# A Thicker Description of Resilience[1]

**by Michael Ungar**

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What happens when we stop using pathologising language and hear the stories of resilience that young people tell? This paper offers a more contextually sensitive understanding of resilience, one that thickly describes resilience as more than just a youth's capacity to survive and thrive. It is a shallow description of resilience to attribute success to something inside an individual alone. It also is a dangerous description that makes us as helpers overlook the sources of resilience and how best to intervene. The author's purpose is to weave a rich tapestry of ideas that can honour lives lived well despite adversity.

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There was a heady excitement when a small group of researchers, followed by clinicians and community workers, began to find it respectable in the late 1970's and early 1980's to speak of resilience. At the time, resilience was understood simply as the ability of individuals to overcome adversity. The term grew in importance as mostly quantitative researchers carried out longitudinal population studies of children exposed to multiple risk factors. Researchers, operating within a conventional research paradigm of assumed objectivity, discovered that a number of these children, anywhere from ten percent to upwards of sixty percent, depending on how resilience was defined, showed a surprising capacity to not only survive, but to thrive[2].

Like other naturalistic accounts of mental health, resilience too came to be perceived as something inside individuals, an innate quality that makes them invulnerable. This was not surprising given that most of those early accounts of resilience came from researchers who had begun their investigations trying to understand the origins of *illness.* They were for the most part deeply steeped in the traditions of western psychological science. As a consequence, a discourse of health as an individual problem led many well-intentioned researchers to ignore the evidence that people's own accounts of their lives show that resilience is not a quality of individuals. Instead, people themselves frequently associate resilience with the context in which they live, their culture and the opportunities each brings for individuals and groups of individuals to experience themselves as resilient. Thus we now speak of community resilience, community capacity, and asset-building communities (Benson 2003; Trickett & Birman 2000). These are concepts which demonstrate a greater understanding of how individual capacities depend on more than the individuals themselves. In this paper I examine an emerging non-naturalistic and contextually relevant understanding of resilience. Such an understanding is useful when I have the honour as an outsider to work therapeutically alongside those whose pathways through adversity are noteworthy for the success that is achieved.

To wrestle resilience away from essentialising discourse, I have proposed that the popular use of the resilience construct be reconsidered (see Ungar 2004a; 2004b). A number of my colleagues internationally in fields as diverse as human development (Gilgun 1999), refugee studies (Boyden 2003), and child and youth care (Gilligan 2001), to name a few, appear to be pushing equally hard at the limits of the resilience discourse. I believe resilience needs to be understood as something paradigmatically different than intrinsic quality or conventional behaviour among those who face significant risk. The dominant discourse of health as an individual phenomenon renders invisible the social context of people's lives. A great deal of work in the field of health promotion, especially with minority world populations, has demonstrated the inappropriateness of considering health solely an individual responsibility. Like these others, I find it helpful to talk about resilience in a manner that recognises the ways in which people 'practise' resilience, as well as exploring how the skills and knowledges of resilience have been developed in the context of a person's history and culture. In other words, it is helpful to 'story' resilience – to examine the place and meaning of resilience in a person's life.

My first goal, then, is to show that resilience is not an internal psychological state of wellbeing, a set of socially acceptable behaviours that occur after exposure to risk, not a condition that results from innate qualities such as a positive temperament or latent capacities. Though I too held all these things to be 'true' earlier in my work, my more recent research and clinical practice have privileged the stories of individuals who 'beat the odds' and survived personal and environmental risks (Ungar 2002; 2004b). As a group, these individuals have convinced me that we must understand resilience in a more ecologically fluid, historically sensitive and culturally anchored way. Therefore, while people may use the term 'resilient' to provide a naturalistic, essentialised account of their survival, it is possible to 'unpack' this term and to more richly describe it. Exploring ways to do this is my second goal. I will demonstrate how a non-naturalistic understanding of resilience informs practice with youth who have been labelled dangerous, delinquent, deviant and disordered, all thin descriptions of how youth cope with the risks they face.

## THIN DESCRIPTIONS OF RESILIENCE

More and more, I find reference to the idea of resilience in both popular press and clinical writing. Unfortunately, the term has become so ubiquitous it is meaningless[3]. It can seem that anyone who overcomes any amount of adversity at all can be known proudly as another exemplar of a life lived with 'resiliency'. We have come a long way from the term's original meaning, when from within a discourse of illness, researchers like Michael Rutter (Rutter, Maughan, Mortimore & Ouston 1979), Emily Werner & Ruth Smith (1982), and Norman Garmezy (1983), still managed to argue that resilience could be found – referring to that proportion of a population that demonstrates health despite exposure to substantial risk. Without significant amounts of risk, however, there is no resilience. The construct of resilience was supposed to be reserved to describe the factors and processes that predicted which individuals would survive well amidst multiple threats to their well-being.

