Resilience Theory:

A Literature Review

with special chapters on

deployment resilience in military families

& resilience theory in social work

by

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CHAPTER FOUR: COMMUNITY RESILIENCE

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 (eg 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 (eg 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 (eg 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 work place 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'. Futhermore, 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, ito 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 superflous 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 copying [*sic*] 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".

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 resilience 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 (eg 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.