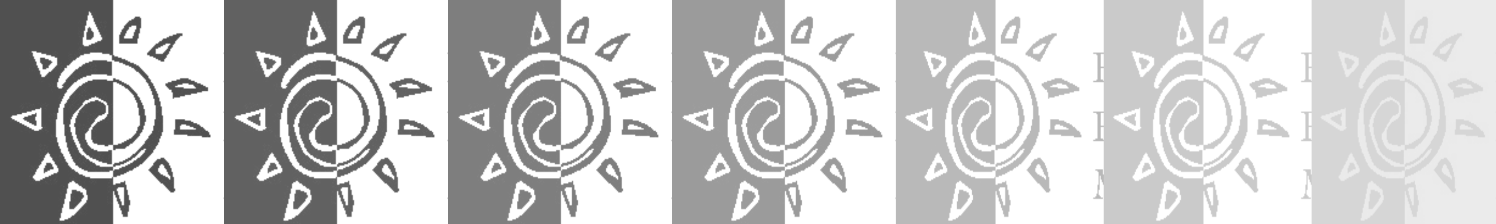

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Integrating Family Resilience and Family Stress Theory

The construct, family resilience, has been defined and applied very differently by those who are primarily clinical practitioners and those who are primarily researchers in the family field. In this article, the family resilience perspective is integrated with conceptual definitions from family stress theory using the Family Adjustment and Adaptation Response (FAAR) Model in an effort to clarify distinctions between family resiliency as capacity and family resilience as a process. The family resilience process is discussed in terms of (a) the meaning of significant risk exposure (vs. the normal challenges of family life) and (b) the importance of making conceptual and operational distinctions between family system outcomes and family protective processes. Recommendations for future family resilience research are discussed.

The perspective that families, like individuals, can be considered resilient as they deal with the challenges in their lives has received increased attention from family scholars in the past decade. The popularity of this concept reflects the general trends in (a) family science, with more emphasis on family strengths (Stinnett & DeFrain, 1985) and resources (Karpel, 1986), rather than family deficits and pathology; and (b) psychology, with a greater emphasis on positive mental health and good functioning (Seligman & Csikszentmihalyi, 2000). However, with the proliferation of research on resilience and applications in practice, confusion has resulted in defining resilience and in deciding who is resilient, particularly when a family is the unit of analysis.

There are multiple sources contributing to this confusion but three issues stand out. First, practitioners and researchers have used the concept of resilience differently. Generally, practitioners use the term to characterize an approach that focuses on family strengths versus deficits; most researchers, on the other hand, have been more interested in outcomes to explain unexpected competent functioning among families (and individuals) who have been exposed to significant risk(s). A second source of confusion follows from the first and relates to the lack of differentiation between (a) resilience as an outcome, (b) the characteristics or protective factors that contribute to families being resilient, (c) the nature and extent of risk exposure, and (d) the process of resilience. The third source of confusion is one that often plagues the family field with regard to other constructs and relates to the unit of analysis. How is a resilient family different from a resilient individual? Wolin and Wolin (1993), for example, wrote about resilient individuals in the context of having survived a toxic, dysfunctional family of origin. In their work, the primary unit of analysis is the individual and their attention to the family system is primarily as a significant source of risk. Is their work about *family* resilience?

In this article, I address the above issues and try to clarify the concept of family resilience. The theoretical foundation for the ideas presented is family stress and coping theory, particularly the stress models that emphasize *adaptation processes* in families exposed to major adversities. An effort is made to integrate the body of work of devel-

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opmental psychologists who have been studying the origins of psychopathology in children. Empirical support for the perspective on family resilience developed in this article is drawn from studies of family adaptation when a child member has a chronic illness or disability, although the relevance of these ideas to families faced with other kinds of significant stress should be apparent.

What Is Family Resilience?