Furthermore, the term resilience can inadvertently be applied in ways that reproduce social norms. At times, the term resilience is used in ways that simply define a person's life as successful in whatever way one's culture and historical period says is acceptable. For example, upon close examination, some research with youth generates arbitrary distinctions between which youth are vulnerable and which are resilient. Such research overlooks how both populations employ the same generic strategies to cope with difficult life events (i.e., spending time with friends, exercising control over aspects of their lives, seeking meaningful involvement in their community, attaching to others, avoiding threats to their self-esteem, etc.) (Hagan & McCarthy 1997; Tyler, Tyler, Tommesello & Connolly 1992; Ungar 2002; 2004b). However, while one group, the 'resilients', are typically seen as achieving their resilience in socially conventional ways, the others are usually labelled 'vulnerable' because the resources they access to maintain health are less socially acceptable: they spend time with friends who are in street families or gangs; their meaningful involvement with their community is defined as crime and drug activity; they feel good about themselves as a consequence of their bullying behaviours.

In practical terms, this means that investigations into the lives of both resilient and vulnerable teenagers show that youth compete with caregivers such as myself for a self-definition as resilient. The youth I work with struggle against a psychopathologising discourse that makes invisible aspects of their coping that might in fact be significant to them. Sadly, all too often it is only those youth who cope in ways that please adults who are awarded the label 'resilient'.

Both labels of 'resilient' and 'vulnerable' can be thin descriptions that are unhelpful when they cast the helper into the role of agent of social control, applauding only the child's conformity rather than unique pathways to survival. Such thin descriptions also imply to children that any socially unacceptable coping strategy which they have developed, especially those strategies that fail to help children access the health resources available from family, community, school and friends, are the result of personal failings. As such, without conversations that detail what resilience really means in the everyday moments of lived experience, the notion of resilience runs the risk of glossing over the initiatives taken by individuals to live well. Furthermore, if our health is held to be the result of inner tangible qualities, it becomes possible to ignore the very real barriers many people face in sustaining health amidst adversity, and even to blame the victims of oppression and marginalisation for their perceived lack of inner strength to overcome 'their lot in life'.

## WHY KEEP THE TERM RESILIENCE?

I am biased, however, towards keeping a word like resilience in our lexicon of therapeutic language if only for the shift in focus it provides away from a century or more of psychopathologising modernist discourse. Terms like resilience, even strengths, empowerment and health, are a counterpoint to notions of disease and disorder that have made us look at people as glasses half empty rather than half full. Resilience reminds us that children survive and thrive in a myriad of ways, and that understanding the *etiology of health* is as, or more, important than studying the etiology of disease.

A resilience paradigm can do more than counter the preponderance by myself and other mental health practitioners to examine psychopathology. Talk of resilience also engages me in a salutogenic (health-focussed) discourse (see Antonovsky 1987) that supports a view of people as health-seeking

and striving to bring coherence to their lives that in turn promotes feelings associated with personal wellbeing. This coherence that promotes feelings associated with wellbeing, can be understood to come from more than inner strengths, personal capacities, or a history of individual success. Thinking about coherence invites us as practitioners to examine people's sense of place, the meanings they give to their lives, and the purposes they have for their lives. These concepts all open up fertile ground for exploration.

## TOWARDS THICKER DESCRIPTIONS OF RESILIENCE

The task, it seems, involves developing thicker descriptions of resilience. One example of this process is provided in White's (2001) account of meeting with Helen, a woman who has experienced abuse and survived. White meets with curiosity Helen's thin description of her life as 'resilient'. He recognises that this was a 'highly valued identity conclusion' (p.46), but requests Helen's permission to explore in more detail how resilience has been an emblem of a complex set of strategies to overcome the effects of the abuse she was subjected to. In their explorations together of Helen's relationship with resilience, its effect on her life, and how she sustains her resilience in light of the injustices she experiences, White fashions with Helen a rich tapestry of ideas that better describe the complexity of how Helen survives, a survival she emblazons with the name resilience. White writes:

> *In response to these questions, Helen developed a rich description of the social skills and of the very knowledges and practices of life that were associated with this notion of resilience … A naturalistic account of resilience as a personal property was not enough, but when resilience was seen as an emblem for a range of alternative identity conclusions as well as knowledges about life and skills of living, when the histories of these were more richly described, and when this inquiry encouraged a significant re-engagement with certain figures of her history, many new options for action became available to Helen. (pp. 48-49).*

This way of understanding resilience moves us away from the belief that one's experience of health depends only upon one's inner capacities to overcome adversity. In order to clarify the differences between this approach and one which focuses on inner qualities, it may be helpful to take care with the terms we employ. I now use the term *resiliency* to describe only the reified inner quality. While I use the term *resilience* to describe the same phenomenon of surviving, thriving, hoping and coping (Ungar & Liebenberg 2005), but, rather than an inner quality, resilience is understood to be an ecologically dynamic and mutually dependent process. When understood this way, resilience is the outcome of experiences and identity stories.

