Resiliency, Connectivity and Environments: Their roles in theorizing approaches to the promoting the wellbeing of young people.

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Abstract

Early theory and findings in the area of resilience among young people emphasised individual differences and personality characteristics to explain different reactions to stress and risk. The 'modern' resiliency literature views the possible explanatory variables for different outcomes in broader contexts such as family, schools and community. Despite this change over time the individualising, problem focused orientation of resilience approaches continues to obscure the environment, leaving it an under-interrogated factor in youth wellbeing. The importance of this rests on its impact on policy and practice in the fields of youth development and health promotion. In this paper we argue that contemporary resiliency theory and research continue to fall short of the paradigm shift called for by those orienting to environmentally-based public health measures to improve population level wellbeing among young people.

"The concept of health promotion, revolutionary in the best sense when first introduced, is in danger of stagnation. This is the case because thinking and research have not been exploited to formulate a theory to guide the field." Antonovsky (1996: 11)

Antonovsky's complaint comes at the end of a long career of attempting to build health promotion theory and practice. His ideas centre on a criticism of what he characterizes as the pathogenic orientation of "all western medical thinking"; the biomedical focus that suffuses mainstream health-related practices, shaping them toward dealing with disease and problems, distracting and detracting from broader interests in wellbeing, in healthiness and its maintenance. While acknowledging the importance of the pathogenic epistemology to the clinical realm, Antonovsky saw it as an anathema to goals around the health of populations, of public health and health promotion, and sought to advance what he called a "salutogenic" theory of health. He rejected the dichotomizing of health and disease inherent in the pathogenic orientation, for a continuum model of health and illness. Antonovsky proposed a coherent theory for health promotion that prioritised the movement of populations toward health, wherever the health status of individuals might fall on the continuum.

In the public health arena the origins of health promotion paid little attention to what was happening at the individual level, for example, approaches to environmental problems such as sanitation and clean water (Macintyre, 1997; Szreter, 1997). A further caution to individualizing theory in health promotion is strongly indicated by modern social epidemiology (Marmot and Wilkinson, 1999; Rose, 1992). For a wide range of conditions it can be demonstrated that shifting the population mean can produce major population level changes in terms of outcomes on dose related conditions (Marmot, 1998). Such observations have profound implications for health promotion, particularly through calling our attention to physical and environmental factors as determinants of youth health and wellbeing (Anae et al., 2002).

In the field of youth wellbeing, resilience and the study of resilience factors (increasingly referred to as protective factors) are currently the key conceptual pegs upon which

researchers and theorists, have attempted to hang a range of possible interventions, including health promotion (Blum, 1998; Roth and Brooks-Gunn, 2000). Yet despite recent revisions the same pathogenic thinking of which Antonovsky was so critical pervades research efforts and the programmatic use of resiliency constructs. This remains a serious problem for the development of strong youth health promotion theory and practice.

The study of resilience arose from observations of young people thriving despite being raised in high-risk social and economic contexts. This dichotomizing of young people exposed to high-risk environments as resilient or non-resilient has lead to the development of treatment, maintenance and targeted prevention interventions (Bowen and Flora, 2002). Much research continues to be directed at evaluating the contribution of risk and protective factors to outcomes and the feasibility of modifying these factors to promote better outcomes. Methods used to investigate these questions are typically cross-sectional surveys and (less commonly) longitudinal studies (Fergusson and Horwood, 2001; Silva and Stanton, 1996). Both of these research methods gather data from individual young people and their subsequent findings typically pertain to specific individual problematic or concerning characteristics and behaviors and their relationship to negative health and social outcomes. They generally do not describe or measure environmental factors that promote positive health and social outcomes.

There have in recent times been attempts to recast resilience outside pathogenic models of health (Blum, 1998, Pittman et al., 2001). However the demarcation of resilience programmes is consistently that they "build on individual strengths and aim at addressing those factors that predispose an individual to one or multiple risks" (p6) Thus the theoretical constructs at the heart of the resilience paradigm are summarized as the "four Cs"; competence, confidence, character and connection. A critical point to make about these conceptualisations is that the first three describe individual characteristices. We contend the issue is not that discernable aspects of the individual are unimportant; of course they can tell us much about the possibilities for development or treatment but that these concepts predispose the theories built from them to a focus on individuals, risks

and problems. This detracts from the development of strong environmentally-focused programmes of health promotion.