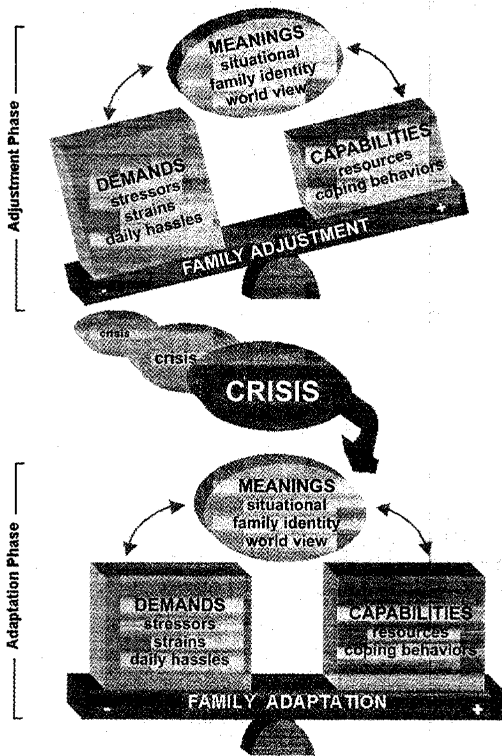
The concept of resilience emerged primarily from studies of children who functioned competently despite exposure to adversity when psychopathology was expected (see, i.e., Garmezy, 1991; Masten, 1994; Rutter 1987; Werner & Smith, 1992). Concurrently, researchers in disciplines other than psychology were noting similar competent functioning following risk exposure. Antonovsky (1987), a medical sociologist, introduced the concept of *salutogenesis* to describe the high functioning of many survivors of the Holocaust. Cassel (1976), an epidemiologist, introduced the idea of *host resistance* to describe the factor(s) that protected the host (person) from becoming ill. The field of family science was following a similar paradigm shift. McCubbin and his colleagues (McCubbin, Boss, Wilson, & Lester, 1980; McCubbin & Patterson, 1982), in explaining variability in military families' responses to the crises of war, observed that many families moved from crises to successful adaptation. The disciplines of public health, medical sociology, psychology, and family science converged at a similar place asking a similar question: "What accounts for why some stay healthy and do well in the face of risk and adversity and others do not?" The phenomenon of doing well in the face of adversity is now called *resilience.*

In these studies, the evidence for resilience was usually based on competent functioning in some domain (such as good social relationships or work success) after exposure to significant risk (such as being reared by a mentally ill parent or having a husband or father disappear in the Vietnam War). The risk was labeled significant because normatively, most persons exposed to it showed symptomatic or dysfunctional behavior. As these unexpected relationships between risk exposure and successful functioning were observed, attention was increasingly drawn to identification of the factors that moderated the relationship, which have been labeled protective factors. Integrating the work of many resilience researchers, Masten and Coatsworth (1998) clarified three conditions necessary for considering resilience in individuals. These three conditions can be adapted to family as the unit of analysis: First, a *family-level outcome* must be conceptualized so it is possible to assess the degree to which a family is competent in accomplishing the outcome. Second, there must be some *risk* associated with the expectation that a family will not be successful. Third, there is a need to understand what *protective mechanisms* prevent poor expected outcome(s). Any application of this perspective requires clear conceptual definitions of family outcomes, significant family risk, and protective mechanisms. Family stress theory has much to offer in formulating these definitions.

Family Stress and Coping Theory

Just as understanding of child resilience emerged from studies of stress and coping in children, family resilience can be examined from the perspective of family stress and coping theory (Boss, 2001; Hill, 1958; McCubbin, McCubbin & Thompson, 1995; McCubbin & Patterson, 1983; Patterson, 1988). In this article, the Family Adjustment and Adaptation Response (FAAR) Model (Patterson, 1988) will be used to emphasize the linkages between family stress theory and the family resilience perspective. In the FAAR Model, four central constructs are emphasized: families engage in active processes to balance *family demands* with *family capabilities* as these interact with *family meanings* to arrive at a level of *family adjustment* or *adaptation* (Patterson, 1988; 1993; see Figure 1). Family demands are comprised of (a) normative and nonnormative stressors (discrete events of change); (b) ongoing family strains (unresolved, insidious tensions); and (c) daily hassles (minor disruptions of daily life). Family capabilities include (a) tangible and psychosocial resources (what the family has) and (b) coping behaviors (what the family does). There are some obvious parallels between risk factors (resilience language) and demands, as well as between protective factors and capabilities. Both demands and capabilities can emerge from three different levels of the ecosystem: (a) individual family members, (b) a family unit, and (c) from various community contexts. The diagnosis of a child's disabling condition would be an example of an individual level demand; marital conflict about how to manage the child's condition would be a family level demand;

FIGURE 1. FAMILY ADJUSTMENT AND ADAPTATION RESPONSE MODEL



Note: From "Families Experiencing Stress: The Family Adjustment and Adaptation Response Model," by J. M. Patterson, 1988, *Family Systems Medicine, 6*(2), pp. 202–237. Copyright 1988 by Families, Systems & Health, Inc. Adapted with permission.

and community stigma about disability would be a community level demand. Parent education, family cohesiveness, and good health and education services are examples of capabilities at each of the three levels, which could be used to help manage the aforementioned demands. Developmental psychologists also have emphasized that the resilience process involves transactions between multiple systems in the ecological context and that both risk and protective factors can emerge within individuals, families, and/or community contexts (Luthar, Cicchetti, & Becker, 2000). Among family stress theorists, Boss (2001) has emphasized the contexts of family stress and the need to take account of community and cultural contexts in which a family resides to understand why and how families are stressed, as well as to understand how families respond to stress.

