC was found to correlate significantly with the various measures of successful aging, with a correlation of $r=-.50$ with physical health (ibid., p. 235). Even when the correlations were controlled for age, income, education, occupation and past health, the correlations ($r=.38$ with life satisfaction, $r=.26$ with social health and $r=-.46$ with physical health) remained significant at $p<.01$ (ibid., p. 236). The researcher concludes that SOC is a significant factor in predicting successful aging.

### 2.4.3.3 Health Very Broadly Defined

**Coping with Recent Life Events.** A study in Israel investigated the importance of personal resources (specifically SOC) and collective resources (belonging to a religious kibbutz rather than a nonreligious kibbutz suggested more collective resources) in coping (defined as maintaining psychological well-being, physical well-being and functional status) with recent life events (RLE) (Anson, Carmel, Levenson, Bonneh, & Maoz, 1993). Two hundred and thirty people participated in the study. The personal resource of SOC was much stronger in accounting for health in the face of RLE than either collective resources or personal and collective resources combined. The study did demonstrate, however, that “collective resources (belonging to a religious community) somewhat foster the development of personal resources (SOC)” (Anson et al., 1993, p. 164). Although the study found a negative correlation between RLE and SOC, it was unclear whether people with stronger SOC avoided RLE or whether RLE tended to erode a person’s SOC.

**Coping with Job Demands.** A small study of 20 public health nurses in Hong Kong, investigated the importance of SOC for the “perceptions of task characteristics and for stress perceptions during interruptions” (Shiu, 1998, p. 273). The study’s methodology involved the nurses wearing a watch that randomly signalled them six times per day for...
seven days. Participants responded to 80% of the signals, which prompted them to complete a dairy concerning task characteristics, work and family role juggling and the effects of these on their mood states. The results indicated that nurses “with high SOC had a greater sense of emotional well-being in the face of occupational stress and work-family juggling, and were more likely to perceive tasks as progressing toward the goal and to be within control” (ibid., p. 278). The researcher concludes that SOC assists nurses in coping with the juggling of work and family responsibilities and in coping with occupational stressors.

Job Performance. In a small retrospective study (sample size not reported), a sample of workers with lower back pain was divided “into two groups based solely on the amount of time lost due to injury”. Both groups completed the SOC scale. The “results show that the two groups were significantly different in their sense of coherence scores, particularly with respect to the comprehension component” (Association of Ontario Health Centres, 1995, p. 2). Although the scientific quality of this study is questionable, it suggests that the job performance (attendance) of workers who are experiencing a life stressor (back pain) may be influenced by SOC, indicating its potential value for occupational social work and industrial psychology.

The Ability to Nurture. A small study (N=72) of homeless mothers with children sought to examine the relationship between SOC and the ability of mothers to nurture their children under the extreme stress of homelessness (Flick & Homan, 1998). Correlations of SOC with the Family Environment Scale and mother-child interaction were significant at p<.10 (ibid., p. 116). SOC correlated significantly (p<.001) with self-esteem and depression (ibid., p. 117). Mothers’ SOC correlated significantly and negatively with child behavioural problems (p<.10, p<.05 and p<.01 for the three subscales) (ibid., p. 120). The researchers conclude that SOC is “an important construct in explaining family environment, mother-child interaction, and child problems in an extremely distressed population” and that as such it is likely to predict better treatment outcome (ibid., p. 123).

Salutogenic Effects of an MBA Programme. A study investigated that salutogenic effect of participating in a US based MBA programme (Ryland, Tegarden, & King, 1998). The sample (N=338) comprised 57% American and 43% foreign students. When age is controlled for, the more experience students have had in the MBA programme, the higher their SOC scores are, suggesting that the MBA experience enhances SOC (ibid., p. 133). However, more detailed analysis indicates that only male American students experience an increase in SOC over the course of the MBA programme (ibid., p. 134).
Male foreign students, who started out with similar scores to male American students, experienced a decrease in SOC scores as a result of the MBA (ibid., p. 137). Female American students had higher SOC scores than female foreign students, but neither group experienced any change in SOC as a result of the MBA programme (ibid.).

**Retirement.** A study of 805 married, retired Israeli men and women investigated the role of SOC in adjustment to ‘on-time’ retirement (Sagy & Antonovsky, 1998). Various methods of determining the family’s SOC were tested and will be discussed in the section on family SOC. Results were however consistent in demonstrating that a strong family SOC predicted adaptation to retirement. When one family member has a higher SOC than the rest of the family, that member seems able to mobilise the family’s coping resources.

**Caring for the Aged.** A study of 126 people caring for chronically ill elderly people (71 caring for nondemented chronically ill people and 55 caring for chronically ill people who were demented) investigated the role of SOC in enabling the caregivers to cope with the demands of giving care (Wagenfeld, Baro, Gallagher, & Haepers, 1998). The SOC of the two groups of caregivers was the same, despite the demented patients having greater levels of disability than the nondemented patients (ibid., p. 256). SOC was found to be “protective against role overload” for all caregivers, but most especially for caregivers of demented patients (ibid., p. 259). The researchers propose a “threshold effect” in which “the SOC seems to be more protective in situations of greater morbidity” (ibid.). Caregivers with stronger SOC tend to utilize healthier coping responses: “redefining the meaning of the situation, selecting realistic coping strategies and avoiding potentially maladaptive or unhealthy behaviors” (ibid.). The researchers conclude that SOC is an important factor in enabling caregivers to cope with the demands of caregiving, particularly when caring for high-stress patients.

**2.4.4 A CRITIQUE OF SENSE OF COHERENCE**

I have been unable to locate any published critiques of the Sense of Coherence. This is surprising given the widespread use of the construct in various disciplines. Perhaps a primary criticism from social work may be the abstract nature of SOC that makes it largely inaccessible to clinical intervention. As a fundamental paradigm or outlook on life, SOC is deeply engrained in the psyche or personality of people. It cannot be affected directly, but only indirectly through generating certain life experiences, which
themselves can only be utilized in the presence of resistance resources. In effect, all clinical work needs to promote the development of resistance resources, and hope that SOC will follow suit.

The clinical utility of SOC (and the GRRs) is largely absent from the literature on SOC. Researchers seem content to demonstrate the role of SOC in one or other form of resilience, but have not made significant progress in addressing the practice utility of SOC. Since there are no practice guidelines detailing how to develop SOC, there are also no evaluation studies addressing the impact of certain interventions on the evolvement of SOC. The study on cancer outcome reported above (Post-White, 1998), for example, addresses the change (or lack of change) in SOC scores over the course of an intervention, but the intervention was not specifically designed to change SOC and thus contributes little to the clinical field.

It appears, therefore, that SOC is of theoretical and research interest, but has few clinical or preventive applications at present.

2.5 THRIVING

In 1998, the Journal of Social Issues (Ickovics & Park, 1998b) brought out a special issue entitled “Thriving: Broadening the paradigm beyond illness to health” in which they made a number of arguments which resemble those of salutogenesis and resilience. The notion of thriving goes somewhat further than these constructs, however, by arguing that the stressor may in fact enhance the functioning of the person. Thriving is here defined as (Ickovics & Park, 1998a):

The effective mobilization of individual and social resources in response to risk or threat, leading to positive mental or physical outcomes and/or positive social outcomes. We suggest that thriving represents something more than a return to equilibrium (i.e. homeostasis) following a challenge … We propose a “value-added” model, whereby an individual or community may go beyond survival and recovery from an illness or a stressor to thrive. (pp. 237-238)

The notion of thriving prompts the following kinds of questions (Ickovics & Park, 1998a, p. 238):

- “What characteristics distinguish the individuals who thrive following a trauma or stressor from those who do not?
“How do communities heal and thrive following severe social challenges that result in extreme divisions among citizens of different racial and ethnic groups?

“Can resources be distributed to or developed in individuals across the developmental life cycle and across social and cultural contexts to promote the ability to thrive?

“How can knowledge about the factors that promote thriving be used to promote public health and inform public policy?

“How does thriving relate (or not) to other concepts in psychology and sociology, and can it provide an inclusive framework for guiding further study?”

The distinction between resilience and thriving is well illustrated in Figure 2.2 (Carver, 1998, p. 246), which posits four possible responses to an adverse event, all of which assume an initial deterioration of functioning (a ‘downturn’):

Firstly, the individual’s functioning may continue to deteriorate below the initial level of deterioration brought about in the midst of the crisis of the adverse event. Here the individual succumbs to the event.

Secondly, the individual’s functioning may improve somewhat after the initial crisis, but not to the level it was before the adverse event – “the person survives but is diminished or impaired in some respect” (Carver, 1998, p. 246).

Thirdly, the person bounces back to the level of functioning enjoyed before the adverse event, which can be called resilience or recovery.

Fourthly, “the person may not merely return to the previous level of functioning, but may surpass it in some manner” (Carver, 1998, p. 246), something the author calls thriving.

Resilience was previously defined as the ability of people to bounce back after exposure to some or other crisis, a "homeostatic return to a prior condition“ (Carver, 1998, p. 247). Resilience literature does not refer to the concept of thriving conceptualised as “better-off-afterward” (ibid.). Thriving by contrast refers to the acquisition of new skills and knowledge (learning about themselves, learning new coping skills, etc), of new confidence or a sense of mastery, and enhanced interpersonal relationships (ibid.).

Carver continues to unpack the notion of resilience and thriving by exploring three processes by which people recover from or thrive from adversity, as illustrated in Figures 2.3 to 2.5 (adapted from Carver, 1998, p. 249).
Figure 2.2 Responses to Adversity: The Domain of Possibilities

(Carver, 1998, p. 246)
Figure 2.3  Adaptation by Desensitisation

(Adapted from Carver, 1998, p. 249)

Figure 2.4  Adaptation by Enhanced Recovery Potential

(Adapted from Carver, 1998, p. 249)

Figure 2.5  Adaptation by Thriving

(Adapted from Carver, 1998, p. 249)
In the first process (Figure 2.3), the individual becomes desensitised to the adverse event through the exposure to it. The downturn experienced at Time II is less than at Time I, because the individual has been ‘inoculated’ against that stress to some degree. The ‘inoculation’ does not enhance the individual’s functioning, but reduces the severity of the downturn next time the adversity is encountered. Eventually it is possible that the individual is so desensitised that the adversity has no noticeable impact at all. The overall level of functioning has still not improved above baseline, however, making this an example of resilience and not thriving.

In the second process (Figure 2.4), the downturn experienced at each exposure to the adverse event is equally disruptive, but the recovery or ‘bounce-back’ time is reduced. The person learns to recover more efficiently from the adversity – “they’re hit as hard, but they bounce back faster” (Carver, 1998, p. 249). As with the previous process, the baseline functioning does not improve making this also an example of resilience and not of thriving.

In the third process (Figure 2.5), which is extrapolated from Figure 2.2, the individual’s functioning after the exposure to the adverse event at Time I is raised above initial baseline. When the adverse event is experienced again at Time II, even if the downturn is equally disruptive, the baseline has already been raised and the event can be used again to enhance the individual’s functioning even more. In this process the functioning or well-being of the individual is enhanced by the adversity, meeting the criteria for thriving.

Thriving thus conceptualised is a transformation, involving a “fundamental cognitive shift in response to a challenge” (O’Leary, 1998, p. 430). Transformation requires an event of great adversity (ibid.):

For such a transformation to occur, the challenge must be profound, an event such as facing a fatal illness, a severe traumatic accident or victimization, a great loss, or an existential crisis – events that shake the foundation of one’s life, calling into questions one’s sense of purpose, meaning or identity. These events are at the extreme because they are the ones that provide the greatest opportunity for a heroic response. (p. 430)

Thriving and transformation require not only a profound challenge or adverse event; they also require an individual with certain qualities who will be able to utilize the challenge for thriving. The question then becomes, what are the qualities of people who, when faced with adversity which should result in nothing more than recovery, thrive? The answer to this question is similar to the question of what makes children resilient (as discussed previously), viz individual resources such as hardiness, coping and a sense of...
coherence; cognitive resources such as accurate threat appraisal, self-efficacy and perceived personal risk; the ability to attribute and mould the meaning attached to life events; social support systems; and social processes or rituals which facilitate transitions in life (O'Leary, 1998).

2.6 HARDINESS

2.6.1 THE HARDY PERSONALITY

A great deal of research conducted during the 1960s and 1970s demonstrated that "stressful life events precipitate somatic and psychological disease" (Kobasa, 1979, p. 1). Important research in this regard was done by Rahe, who found that "Navy personnel who begin a cruise with high stress scores suffer more illness episodes during the months at sea than do sailors who start out with low stress scores" (ibid.). The Schedule of Recent Life Events, which measures the build up of recent stressful life events, was published by Holmes and Rahe in 1967 and is one of the most frequently cited scales used to measure stress in the papers surveyed in this document.

Much of the research that emerged as a result of the Schedule of Recent Life Events (and other similar scales) demonstrated a consistently significant but moderate relationship between stress and illness. "Although correlations range from .20 to .78, the majority fall below .30, and in Rahe's naval data, the correlations are consistently around .12" (Kobasa, 1979, p. 2). This research demonstrated the link between psychosocial phenomena and physical well-being (Kobasa, 1982):

By demonstrating that the occurrence of life events that cause change and readjustment (eg job transfer, death of parent, marriage) increases the likelihood of one's falling sick, Holmes, Rahe, and their colleagues forced our conceptualization of disease beyond physiological and biochemical processes to psychological and sociological processes. (p. 3)

In light of these findings, some researchers began questioning the variability of stress and illness scores, and the relatively moderate correlation between them. “One likely explanation for these data is the presence of subjects with high stress scores who are not getting sick” (Kobasa, 1979, p. 2). As was noted during the discussion on salutogenesis, researchers who had adopted the pathogenic paradigm neglected to investigate the reasons for these findings. Those who were more salutogenically oriented did, however, question such findings. Kobasa was one such researcher.
In order to investigate this, Kobasa surveyed 670 middle and upper executives, and found a correlation of .24 (p<.025) between total stress and total illness scores (Kobasa, 1979, p. 6). Using test scores and random sampling, Kobasa sampled two groups of respondents: 86 high stress/high illness respondents and 75 high stress/low illness respondents. Kobasa's (1979) analysis of the data revealed the following:

Discriminant function analysis, run on half of the subjects in each group and cross-validated on the remaining cases, supported the prediction that high stress/low illness executives show, by comparison with high stress/high illness executives, more hardiness, that is, have a stronger commitment to self, an attitude of vigorousness toward the environment, a sense of meaningfulness, and an internal locus of control. (p. 1)

Kobasa's construct of hardiness is posited as mediating stress and illness, potentially reducing the negative effects of stress. Hardiness itself comprises three subconstructs, viz commitment, control and challenge:

- **Commitment** as opposed to alienation (Kobasa, Maddi, & Courington, 1981, p. 369). “Among persons under stress, those who feel committed to the various areas of their lives will remain healthier than those who are alienated” (Kobasa, 1979, p. 4). Commitment is firstly the valuing of one’s life, one’s self, one’s relationships, and secondly the investment of oneself in these valued dimensions of life (Kobasa, 1982). Commitment results in a sense of purpose that can carry a person through difficult turbulent times. Commitment “is based in a sense of community – what existentialists call being-with-others” (ibid., p. 7).

- **Control** as opposed to powerlessness (Kobasa et al., 1981, p. 369). “Among persons under stress, those who have a greater sense of control over what occurs in their lives will remain healthier than those who feel powerless in the face of external forces” (Kobasa, 1979, p. 3). Control involves acting ‘as if’ one has control over what is happening around one. It entails the belief (and consequent actions) that life events are in part a result of one’s own actions and attitudes, and thus amenable to change. People with control “can interpret and incorporate various sorts of events into an ongoing life plan and transform these events into something consistent and not so jarring to the organism” (Kobasa, 1982, p. 7).

- **Challenge** as opposed to threat (Kobasa et al., 1981, p. 369). “Among persons under stress, those who view change as a challenge will remain healthier than those who view it as a threat” (Kobasa, 1979, p. 5). “Challenge is based on the belief that change, rather than stability, is the normative mode of life” (Kobasa, 1982, p. 7). With this outlook on life, stressful life events are viewed neither with surprise (since...
Kobasa describes the hardy person as follows (Kobasa et al., 1981):

Hardy persons have considerable curiosity and tend to find their experiences interesting and meaningful. Further, they believe they can be influential through what they imagine, say, and do. At the same time, they expect change to be the norm, and regard it as an important stimulus to development. These various beliefs and tendencies are very useful in coping with stressful events. Optimistic cognitive appraisals are made; changes are perceived as natural enough, meaningful, and even interesting despite their stressfulness, and in that sense are kept in perspective. Also, decisive actions are taken to find out more about the changes, to incorporate them into an ongoing life plan, and to learn from their occurrence whatever may be of value for the future. In these ways, hardy persons transform stressful events into less stressful forms. (pp. 368-369)

People who are low in hardiness are, by contrast, described as follows (Kobasa et al., 1981):

Persons low in hardiness tend to find themselves and the environment boring, meaningless, and threatening. They feel powerless in the face of overwhelming forces, believing that life is best when it involves no changes. As such, they have no real conviction that development is either possible or important, and are passive in their interactions with the environment. When stressful events occur, such persons have little basis for optimistic cognitive appraisal or decisive actions. Because their personalities provide little or no buffer, the stressful events are allowed to have a debilitating effect on health. (p. 369)

Kobasa and most other researchers in the field measure hardiness with a set of five scales (Kobasa, 1982):

Those scales that had proven [in the 1979 study] to be the most effective in discriminating between high stress/low illness and high stress/high illness subjects and that were, in interaction with stressful life events scores, the best predictors of illness across the whole executive group were included in the composite. Alienation from Self and Alienation from Work from the Alienation Test (Maddi et al., 1979) were selected as negative indicators of commitment. The dimension of control was also measured negatively through the Internal External Locus of Control scale (Rotter et al., 1962) and the Powerlessness scale of the Alienation Test (Maddi et al., 1979). Finally, challenge was measured negatively by the Security scale of the California Life Goals Evaluation Schedule (Hahn, 1966). The intercorrelations among the five chosen scales were found to be significant in the expected direction. In a principal components factor analysis, a first factor (accounting for 46.5% of the variance) emerges that is interpretable as hardiness. To provide a single personality hardiness score for each executive, z scores were computed for the five measures. As the challenge dimension was indexed by only one scale (Security), its scores were doubled. This weighted security score was added to the other four scores. (p. 14)

It is this composite hardiness score that is used in most of the studies cited and is the scale typically referred to as the Hardiness Scale.
2.6.2 HARDINESS AND HEALTH

One study (Kobasa et al., 1981, p. 376) found that “stressful life events and constitutional predisposition [measured by evaluating the respondents’ parents’ illness history] increase illness, whereas personality-based hardiness decreases illness”. The researchers conclude that hardiness is a resistance resource, protecting vulnerable people from illness.

A study of 137 white male managers investigated the relationships between hardiness, exercise, stress and illness (Kobasa, Maddi, & Puccetti, 1982b). Hardiness and exercise were found to be unrelated, as expected, and each was found independently to contribute to health. The researchers conclude (ibid.):

Subjects high in both hardiness and exercise remain more healthy than those high in one or the other only. These additive effects are consistent with the view that hardiness buffers by transforming the events themselves so as to decrease their stressfulness, whereas exercise buffers by decreasing the organismic strain resulting from experiencing stressful events. (p. 391)

Since the stress-hardiness-illness interaction has often been studied retrospectively, it is possible that the state of health under stressful conditions creates hardiness, rather than the other way round (Kobasa, 1982). As a result, a number of studies have been conducted prospectively to investigate the direction of causation (eg. Kobasa, Maddi, & Kahn, 1982a). This study examined the stress, illness and hardiness of a group of 259 white male middle and upper level managers over a two-year period (plus three years retrospective data). By controlling for illness at Time I, the researchers were able to investigate the effect of hardiness and stress at Time I on the development of illness between Times I and III. The researchers concluded (Kobasa, 1982):

Even when prior illness is controlled for, stressful life events are linked with an increase and hardiness with a decrease in illness reports. The significant stress and hardiness interaction demonstrates that it is especially crucial for one’s health to be hardy when one is undergoing an intensely stressful time. (p. 15)

Another prospective study involved 217 white male middle and upper level managers who were assessed on two occasions, separated by two years (Howard, Cunningham, & Rechnitzer, 1986). These researchers used the dependence/independence dimension of Cattell’s Sixteen Personality Factor Questionnaire as a measure of hardiness. The “results indicate that for individuals classified as Type A1, changes in job stress (role ambiguity) were significantly related to changes in blood pressure and triglyceride levels and that this effect appears to be significantly moderated by the personality dimension dependence/independence” (ibid., p. 241).
A similar study was conducted with 140 white male middle and upper level managers (Kobasa, Maddi, & Zola, 1983). The measures of hardiness and Type A were found to not correlate, indicating their independence. Data analysis demonstrated that while stressful life events lead to illness and hardiness protects health, Type A had no direct influence on health status (ibid., p. 47). The authors concluded (ibid.):

Persons who are not only high in Type A behavior, but simultaneously low in hardiness, show the greatest deterioration of general health in the face of mounting stressful life events. If health is to be preserved in the encounter with stressful events, it would appear important that one’s driven concern for reaching extrinsic goals (high Type A behavior) be mitigated by an ability to experience the intrinsic interest and value of the activities and tasks encountered along the way (high hardiness). (p. 49)

### 2.6.3 Critiques of Hardiness

Despite the apparent unequivocality of the above studies, several studies have found conflicting or inconsistent results. Others have levied various criticisms against the construct hardiness and its measurement.

A study by Schmied and Lawler (1986) of 82 female, mostly white, university secretaries found no mediating effects from Type A and hardiness on the stress-illness relationship. Type A and hardiness did correlate in the expected directions with stress, and stress did correlate in the expected direction with illness, but neither Type A nor hardiness correlated with illness (ibid., p. 1221).

Another study (Ganellen & Blaney, 1984) of 83 female undergraduate students found that hardiness and social support were so closely interrelated as to be not independent and that hardiness contributed little buffering effect to life stress.

Although an exhaustive review of research into hardiness has not been conducted, it is interesting to note that all of the studies cited here which find support for the hardiness theories were conducted with white, male, protestant, middle and upper level managers in the USA. In contrast, the two studies that failed to support the hardiness theory were conducted with female non-managers. Perhaps the hardiness construct is culturally loaded in favour of White Anglo-Saxon Protestant males.

In a critique of the hardiness concept and in particular the measurement of hardiness, Hull, Van Treuren and Virnelli (1987) highlight the inconsistent measurement procedures used, despite the description of the Hardiness Scale provided above. For instance, in a...
1982 study Kobasa “measured commitment with the scales of Powerlessness (previously identified [in the 1979 study] as a measure of control) and Vegetativeness (previously identified [in 1979] as a measure of challenge)” (ibid., p. 521). As a second instance, the use of z scores significantly complicates secondary data analysis, since each study generates a mean hardness score of zero (ibid.). The reviewers then state:

We draw the following conclusions: (a) Hardiness is not a unitary phenomenon, but should be treated as involving three separate phenomena; (b) of the three subcomponents of hardiness, only commitment and control have adequate psychometric properties and are systemically related to health outcomes; (c) lack of control and lack of commitment have direct effects on health because they are psychologically stressful; and (d) if there are buffering effects of commitment and control, they are in addition to these direct effects and are situation specific. (p. 518)

A final critique (Strümpfer, 1990) highlights the pathogenic approach to measuring what is intended to be a salutogenic construct. The concept of hardiness was intended to explain why certain people who are exposed to high stress do not become ill as expected, in line with the salutogenic paradigm. The cluster of scales used by Kobasa and others to measure the three hardiness constructs are all negative indicators, viz alienation from self and from work for commitment, need for security for challenge, and powerlessness and external locus of control for control. Strümpfer (1990) concludes:

To express high levels of a characteristic in terms of low scores on another seems dubious on both theoretical and psychometric grounds. Funk and Houston (1987) pointed out that a low score on, for instance, alienation may represent neutral feelings, and not the presence of feelings opposite to alienation. ... The view that the Hardiness Scale measures pathogenic variables could be supported by Funk and Houston’s suggestion that, on the basis of item contents, the Hardiness Scale may be “better construed as tapping something similar to general maladjustment or psychopathology” (1987, p. 573). Indeed, these authors found that when emotional maladjustment was controlled statistically, significant correlations between hardiness and health reports dropped below significance; Rhodewalt and Zone (1989) confirmed this finding. In view of these conceptual, measurement and validity problems, I am inclined to consider the hardiness construct as part of the salutogenic paradigm but both its operationalization and the supporting evidence is still very much in the pathogenic framework. (pp. 271-272)

### 2.7 Learned Resourcefulness

‘Learned resourcefulness’ (Rosenbaum & Ben-Ari, 1985) emerged in the field of behaviour modification and presented a contrast to ‘learned helplessness’. Learned helplessness studies were conducted to demonstrate that when people’s efforts to change an uncontrollable event are futile, they tend to generalise this expectancy to
situations which are, in fact, controllable (ibid.). Learned helplessness thus accounts for people’s responses to controllable events after exposure to uncontrollable events. During such a process, people learn to believe that they are helpless to influence or control external events.

Self-control studies, by contrast, focus on what happens when a person’s habitual and effective behaviour in dealing with a controllable situation, becomes ineffective in an uncontrollable situation. “The self-regulatory process is activated ... only when the smooth flow of ongoing behavior is disrupted” (Rosenbaum & Ben-Ari, 1985, p. 199). Self-regulation thus enables a person to continue with goal-directed and self-sustaining activities, even in the absence of external reinforcement (success). Training in self-regulation or self-management assists “people to change their behaviour notwithstanding ongoing stimulation that favours the undesirable habits, so that they become less dependent on the environment” (Strümpfer, 1990, p. 273). It is within the context of self-control studies that the construct learned resourcefulness emerged.

Rosenbaum noted that people differ in their capacity for self-regulation or self-control or self-management, and introduced “the term learned resourcefulness to describe an acquired repertoire of behaviors and skills (mostly cognitive) by which a person self-regulates internal responses (such as emotions, cognitions, or pain) that interfere with the smooth execution of a desired behavior” (Rosenbaum & Ben-Ari, 1985, p. 200).

Rosenbaum (1988, in Strümpfer, 1990, p. 273) explained the process of self-regulation as comprising three phases:

- **Representation**, during which the individual experiences, without any conscious effort, a cognitive and/or emotional reaction to changes within him-/herself or the environment;
- **Evaluation** of the changes, first, as desirable or threatening, then, if threat is appraised, evaluation whether anything can be done about it;
- **Action** (or coping in most other terminology) to minimize negative effects of the internal or external changes.”

An example may serve to clarify this process. Assume a social worker has been working with couples with communication difficulties for a number of years and has come to learn that certain clinical interventions and processes are habitually successful. One day a couple arrives for counselling, but the usual therapy no longer works. The social worker notes the lack of success and begins to feel frustrated, angry, anxious and helpless.
The resourceful social worker will, at this point begin to evaluate what is going wrong and whether there is anything she can do about it. She tells herself that she is a resourceful, flexible and creative therapist, who is not locked into only one model of intervention. She begins thinking of other approaches that may be effective with this couple (evaluation). She shifts to adopt another model and begins implementing it (action). By contrast, the less resourceful social worker succumbs to the sense of failure, believes she is useless and that her repertoire of skills is insufficient. She then moves into self-protection and blames the clients, arguing that they are resistant (evaluation). She confronts them aggressively with their lack of co-operation and terminates the counselling (action).

People who succeed in regulating their internal processes during difficult situations, such as the resourceful social worker above, acquire the skill of self-regulation. Next time a difficult situation arises, they are more adept at regulating their internal processes and are thus better able to respond effectively to the situation. In this way, resourcefulness is learned, hence, learned resourcefulness. Rosenbaum and Ben-Ari’s 1985 research demonstrated that (Strümpfer, 1990):

Low resourceful persons judge themselves inefficacious in coping with emotional strains and difficult tasks; as a consequence, they tend to dwell more on their deficiencies than on the task. High resourceful persons, on the other hand, judge themselves more efficacious in dealing with emotional and task demands and are, as a consequence, more likely to continue with self-regulation. (p. 273)

Learned resourcefulness is not a personality trait, but rather a cluster of cognitive skills. “Learned resourcefulness is a basic behavioral repertoire (Staats, 1975) that is learned from the moment of birth and serves as a basis for coping with stressful situations” (Rosenbaum & Palmon, 1984, p. 245).

Rosenbaum developed the Self-Control Schedule (SCS), a 36-item instrument using a 6-point scale, to measure learned resourcefulness. The scale (Rosenbaum & Palmon, 1984):

Covers the following content areas: (a) use of cognitions and self-instructions to cope with emotional and physiological responses, (b) application of problem-solving strategies (eg planning, problem definition, evaluating alternatives, and anticipation of consequences); (c) ability to delay immediate gratification, and (d) a general belief in one’s ability to self-regulate internal events. (p. 246)

The SCS demonstrates good psychometric properties, with alpha coefficients ranging from .78 to .86 in various studies, and test-retest reliability over four weeks of .96 (Rosenbaum & Palmon, 1984, p. 246).
Research comparing high resourceful people with low resourceful ones has yielded consistently positive results (summarised by Strümpfer, 1990, pp. 273-274). High resourceful people, compared with low resourceful people:

- “Tolerated laboratory-induced pain longer and used self-control methods more frequently and more effectively in doing so (Rosenbaum, 1980b);

- “As migraine sufferers, reported lower pain intensity, focused less on the sensory aspects of their pain, and used prophylactic medication more (Courey, Feuerstein & Bush, 1982);

- “As epileptics experiencing low and medium frequencies of seizures (but not for high frequencies), maintained a stronger belief in their control over their seizures and their health, were less depressed, coped better with their disability, and used self-control methods as part of coping with the psychological consequences of seizures (Rosenbaum & Palmon, 1984);

- “As hemodialysis patients, complied more with their fluid-intake restrictions, measured in terms of weight gain between dialysis sessions (Rosenbaum & Ben-Ari Smira, 1986);

- “As diabetics, were more successful in controlling sugar intake (Amir, cited by Rosenbaum, 1988);

- “After natural childbirth, reported that they had engaged more often in breathing-relaxation exercises, used more self-encouraging statements during delivery, and felt more control over the process (Groves, cited by Rosenbaum, 1988);

- “As smokers, were more successful in giving up cigarette smoking on their own (Katz & Singh, 1986);

- “Used self-control methods more effectively to cope with seasickness on missile boats in stormy sea and showed fewer performance deficits, notwithstanding seasickness (Rosenbaum & Rolnick, 1983);

- “As novice parachutists, performed better during jumps and used more coping self-statements that indicated emotional self-control and task orientation (Gal-Or & Tennebaum, cited by Rosenbaum, 1988);

- “In experimentally induced experiences of uncontrollability or failure, reported more positive self-evaluation, fewer negative self-evaluations and more task-oriented
thoughts (Rosenbaum & Ben-Ari, 1985).” (summarised by Strümpfer, 1990, pp. 273-274)

Another study (Simons, Lustman, Wetzel & Murphy (in press), cited in Rosenbaum & Ben-Ari, 1985, p. 200) found that “SCS scores were the single best predictor of success in cognitive therapy of depression,” irrespective of the degree of depression at presentation. “Cognitive therapy probably helped the highly resourceful depressed subjects in developing and applying skills already in their repertoire.”

2.8 SELF-EFFICACY

Like learned resourcefulness, self-efficacy (Bandura, 1982) also emerged within the field of behaviour modification. Bandura argues that many of the constructs covered in this section on individual resilience centre on “people’s sense of personal efficacy to produce and to regulate events in their lives” (ibid., p. 122). Perceived self-efficacy thus entails “judgements of how well one can execute courses of action required to deal with prospective situations” (ibid.).

According to Bandura (1982), people are constantly busy with judgements of self-efficacy. Every action taken is preceded by an unconscious judgement of one’s ability to execute the action effectively. Accurate appraisal of one’s efficacy is important so as to avoid taking on tasks that are, in fact, outside of one’s ability. Perceived self-efficacy also influences effort (Bandura, 1982):

Judgements of self-efficacy also determine how much effort people will expend and how long they will persist in the face of obstacles or aversive experiences. When beset with difficulties people who entertain serious doubts about their capabilities slacken their efforts or give up altogether, whereas those who have a strong sense of efficacy exert greater effort to master the challenges. … High perseverance usually produces high performance attainments. (p. 123)

As with learned resourcefulness, people with a strong sense of efficacy focus their attention on handling the task and are energised by difficulties, while people who doubt their efficacy tend to be consumed by their inadequacies and have little energy to deal with the task at hand (Bandura, 1982). Behavioural research involving the artificial elevation of perceived self-efficacy demonstrates that “people successfully execute tasks that fall within their enhanced range of perceived self-efficacy, but shun or fail those that exceed their perceived coping capabilities” (ibid., p. 126). Even when they know what to
do, people who lack self-efficacy tend to perform ineffectively in accordance with their perceived efficacy (ibid.).

Bandura argues that judgements of self-efficacy are based on information derived from four sources (1982, pp. 126-127):

- **Enactive Attainments.** The most influential source of information is previous success, since success breeds success. Likewise, previous failure decreases perceived self-efficacy and increases the likelihood of future failure.

- **Vicarious Experiences.** Seeing other people, who are judged to be similar in competence to oneself, succeed in tasks, increases one’s own self-efficacy. Likewise, seeing similar others fail in tasks decreases one’s own self-efficacy, through vicarious learning.

- **Verbal Persuasion.** Attempts by others to verbally persuade a person to believe in themselves have limited effect. Nevertheless, such persuasion may result in the person trying harder in the next attempt at a task, increasing the chances of success. This success then provides the enactive attainment that enhances self-efficacy, increasing the chances of future success.

- **Physiological State.** People judge their capability in part on the physiological state of arousal. Excess or aversive arousal informs the individual that failure is imminent and consequently self-efficacy decreases and the chances of failure do in fact increase.

Empirical studies confirm that self-efficacy can be influenced through these four sources of information, and that this has a direct and significant impact on performance (Bandura, 1982, p. 128). This is a large part of the value of the construct self-efficacy – its capacity to be influenced through intervention and the direct effect of this on performance.

Zunz (1998) reports a study examining resilience factors which protect human service providers (n=101) from burnout. Respondents were largely female (69%) and social workers (62%). Each of the seven protective factors used in the study (including self-efficacy) were correlated with at least one of the three measures of burnout (viz emotional exhaustion, depersonalisation and personal accomplishment). Self-efficacy was the only resilience factor to emerge in three regression analyses (using the burnout measures as criterion variables), accounting for “21% of the variance in emotional exhaustion, and along with sense of mission, predicting 32% of the variance in
depersonalization and 39% in personal accomplishment” (Zunz, 1998, p. 50). The researcher concludes that human service agencies should clearly define mastery of and effectiveness in management tasks, thereby increasing the development of manager’s work-related self-efficacy.

### 2.9 Locus of Control

Locus of control, a construct that has much in common with self-efficacy, emerged in the field of social learning theory (Rotter, 1966). Rotter argues that behaviour is reinforced to the degree that the individual perceives the consequences of the behaviour to be contingent on (or controlled by) his/her own behaviour rather than under control of other external forces. These external forces could include “luck, chance, fate, powerful others, or ... unpredictable” (ibid., p. 1). When a “person perceives that the event is contingent upon his own behavior or his own relatively permanent characteristics, we have termed this a belief in internal control” (ibid.). Conversely, when a person perceives an event to be contingent on other forces, this person is said to have a belief in external control.

Research indicates that (Rotter, 1966):

- The individual who has a strong belief that he can control his own destiny is likely to (a) be more alert to those aspects of the environment which provide useful information for his future behavior; (b) take steps to improve his environmental condition; (c) place greater value on skill or achievement reinforcements and be generally more concerned with his ability, particularly his failures; and (d) be resistive to subtle attempts to influence him. (p. 25)

Rotter developed the Internal-External (I-E) scale to measure locus of control (Rotter, 1966). The scale is negatively scored, so that a high score indicates a high external locus of control. “The items deal exclusively with the subjects’ belief about the nature of the world. That is, they are concerned with the subjects’ expectations about how reinforcement is controlled. Consequently, the test is considered to be a measure of a generalized expectancy” (ibid., p. 10). Rotter reports internal consistency scores from .52 to .79 and test-retest reliability scores (over 1-2 months) from .49 to .83 (ibid., p. 13).

Kobasa, who used the I-E scale as a measure of her ‘control’ construct (1981), found that high stress/high illness executives had a greater external locus of control than high stress/low illness executives ($t = 2.03$, $p < .05$) (1979, p. 7). Another study by Johnson...
and Sarason (1978, cited in Kobasa, 1982, p. 13) found that college “students believing in an internal locus of control showed a lower correlation between stressful life events and illness than did subjects who reported an external orientation”.

A study of 50 epileptic patients found a link between locus of control and learned resourcefulness (Rosenbaum & Palmon, 1984). Results indicate that highly resourceful patients had a greater internal locus of control and a greater degree of perceived control over their seizures than low resourceful patients, regardless of the severity of the seizures (ibid., p. 250).

The distinction between Rotter’s Locus of Control and Antonovsky’s Sense of Coherence was detailed previously. Antonovsky criticises Rotter’s Locus of Control construct as being culturally biased in favour of Western, Protestant ethics, and asks “What would someone with a belief that God has already determined his destiny score on Rotter’s scale?” (Antonovsky, 1979, p. 155). Notwithstanding Antonovsky’s concern, the locus of control concept has enjoyed great popularity, and has resulted in the generation of many scales (Fischer & Corcoran, 1994b, printed 17 scales measuring various aspects of locus of control) and much research on the subject.

2.10 OTHER RESILIENCE FACTORS

In addition to these major contributions to the field of resilience theory, a number of other writers have generated resilience factors that are of value, viz potency, stamina and personal causation.

2.10.1 POTENCY

The construct ‘potency’ was developed by an Israeli social worker, Ben-Sira, and is defined as “a person’s enduring confidence in his own capacities as well as confidence in and commitment to his/her social environment, which is perceived as being characterized by a basically meaningful and predictable order and by a reliable and just distribution of rewards” (Ben-Sira, 1985, in Strümpfer, 1990, p. 272). Strümpfer continues:

Ben-Sira viewed potency as a mechanism that prevents the tension which follows occasional inadequate coping, from turning into a lasting stress. It is the outcome of
successful past experiences of coping and hence comprises mastery and self-appreciation; weak potency, on the other hand, results from a history of unsuccessful coping experiences. These same alternatives of experience contribute to either a view of society as meaningful and ordered, or an orientation of anomie, which in turn, are related to either commitment to society or alienation. Similarities to Antonovsky’s SOC seem quite clear; in fact, Ben-Sira and Antonovsky have had close academic and personal associations. (p. 272)

### 2.10.2 Stamina

Strümpfer (1990) reports two researchers who have used the term ‘stamina’ to refer to the concept of resilience. Thomas (1981, in Strümpfer, 1990, p. 272), who conducted longitudinal research on medical students, defined stamina as “The physical and moral strength to resist or withstand disease, fatigue, or hardship; endurance.” She compared psychological, social and family factors that influenced the life course of adults, and concluded, “Human beings are born with different potentialities and susceptibilities which life experiences may then mold into a protective shield undergirding future health” (ibid.).

Colerick also used the term stamina in her study of patterns of aging. She asked, “What qualities distinguish older persons who demonstrate emotional resilience despite age-related losses and life change?” (Colerick, 1985, in Strümpfer, 1990, p. 272). She referred to stamina as a “capacity for growth, personal insight, life perspective, likelihood of functional breakdown and general competence” (ibid.).

### 2.10.3 Personal Causation

De Charms (1968, p. 269) states, “Man’s primary motivational propensity is to be effective in producing changes in his environment. Man strives to be a causal agent, to be the primary locus of causation for, or the origin of, his behavior; he strives for personal causation.” Personal causation is thus concerned with “being the master of one’s fate” or “being an agent of change in the environment” (ibid., pp. 270-271).

De Charms argues that achieving one’s goals and the satisfaction that results from that is not sufficient to explain human behaviour. The process of achieving one’s goals is paramount. “Attaining a goal through luck, chance, or through the benevolent agency of
a helper is not the same as doing it myself” (De Charms, 1968, p. 271). The essence of personal causation is stated as follows (ibid.):

A man is not a stone, for he is a direct source of energy; nor is he a machine, for the direction of the behavior resulting from his energy comes entirely from within him. Rather, man is the origin of his behavior. (p. 271)

De Charms extrapolates from the idea that people are the origin of their behaviour to state that people are constantly struggling against being constrained by external forces, that is, against being moved as a pawn. This distinction between ‘Origin’ and ‘Pawn’ parallels the distinction between ‘free’ and ‘forced’. “An Origin is a person who perceives his behavior as determined by his own choosing; a Pawn is a person who perceives his behavior as determined by external forces beyond his control” (De Charms, 1968, pp. 273-274). An individual’s sense of him or herself as Pawn or Origin directly influences that individual’s behaviour, regardless of any objective external evidence. The most fundamental motivational force is an individual’s own sense of whether s/he is more Pawn or more Origin (ibid., p. 319).

Although De Charms recognises the close similarity between Rotter’s Internal Locus of Control and his own Personal Causation, he argues that locus of control is a more restricted construct than personal causation (De Charms, 1968, p. 321). Locus of control, being located within social learning theory, focuses its attention on the consequences of behaviour, rather than on the behaviour itself, thereby restricting its utility.

De Charms addresses the notion of personal causation at a philosophical, existential level, and does not pull it through to empirical, practical or clinical utility. Nor does he address how a sense of personal causation comes to develop. As such, its practice value is limited.

2.11 CONCLUSION

Two principle aspects of individual resilience are described in the literature and have been reflected in this chapter:

- Firstly, the dominant pathogenic paradigm has been challenged. Some researchers, theorists and clinicians are questioning the value and reality base of a worldview that emphasises the development of pathology as its central concern. They propose an
alternative paradigm, which is most frequently termed salutogenesis, which addresses the origin of health.

- At the centre of this paradigm is a generic question, viz “How is it, when several people are exposed to the same stressor, that some of them break down while others remain healthy or even thrive?”

- The inevitable next question leads to the second aspect of individual resilience described in this chapter, viz the factors that make certain individuals resilient. Numerous factors have been explored in this chapter, including sense of coherence, hardiness, learned resourcefulness, self-efficacy, locus of control, potency, stamina and personal causation. In addition, various factors that protect children from the adverse effects of childhood risk were also outlined.

Unfortunately, the literature on individual resilience has two main shortcomings:

- Firstly, this literature, which dominates (or has dominated) the field of resilience theory, addresses only or predominantly intrapsychic factors in resilience. Many of the key constructs, such as Sense of Coherence, are defined as part of the structure of personality. Little attention is paid to factors within the environment or social system that promote the resilience of the individual.

- Second, this focus on intrapsychic resilience leads to the second shortcoming, viz many of the resilience constructs reviewed in this chapter do not translate easily into clinical practice. Sense of Coherence, for instance, which is a widely cited and researched resilience construct, has no clear clinical implication outside of assessment. A client referred for psychotherapy can be assessed for Sense of Coherence. Once a low SOC score has been attained, the clinician can do nothing with this result other than conclude that the client may struggle to make positive use of a therapeutic relationship.

- Other resilience factors, such as learned resourcefulness and locus of control, seem to lead more easily to clinical intervention, but even, this is not clear in the literature.

This shortcoming is particularly disappointing given the basic salutogenic question, “What enables people to overcome adversity?” The answer to this question should surely provide people who lack resilience with some hope, some kind of answer as to how to become more resilient. A person lacking resilience will not, however, make much use of the advice to develop a sense of coherence or to build their sense of personal causation.
These shortcomings are not to say that the individual resilience constructs do not have clinical implications. Rather, these implications have not been explored and researched. Early in this chapter it was noted that researchers have tended to focus on pathogenesis, while clinicians attended to salutogenesis (Pearlin & Schooler, 1982). It appears, however, now that extensive research has been done on salutogenic factors, that clinicians need to begin exploring how to develop these factors through clinical and other interventions. In particular, preventive issues need to be explored so that resilience factors can be developed as a matter of course in the general public and not only among the small percentage of individuals who have some form of pathology.
CHAPTER THREE: FAMILY RESILIENCE

3.1 INTRODUCTION TO FAMILY RESILIENCE

A great deal has been written on individual resilience; indeed, the very notion of resilience emerged within the context of the individual. Family researchers have begun to address the family as a context for the resilience of the individual and even as a unit of analysis in itself (Frankel, Snowden, & Nelson, 1992). This shift has not, however, been easy.

Research on resilience in children demonstrates that although it is conceptualised as a quality of the child him/herself, it is located within the systems of the nuclear family, the extended family and even the broader community (Butler, 1997). Unfortunately, the relationships and causal patterns between individual, family and community levels are not clear – they appear independent and interdependent and complementary of each other (Silliman, 1994).

Some family researchers conceive of the family as a system impacting on the resilience of the individual. Caplan’s (1982) study on the family as a support system is one such example. Despite addressing the family in the context of family stress and coping, his paper conceives of the family purely as a support system to the individual family member, and thus as a vehicle for individual resilience.

In this regard, Hawley and DeHann (1996) describe the family in two contexts:

- Firstly, and most commonly, the family can serve as a risk factor raising the vulnerability of family members. Some research outlines the kinds of family factors that create risk for family members (eg severe marital conflict, parental mental illness, etc), while other research has identified factors that help family members be resilient in the face of family dysfunction (eg research on adult children of alcoholics). Much of the literature on resilience has, in fact, considered resilience in relation to the profoundly dysfunctional family creating a very negative image of families (Walsh, 1996).

- Secondly, the family can serve as a protective factor to boost the resilience of the family members (as Caplan does). Protective factors include “a good fit between parent and child, maintenance of family rituals, proactive confrontation of problems,
minimal conflict in the home during infancy, the absence of divorce during adolescence, and a productive relationship between a child and his or her mother” (Hawley & De Haan, 1996, p. 285). Walsh (1996, p. 263) comments that “few have considered the family as a potential source of resilience: that is, as a resource.”

Both of these approaches consider the family merely as a context for the individual. Although there is movement from a purely intrapsychic conceptualisation of resilience to a more contextualised conceptualisation, the family remains in the background.

There is, however, another body of research that conceives of the family as an entity in itself, rather than as merely a context for individuals. McCubbin and McCubbin (1988), for example, have developed a set of typologies of resilient families, which address the family system itself. In these theories, individuals do not occupy centre stage; rather, the family is central and the individuals are merely the components of the family. Walsh (1996, p. 266) refers to this as “relationship resilience” as opposed to the “contextual view of individual resilience” detailed in the previous paragraphs.

There is some debate around whether it is valid to conceive of resilience as a family-level construct. In fact, family stress research which dates back to the 1930s and the family strengths literature which dates back to the 1970s both addressed the family as a unit, although the focus of family stress research was somewhat pathogenic and family strengths research lacked a theoretical frame. More recent theories, such as those of McCubbin and his colleagues, have developed and refined the theory of family-level resilience and have introduced new concepts, such as family schema, which strongly take the family as a unit (Walsh, 1996).

The biggest problem in researching family-level resilience remains measurement (Walsh, 1996). Reiss’ work on “shared constructs” (in Sagy & Antonovsky, 1998) has been assessed through direct observations of family interactions. There is, however, some doubt as to whether there is a direct relationship between an intangible construct such as family resilience or family SOC and the family’s actual behavioural patterns (ibid.). Furthermore, such methods of measuring family constructs are costly.

Most researchers make use of self-reports and scales to measure family constructs. The problem then is how to “build a collective measure on the basis of the interrelations of individual perceptions” (Sagy & Antonovsky, 1998, p. 209). Sagy and Antonovsky propose four alternatives (see also Patterson & Garwick, 1998):
❖ **Aggregation Model.** The aggregation model, which is the most common method of creating a collective measure of a family construct, involves taking the average or mean of the individual family member scores. The McMaster Model Family Assessment Device (Epstein, Baldwin, & Bishop, 1983) is scored using such a model. This approach, however, ignores the systems theory notion of the whole being more than the sum of its parts, and Sagy and Antonovsky (p. 210) find no theoretically based justification for this practice.

❖ **Pathogenic Model.** The pathogenic model is based on family systems theory and within the pathogenic paradigm. Here the family score on a construct is taken as the lowest individual family member’s score. “This measure, though it seems an individual one, actually takes into account the entire family by ‘choosing’ the score of only one member according to the relative scores” (Sagy & Antonovsky, 1998, p. 210). This approach to the measurement of family constructs is rare. The approach may, however, be common in clinical work where a family’s overall level of functionality is defined in terms of the worst functioning individual.

❖ **Salutogenic Model.** The salutogenic model is also based on family system theory, but within the salutogenic paradigm. Here the highest individual family member score defines the family’s level on a construct. Again, this approach to measurement of family constructs is rare.

❖ **Consensus Model.** Lastly, the consensus model, which “is based on the assumption that agreement among family members improves its coping and resistance ability” (Sagy & Antonovsky, 1998, p. 210). In this model, the family measurement is the absolute gap between family member scores on the measure. This approach is used quite frequently, in both research and clinical practice.

Sagy and Antonovsky (1998) endeavoured to test which of these four models was most effective but did not reach unequivocal results. They did, however, find considerable support for the salutogenic model of measurement, allowing for:

The characterization of the whole system by one of its subsystems. The pathogenic orientation, which is well known in family therapy, defines the whole unit as ill by identifying the illness of one member. Our findings, however, support a salutogenic orientation, an approach rarely found in family research or clinical work. (p. 223)

Patterson and Garwick (1998) comment on the measurement of family constructs:

Focusing on the family system as a unit of analysis has led to the idea that family meanings are distinct from the meanings held by an individual family member [aggregation model]. Furthermore, family meanings are distinct from consensus
between individually held meanings [consensus model]. Family meanings are the interpretations, images, and views that have been collectively constructed by family members as they interact with each other; as they share time, space, and life experience; and as they talk with other and dialogue about these experiences. They are the family’s social constructions, the product of their interactions. They belong to no member, but to the family as a whole. (pp. 80-81)

Clearly, then, there has been considerable progress in family resilience research over the past seventy years, since 1930:

- There has been a move from considering only individual resilience, to also considering family resilience.
- There has been a move from considering the family as only a source of dysfunction over which individuals must rise, to considering families as a source of resilience and strength.
- There has been a move from considering the family only as a context for the development of individual resilience, to considering the family as a unit, in terms of relational resilience.
- There has been a development in the understanding of family-level constructs that are not easily identifiable from individual family members.
- There has been progress in various conceptions of how to measure family-level constructs.

Such developments are particularly important given the many changes in and challenges facing contemporary families (Arcus, 1992; Schvaneveldt & Young, 1992; Walsh, 1996):

- The median age at first marriage has risen.
- More people cohabit outside of marriage.
- The birth rate has declined, resulting in smaller families.
- More women now work outside the home for pay.
- An increasing number of marriages end in divorce.
- Employers are having to address the work-family interface.
- Families experience increasing financial pressure.
- Health care costs are rising.
- AIDS is taking an increasing toll on families.
- Women’s experience of violence and poverty is receiving increasing attention.
- Family violence is becoming more visible.
- The quality of childcare is problematic.
- More and more adolescents are having children.
- Life expectancy is increasing, resulting in more working families caring for elderly parents.

It seems that today's families need more than ever to be resilient. Walsh (1996) has rephrased the salutogenic question in family terms:

> While some families are shattered by crisis or persistent stresses, others emerge strengthened and more resourceful. A resiliency-based approach aims to identify and fortify key interactional processes that enable families to withstand and rebound from the disruptive challenges they face. A resiliency lens shifts perspective from viewing families as damaged to seeing them as challenged, and it affirms their reparative potential. This approach is founded on the conviction that both individual and family growth can be forged through collaborative efforts in the face of adversity. (pp. 261-262)

How, then, is family resilience defined?