The issue of connection takes a rather different course. Generally understood as the links that young people have to others, connection is a fundamentally social and therefore environmental feature of life. As an area of specific focus in "modern" resiliency research it is also rather better developed and can therefore be the subject of more elaborate critique. Micheal Resnick (2000) reviews a large literature on adolescent health and development and resilience to conclude that "crosscutting protective factors include a strong sense of connectedness to parents, family, school, community institutions, adults outside the family, the development and enhancement of academic and social competence, and involvement in extracurricular activities that create multiple friendship networks." He includes a review of successful interventions with young people to conclude that successful programmes are those that focus on competencies, prosocial attitudes and values, and individual goals of success, mastery and achievement. Critical to these efforts is the sustained involvement of caring adults in the context of individual and group-based relationships. "There is a view that developing capacities and competencies in young people through the involvement of caring, compassionate adults is essential."

Libbey et al. (2002) report data from a longitudinal study that echoes these conclusions stating that a "greater number of areas of connectedness was inversely associated with emotional distress with significantly less emotional distress with each additional area of connectedness. Family connectedness showed the strongest inverse association with emotional distress followed by school, neighbourhood and peer connectedness." These findings are invaluable to the underpinning of the development of treatment and prevention approaches.

From a public health perspective we need to enquire as to whether these kinds of connection are available in the contemporary worlds of youth. In New Zealand

prominent educationalist John Hattie remarked recently at Aotearoa/New Zealand's *Knowledge Wave 2003 Leadership Forum*

> "with one exception New Zealand is a psychologically safe place to be a school student … The exception is the achievement performance of the bottom twenty percent of our students" (Hattie, 2003).

Of concern is that Maori and Pacific students are disproportionately represented in the fifth of students who are not safe and for these students connection with an institution that is fundamentally rooted in a radically different culture, may or may not have positive outcomes.

If connection is only examined in terms of interfaces between persons, what is lost are the environmental characteristics that enable or undercut such crucial linkages. Urgent priority needs to be given to the study of what might be termed the "connectivity" of environments – that is the systemic, physical and social features of everyday worlds that produce the connections that matter so much.

The issue we believe is that to date resilience as a concept and a research field has diverted much attention away from the role of environments in producing the health of populations. This is a subtle phenomenon; the large corpus of research based knowledge about protective factors is very valuable to health promotion approaches; the academic writing often appears to take an environmental perspective. The problem is that the pathogenic underpinnings keep leaking through. Those in youth health research and practice are typically critical of service and treatment approaches which are characterised as "the ambulance at the bottom of the cliff", but often the alternative seems to be "the ambulance at the top of the cliff". At the risk of overburdening the metaphor we would argue that public health approaches must entail working to reduce the drop.

Amongst other things this should encourage us to invest in the kinds of research questions around the characteristics of the everyday environments in which young people

live. We should also learn from indigenous health movements and the damaging health-related experiences of migrant and minority groups. In New Zealand Maori and Pacific models of health such as *Te Pae Mahutonga* (Durie, 1999) and *Fonofale* (Tamasese et al., 1997) with their holistic, communitarian focus can make contributions of the kind Antonovsky envisaged (Anae et al., 2002). Likewise healthy youth development approaches (Pittman et al., 2001) reject youth programmes to focus on building social action around social and environment change. Linked with quality publicly funded research organizations, these conceptual foundations can produce research-based strategies that change social, political, economic and physical environments in to enhance their health-promoting characteristics and reduce their health demoting characteristics in ways that result in population health gains. In *Building on Strengths* (Ministry of Health, 2002) New Zealand now has a national mental health promotion policy that supports actions built around this kind of environmentally-based public health theory.

It will take time and effort to move this new approach into practice given the existing array of commercial, professional and political resistances in play. In health in Aotearoa/New Zealand as elsewhere we have major issues with racism, colonialism and latterly exploitative capitalist globalisation as determinants of health (Ajwani et al., 2003, Cunningham and Stanley, 2003; Scott et al., 2003) all of which sap the strength of individuals, communities, institutions and nations to provide and utilise health promoting environments. A key need is to build a widely accepted strong, autonomous, theoretical rationale as to why we must focus on the social and physical environmental determinants of health in order to enhance and achieve the best possible outcomes particularly for our young people who will be the adults of tomorrow.

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