Family meaning, an important construct in the FAAR Model, is less apparent in individual resilience perspectives but may add understanding to how the resilience process unfolds. Three levels of family meanings have been described in the FAAR Model: (a) families' definitions of their demands (primary appraisal) and capabilities (secondary appraisal); (b) their identity as a family (how they see themselves internally as a unit); and (c) their world view (how they see their family in relationship to systems outside of their family; Patterson, 1993; Patterson & Garwick, 1994). These meanings shape the nature and extent of risk, as well as the protective capacity of a family. The process of adapting to major, nonnormative stressors, such as the diagnosis of a child's chronic health condition, often involves changing prior beliefs and values as a way to make sense of the unexplainable and as a way to adapt (Patterson, 1993).

There are two types of family outcomes in the FAAR Model. On a daily basis, families engage in relatively stable patterns of interacting as they try to balance the demands they face with their existing capabilities to achieve a level of family adjustment. However, there are times when family demands significantly exceed their capabilities. When this imbalance persists, families experience *crisis,* which is a period of significant disequilibrium and disorganization in a family. A crisis is very often a turning point for a family, leading to major change in their structure, interaction patterns, or both. A crisis can lead to a discontinuity in the family's trajectory of functioning either in the direction of improved functioning or poorer functioning. When the discontinuity is in the direction of improved functioning, this would be similar to the developmental discontinuities noted by Rutter (1987), Cowan, Cowan, and Schulz (1996) and others as an indicator of resilience. The processes by which families restore balance (reducing demands, increasing capabilities, and/or changing meanings) are called regenerative power in stress theory if the outcome is good (family bonadaptation). Of course, families can also engage in processes leading to poor adaptation, which is called *vulnerability* in stress theory (McCubbin & Patterson, 1983). Family resilience is similar to family regenerative power when good outcomes follow significant risk situations confronting a family. In the next sections, definitions of the key constructs underlying a family resilience perspective will be clarified by integrating conceptual definitions from family stress theory.

Is Family Resilience Capacity or Process?

A major source of confusion about family resilience is the two different ways this term is used for practice versus research. Generally, for practitioners, family resilience implies the capacity of a family to successfully manage challenging life circumstances—now or in the future (Walsh, 1998). Consistent with this view, McCubbin and McCubbin (1988) define family resilience as "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" (p. 247). Used in this way, family resilience appears to be another name for family strengths. It is not always clear if or how this family capacity is distinct from family protective factors. For practitioners, there is less emphasis on the nature of significant risk exposure or on family-level outcomes that are conceptually distinct from family strengths or protective capacity. From a research perspective, however, significant risk, protective factors, and outcomes each must be distinctly defined—conceptually and operationally—to decide if a family has engaged in a process of resilience.

Most researchers view resilience as a process where there are interactions between risks and protective factors relative to a specified outcome. The processes by which protective factors moderate or mediate the risk and lead to good outcomes continue to be debated (Luthar et al., 2000). For example, protective factors can have direct effects on the outcome (e.g., the factor has a similar effect under conditions of high risk or low risk), or interactive effects (Zimmerman & Arunkumar, 1994). In the latter case, protective factors may only affect the outcome under conditions of high (vs. low) risk—true interactive effect—or the protective factor may be developed or strengthened following risk exposure and contribute to higher than normal competence in the outcome—an inoculation effect. These variations in functioning following risk exposure are similar to Hill's (1958) roller coaster model of family stress when he proposed that stressed families return to a level of functioning at, below, or above their precrisis level.

Psychologists wanting to differentiate between resilience as a trait versus a process have recommended that the term resiliency be used to refer to an individual trait (much like ego-resiliency) and that *resilience* be used to describe the process of successfully overcoming adversity (Luthar et al., 2000; Masten, 1994). If the family field were to adopt a similar convention, *family resiliency* could be used to describe the capacity of a family system to successfully manage their life circumstances and *family resilience* could be used to describe the processes by which families are able to adapt and function competently following exposure to significant adversity or crises. The latter raises additional questions. First, what does it mean for a family system to adapt and function competently, and second, what is significant risk?

Family as the Unit of Analysis

Family System Outcomes

To be considered family resilience (in contrast to individual resilience), the outcome of interest should be at the family system level, where a minimum of two family members are involved; that is, it should represent the product of family relationship(s). Examining this issue from the perspective of family stress theory, family adaptation is the outcome in the FAAR Model most relevant to resilience because it emerges following a crisis, which is a period of serious disruptiveness, implying significant risk exposure. Family adaptation has been defined as a process of restoring balance between capabilities and demands at two levels of transaction: (a) between family members and the family unit, and (b) between a family unit and the community. When the family is successful in this process, bonadaptation is observed in the family's (a) continued ability to promote the development of individual family members and (b) willingness to maintain their family unit so it can accomplish its life cycle tasks (Patterson, 1988). This definition acknowledges two issues relevant to resilience. First, the family serves as a bridge between the individual and other community contexts and is often central to the transactional processes evident when resilience occurs. Second, it points to at least two important functions families fulfill, both for their members and for society: (a) nurturance and socialization and (b) family formation and membership. These are two of the four functions Ooms (1996) has emphasized to policy makers as important in strengthening the capacity of families in contemporary society. The other two functions she identified were (a) economic support and (b) protection of vulnerable members. She advocated that public policies be examined relative to their impact on families' abilities to satisfactorily fulfill these functions. In Table 1,

