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Medical and social models of orphanhood

Resilience of adopted children and adoptive families[1]

AuQ7

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Through all 140 years of its history, scientific psychology was focused on what was going wrong with the human being. That emphasis explains the major role of clinical psychology that was traditionally focused on the treatment of mental illnesses. Scientific research and the practice of the pioneers of the field aimed to cure psychopathology. The practice of treating mental illnesses triggered the development of independent methods and forms of pharmacological and psychotherapeutic approaches. Some of them proved efficient in treating certain types of illnesses. However, regarding mental illnesses as diseases fostered the medical model of treatment, which in its turn inspired further scientific research in the area of mental illnesses and psychiatric disorders. Yet the psychological functioning of a sane person and the question of the normal well-being were disregarded (Seligman, 2003). The term *medical model*, coined by R. D. Laing, is an umbrella notion that implies the whole set of procedures to be studied in universities by the future physicians, medical psychologists and psychotherapists (Laing, 1971). This set presupposes the case-record, analyses and necessary clinical procedures. In this case, the prognosis for a proper treatment is made from the perspective of deficiency. The medical model is a dominant approach to the person and its illness (physical suffering, mental disorder, social problems) with the major goal of unveiling symptoms and syndromes and treating the body (individual or social) as a highly complex mechanism. According to S. Curtis and A. Taket (1996), the medical model is now dominating the world of science. Within this model, the body is regarded as an operative machine, and disorders are compared to disrepairs that should be fixed, i.e. cured. The emphasis is put on diagnosis and treatment, not prevention, which in itself can be a deterioration factor (Curtis & Taket, 1996). Even the language of the medical model reflects its nature: the most commonly used words are *diagnosis, disease, illness, symptoms* and *intervention*. The results can be attained only with the help of interventions, procedures and tests, which may improve health or cure illness through medication, hospitalization or surgery.

Backed by much fundamental research, scientific conventions and figures of authority, the medical model is highly influential; however, it can distort reality by offering only one limited

viewpoint on data, observations, phenomena and theories. Today, this model can be seen, not only as a set of procedures carried out on patients, but as a world model, which has proven highly influential among medical science theoreticians, psychologists, philosophers and anthropologists in the broadest sense of the term. Assisted by literature, mass media, cinema and prevailing ideology, this model of illness boosts and helps to internalize a person's negative self-perception, blocking development. Nowadays health services in most countries are based on the medical model, though it is said that the social model, implying more integral view on person and its health, is becoming more general.

There are two approaches present in modern psychology, as in social sciences in general, that can be compared to the models mentioned earlier, the medical model and the social model. The basic concept of the social model (positive socialization model), which initially emerged as a response to social segregation, is the notion of the equality of both normal and destitute people. Equal rights give a person, being in subject–subject relations with the closer environment, opportunity to decide independently and to live a full life, which is reminiscent of the definition of resilience: "Live well, work well and love well" (Garmezy, 1976). Social activity leads to social changes manifesting in attitudes towards this or that social group, in accessibility of the information in the forms suitable for all types of persons, in forming of the attitudes free from prejudices and, in the long run, in positive socialization. The model is focused on health, and all associated research is aimed at prevention of illness, promotion of healthy lifestyle and reducing the risk of falling ill.

In psychology, the medical model implies the idea that all abnormal patterns of behavior are caused by somatic problems that require purely medical approach. Researchers that are advocating the social model tend to have more integrative view, putting emphasis on embedded systems of social disease in the complex interplay of extended family links, social organization's involvement and cultural and historical contexts (Fergusson, Horwood, Shannon, & Lawton, 1989; Ungar & Liebenberg, 2005). Within the conceptual framework of the social model, improvements in health and well-being are achieved by directing effort towards addressing the social, economic and environmental determinants of health. The model demands social, economic and environmental determinants to be addressed so that health gains can occur. Since the social model provides for a person's health, the research cannot be carried out without regard to its ecology. That's why both the scope (health, person's healthy performance) and the subject (individual in its social environment) overlap with the U. Bronfenbrenner's ecological approach in developmental psychology of (Bronfenbrenner, 1979). In fact, the modern socio-cultural (ecological) perspective in developmental studies includes inter alia the interdisciplinary approach to the process of human socialization. U. Bronfenbrenner's ecological model, describing the structure of child's habitat, identifies four contexts of human development: familial, social, cultural and historic. With respect to children and adolescents, this approach implies research of the interconnection between possible developmental disorders as age progresses and the potential of positive children's socialization that can be promoted by proper use of habitat facilities, resources and resilience factors. The child in this case acts as the subject of possible changes and modifications. Positive socialization as an interplay of inner and outer factors (habitat in the widest sense of the word, cultural context, interrelation with the "significant other"), which makes each orphan more resilient.