Family resilience describes the path a family follows as it adapts and prospers in the face of stress, both in the present and over time. Resilient families respond positively to these conditions in unique ways, depending on the context, developmental level, the interactive combination of risk and protective factors, and the family’s shared outlook. (Hawley & De Haan, 1996, p. 293)

[Family resilience refers to the] characteristics, dimensions, and properties of families which help families to be resistant to disruption in the face of change and adaptive in the face of crisis situations. (McCubbin & McCubbin, 1988, p. 247)

[Family resiliency can be defined as the positive behavioral patterns and functional competence individuals and the family unit demonstrate under stressful or adverse circumstances, which determine the family’s ability to recover by maintaining its integrity as a unit while insuring, and where necessary restoring, the well-being of family members and the family unit as a whole. (McCubbin & McCubbin, 1996, p. 5)]

[Family resiliency refers to those] key processes that enable families to cope more effectively and emerge hardier from crises or persistent stresses, whether from within or from outside the family. (Walsh, 1996, p. 263)
3.2 Family Stress Research

Research on family stress has been conducted for the greater part of the twentieth century and forms the foundation of much of the later research on family strengths and family resilience. Huang (1991) provides a detailed sixty year review of this research, from 1930 until 1990. In the introduction to the chapter, Huang states:

Research on family stress and coping has examined how various life events and hardships affect families. The most frequently studied life events are chronic illness, drug abuse, sudden divorce, death, disaster, war, unemployment, parenthood, captivity, and rape. Stressor events, transitions, and related hardships produce tension, which calls for management (Antonovsky, 1979). When tension is not overcome, stress emerges. Family stress (as distinct from stressor) is defined as a state that arises from an actual or perceived imbalance between a stressor (eg challenge, threat) and capability (eg resources, coping) in the family’s functioning. (p. 289)

A brief summary of Huang’s (1991) review follows:

- **1930s.** In the 1930s, family stress research was dominated by the effect of the Great Depression on families and individuals. These studies identified how families responded to the Depression, and began to identify the qualities of families that survived the Depression.

- **1940s.** During the 1940s, attention shifted to the consequences of World War II for individuals and families. The first studies that form the initial foundation of Van Breda’s (1995a, 1995b, 1995c, 1995d, 1997a, 1997b, 1998a, 1998b, 1998c, 1999a, 1999b; Van Breda, Potgieter, Siwisa, & Banda, 1999) work on deployment resilience (eg those of Hill) were published in this decade. The ABCX family crisis model, which serves as the platform for the current innovative research by McCubbin, was formulated in 1949.

- **1950s.** During the 1950s the Depression and War were ignored, as researchers addressed reactions to illness, disaster, alcoholism and parenthood. Although the research in this decade was still largely descriptive, a more concerted use of theory was apparent, notably crisis theory, role theory and life cycle theory.

- **1960s.** The interests of the 1950s continued into the 60s, with the addition of delinquency and imprisonment.

- **1970s.** During the 1970s, family stress research focused broadly on war-related stress, physical and mental illness, drug abuse, rape, imprisonment, parenthood,
alcoholism and disasters. Longitudinal research began, generating more interesting and explanatory data. Theoretical models tentatively proposed in the previous years were refined and developed, and constructs were better defined and operationalised.

- **1980s.** During the 1980s, family stress research continued with the topics of the 1970s, with the addition of studies of the absent father and divorce. Theory development and testing was much more common in this decade than before, and statistical analysis became increasingly sophisticated.

The growing interest in resilience research can be seen in the number of publications on the subject. In my personal literature collection, I have 194 papers and studies addressing various aspects of resilience (including individual resilience), distributed over the decades as follows:

- 1960s: 2
- 1970s: 7
- 1980s: 56
- 1990s: 129

Early studies on family stress, by researchers such as Burgess in 1926, Angell in 1936, Cavan and Ranck in 1938, Koos in 1946 and Hill in 1949, tended to emphasise family pathology (H.I. McCubbin & McCubbin, 1992). These researchers attempted to describe, explain and predict family dysfunction in the face of certain stressors. As a result of their research we have a much clearer understanding of the family as a system and how that system suffers under stress. Family stress research was not, however, well located within a salutogenic paradigm. It was only from the 1970s that family stress research began to investigate how “family members interact with and support each other, what strengths and capabilities families call upon to adjust and adapt, the specific roles and transactions the community plays and enacts in family coping and adaptation, and suggesting ways to improve the resiliency in families” (ibid., p. 154).

Family stress research is “based on ten fundamental assumptions about the ecological nature of family life and intervention in family systems” (McCubbin & McCubbin, 1992, pp. 155-156):

- **Change is Normal.** “Families face hardships and changes as a natural and predictable aspect of family life over the life cycle.”
- **Homeostasis.** “Families develop basic strengths and capabilities designed to foster the growth and development of family members and the family unit and to protect the family from major disruptions in the face of family transitions and changes.”

- **Flexibility.** “Families also face crises that force the family unit to change its traditional mode of functioning and adapt to the situation.”

- **Self-Protection.** “Families develop basic and unique strengths and capabilities designed to protect the family from unexpected or nonnormative stressors and strains and to foster the family’s adaptation following a family crisis or major transition and change.”

- **Support Networks.** “Families benefit from and contribute to the network of relationships and resources in the community, particularly during periods of family stress and crisis.”

- **Rhythm.** “Family functioning is often characterized as predictable with shaped patterns of interpersonal behavior, which in turn are molded and maintained by intergenerational factors, situational pressures that have evolved over time, the personalities of the family members, and the normative and nonnormative events that punctuate family life throughout the life cycle.”

- **Multidimensional Assessment.** “Family interventions can be enhanced and families supported by both a diagnostic and an evaluation process which takes the strengths, resources and capabilities in the family system as well as the deficiencies of the family system into consideration.”

- **Problem-Oriented Interventions.** “Family functioning can be enhanced by interventions that target both the vulnerabilities and dysfunctional patterns of the family unit.”

- **Strength-Oriented Interventions.** “Family functioning can be enhanced by interventions that target both the family’s interpersonal capabilities and strengths which, if addressed, can serve as a catalyst for other family-system, wellness-promoting properties.”

- **Self-Regulation.** “Families develop and maintain internal resistance and adaptive resources, which vary in their strength and resiliency over the family life cycle but which can be influenced and enhanced to function more effectively. These resources can play a critical role in fostering successful family adjustments and adaptations.”
even after the family unit has deteriorated to the point of exhibiting major difficulties and symptoms of dysfunction.” (McCubbin & McCubbin, 1992, pp. 155-156)

### 3.3 Hill’s ABCX Model

Undoubtedly, Hill’s 1949 formulation of how stressors impact on families, known as the ABCX Model, laid the foundation for all subsequent family stress research and family resilience models (Burr, 1973/1982; McCubbin & Patterson, 1982). The model was slightly modified by Hill in 1958, but has remained essentially unchanged since then. Although other, more sophisticated models have been evolved since then (notably by McCubbin and colleagues), Hill’s model remains the prototype and is presented in some detail here in order to clarify the evolution of later models. The model, slightly adapted from Burr (1973/1982), is illustrated in Figure 3.1.


\[
A \text{ (the event) – interacting with } B \text{ (the family’s crisis-meeting resources) – interacting with } C \text{ (the definition the family makes of the event) – produces } X \text{ (the crisis).}
\]

The second and third determinants – the family resources and definition of the event – lie within the family itself and must be seen in terms of the family’s structures and values. The hardships of the event, which go to make up the first determinant, lies outside the family and are an attribute of the event itself. (p. 5)

#### 3.3.1 The Stressor (A)

The A factor in Hill’s model, the stressor, can be defined as “a life event (eg death, purchase of a home, parenthood, etc) impacting upon the family unit which produces, or has the potential of producing, change in the family social system” (McCubbin & Patterson, 1983b, p. 7). According to Hill, there are four main categories of stressors (in McCubbin & Patterson, 1983b, p. 7):

- “Accession – changed family structure by adding a member (eg birth of a child)
- “Dismemberment – changed family structure by losing a member (eg child’s death)
- “Loss of family morale and unity (eg alcoholism, substance abuse)
- “Changed structure and morale (eg desertion, divorce).”
The amount of change

The family's crisis-meeting resources

The family's definition of the seriousness of the changes

The stressor event

The amount of crisis in the family social system

(A Adapted from Burr, 1982, p. 10)
3.3.2 Family Crisis (X)

In 1949, Hill defined a crisis as “any sharp or decisive change for which old patterns are inadequate” (cited in Burr, 1973/1982, pp. 5-6). Crisis in family literature is most often conceived of as a disruption in the routine or rhythm of a family, that is, a disruption of the family’s homeostasis. The greater the disruption, the greater the degree of crisis, hence $X$ can refer to the amount of crisis (ibid.).

McCubbin and Patterson (1983b) state:

Crisis is characterized by the family’s inability to restore stability and the constant pressure to make changes in the family structure and patterns of interaction. In other words, stress may never reach crisis proportions if the family is able to use existing resources and define the situation so as to resist change within the family system. (p. 11)

The power of a stressor event ($A$) to cause a large degree of crisis in a family system ($X$) is mediated by the family’s crisis-meeting resources ($B$), the family’s definition of the stressor ($C$) and the amount of change required by the stressor.

3.3.3 Resources (B)

The $B$ factor in the ABCX model refers to the crisis-meeting resources at the family’s disposal. Resources refer to the family’s ability to prevent a stressor event or transition in the family from creating a crisis (McCubbin & Patterson, 1982; 1983b). Resources, then, refer to the capacity of a family to resist the development of a crisis in the face of stress. Burr (1973/1982, p. 8), following on from Hansen (1965) who worked with Hill on later developments of the ABCX model, indicates that the $B$ factor can also be called ‘vulnerability’. Although this term is more pathogenic in orientation, it is important in that it is incorporated as a separate component into later family resilience models.

3.3.4 Family Definition (C)

The $C$ factor refers to the family’s definition of the stressor event and the changes that the stressor requires of the family. Hill (in Burr, 1973/1982, p. 8) indicates that there are three types of definitions: (1) definitions formulated by an impartial observer, (2) definitions formulated by the community or society within which the family lives, and (3)
subjective definitions formulated by the family itself. Hill argues that the family’s own subjective definitions are the most important for influencing their response to a crisis. Burr (ibid., p. 9) proposes that the C factor does not act directly on the X factor, but rather that it influences the degree of vulnerability in the family (or the resources at the family’s disposal), as illustrated in Figure 3.1.

### 3.3.5 Amount of Change

According to Burr (1973/1982, p. 9), in Hill’s original formulation of the ABCX model there was another component which was not included in later formulations, viz the “hardships of the event”. In 1949 Hill operationalised this by counting the number of changes required by the stressor, hence Burr refers to this as the “amount of change”. Burr (ibid.) states, “The amount of change [italics added] that occurs when a stressor event occurs in the family social system influences the amount of crisis that results from the event.”

In short, “a stressor does not act directly on the family; rather, it is the perception of the event as mediated by internal and external contexts that determines whether the family will cope or fall into crisis” (Black, 1993, p. 275).

### 3.3.6 The Contribution of Hill’s Model

Hill’s ABCX Model has made a number of significant contributions to the field of family stress and family resilience research:

- It undermines the linear and deterministic notion that stressors cause crisis, by introducing a number of mediating variables.
- It provides clinicians with hints on how to enhance the resilience of families, by identifying two sets of variables (resources and definitions) that are directly within the family’s control.
- It empowers families who are subject to stressors over which they have no direct control (eg war induced separations, death, natural disasters, birth, etc) to resist entering crisis.
3.4 FAMILY STRENGTHS RESEARCH

Whereas family stress research examined families exposed to extreme stress, family strengths research examined families who, by their own or other’s opinion, were considered strong or resilient. The intention was to identify the characteristics of these families. This is somewhat similar to the salutogenic notion of identifying people who thrive in the face of adversity, except that there is no explicit attempt to identify adversity. There is an implicit assumption that routine life events entail stressors that families must deal with.

Family strengths research is largely theory free and tends to be descriptive (Ponzetti & Long, 1989). As such, it is difficult to present it as a coherent model. However, in light of Hill’s ABCX model, one can fit most of the characteristics of strong families under the umbrella of Crisis-Meeting Resources (the B factor), since strong families have more resources with which to meet and mediate the crisis-producing effects of a stressor.

3.4.1 DEFINITIONS OF FAMILY STRENGTHS

There are various definitions of family strengths:

[Family strengths are] those relationship patterns, interpersonal skills and competencies, and social and psychological characteristics which create a sense of positive family identity, promote satisfying and fulfilling interaction among family members, encourage the development of the potential of the family group and individual family members, and contribute to the family’s ability to deal effectively with stress and crisis. (Williams et al, 1985, in Trivette, Dunst, Deal, Hamer, & Propst, 1990, p. 17)

[Family strengths are] those forces, and dynamic factors in the relationship matrix, which encourage the development of the personal resources and potential of members of the family, and which make family life deeply satisfying and fulfilling to family members. (Otto, 1975, in Sawin, 1979, p. 167)
Family strengths are the competencies and capabilities of both various individual family members and the family unit that are used in response to crises and stress, to meet needs, and to promote, enhance, and strengthen the functioning of the family system. (Trivette et al., 1990, p. 18)

Many authors, such as Pollack, Jansen, Otto, Stinnett, Olson, Beavers, Barnhill, Epstein & Bishop, Handsen and Trivette, have generated lists of family strengths. In many cases, these lists overlap, so that a separate review of each researcher’s contribution would be very repetitive. A synthesis of the findings of these various will, therefore, be presented. I identified eleven clusters of family strengths that are summarised in the sections below.

### 3.4.1.1 Cohesion

Family cohesion or closeness is one of the most frequently cited characteristics of strong families, and is particularly valued as a family strength by both healthy and clinical families (Bobele, 1989). Cohesion, as conceptualised in the Circumplex Model, can be defined as “the emotional bonding that families have toward one another”, and can range from extremely low cohesion (disengagement), to moderately low cohesion (separation), moderately high cohesion (connection), and to extremely high cohesion (enmeshment)” (Olson, Lavee, & McCubbin, 1988, p. 22).

Minuchin (1974) has written extensively on cohesion, as H.I. McCubbin and McCubbin (1992) summarise:

He writes that the human experience of identity has two elements: a sense of belonging and a sense of separateness. A family’s structure may range from the one extreme of the “enmeshed” family to the other extreme of the “disengaged” family. In the former, the quality of connectedness among members is characterized by “tight interlocking” and extraordinary resonance among members. The enmeshed family responds to any variation from the accustomed with excessive speed and intensity. In sharp contrast, individuals in disengaged families seem oblivious to the effects of their actions on each other. (pp. 158-159)

The McMaster Model of Family Functioning (Epstein & Bishop, 1981) uses the term “affective involvement” rather than cohesion. Affective involvement can be graded on a 6-point scale: (1) lack of involvement, (2) involvement devoid of feelings, (3) narcissistic involvement, (4) empathic involvement, (5) over-involvement, and (6) symbiotic involvement. Empathic involvement, which is just above the half way mark, is seen as the most effective form of affective involvement (Will & Wrate, 1985, p. 23).
Research indicates that “in nonclinical families, [across the lifespan,] family cohesion level accounts for level of family strain and well-being. In other words, ‘connected’ (more cohesive) families have lower levels of strain and higher levels of well-being than do ‘separated’ (less cohesive) families” (Olson et al., 1988, p. 40); see also (H.I. McCubbin & McCubbin, 1988).

Barnhill (1979) refers to cohesion as ‘mutuality’, in contrast to ‘isolation’. Mutuality is defined as “a sense of emotional closeness, joining, or intimacy” (ibid., p. 95). Barnhill notes that isolation can occur when there is no mutuality, or when the mutuality is so strong (enmeshment) that the separate identities of the family members becomes fused, making it impossible for them to be “close”.

Other writers also indicate the importance of cohesion. Otto (1963, in H.I. McCubbin & McCubbin, 1992, p. 167) cites the importance of “family unity, loyalty, and interfamily cooperation,” as well as “utilizing consciously fostered ways to develop strong emotional ties”. Lewis (1979, in Lee & Brage, 1989, p. 350) indicates the importance of “close knit” families that “share opinions and feelings with each other”. Beavers (1977, in Lee & Brage, 1989, pp. 353-354) refers to optimal families as experiencing “joy and comfort in relating”, and found that they display “an engaging warm, optimistic tone and a striking emotional intensity.” He also found that they “had a high involvement with each other.”

Some writers (eg. Lewis, 1979, in Lee & Brage, 1989) indicate that cohesion in the marriage relationship creates the platform for the strength of the family as a whole:

A family is more likely to be healthy if the parents have a ‘good’ marriage, where both spouses feel competent and share power. They achieve deep levels of intimacy. Neither feels highly vulnerable or competitive. Their individual differences are enjoyed and supported. (p. 350)

As an example of the value of marital cohesion, Conger and Elder (1999) studied the role of marital support as a mediator between economic pressure and emotional distress. Marital support was defined as:

The tendency of each spouse to (a) listen to the other’s cares and concerns, (b) maintain a cooperative and helpful posture in relation to expressed concerns, (c) indicate sensitivity to the partner’s point of view, and (d) express approval of the partner’s qualities and characteristics. (p. 57)

Results indicated that couples who were high in marital support (crisis-meeting resources – B) experienced less emotional distress (the crisis – X) in response to economic pressure (the stressor – A) than couples who were low in marital support (vulnerability – B) (Conger et al., 1999, p. 69).
A study by Burke and Weir (1982, p. 223) found that husbands and wives who were satisfied with the degree of informal help they received from their partners experienced greater life, job and marital satisfaction, reported less stress and fewer psychosomatic complaints. The researchers conclude that spouse helping has therapeutic effects. Spouse helping could be interpreted as an operationalisation of marital cohesion.

Stinnett (1979; 1989) refers to the importance of families spending time together, another operationalisation of the construct ‘cohesion’. Linking on with Olson’s notion of degrees of cohesion, Stinnett (1989, p. 64) indicates that “it is also important that individuals have time alone and time outside the family so that the bonds do not become chains”. He refers to a study by Jacobsen in which 1,500 children were asked what they believed made for a happy family. “Their most frequent response was that a family is happy because they do things together” (Stinnett & De Frain, 1989, p. 63). Stinnett (1989) argues against the “quality rather than quantity” expression, and promotes a “quality in quantity” approach. Finally, he notes that time together does not “just happen” (Stinnett, 1979). Strong families make it happen by scheduling it into their lives. Other authors (Trivette et al., 1990, p. 19) state that strong families make a “concentrated effort to spend time and do things together, no matter how formal or informal the activity or event”. Similarly, Curran (1983, in H.I. McCubbin & McCubbin, 1992, p. 169) indicates that “the healthy family fosters table time and conversation [and] shares leisure time.”

“Commitment” is the second of six qualities of strong families identified by Stinnett (1979; Stinnett & De Frain, 1989), and although it is not equivalent to cohesion, it can be helpfully placed under the cohesion heading. Stinnett (1979, p. 27) found that strong families “were deeply committed to promoting each others’ happiness and welfare. They were also very committed to the family group as was reflected by the fact that they invested much of their time and energies into the family”. Commitment “is the invisible tie that binds [these families] together and [is] perhaps the foundation of the other five qualities” of strong families (Stinnett & De Frain, 1989, p. 57). While cohesion is probably an affective quality (a feeling or sense of being engaged with others), commitment is more volitional: a conscious choice to promote “the well-being and growth of the individual family members as well as that of the family unit” (Trivette et al., 1990, p. 56).
3.4.1.2 Communication

Good communication has long been hailed as the cornerstone of a strong family (Gantman, 1980; H.I. McCubbin & McCubbin, 1992). “These families communicate with a great deal of shorthand, are very spontaneous, and tend to interrupt each other frequently” (Lewis, 1979, in Lee & Brage, 1989, p. 350). Stinnett (1989) emphasises the centrality of good communication in strong families:

They talk about important things, and are often very task-oriented in their communication: what-needs-to-be-done and how-are-we-going-to-get-it-done types of conversations. Strong family members also spend a lot of time talking about small things. ... Communication is important not only to solve problems, but also as recognition that the people in the family simply enjoy each other’s company. (p. 60)

Good communication involves “checking out” the meaning of communications to ensure accurate understanding (Barnhill, 1979, p. 96). Poor communication, by contrast, involves “vague or confusing exchanges of information, paradoxical communication (when one part of a message invalidates another part), or prohibitions against “checking out” meaning” (ibid.).


- Firstly, effective communication is both ‘clear’ and ‘direct’. Clear communication is explicit and straightforward, as opposed to ‘masked’ communication, which is camouflaged or vague. ‘Direct’ communication is “explicitly directed towards the individual for whom it is intended” (Will & Wrate, 1985, p. 17), as opposed to ‘indirect’ communication.

- Secondly, effective communication is ‘congruent’, that is there is a fit between the verbal and nonverbal components of the message, as opposed to ‘incongruent’ communication.

- Thirdly, the recipient of the communication ‘validates’ the message, that is acknowledges receipt of the message and an understanding of the content of the message, as opposed to ‘ignoring’ the message (acting as if the communication has not occurred) or ‘disqualifying’ the message (“denying that the communicator has the experience about which he has communicated” (Will & Wrate, 1985, p. 18)). Other authors also indicate the importance of listening in communication (eg Lewis, 1979,

Strong families evidence moderate amounts of conflict and fighting, “but the hostilities generally do not get to an extreme level” (Stinnett & De Frain, 1989, p. 60). The fights in strong families tend to be task-oriented, honest, direct and solution-focused (Stinnett, 1979). When they fight, they are able to “emphasise positive interactions among family members” (Trivette et al., 1990, p. 19).

An important component of good communication is the capacity of family members to provide each other with positive feedback and appreciation (Stinnett, 1979; Stinnett & De Frain, 1989; Trivette et al., 1990). Stinnett (1989, p. 59) argues that the ratio of positive to negative communications is a key to the success of strong families. He proposes a minimum ratio of 10:1 (at least ten positive comments for every one critical comment) in order to maintain a healthy relationship.

### 3.4.1.3 Problem Solving

“The ability to engage in problem-solving activities designed to evaluate options for meeting needs and procuring resources” (Trivette et al., 1990, p. 19) is an important characteristic of strong families (Beavers, 1977, in Lee & Brage, 1989; Tallman, 1988). Lewis (1979, in Lee & Brage, 1989, p. 351) notes that strong families are able to “identify problems sooner than dysfunctional families” and are able to follow a concerted problem solving process without blaming each other.

The McMaster Model of Family Functioning (Epstein & Bishop, 1981) details the process of problem solving as comprising seven stages, viz; “(1) identification of the problem, (2) communication of the problem to the appropriate person(s)/resources, (3) development of alternative action, (4) decision on one alternative action, (5) action, (6) monitoring the action, (7) evaluation of the success of action” (Will & Wrate, 1985, p. 14). Strong families are able to follow the entire problem solving process.

A problem can be defined as follows (Tallman, 1988):

> A problem is an intrusion in an actor's [ie a person’s] state of affairs that has the following characteristics: (1) it impedes, blocks, or interferes with the actor’s efforts to attain a particular goal; (2) it creates an undesirable situation for the actor that is alterable if and only if the actor engages in mental and/or motor activities that will eliminate, bypass, or overcome the impediments, obstacles, or barriers that are
interfering with goal attainment efforts; (3) there is some degree of uncertainty that
the activities listed in the second statement can be successfully completed. (p. 107)

This detailed definition of a problem has several implications (Tallman, 1988). First,
since the problem is an intrusion on one’s normal or routine activities, activities to solve
the problem must be nonroutine or extraordinary. Secondly, these activities are taken
at some risk. Solving a problem may create other problems and inevitably requires
change that produces instability. The larger the problem, the greater the risk involved in
solving it. Third, a problem can be considered solved when the “barrier, obstacle, or
impediment to attaining a goal is removed, ended, or overcome” (ibid., p. 109). Fourth,
since the problem is defined as the obstacle that prevents the attainment of some goal,
the problem solving process must entail the removal of the obstacle, not the attainment
of the goal itself. Fifth, problem solving can be considered effective when the person is
able to continue on the path towards achieving his/her goal.

Consequently, the problem solving process can be defined as follows (Tallman, 1988):

The problem-solving process involves nonroutine mental or physical activities in
which the actor attempts to overcome a condition that impedes his or her goal
attainment efforts. These activities always entail some degree of risk that the
problem may not be solved. (p. 112)

Conger and Elder (1999) were able to test the strengthening properties of effective
problem solving with couples exposed to economic stress. They measured marital
conflict and marital distress on three occasions at yearly intervals. Marital conflict was
operationalised as “criticism, defensiveness, escalations in negativity, angry withdrawal,
and insensitivity” and marital distress as “negative evaluations of the relationship,
including thoughts of or even actions related to divorce or separation” (ibid., p. 56). The
researchers concluded:

We proposed that couples with strong problem-solving skills would be most able to
effectively respond to marital conflict [at Time II], reducing its impact on later
marital distress [at Time III]. … The findings were consistent with these hypotheses.
Couples who demonstrated the ability to generate realistic and nonexploitive
solutions to their conflicts and disagreements, and who did not engage in protracted
solution generation to the neglect of actually resolving a disagreement, were less
likely to suffer distress in their marriages as a result of such conflicts compared with
less capable couples. Also consistent with expectations, the level of couple
supportiveness did not moderate the relationship between marital conflict and marital
distress. These findings suggest that, when faced with an internal family stressor,
couples need to do more than providing sensitivity and concern. They need to be
able to negotiate, bargain, and reach agreement on realistic solutions to internal
family matters. (p. 69)
The longitudinal Lundby study in Sweden also found that problem solving acted as a significant resilience factor, reducing the incidence of alcoholism and psychopathology among a sample of high risk people (Cederblad et al., 1995, p. 328).

### 3.4.1.4 Spirituality and Values

“This is possibly the most controversial finding in our research, and yet it is undeniable that for many strong families religion – or spiritual wellness, or feelings of optimism or hope, or an ethical value system, or whatever you wish to call it – are important themes in their lives” (Stinnett & De Frain, 1989, p. 65). Some families express their spirituality through active involvement in a religious community, leading to Stinnett’s original formulation of this strength as “a high degree of religious orientation” (Stinnett, 1979, p. 28). In his later writings Stinnett was more accommodating of those who, while not participating in religious activities, have a strong sense of transcendent spirituality.

Others researchers have also identified spirituality as a source of family strength: Otto (1963, in H.I. McCubbin & McCubbin, 1992, p. 167) refers to “spirituality commitment” and Curran (1983, in H.I. McCubbin & McCubbin, 1992, p. 167) says, “The healthy family has a shared religious core”. Olson (1983, in H.I. McCubbin & McCubbin, 1992, p. 168) found that religious orientation, congregational activities and spiritual support were particularly important strengths for families with adolescent children. Trivette et al (1990, p. 19) stress the importance of “a sense of purpose that permeates the reasons and basis for ‘going on’ in both bad and good times”, while Beavers (1977, in Lee & Brage, 1989, p. 354) indicates that “optimal families also experience significant transcendent values which are necessary for enjoyable, hopeful, and optimistic living.”

### 3.4.1.5 Family Identity and Rituals

Curran (1983, in H.I. McCubbin & McCubbin, 1992, p. 167) found that “the healthy family has a strong sense of family in which ritual and traditions abound.” This raises two related concepts, viz family identity and family ritual.
Family Identity

Gunn (1980) describes family identity as follows:

Our concept of family identity [has] two polar aspects. On the one hand, the family’s identity looks back to its history and forward to its future – and to its mythology composed of “patterns, themes, motifs by which [it] recognizes the unity of [its] life” (Novak, 1971, p. 60). On the other hand, the family’s identity is involved with the larger community in which it lives – the formulation of the family story which embodies a family’s identity must set it into the context of the wider community in a way which will be acceptable to the family members themselves. In other words, a sense of family identity creates a symbolic image of the “the family” in the minds of family members. ... The symbolic entity created by a sense of family identity gives a context to family life from which meaning can be derived and personal satisfaction obtained from the family experience. ... If families are to exhibit strengths, if they are to be capable of pulling together and collectively overcoming difficulties, it would seem that they ... need an awareness that their cooperate [sic] lives and endeavors make sense, and that family life is meaningful in the context in which the family lives. (pp. 20-21)

Gunn (1980, p. 18) argues that family identity “lies at the very heart of what it means to have family strengths as distinct from strengths accruing to the individuals who happen to be living in families”. He then identifies four activities that assist in the formation and maintenance of family identity (ibid., pp. 26-29):

- **Telling the Family Story.** Modern, Western families have tended to neglect the ‘family story’. There is a need to piece together and transmit the story of each family to other members of the family, so that the entire system shares the common oral tradition of where the family came from.

- **Photographing the Events of the Family.** Like paintings in a museum, photographs of family activities and members serve to preserve the history of a family. Unless these photographs are linked with the family story, however, they are meaningless and of little value in developing family identity. Families with strong family identity preserve photographs, along with stories, for future generations.

- **Preserving and Perpetuating Traditions, Rituals and Distinctive Ways of Doing Things.** When a new family is formed through marriage, two sets of traditions are also merged. In the process, some must be discarded and others adopted. This process should be a conscious process and ways of honouring both sets of traditions built in. “Of course, these efforts can also mire the family down in endless functions and meaningless repetitions if they become separated from the family story or if they merely become a burden upon one or a few members of the family” (Gunn, 1980, p. 28)
Preserving Mementos of the Past. As with photographs, mementos from the past need to be preserved and linked with the family story to ensure their vitality.

Family identity is able to provide families with strength and dignity (Gunn, 1980):

The key to such family identity lies in transforming the bric-a-brac of the past – the genealogies, the boxes of photographs, the mementos, the rituals, the anecdotes – into a family story which has the power to unite the present generation with its past, and which reveals patterns, themes, and motifs by which a family can recognize the unity of its life. (p. 30)

Family Rituals

Gunn’s explanation of family identity well introduces the theme of family rituals, which can be defined as follows:

We define family ritual as a symbolic form of communication that, owing to the satisfaction that family members experience through its repetition, is acted out in a systematic fashion over time. Through their special meaning and their repetitive nature, rituals contribute significantly to the establishment and preservation of a family’s collective sense of itself, which we have termed the “family identity”. Rituals stabilize this identity throughout family life by clarifying expected roles, delineating boundaries within and without the family, and defining rules so that all members know that “this is the way our family is.” (Wolin & Bennett, 1984, p. 401)

Rituals are coevolved symbolic acts that include not only the ceremonial aspects of the actual presentation of the ritual, but the process of preparing for it as well. It may or may not include words, but does have both open and closed parts which are “held” together by a guiding metaphor. Repetition can be a part of rituals through either the content, the form, or the occasion. There should be enough space in ... rituals for the incorporation of multiple meanings by various family members ... as well as a variety of levels of participation. (Roberts, 1988, p. 8)

Ritual, while perhaps not as honoured in contemporary society as before, remains a cornerstone of resilient families and societies (Imber-Black, Roberts, & Whiting, 1988; H.I. McCubbin & McCubbin, 1988). Rituals serve multiple functions; indeed this is a key part of their value to families. Roberts (1988; see also Wolin & Bennett, 1984, pp. 407-413) identifies the following functions of daily, familial, cultural and religious rituals:

- Rituals facilitate change or transition, while maintaining order through the location of the ritual within the tradition or history of the family or culture.
- Rituals help to teach and promulgate the family’s worldview, meanings and beliefs.
- Rituals help to hold together the many paradoxes and contradictions of life, such as the joy and sorrow of a wedding.
Rituals help to hold and contain strong emotions.

Rituals help to delineate and link roles among individuals, families and communities, and to tie together past, present and future.

Rituals help to integrate left-brain, verbal, analytic functions, with right-brain, nonverbal, intuitive, symbolic functions, which allows for the processing of information that might not otherwise be possible.

Most families report three categories of rituals (Wolin & Bennett, 1984):

- **Family Celebrations.** “Family celebrations are those holidays and occasions that are widely practiced throughout the culture and are special in the minds of the family” (Wolin & Bennett, 1984, p. 404). Roberts (1988) subdivides family celebrations:
  - **Annual Celebrations.** These rituals tend to be located within the broader society, either secular or religious/cultural. These include Christmas, Easter, Passover, New Year, May Day, Freedom Day, etc. The broad nature of these rituals tends to be socially defined, but each family adapts the broad tradition to their own style. Often these celebrations evoke mixed responses, yet they remain important to most families.
  - **Rites of Passage/Family Life Cycle Rituals.** Rites of passage rituals or family life cycle rituals include weddings, funerals, baptisms, circumcision, bar mitzvahs, etc. These rituals “help to define the membership list of the family – baptism, weddings, funerals – and they signify the family’s developmental phase as in bar mitzvahs, confirmations, and graduations” (Wolin & Bennett, 1984, pp. 404-405).

- **Family Traditions.** “Family traditions, as a group, are less culture-specific and more idiosyncratic for each family. They do not have the annual periodicity of holidays or the standardization of rites of passage, though they recur in most families with some regularity” (Wolin & Bennett, 1984, p. 405). Family traditions run according to the family’s ‘internal calendar’, unlike family celebrations which run according to an ‘outside calendar’ (Roberts, 1988, p. 34). Family traditions help to define the family’s identity, and can include birthdays, anniversaries, holiday trips, participation in periodic community or extended family functions, etc. Family traditions can vary in the degree to which they centre on the needs of the children in the family and the degree to which they incorporate people from outside the family.
Family traditions can even be built up around problem-solving activities, such as a regular or ad hoc ‘family council’ (Wolin & Bennett, 1984, p. 405).

- **Family Interactions/Rituals of Daily Family Life.** The last set of rituals are the least standardised of all family rituals, and are often so apparently trivial that families do not even consider them to be rituals; the word ‘routines’ seems more appropriate. Nevertheless, these rituals are performed the most often (Wolin & Bennett, 1984):

  In this category belong rituals such as a regular dinnertime, bedtime routines for children, the customary treatment of guests in the home, or leisure activities on weekends or evenings. In some families, the discipline of children or everyday greetings and goodbyes are rituals. Whatever the patterns, these interactions help to define member’s roles and responsibilities; they are a means of organizing daily life. (p. 406)

Imber-Black (1988) identified five ritual themes in families (which he also uses in therapeutic rituals):

- **Membership.** Membership rituals help to define “who is in and who is out, who belongs to the system, who defines membership, and how one gains or loses membership” (Imber-Black, 1988, p. 51). Membership rituals take place daily (eg hellos and goodbyes, meal times) and at special events (weddings, funerals, etc). Some families experience difficulties because of the absence of membership rituals (eg marriages for homosexual couples, divorce rituals, the formation of stepfamilies).

- **Healing.** Healing rituals help people cope with and adjust to difficulties in life. Funerals are a prime example; the stylised grieving assists in a moderate catharsis that promotes healing. Diary writing is a form of healing ritual that helps some people cope with life’s ups and downs. Even psychotherapy can be thought of as a ritual that helps people heal and grow.

- **Identity Definition and Redefinition.** Many cultural rituals assist in identity definition and redefinition. Weddings assist the bride and groom change identity from a separate individual to a part of a couple. Adolescent rites of passage assist in changing identity from child to adult. Birthdays assist in changing identity from one year to the next. Religious and culture specific rituals (eg church services or Scottish Dancing) assist in reinforcing one’s religious or cultural identity.

- **Belief Expression and Negotiation.** Most rituals serve to give expression to the beliefs and values of a family, thereby locating the family with a broader context, both in time (past, present and future) and space (a current community of people
who share those beliefs). As beliefs develop, rituals change to follow suit; and as rituals change, the beliefs they uphold are gradually transformed.

**Celebration.** Most rituals contain elements of celebration – both rejoicing and reverence (Imber-Black, 1988):

The celebration theme involves that aspect of rituals connected to affirming, honoring, commemorating, and demarcating regular time from special time. Rituals of celebration frequently involve ethnic expression, special food and drinks reserved for certain celebrations, unique music, gifts, and particular clothing. The celebration aspect of rituals is often the most visible and dramatic marker of individual, family and community definition and change, although celebration, per se, is usually only the culmination of a much longer process. (p. 76)

### 3.4.1.6 Affective Responsiveness

Lewis (1979, in Lee & Brage, 1989, p. 351) indicates that “the basic mood of healthy families contains elements of warmth, humor, and concern for each other”. Strong families are able to share their feelings honestly and openly with each other, and respond to the expression of feelings with empathy and acceptance. In particular, feelings of loss in response to the inevitable losses of life can be expressed and dealt with in healthy families.

The McMaster Model of Family Functioning (Epstein & Bishop, 1981) conceptualises this as “affective responsiveness”. This is the capacity of family members to express two sets of feelings: (1) welfare feelings, such as “love, tenderness, sympathy, happiness, and joy; responses which are positive and supportive” and (2) emergency feelings, such as “fear, panic, anger, and disappointment” (Will & Wrate, 1985, p. 20). Strong families are able to express a wide range of feelings (as opposed to a limited range of emergency feelings), and are able to express feelings that are contextually appropriate (as opposed to expressing distorted amounts or qualities of feelings, given the context).

### 3.4.1.7 Boundaries & Hierarchies

According to Beavers (1977, in Lee & Brage, 1989) and Gantman (1980), strong families have very clear boundaries between individual family members (so that they are not enmeshed with each other) and between generations within the family (so that parents
do not behave like children and so that children do not serve the functions of spouse or parent) (see also Barnhill, 1979; Minuchin, 1974).

Furthermore, Beavers (1977, in Lee & Brage, 1989), Lewis (1979, in Lee & Brage, 1989) and Gantman (1980) stress the importance of the parents having the “ultimate power” in the family, and add that the power needs to be equally distributed between the parents to avoid power conflicts.

These views on intergenerational boundaries and parental power were published in the late 1970s and by today’s standards may be considered somewhat old-fashioned. Boss’ 1980 contribution of “boundary ambiguity” was quite farsighted and offers valuable insights to the question of boundaries. Boundary ambiguity occurs when the physical and psychological presences of family members do not coincide or when there is uncertainty concerning an individual’s membership within the family system (Boss, 1980):

If a family member is perceived as psychologically present, but is, in reality, physically absent for a long time, the family boundary is ambiguous and cannot be maintained. The reverse also manifests boundary ambiguity: physical presence with psychological absence, as in some intact families where a parent is consistently preoccupied with outside work. (p. 446)

Boss argues that, regardless of how a family organizes its boundaries, “a high degree of boundary ambiguity” may cause dysfunction (Boss, 1980, p. 446). She continues:

The greater the boundary ambiguity at various developmental and normative junctures throughout the family life-cycle, the higher the family and individual dysfunction. Resolution of the ambiguity is necessary before the family system can reorganize and move on toward new functioning at a lower level of stress. Non-resolution of boundary ambiguity holds the family at a higher stress level by blocking the regenerative power to reorganize and develop new levels of organization. Boundaries of the system cannot be maintained, so the viability of the system is blurred. Dysfunction results. (p. 447)

Boss argues that boundaries in the family will have to be adjusted periodically throughout the family life cycle. Typical life cycle changes which create boundary ambiguity include (1) the formation of the dyad, (2) the birth of the first child, (3) the children first going to school, (4) job-related parent/spouse absence or presence, (5) adolescent children leaving home, (6) taking in children not one’s own or blending children from different dyads, (7) loss of a spouse through death, divorce, etc, (8) loss of parents, (9) formation of a new dyad or remarriage and (10) remaining single (Boss, 1980, p. 448).
Boundary ambiguity focuses not on normative (and hence culture bound) boundary structures, but rather on the ambiguities that can arise in any family structure when there is unclarity regarding who is in and who is out. Boss cites African American families as an example of families who historically used very flexible and need-defined family structures. The elasticity of African American family boundaries allowed for the physical absence of family members for long periods and over great distances, without disrupting the family identity (Boss, 1980; Littlejohn-Blake & Darling, 1993). Informal conversations with African social workers in South Africa suggests that the same may be true in African families who experienced a father separated through migrant labour or parents separated through exile.

### 3.4.1.8 Flexibility/Adaptability

Minuchin (1974, pp. 60-65) indicates that families must constantly adapt to change – change resulting from contact with problems and stressors outside the family, change resulting from transitional or developmental points in the family life cycle, or change from idiosyncratic problems (such as a child being born with a disability). Most families are sufficiently flexible to adjust to these changes. Families who can by termed dysfunctional are those “who in the face of stress increase the rigidity of their transactional patterns and boundaries, and avoid or resist any exploration of alternatives” (ibid., p. 60).

Barnhill (1979) also identifies flexibility (in contrast to rigidity) as an important component of healthy family systems. Gantman (1980, p. 111) states that “families are optimally conceived of as highly flexible systems which respond spontaneously and are open to growth. Structure exists but is subordinate to function or process.” Trivette (1990, p. 19) indicates that strong families are characterised by “flexibility and adaptability in the roles necessary to procure resources to meet needs” and Otto (1963, in H.I. McCubbin & McCubbin, 1992, p. 167) concurs that “flexibility in performing family roles” is one of 14 dimensions of strong families.

Olson’s Circumplex Model (Olson et al., 1988), which was mentioned previously in connection with its plotting of degrees of cohesion (from disengaged to enmeshed) on the horizontal axis, also plots adaptability on the vertical axis. Adaptability ranges from extremely high (chaotic), moderately high (flexible), moderately low (structured), to extremely low (rigid). Flexibility in this model “is defined as the ability of the marital or family system to change its power structure, role relationships, and relationship rules in
response to situational and developmental needs” (ibid., p. 22). Research by Olson and colleagues (ibid., p. 41), however, found that cohesive/connected families that are flexible are more resilient than cohesive structured families, but separated families that are structured are more resilient than separated flexible families. The researchers conclude that “family flexibility, by itself, is not a critical factor in family vulnerability to stress and its resilience in response to demands.”

3.4.1.9 Social Support

Trivette et al (1990, p. 19) indicate that strong families evidence “a balance between the use of internal and external family resources for coping and adapting to life events and planning for the future.” Otto (1963, in H.I. McCubbin & McCubbin, 1992, p. 167) – “active participation in the community” – and Curran (1983, in H.I. McCubbin & McCubbin, 1992, p. 168) – “the healthy family values service to others” and “the healthy family admits to and seeks help with problems” – echo this perspective. Research by Olson (1983, in H.I. McCubbin & McCubbin, 1992, p. 168) found that “family and friends” are important to the maintenance of “balance” in families in all stages of the family life cycle except “family in empty nest stage and retirement stage”. The longitudinal Lundby study found that that social support protected high-risk children from developing alcoholism and psychopathology in later life (Cederblad et al., 1995, p. 328).

Social support, as a family resilience factor, received intensive study during the 1970s and 1980s (H.I. McCubbin & McCubbin, 1992, p. 160). In 1976, Cobb (in H.I. McCubbin & McCubbin, 1992) identified three primary levels of social support, viz:

(1) Emotional support, leading the individual to believe he or she is cared for and loved; (2) esteem support, leading the individual to believe he or she is esteemed and valued; and (3) network support, leading the individual to believe he or she belongs to a network of communication involving mutual obligation and mutual understanding. (p. 160)

H.I. McCubbin and McCubbin (1992) conclude:

Research on the mediating influence of social support for specific stressor events has emphasized the role of social support in protecting against the effects of stressors and thereby contributing to a family’s resiliency. Research has also emphasized the importance of social support in promoting recovery from stress or crisis experienced in the family as a result of life changes, thereby contributing to the family’s adaptive power. (pp. 162-163)

Support systems will be discussed in greater depth in a later section (Section 4.2).
3.4.1.10  Autonomy

Strong families are able to strike a balance between intimacy and autonomy. This balance is similar to the cohesion balance between enmeshment and disengagement. The cohesion balance, however, is more concerned with the family system itself, while the intimacy-autonomy balance is concerned with the place of the individual within the system. Part of promoting the autonomy of family members is respecting them (Otto and Curran, in H.I. McCubbin & McCubbin, 1992).

Lewis (1979, in Lee & Brage, 1989, p. 351) indicates that “healthy families encourage intimacy and individual autonomy. Each person in the family is viewed as a separate, unique individual. Trust, empathy, openness of feelings, and acceptance of individual differences facilitate intimacy and autonomy” (see also Beavers, 1977, in Lee & Brage, 1989; Stinnett, in H.I. McCubbin & McCubbin, 1992). Barnhill (1979, p. 95) describes individuation as “independence of thought, feeling, and judgement of individual family members. It includes a firm sense of autonomy, personal responsibility, identity and boundaries of the self.” Individuation, according to Barnhill, is a prerequisite for healthy family cohesion (see also Gantman, 1980).

3.4.1.11  Coherence

A number of researchers have attempted to translate individual constructs (eg hardiness, coherence, etc) to the family level. Trivette et al (1990, p. 19), for example, state that strong families are characterised by “the ability to be positive and see the positive in almost all aspects of their lives, including the ability to see crises and problems as an opportunity to learn and grow.”

This description has much in common with Antonovsky’s sense of coherence (SOC), which has been translated to the family level (McCubbin, Thompson, Thompson, Elver, & McCubbin, 1998):

[Family Coherence] is a dispositional work view that expresses the family’s dynamic feeling of confidence that the world is comprehensible (internal and external environments are structured, predictable and explicable), manageable (resources are available to meet demands), and meaningful (life demands are challenges worthy of investment). (p. 45)

Similarly, Kobasa’s hardiness concept has been translated up to family level, and pilot research by Bigbee (1992, p. 216) found that “hardiness may serve as a stress-
moderating factor within families. ... Hardiness may have a direct effect as well as a buffering effect in the stress-illness relationship, particularly in relation to negative events.”

### 3.4.2 Measuring Family Strengths

There has been a proliferation of scales that measure various aspects of family strengths:

- The Family Assessment Device (Epstein et al., 1983), based on the McMaster Model of Family Functioning is closely tied to a clinical assessment and intervention model (Epstein & Bishop, 1981; Miller et al., 1994), and has been tested in a variety of settings (Fristad, 1989; Kabacoff, Miller, Bishop, Epstein, & Keitner, 1990; Miller, Epstein, Bishop, & Keitner, 1985; Sawyer, Sarris, Baghurst, Cross, & Kalucy, 1988).

- The Family Adaptability and Cohesion Evaluation Scale (FACES) which is based on the Circumplex Model of family functioning has also been widely tested (Fristad, 1989; Olson et al., 1988).

- Family Strengths Index (cited in Trivette et al., 1990), developed by Stinnett and DeFrain to measure their six qualities of strong families.

- Family Strengths Scale (cited in Trivette et al., 1990), developed by Olson, Larsen and McCubbin to measure family pride and family accord.

- Family Functioning Style Scale (cited in Trivette et al., 1990), developed by Deal, Trivette and Dunst, to measure their 12 qualities of strong families.

- The McCubbin team have brought out a 900 page book entitled “Family Assessment: Resiliency, Coping, and Adaptation: Inventories for Research and Practice” (McCubbin, Thompson, & McCubbin, 1996) which contains 28 scales measuring various aspects of resiliency in families, all of which have reported validity and reliability, such as:
  - The Family Hardiness Index (FHI)
  - Family Inventory of Resources for Management (FIRM)
  - Family Time and Routines Index (FTRI)
Fischer and Corcoran (1994a) published a book called "Measures for Clinical Practice: A Sourcebook: Couples, Families and Children" in which they publish 42 scales measuring family constructs, of which about 20 measure some aspect of family strength, such as:

- Family Beliefs Inventory
- Family Empowerment Scale
- Family Functioning Scale
- Family Sense of Coherence and Family Adaptation Scales
- Kansas Family Life Satisfaction Scale
- Parental Locus of Control Scale
- Parental Nurturance Scale
- Self-Report Family Instrument
3.4.3 A CRITIQUE OF FAMILY STRENGTHS RESEARCH

Family strengths research is subject to a number of criticisms (drawn largely from Ponzetti & Long, 1989):

- Many of the families studied in family strengths research were self-selected. They tend to reflect an implicit bias towards intact, White, nuclear families. (Ponzetti & Long, 1989)

- Family strengths research has tended to lack a theoretical framework. “The purpose of a theory is to organize data so that implications of more general behaviors can be specified. Theories also specify the interrelatedness of the data so that findings can be interpreted and unified, and explanations and predictions made” (Ponzetti & Long, 1989, p. 48).

- Consequently, family strengths literature tends to be quite fragmented, with different writers generating quite different lists of family strengths, or lists that could be integrated were it not for disparate paradigms. (Ponzetti & Long, 1989)

- Family strengths are very culturally bound, and may vary widely over time, place and culture. Much of the literature on family strengths probably reflects the value system of White, American families in the 1960s and 1970s. It is quite probable that other ‘kinds’ of families may value very different strengths. (Ponzetti & Long, 1989)

- The practice of inviting families who define themselves as ‘strong’ to participate in research, which is the methodology used by many of the family strengths researchers, has come under attack as being unsound. Such volunteers tend to come from a subculture that is quite different from the broader culture. (Ponzetti & Long, 1989)

- Assessment by self-report questionnaires may be confounded by social desirability. Families who define themselves as ‘strong’, and who may also have strong religious beliefs, may tend to skew the presentation of themselves in a questionnaire. Data collection needs to combine behavioural and questionnaire data. (Ponzetti & Long, 1989)

- Research by Bobele (1989) demonstrated that families (both clinical/unhealthy and nonclinical/strong) tend to have quite different perceptions of family strengths, when compared with family therapists. Clergymen, in contrast, have perceptions that are
more similar to families than to therapists. Research on family strengths needs to identify clearly the source of data and the method of data collection.

3.4.4 CONCLUSIONS

Family strengths research has been effective in identifying and describing numerous characteristics of healthy families. These findings have provided invaluable guidelines for the development of family strengths, particularly in the field of family life education (Johnson et al., 1998; Lee & Brage, 1989; Schvaneveldt & Young, 1992). What is most lacking in this body of research, however, is a coherent and integrating theoretical framework. Research is largely descriptive and research findings stand free from theory or model.

3.5 McCUBBIN’S RESILIENCE MODELS

Previously it was stated that Hill’s 1949 ABCX model (see Figure 3.1) laid the foundation for most later models of family resilience. One of the main contributors to the evolution of family resilience models is Hamilton McCubbin (Huang, 1991; McCubbin et al., 1996). During the 1970s he worked as a researcher in the US Navy and began studying factors that protected naval families from deployment stress. During the past two decades he and his colleagues have significantly advanced the work of Hill and have generated, in my opinion, the most significant model of family resilience to date.

This section will review of the evolution of Hill’s original ABCX model, concentrating in some depth on the Resiliency Model of Family Stress, Adjustment and Adaptation (McCubbin et al., 1996). Research that supports this model will also be reviewed.

3.5.1 PROPOSITIONS ABOUT FAMILIES UNDER STRESS

In 1973, Burr (1973/1982) created one of the first evolved ABCX models, which he based on the 1965 work of Hansen, who himself had collaborated with Hill on a slight revision of the model in 1964. Burr’s contribution was to formalise the contributions of Hill and Hansen, as well as other researchers in the 1930s and 1940s such as Angell in
1936 and Koos in 1946, into a coherent model. Burr’s formalisation of the ABCX model is important in spelling out the relationships between various family resilience and vulnerability factors, and their relative impact on family adjustment. Furthermore, he highlighted the distinction between family regenerativity (that is, the capacity of the family to recover from crisis) and family vulnerability (that is, the ability of the family to prevent a stressor from precipitating a crisis). This distinction was later incorporated into McCubbin & McCubbin’s Resiliency Model.