TABLE 1. CORE FUNCTIONS OF THE FAMILY FOR INDIVIDUAL MEMBERS AND FOR SOCIETY

Family Function	Ways Each Function Provides Benefits To: Individual Family Members	Ways Each Function Provides Benefits To: Society	Examples of Positive (+) and Negative (−) Family Level Outcomes
Membership and family formation	■ Provides a sense of belonging ■ Provides personal and social identity ■ Provides meaning and direction for life	■ Controls reproductive function ■ Assures continuation of the species	+ Commitment to and maintenance of family unit + Addition of children is planned and desired − Divorce
Economic support	■ Provides for basic needs of food, shelter, and clothing and other resources to enhance human development	■ Contributes to healthy development of members who contribute to society (and who need fewer public resources)	+ Adequate food and clothing + Safe housing − Child neglect − Homelessness
Nurturance, education, and socialization	■ Provides for the physical, psychological, social and spiritual development of children and adults ■ Instills social values and norms	■ Prepares and socializes children for productive adult roles ■ Supports adults in being productive members of society ■ Controls antisocial behavior and protects society from harm	+ Family love and mutual support + Martial commitment and satisfaction + Securely attached children − Domestic violence − Child abuse
Protection of vulnerable members	■ Provides protective care and support for young, ill, disabled or otherwise vulnerable members	■ Minimizes public responsibility for care of vulnerable, dependent individuals	+ Family care for child with special needs − Elder abuse − Institutional placement of member with disability

some ways each of these functions serves the needs of individual family members and the needs of society are elaborated.

One possible way to conceptualize meaningful family-level outcomes for assessing family resilience is the degree to which a family is competent in fulfilling one or more of these four functions. Although this structural-functional approach for defining family competence may no longer seem relevant to post-modern families, it may offer one way to maintain a distinction between family protective mechanisms and family competence as an outcome. Family functions are not the same as family functioning. The term *family functioning* is commonly used to describe relational processes within a family (Walsh, 1998). In other words, family functioning is the way in which a family fulfills its functions. These family relational processes are important in considering family protective mechanisms. To reduce confusion, I use *family relational processes* in lieu of family functioning to distinguish family functions as indicators of family-level outcomes.

Would a family have to be competent in all four of these functions to be labeled resilient? Psychologists have debated this issue and have agreed that a child does not have to be competent in all domains to be considered resilient (Luthar et al., 2000). Deciding which family function(s) are the most relevant indicator of family competence will vary depending on the population being studied and the research question(s) being addressed. For studies of resilience in families with a child who has a chronic health condition, the ability of the family to meet a vulnerable member's needs with internal and external resources is a relevant function (in contrast to the irrelevance of this function for a family who did not have a vulnerable member). However, competence in this one function may be insufficient in deciding if a family is resilient, given that the presence of a chronic health condition often creates risks that other family needs may be ignored or postponed (Reiss, Steinglass, & Howe, 1993). Clinicians have reported that when families live with chronic illness there is a tendency for some families to give a disproportionate amount of their resources of time, energy, and money to the illness needs at the expense of meeting the needs of other family members. When this skew toward the illness is

prolonged, normal family developmental needs may be unattended, which would threaten successful accomplishment of the nurturance and socialization function of the family (Reiss et al., 1993; Steinglass, 1998). It would, therefore, be important to assess a family's competence relative to both of these functions in deciding about their resilience.

It is also possible that a family may show competence in one function but not others. For example, a teenager giving birth to an unwanted child is an example of lack of competence in the family formation and membership function. Challenges faced by unmarried teen mothers are well documented (Corcoran, 1998), and competence in meeting the nurturance, socialization, and economic functions may be difficult for them to achieve. However, over time, some young single parent families recover from this significant risk and move on to become competent in meeting the nurturance, socialization, and economic functions thereby becoming resilient.

If we accept that resilience is a process and not a trait, it follows that families would not necessarily be resilient for all time under all circumstances. Developmental psychologists, too, have pointed out that children are not necessarily resilient across all developmental stages (Luthar et al., 2000). Families may be resilient in responding to one form of significant stress but as new circumstances emerge, their ability to remain resilient could diminish.