On this research basis, with its fundamental ecological approach centered on children, the last few decades have been marked by research on child, adolescent and family resilience. Among the best known studies of resilience is the work of E. Werner (1993) and her colleagues. We must also mention the study of the same phenomena, carried out by M. Bleuer, who within forty years had watched more than 184 children with schizophrenic parents and had described their functioning in family, in communication with peers and relatives and in moments of joy and

sorrow. In the majority of cases, parents produced a negative impact on these children. However, regardless of difficult environmental conditions and negative genetic background, surprisingly, many of these children demonstrated the ability to lead a "normal" or "almost normal" life. Less than 10% of the sample groups were diagnosed as schizophrenics as they aged. The evident resilience of the majority of children is of undeniable scientific interest and can be encouraging both for scientists and common citizens (Bleuer, 1978). M. Bleuer's observations are perhaps one of the first longitudinal studies, showing the interdependence between social and family risks and resilience of certain family members. Being a psychiatrist, M. Bleuer, however, deviates from the medical model of deficiency and lays an extrinsic emphasis on the potentials and resources of the family and individual (without naming them) that give a person the opportunity to change his life regardless of adverse conditions. Bleuer dissuades his patients from following the imposed script – to become as insane as their parents – and paradoxically invites them to look for potential reserves and resources in their families, in communication with peers and relatives, i.e. to become an active source of all necessary changes, to use the relations with others as an important resource. These resources are regarded as a necessary condition that helps the child to withstand and move on without destroying oneself. Interestingly it was not until some decades later that the first up-to-date theoretical study of resilience appeared, basing on relational competence theory (L'Abate, 1994). Within this approach, relational resilience is regarded as a relational competence (on emotional, cognitive and social levels) that is changing depending on cultural context, gender and changes, which occur over the periods of life cycles (Gianesini, 2013).

Medical and social models in respect to the orphanhood

Now we are going to show that the opposition of the *medical and social models* is valid in respect to the field of orphanhood as well. It should be pointed out that actually the medical model dominates both in public and professional discourse. Professionals in the field of orphanhood for a number of reasons prefer to stick to this model, as it allows regarding the orphan as a patient with medical and behavioral problems that can be diagnosed in terms of deficiency. The model still dominates the minds of experts and is highly influential among lawmakers in the field. The social model of orphanhood hasn't yet become basic for working with stigmatized children; it isn't widespread in the areas of orphans' upbringing, development, socialization, education, career choice etc. It is noteworthy that even the orphan's transfer to the substitute family can comply with the medical model of deficiency. The way in which the substitute family is guided after the adoption is of great importance; it must imply the closest interaction with experts, relatives and the community. Unfortunately, child protection and guardianship services continue to regard substitute families as potentially disadvantaged, thus working within the deficiency approach. This situation is frequent as far as destitute families that are unable to bring up children are concerned. For instance, a heavy-drinking (or drug-addicted) mother who leaves her child right after the birth or destitute parents who are being deprived of their child and their rights have to take the child to the orphanage – in both cases, the situation is considered "socially unhealthy", thus calling for procedures typical of the medical model. Often the so-called "treatment" of the social disease – alcoholism, drug addiction – and further socialization of parents constitute part of the medical model of orphanhood: this kind of parents are treated as ill, socially unfit and as those who can only act as passive recipients of help. Unfortunately, the medical model of orphanhood in these cases is being taken over by children, boosting their trans-generational dependency and parasitism. In terms of the phenomenology of the orphanhood, this model regards orphan's environment as made up of "symptoms" and "syndromes" of ill-being, which results in the reproduction of the circle of ill-being: children