Burr’s model (Figure 3.2) depicts the relationships between 23 variables, by means of 25 propositions (Burr, 1973/1982):

- **Proposition 1.** “A stressor event in a family social system influences the amount of crisis in the system, and this is a positive relationship” (Burr, 1973/1982, p. 8). This is the A-impacts-on-X part of Hill’s model (see Figure 3.1).

- **Proposition 2.** “When a stressor event occurs, the vulnerability to stress influences the amount of influence the stressor event has on the amount of crisis and this is a positive relationship” (Burr, 1973/1982, p. 8). This is the moderating influence of B in Hill’s model (see Figure 3.1), although Burr prefers to refer to B as ‘vulnerability’, rather than ‘crisis-meeting resources’.

- **Proposition 3.** “The definition a family makes of the severity of changes in the family social system influences the family’s vulnerability to stress and this a positive, monotonic relationship” (Burr, 1973/1982, p. 9). This refers to the influence of C in Hill’s model (see Figure 3.1), and indicates that the more serious the family defines the situation, the more vulnerable they are.

- **Proposition 4.** “The amount of change that occurs when a stressor event occurs in the family social system influences the amount of crisis that results from the event and this is a positive relationship” (Burr, 1973/1982, p. 9). This is also apparent in Hill’s model as presented by Burr in Figure 3.1. The greater the change required by the stressful event, the greater the crisis in the family.

- **Proposition 5.** “The amount of positional influence in a social system influences the vulnerability of families to stress and this is a positive relationship” (Burr, 1973/1982, p. 11). The concept of positional influence was introduced by Hansen in 1965 and refers to the power to influence the family system that is derived from one’s position in the family. Proposition 5 indicates that the more positional influence used by a family member, the more vulnerable the family is to stress.
Figure 3.2  Burr’s Propositions about Families under Stress

(Burr, 1982, p. 24)
Proposition 6. “The amount of positional influence in a social system influences the regenerative power and this is an inverse relationship” (Burr, 1973/1982, p. 11). Hansen also introduced the term ‘regenerative power’ to indicate “the ability of the family to recover from a crisis” (ibid.). Proposition 6 states that the more positional influence used by a family member, the lower the family’s ability to recover from stress.

Proposition 7. “The amount of personal influence in a social system influences the vulnerability of families to stress and this is an inverse relationship” (Burr, 1973/1982, p. 11). Hansen used the term ‘personal influence’ to refer to the power to influence a family system by virtue of one’s personal relationships with other family members. This proposition is thus saying that the more personal influence a family member has in a family, the lower the family’s vulnerability to stress.

Proposition 8. “The amount of personal influence in a social system influences the regenerative power and this is a positive relationship” (Burr, 1973/1982, p. 11). The more personal influence a family member has in a family, the greater the family’s capacity to recover from stress.

Proposition 9. “The externalization of blame for changes in the family social system influences the vulnerability of the family to stress and this is an inverse relationship” (Burr, 1973/1982, p. 12). ‘Externalization of blame’ was also introduced by Hansen and refers to whether blame for a stressor event is placed on a family member (internal) or on some source outside the family system (external). Proposition 9 states that family vulnerability is reduced when blame is externalised, but that when one or other family member is blamed for causing the stress, the family is more vulnerable to the stress and thus more likely to enter crisis.

Proposition 10. “The regenerative power of families influences the level of reorganization after a period of crisis and this is a positive relationship” (Burr, 1973/1982, pp. 14-15). The term ‘level of reorganization’ was introduced by Koos in 1946 and refers to the recovery or adjustment of the family system, whether or not the actual stressor is overcome. The proposition states that the greater the capacity of a family to recover from stress, the greater the adjustment after the stress.

Proposition 11. “Family integration influences regenerative power and this is a positive relationship” (Burr, 1973/1982, p. 15). Angell introduced the term ‘family integration’ in 1936 to refer to cohesion and good organization within a family.
Proposition 11 says that the more cohesive a family, the greater its power to recover from crisis.

- **Proposition 12.** “Family adaptability influences regenerative power and this is a positive relationship” (Burr, 1973/1982, p. 15). Angell also introduced the term ‘family adaptability’ which refers to the flexibility and adaptability of a family system, that is, its ability to change as required. Flexible families are more able to recover from crisis.

- **Proposition 13.** “The amount of family integration influences the vulnerability to stress and this is a positive relationship” (Burr, 1973/1982, p. 16). This proposition appears contradictory, but both Koos and Hansen found that well-organised families tended to have more severe crises than poorly organised families, that is, they tend to be more vulnerable. Highly cohesive, organised families thus appear to be more vulnerable to stress.

- **Proposition 14.** “The amount of family adaptability influences the vulnerability to stress and this is an inverse relationship” (Burr, 1973/1982, p. 16). Flexible families are less vulnerable to stress.

- **Proposition 15.** “The amount of time stressful events are anticipated influences the vulnerability to stress and this is an inverse relationship” (Burr, 1973/1982, p. 17). Based on research by Hansen and Hill in 1964, it was found that the more time families have to anticipate and prepare for a change, the less vulnerable they are to the stress of the change.

- **Proposition 16.** “The amount of extended familism influences the regenerative power of families” (Burr, 1973/1982, p. 18). ‘Extended familism’, a term developed by Winch and Greer in 1968, is a development on the term ‘kinship-oriented communities’ of Hansen and Hill. Extended familism refers to the degree of contact and closeness with one’s extended family. High extended familism thus refers to having contact with many family members in close proximity (‘extensity’), having close contact with them (‘intensity’), having regular contact with them (‘interaction’) and receiving practical help from them (‘functionality’). The relationship between extended familism and regenerative power is clarified in the following proposition.

- **Proposition 17.** “The length of time a family system experiences disruption influences the relationship in proposition 16, which asserts that extended familism influences the regenerative power of families, and this is a quadratic relationship in
which variation in short periods of time are inversely related and variation in long periods are positively related to the regenerative power” (Burr, 1973/1982, pp. 18-19). Hill and Hansen’s research indicates that when stress is experienced for a short time, families who are separated from their extended family (ie low extended familism) are most able to recover from the stress; but when the stress is experienced for a long time, families who are closely connected to their extended family (ie high extended familism) are most able to recover from the stress.

**Proposition 18.** “The amount of similarity of sentiment in a family influences the regenerative power of families and this is a positive relationship” (Burr, 1973/1982, p. 19). Based on Hill’s 1949 and 1958 research, it was found that families that have internal divisions have less regenerative power. When families have similarity of sentiment, that is, when all family members feel similarly affectionate towards each other, the family is more able to recover from crisis.

**Proposition 19.** “The amount of marital adjustment influences the regenerative power of families and this is a positive relationship” (Burr, 1973/1982, p. 20). High marital adjustment, defined as “consensus, satisfaction, happiness, and stability” (ibid., p. 19) in the marriage, contributes to a great ability of the family to recover from crisis.

**Proposition 20.** “The amount of relative power of spouses is not related to the regenerative power of families” (Burr, 1973/1982, p. 21). Hill found no relationship between the equality of the distribution of power between husband and wife and regenerative power.

**Proposition 21.** “The amount of consultation in decision making influences the regenerative power of families and this is a positive relationship” (Burr, 1973/1982, p. 21). The use of a democratic/consultative process in making family decisions did, however, enhance the ability of family’s to recover from crisis, although Burr (ibid.) suggests that this may be a curvilinear relationship in which excessive consultation could reduce regenerative power.

**Proposition 22.** “The amount of social activity of wives outside the home is related to the regenerative power of families and this is a positive relationship” (Burr, 1973/1982, p. 22). Research during World War II found that wives who had nonwife/mother activities had more regenerative power (both during and after military separations) than wives who did not.
Proposition 23. “The amount of anticipatory socialization for changes in the family social system influences the vulnerability of families and this is an inverse relationship” (Burr, 1973/1982, p. 23). ‘Anticipatory socialization’ is a theoretical term introduced by Burr to explain what Hill operationalised in 1949 as previous experience with the stressor. When people are exposed to a stressor (in reality or in anticipation), they are able to develop the skills and insights to cope with the stressor. Families who have the opportunity to imagine or experience the stressor beforehand are less vulnerable the stressor when it arrives.

Proposition 24. “The amount of anticipatory socialization for changes in the family social system influences the regenerative power of families and this is a positive relationship” (Burr, 1973/1982, p. 23). Families who have the opportunity to imagine or experience the stressor beforehand are more able to recover the stressor when it arrives.

Proposition 25. “The legitimacy of the power structure in a family influences the amount of change in the power structure that occurs in family crises and this is an inverse relationship” (Burr, 1973/1982, p. 23). ‘Legitimacy of power structure’ is a term introduced by Komarovsky in 1940. She found that when the power structure of a family is based on fear or coercion, the power structure changes more when the family is exposed to a crisis, than when the power structure is based on legitimate personal or positional influence.

The purpose of Burr’s model is to illustrate the sources of family vulnerability to stress and family regenerative power. Burr (1973/1982) argues that:

These two variables [vulnerability and regenerativity] are important because they play such an important role (a) in determining whether a family will experience a crisis when they encounter changes in the system and (b) in determining how adequately the family will be able to recover from the crisis situation. (p. 23)

3.5.2 Double ABCX Model

McCubbin and Patterson (1983a) developed the Double ABCX model in 1983. Research by McCubbin and his colleagues during the 1970s led to the identification of various deficits in the ABCX model and the recognition of the need for an expanded model (M.A. McCubbin & McCubbin, 1996, pp. 6-7, based on eight studies published from 1974 to 1979 by McCubbin and various colleagues):
“Longitudinal studies of families faced with crisis situations indicated more factors involved in family recovery than reflected in original ABCX model...

“Families struggle with the pile-up of hardships, prior strains and co-occurring stressors ...

“Families are faced with normative stressors and strains over time and not just the single stressor ...

“When families are faced with a crisis situation which demands change, the appraisal processes appear to be more complex than the definition of the stressor and its severity. Family appraisal involves an assessment of the total situation, inclusive of the family’s resources, capabilities and demands ...

“Confirmation that family crises are not typically catastrophic and do not typically lead to a dysfunctional family situation; family crises do, however, demand changes in the family’s patterns of functioning ...

“Most families in crisis situations appear to transition well and adapt to the situation...

“Families in response to crisis situations change their established patterns of functioning, thus creating a different family situation …”

The Double ABCX Model (McCubbin & Patterson, 1983a), Figure 3.3, emphasises “the factors, particularly coping and social support, which facilitate family adaptation to a crisis situation” (M.A. McCubbin & McCubbin, 1996, p. 5). This differs from the ABCX model by asking what happens to the family after x, that is, after the crisis. McCubbin’s research indicated that most families recovered from the x crisis. Others experienced ongoing pile-up of stressors (aA) which led to bonadaptation or maladaptation (xx), as mediated by coping, by perceptions of x, aA and bB (cC) and by existing and new resources (bB). The Double ABCX Model thus advanced Hill’s ABCX model with five additions, viz the aA, bB, cC and xX factors, and coping patterns (M.A. McCubbin & McCubbin, 1996, p. 7).
Figure 3.3 Double ABCX Model

(McCubbin & Patterson, 1982, p. 46)
3.5.2.1 Family Demands: Pile-up (aA)

Families seldom have to deal with only one stressor at a time. Typically, multiple stressors coincide, requiring a more complex range of coping patterns than originally identified by Hill. This confluence of stressors is termed ‘pile-up’ in the Double ABCX model. Pile-up (aA) differs from the Stressor (a), in that the latter refers to a single stressor while the former refers to a pile-up of multiple stressors. The distinction between stressor and pile-up is also reflected in research studies that use either single or multiple stressors as an independent variable.

3.5.2.2 Family Adaptive Resources (bB)

Families under stress often develop new resources to cope with the pile-up of stressors. In the pre-crisis phase (i.e., in Hill’s ABCX Model), resources (b) referred to existing resources within the family system that help to prevent the stressor from leading to crisis. In the post-crisis phase (i.e., in the second half of the Double ABCX Model), new resources (B) are added to the existing resources (b). These resources can be individual, family or community resources, and are activated by the demands placed on the family by the pile-up of stressors. A resource of particular importance, which is highlighted in the Double ABCX Model, is social support, which promotes the ability of families to resist crisis and to recover from crisis (McCubbin & Patterson, 1983a).

3.5.2.3 Family Definition and Meaning (cC)

The ‘c’ factor in Hill’s ABCX Model addressed the family’s perceptions of only the stressor itself (the ‘a’ factor). Research by McCubbin and colleagues indicate that when faced with multiple stressors, the perceptions families have of the “total crisis situation” are important. The total crisis situation “includes the stressor believed to have caused the crisis, as well as the added stressors and strains, old and new resources, and estimates of what needs to be done to bring the family back into balance” (McCubbin & Patterson, 1983a, pp. 15-16).
3.5.2.4 Family Adaptive Coping: Interaction of Resources, Perceptions & Behaviour

Research by McCubbin and colleagues indicated the importance of looking not only at the perceptions of the crisis situation and the available resources to deal with the situation, but also at what families do to cope with the situation. “Coping, then, becomes a bridging concept which has both cognitive and behavioral components wherein resources, perception, and behavioral responses interact as families try to achieve a balance in family functioning” (McCubbin & Patterson, 1983a, p. 16). The family’s efforts at coping may focus on five areas (ibid.):

(a) Eliminating and/or avoiding stressors and strains; (b) managing the hardships of the situation; (c) maintaining the family system’s integrity and morale; (d) acquiring and developing resources to meet demands; and (e) implementing structural changes in the family system to accommodate the new demands. (pp. 16-17)

3.5.2.5 Family Adaptation Balancing (XX)

The outcome of Hill’s ABCX Model (x) was the degree of crisis. ‘Successful’ families were those who minimized the degree of crisis or disruptiveness of the stressor to the family system. Other research, however, indicated that many families emerge from a period of stress stronger and more resilient than before, and McCubbin and Patterson conclude that “Reduction of crisis’ alone is an inadequate index of a family’s post-crisis adjustment” (1983a, p. 17).

“The concept of family adaptation is used to describe a continuum of outcomes which reflect family efforts to achieve a balanced ‘fit’ at the member-to-family and the family-to-community levels” (McCubbin & Patterson, 1983a, p. 20). The concept of ‘balance’ is introduced in the Double ABCX Model, and refers to the fit between the demands of one system or subsystem and the capabilities of another system or subsystem to meet those demands – hence the ‘demand-capability balance’. McCubbin and Patterson highlight two important points of balance or fit, viz member-to-family fit (in which the demands of one member can be met by the family unit, or when the demands of the family unit can be met by the family members) and family-to-community fit (in which the demands of the family can be met by the community, or when the demands of the community can be met by the family). Demand-capability imbalance results in family stress and creates the need for a restructuring of the family system.
Adaptation (xX), conceptualised as balance or fit, can range from bonadaptation (healthy adaptation) to maladaptation (unhealthy adaptation) (McCubbin & Patterson, 1983a):

The positive end of the continuum of family adaptation, called bonadaptation, is characterized by a balance at both levels of functioning [ie member-to-family and family-to-community] which results in (a) the maintenance or strengthening of family integrity; (b) the continued promotion of both member development and family unit development; (c) the maintenance of family independence and its sense of control over environmental influences. Family maladaptation, at the negative end of the continuum, is characterized by a continued imbalance at either level of family functioning or the achievement of a balance at both levels but at a price in terms of (a) deterioration in family integrity; (b) a curtailment or deterioration in the personal health and development of a member or the well-being of the family unit; or (c) a loss or decline in family independence and autonomy. (p. 20)

The Double ABCX Model, then, improved the ABCX Model by addressing the post-crisis functioning of families, and by incorporating additional variables. Furthermore, the shifting of the outcome variable from crisis to adaptation reflects the evolvement of the resilience orientation of family stress researchers.

### 3.5.3 FAAR Model

In the same 1983 paper that presented the Double ABCX Model, McCubbin and Patterson (1983a) introduced the Family Adjustment and Adaptation Response (FAAR) Model (see also Lavee, McCubbin, & Olson, 1987). The revision to the Double ABCX Model was prompted by a four of studies in 1974 and 1975, which revealed the following (M.A. McCubbin & McCubbin, 1996, p. 8):

- “The observation of complex family processes involving changes in family functioning and recovery in the face of family crisis situations …
- “Families may seize a crisis situation to produce additional changes in the family patterns of functioning and thus a crisis situation may be precipitated by other factors than the initial stressor which allegedly forced the family into a crisis situation …
- “A family systems perspective on coping strategies is observable and definable and needed to be included in the family stress framework and processes of adjustment and adaptation …
“Adaptation was observed to be a more complex process involving an internal restructuring (member-to-family fit) and an external restructuring (family-to-community fit) over time …”

The FAAR Model “evolved as a natural extension of the Double ABCX with an emphasis on describing the processes involved in the family’s efforts to balance demands and resources” (M.A. McCubbin & McCubbin, 1996, p. 5). The FAAR Model (McCubbin & Patterson, 1983a), Figure 3.4, advanced McCubbin’s Double ABCX model with seven additions (M.A. McCubbin & McCubbin, 1996, p. 9):

- "Integrated coping in family stress theory.
- "Introduced the consolidation phase in family stress model.
- "Introduced adaptive coping strategies.
- "Introduced adjustment coping strategies.
- "Introduced resistance phase in family stress process.
- "Introduced restructuring phase in family stress model.
- "Introduction of balance concept of family-to-member and family-to-community fit to the XX or adaptation factor as critical dimension of family adaptation."

Longitudinal studies of families exposed to the stressor of prolonged war-induced separation (viz the husband-father being missing in action), revealed that families went through a fairly predictable process, which is described in the FAAR Model. Families, it was found, go through three stages of adaptation: resistance, restructuring and consolidation (McCubbin & Patterson, 1983a). The resistance stage falls within the adjustment or precrisis phase of the Double ABCX Model, while the restructuring and consolidation stages fall within the adaptation or post-crisis phase. In the FAAR Model, restructuring is considered to be part of level 1 accommodation, while consolidation is part of level 2 accommodation.

When families are initially exposed to a stressor, they tend to resist facing the stressor or making adjustments to the family in response to the stressor, thereby precipitating a state of maladjustment that leads to family crisis (the Resistance or Adjustment Phase). The crisis increases the demand on the family for change, and initial restructuring starts. Frequently, some family members do not support the changes, and demands are not always well managed. Consequently, the family tends to be disjointed and disorganised.
TIME
SOCIAL/CULTURAL, SITUATIONAL AND DEVELOPMENTAL STRESSORS

ADJUSTMENT PHASE

ADAPTATION PHASE

Accommodation - Level 1

Accommodation - Level 2

(Adapted from McCubbin & Patterson, 1983, p. 22)
3.5.3.1 Family Adjustment Phase

When a family is confronted with a stressful event (the ‘a’ factor), a set of three demands are placed on the family: "(a) the stressor event or transition; (b) the hardships directly associated with this stressor; and (c) prior strains already existing in the family system which may be exacerbated by the stressor” (McCubbin & Patterson, 1983a, p. 24). The demand on the family system enters the awareness of the family to the degree that the demand is great. The family then begins a process of adjusting to the stressor and demands that is characterised by resistance. Initially, the family appraises the situation, the seriousness of the demands and the actions that need to be taken (the ‘c’ factor). In response they may experience a fairly positive or neutral feeling of stress or a more aversive feeling of distress.

This leads to an adjustment coping strategy that is often aimed at minimizing the degree of change the family must make. This strategy has three components. Firstly, avoidance, which involves a denial of the stressor in the hope that it will dissipate of its own. Secondly, elimination, which is an active process of getting rid of the stressor. Both avoidance and elimination involve avoiding making family changes by not allowing the stressor into the family system. Thirdly, assimilation, in which the family makes minimal changes which reduce the negative impact of the stressor.

The existing resources in the family (the ‘b’ factor) influence the family’s definition of the problem (if there are few resources the stressor may be defined as more threatening) and the family’s adjustment coping strategies (if there are many resources, the family may be more willing to assimilate the stressor).

In response to the stressor, the resources and the family’s adjustment coping strategy, the family moves into a state of adjustment that ranges from bonadjustment to maladjustment. Adjustment is not equivalent to adaptation (as described in the Double ABCX Model), but rather refers to “a short-term response by families, adequate to manage many family life changes, transition, and demands” (McCubbin & Patterson,
At times, however, the demand-capability fit between the stressor and the family is imbalanced, such that the adjustment efforts are inadequate and the family becomes maladjusted, leading to family crisis (the ‘x’ factor). The factors that can influence the adequacy of the family’s adjustment efforts include (ibid.):

(a) the nature of the stressor or transition involves a structural change in the family system (e.g., prolonged war-induced separation, transition to parenthood, death of a parent, etc);

(b) the nature, number, and duration of demands depletes the family’s existing resources;

(c) the number and persistence of prior unresolved strains also tax the family’s resources;

(d) the family’s capabilities and resources are basically inadequate or underdeveloped to meet the demands; and

(e) the family overtly or covertly seizes the opportunity to produce structural changes in the family unit as a way to promote family and member growth by allowing or facilitating a demand-capability imbalance or family crisis. (p. 26)

The FAAR Model “evolved as a natural extension of the Double ABCX with an emphasis on describing the processes involved in the family’s efforts to balance demands and resources” (M.A. Mc Cubbin & McCubbin, 1996, p. 5).

3.5.3.2 Family Adaptation Phase: Family Accommodation: Level 1: Restructuring

One or other member of the maladjusted family becomes aware that the family’s efforts to adjust to the stressor, now combined with the family crisis to form a pile-up of stressors (the ‘aA’ factor), are inadequate. The family then works towards a shared definition of the situation (the ‘cC’ factor), which is influenced by both the pile-up and the extent of the family’s resources (the ‘bB’ factor). Out of this definition, the family searches for, agrees upon and implements some or other change. This change differs from the change in the adjustment phase in that the adjustment changes are minimal and involve no fundamental change to the family system or family structure (i.e., first order change). In contrast, the changes made in the restructuring stage do involve structural change (i.e., second order change), although the change is problem-focused and the family has little awareness of the broader or long-term implications of the change.
The family’s *adaptive coping* involves *system maintenance*, “designed to keep the family functioning together as a unit [integration], to maintain the esteem of members [italics added], and to maintain *family morale* [italics added]” (McCubbin & Patterson, 1983a, p. 28). The family’s *resources and support* (the ‘bB’ factor) promote family well-being by “buffering the impact of pile-up (eg using resources to resolve problem), by influencing the definition of the situation (eg positive appraisal, sense of mastery, communication skills), and maximizing solution(s) available (eg problem solving ability)” (ibid.).

### 3.5.3.3 Family Adaptation Phase: Family Accommodation: Level 2: Consolidation

In the Restructuring phase the family made a significant second order change to adapt to the initial stressor and the resulting stressors. In this Consolidation phase, the family works towards two goals: (1) to consolidate the changes made by working in the broader consequences of the primary change, and (2) to draw the entire family together in the change, rather than only a part of the family as is typical of the Restructuring phase.

One or more family members become *aware* of the change that the family has made and the lack of fit between that change and the family’s usual structure and functioning. The entire family works together towards a new and shared *life orientation and meaning* which will support and maintain the changes made in the family system. Consequently, the whole family agrees on and implements *concomitant changes* that are needed in response to the primary change made in the Restructuring phase, “so that the family’s new orientation will be coordinated, stable, and congruent” (McCubbin & Patterson, 1983a, p. 30).

The *adaptive coping* in the Consolidation phase involves (1) *synergising*, in which the family members pull together as a unit; (2) *interfacing*, in which the family promotes family-to-community balance; (3) *compromising*, in which the family compromises where the new changes result in unmet needs; and (4) *system maintenance* is in the previous stage.

The family’s adaptive efforts (both restructuring and consolidating) result in *adaptation*, which can range from *bonadaptation* to *maladaptation* (as discussed under the Double ABCX Model).
3.5.4 T-Double ABCX Model

In 1989, M.A. McCubbin and H.I. McCubbin (1989) introduced the T-Double ABCX Model, also known as the Typology Model of Family Adjustment and Adaptation, which further developed the FAAR Model. This development was prompted by five papers published from 1982 to 1988, which yielded the following results (M.A. McCubbin & McCubbin, 1996, p. 10):

- “The importance of family typologies as established patterns of functioning over the family life cycle ...”
- “The importance of typologies as important established patterns of functioning as a factor in family adaptation ...”
- “The importance of social class, ethnicity and family typologies ...”
- “The importance of family problem solving communication in family adaptation ...”

The T-Double ABCX Model “was introduced to emphasize the importance of the family’s established patterns of functioning, referred to as Typologies and family levels of appraisal, as buffers against family dysfunction, and factors in promoting adaptation and recovery” (M.A. McCubbin & McCubbin, 1996, p. 5). The T-Double ABCX Model (H.I. McCubbin & McCubbin, 1989), Figure 3.5, advanced the FAAR Model with the following five additions (M.A. McCubbin & McCubbin, 1996, p. 11):

- “Family typologies (T factor) integrated into the model.
- “Integration of a life cycle perspective to family typologies and adaptation.
- “Introduction of vulnerability (V factor) due to pile-up as a factor in both adjustment and adaptation.
- “Clarification of the importance of family life cycle stage in understanding both vulnerability and family resilience.
- “Family schema is defined and included as another level of family appraisal (CCC) emphasising the importance of the family’s shared views, values and beliefs.”

Resilience Theory: A Literature Review
Adjustment Phase | Adaptation Phase

Key to T-Double ABCX Model

A:  Stressor/Transition: Demands
V:  Family Vulnerability: Pileup & Family Life-Cycle Stage
T:  Family Types: Profile of Family Functioning
B:  Resistance Resources: Capabilities & Strengths
C:  Family Appraisal: Focus on Stressor
PSC: Family Management: Problem Solving & Coping
X:  Family Adjustment, Maladjustment & Crisis: Demand for Change

R:  Family Regenerativity
AA: Family Demands: Pileup
T:  Family Types: Profile of Family Functioning
BB: Family Strengths, Resources & Capabilities
BBB: Community Resources & Supports
CC: Situational Appraisals
CCC: Global Appraisals & Family Schemas
PSC: Adaptive Coping
XX: Family Adaptation

(Adapted from McCubbin & McCubbin, 1989, pp. 8 & 15)
The T-Double ABCX Model is divided into two phases, viz adjustment and adaptation, as in the FAAR Model (these phases were referred to as pre-crisis and post-crisis in the Double ABCX Model). Many of the components of the T-Double ABCX Model have already appeared in and been discussed under the Double ABCX Model, eg the A, B, C, X, AA, BB, CC and XX factors.

3.5.4.1 Family Adjustment

The Adjustment phase corresponds with Hill’s original ABCX Model, with some additions (M.A. McCubbin & McCubbin, 1989, separated into paragraphs for ease of reading):

The level of family adjustment and/or the family’s transition into a crisis situation (x) (and into the adaptation phase or exhaustion) in response to a stressor event or transition is determined by:

A (the stressor event or transition and its level of severity) – interacting with the V (the family’s vulnerability determined in part by the concurrent pileup of demands – stressors, transition, and strains – and by the pressures associated with the family’s life-cycle stage) – interacting with T (the family’s typology – regenerative, resilient, rhythmic, balanced, etc) – interacting with B (the family’s resistance resources) – interacting with C (The appraisal the family makes of the event) – interacting with PSC (the family’s problem-solving and coping repertoire and capabilities). (p. 8)

The additional factors (vulnerability, typology and problem-solving and coping) will be discussed under the Resiliency Model which follows.

3.5.4.2 Family Adaptation

The Adaptation phase of the Typology Model expands on the Double ABCX and FAAR Models (M.A. McCubbin & McCubbin, 1989, separated into paragraphs for ease of reading):

The level of family adaptation (XX) and/or the family’s transition back into a crisis situation (or exhaustion) in response to a crisis situation is determined by:
AA, the pileup of demands on or in the family system created by the crisis situation, life-cycle changes, and unresolved strains –

interacting with R, the family’s level of regenerativity determined in part by the concurrent pileup of demands (stressors, transition, and strains) –

interacting with T, the family’s typology (resilience, rhythmic, balanced, etc) –

interacting with BB, the family’s strengths (the family’s adaptive strengths, capabilities, and resources) –

interacting with CC, the family’s appraisal of the situation (the meaning the family attaches to the total situation) and

CCC, the family’s schema (ie world view and sense of coherence which shapes the family’s situation appraisal and meaning) –

interacting with BBB, the support from friends and the community (social support) –

interacting with PSC, the family’s problem-solving and coping response to the total family situation. (p. 14)

The additional factors (Family Types, Community Resources & Supports, Global Appraisals and Family Schemas, Pileup and Adaptive Coping) will be discussed under the Resiliency Model which follows.

### 3.5.5 Resiliency Model of Family Adjustment and Adaptation

#### 3.5.5.1 Introduction

In 1993 M.A. McCubbin and H.I. McCubbin introduced the Resiliency Model of Family Adjustment and Adaptation (M.A. McCubbin & McCubbin, 1993, 1996), which was an extension of both the T-Double ABCX Model and the FAAR Model. Nine studies published from 1985 to 1994 prompted this development with the following findings (M.A. McCubbin & McCubbin, 1996, pp. 12-13):

- “Ratio of resources to demands too simplistic to explain adaptation …

- “Relational aspects of family adaptation emphasized …

- “Family problem solving communication emphasizing the family’s interpersonal climate an important part of resiliency …
“Family beliefs, identity and family paradigms important aspects of family resiliency …

“The relationship between family’s appraisal processes and problem solving an important part of family resiliency …

“Importance of the Community and Work Environment explaining resiliency and health emphasized …

“Family levels of appraisal in relation to family’s established patterns of functioning important parts of resiliency …

“Ethnic and cultural factors in the family appraisal process and family resiliency emphasized …

“Family patterns of functioning critical to the resiliency perspective of adaptation.”

The Resiliency Model (M.A. McCubbin & McCubbin, 1993, 1996), Figure 3.6, advanced the T-Double ABCX and FAAR models with the following five additions:

“Relational perspectives of family adjustment and adaptation.

“Established and instituted patterns of family functioning included as part of adjustment and adaptation.

“Integration and inclusion of family problem solving and family coping.

“Four domains of family systems functioning: (1) Interpersonal Relationships; (2) Development, Wellbeing and Spirituality; (3) Community Relationships and Nature; and (4) Structure and Function.

“Five family levels of appraisal in relationship to patterns of functioning and problem solving and coping: Schema (CCCCC), Coherence (CCCCC), Paradigms (CCC), Situational Appraisal (CC), and Stressor Appraisal (C).”

The Resiliency Model will be discussed in depth since it is the latest development in the thinking of McCubbin and his colleagues and since it incorporates many of the concepts that have been introduced briefly in the preceding models.
Maladjustment
Crisis Situation
Bonadjustment

Stressor (A)
Vulnerability (V)
Pile-up:
Strains
Transitions

Established Patterns of Functioning (T)
Problem Solving and Coping (PSC)

Family Resources (B)

Balance
Harmony
Interpersonal Relationships
Development, Wellbeing, & Spirituality
Structure & Function
Community Relationships & Nature

Maladaptation
Inadequate and/or Deterioration in Family Patterns of Functioning (T)

Newly Instituted Patterns of Functioning (TT)
Restored Patterns of Functioning (T)
Retained Patterns of Functioning (T)

Family Adaptation (XX)
Bonadaptation

Adjustment Phase
Adaptation Phase

Figure 3.6 Resiliency Model of Family Stress, Adjustment and Adaptation
3.5.5.2 Family Adjustment Phase

Family adjustment refers to the outcome of a family’s efforts to deal with a specific and relatively minor stressor. There are “several important interacting components” which influence the family’s adjustment (M.A. McCubbin & McCubbin, 1996, separated into paragraphs for ease of reading):

The Stressor (A) and its Severity interacts with the family’s Vulnerability (V), which is shaped by the pile-up of family stresses, transitions, and strains occurring in the same period as the stressor.

Family Vulnerability (V) interacts with the family’s typology, which is the Established Patterns of Functioning (T). For example, both parents in paid work with child care support is an established pattern of functioning.

These components, in turn, interact with the family’s Resistance Resources (B). Quality communication between husband and wife and a family’s willingness to be supportive of each other are examples of resistance resources.

This, in turn, interacts with the family’s Appraisal (C) of the Stressor (ie the family’s shared definition of the problem as being minor, a setback, or a catastrophe).

The family’s appraisal interacts with the family’s Problem Solving and Coping strategies (PSC), such as adopting an affirming communication style, seeking help from close friends, and taking advantage of the advice made available by friends. (pp. 16-17)

3.5.5.3 Balance & Harmony

M.A. McCubbin and McCubbin (1996) argue that families strive for harmony and balance in the family. Change inevitably brings about imbalance and sometimes families deliberately create imbalance in order to bring about change. Change can also create disharmony, in which well-being suffers and the family experiences a lack of vitality or energy. Families tend to strive to promote harmony and balance in their family during times of stress. There are four main domains of life in which stress acts and in which balance and harmony are thus important, viz “(a) interpersonal relationships; (b) structure and function; (c) development, well-being, spirituality; and (d) community relationships and nature” (ibid., p. 16). These four domains, together with the desired balance and harmony, thus occupy the centre of the resilience circle, together with an image of the family (Figure 3.6).
3.5.5.4 The Stressor (A)

“A stressor is a demand placed on the family that produces, or has the potential of producing changes in the family system” (M.A. McCubbin & McCubbin, 1996, p. 17). Stressors can be divided into normative and nonnormative stressors:

- Normative stressors “are expectable, scheduled changes involving entrances into and exists from social roles” (Lavee et al., 1987, p. 859). Life events can be considered normative when they are “ubiquitous (they occur in most families), expectable (families could anticipate their occurrence at certain schedules points in the family life cycle), and short-term (not chronic)” (McCubbin & Patterson, 1983b, p. 8). Normative stressors tend to create less strain for families than nonnormative stressors, and the strain caused by a normative stressor tends to increase with the number of changes families must make in response to the stressor (ibid.).

- Nonnormative stressors, by contrast, “are those that occur unexpectedly, such as natural disasters, the loss of a family member, war”, etc (Lavee et al., 1987, p. 859).

Lipman-Blumen (1975, in McCubbin & Patterson, 1983b, pp. 7-8) posed several criteria that can be helpful in determining the stressfulness of a stressor:

- “Is the origin of the stressor from within the family system (eg mother goes back to work) or from outside the family (eg loss of a job)?

- “Does the impact of the stressor extend directly to all family members (eg divorce) or to only some members (eg adolescent has argument with friend)?

- “Is the onset of the stressor very sudden (eg tornado) or does it emerge gradually (eg pregnancy)?

- “Is the degree of severity of the stressor intense (eg a death) or mild (eg the purchase of a new car)?

- “Is the length of adjustment to the stressor short-term (eg child starts school) or long-term (eg parent gets cancer)?

- “Can the stressor be expected (eg child becoming an adolescent) or does it occur unpredictably at random (eg an auto accident)?

- “Does the stressor emerge through natural causes (eg a hurricane) or as a result of artificial, human-made situations (eg loss of a job from increased use of technology)?

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“Does the family believe that the stressor is one that can be solved (eg adjusting to a new home) or is it beyond their control (eg inflation’s effect on family income)?”

According to M.A. McCubbin and McCubbin (1996, p. 17), “The severity of the stressor is determined by the degree to which the stressor threatens the stability of the family unit, disrupts the functioning of the family unit, or places significant demands on and depletion of the family’s resources and capabilities.”

### 3.5.5.5 Family Vulnerability (V)

Family vulnerability refers to “the interpersonal and organizational condition of the family system” (M.A. McCubbin & McCubbin, 1996, p. 17) and is determined by (M.A. McCubbin & McCubbin, 1993):

1. The accumulation, or pileup, of demands on or within the family unit, such as financial debts, poor health status of relatives, and changes in a parent’s work role or work environment, and
2. The normative trials and tribulations associated with the family’s particular life-cycle stage with all of its demands and changes. (p. 28)

Vulnerability therefore indicates how vulnerable the family is to a particular stressor. Since the pileup of stress varies across the life cycle, the family’s vulnerability also varies across the life cycle, and one can predict that a particular stressor will be more or less threatening at different times in the life of a family. A couple without children may be less vulnerable to losing a job, for example, than a family with adolescent children, due to the “accumulation of life strains associated with raising an adolescent and the depletion of family interpersonal, social, and economic resources at this stage” (M.A. McCubbin & McCubbin, 1996, p. 17).

### 3.5.5.6 Family Typology of Established Patterns of Functioning (T)

A family typology is defined as “a set of basic attributes about the family system which characterize and explain how a family system typically [italics added] appraises, operates, and/or behaves” (M.A. McCubbin & McCubbin, 1989, p. 27). A family typology is the family’s typical, predictable or habitual pattern of behaviour, which is established over time. Research by McCubbin and colleagues demonstrated that these patterns can be grouped into typologies, and that once a family’s typology has been identified, the
family’s response to stress can be predicted (ibid.). The notion of family typology was introduced in the T-Double ABCX Model (ibid.).

Different publications use different terms to refer to these typologies or refer only to one or two of the total number of typologies. Most notably, the term ‘resilient families’ (M.A. McCubbin & McCubbin, 1989, 1993) has been replaced with the term ‘versatile families’ (McCubbin et al., 1996), probably to allow for the grouping of a number of family typologies under the general heading of ‘resilient families’ (H.I. McCubbin & McCubbin, 1988). All family types are defined along two dimensions, both of which have been dichotomised into high and low (Figure 3.7).

The Regenerative Family (see Figure 3.7) is high in family hardiness and high in family coherence. “Family coherence is operationalised as the family’s emphasis on acceptance, loyalty, pride, faith, trust, respect, caring, and shared values in the management of tension and strain” (H.I. McCubbin & McCubbin, 1988, p. 250). Family hardiness is defined as “the family’s internal strengths and durability, [and] is characterized by an internal sense of control of life events and hardships, a sense of meaningfulness in life, involvement in activities, and a commitment to learn and explore new and challenging experiences” (ibid.).

Regenerative families can be described as follows (H.I. McCubbin & McCubbin, 1988):

*Regenerative Families* indicate that they cope with family problems by cultivating trust, respect, and maintaining an emotional calm and stability. These families cope through having faith, accepting difficulties, and working together to solve problems. Additionally, they are secure in their sense of purpose, of being able to plan ahead, of being valued for their efforts, and of feeling that life is meaningful. These families feel in control and have a sense that they can influence both good and bad things which happen; they are not victims of circumstances. Additionally, Regenerative Families are active; they try new things, encourage others to be active in addressing their problems and concerns. In general, Regenerative Families are in control, active, and when faced with difficulties, more caring, loyal, and tolerant of hardships. (p. 251)

Vulnerable, Secure and Durable families make up the other four in this typology (McCubbin et al., 1996):

Vulnerable Families are more complacent, less likely to try new and exciting things, tending to do the same things over and over, and are less likely to encourage each other to be active and to learn new things. ... Secure Families are active, in control, but when faced with difficulties are also less supportive of each other, less caring and loyal, and less tolerant of hardships. ... Durable Families may have fewer basic internal strengths, but they appear to compensate for this deficiency by having a strong coping repertoire characterized by caring, respect, trust, reduced tension and calmness. (pp. 67-68)
Figure 3.7  Four Family Typologies

(McCubbin et al., 1996, chap. 2)
The **Rhythmic Family** (see Figure 3.7) is high on *family time and routines* and high on *valuing of family time and routines*. ‘Family time and routines’ is operationalised as “the degree to which the family unit maintains continuity and stability through specific family activities which are repeated on a routine basis” (H.I. McCubbin & McCubbin, 1988, p. 250). ‘Valuing of family time and routines’ is operationalised as “the meaning and importance families attach to the value of such practices designed to promote family unity and predictability” (M.A. McCubbin & McCubbin, 1989, p. 32).

Rhythmic Families “foster development of predictable activities and routines within the family unit involving relatives and with an added emphasis upon valuing these patterns in an effort to foster a shared rhythmic sense of purpose and meaning of family togetherness, regularity, and predictability” (H.I. McCubbin & McCubbin, 1988, p. 250).

By contrast, Unpatterned Families neither value nor implement family routines, Intentional Families value routines and recognise their importance but are unable or unwilling to implement family routines, and Structuralised Families implement family routines rigorously but fail to perceive the value of routine for family wellness (H.I. McCubbin & McCubbin, 1988).

The **Versatile Family** (see Figure 3.7) is high on family *flexibility* and high on family *bonding*. ‘Family flexibility’ is operationalised as “the degree to which the family unit is able to change its rules, boundaries, and roles to accommodate to changing pressures from within and outside the family unit” (McCubbin et al., 1996, p. 70). ‘Family bonding’ is defined as “the degree to which the family is bonded together in a meaningful and integral family unit” (ibid.).

Versatile Families (McCubbin et al., 1996):

Indicate that they have a major strength in their ability to change. These families view themselves as being able to say what they want, as having input into major decisions, being able to shape rules and practices in the family, as well as being able to compromise; they are experienced in shifting responsibilities in the family unit, and willing to experiment with new ways of dealing with problems and issues. These families also indicate that they have a major strength in their sense of internal unity. They are dependent upon each other for understanding and support, feel close to each other, are pleased to engage other family members, and have no difficulty deciding what to do as a family unit. (p. 72)

Fragile Families, by contrast, lack emotional bonding between members and are unable to deal with stress in a flexible, participatory way. Bonded Families tend to rely on their closeness as a family unit, as well as their resistance to change, when faced with stress. Pliant Families feel emotionally disconnected from each other and prefer to rely on the...
support of people outside the family, but are able to handle stress in a flexible way, shifting roles, making decisions, compromising and altering family patterns, as needed. (M.A. McCubbin & McCubbin, 1989)

The **Traditionalist Family** (see Figure 3.7) is low on family *celebrations* and high on family *traditions*.

‘Family celebrations’ are defined as (McCubbin et al., 1996):

Those family behaviors and practices which families choose actively or passively to adopt and maintain in an effort to punctuate and spotlight situations and circumstances which the family deems appropriate for such an emphasis. Family celebrations such as spouse’s birthday, special occasions (e.g., Valentine’s Day, Mother’s Day, etc.) and yearly major holidays (e.g., Christmas, New Year’s Day, etc.) are emphasized as integral parts of family celebrations. (p. 78)

‘Family traditions’ are defined as (McCubbin et al., 1996):

Those family behaviors and practices which families choose actively or passively, to adopt and maintain in an effort to maintain beliefs and values and to pass them on from generation to generation. It includes such practices as decorating around holidays, special experiences (i.e., songs, dances, etc.) around changes, special rules to follow around religious occasions, and which members participate in special events (i.e., reunions). (p. 78)

Traditionalist Families “carry on their lives with minimal emphasis upon celebrating major events, but with a strong belief in and greater emphasis upon family traditions carried on across time and from generation to generation” (McCubbin et al., 1996, pp. 78-79). In contrast with the other three typologies, in which a high measure on both axes yielded the most resilient family type, research on the current typology found that families that were high only on traditions were more resilient than families that were high on both traditions and celebrations (ibid., p. 98).

Situational Families place no emphasis on either traditions or celebrations and merely “develop across the life span” (McCubbin et al., 1996, p. 78). Celebratory Families emphasise celebrations to commemorate special events, but place no value on traditions which cross generations. Ritualistic families value both celebrations and traditions.

The strengths literature reviewed in a previous section highlighted the importance of “family integrity, unity, changeability, predictability, and rituals”, and it is these factors which the four family types are designed to describe (McCubbin et al., 1996, p. 81). Research on the typologies indicates that the four family typologies are related to a small, but significant degree, which the researchers expect given the association between the typologies and family strengths (ibid.). Research also indicates that the
Regenerative family type is most strongly correlated with family satisfaction, marital satisfaction, community satisfaction and general family well-being, while the Rhythmic family type is correlated with family satisfaction and community satisfaction.

3.5.5.7 Family Resistance Resources (B)

M.A. McCubbin and McCubbin (1996) define resistance resources as:

A family’s abilities and capabilities to address and manage the stressor and its demands and to maintain and promote harmony and balance in an effort to avoid a crisis, or disharmony and imbalance, and substantial changes in or deterioration in the family’s established patterns of functioning. (p. 19)

As was highlighted in the FAAR Model, resistance resources in the adjustment phase are aimed at avoiding a crisis with the minimum of change to the family system (M.A. McCubbin & McCubbin, 1993). “Critical family resources include social support, economic stability, cohesiveness, flexibility, hardiness, shared spiritual beliefs, open communication, traditions, celebrations, routines, and organization” (M.A. McCubbin & McCubbin, 1996, p. 19). Resources also vary across the life cycle (ibid.) and can vary from culture to culture.

3.5.5.8 Family Appraisal of the Stressor (C)

“The family’s appraisal of the stressor is the family’s definition of the seriousness of a stressor and its related hardships” (M.A. McCubbin & McCubbin, 1996, p. 19). This can range from a perception of the stressor as catastrophic and overwhelming, through viewing the stressor as manageable, to perceiving the stressor as irrelevant and innocuous. The family’s subjective appraisal of a stressor has a greater impact on family adjustment than the standardised severity of a stressor as agreed upon within a given culture or society.

3.5.5.9 Family Problem Solving & Coping (PSC)

Family problem solving and coping refers to “the family’s management of stress and distress through the use of its abilities and skills to manage or eliminate a stressor and
related hardships” (M.A. McCubbin & McCubbin, 1996, p. 20). Specifically, problem solving and coping can be defined as follows (M.A. McCubbin & McCubbin, 1989):

Problem solving refers to the family’s ability to define a stressor and the situation in manageable components, to identify alternative courses of action, to initiate steps to resolve the discrete issues, and ultimately to resolve the problem.

Coping refers to the family’s strategies, patterns, and behaviors designed to maintain and/or strengthen the organization and stability of the family unit, maintain the emotional stability and well-being of family members, obtain and/or utilize family and community resources to manage the situation, and initiate efforts to resolve the family hardships created by the stressor/transition. (p. 10)

3.5.5.10 Family Bonadjustment, Maladjustment and Crises (X)

If the stressor is not too great, and/or if the family is not too vulnerable, and/or if the family has a helpful pattern of functioning/typology and a positive stressor appraisal and good resistance resources and good problem solving and coping skills, the family may weather the crisis and emerge in a state of bonadjustment. Minor alterations to the family’s functioning, which promote balance and harmony, without fundamental, second order change, may contribute to bonadjustment. Indeed, most stressors probably result in bonadjustment (M.A. McCubbin & McCubbin, 1996).

However, if the stressor is very severe, intense or chronic, the demands placed on the family may be too great to be managed by minor adjustments, as was highlighted in the discussion on the FAAR Model. Families have to make more substantial second order change in order to cope, but frequently resist making such fundamental changes that would disrupt both harmony and balance. These families “will, in all likelihood, experience a state of maladjustment and a resulting condition of crisis” (M.A. McCubbin & McCubbin, 1996, p. 22).

McCubbin frequently points out that family crisis should not be negatively connoted. It merely refers to “a continuous condition of disruptiveness, disorganization, or incapacitation in the family social system” (M.A. McCubbin & McCubbin, 1996, p. 22). In many cases, family crisis is a necessary and desirable precondition for second order family change (M.A. McCubbin & McCubbin, 1993). Some families may even precipitate a crisis deliberately or planfully allow a crisis to develop in order to facilitate change (M.A. McCubbin & McCubbin, 1996). In sum (ibid.):

Family crisis denotes family disharmony and imbalance in the system and a demand for basic changes in the family patterns of functioning to restore stability, order,
balance, and a sense of harmony. This movement to initiate changes in the family system’s pattern of functioning marks the beginning of the adaptation phase of the Resiliency Model. (pp. 22-23)

3.5.5.11 Family Adaptation Phase

Family adaptation refers to the outcome of a family’s efforts to deal with prolonged, severe and multiple stressors. There are several important interacting components that influence the family’s adjustment (M.A. McCubbin & McCubbin, 1996, pp. 25-26, separated into paragraphs for ease of reading):

Families at risk are characterized in part by imbalance and disharmony, a condition which is fostered by the inadequacy of or the problematic nature of the family’s established patterns of functioning (T) in response to stressful situations, and which places the family in a crisis situation (eg being vulnerable, but faced with an opportunity for constructive changes in its patterns of functioning).

These families’ situations are exacerbated by the concurrent pile-up of demands (AA) (eg other life changes and hardships).

By the family’s own accord and will, and possibly with crisis oriented or transitional assistance or treatment, the family and its members may take on the challenge to regenerate itself, to change and to improve upon its situation, enter into a process of change and thereby work to achieve a level of adaptation (XX) characterized by balance and harmony. The goal of this process is the restoration of family harmony and balance in the family’s interpersonal relations, the family’s structure and function, the development, well-being, and spirituality of the family unit and its members, as well as the family’s relationship to the community and the natural environment.

The level of successful adaptation referred to as Bonadaptation (XX) is determined by the interacting influences of

- newly instituted patterns of functioning (TT) (eg patterns of communication, rules, boundaries, etc),
- the modification, maintenance or revitalization of already established patterns of functioning (eg traditions, celebrations, ethnic practices, etc), restoration and/or maintenance of viable established patterns of functioning – (T),
- the family’s own internal resources and capabilities (BB) (eg hardiness, coalitions, respect, support),
- the family’s network of social support (BBB) (eg extended family, neighborhood, church, community, friends, kinship, etc), and
- the family’s situational appraisal by the family’s appraisal processes:

  Schema (CCCCC) (eg family shared values and beliefs);
Coherence (CCCC) (e.g., dispositional view of the family’s sense of order, trust, predictability, and manageability); and

Paradigms (CCC) (e.g., shared expectations as to how the family will function in areas of child rearing, discipline, etc).

These three levels of appraisal impact upon and shape the family’s Appraisal of the Situation (CC) as well as the definition of the Stressor (C) which may well be in a distant past.

Finally, the Instituted Patterns of Functioning, Resources, and Appraisal components of the family unit influence and are influenced by the family’s Problem Solving and Coping abilities (PSC) (e.g., conflict resolution, family problem solving, coping repertoires, etc).

The family engages in a dynamic relational process over time, introducing changes directed at restoring and maintaining family harmony and balance within the family system as well as in the family’s relationships to the larger community and environment.

The dynamic relational process involves a cyclical effort in such situations where the family’s efforts at change prove to be unsuccessful and propel the family into a Maladaptive outcome (XX); and the cycle starts again at changes in patterns of functioning and recycles through the family processes of adaptation. (pp. 25-26)

### 3.5.5.12 Family Adaptation (XX)

Family adaptation refers to the outcome of the family’s efforts to adapt to the demands of the stressor and also to the demands the adaptation itself requires. Bonadaptation can be said to have been achieved when the family has integrated the demands of the stressor into the family functioning, when the family has been restored to a state of harmony and balance, and when the individual-to-family fit and family-to-community fit between demand and capability are balanced (M.A. McCubbin & McCubbin, 1993, 1996).

### 3.5.5.13 Pileup (AA) of Demands

A large part of the reason for the ongoing development of family resilience models has been to explain how families cope with multiple stressors. The confluence of such stressors is termed pileup. McCubbin’s studies indicate that most families “experience a pile-up of demands, particularly from a chronic stressor such as caring for a disabled family member or in the aftermath of a major stressor, such as a death, a major role change for one member, or a natural disaster” (McCubbin & Patterson, 1983b, p. 14).
The greater the pile-up experienced by a family, the more vulnerable the family is to stress and maladaptation.

M.A. McCubbin and McCubbin (1996) identify nine principle sources of pileup:

- **The Stress & Its Hardships.** Firstly, pileup results from the “initial stress and related hardships which develop over time” (M.A. McCubbin & McCubbin, 1996, p. 27). There are various indirect or additional stressors that are inherent in the initial stressor (McCubbin & Patterson, 1983b). For example, the stressor of a father losing his job brings with it the additional stressors of financial difficulties, loss of masculinity and esteem, potential loss of the family home, excess free time, frustrations resulting from searching for a new job, etc.