Even though the label of family resilience does not require competence in meeting all family functions, these examples illustrate how closely interrelated success in meeting these functions can be. Moreover, when a generally successful family shows decline in meeting one of the functions, it is quite likely that they have encountered circumstances that would be labeled significant risk.

It is important to note that although these functions of the family are viewed as ubiquitous across racially and culturally diverse families, the way these functions are accomplished will reflect incredible diversity. This diversity will be apparent in the capacity or resiliency of the family—in the protective relationship patterns they develop to manage life's challenges.

Family Risk Exposure and Mechanisms

Significant Risk

One major issue related to risk exposure that seems to be viewed differently in research and practice is how significant the risk must be before a good outcome can be considered evidence of resilience. Masten and Coatsworth (1998) articulate the view of resilience researchers and define significant risk as emerging from: (a) high-risk status by virtue of continuous, chronic exposure to adverse social conditions, such as poverty; (b) exposure to a traumatic event or severe adversity, such as war; or (c) a combination of high-risk status and traumatic exposure. From this perspective, every family would not have sufficient risk exposure to show evidence of resilience. Theoretically, everyone could be competent but only those exposed to significant risk who functioned competently would be viewed as showing resilience.

However, the perspective of practitioners about resilience seems to suggest that any family who functions competently would be an example of resilience (McCubbin et al., 1995; Walsh, 1998). Perhaps what is implied by this view is that life in general is sufficiently challenging to create risk exposure. All families at some time or another are faced with challenges to their usual way of relating and accomplishing life tasks. Hence, the notion of significant risk as a precondition for resilience may be less relevant to practitioners.

It is important to note that the significant risk perspective emerged from researchers who, as it happens, were studying populations at significant risk. The life-as-risk perspective was articulated primarily by practitioners (and some applied researchers) whose interest was the encouragement of approaches to prevention and intervention that focus on individual and family strengths rather than deficits. The two perspectives are related. Practitioners use the evidence produced by the significant risk researchers as the basis for their approach. Furthermore, resiliency-based practitioners hold the belief that most families can recover from stress and adversity and be successful. In this sense, the resiliency perspective is a philosophy and belief system oriented towards uncovering individual and family assets and strengths (Walsh, 1998).

The significant risk perspective relies on population-based observations of the negative outcomes experienced by the majority of families exposed to any given risk. This objective judgment of significant risk is based on normative data documenting poor outcomes. In family stress theory, a distinction is made between objective judgments about the severity of sources of stress and subjective judgments (i.e., the primary appraisal of the person or family experiencing the source of stress;

Lazarus & Folkman, 1984). Subjective judgments are a critical component of the coping response, which influence behavior and hence, adaptation. In the FAAR Model, the first level of family meanings emphasizes the meaning a family gives to their situation and includes appraisal of the difficulty of the sources of stress and appraisal of the family's capabilities to manage the stress (Patterson & Garwick, 1994). It might be argued that the process of defining the situation is a critical component in understanding resilience processes because these appraisals are a critical link in what Rutter (1987) calls the *chain of risks* or *chain of protective mechanisms.*

Family level meanings are distinct from individual meanings. Family meanings are the interpretations 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 about these experiences. Reiss (1981) emphasized that these family constructions of reality emerge from the family's shared process and that they are more than simple agreement among members. These implicitly shared explanatory systems play a crucial role in organizing and maintaining group process. Shared meanings reduce ambiguity and uncertainty about complex stimuli and make coordination of response among family members possible. Wamboldt and Wolin (1989) called shared family meanings *family reality* to differentiate them from what one family member might report about his or her family's meanings, which they called a *family myth.* A family myth is based on internalizations of family experience and is how a person represents the family in his or her mind. Family reality is observed as the practicing family according to Reiss (1989).

The important point in the present discussion is that a family's shared meanings about the demands they are experiencing can render them more or less vulnerable in how they respond. These family appraisals and responses to discrete demands cumulatively create a pattern. A family's history and experience with successfully managing normative demands (which may not fit the significant risk criteria) can build their protective capacity or resiliency, increasing the likelihood of showing resilience if and when they were exposed to a traumatic event that would be defined as a significant risk. Conversely, difficulty in managing normative demands could cumulatively lead to a downward trajectory in fulfilling family functions, the inability to build a repertoire of protective family relational processes and perhaps high-risk status. From this systemic, process-oriented perspective, the punctuation point for defining significant risk exposure (of the sort where recovery from it would be called resilience) is less clear, particularly with regard to high-risk status as a necessary condition to be viewed as resilient.