## RESILIENCE AND THERAPY: REFLECTING, CHALLENGING, DEFINING

As mentioned earlier, the value of looking at resilience is it reminds us to move away from a discourse of psychopathology and failure (Gergen, Hoffman & Anderson 1996; Walsh 1998), though it works best when we use it as a roadmap rather than a destination. In other words, we need to look at survival strategies and the factors that contribute to thriving without the blinders of prejudging outcomes. In my therapeutic work I follow a three-part process to understand resilience from the perspective of those with whom I'm working and the ecological matrices in which they live. That process includes reflecting, challenging and defining (Ungar 2001; 2004b). Though I discuss each aspect of the process as a distinct part of the approach, in fact all three parts are entangled in a web of conversations. The examples I offer below are of conversations with young people as this is the population I most commonly work with.

*Reflecting on young people's coping strategies*

In reflecting, I ask young people to thicken the description of their lives (Glaser & Strauss 1967), looking closely at the ways they have coped over time, without discounting any of their experiences as necessarily dysfunctional. When done with sincere curiosity, I do not encounter people who resist these conversations. Specifically, I ask questions in everyday language that seek accounts of a young person's life in ways relevant to them. This work builds on that of others like Madsen (1999),

Madigan (1997), and Nylund (Nylund & Ceske 1997). The easy-going conversational language I use with teens is based on the following guiding questions that I keep in my own head to explore different lines of inquiry:

- What's important to you, your family, and community? What do you value? What parts of your life do you prefer?
- Who recognises these values and preferences in your life? Who knows that these things are important to you? Which near-at-hand experiences convinced you these things should be an important part of your life?
- Given what you value and prefer for your life, and your access to health resources, how do you sustain a sense of wellbeing/ mental health?
- What tricks have you learned about navigating your way successfully towards the resources you need to experience health?
- Can you tell me a story of a time when you found ways to protect or sustain your health or that of someone you care about? What tricks did this involve? What would you call these skills or tricks? What enabled you to do this? What is the history of this know-how?

As my work has tended to involve youth harmfully involved with labels that stigmatise them as one of four D's, dangerous, delinquent, deviant and disordered, their answers to these guiding questions often reveal success at negotiating an influential identity they associate with health outcomes. However, their success is often achieved through non-conventional means (for example, taking on the identity of gang member to feel like one belongs). I pay particular attention to acknowledging these choices (even if I personally find them threatening to what I value), and together we look closely at whether these pathways to resilience are the ones most realistically accessible given the barriers these children face. My message is one of tolerance. However, when the young person's decisions challenge my own sense of what is right and wrong, I open space to discuss our differences. These discussions avoid 'resistance' when I manage to convey to the youth that I understand he or she doing what is reasonable given his or her access to health resources and options for survival. In this regard, my work is similar to that of other postmodern, narrative and constructionist therapists who emphasise the necessity of respecting the truth claims of others (for example: Madigan & Law 1998; Nylund & Ceske 1997; Freedman & Combs 1996). Such questions, with their implied tolerance for multiple and contextually relevant explorations of resilience, challenges the homogenising discourse that has dominated the field with singular ideas of what is and is not indicative of a healthy 'individual'.

*Challenging unhealthy identity stories*

With this exploration well underway, I begin the second phase of my work which seeks to respectfully challenge identity stories children experience as unhealthy with stories they say they prefer – ones which portray them in ways they associate with resilience. In this regard, I follow French philosopher Jacques Derrida (1980) whose work demonstrated that the sign, in this case a label as healthy or one of the four D's, in itself signifies nothing. It is us collectively through our use of language that discerns what meaning a word has. In this game of match the sign to the experience it signifies, youth are sorely disadvantaged. Seldom are their accounts of their choices of their pathways to resilience honoured when those pathways do not fit with the way the dominant discourse defines health and the outcomes associated with it. I have no trouble finding the search for health implicit in children's nonconventional paths through life when I see the story of their actions as a search towards the health they themselves identify as missing (see White 2000).

Fortunately in narrative work there is often engagement with that which is 'absent but implicit' (White 2001, p.57). In the case of youth whose pathways to resilience are destructive of self or others, young people still strive towards something that they call success, power or health. I want to know from the young people themselves:

- How did you get the idea that health was worth striving for?
- Did someone introduce you to this idea? Who? Who would be least surprised to know that you care about your own health?
- How have you sustained your desire for a healthy identity over time?

- The labels that others place on you, how do they add to, or take away from, the story you tell about your identity as healthy?
- How are you different from others who have overcome adversity the same way?