- **Normative Transitions.** Secondly, pileup results from “normative transitions in individual family members and the family as a whole which happened during the same period of time” (M.A. McCubbin & McCubbin, 1996, p. 27). Stressors and normative, family life-cycle transitions may co-occur independently of each other, but combine in ways which increase the pileup of family stress. The families researched by McCubbin and Patterson (1983b):

  Experienced the normal growth and development of child members (eg increasing need for nurturance and supervision; increasing need for independence), of adult members (eg spouse’s desire to continue with her career; mother’s increasing need for a meaningful relationship), of the extended family (eg illness and death of grandparents); and family life cycle changes (eg children entering school, adolescence). (p. 14)

- **Prior Strains.** Previous stressors create strains in the family that are often not resolved at that time and continue to exert a subtle influence over the family. “These prior strains are not usually discrete events which can be identified as occurring at a specific point in time; rather, they emerge more insidiously in the family” (McCubbin & Patterson, 1983b, p. 15). The introduction of a new stressor in the family system may exacerbate the prior strains thereby contributing to increased pileup and to the vulnerability of the family to the stressor.

- **Situational Demands and Contextual Difficulties.** The society or community within which the family is situated may contribute to the stress of a family or undermine the ability of a family to resolve crises. For instance, the employer of a mother with a disabled child may be unaccommodating regarding her working flexitime in order to care for the child’s medical needs. The lack of adequate childcare facilities may be a contextual difficulty or concern for many.
instability, crime or a history of discrimination are all examples of situational
demands and contextual difficulties that contribute to pileup.

- **Consequences of Family Efforts to Cope.** Not only the stressor itself contributes
to pileup, but also the family’s efforts to deal with the stressor (McCubbin &
Patterson, 1983b). “These stressors and strains emerge from specific behaviors or
strategies that a family may have used in the adjustment phase, ... or that the family
currently uses in their effort to adapt to the crisis situation” (M.A. McCubbin &
McCubbin, 1996, p. 29). Some of a family’s coping efforts may be obviously negative
and stressful (such as the use of alcohol or drugs to cope with the stressor), but
others may be apparently positive and helpful (such as avoiding discussing the
problem which reduces the short term stress but leads to aversive medium and long
term consequences). This can be seen in the FAAR Model (Figure 3.4) in which the
adjustment and restructuring processes themselves constitute pileup (aA).

- **Intrafamily and Social Ambiguity.** All change results in a degree of uncertainty
about the future, and this uncertainty constitutes ambiguity. There may be
ambiguity within the family system, such as the boundary ambiguity discussed
previously (Boss, 1980) or shifts in family roles and responsibilities following a
divorce. There may also be ambiguity in the family’s social context, such as when
the community is unable to decide how to handle a family. For instance, a catholic
wife who believes divorce is the only viable final response to being battered by her
husband may face ostracism by the Church and the congregation (M.A. McCubbin &
McCubbin, 1996).

- **Newly Instituted Patterns of Functioning Create Additional Stress.** The
healthy new patterns of functioning instituted during the adaptation phase of the
Resilience Model may demand changes in the family system that create additional
stress. Positive long-term changes tend to produce increased disharmony and
imbalance in the short-term. These additional changes constitute pileup.

- **Newly Instituted Patterns of Functioning Clash with Family Beliefs.** Eighthly,
pileup results from the “newly instituted patterns of functioning which are in conflict
with or incongruent with the Family’s Schema (values and beliefs) and/or the
Family’s Paradigms (ie rules and expectations)” (M.A. McCubbin & McCubbin, 1996,
p. 28). Not all family members may agree with the changes that are implemented
during adaptation, creating additional strain.
Established Patterns of Functioning. Lastly, pileup may result from “old patterns of functioning which are in conflict or not compatible with newly adopted patterns of functioning” (M.A. McCubbin & McCubbin, 1996). Established patterns of functioning continue while the family is adapting to the stressor and crisis, thereby providing much-needed stability and continuity for the family. However, these patterns may be in conflict with the new patterns that are being established, resulting in conflict and tension.

3.5.5.14 Family Types and Newly Instituted Patterns of Functioning (T & TT)

The family’s typical patterns of functioning influence the adaptability of the family. The Resiliency Model (M.A. McCubbin & McCubbin, 1996) contains four items marked by T or TT:

- **Inadequate and/or Deterioration in Family Patterns of Functioning (T).** The first item influences the degree of maladjustment and crisis that the family experiences by the end of the adjustment phase and as it enters the adaptation phase. A large part of the reason why the family enters a state of maladjustment rather than bonadjustment is that the family’s typology (or more generally, the family’s pattern of functioning) is inadequate to meet the demands created by the stressor. Furthermore, through the unsuccessful adjustment process, the family’s pattern of functioning may deteriorate, thus exacerbating the family crisis.

- **Retained Patterns of Functioning (T).** The family enters the adaptation process with many of the patterns of functioning intact. Some of these patterns may facilitate the bonadaptation process, while others continue to exert a pathogenic influence over the family or clash with the newly forming patterns.

- **Restored Patterns of Functioning (T).** The family crisis (X) may reactivate and restore patterns of functioning which once were present in the family by have been lost over time. Particularly in the face of prolonged stress, families may temporarily lose health patterns. Some stressors (eg the death of a spouse) force the family members to return to patterns long abandoned (eg the surviving spouse must regain patterns of functioning from her/his single days).
Newly Instituted Patterns of Functioning (TT). As was illustrated in the FAAR Model (Figure 3.4), the adaptation phase involves the family making significant, second-order changes to the family system that facilitate its adaptation. These changes constitute new typologies. For example, the family may begin to place greater emphasis on family routines and times, thereby moving from an ‘intentional’ family type towards a ‘rhythmic’ family type, which in turn augurs well for bonadaptation.

3.5.5.15 Family Resources (BB)

Family Resources comprise family capabilities and resiliency or adaptive resources (M.A. McCubbin & McCubbin, 1993, 1996). A family’s capability is defined as (M.A. McCubbin & McCubbin, 1993):

A potential the family has for meeting all of the demands it faces. We emphasize two sets of capabilities: (1) resources and strengths, which are what the family has and (2) coping behaviors and strategies, which are what the family does as individual members and as a family unit. (p. 45)

A resiliency resource is a characteristic, trait or competency found in an individual, family or community that facilitates the family’s adaptation (M.A. McCubbin & McCubbin, 1996). The individual or personal resources that can be used to assist the family in adaptation have already been discussed in depth in the section on individual resilience. M.A. McCubbin and McCubbin (1996, p. 33, emphasis added) provide a list of eight important individual level resources:

- The innate intelligence of family members, which can enhance awareness and comprehension of demands and facilitate the family’s mastery of these;
- Knowledge and skills acquired from education, training, and experience so that individual family members, and the family unit can perform tasks with greater efficiency and ease;
- Personality traits (for example, a sense of humor, temperament and hardiness) that facilitate coping;
- Physical, spiritual and emotional health of members so that intact faculties and personal energy may be available for meeting family demands;
“A sense of mastery, which is the belief that one has some control over the circumstances of one’s life;

“Self-esteem, that is, a positive judgement about one’s self-worth;

“Sense of coherence, which is the family member’s world view that life can be trusted, is predictable and manageable;

“The ethnic identity and cultural background of family members and the ethnic orientation or world view adopted by the family unit to guide the family’s functioning.”

In addition to personal resources, families can also draw on family system resources to assist them in the adaptation process. Many of these resources were addressed in depth the section on family strengths. M.A. McCubbin and McCubbin (1996, p. 34) identify the following important family strengths:

- Cohesion, defined as “the bonds of unity running through the family life.”

- Adaptability, defined as “the family’s capacity to meet obstacles and shift course.”

- Family organization, which includes “agreement, clarity, and consistency ... in the family role and rule structure.”

- “Shared parental leadership and clear family generational boundaries.”

- Communication.

- Family problem solving.

- Family hardiness, which is “characterized by a sense of control over the outcome of life events and hardships, a view of change as beneficial and growth producing, and an active orientation in responding to stressful situations.”

- “Family time together and family routines in daily living” help to facilitate “harmony and balance while inducing changes in the family system.”
3.5.5.16 Social Support (BBB)

M.A. McCubbin and McCubbin (1989) describe community resources or social supports as follows:

Community-based resources are all of those characteristics, competencies, and means of persons, groups, and institutions outside the family that the family may call upon, access, and use to meet their demands. This includes a whole range of services, such as medical and health care services. The services of other institutions in the family’s meso environment, such as schools, churches, and employers, are also resources to the family. At the macro level, government policies that enhance and support families can be viewed as community resources. (p. 20)

McCubbin and colleagues have most frequently used Cobb’s conceptualisation of social support, which comprises three dimensions, and have added two additional dimensions (M.A. McCubbin & McCubbin, 1989):

Social support can be defined as] information exchanged at the interpersonal level which provides:

(a) emotional support, leading the individual to believe that he or she is cared for and loved;

(b) esteem support, leading the individual to believe he or she is esteemed and valued; ...

(c) network support, leading the individual to believe he or she belongs to a network of communication involving mutual obligation and mutual understanding; ...

(d) appraisal support, which is information in the form of feedback allowing the individual to assess how well he or she is doing with life’s tasks; and

(e) altruistic support, which is information received in the form of goodwill from others for having given something of oneself. (p. 21)

McCubbin and McCubbin distinguish between social support (which involves exchange of information within a trusting relationship) and social network (which is the sum of people with whom one has contact and from whom one potentially can derive support). Much of the research on social support, however, uses these terms interchangeably and researchers have often found that the mere number of people on whom one can depend for support is predictive of well-being, irrespective of the quality or nature of that support (eg Hiew, 1992).
3.5.5.17 Family Appraisal Processes (C to CCCCC)

It is perhaps McCubbin and colleagues’ work on family appraisal processes, and in particular the notion of family schema, that is the most unique contribution of family resiliency theorists to the broader field of resiliency theory (Hawley & De Haan, 1996). A review of family appraisal in the various family resiliency models will demonstrate how this construct has evolved. In Hill’s original ABCX Model of 1949 (see Figure 3.1), the ‘C’ factor refers to the family’s definition of the seriousness of the changes demanded by the stressor event. In the Double ABCX Model (see Figure 3.3) and the FAAR Model (see Figure 3.4) of 1983 the ‘CC’ factor was added and refers to the family’s appraisal of the whole situation, including the stressor, the family’s resources and the pileup of stressors or vulnerability. In the T-Double ABCX Model of 1989 (see Figure 3.5) and in the first presentation of the Resiliency Model (M.A. McCubbin & McCubbin, 1993) the ‘CCC’ factor was added, which refers to the family’s global appraisals and family schemas.

Finally, in the 1996 presentation of the Resiliency Model (M.A. McCubbin & McCubbin, 1996), on which this document is based, the ‘CCC’ factor of family paradigms, the ‘CCCC’ factor of family coherence and the ‘CCCCC’ factor of family schema are added. Consequently, the most current model of family resilience proposes five levels (C to CCCCC) of family appraisal. Depending on the nature of the stressor, higher and higher levels of family appraisal are activated in the family appraisal process. Lower severity stressors may activate only the first two or three levels, while severe or prolonged stressors may activate all five levels. This will be discussed in greater detail later.

McCubbin and colleagues have also introduced the important notion of ethnicity, and have begun to explore how a family’s culture or ethnicity influences the appraisal process (McCubbin et al., 1998; M.A. McCubbin & McCubbin, 1996). This too will be discussed in greater detail later.

Family Appraisal Process Level 5: Family Schema (CCCCC)

The family schema is defined as “a generalized structure of shared values, beliefs, goals, expectations, and priorities, shaped and adopted by the family unit, thus formulating a generalized informational structure against and through which information and experiences are compared, sifted, and processed” (McCubbin et al., 1998, p. 43). Family schema is a deeply held, largely unconscious cluster of beliefs that locate the family’s day-to-day experiences within a larger context. Family schema develops
The family schema plays the equally important role of developing family meanings. “This aspect of family appraisal involves the creation of family ‘stories’ or ‘understandings’ shared by family members for the purpose of facilitating the family’s adaptation to the crisis situation” (McCubbin et al., 1998, p. 45). Family meanings at this worldview level are still very broad and families will probably not be able to articulate them; nevertheless family meanings may be detected in qualitative research in which families are asked to tell their stories about coping with life stressors (Patterson & Garwick, 1998). Patterson and Garwick (ibid.) state that family worldview meaning “focuses on the family’s orientation to the world, how they interpret reality, what their core assumptions are about their environment, as well as their existential beliefs, such as the family’s purpose and place in life”.

The family schema helps families develop meaning through five primary functions (M.A. McCubbin & McCubbin, 1996, p. 41):

- **Classification.** “The process of framing the family crisis situation in terms of shared values and expectations of the extended family and the tribal structure.”

- **Spiritualization.** “The process of framing the family crisis situation in terms of shared beliefs and the goal of units with the cosmos as a way to achieve harmony.”

- **Temporalization.** “The process of framing the family crisis situation in terms of the long view and long-term consequences but also taking advantage of the positive nature of the present.”

- **Contextualization (nature).** “The process of framing the family crisis situation in terms of nature and the order of living things; harmony with nature and the land is pursued with all aspects of life.”
Contextualization (relationships). “The process of framing the family crisis situation in terms of human relationships, a ‘we’ group orientation whereby the needs of the whole rise above the needs of the individual.”

Family meanings are derived from the broad family schema (M.A. McCubbin & McCubbin, 1996) or family worldview (Patterson & Garwick, 1998), but are expressed at stressor or situational level. “The meanings are often described in cryptic phrases or special phrases such as ‘God’s will’ …, used to encourage understanding and in some cases the acceptance of adversity” (M.A. McCubbin & McCubbin, 1996, p. 39). There is a reciprocal relationship between the situation specific meanings and the family schema – the schema facilitates the development of family meanings that help the family to adapt to the stressor, but the stressor may also shake the foundation of the family schema leading to alteration in the schema (Patterson & Garwick, 1998). Nevertheless, a family schema is stable and resistant to change. Consequently, it is an important dimension in the ability of families to “transcend the immediate stressor and the situation and place the family crisis in a larger context of experiences” (M.A. McCubbin & McCubbin, 1996, p. 40).

The family has long been regarded as the bastion of cultural beliefs and it has often been said that families pass on cultural beliefs and practices from generation to generation (M.A. McCubbin & McCubbin, 1996). However, there is “a dearth of research and inductive theory-building common to the advancement of family stress and resiliency theories linking cultural and ethnic factors to the ways in which families respond to and cope with catastrophes and life’s crises” (ibid., p. 37).

A family’s ethnic or cultural beliefs are stored in or comprise the family schema (McCubbin et al., 1998; M.A. McCubbin & McCubbin, 1996). For instance, Native Hawaiians place value on the extended family, on mutual concern and care, on a “we” or group orientation, on *malama* or caring (which is probably similar to the African notion of *ubuntu*), on spirituality as fundamental to all aspects of life, on the environment as living and thus to be respected and preserved, on the importance of harmony, wholeness and balance, and on time as relative and cyclical (McCubbin et al., 1998, pp. 50-51). These beliefs are clearly the content of the family schema. However, it is also clear that these values and beliefs are specific to and influenced by the Native Hawaiian culture. Thus (M.A. McCubbin & McCubbin, 1996):

In solving problems and managing family life, the family’s culture fundamentally influences three critical levels of family appraisal involved in the process of adaptation: the Family’s Schema, Family Coherence, and Family Paradigms … [which
in turn] help families to give meaning to stressful life events and family struggles, and they appear to play a fundamental role in shaping the family’s responses and strategies directed at adaptation. (p. 38)

Family Appraisal Process Level 4: Family Coherence (CCCC)

M.A. McCubbin and McCubbin (1996) describe family coherence as:

A construct that explains the motivational and appraisal bases for transforming the family’s potential resources into actual resources, thereby facilitating changes in the family systems, coping, and promoting the health of family members and the well-being of the family unit. This is a dispositional world view that expresses the family’s dynamic feeling of confidence that the world is comprehensible (internal and external environments are structured, predictable and explicable), manageable (resources are available to meet demands), and meaningful (life demands are challenges worthy of investment). (p. 42)

Research by McCubbin and associates confirmed that family sense of coherence indirectly reduces family dysfunction by mobilising family resources (McCubbin et al., 1998):

The sense of coherence plays a catalytic role in family resiliency by combining with and fostering the family’s resistance resources, such as family hardiness (the family’s dispositional resource of having a sense of commitment, control, confidence, and challenge) and family problem-solving communication (affirming style of communication). (p. 60)

Other researchers also have demonstrated the salutogenic effect of family sense of coherence (eg Anderson, 1998; Sagy & Antonovsky, 1998). Family SOC and family schema seem closely related, but are in fact conceptually distinct. While neither SOC nor schema addresses the specific situation within which the family finds itself, the family schema is related to beliefs about life in general, while the family SOC is related to stressors in general. This is empirically demonstrated in research that found that the family schema is causally related to coherence, and not the other way around (McCubbin et al., 1998, p. 57). In other words, schema influences SOC, suggesting that schema is a higher order construct.

Family Appraisal Process Level 3: Family Paradigm (CCC)

The family paradigm is (McCubbin et al., 1998):

A model of shared beliefs and expectations shaped and adopted by the family unit to guide the family’s development of specific patterns of functioning around specific...
domains or dimensions of family life (e.g., work and family, communication, spiritual/religious orientation, child rearing, etc.). (p. 46)

The family paradigm is a lower order appraisal process, more closely connected to daily living and consciousness than either family SOC or family schema. While family SOC and schema both relate to general life events and stressors, family paradigm relates to specific family functions, patterns and dimensions. It is not, however, concerned with specific stressors, but rather with the family that functions around the stressor.

M.A. McCubbin and McCubbin (1996) report on a study demonstrating the effect of family paradigms:

In a recent study of Navaho children with autism and their families, it was shown that despite some families’ conscious choice to follow a less traditional path and thus define themselves as modern (rejection of ethnically based traditional ways) or semi-traditional (living in a non-traditional way, but incorporating some ethnically based traditional ways), the influence of cultural beliefs and definitions of disability had a wide-ranging and powerful effect on the family’s paradigms and the family’s adaptation to the long-term care of their disabled member (Connors, 1992). (p. 43)

The distinction between ‘modern’ and ‘semi-traditional’ families in this study concerns both the family schema (the ethnic beliefs and values held by the family) and the family’s paradigm (the beliefs about patterns of family functioning). Families were able to change their paradigms with greater ease, as evidenced in changes to the family structure, role allocation, power relations, etc. However, the family schema was less malleable, and the traditional ethnic values and beliefs regarding disability continued to exert an influence on the family paradigm, which in turn influenced the family’s adaptation to the stress of having an autistic child.

Family paradigm is similar to or equivalent to Patterson and Garwick’s (1998) notion of ‘family identity’:

How a family defines itself is reflected in both its structure (who is in the family) and its functioning (the patterns of relationship linking members to each other). Implicit rules of relationship guide family members in how they are to relate to each other. These rules include (1) definitions of external boundaries (who is in the family) and internal boundaries (for example, encouraging subsystem alliances), (2) role assignments for accomplishing family tasks, and (3) rules and norms for interactional behavior. (p. 76)

Family Appraisal Process Level 2: Situational Appraisal (CC)

Situational Appraisal is defined as (McCubbin et al., 1998):
The family’s shared assessment of the stressor, the hardships created by the stressor, the demands upon the family system to change some of its established patterns of functioning. The appraisal occurs in relation to the family’s capability for managing the crisis situation. (p. 46).

While the family paradigm focused on the family’s functioning in general, situational appraisal focuses on the specific stressor in general, that is on the stressor itself as well as those factors which are contingent on the stressor, including the family’s resources for managing the stressor, the other hardships and strains which the stressor causes, etc.

**Family Appraisal Process Level 1: Stressor Appraisal (C)**

Stressor appraisal is equivalent to that described in Hill’s 1949 ABCX Model (see Figure 3.1), viz the family’s definition of the stressor and its severity. It is narrower in focus than Situational Appraisal. Stressor appraisal focuses principally on the stressor itself, while situational appraisal broadens the focus to other factors contingent on the stressor.

Stressor Appraisal is not reflected in the Adaptation Phase of the Resiliency Model (see Figure 3.6) because by that stage the family is having to deal not only with the initial stressor (as in the Adjustment Phase), but also a host of other related stressors which together comprise the situation (McCubbin et al., 1998). Indeed, part of the distinction between the Adjustment and Adaptation phases is the shift in focus from (1) trying only to get rid of the stressor with minimal impact on the family system (in the Adjustment Phase) to (2) trying to deal with the stressor in a more functional way, by making second order changes to the family system, which has many more ramifications for the family system as a whole (in the Adaptation Phase). It is because the family has to deal with a much larger scope of change in the Adaptation Phase that the higher levels of appraisal (paradigm, coherence and schema) become involved.

**The Process of Appraisal**

Not all five levels of stressor appraisal are activated every time a family encounters a stressor. The nature of the stressor influences which levels of appraisal are used. Stressors that “call for predictable and straightforward responses” tend to use fewer and lower levels than stressors which “the established patterns of family functioning are not adequate to manage” (McCubbin et al., 1998, pp. 46-47). In the case of a less stressful
situation, the first three levels of family appraisal (stressor, situation and paradigm) may be activated to assist the family in adapting to the stressor and its various consequence.

In the case of a more profound stressor, such as the birth of a child with a physical disability or the destruction of the World Trade Centres in September 2001, the family’s existing patterns of functioning (paradigms) will be inadequate to help the family adapt. Furthermore, the crisis may precipitate changes in the family’s sense of coherence and the family schema. These higher orders of appraisal are indispensable for helping a family incorporate and adapt to the fundamental changes that are required in the family system.

This process can be described as follows (McCubbin et al., 1998):

Working backward from the initial stressor, family situational appraisals are first called into action by the demands of the crisis situation, challenging the way the family will function. Family routines will likely be altered; family roles related to providing physical care will need to be reexamined; family paradigms, which have served as the family framework to guide, affirm, and reinforce the established patterns of family functioning, will be challenged and called into question; and newly instituted patterns and accompanying roles and expectations will emerge. New paradigms will also emerge to reinforce and legitimate the new patterns of functioning – a necessary process to provide family stability and predictability. The family’s sense of coherence, always available as a dispositional resource to facilitate adaptation, will be of greater importance in fostering the family’s world view in the face of this adversity or challenge. The family’s sense of coherence allows the family to maintain their confidence that the world is comprehensible, manageable, and meaningful. Thus the family’s level of coherence shapes the degree to which the family transforms its extant or potential resources into actual resources and thereby facilitates the creation of new patterns of functioning, promotes harmony and congruency, and fosters coping and adaptation. Because the family’s established patterns of functioning are threatened, the family’s schema, the hub of the family’s appraisal process, is also involved. ... culture and ethnicity may play a critical role in helping the family derive meaning by placing the family’s situation into a broader and more transcendent context. This new meaning may result in the family framing the crisis situation as less threatening when viewed over time, when viewed in the context of the cultural acceptance of all children in the community, when viewed as a spiritual challenge, and when viewed as part of the natural ebb and flow of nature. This family world view may foster the adoption of new patterns of functioning and coping. When combined with the three other central processes of appraisal (coherence, paradigms, and situational appraisal), the family’s schema serves the family unit by fostering the creation of the family’s unique identity and enhancing the development of the family’s sense of coherence. (pp. 47-48)

Patterson and Garwick (1998) note that changes in the family’s appraisal processes can occur both up and down the levels. For example, if the child in a family is diagnosed with a chronic illness, the family may begin to process this crisis through the meanings derived from the family schema, so as to locate the crisis within a broader and more transcendent context. The family’s patterns of functioning will need to adjust, with a
concomitant adjustment in the family paradigm or identity. The changes in functioning will, in part, be guided by the family schema. Should, for example, the family schema hold the value of families caring for themselves, the family may choose to raise the child themselves, whereas if the schema saw the disabled as an intrusion and as needing professional care, the family may choose to place the child in a special home (see McCubbin et al., 1998). If, however, the family directs a “disproportionate share of their resources toward the illness needs, reducing resources needed for normative family needs,” the family may change its identity to that of an ill family (eg “the diabetic family”) (Patterson & Garwick, 1998, p. 85). In such a case, the change to the family’s paradigm will precipitate a change in the family schema, whereby the family redefines its goals, values and purpose in terms of the illness. “The illness [then] becomes the center-piece for organizing all family activity” (ibid.).

It can thus be seen that the process of influencing change within the family appraisal process is reciprocal and flexible. However, the higher up the order of appraisal processes one goes (from stressor appraisal to family schema), the more intransigent the process becomes. Consequently, it is more likely that the family schema and coherence will provide stability for a family system and influence the way families handle specific stressors and the resultant situations. When families are exposed to fairly severe or prolonged stressors, the family schema and coherence may be shaken but will probably recover or may shift somewhat. When families experience catastrophic or profound and prolonged stressors, the family schema and coherence may disintegrate and a new schema will gradually take its place.

### 3.5.5.18 Family Problem Solving and Coping (PSC)

Family problem solving and coping, “the process of acquiring, allocating, and using resources for meeting crisis-induced demands,” was discussed in the Adaptation Phase of the Resiliency Model (M.A. McCubbin & McCubbin, 1996, p. 49). “Coping and problem solving may be directed at the reduction or elimination of stresses and hardships, the acquisition of additional resources, the ongoing management of family system tension, and shaping the appraisal at both the situational and the schema level” (ibid., p. 50).
3.5.5.19  Research on the Resiliency Model

The work of McCubbin and colleagues involves three closely interwoven processes, viz theory and model development, scale development and empirical research. It seems that their research leads to the formulation of new concepts and hypotheses, which are then tested empirically, which itself often requires the development of a new scale, which then confirms the hypothesis, which leads to the formalization of theory. There is, consequently, a great deal of research to support and guide the various models of family resilience presented here and a complete review of this data is beyond the scope of this document. A few representative findings can, however, be highlighted:

- A test of the Double ABCX Model with 288 military families relocated from the USA to Germany in 1983 (Lavee, McCubbin, & Patterson, 1985, p. 821) found that over 90% of the variance in family adaptation (xX) (operationalised as well-being, satisfaction with the Army family lifestyle and family distress in terms of health, emotional, marital and legal problems in the family) was accounted for by the following five variables:
  - *Relocation strain* (aA), measured as strain related to leaving home and strain related to adjusting to the new country;
  - *Family life events* (aA), measured as the severity of major life events in the family in the year prior to relocation;
  - *Family system resources* (bB), measured as family cohesion, family adaptability and supportive communication;
  - *Social Support* (bB), measured as community support (feeling supported by the community), friendship support (feeling supported by friends) and community activity (participating in community activities); and
  - *Coherence and Meaning* (cC), measured as the degree to which the family perceives a positive Army-family fit, the predictability of the immediate future of work and family schedules, and the feeling of commitment to the Army lifestyle.

- A study of 1,251 American families (Olson et al., 1988, p. 32) in terms of the Circumplex Model found that connected-flexible families, which are elsewhere referred to as the Versatile Family Type (McCubbin et al., 1996), experienced the greatest well-being and the lowest intrafamily strains, even though they did not experience significantly fewer stressors/transitions. Overall, Versatile and Bonded
families did better than Fragile and Pliant families, indicating the importance of family cohesion (Olson et al., 1988, p. 34).

- Further analysis of the data from the previous study (Lavee et al., 1987, p. 867) demonstrated that stressful events (losses and illnesses) and normative family transitions increase intrafamily strain, that family strain influences marital adjustment and sense of coherence, and that family strain, marital adjustment and sense of coherence influence family well-being. In total, 58% of the variance in well-being was explained by the other variables (ibid., p. 869).

- Research on the family typologies yielded the following results (McCubbin et al., 1996, chap. 2):

  - Regenerative families, in comparison with Durable, Secure and Vulnerable families, “indicated a more positive family adaptation as reflected in the areas of Family Satisfaction, Marital Satisfaction, Child Development Satisfaction, Family Physical and Emotional Health, and Community Satisfaction, as well as in overall Family Well-being” (p. 69).

  - Versatile families, in comparison with Pliable, Bonded and Fragile families, “indicated a more positive family adaptation as reflected in the areas of Family Satisfaction, Marital Satisfaction, Child Development Satisfaction, and Community Satisfaction, as well as in overall Family Well-being” (p. 73).

  - Rhythmic families, in comparison with Structuralised, Intentional and Unpatterned families, “indicated a more positive family adaptation as reflected in the areas of Family Satisfaction, Marital Satisfaction, Child Development Satisfaction, and Community Satisfaction, as well as in overall Family Well-being” (p. 77).

- In a study of 150 Native Hawaiian families (McCubbin et al., 1998), community social support contributed to both family hardiness and family schema, family schema contributed to family coherence and problem solving communication, coherence contributed to hardiness and problem solving communication, hardiness also contributed to problem solving communication, and problem solving communication in turn contributed to family functioning.

Much of the research on military families and deployments that will be addressed in chapter 8 is based on and helped to shape McCubbin’s family resilience models and will not be dealt with here. The Resiliency Model, the latest in the evolution of the models, has been widely tested on various ethnic groups, particularly native Hawaiians, native
Americans and African-Americans (McCubbin, Thompson, Thompson, & Fromer, 1995a; McCubbin, Thompson, Thompson, & Futrell, 1995b).

McCubbin and colleagues have published the scales they have developed to measure the various constructs they have developed in their theoretical models (McCubbin et al., 1996). These scales were listed in a previous section on the measurement of family strengths (Section 3.4.2).

### 3.6 CONCLUSIONS

Although it may have appeared that the field of family resilience theory was nascent, this chapter will have clearly illustrated that there is a strong history of several decades of research and theory concerning family resilience.

Some of this research has tended to view the family merely as a context for developing individual resilience, while other research has tended to consider only factors that impact on the group of individuals called a family. Much of the literature covered here, however, particularly concerning the models of family resilience developed by Hill, Burr and McCubbin and associates, has demonstrated a commitment to seeking to understand the resilience of families as a unit of investigation.

The complications of measurement remain largely unresolved. Most of the scales that measure aspects of family resilience endeavour to tap into family constructs through the formulation of family-oriented questions. There remain, however, no clear guidelines for collecting, analysing and interpreting data from multiple family members.

The criticisms of the field of individual resilience (Section 2.11) have been largely resolved:

- Firstly, family resilience considers interpersonal and intrafamilial factors, not intrapsychic. There is more attention paid to systems issues, including the goodness of fit between member and family, and between family and community. In this way, the social work principle of person-in-environment is more fully addressed.

- Secondly, family resilience theory and models point more clearly towards clinical utility. Perhaps because the resilience factors are not located within the individual psyche and because they do not develop in the first years of life, family resilience factors are more amenable to intervention. It is more possible, for instance, to
develop a family’s support systems, patterns of communication and cohesion, than to
develop an individual’s sense of coherence, hardiness or sense of self-efficacy.
4.1 Introduction to Community Resilience

The expansion of the resiliency concept from individual level to family level has been a difficult one, as indicated in section 3.1 on Family Resilience. The expansion of the resiliency concept from the family level to the community level has been similarly a difficult one, as the following pages will indicate (Bowen, 1998). Perhaps more so, because this development has begun only recently (almost all the papers in section 4.3 are dated 1997 or later) and because there is still a tendency to view community resilience as the community promoting the resilience of the families and individuals which it comprises.

With respect to family resilience theory, it was previously noted that there are three main contexts in which families are considered (Hawley & De Haan, 1996; Walsh, 1996), viz (1) the family as a risk factor increasing the vulnerability of individuals, (2) the family as a protective factor increasing the resilience of individuals, and (3) the family as an entity itself with resilience factors of its own. Antonovsky’s debate about measuring family coherence was also noted (Patterson & Garwick, 1998; Sagy & Antonovsky, 1998): the aggregation, pathogenic, salutogenic and consensus models.

These debates concerning the difficulties associated with the evolution of family resilience theory and measurement are undoubtedly paralleled by the difficulties associated with community resilience theory. Resilience theory has, historically, considered the community as a risk factor, making life difficult for families and communities. The stressors which families have to withstand and which precipitate crises are often considered as coming from the community, the system above or around the family. Poverty, crime, political instability, discrimination and lack of community resources have all been identified as community stressors that impact negatively on families.

As resilience theory has evolved, increasing attention has been given to the community as a source of protective factors. In particular, social support has been well-explored, researched and documented. Support systems are located outside the immediate family boundaries – extended family, religious communities, the local community, the work
community, etc. This theory and research will be discussed in the following section (Section 4.2).

More recently, however, there have been a number of attempts to think about the community as a system in its own right (e.g., Blankenship, 1998; Bowen, 1998; Bowen & Martin, 1998; McKnight, 1997). Owing to the newness of these attempts, they tend to be somewhat fragmented and incomplete, and still at a very conceptual level. The difficulties associated with measuring family-level constructs, which have still not been adequately resolved, have not even been considered at community-level. Nevertheless, these fledgling efforts will, no doubt, continue to evolve over the coming years.

4.2 Social Support Systems

H.I. McCubbin and McCubbin (1992) note that social support has been a main subject of family stress research during the 1970s and 1980s. This research has been targeted at three questions:

- “What is social support?”
- “What kinds of social networks offer support to the family or individuals within the family in times of stress?”
- “In what ways and for which types of stressor events is social support a mediator of family stress?”

These three questions serve to structure the content to follow.

4.2.1 Definitions of Social Support

Many use Sidney Cobb’s work on social support as the basis for all new research and theory related to social support (H.I. McCubbin & McCubbin, 1992). Cobb (1982, pp. 189-190) identified four kinds of support:

- **Social Support.** This kind of support involves the caring exchange of information and has three components:
“Emotional support leading the recipient to believe that she is cared for and loved.

“Esteem support leading the recipient to believe that she is esteemed and valued.

“Network support leading the recipient to believe that she has a defined position in a network of communication and mutual obligation.”

- **Instrumental Support.** This kind of support, also called counselling, helps people towards better coping or adaptation, through advice and guidance, in a way that promotes their self-sufficiency.

- **Active Support.** Active support or “mothering” is a more total support which, when provided unnecessarily, leads to dependency.

- **Material Support.** Material support, involves the provision of goods and services that assist the individual in achieving her/his objectives.

Cobb (1982, p. 190) argues that of these four types of support, social support is by far the most important; “social support is more important than all the others put together”.

Sarason, Levine, Basham and Sarason (1983, pp. 128-129) developed the Social Support Questionnaire to measure social support and based it on the notion that support has two basic elements: “(a) the perception that there is a sufficient number of available others to whom one can turn in times of need and (b) a degree of satisfaction with the available support.” The authors note that some people may consider a large number of friends necessary for a sense of support, while others may consider one or two friends sufficient. Furthermore, people’s satisfaction with support may be influenced by many extraneous factors, such as self-esteem or recent life events. Their research demonstrated that these two components are independent (ibid., p. 137).

Some authors (e.g., Myers, Lindenthal & Pepper, 1975, in Kobasa, 1982, p. 18) define social support in terms of “social centrality versus social marginality”. People who are integrated into the mainstream of society, that is who have a job, are married, are not poor, are not Black, etc, are said to be central and thus to have social support. Other authors (e.g., Bovard, 1959, in Kobasa, 1982, p. 18) argue that “the mere presence of others is sufficient” for a person to be socially supported.
4.2.2 SOURCES OF SOCIAL SUPPORT

McCubbin and McCubbin (1992), from their review of family stress literature, indicate that four main sources of support are discussed in the literature:

- **Neighbourhoods.** The role of the local neighbourhood or community has been explored and studies have shown that such support systems are able provide practical assistance for short-term problems, such as short illnesses or babysitting (H.I. McCubbin & McCubbin, 1992).

- **Family & Kinship Networks.** The extended family is a source of support for many, particularly in “ethnic and minority” families (McAdoo, 1982; H.I. McCubbin & McCubbin, 1992). Caplan in 1976 identified nine characteristics of supportive family and kinship networks (in H.I. McCubbin & McCubbin, 1992):
  
  (1) Collectors and disseminators of information about the world; (2) a feedback guidance system; (3) sources of ideology; (4) guides and mediators in problem-solving; (5) sources of practical service and concrete aid; (6) a haven for rest and recuperation; (7) a reference and control group; (8) a source and validator of identity; and (9) a contributor to emotional mastery. (pp. 161-162)

- **Intergeneration Supports.** Reciprocal support between generations is a source of satisfaction for many families, both in terms of quality and frequency of contact. Hill’s 1970 study of three generations (grandparents, parents and young married childless children) revealed that (in H.I. McCubbin & McCubbin, 1992):
  
  (1) The grandparent generation received the most assistance and was viewed as dependent; (2) the parental generation contributed the most assistance and held a patron-like status; and (3) the young married children provided and received moderate assistance and were viewed as reciprocators. The important point is that all three generations – older, middle, and younger – were involved in patterns of support and resource exchange which increased their viability and protected them against the harmful effects of stress. (p. 162)

- **Mutual Self-help Groups.** A mutual self-help group can be defined as an association of “individuals or family units who share the same problem, predicament, or situation and band together for the purpose of mutual aid” (H.I. McCubbin & McCubbin, 1992, p. 162). These groups have often been found to meaningfully enhance the quality of life of its members.
4.2.3 **MECHANISMS OF SOCIAL SUPPORT**

Cobb (1982, p. 198) indicates that social support, rather than acting directly on health, well-being or stress, “operates to facilitate stress reduction by improving the fit between the person and the environment”. It does this in two principal ways. Firstly, a person who has esteem support (and thus self-confidence) and emotional support (and thus a sense of comfort) is in a better position to *adapt* to environmental stressors. In this way, the person experiences less stress, because the stressor has been accommodated. Secondly, a person who has network support (and thus a sense of participation in decision-making) and esteem support (and thus self-confidence and autonomy) is in a better position to take *control of* and change the environmental stressor. In this way, the person experiences less stress because the stressor has been modified. Taken together, people who are supported are theoretically better able than people who are not supported to adapt to and/or modify environmental stressors, thereby promoting the person-in-environment fit. This results in better adjustment and psychosocial functioning.

H.I. McCubbin and McCubbin (1992) note that support systems function in two primary ways. Firstly, they protect the family from the effects of the stressor. In this way, support systems act as a *buffer* working between the stressor and the stress. In theory, individuals and families who have support systems will experience less stress in response to a stressor than unsupported individuals and families exposed to the same stressor. Secondly, support systems enable individuals and families to *recover* more quickly from stress, thereby promoting the resilience and adaptability of the family system. In theory, individuals and families who have support systems will recover more quickly from a crisis than unsupported individuals and families experiencing the same degree of crisis in response to the same stressor.

4.2.4 **RESEARCH ON SOCIAL SUPPORT**

Despite the widespread conceptual agreement that social support protects individuals and families from stress and illness, the research on the subject is inconsistent (Ganellen & Blaney, 1984). This inconsistency may result from the diverse ways in which social support is conceptualised and operationalised (Kobasa, 1982). Suls (1982, p. 259), however, in a review of the role of social support in health promotion, concludes, “the
bulk of the available evidence suggests a beneficial effect for social support"; nevertheless, there are many exceptions to this general rule.

The following studies reflect the kind of positive results that can be found on the role of social support as a resilience factor:

- A series of five studies with psychology undergraduate students indicated that the Social Support Questionnaire, which measures the number of people who can be relied on for support and the degree of satisfaction with that support, correlated with several measures of health and well-being (Sarason et al., 1983). High social support scores were associated with: (a) lower levels of anxiety depression and hostility; (b) experiencing more positive/desirable events in life; (c) greater self-esteem, an internal locus of control and a more optimistic view of life; and (d) greater ability in persisting in tasks that are not easily solved (ibid., p. 137).

- The longitudinal Lundby study (Cederblad et al., 1995) found that social support was a frequently used coping resource, and was statistically associated with positive mental health and lower frequencies of mental disorders and alcoholism. Sociable children (ie children with high social capacity) were able to mobilise and utilise support systems and consequently experienced less psychopathology as adults.

- In a longitudinal study of 285 veterans with a chronic illness, ‘household type’ (together with functional health) at baseline was found to predict survival after five years (a third of the veterans had died in the interim) (Coe et al., 1998, p. 271). This indicates that veterans who live with their spouses and/or children are, when other factors are controlled, more likely to survive than those who live alone.

- A study of 87 university students (Crandall, 1984) investigated the role of social interest as a moderator of life stress. Social interest is defined as “valuing (being interested in and caring about) things that go beyond the self. ... it involves an interest in and concern for others” (ibid., p. 164). The study found that higher social interest scores were associated with fewer stressful experiences encountered during the following year and a lower correlation between these stressors and anxiety, depression and hostility, thereby moderating the negative impact of stressors (ibid., pp. 164 & 171).

- A study of 42 single parents and their child (the one closest to the age of 15) investigated the factors contributing to the physical and mental health of parent and
child (Hanson, 1986). Social support was found to correlate positively with health for both parents and children.

- A study of 13,799 Swedish male and female employees investigated the relationship between the psychosocial work environment and cardiovascular disease (Johnson & Hall, 1988). One of the work factors, work-related social support, was operationalised as the ability to interact informally with co-workers. Results indicate that, when age was controlled, workers in low demand and high control jobs and with high social support experienced significantly lower risk for cardiovascular disease than workers in high demand, low control jobs and low social support (ibid., p. 1336).

- “De Araujo and associates (De Araujo, Dudley, & Van Arsdel, 1972; De Araujo, Van Arsdel, Holmes, & Dudley, 1973) reported that asthmatic patients with good social supports required lower levels of medication to produce clinical improvement than did asthmatics with poor social supports” (in Sarason et al., 1983, p. 128).

- “Results from a prospective study of caregivers found that those with more support and less distress at baseline were protected from declines in immune functioning over the 13-month study period (Kiecolt-Glaser, Dura, Speicher, Trask, & Glaser, 1991)” (in O’Leary, 1998, p. 433), leading the researchers to speculate that social supports protect health by mediating the immune system.

- “LaRocco, House, and French (1980) have recently demonstrated the efficacy of perceived social support in moderating the effects of occupational stress on both physical health and symptoms of anxiety, depression and irritation” (in Crandall, 1984, p. 166).

- “Inadequate workplace social support and social isolation has been shown to be associated with a higher incidence of angina pectoris among male workers in Israel; a greater incidence of coronary heart disease among female clerks; psychological problems among air traffic controllers; higher cholesterol values among those whose work mates were constantly changing; higher levels of illness among the unemployed; a greater physical health impact from perceived stress among male petrochemical workers and increased job stress and psychological strain among men in 23 occupations. Studies which have looked at the moderating or so-called ‘buffering’ effect of social support have found that it ameliorates the impact of perceived stress and job strain on physical and mental health” (in Johnson & Hall, 1988, p. 1336).
Just over two thirds (64%) of 482 South African Naval employees indicated that they could rely on another person at work for support with a personal or family problem. These employees, when compared with those who felt they could not rely on anyone, tended to have healthier marriages, healthier social functioning, more satisfaction with work, finances, friendships and family life, more energy, fewer health concerns and less depressed moods (Van Breda, 1996, p.2). Interestingly, sea-going employees were more likely to report being able to rely on a colleague at work than land-based employees (70% vs 59%) (ibid.).

Holmes’ research demonstrated that a “high incidence of tuberculosis also was found among those persons, irrespective of ethnic group, who were living alone in one room, who had made multiple occupational and residential moves, and who were single or divorced. Thus, disease was more common in people who had no friends, family, or intimate social group to which they could relate” (in Suls, 1982, p. 257).

“In a review of the literature on patient compliance, Haynes and Sackett (1974) considered 25 studies dealing with predictors that can be taken as indicators of social support (eg influence of family and friends, family stability, and social isolation). Sixteen of these studies reported findings consistent with the thesis that social support encourages compliance; one study showed a negative relationship. Eight others showed no significant relationship; however, Haynes and Sackett questioned the quality of four of these eight studies on the basis of the measures employed” (in Suls, 1982, p. 259).

In contrast, the following studies found that social support did not play a resilience role, and in some cases, support even acted as a risk factor:

A study (Anson et al., 1993) of 230 members of kibbutzim compared the relative values of collective and personal resources. Collective resources were conceptualised largely as a sense of community, derived from belonging to a religious (as opposed to a nonreligious) kibbutz, with the kibbutz itself being viewed as a powerful, collective coping resource. Results indicate that while collective resources have a small salutogenic effect, by promoting health, personal resources (specifically the sense of coherence) was much more significant in moderating the effects of stress on physical and mental health.

A study of 40 HIV positive men (20 White and 20 Black) investigated the relationship between social support and psychological adaptation (Gant & Ostrow, 1996). Despite the perception that support systems are ubiquitous among African-Americans, this
study found that the correlations between support and mental health were extremely small or nonsignificant for Black respondents, and moderate for White respondents.

- A study of 83 university students investigated the relationship between social support, hardiness and life stress (Ganellen & Blaney, 1984). Social support was found to correlate negatively with depression (the outcome variable), but was not found to buffer the effects of life stressors. In other words, the relationship between support and stress/adjustment was direct, rather than buffering.

- A study of 206 Hispanic, African-American and Caucasian families with young children investigated the families’ coping strategies (Hanline & Daley, 1992). “Within-culture analysis showed that the use of internal family coping strategies tended to be more predictive of family strengths than was the use of social supports outside the family within all three ethnic groups” (ibid., p. 351).

- A study of 170 middle and upper level male executives found an inconclusive relationship between support and illness (Ouellette Kobasa & Puccetti, 1983, p. 848). Support in the workplace (ie support from one’s employer) reduced illness among workers, especially when those workers are under stress. However, support from the family increased illness when the worker lacked a hardy personality.

- In a large longitudinal study by Lieberman and Mullan reported in 1978 (in Suls, 1982, p. 259), people in the Chicago area who had been exposed to various life stressors were divided according to the kind of assistance/support sought (formal, informal or no support). Adaptation to stress was measured by “symptoms of anxiety and depression, [and] perceived stress in the marital, occupational, economic, and parental roles” (ibid.). When various factors were controlled (eg perceived stress, demographic characteristics, etc), “no evidence was found that seeking help from either professionals or one’s social network had positive adaptive consequences. Those who obtained help showed no significant reduction in symptoms of distress compared to those who did not seek help” (ibid.).

- In a study of 2,300 people in 1978, Pearlin and Schooler (cited in Suls, 1982, p. 260) found that “self-reliance is more effective in reducing stress than the seeking of help and advice from others in the two areas in which it is possible to observe its effects, marriage and parenthood.”
4.2.5 CONCLUSIONS

In conclusion, it would seem that social support has a potentially stress buffering effect on families, as well as a direct effect on family adaptation. Part of the inconsistencies in research results may be due to very diverse definitions and operationalisations of ‘social support’. Furthermore, social networks may not always have a positive effect on people – relationships can introduce stress, irritation, negative role modelling, etc, which may constitute risk rather than protection (Suls, 1982).

Social support, although often equated with community resilience, cannot be considered a community-level resilience factor, however. It is largely conceived as the role that individuals or resources within a community play in the life of an individual, and are thus individual resilience factors located within the community context. Nevertheless, it could be argued that a community could be considered resilient when the majority of members of a community have a strong sense of being connected with other members of and resources in the community. Conceived in this way, one begins to move from looking at support as merely a resource for individuals, but rather as a characteristic of the community itself. Other efforts to move in this direction are discussed in the following section.

4.3 COMMUNITY-LEVEL RESILIENCE

Several authors have endeavoured to establish a framework for thinking about and researching community resilience. These contributions remain very sketchy and fragmented, preventing a comprehensive model or theory of community resilience. These endeavours will therefore be presented separately and links between them will be established where possible.

4.3.1 GARY BOWEN’S CONTRIBUTION

Gary Bowen, a social worker in the USA, has been researching military families for the past two decades. In the late 1990s he began developing frameworks for discussing community resilience and community capacity. As part of this work, Bowen has proposed several working definitions that serve as valuable points of reference for the
discussion to follow. Bowen (1998) points out, however, that these definitions are preliminary and may be refined over time.

Firstly, Bowen provides a definition of the ‘community’ which will be acceptable to most social workers, and which allows for both functional and geographic community types (Bowen, 1998):

A network of informal relationships between people connected to each other by kinship, common interest, geographic proximity, friendship, occupation, or giving and receiving of services – or various combinations of these. (pp. 3-4)

According to Bowen (1998, p. 4), there are four main dimensions of communities which can impact on the well-being and social health of individuals and families, viz: the physical infrastructure, the sociodemographic dimension, the institutional capacity and the social organization:

- The physical infrastructure includes the placement of houses, roads, water and electricity facilities, shops and recreational facilities, etc.

- The sociodemographic dimension refers to the profile of the people comprising the community, its education, socioeconomic status, race/ethnicity, age, marital status, etc.

- The institutional capacity refers to the “number, types, and quality of formal support agencies and organizations in the community” (Bowen, 1998, p. 4).

- Lastly, the social organizational dimension refers to the “degree to which community residents experience social interdependence and a psychological sense of connection” (Bowen, 1998, p. 4).

The ‘social organizational dimension’ is also termed ‘community capacity’ or ‘social capacity’ by Bowen, and refers to the capacity of a community to provide social care to its members. Community capacity is not considered the responsibility of the formal elements of the community, but it is influenced by the physical infrastructure, the sociodemographic profile of the community and the capacity and operation of its institutional capacity (Bowen, 1998). Bowen formally defines community capacity as follows (Bowen & Martin, 1998):

Community capacity is defined as the adequacy and effectiveness of formal and informal systems of social care in providing military families with the necessary symbols, resources, and opportunities required to: (a) develop a sense of community identity and pride, (b) meet individual and family needs and goals, (c) participate meaningfully in community life, (d) secure instrumental and expressive support, (e)
solving problems and manage conflicts, (f) affirm and enforce prosocial norms, (g) cope with internal and external threats, and (h) maintain stability and order in personal and family relationships. (p. 2)

Inasmuch as there is a need to define the outcome of the family resilience models, there is a need to define the outcome of community resilience models. The outcome of both family and community resilience is ‘adaptation’. Bowen (1998, p. 4) defines community adaptation in the military context as “the outcomes of efforts by community members to manage the demands of military life and to work together in meeting military expectations and achieving individual and collective goals.”

Community resiliency is thus defined as “the ability of a community facing normative or nonnormative adversity or the consequences of adversity to establish, maintain, or regain an ‘expected’ or ‘satisfactory’ range of functioning that is equal to or is better than prestressor functioning” (Bowen, 1998, p. 5).

There is some blurring between Bowen’s concepts of community capacity, community adaptation and community resiliency, and Bowen proposes that community capacity should occupy centre stage in the debate concerning the development of resilient communities. He therefore linked the concepts of community capacity and resilience and proposed the following amended definition of community resilience (adapted from Bowen, 1998, p. 14): Community resiliency is the ability of a community to establish, maintain, or regain an ‘expected’ or ‘satisfactory’ level of community capacity in the face of adversity and positive challenge.

With community resilience linked to community adaptation, it becomes superfluous to specify community adaptation. Bowen (1998) proposes that family adaptation be used as the outcome of community capacity; that is, one determines whether community capacity and community resilience are effective by examining their effect on family adaptation.

Bowen (1998) broadens the term ‘community capacity’ to ‘social capacity’ which can refer to individuals, families or communities. He states (Bowen, 1998):

There is an interdependency among the family, work unit, and community areas of social capacity. Deficits in social capacity in any one area may have negative implications for the other areas. Similarly, strengths in any one area may help compensate for deficits the other areas. (p. 15)

For example, a deficit in social capacity at the workplace may be compensated for by a strong social capacity at home. Similarly, when the informal community supports (eg extended family) are inadequate (such as when the family has been relocated to a new
city), the formal community supports (eg a community welcoming committee or the workplace) become more important and compensate for the deficit (Bowen & Martin, 1998).