Rutter (1987) articulated the view of many resilience researchers that risk should be examined in terms of mechanisms, rather than factors per se, emphasizing that there are processes by which exposure to a static risk factor interacts with a person in the context of his or her life. This perspective is similar to Boss' (2001) view that family stress expression and response must be examined within the social and cultural contexts of a family's life. For example, parenting a child with asthma is different for a poor family than for a middle-class family. A poor family is more likely to live in a social context with fewer social supports, have difficulties accessing health and education services, have less parental understanding of ways to minimize asthmatic attacks, have less control over the physical environment that exacerbates reactivity in the child's airways, and experience more challenges in meeting basic economic needs of the family (Mansour, Lanphear, & DeWitt, 2000). In such a context, the needs of the child with asthma may be minimized because other basic needs are viewed as more pressing. Inattention to the child's asthma needs may contribute to more medical emergencies, fewer preventative measures, school absences, and often, increased morbidity and earlier mortality.

Risks often cascade, with one risk leading to another, in a downward spiral (Rutter, 1987). McCubbin and Patterson (1983) used the phrase "pile-up of family demands" to describe such an accumulation of sources of stress. This cascading of risks often is related to having inadequate resources for meeting family needs. When a need is unmet, it can generate more problems, hence increasing the risks. When there are too few resources available relative to needs of family members, a demand-capability imbalance emerges, moving a family into crisis.

Normative Versus Nonnormative Demands

Usually normative family demands (expectable family life cycle changes, such as getting married or having a child) would not be considered a significant risk for families. However, in some instances and contexts, they could pose significant

risk. For example, if the timing of a normative change departs from societal expectations it may be harder to manage, such as a teenager having a baby. Or the meaning of a normative event, influenced by social and cultural factors, could increase the risk. Also, families could be classified as high risk if they had few protective resources (such as income, education, social support) and would be more likely to have difficulty with normative transitions. Thus, there is no clear rule that competence in managing normative demands could not be characterized as resilience.

Generally, however, it is not likely that normative demands would fit the significant risk category, which is not meant to suggest they are not challenging. Rather, it means that the majority of families are competent in making these transitions. Furthermore, families who have adequate protective capacity (resiliency) are more likely to be competent in managing normative demands.

However, nonnormative demands, which are unexpected and many times traumatic, are more likely to fit the definition of significant risk. Clearly, there is a range of such events from natural disasters, such as floods and tornados, to the premature death of a parent or child. The diagnosis of a child's chronic illness and the ongoing strains of managing it have the potential to fit the significant risk category. Epidemiologic data related to the impact of a child's chronic condition on the family indicate twice the risk for psychological or behavioral problems in the target child (Lavigne & Faier-Routman,1992; Pless, Power, & Peckham, 1993) or the siblings (Breslau, 1983), as well as a comparable risk for family problems (Wallander & Varni, 1998).

It is not uncommon that the child's chronic condition could trigger a chain of other risks and thereby move the family into high-risk status. The daily caregiving demands for some chronic conditions can lead to physical and emotional exhaustion in parents, which may contribute to depression or other psychological symptoms. In a study of medically fragile children living at home, 75% of the families had one or both of the parents scoring in the psychiatric case range on a standard symptom inventory (Patterson, Leonard, & Titus, 1992). In this same study, continuous hassles with insurers of their children's services and conflicts with professionals caring for their children in their homes also contributed to parental distress. Many families experienced social isolation, which was related to lack of time for social activities, the large effort required to arrange child care when going out, and the social stigma encountered if they tried to take their child with them to public places. In addition, many families reported loss of their prior social networks—former friends said or did insensitive things or avoided them (Patterson et al., 1992). Parental depression and social isolation are likely to contribute to additional risks, such as compromised parenting and/or increased marital dissatisfaction and conflict. Although all children with chronic health conditions do not have such high caretaking needs as those who are medically fragile, a comparable chain of risks is still quite plausible for many families engaged in daily caregiving for a vulnerable member. The likelihood is greater if there are insufficient capabilities or protective factors to help families meet these needs.

Family Protective Processes

The key to understanding family resilience is the identification of protective factors and processes that moderate the relationship between a family's exposure to significant risk and their ability to show competence in accomplishing family functions. As already noted, protective factors that contribute to competent family outcomes can emerge from within individual family members, from a family unit, and from multiple community contexts. Most scholars writing about family resilience or resiliency have focused on the relational processes within families as the primary basis for considering their resiliency (see, for example, McCubbin et al., 1995; Walsh, 1998). Two central aspects of these family relationship patterns are family cohesiveness and flexibility. These patterns are most protective when there is family agreement about the balance between closeness and distance and between change and stability. In addition, the quality of affective and instrumental communication patterns within a family usually is protective because it facilitates how families accomplish core functions.

These and many other family relational patterns are crucial in the ways families respond and adapt to stress. The authors just referenced have been careful to point out that racial, cultural and ethnic variation produce a wide range of family relational patterns that can contribute to family competence. It is important not to become too narrow in defining what these family patterns should be, which sometimes happens because so many methods for assessing family relationships have been developed and normed using primarily

White, middle-class families. Fortunately, we have an extensive literature on diverse family strengths and protective processes, including a growing body of work on ethnic diversity in families (see McCubbin et al., 1995).