Answering these questions, the youth and I find clues about places where they resist definitions of themselves as unhealthy, and find clues to openings to alternative health-saturated identities. This part of the therapeutic process challenges old problem-saturated stories and encourages thicker descriptions of less privileged accounts of young people's lives.

Because I think about the construct of resilience, about the way youth navigate towards resources for health and negotiate for healthy identities with others, and because I do not assume that any one word (sign) such as 'delinquent' necessarily attaches to another (that which it signifies) such as 'unhealthy,' I am open to exploring unique descriptions that children provide of their lives. In the case of 'delinquents', feelings of personal worth and shared power can be present and experienced by the youth as a sign of resilience, even though this resilience may remain hidden beneath the pathologising descriptions of others.

Take for example a fifteen-year-old young woman who steals a car while stoned. When the police drive up behind her and flash their lights, demanding she pull the car over, she speeds away. At the same moment, she reaches over and fastens her seat belt. A few minutes later, even though the police have pulled back fearing an accident, the young woman loses control of the car. It careens off the road and rolls several times as it goes into a ditch. The young woman survives with minor fractures. Later in custody, the thing I most want to discuss is not the drugs, the theft, or the disregard for authority, but that moment of decision when she fastened her seatbelt. It is in that moment when, despite appearances to the contrary, one gets a glimmer of a young person committed to survival.

It is a rich experience for me as the therapist to work with young people like that young driver who will patiently explain (when there is space for their identity stories to emerge) that they are doing the best they can with what they have. They also tell me that when they are offered substitute health resources that are less destructive to themselves and others, but every bit as powerful, they are happy to take advantage of these other opportunities to create a sense of themselves as resilient (Klevens & Roca 1999; Tyler et al. 1992; Ungar 2004b).

*Defining and performing new identities*

In the third part of my therapeutic approach, I encourage young people to take advantage of opportunities we create that allow them to perform their new identities, identities they experience as signs of resilience. In this regard, I am guided by the Russian philosopher Mikhail Bakhtin's (1986) work on performativity. Bakhtin emphasised that, for my identity story to take hold, I must perform it. I must define myself by influencing the dominant discourse and how it portrays my life. It is this enacting of my identity in front of an 'audience' by which my personal and collective identity story comes to be invested with power (Madsen 1999).

From clinical experience and a number of qualitative studies, I have become convinced that wellbeing will be sought and nurtured by children in any environment from any resources available. I have also become convinced that the *arbitrary* outsider judgement of what should and should not contribute to health cannot ever adequately do justice to the intricacies of other people's lives. The children who have worked alongside me to understand their pathways to resilience in resource-poor environments, tell me they seek an identity as competent/resilient and may actually successfully negotiate for such an identity through dangerous, delinquent, deviant and disordered self-expression. They skip school, they resist authority, they act out in their communities. If they are bored at school they will leave and satisfy their need for intellectual stimulation, social bonding and recreation through their street family. These localised 'truth claims' offered to me by young people have convinced me it is helpful to always understand resilience, and the striving for health, as contextually specific, enacted through a complex warp and weave of experience and identity.

## INVITING COMPLEXITY IN HOW WE UNDERSTAND RESILIENCE

To my understanding, resilience is not an intrinsic quality or set of behaviours, nor is it the

result of an ordered hierarchy of specific health resources available from a predictable environment. A thicker description of resilience reveals a seamless set of negotiations between individuals who take initiative, and an environment with crisscrossing resources that impact one on the other in endless and unpredictable combinations. In my role as a therapist, the onus is on me to be open to hearing about the stories that create and sustain resilience. In this way, conversations of hoping and coping may then replace conversations focussed on disorder and disease. I have found that when I approach those people with whom I work with a curiosity about the negotiations they have undertaken to achieve success, then I am better able to help people story their lives as lived well despite adversity.

## NOTES

[1] I would like to thank Todd Augusta-Scott for his helpful comments on an earlier draft of this paper. I would also like to acknowledge the support of the Social Sciences and Humanities Research Council of Canada which helps fund my work.

[2] It is this link between exposure to risk and outcomes associated with wellbeing that distinguishes resilience from more general discussions of health. The resilient child or adult, family or community, may demonstrate health, but not all healthy people, families or communities are resilient. The distinction is an important one. Resilience only exists when one (or one's family and community) has beaten the odds and survived and thrived after exposure to adversity that threatened healthy outcomes. Without exposure to significant amounts of risk, there is no resilience.

[3] Resilience, like its older sibling, empowerment, are words that have had powerful forces at play co-opting them into becoming part of the oppressive practices of globalisation and oppression. Businesses now routinely talk about empowering employees to increase profits; wars of occupation are disguised as efforts to empower oppressed citizenry; an article in the Harvard Business Review recently discussed resilient businesses as those that survive strikes by their employees (Coutu 2002).

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