Bowen facilitated a workshop of military and civilian researchers, policy makers, and programme managers in which these working definitions were presented. The workgroup generated the following research questions in response to some of these definitions (Bowen, 1998):

- “In way ways do the following organizational factors challenge a community’s level of resiliency: unclear military objectives, leadership styles and demands, available resources, level of organizational commitment/identification, unit cohesion, job and career security, unit performance history, mission tempo, nature and frequency of deployments, and level of organizational predictability/stability?”

- “What types of unit leadership contribute most to building community capacity? Are some unit leadership types more effective than others in helping members and their families stay connected and provide social care to one another?”

- “In what ways do the following community-level factors challenge a community’s level of resiliency: natural disasters, ... mission changes, remoteness of installation, employment climate of surrounding community, physical safety and crime, community resources, events in the host community, insertion of non-homogenous groups (eg refugees, flood victims, new wing), and transportation infrastructure, especially for off-base personnel and families?”

- “What are the community-level features that allow a community to bounce back after adversity?”

- “Is it possible to develop a community resilience checklist, including the nature and operation of formal and informal associations and clubs, civic involvement, level of volunteerism, and pride in installation and surrounding community?”

- “Is it possible to develop an index that measures community capacity? What would be the indicators on this index and how would it be used?”

- “What are the signs of a disorganized community? Possible indicators would include high crime rates, poor maintenance of streets and roads, weak informal support channels, high rates of marital separation and divorce, lack of coordination of...
services and programs for members and families, and inability to meet mission goals.”

4.3.2 **Sonn & Fisher’s Contribution**

Sonn and Fisher (1998) explore the meaning of community resilience and introduce the term ‘community competence’. They argue that while communities that are exposed to oppression and discrimination are often seen as becoming dysfunctional, many in fact become stronger as a result of the adversity. Hence, these communities could be termed ‘resilient communities’.

Sonn and Fisher (1998) discuss the term ‘community competence’:

Cottrell (1976) discussed the concept of community competence and theorized that a competent community provides opportunities and conditions that enable groups to cope with their problems. Iscoe (1974) described a competent community as one that “utilizes, develops, or otherwise, obtains resources, including of course the fuller development of the resources of human beings in the community itself” (p. 608). Bishop and Syme (1996) referred to competent communities when discussing communities that are able to tolerate internal conflict and maintain diversity. According to these conceptualizations, a competent community is one that can develop effective ways of coping with the challenges of living. Competent communities, like resilient individuals, have the capacity and resourcefulness to cope positively with adversity. (pp. 458-459)

Sonn and Fisher (1998, p. 460) emphasise the importance of having a ‘sense of community’, in which a person feels that s/he is a member of a community of positive relationships – similar to Bowen’s (1998) ‘social organizational dimension’. People are members of many communities and thus derive a sense of community from several sources. However, there is one primary community from which an individual derives her/his “values, norms, stories, myths, and a sense of historical community” (ibid., p. 461).

Sonn and Fisher (1998) mainly address the issue of how oppressed cultures maintain a sense of cultural identity. They argue that many oppressed culture groups may appear to have succumbed to oppression by internalising the oppressive messages they have been told (eg they believe that they are stupid since all members of their group are supposedly stupid) or assimilating the dominant culture (ie becoming like the oppressor). However, they argue that many of these cultures continue to practice and hold to the primary culture when they are in other settings, such as church groups, cultural groups, families, etc (ibid.):
At a surface level, communities show signs of capitulation and assimilation, while at a deeper, internal level they manage to protect core community narrative and identities. That is, they acquire the skills, competencies, and behaviors that are functional in the dominant group context; thus, they become bicultural. ... There is no denying that oppression, the imposition of cultural systems, and other negative social forces (eg economic depression) can adversely affect individuals and groups, often leading to pathological outcomes. However, this may not always be the case. Groups may develop processes and mechanisms that ensure the survival of valued cultural identities and the positive development of group members. (p. 464)

In particular, Sonn and Fisher (1998) note the importance of alternative settings in which cultures may continue to practice their culture in freedom. These settings allow communities the “opportunities for awareness raising, participation, sense of community, and belonging (ibid., p. 468). These settings become the storehouse of the community’s culture and thus the centre of community resilience and survival.

Sonn and Fisher’s (1998) paper highlights a number of important points for the general discussion on community resilience: (a) they identify one clearly community-level stressor (viz cultural oppression) that can be responded to at a community level, thus confirming the concept of community resilience; (b) they add to the concept of community resilience with the notions of community competence; (c) they highlight the importance of alternative settings, cultural harbours, within the community as a requirement for community resilience; and (d) they highlight the concept of ‘sense of community’ which has similarities to the concept of family bonding or family cohesion discussed in the previous sections on family resilience.

4.3.3 JOHN McKNIGHT’S CONTRIBUTION

McKnight (1997) addresses the question of how, through policy, to develop healthy communities and families. The fundamental tenet of his paper is that policy makers need firstly to shift their focus from ‘systems’ to ‘associations’ and secondly to ensure that the former serves the needs of the latter (not the other way round).

Systems are, in McKnight’s (1997) paper, the ‘tool’ of society to achieve greater social well-being. Systems include all social service delivery systems, welfare policies, grants, etc. Systems have three primary characteristics (ibid.): (a) they promote a hierarchical system of control in which a few have control over many; (b) they aim to mass produce large quantities of uniform products; and (c) they require consumers who believe that they want and need the products. Systems thus have two main failings (ibid.): firstly they are unable to generate individualised, tailor-made products and secondly they tend
to promote dependency since their efficacy is measured in terms of the number of consumers or clients.

Communities, by contrast, comprise 'associations', which McKnight (1997) advances as more central than systems. Associations are "small-scale, face-to-face groups in which the members did the work" (ibid., p. 119). Associations thus also have three characteristics (ibid.): (a) they promote equal partnership in which there is no control but rather free will; (b) they produce small quantities of products, viz a context in which care can be demonstrated; and (c) they are comprised of citizens who have power. By depending on the contribution of its members, communities promote the creativity, productivity, gifts and participation of people.

As such, associations have nine important capacities which systems do not share (McKnight, 1997, pp. 123-125):

- (a) associations provide a network of mutual care and support;
- (b) associations enable a rapid response to localised problems;
- (c) associations enable an individualised or personalised response to problems;
- (d) associations allow for the recognition and utilisation of the unique gifts and abilities of its members, which promotes creative problem solving;
- (e) associations allow citizens the opportunity to be independent, responsible and self-efficacious;
- (f) associations allow citizens the opportunity to be citizens, such as to vote, and to participate in problem solving and decision making;
- (g) associations provide citizens with the opportunities to develop and exercise their leadership potential;
- (h) associations cultivate the knowledge and skills needed for local enterprise; and
- (i) associations mobilise the capacities of people and promote the effectiveness of society.

Although McKnight does not use the term ‘resilience’, his conceptualisation of community, association and system suggests that resilient communities are those which comprise associations and in which systems are designed to serve, facilitate and
promote associations, rather than replace them. This links with Bowen’s notion of a balance between formal and informal supports within a community. It is also possible that ‘community capacity’ could be defined as ‘the degree to which a community is an association’.

4.3.4 **Kim Blankenship’s Contribution**

Blankenship (1998) addresses the issue of how race, class and gender impact on resilience or thriving. In particular, she highlights the fact that being Black, poor or female both increases the likelihood that one will experience resilience producing life circumstances and decreases the likelihood that one will benefit from these experiences. To illustrate, Blankenship contrasts the Gay community and Black community’s responses to the HIV crisis in the USA:

As devastating as HIV/AIDS has been to the gay community in the United States, Gamson (1989) has shown the extent to which it has also inspired a social movement in this community. Through AIDS, he argues, and the activism it has inspired, the diseased bodies of gay men have “become a focal point of both oppression and resistance” (p. 364). In contrast, Quimby and Friedman (1989) analyze the failure to spark Black mobilization around AIDS in New York City during the same period. They note that although considerable networking occurred among Black elites, and many Blacks become informed about AIDS at conferences and the like, this was not translated into interventions or activities aimed at the lower- and working-class groups of Blacks most affected by HIV. (p. 394)

Blankenship argues that the ability to mobilise a community, as demonstrated by the Gay community in response to HIV, is contingent on the community’s access to “structures of power and influence in which the relevant populations are embedded” (1998, p. 394). Such structures and resources are, at the community level, equivalent to the characteristics of resilience identified for children exposed to stress. In the same way that children who lack an optimistic disposition, who do not have a secure relationship with some or other adult, and who are not physically attractive are unlikely to develop the resilience to rise above their adversity, communities that lack access to power, influential structures and resources tend to succumb to the stress of community demands.

The literature on thriving and resilience has indicated that resilience comes to the fore only in the face of adversity – without adversity, there is no need for resilience. Similarly, communities that are not exposed to adversity have no need to develop resilience. (Parenthetically, this may explain the virtual absence of a sense of
community in most middle class White communities in this country, in contrast with the fairly strong sense of community in most lower class Black communities.) Blankenship (1998), however, points out that poor communities, Black communities and women experience a disproportionately large share of such adversity. In theory, then, poor people, Black people and women should evidence the highest levels of resilience.

The other side of the coin, however, is that communities need certain resources to transform such risk experiences into growth-producing experiences. Blankenship (1998) points out that such resources are, like adverse experiences, not evenly spread (see also Moen & Erickson, 1995; O'Leary, 1998). Indeed, those communities that experience the most adversity also tend to have the least access to the resources needed to transform the adversity (Blankenship, 1998):

By definition, certain social groups, because they lack access to social resources due to race, class, or gender, may have a more difficult time or be precluded altogether from thriving. On the other hand, for precisely this same reason – their position in the social hierarchy and correspondent lack of access to resources – these groups are more likely to face the kinds of risk that can precipitate thriving. (pp. 396-397)

Blankenship (1998) argues strongly that thriving or resilience, while most often conceptualised at the individual level, can also be addressed at community level, that is, where the community is the unit of analysis. She does not provide a formulated description or definition of community resilience, but hints at it in the following comment: “Measures of their [communities’] thriving include such community-level variables as the extent to which they gain a political voice and begin to exercise influence over the public discussion of health issues” (Blankenship, 1998, p. 395).

This statement indicates that in order to consider community-level resilience one must first consider a community-level stressor, such as the AIDS crisis, or poverty, or a community disaster such as a flood or fire. In the face of such a stressor (A), one can begin to explore the various community level resources (B) and the way the community processes and makes sense of or defines the stressor (C), to discover how the community adjusts to the stressor (X). Blankenship (1998) assists in directing attention to community variables and away from additive individual variables.

### 4.3.5 Albert Bandura’s Contribution

Bandura (1982, p. 122) introduced the term ‘self-efficacy’ to refer to “judgements of how well one can execute courses of action required to deal with prospective situations”.

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Bandura also proposed that one can talk about collective self-efficacy, “The strength of groups, organizations, and even nations lies partly in people’s sense of collective efficacy that they can solve their problems and improve their lives through concerted effort” (ibid., p. 143). Elsewhere Bandura defined collective efficacy as “a group’s shared belief in its conjoint capabilities to organize and execute the courses of action required to produce given levels of attainments” (1997, in O’Leary, 1998, p. 434).

In line with Blankenship’s argument, Bandura (1982) notes that research has demonstrated that when a community is oppressed, it is those members within the community who have had experience of success in the face of adversity who are most able to initiate group and political action against the oppression. These individuals, in comparison with those who do not initiate action, “are generally better educated, have greater self-pride, have a strong belief in their ability to influence events in their lives, and favor coercive measures, if necessary, to improve their living conditions” (Bandura, 1982, p. 143).

This pattern can, perhaps, be seen in the ANC’s politics during the Apartheid era. One may wish to characterise the struggle against Apartheid as a mass movement, in which all oppressed people participated (eg O’Leary, 1998). Another view, however, indicates that the petit-bourgeois members of the African community (who were better educated, wealthier, etc) took the lead and formed the bulk of the movement (McKinley, 1997). In Bandura’s terms, the poor masses lacked the self-efficacy to mobilise and voice their political will.

4.3.6 PERSON-ENVIRONMENT FIT

A number of authors have conceptualised community resilience as a degree of fit between individuals or families and the community or environment (Elsass, 1995):

What are the conditions that allow some communities to survive, while others perish? Survival is dependent on external relations, such as the Indians’ geographical location, colonization of the area, and illnesses that intrude as a result of contact with foreigners. However, it is the interaction between these external factors and certain internal relations in the community that constitutes a psychology of survival. (p. 175)

Melson (1983) notes that inasmuch as families have expectations of and place demands on their community, communities also have expectations of and place demands on families. The various systems in which an individual is located make various and
potentially conflicting demands. Environmental demands, then, can be considered as the “number of microsystems and the ease of making transitions among them” (ibid., p. 153). Melson argues that different cultures or societies or communities may differ in the “number, complexity, ambiguity, and rate of change of their demands” (ibid., p. 154).

If resilience is defined as a balance between family capacity and environmental demands, then it is possible to consider some communities as more resilient than others. Specifically, those communities in which the environment does not make unmanageable demands on families are more resilient than those communities that do. Since the demand-capability balance (M.A. McCubbin & McCubbin, 1996) is reciprocal, one could expand this notion by adding that resilient communities provide families with sufficient resources to cope with the environmental demands created by the community.

4.3.7 **The Strength Perspective’s Contribution**

The strengths perspective in social work (which will be dealt with in greater depth in a later chapter) has endeavoured to make a contribution to the field of community level resilience. Benard (1997) for example addresses the protective factors at schools that promote the resiliency of children, highlighting caring and support, high expectations, and youth participation and involvement as key factors.

Saleeby (1997a) indicates that community development theory has, unknowingly, advanced the notion of community resilience:

> Community development involves helping unleash the power, vision, capacities, and talents within a (self-defined) community so that the community can strengthen its internal relationships and move closer toward performing the important functions of solidarity and support, succor and identification, and instructing and socializing. (p. 202)

According to Saleeby (1997a, p. 203), community development and community resilience overlap inasmuch as community development involves unleashing the resiliency of a community (to use the framework in the quotation above). It is likely that a description of a resilient community will be virtually identical to a description of a ‘developed’ community.

A number of strengths oriented writers have introduced the concept of ‘niches’ into the debate around community resilience. Sullivan (1997, p. 192) notes that “human beings forge an accommodation with their environment – a task marked by action, decision
making, goal setting, and perceptions of past and future experience.” This accommodation process results in a ‘niche’, which is “the unique place in which one ‘fits’ into the environment, the workplace or community. It is a special place within which one feels comfortable” (ibid.).

A niche is the product of both individual and community or environmental factors (Sullivan, 1997, p. 193). Individual factors influencing the creation of niches include desires, skills, talents, confidence, power, etc. Environmental factors influencing the creation of niches include opportunities, supports, being cared for and respected, etc. The niche results in quality of life, achievements, a sense of competency and life satisfaction.

Taylor (1997) distinguished between entrapping and enabling niches. Entrapping niches are niches that do not allow people to grow or develop. The lack of resources in entrapping niches and the stigma society attaches to members of entrapping niches disempowers these people, restricting their range of choices. They are forced into an exclusive association with other members of the niche with little chance of movement (Sullivan, 1997; Taylor, 1997).

Enabling niches stand in contrast to entrapping niches (Sullivan, 1997):

[Enabling niches] offer a range of opportunities and experiences that facilitate growth and achievement … Access to resources and opportunities increases the ability to have meaningful interaction with others who bring different perspectives and expand one’s social world. In this environment, growth and development are both expected and encouraged. (p. 193)

Taylor (1997) lists eight characteristics of enabling niches:

- “People in enabling niches are not stigmatized, not treated as outcasts.
- “People in enabling niches will tend to turn to ‘their own kind’ for association, support, and self-validation. But the enabling niche gives them access to others who bring different perspectives, so that their social world becomes less restricted.
- “People in enabling niches are not totally defined by their social category; they are accepted as having valid aspirations and attributes apart from that category. The person is not ‘just’ a ‘bag lady,’ a ‘junkie,’ an ‘ex-con,’ a ‘crazy.’ …
- “In the enabling niche, there are clear, earned gradations of reward and status. People can work up to better positions. Thus there are strong expectations of change or person progress within such niches.
“In the enabling niche, there are many incentives to set realistic longer term goals for oneself and to work toward such goals.

“In the enabling niche, there is good reality feedback; that is, there are many natural processes that lead people to recognize and correct unrealistic perceptions or interpretations.

“The enabling niche provides opportunities to learn the skills and expectations that would aid movement to other niches. This is especially true when the enabling niche pushes toward reasonable work habits and reasonable self-discipline and expects that the use of time will be clearly structured.

“In the enabling niche, economic resources are adequate, and competence and quality are rewarded. This reduces economic stress and creates strong motives for avoiding institutionalization.” (p. 223)

4.3.8 CONCLUSIONS

Several of the authors cited above have attempted to conceptualise resilience at the community level. These authors have begun to move beyond earlier conceptualisations of community level resilience that tended to look at factors within a community that promote individual resilience (e.g., Kaplan et al., 1996). Rather, these authors have endeavoured to conceptualise the community as a system or unit in itself, and to describe how a community may or may not evidence resilience in the face of community challenges.

Clearly, a great deal more work is needed. The conceptions of community resilience are still tentative and underdeveloped. There is still a tendency to return to individual aggregates as the conception of community resilience. There has been no operationalisation of community level resilience. The field continues to be dominated by individual level constructs (such as Bandura’s ‘collective efficacy’ and Antonovsky’s ‘collective SOC’) that may have to be abandoned in order to move truly to the collective level. Blankenship’s (1998) paper, while not proposing much in the way of a theory of community resilience, hints most clearly at the way forward by indicating community level stressors and community level responses. Perhaps further exploration of such phenomena will lead to a better formulation of community resilience.
CHAPTER FIVE: RESILIENCE-BASED POLICY

5.1 INTRODUCTION TO RESILIENCE-BASED POLICY

The previous chapter indicated that the theory of community-level resilience was still in its infancy. This current chapter suggests that the theory of resilience-based policy and resilience policy development processes have been barely birthed. As few as six publications (Bogenschneider, 1996; Chapin, 1995; Dumon, 1988; Figley & McCubbin, 1983; National Network for Family Resiliency, 1996; Weick & Saleebey, 1995) could be located addressing the question of resilience theory and policy development. Even in these six, the ideas are as yet quite unformulated and undeveloped.

The six writers concur that most family policy has been pathology or deficit oriented, rather than strengths or resilience oriented. This is particularly so in the United States of America (Dumon, 1988; Weick & Saleebey, 1995). According to Chapin (1995, p. 506), the “problem-centered approach to policy formulation with its intense focus on problem definition and assessment has not been coupled with similar attention to assessment of the strengths of the people and environment that the policy targets.”

In a resilience framework, policies are not primarily focused on correcting deficits, but on promoting a social environment that is conducive to individual, family and community well-being or functioning (Chapin, 1995). Individuals who have deficits are considered to have these deficits not because of some inherent deficiency, but because of exclusion from social processes on the basis of demographic characteristics (ibid.). Consequently, resilience or strengths based policies “identify individual and community resources that can be used to create opportunities for inclusion or to provide clear-cut alternatives that bypass the predominant system ‘in favor of those which work better for a given community’” (Chapin, 1995, p. 509).

In order to achieve the shift in focus from deficits to strengths, Chapin (1995) argues that policy should focus not on problems (which tend to be unique to certain demographic groups – deficient people) but on common human needs. This shift in focus “mitigates the labeling process and helps illuminate the various ways people get help in meeting these needs without being labeled as deviant or deficient” (Chapin, 1995, p. 509). In this way, policy development becomes a process of empowering families (National Network for Family Resiliency, 1996).
Figley and McCubbin (1983) argue that policy developers should take cognisance of research that demonstrates factors which promote the resilience of individuals and families in the face of adversity. Policies should focus not so much or not only on remedial strategies to help those facing adversity, but also on establishing the resistance resources which reduce the vulnerability of all people to the negative consequences of adversity. This is more in keeping with the Salutogenic perspective (Antonovsky, 1979), which argues that stress is ubiquitous and not inherently bad. One cannot finally rid society of stress, but one can raise the capacity of families to resist the negative consequences of stress (see also Bogenschneider, 1996 for an application of this approach to at-risk youth).

Weick and Saleeby (1995) emphasise the flexible nature of the modern family and the conflicts between societal values, family processes and family policies. They argue that the All-American values of individualism and economic self-sufficiency form the bedrock of modern policy. Yet, they argue, these policies consequently do not adequately support family well-being (Weick & Saleebey, 1995):

> In the absence of an overarching philosophy and value system that establish societal responsibility for family well-being, these policies rest on a hodgepodge of prejudice, fears, and grudging assistance. They do not make necessary resources available to marginalized and struggling families, nor do they provide families with increasing control over such resources. (p. 142)

According to Weick and Saleeby (1995), policies that are informed by resilience theory will acknowledge the responsibility of society as a whole to the development of all families. Furthermore, families will be defined flexibly, not in traditionalist terms (nuclear families with a male head). Such policies will develop ‘enabling niches’ for families (as discussed in the previous chapter), that is, environments in which families fit, feel comfortable and are able to thrive (ibid.).

Ooms and Preister (in National Network for Family Resiliency, 1996) developed six principles by which to evaluate the impact of family policies on families:

- **Family Support & Responsibilities.** Policies should support and supplement family functioning and provide substitute services as a last resort.
  - **Underlying Value: Families fill some functions best; substitutes are a last resort.**
- **Family Membership & Stability.** Policies should encourage and reinforce family commitment and stability, especially when children are involved.
“Underlying Value: Removal of family members is justified only as protection from serious harm.

“Family Involvement and Interdependence. Policies must recognize the interdependence of family relationships, the strength of family ties and obligations, and the resources families have to help their members.

“Underlying Value: Solutions to individual problems shouldn’t harm other family members.

“Family Partnership & Empowerment. Policies must encourage family members to collaborate as partners with professionals in service delivery.

“Underlying Value: Policies usually are more relevant to family needs when families are involved in their development.

“Family Diversity. Policies must acknowledge and value the diversity of family life and recognize the different ways families may be impacted.

“Underlying Value: All families need support and shouldn’t be disadvantaged because of structure, cultural values, life stage, or circumstance.

“Family Vulnerability. Families with the greatest economic and social need should have first priority in government policies.

“Underlying Value: All families deserve support. Policies should give special consideration to those with the greatest social and economic limitation, and to those most likely to break down.”

Although these principles are presented as consonant with family resilience theory, they seem to reflect the underlying value system of the residual welfare system, in which welfare policy is targeted at helping only those who are most vulnerable. In contrast, a developmental welfare approach aims to develop the well-being and resilience of all, not only the most vulnerable.

Dumon (1988) contrasts family policy in Western Europe with family policy in the United States, and in so doing confirms the sentiment of the previous paragraph. She says, “Family policy in Europe … has been based on the idea or ideology of social justice, more than on any type of charity, help, or welfare. … Therefore, family policy was not directed to deficient families” (Dumon, 1988, p. 239). Family policies are for all families and all families benefit from them, even, says Dumon, the Prime Minister.
Dumon (1988, p. 239) identifies three classes of family policy: “(1) policies aimed at strengthening families economically, (2) remedial policies, and (3) substitutional policies”:

- **Economic Enabling Policies.** This category of policy has two main foci, viz family allowances and tax reductions. Both are based upon the number of children in a family unit, and are thus not about distributing resources from rich to poor (as in many other welfare systems). Rather the emphasis is on “a horizontal redistribution of income from small to large families” (Dumon, 1988, p. 240). In this way the policy is child and family centred – money is provided to the caregiver of the child (regardless of marital status or gender) and this pairing of child and caregiver is considered a family unit. Unlike other welfare policies, Western Europe has no ‘means test’ which must be passed in order to ‘qualify’ for welfare assistance – the mere fact of having a child qualifies one for financial relief so that adults who raise children are not economically disadvantaged.

- **Remedial Policies.** After the Second World War, many European countries introduced “nonmaterial” family policies that focused on providing families with “family life education and information on family matters” (Dumon, 1988, p. 240). In order to reduce the interference of the state in private matters, most of these services were outsourced to private organisations, often with 100% subsidisation. Using a quota system, governments ensured that all segments of the population (based on language, religious affiliation, culture, etc) were catered for. The remedial policies tended to focus more on individual and interpersonal well-being, in contrast with the previous class of family policies which focused more on situational elements of the family as a unit.

- **Substitutional Policies.** In the 1970s a new class of family policies emerged in Europe, namely substitutional policies, in which provision was made for services which substituted for certain family functions. Day care for children is a key example. “A new policy was the provision of household substitutes for mothers, and later on for either parent falling ill or being disabled on a temporary basis” (Dumon, 1988, p. 241). These policies were means based, with lower income groups enjoying first priority. The substitution services were paid for, however, although on a sliding scale with lower income families paying less than wealthier families.
Clearly, a great deal more work is required to unpack what is meant by resilience-based policies. Some of the key ingredients that can be synthesised from these six authors and hints from previously cited writers are:

- Policies must move from a deficits emphasis to a strengths emphasis.
- Policies must create environments that are conducive to healthy resilient families.
- Policies must incorporate resilience research that identifies protective community factors.
- Policies must focus on the development of all families, not exclusively on vulnerable families.
- Policies must be flexible, must involve the participation of its clients and must cater for the diverse range of family types, cultures, norms, etc.
- Policies must aim both to create experiences that promote resilience and to reduce experiences that create vulnerability.

5.2 **Work-Life Interface**

A unique example of resilience-based policy is the area of the work-life interface. I am using the term ‘work-life interface’ to refer to the often conflictual relationship between the occupational or work role/system and the personal, ‘life’ or family roles/systems of people. Changes in the modern workforce, particularly since the 1980’s, have lead to great increases in work-life conflicts (Googins, 1991). Employers are increasingly having to address how to reduce these conflicts in order to retain qualified personnel, reduce absenteeism, increase productivity and improve client satisfaction. Most organizations at the turn of the 21st century have introduced policies that facilitate this interface – work-life initiatives, alternative working arrangements, family-friendly policies, etc.

None of the literature on the work-life interface is explicitly grounded in resilience theory. Nevertheless, there are a number of characteristics of this field which suggest that it can be meaningfully considered as an example of resilience-based policy:

- The work-life policies promote the interface between two conflicting systems in order to promote the well-being of both systems.
The outcome of work-life policies can be described as a balance between demands and capabilities between the two systems of work and family.

Work-life policies create a societal system that is much more flexible and cohesive, characterised by greater commitment and a greater ability to cope with stress and change.

Work-life policies in general focus on the entire working community rather than only on those with problems, and in this way have a preventive, strengths-building approach rather than a purely remedial one.

This section will provide an overview of theory related to the work-life interface in order to clarify the concept, provide examples of work-life conflicts and highlight the impact of such conflicts on the workplace and on the family/person, provide examples of work-life policy initiatives, and highlight the impact of such policies on the workplace and on the family/person.

### 5.2.1 Theory of the Work-Life Interface

The theory of work-life interface originates in two sets of changes, viz changes in the workforce and changes in organizational processes. In addition, much work-life theory addresses the degree or nature of the interface between these two systems.

#### 5.2.1.1 Changes in the Workforce

The workforce has changed dramatically over the past few decades. Society has also changed greatly, along with economic change, cultural change, and changes in the workplace itself. These changes have necessitated radical change in how one thinks about work and in how employers approach employees (O'Connell, 1999), and more and more companies are realising the importance of attending to the family and other social needs of their employees (Moore, 1997).

The ‘Baby-Boomer’ generation, which entered the workforce during the 1960s, placed great emphasis on work. Their personal identities were very tied up with their work identity (Gibbon, 1995). Consequently, they had a very strong work commitment or psychological contract. Many of these workers were prepared to put in 60 or more hours
of work per week (Keele, 1984) and were willing to sacrifice family time for work time. Workers prior to that, in the wake of the Depression, were willing to take any job that provided security, and found their family or religious identity as important as their work identity (ibid.).

The employee of the last two decades of the 20th Century, Generation X, however, is seeking a better balance between work and family life, and is demanding that the workplace take a less central role in life (Allen & Russell, 1999). One of the reasons for such a shift is the changing demographic of the workforce. Only a small percentage of the workforce conforms to the traditional American family type: breadwinner husband and stay-at-home mother/wife. “In fact, it is estimated that among American two-parent heterosexual families, only 20% fit the description of a traditional household” (ibid., p. 166).

As we move into the 21st Century, one may wonder what is in store for us. A team of panellists believe that one of the major changes in the workplace during the first decade of the 21st Century will be a shift towards “working to live, not living to work” and that companies will free up workers to seek fulfilment at home and in the community (Kemske, 1998). These panellists believe that in the future work will not occupy the centre of people’s emotional lives and identity (ibid.; see also Segal, 1989).

One of the main changes in the demographics of families is the rising number of dual-income families (Portner, 1983). In Canada the percentage of all two-parent families that were dual-income families increased from 20% in 1961 to 40% in 1981 and to 65% in 1991 (Duxbury, Higgins, & Lee, 1994, p. 449). In the USA in 1997, 78% of married full-time employees had a partner who was also employed (Bond, Galinsky, & Swanberg, 1998, p. 5).

In addition, increasing numbers of families have only one parent – whether divorced parents, never-married parents or widowed parents (Portner, 1983). “In 1991, 12.8% of Canadian families were classified as single-parent families, ... the majority of which are headed by women” (Duxbury et al., 1994, p. 449). In 1997 in the USA, almost 20% of employed parents were single parents (Bond et al., 1998, p. 5).

Other studies have indicated that increasing numbers of employees are responsible for the care of children or elderly relatives (Weiss, 1998). As society ages it is likely that there will be a tremendous increase in the percentage of employees caring for the elderly. Currently, about one in four American households cares for an elderly family member or friend, and about 60% of caregivers find that caring for an elderly person...
causes them to miss work, arrive late, leave early, take extended lunch breaks, etc (Rachor, 1998, p. 20).

Men are taking an increasingly active role in family life, way beyond the traditional role of ‘providing’ for the family economically (Cohen, 1993; Segal, 1989; Stanford, 1998). Although employed mothers still spend more time with their children than do fathers (3.2 vs 2.3 hours respectively per workday in 1997), employed fathers in 1997 are spending 30 minutes more per workday with their children than they did in 1977, while employed mothers’ time per day has remained constant (Bond et al., 1998, p. 5). In addition to spending more time with their children, employed fathers are spending more time on home chores – “mothers’ workday time on chores has decreased by 36 minutes per day [from 1977 to 1997], while men’s time has increased by one hour” (ibid., p. 6).

Ellen Galinksy is quoted as saying (in Pleck, 1993):

*When we first started doing this the groups of men and women sounded very different. If the men complained at all about long hours, they complained about their wives’ complaints. Now if the timbre of the voice was disguised, I couldn’t tell which is which. The men are saying: “I don’t want to live this way. I want to be with my kids.” I think the corporate culture will have to begin to respond to that.* (p. 234)

The establishment of the Fatherhood Project in 1981 (Levine & Pitt, 1999) provides an example of the growing commitment of men to life beyond the workplace. This project aims to help men find a better balance between work and family responsibilities. The Fatherhood Project lists 19 additional websites dedicated to addressing fatherhood issues, particularly work-family issues (ibid.).

### 5.2.1.2 Changes in the Workplace

In addition to changes in family structures, there have been major changes in the workplace as well (Cooper, 1998). Three of the main changes are “downsizing, diffusing information via computerized telecommunication technologies, and increasing reliance on high-involvement team approaches” (Crouter & Manke, 1994, p. 117):

- **Downsizing.** Many American organisations began a substantial process of downsizing during the 1980s and 1990s. These retrenchments went beyond the natural shrinking of the formal market during a recession, but reflected changes in the way the contemporary market is being structured. In order to gain a corner of the global market, companies are having to be smaller and more efficient (‘lean &
mean’), and are out contracting specific portions of their work. This has implications for both those who are laid off and those who remain behind. (Crouter & Manke, 1994)

- **Information Technology.** More and more production and service processes are becoming automated. Consequently, fewer workers are required with technical or manual skills, and workers are increasingly required to work with data rather than materials. This places greater conceptual and cognitive demands on workers, fewer workers are needed and the boundaries between workers and managers become blurred. (Crouter & Manke, 1994)

- **High-involvement Teams.** Many companies are making increasing use of high-involvement work teams to solve work problems. Previously, workers became highly specialised in their specific field, often without understanding the broader process. Work teams require everyone to know most everything about the process, providing workers with a much broader range of knowledge and skills. Consequently, work becomes more stressful and demanding and workers become much more emotionally and psychologically involved in the work. (Crouter & Manke, 1994)

These changes in the workplace – downsizing and retrenchments, shortened work weeks, privatisation, increasing self-employment, working by contract rather than life-long employment, the rapid changes in technology, increased mechanisation and depersonalisation of work processes, increasing percentage of women in the workforce, etc – have had and will continue to have a profound impact on society’s workforce and families (Cooper, 1998). The changes introduce various challenges for families including: (1) having to cope with marked job insecurity, (2) learning to incorporate work and family into the same building as more and more people work from home, (3) coping with working longer hours, (4) the shifting roles and power relationships between men and women at work and home, (5) changing levels of commitment or loyalty towards work, and (6) changes in the factors that motivate people to work (ibid.).

One of the major changes in the workplace is the large number of women who are now working. Almost half of all employed people (46-49%) are women (Gini, 1998, p. 3). Although they make up only 3% of senior managers, women have an influence on the nature of the workplace, and its responsiveness to the needs of families (ibid.).
The separate spheres model regards work and family as naturally and biologically determined separate systems. It is assumed that the nuclear family is the universal, desirable family form, that work and family are static, unchanging institutions, and that gendered division of labor and gender inequality are inevitable and necessary for societal and family stability. Conflict is believed to arise when families fail to keep the spheres separate. (pp. 795-796)

In pre-industrial society the worlds of work and family were often identical. The industrialisation took much of the work out of the home and into a new world – the work world – triggering the separation of the spheres of work and family (Andrews & Bailyn, 1993). Men occupied and controlled the work world while women occupied and largely controlled the family/home world (Brinkerhoff, 1984). “In short, in pre-industrial times the family unit served as both producer and consumer, whereas contemporarily the family consumes as a unit but produces in separate, disjunctive roles that are external to the family” (ibid., p. 5).

This distinction between work and family systems is evident in sociology, which examines two main social structures (Davis, 1982):

The first is the rational bureaucratic organization, as described by Max Weber (Henderson and Parsons, 1947); the second is the primary group, as conceptualized by Cooley (1923). The typical work organization, of course, belongs to the first category; the family unit is invariably classified in the second. (p. 3)

This first conceptualisation of the relationship between family and work, referred to as the ‘separate worlds model’ has dominated much of academic and popular thinking (Andrews & Bailyn, 1993). The world of work is seen as a masculine world, the world of men, while the family is seen as the world of women. Issues regarding childcare and family responsibilities are thus relegated to the private sphere and are seen as having no place at work (ibid.). The world of work can be thought of as making the following demand on employees: “While you are here, you will act as though you have no other loyalties, no other life” (ibid., p. 263). The myth of separate worlds serves the “interests of employers by permitting them to deny the possibility of any spillover of negative or dysfunctional effects of organizational policies and procedures upon the family life of employees” (Neenan, 1989, p. 59).
A second conception of the relationship between family and work is referred to as the 'spillover effects model' (Googins, 1991; Segal, 1989; Skrypnek & Fast, 1996). Here, the two worlds of work and family are considered intersecting and the characteristics of one or other is thought to spillover into the other. Most commonly, spillover refers to the negative consequences of the work spilling over into the family (Brinkerhoff, 1984; Marshall, 1991; Marshall, Chadwick, & Marshall, 1991; Skrypnek & Fast, 1996). There is, however, much interest in the spillover of marital and life satisfaction into job satisfaction, and vice versa (Neenan, 1989).

A third conception of the relationship between family and work is referred to as the 'interactive model' (Skrypnek & Fast, 1996). In this model the worlds of work and family are considered to be closely interrelated and contribute both positively and negatively to the other. The emphasis is on the mutuality of the relationship between the two systems, and it is believed that the systems can be better integrated. The close interrelationship between work and the rest of life can be seen in the strong correlations and mutual causation between job and life satisfaction, even longitudinally (Judge & Watanabe, 1993).

Ishii-Kuntz (1994) takes the challenge to the separation of the worlds of paid work and family somewhat further than many other writers. This author notes that in many third world countries there is no physical separation between work and family:

Many men and women around the world who work in their homes for pay are engaged in a variety of economic activities: They assemble electrical and electronic parts, package and label industrial goods, weave carpets, produce shoes and purses, sew traditional clothes, peel shrimp, and process seaweed. (p. 495)

Such a blurring of work and family is becoming increasingly common in the first world as well, particularly with the explosion of information technology and IT based occupations (Ishii-Kuntz, 1994) and the increasing number of women who are becoming self-employed in order to be at home with their children (Boden, 1999). With the work and family roles so enmeshed it becomes difficult to talk about work-family conflicts as if they are two separate spheres colliding. A different paradigm is required.
5.2.2 WORK-LIFE CONFLICTS

Work-life conflicts, usually played out in the arena of work-family conflicts, involve difficulty in balancing family and work responsibilities. Portner (1983) identifies several main sources of work-family stress:

- **Perceived Social Expectations.** People may have perceptions about what society expects of them that create stress at the work-family interface.

- **Self-expectations.** People may place unrealistic expectations on themselves to be superhuman – juggling work, family and social responsibilities with ease.

- **Employer Expectations.** Employers may have unrealistic expectations regarding the number of hours to be worked in a week, the flexibility of working hours and travelling and the expectation that family responsibilities will never intrude on work time.

- **Allocation of Time and Energy.** There is only a finite quantity of time and energy available to any one person, and sometimes there is not enough to meet all the demands and expectations of work and family.

- **Child-care Responsibilities.** Working parents often worry about their ‘neglect’ of child-care responsibilities.

- **Household Responsibilities.** Managing work and household responsibilities is a source of stress for many employed women, who continue to be largely responsible for housework, even when they are employed fulltime.

5.2.2.1 Role-Overload

Work-family conflict is the result of an inability to balance the demands of both work and family (Duxbury et al., 1994):

Each of these roles imposes demands requiring time, energy, and commitment to perform the role adequately. The cumulative demands of multiple roles can result in role strain of three types: overload, interference from work to family, and interference from family to work. (p. 450)

Perceived role-overload has been shown to be predictive of perceived stress (Berger, Cook, DelCampo, & Herrera, 1994), providing support for role strain theory. Role-
overload occurs when the cumulative demands from the various roles a person carries reduce the chances of success in any of those roles (ibid.). The scarcity hypothesis, which is part of this theoretical frame, suggests that a person has a finite quantity of personal resources. When a person is carrying an excessive number of roles, their time and energy are drained, resulting in a sense of role-overload, role strain (trying to juggle these various roles) and stress (ibid.).

Despite the increasing involvement of men in family responsibilities, women continue to experience more role-overload than men (Brinkerhoff, 1984):

In the event of role overload, the wife is often expected to be the adaptive one, because her work role is usually considered lower status. Family emergencies, such as a sick child, are usually handled by the wife's juggling her occupational responsibilities, not by the husband. (p. 8)

The consequences of the role overload experienced by employed mothers are illustrated by some of the findings of the 1992 National Study of the Changing Workforce (Galinsky, Bond, & Friedman, 1996). In this study, employed mothers in comparison with employed fathers:

- Were more likely to be single parents (23% vs 4%),
- Worked fewer hours per week (38.3 vs 47.1 hours),
- Were more likely to work part-time (26% vs 4%) (see also Boden, 1999; Caputo & Dolinsky, 1998),
- Were more willing to trade job advancement in order to work part time (29% vs 14%),
- Were more willing to trade job advancement in order to work at home regularly (36% vs 20%),
- Were more willing to trade job advancement in order to have flexitime (41% vs 31%),
- Were more likely to want their jobs to retain the current level of responsibility (43% vs 32%),
- Were less likely to want more job responsibility (51% vs 64%),
- Were more likely to be responsible for cooking family meals (83% vs 11%),
Were more likely to feel tired when getting up in the morning (48% vs 35%),

Were more likely to feel emotionally drained from their work (30% vs 23%),

Were more likely to experience minor health problems (23% vs 11%), and

Were more likely to feel nervous and stressed (38% vs 19%).

Overall these results point to the consequences of stress overload. Employed mothers continue to carry the dual responsibilities of both family and work, while fathers remain primarily engaged in the world of work (although the men’s results are not insignificant). The 1997 replication of the above study (Bond et al., 1998, p. 7) revealed, for example, that in dual-income families when a child is ill and needs medical attention 83% of employed mothers indicated that they would take time off from work, while only 22% of fathers said that they would take the time off. Employed mothers are, therefore, more likely than employed fathers to make adjustments to their working schedule to cater for family needs (Lee & Duxbury, 1998).

A study of 318 people found that dual-career families experienced the highest work-to-family conflict, and that dual-career and single parent families experienced the highest family-to-work conflict (Eagle, Icenogle, & Maes, 1998). It is likely that these families experience the highest role overload.

Perceived control over one’s life has a moderating effect on role-overload. Even when individuals experience the same objective quantity of role-overload, perceived control reduces the stress effects of the overload (Duxbury et al., 1994, p. 463). This would suggest that giving workers greater control over the structure of their work (eg working hours, place of work, flexitime, etc) would contribute to the reduction of the negative consequences of carrying multiple roles.

Work overload was found to predict negative physical health in another study (Barnett, Davidson, & Marshall, 1991). However, being able to help others at work was found to moderate these negative health consequences. Furthermore, getting a higher salary and having a satisfying intimate partnership were as powerful at directly predicting health as was work overload.
5.2.2.2 Work-to-Family and Family-to-Work Interference

Work-to-family conflict or interference occurs when the general demands of the workplace, the amount of time devoted to work tasks and the stress or strain caused by the work system interfere with the completion of family tasks (Frone, Yardley, & Markel, 1997; Netemeyer, Boles, & McMurrian, 1996). There are three primary processes of work-to-family interference, viz time (spending excessive time away from the family), psychological (being psychologically absorbed in work to the exclusion of family) and energy (being physically or emotionally drained by the work demands) (Small & Riley, 1990).

Conversely, family-to-work conflict or interference occurs when the general demands of the family, the amount of time devoted to family tasks and the stress or strain caused by the family system interfere with the completion of work tasks (Frone et al., 1997; Netemeyer et al., 1996). There has been a tendency for researchers to concentrate largely on work-to-family conflict and to equate the term ‘work-family conflict’ with ‘work-to-family conflict’ (eg Burley, 1995; Matthews, Conger, & Wickrama, 1996). Part of the reason for this may be that family boundaries appear more permeable than work boundaries, allowing work stress to permeate the family more easily than for family stressors to permeate the workplace (Eagle et al., 1998). Some researchers have begun to examine the reciprocal role of the conflicts (Crouter, 1984).

A series of studies found that work-to-family conflict and family-to-work conflict both correlated negatively with organisational commitment, job satisfaction, life satisfaction and relationship agreement, and positively with burnout, job tension, role conflict, role ambiguity and the intention to leave the organization or employer (Netemeyer et al., 1996, p. 406). In addition, family-to-work conflict correlated positively with searching for another job and negatively with relationship satisfaction, while work-to-family conflict correlated positively with number of hours worked (ibid.).

A study of 277 professional psychologists found that work-to-family conflict was negatively correlated with marital adjustment (Burley, 1995, p. 490). Two mediating variables (spousal support for one’s career and perceived equity in the division of labour at home) were found to account for 34% of the relationship between work-to-family conflict and marital adjustment (ibid., p. 492).

Another study of 337 couples explored the relationship between work-to-family conflicts and happiness or satisfaction with the marriage (Matthews et al., 1996). The researchers found that the work-to-family conflicts experienced by both partners
influenced their own and their partner’s psychological distress, which in turn both
directly and indirectly (via the impact on the hostility versus warmth and supportiveness
of the marital interactions) influenced marital satisfaction (ibid., p. 71).

A model testing study of 372 employed adults (Frone et al., 1997) had a number of
interesting findings. Firstly, the study demonstrated that support in the workplace
reduced work distress and work overload, which in turn reduced work-to-family conflict. Conversely, support in the family reduced family distress and parental overload, which in
turn reduced family-to-work conflict (ibid., p. 162). Secondly, work related distress led
to work-to-family conflict, which in turn led to family distress. Conversely, family related
distress led to family-to-work conflict, which in turn led to work distress (ibid., p. 163).
Thirdly, work-to-family conflict was associated with negative family outcomes, while
family-to-work conflict was associated with negative work performance (ibid.).

A study of 334 male and 189 female married white-collar workers found complex
relationships between work and family functioning (Hughes, Galinsky, & Morris, 1992).
The researchers hypothesised that although there would a direct relationship between
job characteristics and marital qualities, this relationship would be mediated by work-
family interference. Some support for this hypothesis was found, such as the finding
that the significant positive relationship between the job characteristic of high pressure
and low supervisor support and the marital quality of marital tension was fully accounted
for by the variable work-family interference (ibid., p. 40). Other findings did not support
the hypothesis, however, such as the finding that “having an enriching job was directly
associated with more marital companionship, independently of” work-family interference
(ibid.). The researchers conclude with a statement quite congruent with resilience
theory:

On possibility is the process of positive carryover, explicated by Piotrkowski (1979),
in which the satisfied worker generates positive energy and interactions in the family
domain. This process may be important for marital quality and may be distinct from
the mere absence of negative mood states. (p. 40)

One researcher (Crouter, 1984) investigated the spillover from family-to-work using
semi-structured interviews with 55 employees. Two thirds of the respondents (37 out of
55, 67.3%) reported that there was family-to-work spillover. Both positive and negative
spillover was reported (ibid., p. 430). Positive spillover included being able to translate
interpersonal skills learned in the family (such as sensitivity to people’s needs,
communication, etc) into the workplace. Negative spillover included the inhibiting effect
of the family (restricting the employee from fulfilling work demands) and the influence of
negative energy and mood spilling over from the family into the workplace. Women with
young children were found to report the highest levels of family-to-work spillover, while women with older children or no children and men (all men) reported similarly lower levels of spillover (ibid., p. 425).

In a study of factors predicting job satisfaction and intention to resign among police officers, family related factors were not significant (Burke, 1994, p. 794). However, the upsets at work, concerns of the impact of the job on one’s health and safety, the burden on the families of police officers to behave in an exemplary fashion and emotional exhaustion all contributed to reduced job satisfaction and increased intention to resign (ibid.).

A study of female school teachers, 78% of whom were parents, found work-to-family conflict did not directly predict intention to resign, but that it did predict stress symptoms, which in turn predicted intention to resign (Kirchmeyer & Cohen, 1999, p. 69). Work-to-family conflict was reduced through the availability of workplace support, operationalised as the employer’s respect for and accommodation of the workers’ nonwork life. Family-to-work conflict predicted work absenteeism and stress symptoms, and was reduced by effective personal coping skills that seek to reduce work-family strain. There was also a direct relationship between work-to-family and family-to-work conflict.

In a study of 989 Finnish technical designers (Feldt, 1997) the Sense of Coherence (SOC) of employees was examined as a moderator of the relationship between work characteristics and well-being. As in other research, SOC contributed significantly to the protection against psychosomatic symptoms and emotional exhaustion, accounting for 25.8% and 14.5% in the variance of each respectively (ibid., pp. 139-141). The relations between work characteristics (such as organisational climate, good relationships with managers and time pressures) and well-being (both psychosomatic symptoms and emotional exhaustion) were moderated by SOC, albeit only somewhat. Employees with low SOC scores tended to have low well-being in the presence of negative work circumstances, while the well-being of employees with higher SOC scores tended to be independent of work circumstances (ibid.). Interestingly, having a demanding job was found to increase emotional exhaustion for employees with low SOC scores, but to decrease emotional exhaustion for employees with high SOC (ibid.). This last finding “supports the assertion of Antonovsky (1987b) that some work factors can be salutary when accompanied by a strong SOC and pathogenic when accompanied by a weak SOC” (ibid., p. 144).
5.2.3 **WORK-LIFE POLICIES**

5.2.3.1 **Types of Policies**

There are, perhaps, six main groups of work-life policies: family-related leave, child care, adult dependent care, alternative working arrangements, education and wellness programmes, and benefits (Crouter & Manke, 1994; Skrypnek & Fast, 1996).

**Family-Related Leave**

“Family-related leave includes maternity leave, other parental leave for new mothers and fathers, bereavement leave, and family responsibility leave” (Skrypnek & Fast, 1996). Family responsibility leave was the most frequently cited form of support employees received from employers to assist them in balancing work and family responsibilities – cited by 58% of respondents in one study (Lee & Duxbury, 1998).

The Employment Relations Bill in the United Kingdom has introduced longer (18 weeks) and more flexible maternity leave policies with greater protection to mothers making use of such leave as well as parental or domestic leave for both mothers and fathers of biological and adoptive children (Aikin, 1999). Some companies in the United Kingdom have extended these benefits. One company allows employees with more than six months’ service to take 40 weeks leave after the birth of a child. If both parents work for the company, the couple can share the leave period, with the mother returning to work after three months and the father taking the rest of the leave, for example. The policy also applies to same sex couples who have a child, as well as to adoptive parents with more than one year’s service (Johnson, 1999). Two nurses in the United Kingdom won a court case over an attempt to force them to work shift patterns that they argued was detrimental to their ability to adequately care for their children (Whitehead, 1999).

The introduction of family-related leave, particularly the inclusion of parental leave for both men and women, indicates a movement away from the separate worlds myth (Skrypnek & Fast, 1996). Older maternity leave policies prevented fathers from participating in family responsibilities (including prenatal classes, the birth of a child, the ongoing care of children during times of illness, etc). It assumed that women were exclusively responsible for family matters and that the woman would be at home to attend to them. The man’s primary responsibility was in the place of work.
Surely the provision of family-related leave has positive consequences for families – people have time to care for their families, men have greater opportunities to participate in family life, infants have greater opportunities to bond with both male and female caregivers, etc. It also has some positive consequences for employers – workers may be more willing to stay employed, women are more likely to return to the workplace after having a child, employers save on the costs of recruiting and training new employees, etc. Ultimately, employers who institute a full range of family-related leave benefits are indicating that the responsibility for children is collectively held by parents, employers and the state (Skrypnek & Fast, 1996).

About half of the companies (49%) in one survey allowed their employees to take some time off to care for a mildly ill child, without having to put in vacation leave or lose pay (Galinsky & Bond, 1998, p. iv). About three-quarters of the companies surveyed (74%) provide men with the required 12 weeks paternity leave, and a further 16% allow more than this. However, only 13% of companies provide men with at least some replacement pay during paternity leave. Ten percent of the companies surveyed believed that employees who make use of flexitime and parental leave jeopardize their career – this is in contrast to the 40% of employees who believe this (ibid.).

**Child Care**

Half the companies surveyed in one study reported that they provide employees with Dependent Care Assistance Plans that help employees pay for child care with pretax dollars, while only 9% provide child care facilities at or near the workplace (Galinsky & Bond, 1998, p. v). Only 6% of companies provide child care for school children during vacations, and 4% provide back-up or emergency care for employees when their usual child care arrangements fail. About a third of the companies (36%) provide employees with information about child care facilities in the community. Only 36% of companies providing some form of child care benefit believe the benefits to the company outweigh the costs (ibid.).

**Adult Dependent Care**

“Adult dependent care refers to a broad range of services, from transportation and housekeeping assistance to institutional care, for aging or disabled individuals who cannot live independently. The vast majority of these services are provided by family

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members” (Skrypnek & Fast, 1996, p. 804). Research in the United Kingdom indicates that eldercare will eclipse childcare as the central work-life programme in the 21st Century (Overell, 1996).