However, less attention has been given to the transactions between the multiple sources of protectors in the ecosystem (individual, family, and community contexts). We need to consider more fully the mechanisms that bring multiple protective factors in a family's ecological context into play and how they build on each other to create cascade or chain effects.

Nonnormative chronic stress has a way of pushing a family to the extremes of adaptation—either they decline in competence or they become even more competent (Hetherington, 1984). When stressors bring out greater than average strengths in families, this represents the inoculation or challenge model of resilience (Zimmerman & Arunkumar, 1994). In one study of families who have children with chronic health conditions, scores were higher than norms on standardized measures of child and family relational processes, suggesting that some families do get stronger from stress exposure (Patterson, 2000). Some families showed more cohesiveness, more affective communication, and clearer family role organization than families without children with chronic conditions. The families in the study were not representative of all families living with a chronic health condition, however. Most of the children lived in two-parent families, with middle-class family incomes and higher levels of parental education. They also lived in states where they had health and education services that were higher quality and more accessible than the national average. In other words, these families had resources that were protective at the individual (parent education and income), family (cohesiveness, communication skills) and community (health and education services) levels. There were transactions between these systems to make sure the needs of their children were met. Parents of children with special needs repeatedly tell stories of how they advocate for their children within school systems and health systems and among private and public payers of services to assure that they get the services guaranteed by law. This is an active process that emerges from families' commitment to their children (a family level resource), education and knowledge about their rights (individual resources), and support from other parents (community level resource) engaged in the same advocacy efforts. These are examples of how a chain of protective factors can be set in motion and contribute to family resiliency and resilience.

In the FAAR Model, coping is viewed as part of family capabilities and for the purposes of the present article, a component of protective factors associated with resiliency. In an earlier review of the literature examining resiliency in families who have children with disabilities, nine family coping strategies or processes were identified that seem to be protective for these families: (a) balancing the illness with other family needs, (b) maintaining clear family boundaries, (c) developing communication competence, (d) attributing positive meanings to the situation, (e) maintaining family flexibility, (f) maintaining a commitment to the family as a unit, (g) engaging in active coping efforts, (h) maintaining social integration, and (i) developing collaborative relationships with professionals (Patterson, 1991).

Several of these processes involve transactions between families and community systems. Maintaining clear family boundaries involves family protection of their integrity, sense of identity, values, routines and rituals from overdirectedness by health, education, and social service providers who are trying to help meet special family needs. Maintaining social integration is a reciprocal process between a community that is open and encouraging of involvement by persons with disabilities and family initiative to help reduce physical and psychological barriers that can isolate them. Similarly, collaborative relationships with professionals are reciprocal processes involving attitudes of mutual respect and skills for effective communication.

Included in the above list is the coping behavior, attributing positive meanings to the situation, which is a central process associated with family resilience. A family's ability to alter or make meaning from their significant risk experiences has been emphasized by many scholars (Antonovsky, 1987; McCubbin et al., 1995; Walsh, 1998). Families implicitly construct and share meanings at three levels: (a) about specific stressful situations, (b) about their identity as a family, and (c) about their view of the world (Patterson & Garwick, 1994).

For any given stressful situation, families implicitly evaluate how difficult it is or will be (primary appraisal). Their level of experienced stress is related to this subjective appraisal. Many sources of stress only exist by virtue of the expectation a family has (e.g., we are bad parents if our child

has a birth defect). Each stressful situation also is appraised relative to a family's capabilities (secondary appraisal). Many capabilities are primarily subjective as well, such as a family's sense of mastery. This meaning making process influences how a family copes with stress. In a study of families with a medically fragile child, some families developed positive meanings about their situation as a way to cope (Patterson, 1993; Patterson & Leonard, 1994). Many parents emphasized the positive characteristics of their child (warmth, responsiveness, and the ability to endure pain), of their other children (empathy and kindness), of themselves as parents (assertiveness skills in dealing with service providers), and of their family (greater closeness and commitment to each other from facing the challenge together). Many of these families faced real limits in getting the services and help they needed because of the severity and extent of their child's medical needs. It was difficult, if not impossible, to achieve a balance between the accumulation of added strains and caretaking needs (demands) and resources to meet them. Thus, many families coped by changing the way they thought about their situation. They emphasized what they had learned and how they had grown as a family rather than the hardships they had experienced. Through the meaning making process, they increased their capabilities and reduced their demands.

A family's belief in their ability as a group to discover solutions and new resources to manage challenges may be the cornerstone of building protective mechanisms. Success in coping with one situation creates the foundation for this belief to generalize to other situations and ultimately to a set of meanings about the family unit, or what is referred to as a family's identity.