In a national survey of companies in the USA in 1992, 23% indicated that they provide an information and referral service to employees who are caring for an elderly family member (Galinsky & Bond, 1998, p. vi). A national survey of employees in 1997 found that 25% of employees had provided care to an elderly relative during the previous year, providing an average of almost 11 hours care per week, equally distributed for men and women (Bond et al., 1998, p. 15; see also Googins, 1991). More than a third of these employees had to reduce their work hours or take time off work to provide this elder care, again men and women taking off equal amounts of time (Bond et al., 1998, p. 15).

Similarly, in the United Kingdom, women employees are more likely to be caring for an elderly person than for a preschool child (Overell, 1996, p. 7). Employees (of both sexes) are as likely (one in six) to be caring for an elderly person as women employees are to be caring for a child under 16 (ibid.).

In response to this new form of care, some organisations are offering benefits to employees to assist them in balancing the demands of work with the demands of caring for an elderly or disabled relative (Anfuso, 1999).

Alternate Working Arrangements

“Alternate working arrangements allow employees to alter the number of hours they work, when they work, and where they work and include part-time work, job sharing, condensed work weeks, flexitime, shorter work days, and work-at-home arrangements” (Skrypnek & Fast, 1996, p. 807; see also Barham, Gottlieb, & Kelloway, 1998).

In the 1998 Business Work-Life Study in the USA of 1057 for-profit and not-for-profit companies with 100 plus employees (Galinsky & Bond, 1998, p. ii), most companies allowed workers to take time off to attend school and child care functions (88%) and to return to work on a gradual basis following the birth or adoption of a child (81%). Most companies allowed their workers to work flexitime (68%) and to work from home (57%) on occasion. Job sharing, routinely working from home and routine flexitime were not frequently allowed options (24-37.5%). Gallinsky and Bond (ibid.) found that 46% of the companies surveyed believed that these arrangements benefited the company, while only 18% believed the costs outweighed the benefits. (see also Greenwald, 1998)
Educational & Wellness Programmes

Many organisations are offering employees and families educational programmes that seek to facilitate the work-family/life interface.

Keele (1984) presents one such programme designed for business executives, which aims to developed a healthy family system able to withstand the stresses of the business life. Van Breda (1998a, 1999a) presents a programme designed for couples in which one partner is required to travel as a routine job requirement. The programme, the Separation Resilience Seminar, aims to develop the capacity of these families to resist the stress of repeated separations of one family member out of the family system. Wiersma (1994) conducted research into the behavioural strategies employed by dual-career couples to solve work-family role conflicts, the results of which could be of value in counselling or educational programmes with such couples. A growing number of counsellors in organizations and employee wellness programmes are addressing ways of helping employees find a better balance between work and family priorities (Hitchin & Hitchin, 1999).

In a survey of 1057 companies in the USA, 56% indicated that they provided an Employee Assistance Program designed to assist employees with work or personal problems and 25% provided workshops or seminars on parenting, child development, care of the elderly or work-family problems (Galinsky & Bond, 1998, p. vii). Very few companies provide any kind of service to the families of employees – 5% of the companies in this study provide an EAP service to the teenage children of employees, 3% provide a counselling service and 2% provide workshops and seminars (ibid.). Given the interrelatedness of family well-being and employee functioning, this figure is surprisingly low.

In the same study it was found that 62% of companies train their supervisors in how to manage a diverse workforce, 44% consider how well supervisors manage the work-family interface during performance assessments, 43% train their supervisors in how to respond to the work-family needs of employees, and only 22% provide a career counselling programme or a management or leadership programme for women (Galinsky & Bond, 1998, p. ix).

Some companies have found a parallel between the health of an employee’s relations at home and at work. They strive to train their employees in interpersonal skills that are transferable across the various domains of their employees’ lives (Moore, 1997). One manager says (ibid.):
Every dollar we invest in a person’s marriage is as important as every dollar spent “on the job”. … People don’t change character, personality traits and habits on the drive to work or on the way home. It’s all the same. The biggest lie in corporate America is “just leave your problems at the door”. (p. 19)

Other Family Benefits

Some companies offer “cafeteria benefit plans that permit employees to select an individualized set of benefits” (Crouter & Manke, 1994, p. 122). For example, one parent may choose to exchange a family medical aid scheme (which the other parent in a dual-career family is taking) for child-care support or an educational scholarship (Portner, 1983).

Many companies have introduced various benefits that make working a little easier for employees. These include dry-cleaning, take away meals, subsidised lunches, fitness centres or fitness centre memberships, onsite hair salons, onsite car washes and casual dress codes (Federico & Goldsmith, 1998; Flynn, 1995).

Some companies have introduced various benefits to promote the family lives of employees. For example, the National Institute of Information Technology, “rents a limo and kicks in $100 to cover the cost of a night out for the employee and his family” on each anniversary of their employment (Unknown, 1999, p. 19). NIIT also provides employees with $100 each year for “granny gratitude day” in order for employees to celebrate with their grandparents or other family members (ibid.). NIIT attributes policies such as these for their low turnover rate of only 12% compared with the industry standard of 20-40%. Other companies provide a $1,000 savings bond to children born to their employees (Cowans, 1998).

Other employers are allowing employees to turn business trips into combined family vacations, by allowing their employees to travel with the family (McGuire, 1999). Some companies are allowing their employees to bring their children to work on occasion to see where the parents work (Terez, 1998), while others are allowing women to bring infants to work on a continual basis (Lonkevich, 1998; Martinez, 1997). Some even allow employees to bring their pets to work (Stamps, 1997). Some companies have made provision for women to either breastfeed their infants on site or have established facilities for mothers to express and store breast milk during the day for use by their infants in childcare the following day (Danyliw, 1997).
A number of companies (23% of companies in a 1995 survey) are offering families adoption benefits (Manewitz, 1997, p. 97). Apart from extending maternity and paternity type leave to adoptive parents, some companies are offering financial assistance to adoptive parents. Some companies give parents $3,000 per adoption, including the “adoption of stepchildren after remarriage and grandchildren when empty-nesters assume child-rearing responsibilities” (Wojcik, 1998). One company gives $4,000 per child, increased to $6,000 if the child has special needs, in addition to paying “a licensed adoption fee (including fees for placement or counseling), legal costs (including attorneys fees or costs of legal proceedings), state-required home study fees, temporary foster care prior to placement, and domestic transportation for the child and parent” (Manewitz, 1997, p. 96).

5.2.3.2 Men and Childless Adults

There is some debate about whether or not men (who are traditionally seen as having little involvement in family life) and childless adults, both married and unmarried, would be interested in or make use of work-family programmes. Some writers have indicated a ‘backlash’ against the work-family initiatives from those employees who feel their needs as single adults are neglected by companies who devote all their attention to employees with children (Young, 1998).

**Single Employees.** One study, for example, in which it is unclear whether the respondents are from the general population or the single/unmarried population, found the following:

- “To ‘With all the work/family programs being introduced today, are single employees without children being left out?’ 80% responded yes.

- “To ‘Do single employees end up carrying more of the burden than married employees?’ 81% answered yes.

- “To ‘Do single employees receive as much attention to their needs as married-with- children employees?’ 80% responded no.

- “To “Will Corporate America see a backlash from single employees?’ 69% said yes” (Flynn, 1996, p. 58).
**Male Employees.** Regarding men, there is growing evidence that indicates that men are becoming increasingly involved in family life and that the traditional stereotypes that men spend an average of 10 minutes per day with their children are untrue (Pleck, 1993). Together with this growing involvement in family life (Berry & Rao, 1997) is a growing interest from men in utilising work-family programmes (Pleck, 1993):

Men’s interest in using specific policies to reduce work-family stress is also increasing. In surveys of large samples of Dupont employees, the proportion who said they wanted the option of part-time work to allow them to spend more time with their children rose from 18% in 1985 to 33% in 1988 (Thomas, 1988). The percentage expressing personal interest in leave to care for newborn children increased from 15% in 1986 to 35% in 1991; the proportion interested in leave to care for sick children rose from 40% to 64% in the same period (“Labor Letter,” 1991). (p. 223)

Haas (1993) provides a review of the work-family policies in Sweden, highlighting the way these policies promote the equal involvement of men in parenting and facilitate the work-family interface of men and fathers. Interalia, she notes that Sweden has introduced the following policies since 1968:

- “At childbirth, men are granted 10 days off from work with full pay – so-called daddy days – to take care of family responsibilities and to become acquainted with their new offspring” (Haas, 1993, p. 240).

- “In addition to the daddy days at childbirth, Swedish men have access to a wide array of programs designed to help working parents care for children. ... The programs were deliberately designed to help fathers as well as mothers combine work and family roles” (Haas, 1993, p. 241).

- “Since 1974, employers have been obliged [italics added] to grant parents of both sexes paid leave with job security at childbirth or adoption. Parents receive at least 90% of their former salary. As of 1991, fathers and mothers could share up to 12 months of this generously paid leave, 3 additional months of low-paid leave (approximately $10 a day), and 3 months of unpaid leave” (Haas, 1993, p. 241).

- “Fathers as well as mothers are allowed to take up to 120 days off work per year, with pay, to care for sick children or to step in for sick caretakers” (Haas, 1993, p. 241).

- Both fathers and mothers “may reduce their workday to 6 hours (with a corresponding loss of pay) until their children reach age 7” (Haas, 1993, p. 241).
“A government-subsidized network of high-quality child care facilities helps working parents retain an attachment to the labor force. Parents pay only 8% of the cost of a place in a day care center or licensed day care home” (Haas, 1993, p. 241).

Although these policies seem to have had an impact on Swedish society (women are more likely to be employed and men have more liberal attitudes towards their role in the family), men continue to attend primarily to the workplace while women continue to attend primarily to the family (Haas, 1993). Nevertheless, Swedish work-family policies appear to have eased the work-family interface for many men and women.

**Childless Employees.** Regarding employees without children, many feel their lot has deteriorated as employees with children obtain unfair benefits (Picard, 1997):

Childless ... employees complain that they are expected to work later, travel more, and forfeit weekends and holidays. They are also less likely to be granted flexible work schedules; they must justify leaving early; they get transferred more often; and they pay health care premiums that are less generously subsidized than those of coworkers with families. Childless workers are often hesitant about speaking up because they do not want to appear to be anti-family or to be called complainers, but the resentment is likely there. (p. 33)

**Alternative Family Structures.** Studies of men and single employees suggest that organisations need to be more flexible in how they define ‘family’ so as to accommodate a wider variety of family types, including single adults, fathers, gay couples, etc (Young, 1998). The inclusion of gay couples in work-family benefits is illustrated by the finding that 43% of organisations with domestic partner benefits cover same-sex relationships, while a further 21% limit the benefits to only same-sex partnerships (Starcke, 1997, p. 53).

### 5.2.3.3 Work Culture

There is a growing number of people arguing that it is inadequate to merely put in place programmes which offer greater flexibility to workers who are juggling work and family responsibilities (Moskowitz, 1997; Skrypnek & Fast, 1996). What is required is a fundamental change in the work culture (eg Warren & Johnson, 1995). One study reports that “today’s employee commitment is most strongly correlated with management’s recognition of the importance of personal and family life, and the effects of work on workers’ personal lives” (Laabs, 1998, p. 54; also Talley, 1998). One manager argues that people looking for work will take a job that pays 30% less than another because that job has the right kind of culture (Ernst, 1998).
The finding that the proportion of female managers, rather than the proportion of female employees, increased the chances of organizations introducing work-family initiatives suggests that many companies require a fair amount of pressure to accommodate family needs (Ingram & Simons, 1995, p. 1479). Nevertheless, even in companies where programmes to ease the work-family interface are available, many employers and managers continue to behave as they always did, making the use of such programmes difficult (Berry & Rao, 1997). This is well illustrated by the following statement by a manager, “Work/family is not an issue here, because there are no women in this firm” (in Andrews & Bailyn, 1993).

One of the main reasons for such a perspective is the reluctance of many workers to make use of work-life programmes for fear of one or other form of discrimination or career disadvantage (Milligan, 1998) – and this is particularly so for men (Pleck, 1993). Men who make use of work-life benefits, such as parental leave, are more likely to be seen as lacking commitment to the organisation, and are thus less likely to be recommended for rewards (Allen & Russell, 1999). Women, in contrast, are less penalised than men for making use of work-life benefits, probably because such benefits are seen as more congruent with the traditional role of women as mothers and family makers (ibid.). Many managers are more likely to allow junior employees and women to make use to work-life programmes such as alternative work arrangements than senior employees and men (Barham et al., 1998).

There is a double message given to many employees: “Although men have been encouraged to increase their involvement in family responsibilities, employers may not want them to stray too far from the current norms” (Allen & Russell, 1999, p. 185).

In a national study of companies in the USA, employers were asked to what extent they believed their companies had a supportive culture (Galinsky & Bond, 1998, p. viii). Just over half the companies (55%) indicated that it was very true that supervisors were “encouraged to be supportive of employees with family problems and to find solutions that work for both employees and the organization” and 66% indicated that it was very true that “men and women who must attend to family matters are equally supported by supervisors and the organization” (ibid.). However, only 19% believed it was very true that “the organization makes a real and ongoing effort to inform employees of available assistance for managing work and family responsibilities” and 31% believed it was very true that “management takes employees’ personal needs into account when making business decisions” (ibid.).
One of the most powerful predictors of whether an organisation provides work-family initiatives is the presence of women in top executive positions (defined as the CEO or a direct reporter to the CEO). In a national survey of companies with 100 or more employees, 30% had no women in top executive positions, while 70% had one or more female top executives and 14% of these had women in half or more of these top positions (Galinsky & Bond, 1998, p. xii). The influence of women in top positions is well illustrated by this study – Companies with women in half or more of the top positions are more likely than companies with no women in top positions to (ibid.):

- Provide traditional flexitime (82% vs 56%).
- Provide childcare on or near the workplace (19% vs 3%).
- Provide dependent-care assistance plans (60% vs 37%).
- Provide elder care resource and referral programmes (33% vs 14%).

Galinsky and Bond (1998, p. xiii) report similar findings regarding the presence of minorities in top executive positions, although only 27% had one or more minorities in these positions.

Some companies have introduced policies and practices which are not directly aimed at easing the work-family interface, but which promote an image to the employees of the company being concerned for human well-being. For example, a number of companies have introduced policies allowing employees to take off time from work (up to 10 hours paid leave per month) to engage in volunteer work (Hays, 1999a). These programmes appear to have little positive or negative impact on the company’s revenue, but create a perception in the minds of the employees that the company cares about people and the well-being of the community, which in turn increases their loyalty towards the organisation and creates a more conducive work environment or culture. “Employer-sponsored opportunities for volunteerism tend to increase not only employee commitment and morale, but the company’s reputation in the broader community” (Hays, 1999b, p. 66).

The effects of a supportive supervisor or an organizational culture supportive of family life have been well documented (Laabs, 1998; Lee & Duxbury, 1998; Milligan, 1998; Young, 1998). Some organisations have introduced mandatory training for supervisors in promoting the work-life interface of their subordinates (Seitel, 1998; Vincola, 1998) and some authors are publishing guidelines to help supervisors become more family-friendly (Ramsey, 1998; Van Breda, 1999b).
The connection between work culture and work-life policies is illustrated by the following "work/family change model proposed by Dana Friedman and Ellen Galinsky of the Families & Work Institute" (Lobel & Faught, 1996, p. 55):

- “In Stage I, organizations take a programmatic approach in responding to family needs. Without challenging existing norms, they try out a number of initiatives, such as resource and referral services, flexible benefits plans, and parenting seminars.

- “In Stage II, a number of developments take place. Top management begins to champion some programs; a work/family manager or group may be named; and human resources policies and benefits are evaluated for their contribution to work/family issues.

- “In Stage III, the company’s culture becomes truly 'family friendly.' The company may change its mission statement; it may evaluate managers on how well they handle employees’ work/life conflicts; and it may mainstream work/family issues and integrate them with other efforts, such as diversity.

- “Finally, in Stage IV, the company integrates work/life concerns with business planning” (Lobel & Faught, 1996, p. 55).

5.2.3.4 Effects of Work-life Policies

A study (Warren & Johnson, 1995) of 116 employed mothers with preschool children found that work-family role strain was predicted by a number of workplace variables. Work-family role strain was defined as a sense of not being adequately able to fulfil the demands of both work and family life. In this way it is a combination of the work-to-family conflict and role-overload concepts. Organisational climate (measured by the perception of the organisation being accommodating of employees having difficulties balancing work and family demands and the availability of family-oriented benefits), supervisor support (measured by the sensitivity of the supervisor towards work-family conflicts and the flexibility of the supervisor in adjusting work demands) and use of family-oriented benefits each significantly reduced work-family role strain (ibid., p. 166). However, when all three were combined, only organisational climate remained significant, suggesting that the family-friendliness of the organisational culture is an overriding factor in the capacity of women to balance work and family demands (ibid.).
One study examined the effects of work-life initiatives on two organizations (Szostak, 1998), including shifting administrative tasks from professionals to administrative assistants, reorganising the flow of work and allowing flexitime and telecommuting. The researchers found several positive effects on the productivity and well-being of employees:

- “The average percent of work time spent doing real underwriting rose to 60 percent, compared to 52 percent before the experiments;”
- “Employees reported that they were able to spend more quality time with their families;”
- “Disturbed sleep, a common manifestation of stress, decreased dramatically. The number of employees reporting that sleep was ‘frequently’ or ‘sometimes’ disturbed dropped to 50% from 79%. This finding has major relevance for increased productivity on the job;”
- “For virtually all weeks in the [experimental] period, on-time turnaround was at or above 80 percent, meeting a key production goal; and
- “Flexitime helped employees meet work and family responsibilities” (Szostak, 1998, p. S13).

Landauer (1997) and others have identified several main benefits of family-life programmes to employers:

- **Employee Time Saved.** Employees making use of in-house counselling and referral services save time (an average of 17 hours per year (Landauer, 1997)) that they would have spent going to community organisations for help.

- **Increased Motivation and Productivity.** When employees believe their company cares for them and their family, they are more willing to give more (Landauer, 1997). Employees who have access to flexitime tend to be less stressed, more productive and more committed to their jobs than those who work in inflexible organisations (Collins, 1997, p. 12).

Furthermore, certain flexible work schedules are good for both the employee and the organisation. One company found that employees who worked a compressed work week of four 10-hour days, rather than the usual five 8-hour days, completed 36% more job transactions per day (Martinez, 1997, p. 111). The company attributes the
increase to a quieter environment in the early morning and evening, employees getting into a work pattern over the ten-hour day, increased contact with customers, etc.

- **Employee Retention.** Employees at IBM overall rated work-family balance sixth in a list of 16 factors influencing their retention. Employees rated as having the highest performance at IBM, however, rated work-family balance second in the list (Landauer, 1997). Another company reduced attrition of new mothers by 50% by allowing a more flexible return-to-work policy (Martinez, 1997), and yet another company reduced the attrition of women employees from 16.2% to 7.6% after three years of work-family and diversity programmes (Lobel & Faught, 1996, p. 51; Moore, 1997, p. 51).

- Several authors have noted that although work-family/life policies may not impact noticeably on revenue, or may even impact negatively on revenue, such policies promote recruitment of quality employees (Moskowitz, 1997) and the retention of these employees (Thatcher, 1998). One company estimates that their work-life programmes have improved retention rates, saving them $2 million per annum in recruiting, hiring and retraining costs (Martinez, 1997).

- **Decreased Healthcare Costs and Stress-Related Illnesses.** A study conducted in 1992 found that “employees from companies with supportive work/family policies were half as likely [as workers from companies without such programmes] to experience stress-related illness or job burnout, regardless of whether they participated in the programs” (Landauer, 1997, p. 4).

- **Absenteeism.** Studies show that 46% of unscheduled work absences are family related, while only 28% were related to personal illness (Landauer, 1997, p. 4). Furthermore, companies that introduced work-life policies reduced this rate by 50% among those who used flexible work options (ibid.). Another company reduced absenteeism by 30% by allowing flexible working hours, including working four longer days in order to have one off each week (Martinez, 1997). Another study found that workers who can make use of alternative working arrangements are absent for only two days per year in comparison with workers in low-flexibility jobs who are absent an average of six days per year. They also tend to be late less often (Collins, 1997, p. 12).

- Similarly, companies that provide back-up child care facilities or services reduce the amount of time parents take off from work when regular child-care falls through –
one company found that 3200 days of absences were prevented over one year, and estimated that the company consequently saved a conservative net of $40,200.00 (after paying the operating costs of $419,000.00) (Lobel & Faught, 1996, p. 52).

- **Human-Investment.** While most literature on work-life benefits attempts to demonstrate the financial advantage of such policies and programmes to the company, some literature argues that these programmes are valuable in that they develop the capacity of the people in the company. Such an investment in human capacity may have no financial advantage, and may even cost the company at face value. Nevertheless, it is argued that such an investment promotes the development and loyalty of employees.

- For instance, “at IBM, high-performers ranked work/life programs second in importance, after compensation, as a factor contributing to their desire to stay with the company. This compares with the fifth-place ranking these programs received from the employee population in general” (Lobel & Faught, 1996, p. 53).

- **Customer Retention.** Studies show that companies that promote the work-family/life interface have employees who have better job satisfaction, which in turn results in better performance and customer relations, which in turn promotes customer retention (Martinez, 1997).

Other research suggests that such policies may have less effect on the work-life interface than generic working conditions. The 1992 National Study of the Changing Workforce, for example, found that while job characteristics (such as autonomy, job demands, job security and control over one’s work schedule) explained 6% of work-family/life conflict, family oriented fringe benefits (such as flexitime, leave and dependent care) and a supportive workplace did not explain work-family conflict (Galinsky et al., 1996, p. 129). Employed parents coped better and experienced less stress when they had more job autonomy, less demanding jobs, more job security, more control over their work schedules, a more supportive supervisor and workplace culture, and equal opportunities for advancement (on the basis of gender and race) (ibid., p. 131).
5.2.3.5 Symbiosis

It would, of course, be naïve to think that companies put work-life initiatives in place out of altruistic concern for the well-being of employees and their families. One author notes somewhat sardonically, “These ‘perks’ are really nothing more than the greed of the ‘80s dressed all warm ‘n fuzzy in the fleece of the ‘90s” (Ellerbee, 1998, p. 10). The number of publications that argue how work-family initiatives increase the productivity of workers and the revenue of companies testifies to the ‘greed’ motivation for many companies introducing such initiatives (Federico & Goldsmith, 1998; Starcke, 1997).

Some employees feel that work-family benefits increase the work component of the work-family balance – “A parent who isn’t forced to dash away at 5 pm to fetch a child from a day care center across town can squeeze in an extra hour of work before dashing down to pick up the child at an on-site day care facility” (Stamps, 1997, p. 43). This may be confirmed by one manager’s report that a family benefits policy has allowed his company to increase production without increasing the workforce – clearly more work is being done by these employees in exchange for benefits which supposedly enhance their quality of family life (Unknown, 1997).

However, a more balanced view suggests that companies who initiate work-family policies “pursue a double agenda in the workplace – one that considers both the employer’s and the employee’s needs – which not only eases employees’ lives but also leads to enhanced productivity and other tangible business benefits” (Starcke, 1997, p. 56). A colleague of mine came to refer to this as symbiosis (Heinrich Potgieter, personal communication, January 25, 2001).

5.3 CONCLUSIONS

Work-life policies are certainly not theoretically or empirically grounded in resilience theory. Nevertheless, they have a number of qualities that suggest that they could be used as a prototype of a new generation of resiliency-based policies.

At the end of section 5.1, a set of six key ingredients of resilience-based policies were presented, based on the six papers on the subject. The discussion on work-life policies presented above can be critiqued in relation to these six ingredients:
Policies must move from a deficits emphasis to a strengths emphasis. Many or most of the work-life policies and initiatives described do just this. Although the provision of Employee Assistance Programmes and other similar counselling and remedial services fall within the ambit of work-life policies, they certainly do not make up the work-life arena. Many of the work-life policies attempt to bring out the best in employees and employers/supervisors, both at home and at work.

Policies must create environments that are conducive to healthy resilient families. Although the policies under discussion are workplace policies, they contribute to family healthy resilient families by reducing work-to-family conflict, role overload and spillover, and by improving the demand-capacity balance. In effect, they create a social system in which there is a better fit between families and workplaces.

Policies must incorporate resilience research that identifies protective community factors. Although work-life policies are not consciously linked with resilience theory and research, there is some attempt to create a community/workplace environment that is conducive to healthy individuals, families and work teams. The research on work culture detailed in section 5.2.3.3 indicates the awareness among many companies that was is required is not merely a number of programmes that support families, but a fundamental, second-order shift in the work environment in which workers spend half their waking hours.

Policies must focus on the development of all families, not exclusively on vulnerable families. EAP services focus almost exclusively on vulnerable families, but work-life policies as a whole provide services to all families, not just vulnerable families. The mood of most of the literature I have studied on work-life policies suggests a sense of developing all employees into healthy, well-rounded, happy, productive, fulfilled individuals and family members. The tone is not primarily one of fixing up or helping families that are falling apart or experiencing difficulties.

Policies must be flexible, must involve the participation of its clients and must cater for the diverse range of family types, cultures, norms, etc. Many of the work-life initiatives are quite liberal in their understanding of families – many promote men as fathers, many attend to the acquisition of children through adoption and not only through birth, many attend to same sex couples. Section 5.2.3.2 on men and childless adults did, however, indicate the tendency of work-life initiatives to devolve to work-family initiatives, effectively excluding and even prejudicing
people who are not part of a family system or who do not have children. That section concluded with the remark that work-life initiatives would need to broaden their conception of family even further.

- The degree to which the participation of employees and families in the development of work-life policies and initiatives is promoted is not clear from the literature. Clearly, resilience-based policies, even in the workplace, would require a community development approach, in which employees are able to contribute to shaping the nature of the policies that are implemented for their benefit.

- **Policies must aim both to create experiences that promote resilience and to reduce experiences that create vulnerability.** There is probably a tendency for work-life policies to concentrate more on reducing vulnerability-creating experiences than promoting resilience-creating experiences. Child and elder care facilities and family-related leave are principally concerned with giving employees the opportunity to restrict the development of family problems. These initiatives serve to help families that have problems prevent these problems from getting larger or more intrusive in the workplace.

- Other initiatives, such as alternative working arrangements, education and wellness programmes and benefits such as time off for volunteer work or on-site gym facilities, probably are more effective in promoting resilience. These policies serve to enhance the quality of life of employees regardless of whether there is any kind of risk or not. As such, they can be considered primary prevention interventions.

As the field of resilience theory develops to larger systems (from individual and family, through to community, workplace and society) it is likely that the field of resilience-based policy will also develop. Considerable effort will be required to develop the conceptual frameworks that have evolved at individual and family levels to these higher levels. It is hoped that this exploration of work-life policies will provide a platform to advance this thinking.
6.1 INTRODUCTION TO RESILIENCE THEORY IN SOCIAL WORK

There is a popular perception among many social workers that the social work profession is grounded in a resilience perspective, even if not called by that name. A review of social work history and theory will, however, indicate that this is not the case. Despite frequent references to client strengths and resources, social work theory remains dominated by a pathogenic paradigm.

My experience of working with many social workers and my own training as a clinical social worker indicate that social workers are most comfortable assessing and intervening with client pathology. Social workers often lack the conceptual and technical tools to assess strengths or to intervene to enhance the resilience of their clients.

A number of social workers are, however, promoting a resilience perspective in social work. Notable among these are Dennis Saleebey, Michael White and Steve De Shazer. These social workers are attempting to create paradigms, conceptual frameworks, assessment tools and intervention models that promote resilience and strengths in social work clients.

6.2 HISTORICAL TRENDS IN SOCIAL WORK THEORY & PRACTICE

Social work’s commitment, as a profession, to resilience and strengths has a chequered history. At face value one may think social work has always thought and worked within a resilience framework, even if it was without calling it by that name (Kaplan et al., 1996; McQuaide & Ehrenreich, 1997). However a review of the development of social work theory will demonstrate a large degree of inconsistency (Weick & Saleebey, 1995). Broadly speaking, social work’s origins included a commitment to developing client strengths. Social work’s desire to gain status in the professional community led to an alliance with psychoanalysis with its pathogenic worldview. Only more recently, with the
emergence of the ecological perspective, has social work begun to reclaim its strengths-based roots. Even today, however, social work is inconsistently committed to a resilience framework.

Social work’s first roots lie in the Charity Organization Society and the Settlement House Society at the end of the nineteenth century. Industrialisation at that time, combined with the waves of immigrants to the USA, resulted in greater levels of social pathology than seen before – unemployment, child abuse, homelessness, poverty (Weick & Chamberlain, 1997). Workers (not social workers as such, because the profession had not yet been formed) had to develop innovative ways to meet these challenges. Family and community oriented interventions evolved, and social workers placed themselves strongly at the interface between family and community (Weick & Saleebey, 1995).

These early workers, however, introduced the first inconsistencies regarding social work’s position on the issue of resilience. The workers from the Charity Organization Society, a religious organisation, attributed social problems to individual-level moral deficits (Bendor, Davidson, & Skolnik, 1997), and the social work profession followed accordingly (Weick, Rapp, Sullivan, & Kisthardt, 1989):

Poverty was attributed to drunkenness, intemperance, ignorance, and lack of moral will. ... Change was to come about not through provision of monetary assistance but through persuasion and friendly influence. The emphasis on human failing as a cause of difficulties established a conceptual thread whose strands are found in practice today. (p. 350)

By contrast, the workers from the Settlement House Movement emphasised environmental factors as causative of social pathology (Bendor et al., 1997). They “believed that resources such as housing, sanitation, education, neighborly assistance, and enriched social interactions would enable people to move beyond the limits of their situations” (Weick et al., 1989, p. 350).

To the extent that the Settlement House Movement workers focused on environmental factors influencing the functioning of individuals one can say that the foundations of community work were laid. This focus removed the pejorative view of individuals as dysfunctional, but simply transferred the deficit and pathology oriented perspective to the community level. It cannot be said that either of these approaches was based in some conception of resilience or strengths.

Nevertheless, both approaches provided fairly ‘matter-of-fact’ approaches to people’s problems, addressed the challenges of coping with daily life, advanced a community and family based approach to helping, were willing to engage more closely with people and...
identified social factors which influenced human functioning (Weick & Chamberlain, 1997; Weick et al., 1989).

In the first decades of the twentieth century social work began a process of professionalising, with the influence of Mary Richmond being felt particularly strongly. Richmond advocated a more empirical, rational or scientific approach to helping, rather than a moral or intuitive approach. “Through her efforts, increasing attention was paid to defining the problems in people’s lives so that a rational, rather than a moralistic, strategy of intervention could be pursued” (Weick et al., 1989, p. 350). In Richmond’s work the individual perspective continues to dominate, but the tone is less moralistic or deficit oriented (Bendor et al., 1997). Richmond advocated the need to assess both pathology and strengths or resources. This attempt at achieving a balance was not very successful however (ibid.):

A review of Richmond’s suggestions reveals only one question out of hundreds that suggests a view to capacity, when in speaking of the “homeless man,” she asks under “Plans for the Future,” what does he look back upon as his best period? What marks of it still remain, such as cleanliness, for example? (1917, p. 428). (p. 4)

During the 1930s, as social work strove for greater status in the professional community, the psychoanalytic theory that was prevalent at the time was strongly incorporated into social work theory (Bendor et al., 1997; Weick & Chamberlain, 1997; Weick et al., 1989). Freudian theory provided a strong theoretical foundation to social work, provided the much-needed empirical framework that Richmond strove for, and allowed social workers to speak a language that was respected in the professional community. However, it also created greater distance between client and worker and introduced an extraordinarily complex set of explanations for human behaviour that had previously been simple and easily understood (Bendor et al., 1997; Weick & Chamberlain, 1997; Weick et al., 1989). In addition, the influence of psychoanalysis shifted social work’s attention strongly to intrapsychic explanations as the cause of social problems and permeated social work thinking with a pathogenic perspective.

The psychosocial casework models of Hamilton and Hollis in the 1950s and 1960s attempted, through the incorporation of the person-in-environment concept (Hollis & Woods, 1981), to promote an approach to social work that (1) focused on both individual and environmental problems and (2) focused on both weaknesses or deficits and strengths (Bendor et al., 1997). However, both authors tended to emphasise most strongly the individual as a locus of change and neither author provided guidelines on how to assess client strengths and resources (ibid.).
Perlman’s problem-solving model of casework initiated the movement of social work towards a greater appreciation of strengths and resilience (Bendor et al., 1997):

Perlman was able to teach the use of strengths in helping clients solve problems (1975). The client became a copers and a learner, and action became a helping tool. The concept of coping itself implied a strengths potential when defined as “a person’s conscious, volitional effort to deal with himself and his problem in their interdependence” (Perlman, 1975, p. 213). (p. 6)

Bendor (1997, p. 6) concludes that “historically, it appears that the broader the view of the person-in-situation and the more multi-dimensional the causal elements in the problem situation, the more likely that the person is perceived from a stance which incorporates strengths.” Social work theories and models which have evolved over the past few decades tend to provide a greater opportunity for the incorporation of a strengths or resilience perspective: Germain and Gitterman’s life model, Shulman’s interactional model, Middleman and Goldberg’s structural model and Pincus and Minahan’s systems model (Bendor et al., 1997). These models all integrate more strongly the person and environment components of social work interest, and provide a more holistic and system oriented explanation for human functioning. Consequently, there is more scope to address not only the causes of problems but also the causes of healthy functioning.

Recent models and theories of social work practice, such as the strengths perspective and the narrative approaches, are explicitly committed to a resilience framework and have recognised the dangers of a dominant pathogenic paradigm.

### 6.3 The Strengths Perspective

The strengths perspective is a new or consolidated paradigm for social work theory and practice, in which the focus is on the strengths and capacities of clients, rather than the problems of clients (Saleebey, 1997d). In effect, the strengths perspective is social work’s version of Antonovsky’s salutogenesis – both emphasise the origins of strength and resilience, and both argue against the dominance of a pathogenic or problem-focused perspective.

Strengths can be described as follows (McQuaide & Ehrenreich, 1997):

The capacity to cope with difficulties, to maintain functioning in the face of stress, to bounce back in the face of significant trauma, to use external challenges as a stimulus for growth, and to use social supports as a source of resilience. (p. 203)
The list of strengths is lengthy – many of the factors that can qualify as strengths have been highlighted in the previous chapters of this document. Saleeby (1997c) has identified several groups of strengths, including:

- What people have learned about themselves, others and their world, ... personal qualities, traits, and virtues that people possess, ... what people know about the world around them, ... the talents that people have, ... cultural and personal stories and lore, ... pride, ... [and] the community. (pp. 51-52)

### 6.3.1 The Problems with Problems

The pathogenic paradigm in social work has, according to Saleeby (1997b), several consequences:

- **The person is the problem or pathology named** (Saleebey, 1997b, p. 5). Once a person has been given a label (such as having schizophrenia), the person becomes defined by that label (now the person is just a schizophrenic) and consequently all that person’s experiences, feelings, desires, etc become defined in terms of that label. “When the cause of a problem is defined, the problem exists in a new way. The process of naming something heretofore unnamed creates it as a reality toward which therapeutic effort must be directed” (Weick et al., 1989).

- **The voice of the problem/deficit orientation speaks the language of ‘base rhetoric’** (Saleebey, 1997b, p. 5). Base rhetoric, as opposed to noble rhetoric, refers to the kind of professional talk (or rhetoric) that disempowers people by robbing them of the control over their own lives and the power to change. This rhetoric can become a self-fulfilling prophecy.

- **Distance, power inequality, control, and manipulation mark the relationship between helper and helped** (Saleebey, 1997b, p. 6). The use of complex, pathologising terminology to ‘formulate a case’, the use of a complex and jargon-filled diagnostic system and the use of sophisticated treatment modalities create a schism between the client and social worker, with the workers having power over the client.

- **Problem-based assessment encourage individualistic rather than ecological accounts of clients** (Saleebey, 1997b, p. 6). Contextual issues influencing a client become lost when the focus is on the pathology of the client. Furthermore, the uniqueness of the individual him or herself also become lost in the generic label that
has been attributed to the person and the individual experiences must be fitted into the label (Weick et al., 1989).

❖ “The focus on what is wrong often reveals an egregious cynicism about the ability of individuals to cope with life or to rehabilitate themselves” (Saleebey, 1997b, p. 6). The preoccupation with pathology leads to a sense of hopelessness in the social worker and a belief that individuals are unable to truly change.

❖ “The supposition of disease assumes a cause for the disorder and, thus, a solution” (Saleebey, 1997b, p. 6). The belief that knowing the problem explains the cause and presents the solution is not true. In many cases, the cause is irrelevant to the solution (Weick et al., 1989).

Saleebey’s critique of the pathogenic perspective in social work is somewhat sweeping. Given that most social work models are largely pathogenic, his critique would imply that most social workers are toxic to their clients. Perhaps it is fairer to argue that a strongly pathogenic approach restricts the development of clients, and that a more explicit theory of strengths needs to be developed and integrated into social work theory.

6.3.2 **PRINCIPLES OF THE STRENGTHS PERSPECTIVE**

Various authors within the strengths perspective field have identified principles of the strengths perspective, in order to unpack what is meant the perspective. Key principles follow:

❖ “Every individual, group, family, and community has strengths” (Saleebey, 1997b, p. 12). This first principle, as with many of those that will follow, reflects a belief or attitude that the social worker must have in order to work from a strengths perspective (Bricker-Jenkins, 1997). According to Holmes (1997) the strengths perspective is not so much about our clients as about us as social workers and how we see our clients. Fundamentally the strengths perspective is a belief system that says that, while they may also have problems, people are people who have strengths and abilities and a capacity for growth and change and with much to teach others (Kisthardt, 1997; Weick et al., 1989). According to Saleebey (1997b):

> Clients want to know that you actually care about them, that how they fare makes a difference to you, that you will listen to them, that you will respect them
no matter what their history, and that you believe that they can build something of value with the resources within and around them. But most of all, clients want to know that you believe they can surmount adversity and begin the climb toward transformation and growth. (p. 12)

- I have witnessed the work of Michael White (a social worker whose narrative therapy approach will be described in a later section of this chapter) during one of his visits to South Africa. One of the main conclusions one can draw is that he wills his clients to get better by his incredibly strong belief in their capacity to grow.

- “Trauma and abuse, illness and struggle may be injurious but they may also be sources of challenge and opportunity” (Saleebey, 1997b, p. 13). This argument is identical to Antonovsky’s (1979) that stressors are ubiquitous and not necessarily destructive but even promotive and also picks up on the notion of thriving (Ickovics & Park, 1998b) discussed in a previous chapter. Weick and Chamberlain (1997, p. 45) argue that a client’s problems should not occupy centre stage, but should rather take the role of “minor characters with small roles”. They explain that “although some problems are too critical to be ignored, they need to be consigned to a position secondary to the person’s strengths once a crisis has passed” (ibid., p. 44).

- The person’s problem does not constitute all of a person’s life and focusing excessively or exclusively on problems can result in more problems, not less. Consider the example of a person with a specific problem and who needs counselling. Many other people may have the same problem and not need counselling. So the problem is not the problem. The focus need not be so much on the problem itself as on the factors around the problem that influence how the problem is perceived and handled.

- “By placing an emphasis on the already realized positive capacities of an individual, the individual will be more likely to continue development along the lines of those strengths” (Weick et al., 1989, p. 353). The strengths perspective does not argue against addressing problems. Rather it argues that by highlighting the strengths that a person with a problem has already demonstrated there is a greater likelihood that the person will not only maintain those strengths but also develop new strengths. In this process of developing strengths, the problem frequently disappears. By contrast, highlighting the problems of a person with strengths tends to result in a weakening of the person’s confidence and a deterioration of those existing strengths.
“Assume that you do not know the upper limits of the capacity to grow and change and take individual, group, and community aspirations seriously” (Saleebey, 1997b, p. 13). Once a client has been given a diagnosis, a prognosis is often implied. Knowing that a person has a personality disorder or bipolar disorder may lead to the social worker’s belief that growth is not possible or that growth is severely restricted. It is, however, probably true that the perceived level of potential growth sets the upper limit for actual growth. The greater the potential growth perceived, the greater the possibility for actual growth. It is thus important that the social worker working from a strengths perspective believe in virtually unlimited growth and allow themselves to be surprised by the growth potential of clients.

“We best serve clients by collaborating with them” (Saleebey, 1997b, p. 14). The independence of a worker from a client is replaced with interdependence – there is a quality of mutuality and collaboration in the helping process that is often absent when working from a pathogenic orientation (Kisthardt, 1997). According to Saleeby (1997b):

The role of “expert” or “professional” may not provide the best vantage point from which to appreciate clients’ strengths and assets. A helper may best be defined as a collaborator or consultant: an individual clearly presumed, because of specialized education and experience, to know some things and to have some tools at the ready but definitely not the only one in the situation to have relevant, even esoteric, knowledge and understanding. (p. 14)

The client’s narrative or story is the most important story and the social worker’s role is to collaborate with the client to achieve the greatest growth potential of the client.

“Every environment is full of resources” (Saleebey, 1997b, p. 15). Saleeby argues that, even in the poorest of communities, there are resources and that these resources are frequently unrecognised and untapped (see also Kisthardt, 1997). While he is neither arguing that communities should be seen as equally rich in resources nor advocating that community work be abandoned, he is arguing that, in the meantime, clients can draw on resources in the community that may have previously been overlooked. In some ways, this principle is akin to the belief in the growth potential of clients, with the client here defined as the community – no matter how barren a community may feel itself or appear to be, it still has resources which can be of mutual benefit to its members.

“People have the capacity to determine what is best for them” (Weick et al., 1989, p. 353). This principle is similar to the social work value of client self-determination, but with a difference. There is often a tendency to think of client self-
determination as the right of clients to disregard the good advice of social workers even if it means hurting oneself. The principle advance here by Weick et al indicates a belief in the innate wisdom of people to know what is best for themselves. The social worker endeavours to mobilise this wisdom to the benefit of the client.

“People do the best they can” (Weick et al., 1989, p. 353). According to the strengths perspective there is no one correct way for people to live or grow. Each person, family or community will find their own best way that works for them. The social worker’s job is to help them achieve this and to attribute the label of success to the achievement.

6.3.3 THE STRENGTHS PERSPECTIVE IN PRACTICE

6.3.3.1 Assessment of Client Strengths

Working from the strengths perspective must begin from the first contact between worker and client. The assessment process is a critically important phase of the helping process. Many of the writers on the strengths perspective argue that the assessment should focus “exclusively on the client’s capabilities and aspirations in all life domains” (Weick et al., 1989, p. 353).

Other writers, however, argue that an exclusive focus on strengths will not meet the client where s/he is and may lead the client to believe that the worker will tolerate only success and strength (McQuaide & Ehrenreich, 1997). The premature asking of strength related questions might lead the client to feel misunderstood and even manipulated. The process of moving a client from the ‘problem-saturated story’ towards an appreciation of strengths may be part of the process of intervention itself (as will be discussed in the section on narrative therapy, Section 6.4).

Assessing client strengths requires a different repertoire of assessment questions (Weick et al., 1989):

Instead of asking, “What’s wrong with this family?” the question becomes, “What are the strengths in this family that will help them grow and change?” Instead of asking, “Why is this person mentally ill or delinquent or abusive?” the question can be, “What do they need to develop into more creative and loving adults?” (p. 354)

Saleeby (1997c, pp. 53-54) highlights five kinds of strength oriented question styles:
“Survival questions. How have you managed to survive (or thrive) thus far, given all the challenges you have had to contend with? How have you been able to rise to the challenges put before you? What was your mind-set as you faced these difficulties? What have you learned about yourself and your world during your struggles? Which of these difficulties have given you special strength, insight, or skill? What are the special qualities on which you can rely?

“Support questions. What people have given you special understanding, support, and guidance? Who are the special people on whom you can depend? What is it that these people give you that is exceptional? How did you find them or how did they come to you? What did they respond to in you? What associations, organizations, or groups have been especially helpful to you in the past?

“Exception questions. When things were going well in life, what was different? In the past, when you felt that your life was better, more interesting, or more stable, what about your world, your relationships, your thinking was special or different? What parts of your world and your being would you like to recapture, reinvent, or relive? What moments or incidents in your life have given you special understanding, resilience, and guidance?

“Possibility questions. What now do you want out of life? What are your hopes, visions, and aspirations? How far along are you toward achieving these? What people or personal qualities are helping you move in these directions? What do you like to do? What are your special talents and abilities? What fantasies and dreams have given you special hope and guidance? How can I help you achieve your goals or recover those special abilities and times that you have had in the past?

“Esteem questions. When people say good things about you, what are they likely to say? What is it about your life, yourself, and your accomplishments that give you real pride? How will you know when things are going well in your life – what will you be doing, who will you be with, how will you be feeling, thinking, and acting? What gives you genuine pleasure in life? When was it that you began to believe that you might achieve some of the things you wanted in life? What people, events, ideas were involved?” (Saleebey, 1997c, pp. 53-54)

Cowger (1997, pp. 63-66) provides 12 guidelines for assessing client strengths, briefly stated:
The client’s understanding of the facts and perception of their situation is most important.

Believe what the client says, and assume that the client is honest and trustworthy.

Discover what the client wants from the helping relationship and in relation to the presenting problem.

Move the assessment from the problem towards personal and environmental strengths.

Make the assessment of strengths multidimensional, including, among others, the client’s interpersonal skills, motivation and emotional strengths, the environment’s family networks, organizations, community groups, etc.

Discover the uniqueness of the client through the assessment, rather than discovering only how they fit into a generic category.

Use language the client can understand.

Conduct the assessment collaboratively, as a joint effort between client and worker.

Reach mutual consensus on the results of the assessment.

Avoid blaming.

Avoid linear cause-and-effect thinking.

Assess the client’s situation – do not diagnose the client’s ‘problem’.

Cowger (1997, p. 68) advocates a four-quadrant assessment framework, in which the horizontal axis moves from environmental factors to personal factors, and the vertical axis moves from obstacles to strengths, as can be seen in the table below:

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<thead>
<tr>
<th>Quadrant 1: Environmental Strengths</th>
<th>Quadrant 2: Personal Strengths</th>
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<tr>
<td>Quadrant 3: Environmental Obstacles</td>
<td>Quadrant 4: Personal Obstacles</td>
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Cowger (1997, p. 68) advocates a four-quadrant assessment framework, in which the horizontal axis moves from environmental factors to personal factors, and the vertical axis moves from obstacles to strengths, as can be seen in the table below:
Using this framework provides a holistic and balanced assessment of the problems and strengths of an individual within an environment/situation. The strengths assessment would emphasise quadrants one and two, which are often missing or neglected in social work assessments (Cowger, 1997).

6.3.3.2 Intervention from the Strengths Perspective

Saleeby (1997c, pp. 54-56) provides a broad outline of the practice of strengths-based social work:

- Firstly, acknowledge the client’s pain. Although the worker is interested in the client’s strengths, the client arrives with a preoccupation with problems and pain. Beginning here allows time to gain a sense of the client’s concerns, allows the development of trust and gives an opportunity to search out the “seeds of resilience”.

- Secondly, “stimulate the discourse and narratives of resilience and strength”. The process of unearthing client strengths is a difficult one. When one is seeking for a strength narrative or story, rather than a superficial listing of strengths the process becomes even more complex. Considerable reframing by the social worker may be needed in order to assist a client in reinterpreting past events (Saleeby, 1997c):

  In a sense, then, the stimulation of a strengths discourse involves at least two acts on the part of the worker: providing a vocabulary of strengths (in the language of the client), and mirroring – providing a positive reflection of the client’s abilities and accomplishments, and helping the client to find other positive mirrors in the environment. (p. 55)

- Third, the client must begin to act on their new understanding of their own resilience and strength, and begin to expand upon these.

- Fourth, the newly discovered strengths must be reinforced, consolidated and integrated into the client’s behaviour, self-image and relationships. Once this is done, termination can take place.

The strengths perspective literature provides various case studies of its application with various client groups, including clients who are alcoholics (Rapp, 1997), clients who are mentally ill & homeless (Kisthardt, 1997), the aged (Fast & Chapin, 1997), children in schools (Benard, 1997), and adolescents at risk of substance abuse (Kaplan et al., 1996).
6.3.4 Debates About the Strengths Perspective

Saleeby (1996; 1997e) advances several critiques of the strengths perspective and provides rebuttals to the critiques. These debates are helpful to understand the strengths perspective:

- **The strengths perspective is positive thinking in a new form.** According to Saleeby (1996, 1997e) the strengths perspective involves more than teaching oneself new thought patterns through the repetition of mantras. It involves working towards profound and lasting transformation.

- **The strengths perspective simply reframes people’s pain and minimizes their problems without actually changing anything.** According to Saleeby (1996, 1997e) the strengths perspective acknowledges pain and problems, but also reframes them in order to discover the value of certain problems and in order to realise that life is not made up exclusively of pain.

- **The strengths perspective is naïve, ignoring the fact that many clients are manipulative.** According to Saleeby (1996, 1997e) the strengths perspective demands that social workers give the client a chance before making judgements about the manipulativeness or danger of the client. Every client is given the chance to grow and change.

- **The strengths approach ignores people’s problems.** According to Saleeby (1996, 1997e) the strengths perspective acknowledges the fact that clients have problems, but does not allow this to become the whole story. The focus is on how the client can cope in spite of or transcend that problem, in the belief that when this is achieved the problem often disintegrates or becomes peripheral.

- **The strengths approach is redundant because social workers already assess and work with client strengths.** According to Saleeby (1996, 1997e) social work assessment reports are dominated by pathology and the strengths assessment is frequently relegated to a few lines at the end. A strengths perspective is not the dominant mode of thinking for most social workers.
6.3.5 **Conclusions about the Strengths Perspective**

In my opinion, the strengths perspective cannot, as yet, be considered either social work theory or a model of social work practice. Most of the practice components have been cannibalised from the narrative and solution-focused therapies to be discussed in the following section and the theory is very insubstantially based on constructivism. At best the strengths perspective can be thought of firstly as political rhetoric and secondly as a framework for pulling together fragmented theories and models under a common umbrella. And yet both of these are valuable in their own right.

Firstly, there is certainly a great need in social work for an evaluation of the degree to which we succeed in actually empowering clients. The argument of the strengths perspective is that social work is preoccupied with pathology, even though such a preoccupation is actually against the stated values of our profession. Saleeby and his colleagues contribute by drawing our attention to what is important in social work, to what makes (or should make) social work unique from other helping professions, to the value base of social work. In a way, it is a form of self-confrontation and self-therapy.

I have been introducing an integrated assessment framework into the organization where I work (the South African Military Health Service). The framework includes both vulnerabilities and strengths. The social workers, despite avowing that they have always assessed strengths, demonstrate great difficulty in conducting strengths assessments. Yet their assessments of vulnerability are lengthy and often quite sophisticated. Clearly, social workers have not been given the conceptual frameworks and practice tools to adopt a strengths perspective. In this way, Saleeby’s contributions are timely.

Secondly, there is a great deal written in various literatures on resilience and strengths, as this document testifies to. But these writings tend to be quite fragmented and many authors seem unaware of what others are writing. Writers on resilience are also emerging from various professional backgrounds – psychology, social work, nursing, anthropology, medical sociology, sociology, etc. The strengths perspective could serve as an umbrella for these pieces of the bigger picture. Saleeby (1996, 1997b) often refers to the concepts of health, resilience, empowerment, healing and wholeness, narratives, etc.
6.4 THE NARRATIVE & SOLUTION-FOCUSED THERAPIES

It can be argued that much of resilience theory, as covered in this review, has little practical application. Certainly, it is very difficult to translate certain aspects of resilience theory into the clinical field. Social work, with its emphasis on practice more than theory, has generated a number of practice approaches that give expression to resilience theory and the strengths approach. Most notable of these are the narrative therapy of Michael White (an Australian social worker) and the solution-focused therapy of Steve De Shazer (an American social worker).