Families develop a shared identity from the spoken and unspoken values and norms that guide their relationships. Daily routines and rituals contribute to this process of building a sense of who a family is and how they are different from other families. For example, engaging in family rituals without the influence of alcoholic behavior has been identified as a major process protecting families from the intergenerational transmission of alcoholism after growing up with alcoholic parents (Steinglass, Bennet, & Wolin, 1987). On the other hand, routines and rituals can be disrupted when adversity such as chronic disease or other unpredictable risks strike a family. Steinglass (1998) emphasized that disruption of family routines and rituals, which regulate daily processes, threatens the development, maturation, and stability of families with members with chronic illnesses. With the ongoing stress of chronic disease, the family's valued routines and rituals may be subsumed by illness needs and if this pattern persists over time, there can be undesirable consequences. We found that parental coping that focused on balancing across family needs was associated with a better 10-year trend in pulmonary function (a key health status indicator) for children with cystic fibrosis (Patterson, Budd, Goetz & Warwick, 1993). Maintaining their own integrity about how to balance competing family demands is also an example of maintaining family boundaries discussed above.

A family's world view (the third level of meaning) can be instrumental in shaping day-to-day family functioning. A family's world view shapes their orientation to the world outside of the family and is often grounded in cultural or religious beliefs. In the aftermath of a major adversity, the family's world view may be changed as they reflect on the losses they have experienced. When a world view is shattered by a nonnormative experience like the death of a child, the family's ability to heal, grow, and move forward often involves reconstructing a new view of the world that allows them to make sense of such an event (Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000). Hence, this meaning making process is a critical component of family resilience and is facilitated by group interaction within the family as well as through transactions in the community with other families experiencing similar circumstances.

Implications for Future Research on Family Resilience

The family resilience perspective has much to offer the family science discipline. Although, in many ways, the concepts that underlie it are already contained in family stress theory, a focus on resilience draws greater attention to family success and competence. The knowledge derived from family resilience studies can contribute to the resiliency approach being used in practice settings. However, greater understanding of how families remain or become competent following exposure to significant risk will require rigor and precision in the methodology employed to capture these dynamic processes in families. The following strategies are recommended:

Provide clear conceptual and operational definitions of key variables. It will be a major challenge

to make the definitions of family outcomes indicating competence conceptually and operationally distinct from family protective processes. In this article, core family functions were suggested as one possible way to conceptualize meaningful family level outcomes but determining appropriate methods for measuring competence in fulfilling these functions will still be necessary. There well may be other meaningful ways to conceptualize family competence as an outcome that would be distinct from family relational processes that serve as protectors.

Develop and test conceptual models for risk and protective processes. These models should take account of the mechanisms by which risks or protectors accumulate and how the latter moderate risks and influence outcomes of family competence. The transactions between family risks and protectors and individual and community factors should be considered in models.

Study populations of families experiencing significant risk. The processes by which families succeed or fail will be more evident and sensitive to our measures if we examine more extreme situations of risk exposure, rather than the more normative challenges of daily life. Furthermore, it is only under conditions of significant risk that resilience as a process is operative. Such studies will help us discover which family relational processes are protective across a range of risk exposures and which are unique to specific adversities.

Conduct longitudinal studies. The only way to understand the dynamic processes associated with the cascade of risks and the cascade of protectors and the interactions between them is to follow families over time. Cross-sectional studies are limited in their ability to explain change processes given the unreliability of retrospective family reports about themselves. The nature of significant risk makes it difficult, if not impossible, to assess a family before the significant risk exposure, although this would be less of a problem for studying families characterized as high-risk status. In either case, the trajectory of the families' functioning can be assessed for change and factors and processes associated with improvement can be studied.

Include qualitative methods in research. Because family meaning–making processes are so important to family resilience and given the subjectivity of meanings, qualitative methods would help clarify how these processes unfold and the content of these meanings. We need to complement quantitative model testing with inductive approaches to understand the array of processes shaping family resilience.

A family's ability to be resilient in the face of normative or significant risk is related not only to their internal relational processes but also to risks or opportunities in the social systems in their ecological context. Living in poverty and in crime-ridden, violent neighborhoods place families at high risk and contribute to their inability to satisfactorily accomplish their core functions. Risk processes in the family (marital conflict, child abuse, etc.) are more likely to emerge under these social conditions. The absence of needed community resources to support families in fulfilling their core functions further undermines family resilience. Public programs and policies, societal norms and values, and other community institutions shape the style and degree to which families are able to fulfill their functions, as well as their ability to acquire and develop new capabilities when challenged. Successful functioning for the population of children and families living with chronic health conditions requires public policies and programs, and adequate funding of these, to assure full community integration and access to the resources all citizens enjoy, which contribute to a high quality of life.

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