Michael White’s narrative therapy (1989a, 1989b, 1989c, 1992) is grounded partly in social constructivism and partly in resilience theory. Social constructivism introduces principles such as reality is socially created or constructed and has no objective existence, taken-for-granted ‘realities’ must be challenged and reconstructed, new ‘realities’ can be created out of the neglected pieces of experience from the past that did not fit with the past ‘realities’, and ‘reality’ is created largely through a process of narrative or story construction (White, 1992).

It is not my intention to provide a thorough review of White’s work, since this goes far beyond the scope of this already lengthy document and will require a detailed introduction to social constructivism. Rather, I wish merely to note that White has managed to translate some of the resilience concepts into practice.

In essence, White argues that people live their lives by stories or narratives that they have created through their life experience and which (very importantly) then serve to shape and guide their further life experience (White, 1992). A narrative is considered to have two landscapes, viz a landscape of action and a landscape of consciousness. The landscape of action comprises “(a) events that are linked together in (b) particular sequences through the (c) temporal dimension –through past, present and future – and according to (d) specific plots” (ibid., p. 123). The landscape of consciousness comprises the meanings and interpretations of the narrative, through reflection.

When people come to therapy for help, they typically arrive with a “problem-saturated description” of the family narrative (White, 1989a, p. 5) – in resilience terms, one could say that the family has a pathogenic view of themselves. When a family is dominated by a problem-saturated description or narrative, only facts that are consonant with the narrative are perceived – other facts are simply not seen. In many senses, therefore, the family is dominated or subjugated by this narrative. There is however a second
story available to the therapist, namely the story comprising the invisible facts. Narrative therapy is a process of deconstructing the problem-saturated story and constructing an alternative solution-saturated story – a kind of salutogenic view of themselves.

The process involves the following broad steps:

- Firstly, the presenting problem is externalised. A feature of the problem-saturated story is that the problem is seen as located within and inseparable from the index client. "The externalizing of the problem enables persons to separate from the dominant stories that have been shaping their lives and relationships" (White, 1989a, p. 7). Externalising a problem places it "out there", thereby giving the person a greater opportunity to relate to it in a critical fashion, which enables the deconstruction of the problem. White has developed a sophisticated repertoire of questions that are used to externalise problems (White, 1989b).

- Secondly, now that the problem is external, the therapist begins to explore the family's relationship with the problem, both the influence that the problem has over the family and the influence that the family has over the problem (Nichols & Schwartz, 1991; Tomm, 1989). Most notably, the family begins to discover the lost facts – facts that were lost because they were discordant with the dominant, pathogenic story. White terms these facts "unique outcomes" because they are outcomes which one would not expect in terms of the dominant story (White, 1989a, 1992). As with the externalisation of the problem, the unique outcomes are elicited through a process of structured questioning (White, 1989b).

- Thirdly, once a number of unique outcomes have been generated, the therapist begins to piece these outcomes together into a new landscape of action. Various questions (landscape of action questions) are used to weave the unique outcomes together into a story. Other questions (landscape of consciousness questions) then "encourage persons to reflect on and to determine the meaning of those developments that occur in the landscape of action" (White, 1992, p. 127).

- Through this process of reauthoring, an alternative story, a salutogenic story, which is often more powerful than the problem-saturated story, is constructed. This is not simply a process of pointing out the positives or of positive thinking, but is rather a process of creating an entirely new paradigm comprising pieces of information that have not been perceived previously (White, 1992).
White (and some of his colleagues) have documented dozens of case studies concerning the use of narrative therapy with various client groups, including grief, schizophrenia, encopresis, family violence, etc (Epston & White, 1992; Jenkins, 1990; White, 1989c).

Steve de Shazer’s solution-focused therapy (De Shazer & Berg, 1988; Nichols & Schwartz, 1991) has much in common with Michael White’s narrative therapy, and is also based on constructivism and is an expression of resilience theory. De Shazer’s point of departure is that there is little therapeutic value in analysing problems, that problem solving models of intervention are thus inappropriate and that the notion of problem symptoms being manifestations of underlying problems or causes is unhelpful (ibid.).

Therefore, instead of assessing how problems develop, solution-focused therapy advocates the assessment of how solutions develop (De Shazer & Berg, 1988). There is consequently nothing in solution-focused therapy about how problems develop, about ‘normal’ human or family development, etc (Nichols & Schwartz, 1991). De Shazer and Berg (1988, p. 42) state, “We once thought that solutions evolved from changing (eliminating, modifying) the problematic pattern. Now we think that solutions develop out of amplifying non-problematic patterns without attempting to determine what caused the problem.”

De Shazer and his colleagues developed and tested various ‘formula tasks’, that is, tasks which are prescribed to all families and which are demonstrated to have universal value (De Jong & Miller, 1995; Nichols & Schwartz, 1991, p. 483). Key tasks include:

- Asking “clients to observe what happens in their life or relationships that they want to continue” (Nichols & Schwartz, 1991, p. 483).

- The “miracle question”, viz “Suppose one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different?” (Nichols & Schwartz, 1991, p. 483).

- The “exception question”, which explores time in the past or present when the person did not have the problem at a time when s/he should have had the problem (Nichols & Schwartz, 1991) – a technique parallel to White’s seeking out unique outcomes.

Although clearly narrative and solution-focused therapy are more than just operationalisations of resilience theory – the powerful place of constructivism is critical – both embrace many of the principles of resilience theory (De Jong & Miller, 1995). They place problems and pathology in a secondary perspective, external from the individual.
They assume that hidden inside the most pathological narrative there are instances of strength and resilience. They seek to weave these instances or unique outcomes into a story of victory and strength over the problem – a story of resilience. They do not deny the problem or even deal directly with it, but rather find ways to strengthen the ability of the family or individual to be resilient in the face of the problem, thereby reducing the problem in actual terms or in terms of influence.

6.6 CONCLUSIONS

The conclusions of a number of the previous chapters have indicated the difficulties with translating resilience theory into clinical practice. This chapter continues with this observation. The work of White and De Shazer, while producing strong clinical models, is not explicitly located within a resilience framework. The work of Saleeby on the Strengths Perspective in social work provides few clinical implications beyond those already developed by White and De Shazer. Saleeby’s writings contribute most valuably by requiring social workers to think in a different way about themselves and their clients.

In addition to these reservations about the clinical application of resilience theory in social work, I am also concerned about the lack of attention paid to clinical work other than individual or family therapy. There are very few contributions in social work literature to the application of resilience theory to group and community work. Saleeby’s writings imply that the strengths perspective is closely related to community work, but in fact, all the case studies and examples provided in his writings and those of his colleagues are focussed on therapeutic issues.

Clearly, a great deal of further work is required of social workers to explore and integrate resilience theory into the profession. Given the history of social work, it is likely that such an integration will be appropriate but conflictual.
CHAPTER SEVEN: CROSS-CULTURAL PERSPECTIVES ON RESILIENCE

The place of resilience theory in cross-cultural writings is unclear. Literature on the subject is sparse and there has been no real effort to define what is meant by cross-cultural resilience or cultural resilience. Nevertheless, the notions of strength and resilience do emerge in cross-cultural literature. Many of these references have a somewhat political tone, in which writers argue that Black culture is not inherently pathological, but is determined to be pathological when assessed according to White or western paradigms (see Stevenson & Renard, 1993). These writers argue that there are various unique strengths and resiliencies in African families, many of which grew out of decades and centuries of oppression.

Undoubtedly, there is a shift in some cross-cultural thinking from a pathogenic to a salutogenic perspective. This is accompanied with a greater respect for diverse forms of resilience and the ways in which whole cultures have been resilient in the face of adversity or have even thrived – linking with the previous chapter on community level resilience (Littlejohn-Blake & Darling, 1993; Sonn & Fisher, 1998; Sullivan, 1997). The importance of cultural identity or ethnic schema has been highlighted as an important ingredient in resilience (McCubbin et al., 1998). The need for examining resilience within a sociological or power perspective has also been identified (Blankenship, 1998). There has, lastly, been some exploration of differences in resilience between cultures (Antonovsky, 1998a; Antonovsky, 1998b; Gomel, Tinsley, Parke, & Clark, 1998; Hanline & Daley, 1992; H.I. McCubbin & McCubbin, 1988; McCubbin et al., 1995a, 1995b; Reinsch, 1997).

Several writers have cited the importance of cultural identity as an important component of resilience in individuals, particularly individuals from minority or oppressed cultures (McCubbin et al., 1998, 1995a, 1995b). Having a healthy cultural identity requires identifying the innate cultural strengths in that culture. These strengths may or may not differ from the strengths of other cultures – the emphasis here is not comparative, but rather looking at features within individual cultures.

HeavyRunner and Morris (1997, p. 1) state, in relation to Native American cultures:
Our world view is the cultural lens through which we understand where we came from, where we are today, and where we are going. Our cultural identity is our source of strength. In historical times the cultures and world views of tribal peoples were regarded by non-Indians as impediments to the speedy assimilation of the young. Regrettably, remnants of such viewpoints continue to be held by some professionals who impact the lives of contemporary Indian youth. It is critical that researchers, educators, and social service providers recognize the valid and positive role culture plays in supporting Indian youth and tapping their resilience.

A culture’s world view is grounded in fundamental beliefs which guide and shape life experiences of young people. It is not easy to summarize fundamental Indian values and beliefs because there are 554 federally recognized tribes in the U.S. alone and an almost equal number in Canada. In spite of tribal differences, there are shared core values, beliefs, and behaviors. Ten are highlighted here to guide our thinking about innate or natural, cultural resilience: spirituality, child-rearing/extended family, veneration of age/wisdom/tradition, respect for nature, generosity and sharing, cooperation/group harmony, autonomy/respect for others, composure/patience, relativity of time, and non-verbal communication.

HeavyRunner and Morris (1997) argue that when these cultural values are taught, cherished and nurtured in children, these children develop natural resilience. This resilience is grounded in a healthy and respectful cultural identity.

In a similar vein, Stevenson and Renard (1993) argue that White therapists working with African American clients need to promote the “racial socialisation” of their clients (see Daly, Jennings, Beckett, & Leashore, 1996 for a similar perspective in social work). “Racial socialisation” is held to mean the interpersonal transmission of values about one’s culture. The authors argue that therapists need to nurture racial socialisation, so as to enhance the resilience and strengths of clients. In particular, the authors identify the African American cultural strengths of “dependence on helpful extended relatives, transmission of cultural childrearing values, influence of a religious worldview, and family communication about surviving societal racism struggles, educational achievement, and Black pride and culture” (Stevenson & Renard, 1993, p. 433). These strengths provide African Americans with the resources needed to survive oppression and to develop healthy and productive family systems.

Sudarkasa (1997, p. 30), regarding African American families, indicates the importance of “rediscovering and instilling the values that made it possible for these families to persist and prevail in the past.” African American families have endured great hardships over the centuries and yet have survived. Inherent in this survival is strength in the face of adversity, the foundation of resilience (Daly et al., 1996). The promotion of these values will contribute to the resilience of these cultures.
In particular, Sudarkasa (1997, pp. 32-38) highlights seven African American family values:

- **Respect.** Respect to people who are older or more senior.

- **Responsibility.** Believing oneself to be responsible for others, beyond one’s immediate family.

- **Reciprocity.** Giving back to one’s family and community in return for what has been received from them.

- **Restraint.** Putting one’s own needs on hold in order to accommodate the needs of others.

- **Reverence.** A reverence for God, for the ancestors, for spirituality.

- **Reason.** Working towards solutions through reasonable dialogue rather than impulsive action.

- **Reconciliation.** The importance of being reconciled with one’s neighbour.

Sudarkasa (1997) is not arguing that these values are present in all African American families. Rather, the author argues that these are historical values that enabled the survival of the first African families to come to America and which need to be recovered now:

These Seven R’s ... represent African family values that have supported kinship structures (lineages, compounds, and extended families) that have lasted for hundreds, even thousands, of years. The strength of these values is indicated by the fact that most of them were retained and passed on in America, thereby enabling African Americans to create and maintain extended family networks that sustained them here, just as their prototypes had sustained their ancestors on the African continent. Today, in the face of circumstances that threaten the existence of these extended family structures, a revival of the values that allowed them to persist could strengthen the family and community structures on which African Americans must depend in the twenty-first century.

The resilience of African American family values is evident in a study by McAdoo (1982, p. 250) in which it was found that Black families under high stress made greater use of extended family supports than Black families under low stress. However, this pattern continued for families that had moved into a higher socioeconomic bracket – they continued to make use of extended family support and often took on a supporting role for families ‘back home’.
The issue of cultural paradigm is important not only to members of various cultures, but also to researchers. The theoretical perspective of a researcher can influence the conclusions that researcher draws from the data, even from the same data, as Johnson (1997, p. 94-95) notes:

The works of Moynihan (1965) and Hill (1972) demonstrate the critical link between data and interpretive frameworks (see Johnson 1978). Although both analyzed the same U.S. Census data, they employed different theoretical perspectives and arrived at divergent conclusions. Moynihan reported a deteriorating Black family and recommended social policies that would encourage changes in the Black family’s structure and values. Hill observed the resilience of Black families and recommended social policies that could build on the strengths of Black family values and structure. Without arguing the validity of either conclusion, the importance of studying perspectives governing Black family research should be evident.

It would appear, therefore, that the resilience perspective might be valuable not only in directing the kinds of variables that are studied (strengths rather than pathologies), but also the kinds of interpretations given to research results (opportunities for growth rather than maintaining oppressive social systems).
8.1 INTRODUCTION TO DEPLOYMENT RESILIENCE

An area of resilience theory that has been extensively researched, and which forms the genesis and basis of much of the family resilience theory enjoyed today, is that of the resilience of military families during military deployments. Deployments (separations in the family due to military operations, missions, exercises, etc) place great stress on a family system (Knox & Price, 1995). Military members are often away from home for extended periods – among US military members who are married or have children, 26.1% report being separated from their families for 3-6 months and 16.2% for 7-12 months over the previous 12 months (Westat Inc, 1994, p. 5). Separations such as these threaten the entire family system and can cause complete fragmentation of the sense of ‘family’.

The Salutogenic Question. My research and clinical experience indicate that some families, exposed to the same deployment stressor, were able to cope better than others. I have termed this ability to cope, that is the ability to resist the stress of deployment, “deployment resilience” (Van Breda, 1997a, 1998b, 1998c, 1999a, 1999b). This is an application of the salutogenic question described in section 2.3.2, viz “Why, when families are exposed to the same deployment which causes some to break down, do some remain healthy?” The theoretical answer to this question is that these latter families are resilient to deployment stress, that they have deployment resilience. The research and clinical question in response to this is to identify what constitutes deployment resilience, that is, what are the factors that make families resilient to deployments. [Many US military family programmes are also based in the salutogenic paradigm, such as the wellness model (US Army Community and Family Support Center, 1994h, p. 11)].

Based on a literature review on military families and deployments conducted in the mid-1990s, I identified eight primary dimensions of deployment resilience (Van Breda, 1997a). On the basis of these dimensions I designed the Deployment Resilience Seminar (Van Breda, 1998a, 1999a), a one-day psychoeducational workshop for military couples aimed at enhancing their resilience to deployments or routine separations. The seminar was generally effective and has led to a greater refinement of the concepts of deployment resilience (ibid.).
Seven of the eight deployment resilience dimensions are located within the family system, while the eighth is located in the broader military system. This bias towards the family system was deliberate – I wanted to identify dimensions over which the family had control, rather than dimensions which, while influential, were beyond their control. The eight dimensions are as follows (Van Breda, 1999a, pp. 598-600):

- **Dimension 1: Emotional Continuity.** “This first dimension, emotional continuity, is defined as families having a reasonably stable emotional life over the cycle of a separation.”

- **Dimension 2: Positive Perspectives on Separations.** “The second resilience dimension is defined as the family’s positive attitude towards separations and the employing organization.”

- **Dimension 3: Support Systems.** “The third dimension is defined as the presence of support systems (viz family, naval, community and religious) for the family and employee.”

- **Dimension 4: Financial Preparation.** “The fourth separation resilience dimension is defined as the family having adequate financial resources during separations.”

- **Dimension 5: ‘Partner-Aware’ Family Structure.** “This fifth dimension of separation resilience is defined as the family having a ‘partner-aware’ family structure.”

- **Dimension 6: Resilient Children.** “The sixth dimension is defined as the family actively developing the separation resilience of their children.”

- **Dimension 7: Flexible Marriage.** “This sixth dimension, flexible marriage, is defined as a secure marriage in which partners are flexible in the allocation of gender roles and responsibilities.”

- **Dimension 8: Family-oriented Management.** “This last separation resilience factor is defined as the family-oriented management of the workforce and of separations.”

Much of the content of deployment resilience and my Deployment Resilience Seminar (Van Breda, 1998a) is based on indigenous knowledge or the wisdom of experience – the experience of military families. In Cline’s (1992) book for military wives, five pages of ‘tips’ from the ‘VMSC’ or ‘Veterans of Many Separations Club’ are provided. Here women
who have learned to cope with deployments provide ideas that have worked for them to those who are new to deployments or who have not yet learned to cope. In this way, they provide the solutions, strengths and resiliencies that they have discovered to others – a clear example of resilience theory in action.

**Work-Life/Family Interface.** Deployment resilience concepts are important not only for families (inasmuch as they point families towards greater resilience in the face of the stress of deployments and separations) but also for the military organisation (inasmuch as they promote the work-family interface and contribute to mission readiness) (US Army Community and Family Support Center, 1994h, p. iii). The notion of individual and unit readiness is widely discussed in the literature on military families that will be cited in this chapter.

Individual or soldier readiness can be defined as “the capability of an individual in an Army unit to perform so that the unit may accomplish the mission for which it is organized” (Kralj et al., 1988, in Bell, Scarville, & Quigley, 1991, p. 23). Individual readiness includes various dimensions, including the professional/military knowledge and skill of the soldier, cooperation, job discipline, etc (Sadacca & Di Fazio, 1991, p. 6). There is, however, a body of research indicating that family factors contribute to individual and unit readiness (Knox & Price, 1995; Sadacca, McCloy, & Di Fazio, 1992; Sadacca, McCloy, & Di Fazio, 1993). The notion of ‘deployment resilience’ is an umbrella term for these family factors.

Theoretically then, deployment resilience works two ways:

- Firstly, deployment resilience protects families from the negative impact of deployments, enhances family coherence and integration and promotes family adjustment at reunion.

- Secondly, deployment resilience enhances the individual readiness of the soldier by enabling soldiers to focus more fully on the mission in the knowledge that their families are healthy (US Army Community and Family Support Center, 1994h; Wright et al., 1995). This in turn enhances unit readiness, that is “the capability of an Army unit to perform the mission for which it is organized” (Sadacca & Di Fazio, 1991, p. 23).

Deployment resilience is thus also an application of work-family theory in the military context (Bowen & Orthner, 1989). For health professionals, such as social workers and psychologists, the first result of deployment resilience may be of greatest concern –
reducing the negative impact of deployments so as to protect family systems. For employers such as the military command structures, the second result of deployment resilience may be of greatest concern – ensuring the military’s bottom line, viz effective military missions. For professionals who intervene at the work-family interface, such as occupational social workers, it is the fact that deployment resilience works at both family and work levels that is of greatest concern – ensuring the goodness of fit between military families and the military organization.

Chapter eight will provide a detailed review of literature and theory regarding each of the eight deployment resilience dimensions. This will highlight not only the effects of deployments on families, but also the ways in which families can become resilient to deployment stress.

### 8.2 Emotional Continuity

“Emotional continuity is defined as families having a reasonably stable emotional life over the cycle of a separation” (Van Breda, 1999a, p. 598).

Families that are resilient to deployment stress report experiencing a fairly stable sense of well-being before, during and after deployments (Van Breda, 1997b). This is not to say that the family is unresponsive to the departure, absence and return of the military member. Rather, the family is able to retain a sense of emotional continuity in spite of this disruption, which sustains the family. The emotional and relational processes through which families go during deployments have been well described by Logan (1987).

Logan’s (1987) model of the Emotional Cycle of Deployment proposes a cycle of seven stages with each deployment, beginning some time before the deployment and ending some time after (see Table 8.1). It is termed a ‘cycle’ in that, with ships coming and going on a routine basis, the seven stages are constantly cycling. Each stage of the cycle can be described according to changes in the emotions of the people involved.
### Table 8.1 Emotional Cycle of Deployment in Peacetime

<table>
<thead>
<tr>
<th>Stage</th>
<th>Title of stage</th>
<th>Duration of stage</th>
<th>Characteristics of stage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>PRE-DEPLOYMENT PHASE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 1</td>
<td><em>Anticipation of loss</em></td>
<td>Four to six weeks prior to deployment</td>
<td>Crying, irritability, depression, marital conflict.</td>
</tr>
<tr>
<td>Stage 2</td>
<td><em>Detachment and withdrawal</em></td>
<td>Few days prior to deployment</td>
<td>Withdrawal, sexual tension, despair, hopelessness.</td>
</tr>
<tr>
<td></td>
<td><strong>DEPLOYMENT PHASE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 3</td>
<td><em>Emotional Disorganization</em></td>
<td>First six weeks of deployment</td>
<td>Adjusting, worry, irritability, depression, aimlessness, numbness, sleep disturbance, anger, guilt.</td>
</tr>
<tr>
<td>Stage 4</td>
<td><em>Recovery and stabilization</em></td>
<td>Middle of deployment</td>
<td>New life is established, independent, anxious, depressed, illness.</td>
</tr>
<tr>
<td>Stage 5</td>
<td><em>Anticipation of homecoming</em></td>
<td>Six weeks prior to return</td>
<td>Excitement, joy, apprehension, tension, nervousness.</td>
</tr>
<tr>
<td></td>
<td><strong>POST-DEPLOYMENT PHASE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 6</td>
<td><em>Renegotiation of marriage contract</em></td>
<td>Six weeks after return</td>
<td>Excitement, emotional distance, sexual difficulties, conflict, loss of independence, negotiation of roles.</td>
</tr>
<tr>
<td>Stage 7</td>
<td><em>Reintegration and stabilization</em></td>
<td>Six to 12 weeks after return</td>
<td>Established roles and routine, marital closeness.</td>
</tr>
</tbody>
</table>

(adapted from Logan, 1987)

Logan’s model suggests a steady, predictable progression through the deployment. This is probably true for routine, peacetime deployments, but is not true for wartime deployments, such as Operation Desert Storm (Peebles-Kleiger & Kleiger, 1994, p. 184). A somewhat different progression is found in such deployments, as outlined in the following table (Table 8.2).
Table 8.2  Emotional Cycle of Deployment in Wartime

<table>
<thead>
<tr>
<th>Phase</th>
<th>Title of Phase</th>
<th>Characteristics of Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1</td>
<td>Initial shock</td>
<td>An initial powerful surge of intense affect – fear, despair and protest – followed by (or alternating with) emotional numbing. This numbing assists the family to complete the necessary predeployment tasks. Maintaining communication in the family, even if feelings are disconnected, is essential.</td>
</tr>
<tr>
<td>Phase 2</td>
<td>Departure</td>
<td>Although emotional disorganisation, sadness and despair may appear at the point of departure, emotional numbness is very common in wartime, as a defence against potentially overwhelming affect. Children often carry and express the emotional load of the family.</td>
</tr>
</tbody>
</table>
| Phase 3 | Emotional disorganisation      | Emotional disorganisation typically sets in only some weeks (1-7) after departure, once the family runs out of activities to keep busy and the reality of the war separation sets in. Whereas emotional disorganisation in peacetime usually lasts only for several weeks, during wartime it can become chronic, with peaks during times of intense war conflict.  
In addition to the depressive symptoms experienced during peacetime separations, wartime separations introduce trauma symptoms, such as fears, nightmares, irritability, ager, vigilance, paranoia, etc. Continual reality testing is important. |
| Phase 4 | Recovery and stabilisation     | Stabilisation during a wartime deployment is transient, and tends to alternate with emotional disorganisation. Much of this is reactive to media information and rumours.                                                                                                                                   |
| Phase 5 | Anticipation of homecoming     | In peacetime, the homecoming date is usually known and families may spend several weeks preparing for it. In wartime, the homecoming is often as sudden as the leaving, and families often have only a day or two to anticipate and prepare. Consequently, there is little or no time to process feelings or complete practical preparations.                                                                                     |
| Phase 6 | Reunion                        | The reunion phase in peacetime lasts several weeks, but in wartime can continue for 3-9 months, often with residual effects 12-18 months later. There is often an incubation period, with the reunion crisis only starting a year after physical reunion.                                                                                                                   |
| Phase 7 | Reintegration and stabilisation| Stabilisation of the family system is a continual process for many families, with period recurrences of wartime crisis. These crises can recur decades after homecoming, often in response to conflictual precipitants (eg a new war, a particular sensory stimulant).                                                                                                         |

(adapted from Peebles-Kleiger & Kleiger, 1994, pp. 184-189)
Pre-deployment. In the pre-deployment phase, many wives experience shock and loss reactions upon hearing the news of the pending deployment (Bey & Lange, 1974; Black, 1993). Some describe the experience of the deployment being unreal (Paap, 1991, p. 17).

According to qualitative research in South Africa by Van Breda (1997b):

The pre-separation phase (stages 1-2) seems characterised by conflict, anxiety and sadness. In addition, many subjects seem to withdraw, particularly just prior to the actual separation. Apprehension or fear of the separation, as well as optimism or bravery about the separation are also apparent, particularly in the few weeks prior to separation. It would appear that detachment, by means of passive emotional withdrawal, conflict or task orientedness, is functional in this phase. (p. 157)

Deployment. During the deployment phase, researchers (Wexler & McGrath, 1991, p. 516) found that common feelings experienced by wives included loneliness (78% of respondents), worry (74%), sadness (65%) and anxiety (56%). Pride (75%), patriotism (57%) and commitment (53%) also featured strongly. This study also found that the level of stress peaks between the first and third weeks of the deployment, then decreases (ibid., p. 518; see also Helms & Greene, 1992, p. 2-10).

During deployments wives visit doctors for illnesses 5.4 times more frequently than usual (Snyder, 1978, p. 639; see also Neubauer Lombard & Neubauer Lombard, 1997, p. 80). Many spouses develop clinical levels of depression (Beckman, Marsella, & Finney, 1979; also Kelley, 1994b; Nice, 1983), with symptoms such as irritability (89% of wives), sleep difficulties (58%) and loss of appetite (36%) (Adler, Bartone, & Vaitkus, 1995, p. 15). Problems at home are perceived to increase in frequency and severity during deployments (Bell, Teitelbaum, & Schummm, 1996b; Bloch, Zimmerman, Perez, Embry, & Magers, 1991; Decker, 1978), loneliness is common (Duvall 1945 in Farish, Baker, & Robertson, 1976; and self-esteem deteriorates (Roenzweig, Gampel, & Dasberg, 1981). Husbands/soldiers experience worry and guilt over ‘abandoning’ their families (Den Dulk 1980 in Hunter, 1982; Rosenfeld, Rosensteirn, & Raab, 1973). The most common problem resulting in spouses seeking help during Operations Desert Storm/Shield was emotional problems, such as “feeling lonely, frightened for spouse, overburdened with responsibilities, anxiety about future” (Scarville, 1993).

Regarding the experience of aloneness during deployments, Boynton and Pearce (1978, pp. 140-141) stress that this is a normal though typically aversive experience. They argue that the sense of aloneness needs to be normalised, and that families should learn to understand, tolerate and grow from the experience, rather than merely avoid it. The avoidance of aloneness simply perpetuates rather than resolves it.
In a qualitative study among South African naval sailors and their wives, Van Breda (1997b) found:

The *separation phase* itself (stages 3-5) is characterised by longing and loneliness, two closely related variables, which indicate the importance of the family relationships. Men express marked concern about the family’s coping over the bulk of the separation. A task or work orientation serves as a strong protective mechanism during this time. As the separation progresses from the initial stages into the middle of the separation, loneliness appears to give way to a sense of adjustment or having come to terms with the separation, which seems to indicate the growth and tenacity of naval couples. However, by the middle of the separation subjects are feeling restless and bored, and frustrated by the separation. As the separation draws to an end, couples feel excited and experience strong desires to be reunited, but also feel anxious and nervous about the pending homecoming. (p. 157)

In addition to the negative effects of deployment, separation can also be a positive or constructive experience for some (Caliber Associates, 1992):

As early as 1945, Hill noted that many wives grew as individuals due to their war-induced separations. Not only do separations provide the opportunity for greater independence, they can promote development of independence, self-sufficiency, and maturity (Schwartz et al., 1987; Hunter & Hickman, 1981; Jensen 1986). Many women also take advantage of the opportunity to enhance themselves educationally or vocationally (Lexier, 1982). Though separations may cause conflict and anxiety because the spouse must assume the role of both mother and father, the success of doing both well may also result in increased self-confidence (Hunter, 1982). (p. I-6)

It is likely that there is a curvilinear relationship between the duration of a deployment and its impact on the family. Deployments that are very short (under one month) allow the family little time to adjust to the separation, which can be very stressful (Howe, 1983), particularly if there is a rapid cycling of these short deployments (Van Breda, 1997b). Deployments that are very long (over six months) place excessive strain on the family’s ability to maintain a sense of virtual family coherence in the face of prolonged physical absence (Bell, Bartone, Bartone, Schumm, & Gade, 1997, p. 3; Huffman, Adler, & Castro, 2000, pp. 4 & 10; Martin, Vaitkus, Johnson, & Mikolajek, 1992, p. 6). Deployments of moderate length (probably around two to four months) allow sufficient time for the family system to adjust to the separation but reunite the family before the separation ‘turns sour’ (Schumm, Knott, Bell, & Rice, 1996).

**Post-deployment.** The “stress of father-return after prolonged absence is as great as that experienced at the time of his departure” (Baker et al., 1968, p. 347; see also Orr, 1992, p. 46; Rindfuss & Stephen, 1990). Contrary to the popular impression that homecoming is a time of uncomplicated joy, it is typically marked by ambivalence and anxiety (Figley, 1993; MacDonough, 1991; Spellman, De Leo, & Nelson, 1991), as well
as disappointment when the fantasy of reunion does not materialise (Potts, 1988; United Nations, n.d.). Poor communication, emotional distancing, sexual difficulties and anger are common in marriages (Bey & Lange, 1974; Blount, Curry, & Lubin, 1992; Jolly, 1987; Pearlman, 1970). These difficulties, which occur transiently immediately after return, are termed a “releasing phenomenon” by some writers (Rothberg, Shanahan, Koshes, & Christman, 1994). Several programmes have been developed to facilitate homecoming and reunion (US Army Community and Family Support Center, 1994g).

Common tensions upon returning home are described by Figley (1993, p. 57):

1. **Family conflict** over what is done at home, how, and by whom;
2. **Criticism about maintaining contact**, involving evaluation over the frequency and quality of letters, calls, and other communications from the trooper during her or his absence;
3. **Family rearrangement** (reorganization of family roles, routine, rules, due to the trooper’s absence);
4. **Shifts in the social support networks** (eg trooper may discourage continuing contact with these individuals);
5. **Jealousy** regarding potential or real extramarital affairs; and
6. **Disappointments** over each person’s homecoming fantasies (competition among the trooper and family members about activities to do when, where, and with whom).

In a qualitative study in South Africa, Van Breda (1997b) reports on the post-deployment period:

Happiness and contentment are the hallmarks of the post-separation phase (stages 6 & 7), with a growing sense of having adjusted back to a normal family life. The anxiety experienced immediately after reunion gives way to a sense of calm. However, conflict plays a role immediately after the reunion, and is perhaps a result of the difficulty experienced in resuming family roles and rules. In addition, apprehension about the next separation emerges within a week of the homecoming – a manifestation of the rapid deployments experienced by local sailors. (pp. 157-158)

Soldiers who were involved in combat or other trauma may introduce the after-effects of these experiences into the family system (Figley, 1993; Gimbel & Booth, 1994; Solomon, 1988), often for many years following the experience (Solomon et al., 1992). A study of soldiers and families in Operation Desert Storm found that 62% to 73% of respondents felt they had readjusted to family life within one month after return home, 17% to 21% had readjusted after several months, and 8% to 17% were still adjusting two years after return (single parents being the largest group – 17%) (Caliber Associates, 1993, p. VII-1). Factors which are associated with a speedy recovery
(bearing in mind these are correlations, not predictions) include (ibid., pp. VII-4 to VII-9):

- Being better prepared for the deployment.
- Experiencing less financial hardship as a result of the deployment.
- Experiencing pre-deployment information as helpful.
- Spouses receiving regular and adequate information from the base unit.
- Soldiers experiencing less stress during the deployment regarding missing the family, communicating with the family, worrying about the family’s well-being, supporting the family emotionally and assisting the spouse with family matters.
- Spouses experiencing less stress during the deployment regarding getting information about the service member, staying in touch with the service member, managing the family’s finances, running the entire household, missing the service member and handing reports from the news media.
- Eldest child not experiencing a negative impact from the deployment.
- Receiving a briefing on reunion and family homecoming.
- Spouse’s perception of the soldier's supervisor being supportive of family needs following the deployment.

Sometimes these effects are only experienced some time later, following an "incubation period" (Ford et al., 1993, p. 94; Hogancamp & Figley, 1983, p. 152; Hunter, 1986). Trauma debriefing or time-limited family therapy on return from the field contribute significantly to long-term improved personal and family functioning and should be sought out by soldiers and families (Ford et al., 1998; Ford et al., 1997; Ford et al., 1993). Families seeking to bolster their resilience by requesting such interventions can be considered to be taking positive, adaptive action.

**Gender Comparisons.** While a great deal of attention has been paid to the experiences of families and wives who stay at home, little research has addressed the experience of soldiers as family members and husbands (Segal, 1989). One of the unique contributions of Van Breda’s South African naval study was to directly compare the emotional cycle of male sailors with female wives, thereby confirming the hypothesis...
(Logan, 1987) that, on the whole, their experiences are markedly similar (Van Breda, 1997b):

One of the key questions asked by this study was, ‘Do the men who are deployed experience the separation as substantially different from the wives who are left behind?’ The answer is, on the whole, ‘No’. The differences that were found between men and women were confined to a few differences in the emotional cycle of separation. Men indicated significantly more ‘work orientation’ than did women ($X^2=4.10, p<.05$). Men seem to focus on the tasks at hand, which may account for two other gender differences. Although men and women report similar frequencies of anxiety, men experience the bulk (two thirds) in the pre-separation phase, while women experience the bulk (two thirds) during the separation itself ($X^2=11.67, p<.05$). Men also experience less loneliness than women ($X^2=8.59, p<.01$). It would appear that men experience anxiety and tension in the lead-up to the separation, but once they have left, they become absorbed in their work and experience less worry and loneliness. (p. 158)

Other researchers, however, have found that deploying members experience less distress than those staying at home, as measured on standardised scales, such as the SCL-90 (Zeff, Hirsch, & Lewis, 1997, p. 385).

The above information has the following implications for enhancing deployment resilience:

- Families and soldiers can normalise the emotional cycles of deployment, thereby reducing their aversiveness.
- Families and soldiers can track their emotional well-being, taking preventive steps against depression and other psychopathology and identifying and dealing with symptoms early.
- Families and soldiers can talk with others who also experience deployments, to gain better perspective and to ventilate.
- Families and soldiers can attend to each other’s emotional needs more consciously, with the understanding that there are more similarities in experience than differences.
- Families can obtain briefings about the deployment at all stages of the deployment cycle – these briefings would address both deployment and family related information.
Families and soldiers can ensure adequate family preparations prior to deployment, including both instrumental tasks (e.g. arranging finances and servicing the vehicles) and affective tasks (e.g. talking with each other and with the children).

Families can do small, special things that help to boost their resilience, e.g. cooking a special meal from time to time, decorating the house with flowers, growing vegetables, etc.

8.3 POSITIVE PERSPECTIVES ON DEPLOYMENTS

Positive perspectives on deployments are defined as “the family’s positive attitude towards separations and the employing organization” (Van Breda, 1999a, p. 598).

The literature indicates that one’s perception of, or attitude towards, deployments and the military has a significant impact on one’s coping with deployments (Bowen, 1984; Bowen, 1986, p. 194; Burnam, Meredith, Sherbourne, Valdez, & Vernez, 1992, p. 46; Frankel et al., 1992, p. 110; Kirby & Naftel, 1998; Milgram & Bar, 1993, p. 37). Knapp and Newman (1993, p. 78) found that wives who perceived the military life as more stressful experienced less psychological well-being than those who perceived the military life as less stressful (see also Amen, Merves, Jellen, & Lee, 1988, p. 442). Another study found that wives’ attitudes to their husband’s units affect their husband’s morale and that personal morale influences one’s perception of the army-family interface (Rosen, Moghadam, & Vaitkus, 1989b, pp. 208-209). Yet another study found that the degree to which spouses identified with the military influenced the adjustment of their children, while the military employee’s identification with the military was unrelated to child adjustment (Marchant & Medway, 1987, p. 293).

A further study found that perceptions of deployments was a more important factor predicting retention in the military than the actual frequency and duration of separations (Szoc, 1982, in Caliber Associates, 1992):

How the separations are viewed may be as important – if not more important – than actual time away. Indeed among those who left the service, separations were viewed as far more problematic than among those who stayed, but the actual amount of separation was [only] slightly higher among the stayers. (p. I-4)

Although commitment appears to buffer the aversive consequences of deployments, the experience of deployments, conversely, may have a negative effect on the commitment
of families to the military. Studies of families involved in Operation Desert Storm found that 26% - 30% of members experienced a deterioration in commitment to the military (from before to after the deployment), and only 2% - 6% experienced an increase in commitment (Caliber Associates, 1992, p. III-63). Factors that were associated with negative changes in commitment included not feeling adequately informed about the impact of deployment on children, experiencing greater stress around being separated from their children, not receiving pre-deployment briefings and experiencing the military supervisor or unit as unsupportive of families (ibid.). Interestingly, just over half the people who indicated a deterioration in commitment six months after returning from Operation Desert Storm, indicated that they felt more committed six months after that (Janofsky, 1992, p. III-25).

Perceptions of the military-family interface, particularly perceptions by the military spouse (Kirby & Naftel, 1998), have been repeatedly found to influence the military member’s intention to stay in the military (Gill & Haurin, 1998; Green & Harris, 1992; Potts, 1988). One study, for example, found that “married soldiers whose spouses are more committed to the Army tend to be more committed themselves and expect to serve more years in the Army” (Burnam et al., 1992, p. 47). Although intention to stay in the military and retention rates are not directly related to deployment resilience they may suggest deployment resilience (Bowen, 1989a). A military job, whether a combat job or not, requires regular separation between soldier and family (to attend courses, do duties, deploy, etc). Intention to remain in the military can be seen as one outcome of deployment/separation resilience. A family that is resilient to separations will be more likely to remain in the military, and conversely a family that intends to remain in the military must have come to terms with the routine separations required by the military. This principle has been demonstrated in a number of studies of the intentions to remain in the military of soldiers involved in Operation Desert Storm (Kirby & Naftel, 1998; Rosen & Durand, 1995).

Deployments have been found to be less stressful when one has a positive attitude towards them (Eastman, Archer, & Ball, 1990, p. 114). A study of wives whose husbands were deployed in the Persian Gulf found that, “Groups with high levels of [emotional] distress also had the highest levels of unsatisfactory use of [military] services and the highest expectations of [what] the Army [should provide for them]” (Rosen, Westhuis, & Teitelbaum, 1994, p. 43). Indeed many families report positive results of deployment, such as learning new things, becoming more independent and enhancing the marital relationship (Adler, 1995; Segal, 1989).
A study (Bell et al., 1997) of families during Operation Joint Endeavour (a US deployment to Bosnia and Hungary in 1996) found that spouse support for the deployment correlated with various other relevant factors, viz:

- Just over half (52%) of spouses who felt they were very prepared for the deployment supported the deployment, compared with only 15% of spouses who felt they were very unprepared (Bell et al., 1997, p. 2).

- Spouse support for the deployment was lowest “among spouses who were troubled by or worried about: (1) mission uncertainty, (2) their soldier’s safety, (3) accuracy or timeliness of information about the mission, or (4) news (probably bad news) about Bosnia” (Bell et al., 1997, p. 2).

- The following factors were not related to spouse support for the deployment: “spouse gender, pregnancy status, number of children, distance from post, and time assigned to Europe” (Bell et al., 1997, p. 2).

Given the link between support for a deployment and coping with that deployment (as detailed above), it becomes important for families to ensure that they have adequate information about a deployment before it begins and during the deployment, and that families are helped to understand and appreciate the need for and importance of the deployment (Bell et al., 1997).

Studies indicate that identifying with and adopting the identity or lifestyle of the organization decreases the stress that results from the demands of the organization (Boss, McCubbin, & Lester, 1979, p. 83; Fernandez-Pol, 1988, p. 420; McCubbin, 1979, p. 240). With the changes in the role of women in society, naval wives have moved out of the military community and lifestyle (Hunter, 1978; Kohen, 1984; Segal, 1989; Stoddard & Cabanillas, 1976). This may increase their deployment stress. In South African studies, the employment status of women (which may be an indicator of attachment to the military) was not, however, found to correlate with deployment stress (Van Breda, 1995d, p. 29).

Related to perceptions of deployment may be the psychological impact of deployments. One study found that the mental health conditions of 83% of the people diagnosed during a deployment in Bosnia predated the deployment (Winfield & Lafferty, 1997, p. 104). It therefore seems important that soldiers ensure their mental health prior to deployment.
The management of deployments by the military organisation can precipitate negativity among family members (Van Breda, 1997a):

In the South African Navy [in the mid 1990’s], there are many external factors which impede the maintenance of positive attitudes. These factors include unpredictable and erratic deployments (which have been found to correlate with high deployment stress), lack of personnel which results in extended sea duty and slow promotions, frequent night duties which disrupt family life, frequent and brief deployments which increase the frequency of family adjustments, and lack of material and interpersonal rewards for going to sea. The subjective impression of naval social workers is that these factors prompt perpetually negative perceptions of deployments that result in poor deployment coping. (p. 20)

Families of deployed soldiers may become preoccupied with concerns over which they have no influence. During Operations Desert Shield/Storm, for instance, 86% of spouses reported at least moderate amounts of distress over the soldier’s well-being and safety, 80% over their inability to predict the length of the deployment, and 61% over the living conditions the soldier was experiencing (Bell, 1991b, p. 2). These concerns, while valid and probably unavoidable, contribute to a perception of deployment which actually reduces deployment resilience, by virtual of their uncontrollability which results in a sense of powerlessness. Families would probably experience greater deployment resilience if they concentrated on what they can control, which would enhance their sense of coherence (ibid., p. 7; see also Covey et al., 1994).

The above information has the following implications for enhancing deployment resilience:

- Families and soldiers can spend time discussing the positive and negative implications of the deployment.
- Families and soldiers can make a conscious decision to dwell on the positive implications of deployments.
- Families and soldiers can learn cognitive techniques (eg ABC) to control and channel their thinking in a helpful direction.
- Families can get involved in the military community, thereby learning about the rationale for deployments (both in general and in specific).
- Families and soldiers can seek out sources of information that provide meaning and purpose to military deployments.
Families and soldiers can concentrate on factors within their sphere of influence, rather than on factors within their sphere of concern but outside their sphere of influence.

Families and soldiers can seek out counselling when their thinking becomes excessively negative.

Families and soldiers can thoroughly prepare for deployments, thereby reducing the likelihood of negative experiences during the deployment that would contribute to negative perceptions of the deployment.

Families and soldiers can develop effective problem solving skills that will enable them to deal with inevitable life stressors effectively with minimal impact on emotional well-being.

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### 8.4 Support Systems

The resilience factor ‘support systems’ “is defined as the presence of support systems (via family, naval, community and religious) for the family and employee” (Van Breda, 1999a, p. 599).

The literature strongly indicates that social support buffers the family and the deploying member from the stress of deployments (Adler et al., 1995, p. 18; Amen et al., 1988, p. 445; Caliber Associates, 1992, p. I-10; Koshes & Rothberg, 1994, p. 456; Pehrson & Thornley, 1993; Solomon & Mikulincer, 1990). One study found that “more active wives felt less lonely than less active wives” (Duvall 1945, in Farish et al., 1976, p. 332). Other researchers found that “dissatisfaction with social support was predictive of decreased marital happiness between pre-deployment and early deployment” (Frankel et al., 1992, p. 109). The children of mothers who felt supported showed better adjustment at home and school during deployments (Hiew, 1992, p. 219). Even for children, social support systems facilitated better coping with the deployment of their parents (ibid., p. 222). Studies of spouses of soldiers deployed in Operations Desert Storm/Shield indicate that a comprehensive support system reduces the incidence of negative events, which in turn enhances adjustment and emotional well-being (Rosen, Westhuis, & Teitelbaum, 1991, p. 9).
Support networks used by women and men during deployments tend to be informal, viz. friends and family (Black, 1993; Decker, 1978; Montalvo, 1976; Pehrson & Thornley, 1993), although more recent studies suggest an increase in the use of formal, non-professional military support systems (Albano, 1995; Bell et al., 1997; Bell et al., 1996b; Department of Military Psychiatry, 1995; Helms & Greene, 1992; Martin, Vaitkus, Kikolajek, & Johnson, 1993).

A variety of strong support systems become increasingly important as most military families are dual-income families, and many are even dual-military families – 6-10% of military personnel were in dual-military families (that is, married to another military employee) in 1985 (Janofsky, 1989, p. 99; Morrison, Vernez, Grissmer, & McCarthy, 1989, p. 2). In the case of dual-military families, it is quite possible for both parents to be deployed simultaneously, requiring greater use of support networks for child care, pet care, home care, etc (Military Family Resource Center, 1998; Morrison et al., 1989, p. 50) – during the Gulf War, for instance, 5,700 military couples were deployed (Martin, 1992).

Four main types of social supports are described in the literature on military families: military, community, family and religious support systems.

8.4.1 **Military Supports**

Women who felt they could rely on another military wife for help with a personal or family problem tended to experience a greater sense of general well-being, especially in the face of greater stress (Rosen & Moghadam, 1988, p. 68; Rosen & Moghadam, 1990, p. 200). Bell and colleagues (1996a) report a similar finding among soldiers who have a ‘confidant’ in the unit with whom to discuss their problems (see also Etzion & Westman, 1994).

These findings have been repeatedly confirmed in South African studies. Amongst sea-going men and their wives, those who felt unsupported tended to experience more sadness and depression during deployments (Van Breda, 1995d, p. 64). In another local study of sea-going and land-based naval personnel, those who felt supported were found to have better overall social functioning, were more satisfied with their work, finances, family and friendships, and experienced better health, less depression and higher levels of energy (Van Breda, 1996).
Much research on deployment resilience indicates that as soldiers and families get older (or perhaps more experienced in coping with deployments) their deployment resilience increases and deployment stress decreases (Aldridge, Sturdivant, Smith, & Lago, 1997b; Caliber Associates, 1992; Caliber Associates, 1993; Rothberg et al., 1994; Scarville & Dunivin, n.d.; Wong, Bliese, & Halverson, 1995). This finding is not very helpful to military families, nor is the advice “It will get better as you get older”. One way in which to make use of age is through mentoring. Having a relationship with another military family in the same situation is valuable inasmuch as the families share a common experience. Having a relationship with a person more experienced in deployments opens the possibility for the sharing of deployment resilience factors (Parker, Hutchinson, & Berry, 1995, p. 90).

The availability of military support and the perception that the military is a supportive environment (ito family friendly policies) have been found to be particularly important for single military parents, both mothers and fathers. “These policies, such as family support during deployment, on-post housing assignment, military child care priority, and emergency financial assistance, provide a supportive context for single parents and reflect a positive respect and appreciation for the family responsibilities of service members” (Bowen, Orthner, & Zimmerman, 1993, p. 302). Policies such as these assist single parents in balancing work-family role demands (as discussed in section 5.3).

There are four main forms of military support systems, viz informal friendships with other military families, formal Family Support Groups, rear detachment systems, and professional military support services.

**Informal Military Friendships.** Friendships with other military families are an important source of support for military families experiencing deployments (Wood, Scarville, & Gravino, 1995). Three quarters (75%) of the spouses of soldiers deployed to Somalia in Operation Restore Hope in 1993 relied on other army spouses for support, the second largest form of support used by these families (after friends and neighbours at 78%) and equal to support from extended family members (Bell, 1993, Figure 9). These families understand the experience of separation and are able to provide a kind of support not easily available elsewhere (Hunter, 1983). Other research suggests that military community cohesion promotes deployment readiness, retention and the overall ability of families to cope with the demands of military life (McClure & Broughton, 1998).

**Formal Family Support Groups.** Family Support Groups (FSG) are a cornerstone of nonprofessional military support systems in the USA and in some units in South Africa –
approximately half (52%) of the spouses of soldiers deployed to Somalia in Operation Restore Hope in 1993 made use of FSGs (Bell, 1993, Figure 10). “The Family Support Group is an officially sanctioned voluntary association of Army family members who join together to provide social and emotional support to one another” (Bell et al., 1996a, p. 3). The four primary functions of the FSG are “organizing social events, holding informational meetings, maintaining phone circles (trees), and publishing newsletters” (ibid.).

FSGs have been found to buffer families from the stress of deployments and increase emotional well-being (Martin et al., 1993, p. 26; Rosen, Westhuis, & Teitelbaum, 1993b, p. 1592). Families with easy access to well functioning support groups experience lower levels of depression, compared with families with access to poorly functioning support groups or who live far from family support groups (Adler, 1995; Adler et al., 1995). The families of Reservists, who are not permanently attached a military unit, often experience a lack of military support resulting in a sense of isolation and greater deployment stress (Stuart & Halverson, 1996). FSGs are of value not only for the family, but also for the soldier – knowing that there is a FSG to care for one family during a deployment enables the soldier to concentrate on the mission (US Army Community and Family Support Center, 1994h, p. 8; Van Breda, 1995a).


**Rear Detachment.** Military units in the USA also have a Rear Detachment, as part of the formal, nonprofessional support system (Bell et al., 1996a; Godwin, 1992). Approximately half (53%) of the spouses of soldiers deployed to Somalia in Operation Restore Hope in 1993 made use of Rear Detachment command staff (Bell, 1993, Figure 10).

The SANDF also used to make use of a form of Rear Detachment. Recent transformation of the SANDF has resulted in the abolition of this system – when a unit deploys, the entire unit deploys and no-one is left behind. This has created various problems regarding the support of families and the liaison/communication between families and deployed soldiers.

**Professional Military Support Services.** Access to professional military support services plays an increasingly important role in the deployment resilience of military
families (Spellman et al., 1991). These services include professional social workers, chaplains, counsellors, financial advisors, etc. A study of army spouses during Operation Desert Storm and Desert Shield found that 17% of military spouses made use of military services during the deployment. Military families who “lived off-post (particularly those who lived beyond a 1 hour drive of the post) reported the greatest number of problems” (Helms & Greene, 1992). Although the authors do not make this interpretation, one can hypothesise that families who live ‘off-post’ have less easy access to military services.

There are various documents and manuals that guide the provision of such services (US Army Community and Family Support Center, 1994e).

8.4.2 Community, Religious & Family Support

Community Support. Developing a social network, for both military employees and their families, has been shown to help families reduce deployment related stress, as well as general life stress (Eastman et al., 1990, p. 114; McCubbin, 1979, p. 240; H.I. McCubbin & McCubbin, 1988, p. 248; Riggs, 1990, p. 152), particularly for couples without children and families with adolescent children (McCubbin & Lavee, 1986, p. 227). The spouses of soldiers deployed to Somalia in Operation Restore Hope in 1993 cited friends and neighbours as the most commonly used (78%) support system (Bell, 1993, Figure 10). Civilian friends are able to provide an important quality of support to military families that is distinct from military friends and that promotes the health and well-being of military families (Martin & Orthner, 1989).

Although being employed has usually been found to be unrelated to wives’ coping with deployments (eg Van Breda, 1995d, p. 29), one study (Wood et al., 1995) found that employment and other social supports (ie religion, church involvement and family support) improved adjustment to separation. The wives in the study who coped well with the separation most often indicated that their job helped them cope well (ibid., p. 228). Perhaps it is the nature of the job, or of the relationships in the workplace, that determine whether being employed is helpful. Another study found that soldiers whose partners were employed experienced fewer concerns during separations (Aldridge et al., 1997b, p. 41).

Religious Support. Religious support has been found to buffer families from the stress of deployments and increase emotional well-being (McCubbin, 1979, p. 241; Wood et al., 1995, p. 228), particularly in families with preadolescent children (McCubbin & Lavee, 1986, p. 227).
1986, p. 227). A “religious orientation” and “spiritual support” have also been identified as ingredients that foster family “balance” for families with adolescent members (H.I. McCubbin & McCubbin, 1992, p. 168). Close to one third (29%) of the spouses of soldiers deployed to Somalia in Operation Restore Hope in 1993 made use of church members for support (Bell, 1993, Figure 9).

The use of religion as a coping mechanism during deployments was found to be particularly advantageous to wives who were prepared for the possibility that their husbands might not return, but who were struggling with the demands of being both mother and father (McCubbin, Dahl, Lester, Benson, & Robertson, 1976b, p. 469).

**Family Support.** “Family and friends” were found to be an important component of “family balance” in all stages of the family life cycle prior to the empty nest and retirement stages (H.I. McCubbin & McCubbin, 1992, p. 168). Three quarters (75%) of the spouses of soldiers deployed to Somalia in Operation Restore Hope in 1993 made use of extended family members for support (Bell, 1993, Figure 9) – this was the second most common form of support used by these spouses.

Evaluations of the Deployment Resilience Seminar, developed by Van Breda (1997a, 1998a, 1998b, 1999a) found a deterioration in satisfaction with family support following participation in the seminar. Van Breda (1999a, p. 602) explains, “Clinical experience indicates that the relationship with the extended family is a frequent source of conflict and tension during and after separations. It is possible that the [Deployment Resilience Seminar] conscientizes participants to this conflict without providing adequate tools for managing it.” It appears that family support is both important and dangerous – it provides families with important historical support during separations but can be fraught with complex history and baggage.

**The above information has the following implications for enhancing deployment resilience:**

- Families and soldiers can seek out healthy and constructive friendships with other military families.
- Families and soldiers can develop strong, healthy and constructive support systems in their local communities, especially with neighbours, religious organisations and extended family.
Families and soldiers can ensure both the quantity and quality of their relationships with others.

Families can make active use of any military support before, during and after deployments, including Family Support Groups, Rear Detachment and professional support services.

Families and soldiers can sort out conflicts or tensions with their extended families before deployments. This may entail establishing clear boundaries and expectations with the extended family.

Families can set up a telephone circle with several other families whose partners are deployed.

Families can take the initiative to establish small support groups with other military families.

Families and soldiers can take active steps prior to a deployment, to ensure the availability to instrumental support systems, eg people who can assist with repairing a broken-down car, with transport, with child care, with health concerns, etc.

Families and soldiers can foster their spiritual beliefs and relationships.

Regarding Family Support Groups (FSG) and FSG leaders:

FSGs can be flexible in form and content, and can be created to meet the unique needs and styles of the families it supports.

FSGs can organise social meetings so that families can meet each other and develop informal military friendships.

FSGs can arrange welcome home parties or functions.

FSGs can arrange information meetings for families to address deployment (eg the status of the mission) and/or family (eg how to promote the resilience of children) issues.

Families who are new to a unit can be welcomed by the FSG.
FSGs can establish telephone trees or circles, whereby messages or information can rapidly be communicated to families, even those who live far away.

FSGs can develop and provide families with a deployment handbook that addresses issues concerning deployment resilience, telephone and contact details of key people or agencies, etc.

FSGs can develop and distribute regular newsletters to families.

FSGs can obtain a roster of unit members, including contact details prior to the deployment.

FSGs can be trained to provide emotional support to those in distress and refer them for counselling as indicated.

FSGs can be familiar with the range of support services available in the military and in the local communities.

FSGs can be sensitive to issues of rank and race, and especially to the role of the wives of junior members in the FSG who often feel excluded.

8.5 Financial Preparation

The resilience factor ‘financial preparation’ “is defined as the family having adequate financial resources during separations” (Van Breda, 1999a, p. 599).

“Deployments place additional financial hardships on families; the hardships are compounded if deployments are frequent and unexpected” (USA Department of Defense, 1993, p. 9). The presence of financial difficulties (operationalised as not paying bills) has a direct and negative impact on unit readiness, that is, on the military unit’s ability to execute its mission (Sadacca et al., 1992, p. 43; Scarville & Dunivin, n.d., p. 18), as well as on the well-being of family members (Adler et al., 1995, p. 16). In a South African naval study, 74% of sea-going families were significantly concerned about their finances (Van Breda, 1995d, p. 74), and financial concern was found to be highest amongst those who experienced the most deployment stress (ibid., p. 30). In another South African study with predominantly African infantrymen and their wives, the
management of financial affairs was one of the most common and severe problems reported by soldiers and wives (Van Breda et al., 1999, pp. 7SAI-22 & 2SAI-22).

This can be compared with a US study in which 27% of military members were concerned about whether the family had enough money to pay bills during separations (Westat Inc, 1994, p. 5). According to one author, 90% of the family problems reported by leaders during deployment are financial (Krueger, 2001, p. 15). A 1991 survey of US army families found that 34% of families deployed in Europe and 48% of other army families experienced financial difficulties (Martin, 1992). A study of families requesting assistance from Family Support Centres during Operation Desert Shield found that the most prevalent and severe problem was financial (Fuller, Myslewicz, & Brockwell, 1991, p. 1-5; Helms & Greene, 1992, p. 2-8). Another study from Operation Desert Shield found that soldier and spouse deployment stress was higher when they were concerned about family finances (Caliber Associates, 1993, p. III-17), and conversely that adaptation was enhanced when good financial resources were available (Bell, 1991a).

Financial problems were experienced by 43% of the spouses who reported having problems during Operations Desert Storm/Shield (Scarville, 1993). These problems were related to the purchasing of deployment related items, postage overseas, job loss by spouse, loss of soldier’s second job and telephone accounts (ibid.).

Financial concern among South African naval families was associated with higher levels of anxiety and loneliness (Van Breda, 1995d, p. 45), and was considered a significant factor in the stress wives experience due to deployments (ibid., p. 49). Another study found that “financial difficulties had more impact on operational readiness than housing, child care, health care, or partner’s job” (Luther, Garman, Leech, Griffitt, & Gilroy, 1997; see also Segal & Harris, 1993, p. 30).

Deployments are expensive for families. One area of expense for many families is the use of telephones during deployments (Bell et al., 1996a). Some families, particularly junior families, ring up enormous telephone accounts during deployments (Applewhite & Segal, 1990; Ender, 1995). These accounts (Bell et al., 1996a):

- can be reduced if the families know in advance what calling plans are available, when the soldier can receive calls, what the time differences are between the family’s location and the deployment site, and what the costs are likely to be. It also helps if the families know how and when to use alternative means of communication (eg audio and video tapes, FAXs, and government telephones). (p. 22)

It is, however, important to note experiencing financial hardships during a deployment is related to many other stress factors in the family, which suggests that certain families...
experience multiple problems that may or may not be related to finances alone. These ‘multi-problem families’ may manifest financial problems as merely one of several symptoms of a basic dysfunction of the family system as a whole. In one study families who experienced financial hardships during Operation Desert Storm also experienced (Caliber Associates, 1993, pp. III-28 – III-31):

- Stress in managing the family finances.
- Stress in caring for the children.
- Stress in missing their spouse while deployed.
- Stress in managing the household.
- A weaker marriage following the deployment.

Finance is an important dimension of deployment resilience not only prior to deployments, but also after deployments, when financial control may be handed back to the returned soldier. A quarter (26%) of families in Operation Desert Storm reported difficulty in this regard (Bell et al., 1996a, p. 28). Finances may become the territory over which a power struggle between husband and wife is acted out – some researchers interpret female control over finances during deployments as an indication of female androgyny (Rieger, 1978). During the separation, the wife may take ownership of the family’s financial management. When her husband returns home, she may be unwilling to relinquish this control and authority to her husband, resulting in family conflict (see section 8.8 for further details).

**Developing Financial Health.** One study found that sound “financial management” was significantly related to family “balance” in families with children at home (H.I. McCubbin & McCubbin, 1992, p. 168). Similarly, financial security was found to correlate with general well-being and global life satisfaction (Rosen, Moghadam, & Carpenter, 1989a, p. 120). Other studies showed that financial preparedness (eg. having emergency funds available) decreased worry during military separations (Martin et al., 1993, p. 25; Segal & Harris, 1993, p. 85; Van Breda, 1995a, p. 11) and facilitate family adaptation to deployment (Caliber Associates, 1992, p. I-10).

Financial preparation before deployment is a critical component of deployment resilience (Marchant & Medway, 1987, p. 49 & 53), and includes actions such as writing a will, granting another person power of attorney and arranging life insurance (Caliber Associates, n.d.; Pliske, 1988, p. 28). Anecdotal information in the SANDF indicates that
one of the main reasons why soldiers have to return home from a deployment is financial problems. Families need to learn to manage the family expenses and other financial matters well before a deployment starts (Cline, 1992, p. 202).

The US military advises families to have two weeks pay available in case of emergencies during the deployment. Families that were unable to do so during Operation Desert Storm tended to have children or to hold junior ranks – two factors that probably increase the need for emergency cash (Caliber Associates, 1992, p. III-4).

Not having financial hardships during a deployment is related largely to having a more senior military rank and ensuring adequate preparation before the deployment (Caliber Associates, 1993, p. III-32). In addition, the following factors were associated with fewer financial worries during Operation Desert Storm (ibid., pp. III-28 – III-31):

- Reviewing the family’s finances prior to deployment.
- Developing a budget prior to deployment.
- Having two weeks pay available for emergencies before the deployment starts.
- Spouse was employed.

The above information has the following implications for enhancing deployment resilience:

- Families and soldiers can discuss the family finances on an on-going basis.
- Families and soldiers can ensure the availability of two weeks pay for emergencies during deployments.
- Families and soldiers can arrange for credit facilities prior to deployment.
- Families and soldiers can make arrangements for the paying of accounts during the deployment.
- Families and soldiers can arrange for power of attorney for the family during the deployment.
- Families and soldiers can avoid getting into debt, and make use of services when they do get into debt.
- Families and soldiers can ensure routine, clear and participative budgeting.
Families can exercise discretion in spending during the deployment, including their use of telephone and other communication facilities.

Families and soldiers can avoid the use of credit facilities.

Soldiers can ensure that their families know how to use cash machines, credit cards, debit cards, chequebooks, etc.

Male soldiers who are reluctant to hand over financial control to their wives can find creative ways to ensure the financial well-being of their families without losing control of family finances, eg by arranging a routine (monthly or weekly) debit order from their account into their wife’s account for family expenses.

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### 8.6 ‘Partner-aware’ Family Structure

The resilience factor ‘partner-aware family structure’ can be defined as the family maintaining a firm but flexible boundary around the family, accommodating the smooth entry and exit of the deploying parent, and maintaining a symbolic or virtual intact family structure during separations.

Several studies indicate that military families often develop dysfunctional structures to assist in coping with the repeated coming and going of the husband-father. In some families, the father is pushed out of the family, in order for the family to cope without him during deployments. This family pattern, termed “closed-ranks” in military literature (Amen et al., 1988, p. 442), results in substantial post-deployment difficulties (Hall & Malone, 1974, in Lagrone, 1978, p. 1041; McCubbin, Dahl, & Hunter, 1976a, p. 304). The husbands in these families find it very difficult to regain entry into the family system, and often feel like a ‘spare wheel’ (Hunter, 1982, p. 16). Anecdotal information suggests that some husbands may resort to force, even violence, to regain their position as ‘head of the house’.

In other families the ranks are kept open (termed “open-ranks”), resulting in the father being welcomed back in on his return. During the deployment, however, the family is unable to continue functioning effectively without the absent family member and disintegrates (Jensen, Lewis, & Xenakis, 1986, p. 227). Boynton and Pearce (1978, p. 130) note that, “The extent to which this adjustment to separation is successful,
however, is inversely related to the ease with which the family can accommodate his return” (see also Amen et al., 1988, p. 442; Bell, 1991a; Segal, 1989).

The net result of these coping styles is a sense of dissolution of the family as a unit. Mental health professionals and the military organization may, unwittingly, contribute to the demise of the family unit by advocating a closed-ranks approach with the intention of maintaining family integrity during deployments. While this may prove effective in the short term, it “often leads to a sense of artificiality and a chronic sense of fragmentation in the family and an ever-present threat to family stability” (Hunter, 1982, p. 29). I have had many cases of families who contemplate divorce once the sailor is drafted off a naval ship because they cannot tolerate the prolonged intimacy of living together every day.

Some writers suggest that maintaining a symbolic presence of the family (or soldier) helps soldiers (or families) cope better with separations (Jensen et al., 1986, p. 231; Kirkland & Katz, 1989, p. 66; Office of Family Policy, 1997, p. 26; US Army Community and Family Support Center, 1994h, p. 99; Waldron, Whittington, & Jensen, 1985, p. 106). This idea has been experimented with in clinical practice by South African naval social workers and has met with some success. It is hypothesised that such a practice helps the family find a balance between open and closed ranks, and has been termed “maintaining a partner-aware family” by the author (Van Breda, 1999a, p. 599).

Perhaps the simplest way of maintaining a partner-aware family is through regular telephonic contact between soldier and family during deployment. Although this can create problems (such as the negative experience of knowing about a problem that one can do nothing to solve), it is likely that the positive consequences such contacts outweigh the negatives (Applewhite & Segal, 1990; Wright et al., 1995).

Family rituals (Imber-Black, 1988; Imber-Black et al., 1988; Van Breda, 1995e) can assist families in maintaining a partner-aware family. The Deployment Resilience Seminar, for example, advocates keeping photographs and other mementos nearby as a reminder of the absent member(s), keeping the soldier’s chair vacant at the meal table, and planning welcome home rituals or parties to facilitate reintegration of the absent family member (Van Breda, 1998a).

One aspect of these shifts in family structure is the shifts in role allocation. These shifts create stress for many military families (Boss et al., 1979; Hawes-Dawson & Morrison, 1992; Hertz & Charlton, 1989; Hunter, 1982; Rosenfeld et al., 1973; Rozenzweig et al., 1981; Stone & Alt, 1990), particularly when there is lack of marital consensus regarding
role allocation (Hunter, 1978, p. 190). The South African naval study found that 59% of couples “were not coping adequately with the continual changes in roles between themselves and their partners” (Van Breda, 1995d, p. 23). These difficulties were associated with higher stress, anxiety, loneliness and marital conflict, a lack of social support and a feeling of loss of control. Developing effective means to shift roles, then, is crucial for effective coping with routine family separations (Eastman et al., 1990, p. 123; Kralj, Sadacca, & Kimmel, 1991, p. 49). “The well being of the family unit directly impacts on the soldiers’ readiness, retention, and overall effectiveness” (Amen et al., 1988, p. 441; also Potts, 1988, p. 66).

The above information has the following implications for enhancing deployment resilience:

- Soldiers can find creative ways to maintain a symbolic presence of their family during deployments, eg having photographs, personal mementos, tape recordings, etc of family members, writing a daily family journal that will be given to the family after the deployment, etc.

- Families can find creative ways to maintain a symbolic presence of their parent/partner/soldier during deployments, eg having photographs, personal mementos, tape recordings, etc of the soldier, writing a daily family journal that will be given to the soldier after the deployment, keeping the soldiers chair at the meal table vacant, etc.

- The remaining spouse can consider what the deployed spouse would say when decisions are required.

- Families can prepare a welcome home party for the deployed member.

- Families and soldiers can develop rituals that promote rhythm and identity in the family and that can be maintained during the deployment.

- Families and soldiers can maintain communication during the deployment.

- Families and soldiers can negotiate shifts in roles and responsibilities before and after deployments, which will help to prevent conflict and promote healthy shifts in the family structure.
The resilience factor ‘resilient children’ “is defined as the family actively developing the separation resilience of their children” (Van Breda, 1999a, p. 599).

The containment of children is a significant factor in effective coping with deployments. This author’s studies indicated that men perceive the needs of the children to be the greatest factor making deployments difficult for their wives (Van Breda, 1995d, p. 47); see also (Adler et al., 1995, p. 16; Rosenfeld et al., 1973, p. 37). A study of US military families found that about half (40% - 58%) of all military members with children were often or very often worried about their child’s health and well-being during deployments (Westat Inc, 1994, p. 46). Mothers (50% - 58%) tend to experience more worry than fathers (40% - 55%), and single parents (55% - 58%) tend to experience more worry than married parents (40% - 54%) (ibid.). One study found that “service members with dependents report more problems getting ready to deploy than do members without dependents” (USA Department of Defense, 1993, p. 13).

Military children experience an emotional cycle of deployment similar to that of military wives (Kelley, 1994b, p. 171), exhibiting sadness, anxiety, anger, encopresis, sleep disturbance, somatic complaints, behavioural and academic problems, acting out, eating problems, regression, fighting and arguing, concentration difficulties, truanting and dependency (Amen et al., 1988; Applewhite & Mays, 1996; Bloch et al., 1991; Herbst, 1995; Hillenbrand, 1976; Igel, 1945; Levai, Ackermann, Kaplan, & Hammock, 1995; Rosen, Westhuis, & Teitelbaum, 1993a).

The deployment of single parents and dual-military couples (when both are deployed) has a disruptive impact on children. Studies of these parents during Operation Desert Storm indicate that 60-75% of children are placed in alternative care outside of their usual living area – 90% of these children are placed more than 150 miles away from home during the deployment (Croan, 1993, p. 2). Most children (43% of children living with a single parent and 70% of children living with dual-military parents) live with grandparents during the deployment (ibid.).

Some children develop clinical problems during deployments, notably dysthymia (Levai et al., 1995; Levai, Kaplan, & Daly, 1994). Many of these children, however, evidenced premorbid psychopathology that was precipitated into a crisis by the departure or absence of the military parent (Amen et al., 1988). Some studies have found that military children (outside of a period of deployment) do not evidence higher levels of
psychopathology than found in the general population (Jensen et al., 1995; Orthner, Giddings, & Quinn, 1989). Other children in fact become stronger as a result of deployments – more “stress-resistant” and “competent” (Hillenbrand, 1976, p. 452; Jensen et al., 1986, p. 228) – an example of the resiliency effects of stress. Just over one third (38-40%) of single parents and dual-military couples reported a negative long-term impact of deployment during Operation Desert Storm on their children, while 27% of these parents reported the deployment had a positive impact (Croan, 1993, p. 9).

The primary factors which influence the responses of children to deployment separations are “(1) potential death of a parent, (2) uncertainty of time of return, (3) a feeling of lack of control of the outcome, (4) the need for a base of emotional support, and (5) a critical period of development for children (Traylor, n.d., pp. 5-6). Traylor continues to point out critical periods in child development, notably the period between eight and twenty months during which core personality structures are developed. He recommends that “single parents should not be deployed to a combat zone until a child reaches school age and care for the child during the parent’s absence has been clearly established” (ibid., p. 6).

Table 8.3 (on the following page) provides a description of the changes children of three developmental stages and their parents go through over the deployment cycle.

Father absences have been shown to have a detrimental effect on many children (Stolz, 1951), particularly boys (Applewhite & Mays, 1996; McCubbin & Dahl, 1976; Mott, Kowaleski, & Menaghan, 1997) and younger children (Croan, 1993; Kelley, 1994a). Children, particularly the eldest son, are often parentalized during deployments (Long, 1986; Peck & Schroeder, 1976, p. 25; Riggs, 1990, p. 155), which can precipitate significant enmeshment with mother (Keller, 1973, p. 27; Wertsch, 1991, p. 187) and conflict with father (Levai et al., 1995, p. 106; Rienerth, 1978, p. 182).

Maternal coping and well-being, social support and the family functioning prior to deployment have repeatedly been shown to have a buffering effect on children (Amen et al., 1988, p. 442; Black, 1993; Hiew, 1992, p. 219; Kelley, 1994a; Segal & Harris, 1993, p. 85). One study found that parents who felt they were prepared for Operation Desert Storm also felt that the deployment did not impact negatively on their eldest child – 50% of soldiers and 60% of spouses who felt they were unprepared indicated no negative impact on the child, compared with 75% of soldiers and about 79% of spouses who were prepared (Caliber Associates, 1993, p. VI-14 & VI-15).
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<thead>
<tr>
<th></th>
<th>Pre-Deployment Phase</th>
<th>Deployment Phase</th>
<th>Post-Deployment Phase</th>
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<tr>
<td><strong>Parents</strong></td>
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<td>Any combination of these feelings</td>
<td>Could lead to any of these behaviours</td>
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<td>Resentment.</td>
<td>Arguing - to distance and/or express anger.</td>
<td>Feel overwhelmed and depressed.</td>
<td>Fear of infidelity.</td>
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<td>Anger.</td>
<td>Displaced anxiety.</td>
<td>More independent and assertive.</td>
<td>Let down (fantasy reunion doesn't live up to expectations).</td>
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<td>Frustration.</td>
<td>Mom resents kids taking their anger out on her.</td>
<td>Things start to be done Mum's way.</td>
<td>Jealousy of kid's preference for one parent.</td>
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<td>Anxiousness.</td>
<td></td>
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<td>Husband forgets normal noise and confusion.</td>
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<td>Sadness.</td>
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<td><strong>Pre-Schoolers</strong></td>
<td>Confusion.</td>
<td>Sadness.</td>
<td>Joy and excitement.</td>
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<td>Guilt during magical thinking period.</td>
<td>Separation anxiety.</td>
<td>Anger causes desire to punish or retaliate against Dad.</td>
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<td>Sadness.</td>
<td>Confusion at routine change.</td>
<td>May be afraid of Dad.</td>
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<td>Feelings of guilt for Mum's sadness.</td>
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<td>The four or five year old child is most sensitive to separation from Dad.</td>
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<td><strong>Junior Schoolers</strong></td>
<td>Sadness.</td>
<td>Change in appetite or sleep.</td>
<td>Joy and excitement.</td>
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<td></td>
<td>Guilt during sub A&amp;B.</td>
<td>Behaviour problems - may act out Mum's anger or anxiety.</td>
<td>Anger causes desire to punish or retaliate against Dad.</td>
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<td>May feel cause of father's leaving even if discussed.</td>
<td>Evidence of lowered self-esteem.</td>
<td>May be afraid of Dad.</td>
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<td>Feels lonely before he leaves.</td>
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<td>Joy and excitement.</td>
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<td>Remains anger.</td>
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<td>Anxiety over changing roles in family.</td>
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<td>Competition with Dad for masculine role.</td>
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<td>School problems (&quot;Dad's nowhere to make me do it&quot;).</td>
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<td>Swing from very responsible to very irresponsible.</td>
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<td>Encopresis and enuresis increase.</td>
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<td>May act out Mum's distress.</td>
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<td>May act out own anger.</td>
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<td>Increased aggressive or hypermasculine behaviour.</td>
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<td><strong>High Schoolers</strong></td>
<td>Sadness.</td>
<td>School problems.</td>
<td>Anger.</td>
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<td></td>
<td>Denial of feelings.</td>
<td>Control problems (Dad not there for control).</td>
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<td></td>
<td>Anger.</td>
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<td></td>
<td>Aloofness, &quot;don't care&quot; attitude (arguing as defence against closeness or expression of anger).</td>
<td>Anger.</td>
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<td>Friends take on increased value.</td>
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Table 8.3 Children's Reactions to Deployments

(Adapted from Amen, Merves, Jellen, & Lee, 1988, p. 443)
Kelly (1994b) notes that when one family member is found to experience deployment stress, the entire family is likely also to be stressed, indicating that separation affects the entire family system. A related study found that the more stress experienced by the deploying parent or the at-home parent the greater the likelihood of the deployment having a negative impact on the eldest child (Caliber Associates, 1993, p. VI-13). Other authors suggest that deployments are not intrinsically stressful for children, but that they disrupt families that are already vulnerable (Levai et al., 1995).

**Deployment of Mothers.** More recent papers address the differences, or rather, the absence of differences between maternally and paternally separated children in military families (Applewhite & Mays, 1996; Kelley, Herzog-Simmer, & Harris, 1994). Contrary to the common sense expectation that children whose mothers are deployed would suffer more than children whose fathers are deployed, comparative research by Applewhite and Mays (1996) found no significant differences between the two groups of children.

Women, in a society that is making steady though slow progress from patriarchal to more egalitarian, tend to retain primary responsibility for the care of children, creating significant implications for mission readiness. One large survey of the US DoD, for example, found that “53.3% of females with children in joint-Service [ie dual-military] marriages reported dependent care considerations as a problem [delaying their ability to respond quickly to recall/alert or change in work schedule], compared to 30.1% of males with children in joint-Service marriages” (Westat Inc, 1994, p. 4).

Mothers express more concern about their husbands being able to care for their children during a deployment than do fathers regarding their wives – 81% - 84% of mothers were confident in their husband’s ability to care for the children during a deployment, compared with 91% - 92% of fathers who were confident in their wife’s ability to care for the children when they were deployed (Westat Inc, 1994, p. 56). A study of soldiers in Operation Desert Storm found that female soldiers experienced greater stress regarding their children than did male soldiers (Stuart & Halverson, 1996, p. II.1.2 & G.1.2).

Contrary to the popular military perception of problems related to the deployment of women (especially regarding single mothers, dual career married women and pregnant female soldiers), Teitelbaum (1990, pp. 3-4) notes that mothers, whether married or single, “report low levels of lost deployment time for their family needs” and indicates that “male single parents report a much higher percentage of lost deployment time for family reasons than female single parents and all other soldiers” (see also Wright, 1989).

The above information has the following implications for enhancing deployment resilience:

- Parents can prepare children for deployment by explaining, with the aid of maps, calendars, photos, etc, where the military parent is going, for how long and for what purpose.

- Parents can develop creative methods to assist younger children visualise the passage of time, eg a deployment snake that is coloured in each day until the soldier’s return.

- Soldiers can provide symbols or transitional objects to assist children maintain a symbolic relationship with the absent parent, eg photographs, personal mementos, tape recordings of children’s stories or letters, assignment of age appropriate responsibilities during the separation, etc.

- Make tape recordings of stories or letters for the child to listen to during the deployment.

- Children can create a “survival kit” for the departing parent, including family photos, stationary, books, and something by which the parent can remember the child.

- Parents can help children talk about their feelings regarding a deployment, and to express these feelings through projective media, eg painting, sport, etc.

- Parents can help children understand the inevitable incidents of marital conflict prior to deployment, and to relieve the child’s belief that the soldier has left because of the conflict.

- Parents can avoid allocating the oldest child or son the responsibility of being the ‘man of the house’ or of ‘taking care of mummy’.
- The deploying parent can allocate a specific and age appropriate responsibility to each child – one that the deploying parent is usually responsible for.

- The parent who stays at home can avoid taking excessive responsibility for being both mother and father.

- The parent who stays at home can continue to care for self, so that s/he is in a better and richer position to care for the children.

- Soldiers can write *individual* letters to the children, and post them in separate envelopes so that each child receives their own complete and sealed letter.

- Children can write letters to or make drawing for the deployed parent.

- Children can prepare a welcome home party for the absent parent.

- Parents can read about how children of different ages respond to family separations so as to better understand and respond to their children’s reactions.

- Parents can create or use deployment-related stories or colouring-in books for the child during the deployment.

- Parents can speak with other parents in the same situation to normalise the negative responses of their children and to learn new ways to cope.

- Parents can maintain family routines and rituals before, during and after deployments.

- Parents can plan how to handle discipline of the children during the deployment.

- The returning parent can enter the family and their role as parent gently, rather than suddenly.

- The returning parent can tolerate the children’s ambivalent feelings as a normal part of the transition back to a complete family.

- Parents can prepare adequately for the deployment, thereby reducing the stress of the remaining parent, thereby reducing the family stress for the child.

- Parents can arrange support systems for the remaining parent prior to the deployment.
Parents can track the emotional well-being of their children and respond appropriately, even taking the child for family counselling if indicated.

Parents can ensure shared responsibility for parenting as a norm, particularly when the deploying parent is a mother.

The remaining parent can take the children to see the soldier off at the point of departure.

Parents can inform the child’s teachers of the deployment, so that the teacher can be aware of and respond appropriately to any changes in the child’s behaviour.

8.8 FLEXIBLE MARRIAGE

A ‘flexible marriage’ “is defined as a secure marriage in which partners are flexible in the allocation of gender roles and responsibilities” (Van Breda, 1999a, p. 599).

The author’s research showed that, for both men and women, having a stable, secure and happy marital relationship was, by far, the most important factor in helping families cope more effectively with deployments (Van Breda, 1995a, p. 8). This finding confirms that of other researchers (Amen et al., 1988, p. 442; Blount et al., 1992, p. 78; Ferreira, 1988, p. 146; Jensen et al., 1986, p. 227; McCubbin & Dahl, 1976, p. 131), although even couples with healthy, well-functioning marriages find deployments stressful (Segal, 1986, p. 20). Deployments can place great stress on the marital relationship (Woelfel & Savell, 1978, p. 20), often contributing to divorce (Aldridge, Sturdivant, Smith, & Lago, 1997a; Gomulka, 1993; Spence, 1997).

A key dynamic in the marital relationship is that of role changes and authority. Riggs notes, for example, that wives’ “establishing independence and self-sufficiency” enhances coping with deployments, and advocates women adopting an andrognous gender role (1990, p. 152; see also Bell et al., 1997; Bell et al., 1996a; Chapman, 1946; Cline, 1992; Hunter, 1982; Kirkland & Katz, 1989; Kralj et al., 1991; McCubbin et al., 1976b; Riekerth, 1978).

Androgyn for a military wife implies being able to take on roles and responsibilities that are traditionally considered male territory – such as taking family decisions, managing family finances, fixing the car, mowing the lawn, shovelling snow, ensuring the security...
and safety of the family, etc (see for example US Army Community and Family Support Center, 1994h, p. 108). With the increase in the number of women who are beginning to deploy, one may also consider what androgyny for a military husband means, viz being able to take on roles and responsibilities that are traditionally considered female territory – such as cooking, cleaning, washing and ironing, attending to shopping and household hygiene, caring for children, attending parent-teach meetings, assisting with homework, ensuring the affective and emotional needs of family members, etc.

One study (Burnam et al., 1992, p. 44) found that soldiers in training units, support units and combat units reported increasing levels of confidence in their spouses’ ability to cope fully with family responsibilities during separations, indicating the importance of spouse self-sufficiency during deployments. This study also found that soldiers who had confidence in their spouses’ self-sufficiency experienced greater emotional well-being and marital satisfaction than soldiers who were concerned about their spouses’ self-sufficiency (ibid., p. 47). Other studies have similarly found that the individual readiness of soldiers is related to, among other variables, “spouse employment referral use [and] spouse having a driver’s license” which suggest the independence of the spouse during the soldier’s absence (Scarville & Dunivin, n.d., p. 17).

Advocating an androgynous gender role for military wives does not necessarily mean that the couple has an egalitarian relationship. It is quite possible for the wife to be capable of coping independently of her husband and running the family in his absence, without her considering herself or being considered by her husband to be an equal in the relationship (Mederer & Weinstein, 1992). Indeed, many military families have very traditionalist gender roles – the wife has learned to cope independently when alone, but moves back into a subordinate role on the return of her husband (Desivilya & Gal, 1996; Jolly, 1987). In other instances, however, a wife may resist returning to a subordinate role, having experienced her own competence and autonomy (Caliber Associates, 1992, p. I-12), potentially resulting in marital conflict.

Some authors suggest, in consequence, that husbands need to be able to cope with an independent wife (Lagrone, 1978, p. 1042). This can become a source of conflict, particularly with repeated or prolonged separations, when the wife does not want to hand over control to her husband on his return (Bell, 1991a; Hunter, 1982, p. 13). Men need to learn to adjust to an alternative marital relationship in order for the family to continue to function effectively in the face of repeated separations. At base, couples need to agree on the allocation of roles, whether patriarchal, matriarchal or egalitarian (Hunter, 1978, p. 190).
A study (Wooddell, Gramling, & Forsyth, 1994) of offshore oil personnel found that a husband’s or wife’s egalitarianism had no effect on life satisfaction for three samples: offshore oil workers (analogous to military employees who deploy), shift workers (which bears some resemblance to some military employees) and routine 8-5 workers. There was one exception, however, viz the egalitarianism of wives of offshore workers impacted positively on the life satisfaction of their husbands (ibid.):

The relatively strong effect of wife’s egalitarianism upon offshore husband’s life-satisfaction may lie in his reliance upon her to take care of absolutely everything – even the “man’s” work, while he is offshore for extended periods of time. In some sense this finding would seem to support the notion, long held by feminists – men and women alike – that equality between the sexes constitutes liberation for them both. (p. 131)

These researchers do, however, present an alternative explanation, which will be agreed to by many of the military wives I have interviewed. They suggest that the shift to an ‘egalitarian’ marriage is the husband’s means to the end of being able to continue his job, rather than an embracing of a liberated marriage. “The husband … stands to benefit from a shift of the division of labor in the direction of his wife, and the principles of egalitarianism is the means of that end” (Wooddell et al., 1994, p. 131).

Deployment of Women. Although few studies have been reported on the deployment of women (and mothers), Burnam et al (1992, p. 51) indicate that “female soldiers with accompanying children, other things being equal, are least confident that their spouses can take full responsibility for family matters in the event of a wartime deployment.” This finding suggests that the fairly well documented conclusion that military wives need to be androgynous applies also to military husbands. While military wives need to be able to make independent decisions, fix the car and fight with the building contractors, military husbands need to be able to care for the developmental needs of the children, manage the family routine and be available to comfort frightened children. Certainly, gender roles are shifting (as discussed in section 5.3 of this document) and the role of men in nurturing the family in increasing, even in military families (Jolly, 1987, p. 9). It would seem, however, that women (military wives) may be more able to adopt an androgynous style than men (military husbands).

Another study (Dukes & Naylor, 1991) investigated the perceptions of civilian and military respondents to a pair of scenarios: (1) a male captain deploys and leaves his wife at home with the children, (2) a female captain deploys and leaves her husband at home with the children. Civilian respondents expressed more sympathy for the husband left at home than for the wife left at home, while military respondents expressed more
sympathy for the wife left at home than for the husband. Both civilian and military respondents, however, considered that women who were deployed away from home would have a more difficult time than men deployed away from home. These differences are not interpreted by the authors, but may reflect that military respondents have learned to cope with deployments (typically deployment of men, however). Consequently, they believe men will cope with being either at home or deployed, that women will cope with being at home but not being deployed. It would be interesting to replicate this study ten years later to see how these perceptions have changed.

A study of US military employees found that “male military members expressed greater confidence in their spouses’ abilities to take care of family responsibilities than did female members” (Westat Inc, 1994, p. 6). Clinical experience in South Africa indicates that women are often more flexible in their gender roles and are able to learn and adopt their husband’s roles with relative ease, when compared with men who are less easily able to adopt their wives’ roles. Perhaps this is a consequence of gender role socialisation, which has probably become more flexible for women (in response to the woman’s movement) than for men (who remain somewhat trapped in a rigid male gender role).

Communication & Conflict. Riggs (1990, p. 153) points to the issues of communication, conflict and estrangement just before and after separations (see also Bey & Lange, 1974; Blount et al., 1992). One large study found that “those living apart from their spouses in 1976 were nearly twice as likely to experience a marital dissolution within three years, compared with persons cohabiting with their spouses” (Rindfuss & Stephen, 1990, pp. 259 & 265; Williams, 1976, p. 235) – one of the primary reasons for non-cohabitation was military service.

Couples who cope well with deployments learn to communicate and handle conflict. Research in the South African Navy found that families who deploy do not experience significantly greater levels of family violence than families who do not deploy (Van Breda, 2000). Nevertheless, other research suggests that family violence may be more prevalent in military families (Cronin, 1995) and clinical experience suggests that family violence is more likely just before or just after deployments (Stone & Alt, 1990, p. 112).

Communication is perhaps the central ingredient of a resilient marriage both for couples who do not experience deployments and for those that do (Bell, 1991a; Van Breda, 1995a). Maintaining frequent contact during the separation assists in maintaining the health of the marriage (Hunter, 1982, p. 31). Couples sometimes report that these
Phone calls are uncomfortable and that they even create more stress at the time. Nevertheless, these phone calls have long-term benefits of maintaining the couple system, despite the short-term stress (Applewhite & Segal, 1990).

<table>
<thead>
<tr>
<th>The above information has the following implications for enhancing deployment resilience:</th>
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<tbody>
<tr>
<td>❖ Remaining partners can develop a more androgynous gender role, so as to be able to fulfil most family functions during a deployment.</td>
</tr>
<tr>
<td>❖ Deploying partners can develop an appreciation for their partner’s self-sufficiency, independence and androgyny.</td>
</tr>
<tr>
<td>❖ Remaining partners can actively include the soldier back into the relationship after a deployment.</td>
</tr>
<tr>
<td>❖ Partners can promote on-going healthy, clear, direct and constructive communication patterns in their relationship.</td>
</tr>
<tr>
<td>❖ Partners can maintain communication during the deployment, through phone calls, letters, journals, etc.</td>
</tr>
<tr>
<td>❖ Partners can commit to sexual and emotional fidelity.</td>
</tr>
<tr>
<td>❖ Partners who are not sexually faithful during deployments can use condoms to reduce the possibility of the transmission of sexually transmitted infections such as HIV.</td>
</tr>
<tr>
<td>❖ Parents can develop health conflict management styles, with a prohibition on violence.</td>
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### 8.9 FAMILY-ORIENTED MANAGEMENT

“The last separation resilience factor is defined as the family-oriented management of the workforce and of separations” (Van Breda, 1999a, p. 599), in which the military organization promotes the goodness-of-fit between employees/families and the organization, and seeks to minimize the impact of necessary deployments on families.
South African research highlights a number of factors external to the family that influence the family’s ability to resist separation stress (Mathee, 1997; Van Breda, 1995d). The experience of separation was found to vary between different groups of ships. In exploring the reasons for this, two main factors emerge (Van Breda, 1997b):

- Firstly, those with the highest separation stress work on ships which have erratic, unpredictable separations, and which have no support groups for families during separations.

- Secondly, it appears that the duration of separations is a less significant factor in predicting separation stress than is the frequency of separations (Van Breda, 1997b). When separations are longer and less frequent, families have time to adjust to the phases of togetherness and separation. Short but frequent separations require the family to adjust continually to the coming or going of the worker, which effectively prevents the family from ever achieving a period of stable functioning (Howe, 1983; Peck & Schroeder, 1976).

**Timing of Deployments.** The way in which the military manages deployments may impact on the resilience of families. In particular, when soldiers are required to move rapidly from one deployment to another, with inadequate time at home in between, and when the ‘coming home’ date is undetermined, families experienced heightened stress (Bell et al., 1997, p. 3; Martin et al., 1992, p. 7). When deployments are erratic, implemented with little warning, of undetermined duration and likely to be hazardous or dangerous, the deployment escalates from being a routine separation stressor to being a catastrophic family stressor, with a much greater likelihood of precipitating severe family and personal breakdown (Bell, 1991a; Caliber Associates, 1992, p. III-2; Peebles-Kleiger & Kleiger, 1994, p. 179).

The US military endeavours to regulate the timing of deployments by policy directives. The Navy and Marine Corps, for instance, aim for deployments of no longer than six months, “with a minimum turnaround time between deployments equal to twice the length of the deployment” (Krueger, 2001, p. 6). The Army and Air Force aim to deploy individuals for no longer than 120 days per year (ibid.). There do not appear to be comparable policies in the SA National Defence Force.

**Leader Support for Families.** Soldier and family perceptions of the adequacy of military leadership and practices have been found to correlate with deployment readiness and individual well-being (Burnam et al., 1992, p. 29 & 44), highlighting the important role of ‘soft issues’ in the management of military operations (Oliver, 1991).
In particular, the perceived support of supervisors for family issues and needs is closely related to soldier and family well-being, deployment readiness and retention intention (Caliber Associates, 1993, p. III-17; Croan, 1993, p. 16; Sadacca et al., 1993, pp. 51-52; Segal & Harris, 1993, p. 27; see also Ullenberg & Rundmo, 1997 for a similar finding among offshore oil personnel).

Units in which a soldier’s family problem is seen as a unit problem evidence greater combat readiness than units in which a soldier with a family problem is considered a trouble maker (Kirkland & Katz, 1989, p. 69). Another study found that leaders who prioritised morale highly had units that functioned better and were more combat ready, compared with leaders who prioritised discipline, decisive leadership, combat skills, etc highly (Kirkland, Bartone, & Marlow, 1993). Similar studies found that the family variable that most strongly influenced unit readiness was the “amount perceived support given to families by the unit” (Sadacca et al., 1992, p. 44). Peacekeeping soldiers in the Canadian Forces indicate strongly that “family support was central to the morale and well-being of those who had left spouses/partners and children behind” (Pinch, 1994, p. 56).

Research on military families indicates a strong relationship between a male soldier’s sense of the goodness of fit between the family and the military organisation, and both personal and work adjustment (Bowen, 1989b; Bowen, Orthner, & Bell, 1997). Since a soldier’s readiness for deployment (one of the dimensions of work adjustment in this study) is in part dependent on that soldier’s perception of a good fit between organisational and family demands, it is in the military interests to promote goodness of fit between these two systems.

One of the principles ways in which military leaders can demonstrate their support for families is by promoting and supporting Family Support Groups during deployments (US Army Community and Family Support Center, 1994h, p. 8).

Communication Facilities. “Information flow [between partners has been] identified as the major concern of family members” during the deployment of US soldiers to Europe and South-West Asia in 1991 (Martin et al., 1992, p. 3). One of the most important ways military management can enhance the resilience of military employees and families is to ensure the availability of communication facilities between deployed soldiers and their homes (Bell, 1991a; Caliber Associates, 1992; Pinch, 1994). Modern technology allows easy communication, with the ready availability of commercial telephones, military/satellite communications, email, cellular phones, etc.
In a study of soldiers and wives at two infantry units in South Africa, with research samples comprising predominantly Africans (84-100% of respondents), communication between soldiers and families was one of the top three concerns for participants (Van Breda et al., 1999, p. 7SAI-22 & 2SAI-22). This included issues such as lack of communication facilities (phones, postal services, etc), messages not being received, families being ill-treated when they phone the unit, the use of cell phones being restricted, families not knowing who to contact about family problems, and messages taking a very long time to be delivered (ibid., pp. 7SAI-13 & 2SAI-13).

Applewhite and Segal (1990, p. 125) and Ender (1995) note that the availability of telephones to deployed soldiers may be a “mixed blessing”. While the majority soldiers in their study indicated extremely positive feelings towards the availability of telephones, several respondents had very negative experiences (for example, see Caliber Associates, 1993, p. III-16). These were largely related to being confronted with a family problem over which they had no control or ringing up very large telephone accounts. Nevertheless, the availability of telephones assists in maintaining a sense of family integrity in the face of physical separation (Applewhite & Segal, 1990; Bell et al., 1997), and it would seem that the benefits of having communication facilities available outweigh the negative consequences.

**Information and Spouse Readiness.** Spousal support for deployments is an important component of mission readiness, so much so that some researchers even refer to the concept of “spouse readiness,” one component of which is spouse support for the military (1991, p. 42; Kralj et al., 1991, p. 61). Research (Bell et al., 1997, p. 2) on the families of soldiers deployed in Bosnia and Hungary in 1996 found that spouse support for the mission was lowest “among spouses who were troubled by or worried about: (1) mission uncertainty, (2) their soldier’s safety, (3) accuracy or timeliness of information about the mission, or (4) news (probably bad news) about Bosnia”. Ensuring adequate information during deployments and ensuring that families understand the reasons for a deployment are thus critical components of the management of people (soldiers and families) during deployment.

**Preparation & Planning Opportunities.** The first seven resilience dimensions discussed in this chapter all require adequate planning by the family. Indeed, time to plan for a deployment is probably the most essential ingredient in deployment resilience and underlies all of the dimensions, including this eighth dimension of family-oriented management. In a study of US military families whose partners were deployed in 1991 to South-West Asia, 35% “felt that they were not given adequate information, 65% said
that there was insufficient time for family needs, and 41% said that leaders were not supportive of families during the pre-deployment period (Martin et al., 1992, p. 6). Without preparation, all of the efforts of families to develop their resilience are undermined (Bloch et al., 1991; see Simon, 1990 for a similar perspective regarding shift work schedules).

Planning and preparation need to be on-going tasks for all who may be required to deploy (Caliber Associates, n.d.). If planning is only done on a deployment-by-deployment basis it will be inadequate – all soldiers and families must be in a constant state of readiness (Dibert, 1994; Hunter, 1983; Martin et al., 1992). Deployment simulations are helpful in ensuring readiness, as well as routine preparation for deployments (whether or not a deployment is foreseen in the near future). These preparations keep the family system resilient to potential deployments and ensure that the military can deploy at short notice when required.

**Military Responsibility for Preparing Families.** Military management can also assist in preparing families (Bell et al., 1996a):

- This principle is seen in many of the activities that the Army undertakes just prior to a deployment. Dual military couples and single parents are asked to see if their child care plan is currently viable. Soldiers are given opportunities to make wills and draw up powers of attorney. Soldiers and families are given briefings and written materials. If possible, the soldier is also given time off just before the deployment to get his/her personal and family affairs in order and to spend time with his/her family. (p. 29)

The military has a great responsibility for communicating well with families, particularly prior to deployment. Studies of families during Operation Desert Storm found that while 30% of couples who received two or more briefings prior to the deployment experienced the deployment as very stressful, “this number jumped to 50% or higher for respondents who received one briefing or no briefings” (Caliber Associates, 1992, p. III-11).

Another study of the same operation found that receiving a briefing or deployment handbook prior to deployment significantly increased the likelihood of families (Caliber Associates, 1993, p. II-13 & III-16):

- Making the necessary family arrangements prior to deploying.
- Reviewing the family’s finances with spouse.
- Developing a budget or spending plan.
- Arranging for two weeks salary for emergencies.
Arranging ID cards for family members.

Getting a power of attorney for spouse.

Experiencing less stress during deployments

The Deployment Resilience Seminar (Van Breda, 1998a), which is being used to prepare South African soldiers for deployments, has also yielded positive results. At two month follow-up, with a one-month deployment in between, 20 of the 24 participants indicated that the seminar had helped a lot or quite a lot in enabling them to cope better with the latest deployment (Van Breda, 1999a, p. 602). A positive correlation was found between the reported helpfulness of the intervention and the number of changes the family had made based on the intervention ($r = .91$, $p < .001$) (ibid.). An evaluation of the intervention indicated that “those who incorporated the principles of separation resilience in their families showed relative improvements in 80% of the [35] factors assessed” (ibid.).

Care of Deployed Soldiers. The military organisation also has a responsibility to promote the psychosocial well-being of soldiers during deployments. One study of US soldiers deployed in Europe in 1993 found that about 14% of soldiers increased their intake of alcohol to reduce tension, and that these soldiers also reported “experiencing significantly greater stress from boredom, isolation, separation from spouse, and unit leadership than those who reported no alcohol increase” (Adler & Bartone, 1995, p. 2).

The above information has the following implications for enhancing deployment resilience:

- Management can regard family care and support as part of the core business of the military, from the top management structure down to section leader.
- Management can express and actively demonstrate their concern for family well-being, eg by allowing soldiers time off for family matters even when these are not urgent.
- Management personnel (from top down to section leader) can model care for their own families and the families of their subordinates.
- Management can evaluate unit leaders and supervisors at least partly on the basis of their success in meeting soldier and family needs.
Management can arrange unit family activities.

Management can, as a rule, give families fair warning of pending deployments so that families have adequate time to prepare.

Management can give soldiers leave prior to deployments to make family arrangements, particularly for soldiers whose families live elsewhere.

Management can give soldiers and families detailed information about a deployment prior to separation. Predeployment briefings can be scheduled at several different times to promote maximum attendance.

Management can ensure opportunities (facilities, affordability and time) for soldiers and families to stay in communication during deployments.

Management can promote and facilitate the establishment of Family Support Groups during separations, with the support of military social workers. Management can ensure instrumental support to the FSGs, eg information, phone numbers, photocopying facilities, transport, etc.

Management can ensure that Rear Detachments are staffed by mature and experienced personnel who are committed to family well-being and who liaise closely with the Family Support Groups.

Management can promote and facilitate the availability and use of professional military support services, such as social workers.

Management can arrange family deployment briefings to educate families and assist in developing their deployment resilience. Briefings can also be arranged for families and soldiers just prior to reunion, to assist in preparing families to reintegration.

Management can compensate families for deployments, by allowing additional leave time.

Management can ensure the soldiers plan for financial and child care of their families during deployments as a prerequisite for individual deployment readiness.

Management can ensure smooth coordination between the soldier, the family, the military and mental health services in the event of a family problem.
Management can ensure the routine availability and presence of an occupational social worker or industrial psychologist who is able to assess and intervene at the work-family interface, through organisational interventions, to ensure the goodness-of-fit between the military and family systems.

Management can conduct comprehensive routine and predeployment health assessments, which include social work assessments, to identify families with potential difficulties and to ensure that these families receive predeployment interventions before being marked as ready for deployment.

Management can ensure the psychosocial well-being of deployed soldiers by providing adequate recreational opportunities, information, food, etc during deployments.

Management can ensure the debriefing of soldiers during demobilisation to reduce the spillover of deployment stress into the family system.

Management can ensure the habitual readiness of families for deployment.

Management can regulate the duration and frequency of deployments and the turnaround time between deployments.

Management can provide a reasonable amount of flexibility to soldiers undergoing family transitions, eg marriage, parenthood, separation, divorce and bereavement).


8.10 CONCLUSIONS ABOUT DEPLOYMENT RESILIENCE

There are many examples of work-family conflicts. Perhaps one of the most outstanding of these is that of military deployments. Such work demands are unique in their duration, geographical separation, danger component, and frequency. Early literature on deployments has tended to work from a pathogenic model, examining principally families that do not cope or who experience various forms of personal or family problems in consequence to the deployment.

Deployment literature over the past two decades has, however, increasingly worked from a salutogenic or resilience perspective. The theoretical models underpinning such literature are not always explicit, or have different terms, such as the ‘wellness model’.

The work of McCubbin and others in the field of family resilience (as described in Chapter

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3 of this document) was largely based on exploring what makes families resilient to deployments.

On the basis of this literature and my clinical experience, I coined the term “deployment resilience” to refer to the capacity of families to resist the stress of deployments. A review of the literature has identified eight primary components of deployment resilience. It is theorised that families with high deployment resilience will also evidence family and individual readiness, which in turn will contribute to unit readiness and an effective mission. It is further theorised that families with high deployment resilience will not suffer adversely as a result of deployments, when compared with families with low deployment resilience.

This chapter has provided details concerning the research on these eight components and has also provided practical guidelines for families, soldiers and the military organisation on how to promote these deployment resilience components. It should be clear that deployment resilience requires a close and collaborative partnership between soldiers, their families and military management. This chapter has, however, endeavoured to highlight those things that families and soldiers can do for themselves to promote their own deployment resilience, rather than to concentrate excessively on the role of the military in promoting the deployment resilience of families.
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