that never experienced the building-up of subject–subject relations will become ill parents themselves and will raise identical children and so on. This circle of ill-being is manifested in unstable self-esteem, dependence (as a person's characteristic, including permanent need of love and acceptance), as well as the negative self-perception as a person, member of family and member of society. From our viewpoint, the deficiency-based approach to the substitute family and the orphan is inherent to the medical model. And the social model implies the approach that is based on development and use of family's resources and potentials.

In order to analyze medical and social models of orphanhood in their historical perspective in Russia, let's consider how these models are marked in public and social discourses. In Russia, before World War II, orphanhood wasn't studied, although the number of orphans was great (because of the 1917 Revolution, the civil war of 1917–1923, collectivization and the resulting famine of 1927–1932). The little research that was carried out would never touch the problem of finding a new family for orphans. Starting in the 1930s, scientists had been mainly focusing on questions of deprivation and hospitalism of orphans in the process of their development. Because of country's isolation, Russian psychologists, both theoreticians and practitioners, knew nothing about the Western phenomenology of orphanhood, which had been developing within child psychoanalysis and developmental psychology. The second wave of orphans that came after the World War II didn't raise as much scientific interest in the USSR as it did in Europe. A scarce number of studies of the period, carried out mainly by pediatricians and educators and rarely by psychologists (Figurin & Denisova, 1949; Schelovanov & Aksarina, 1955), can be explained by political causes. There were no reasons to study those who had "happy childhood", which is "the must" in Communist society, particularly for orphans, who guarded by the state with its "children-are-our-future" declarations.

The *first period* can only be associated with the medical model that neglected the issues of adaptation and adoption. The emphasis was laid on health: good diet, sport, summer camps, cold training and etc. Thus, between 1917 and 1980s, the country had been suffering endless social disruptions – revolution, civil war, famine, World War II, post-war ruins – which resulted in two huge waves of orphans. This time range we will call the *first period*. As I have already mentioned, all studies of that time were closely associated with the principles of the medical model.

Within the *second period* of orphanhood studies, there appeared those focused on adoptive families (both adoption and guardianship), children from family-type orphanages. However, the results of these studies were rarely published (Prikhozhan & Tolstykh, 1980) and were also associated with the medical model, though certain elements of the socially oriented approach were beginning to take shape.

The *third period* is related to the new forms of orphans' family placement and can be outlined by the 1990s–early 2000s. During this period, a number of studies were already associated with the social model. This short period coincided with the new flow of orphans that took place in Russia in early 1990s. As for studies, the new terminology, the subject-oriented approach, the means and the forms of cooperation with adoptive families were the signs of gradually emerging features of the social model. Unfortunately, only a few research papers and data are left of this period. It is even sadder for us today, as we realize that the big wave of orphans was left without professional examination, care and support. Faced with social disruptions and witnessing so many orphans still alive but leading an asocial life, parents and psychologists began to recognize social roots of orphanhood and to look for social means of dealing with it. Some researchers "have passed through" the third period of studying new forms of orphans' family placement (family-type orphanages, SOS Kinderdorf villages, foster care families) far too quickly. It is regrettable that there were only few studies, touching the problem of putting in place of these new forms of family placement and comparing them with traditional ones.

The last *fourth period* is predominantly associated with the social model of orphanhood. The researchers take mainly foster families as case studies. This period is marked by interest in the new social institution of professional foster-family care.

Thus, history and economic conditions that determined the development of Russian psychology, as well as many other factors, prevented the experts from paying attention to the problems of orphanhood. Many questions described here are still left without answers, though they directly concern the need in changing the model of orphanhood.

These are the problems in the orphanhood domain associated with public and general social attitudes:

- Actual stigmatization of orphans; the widespread image of orphans as suffering from various illnesses and mental disorders and being unable to establish close reliable relationships
- The idea that the majority of orphans don't have a fine family life and professional career ahead of them
- Low level of society's involvement in the direct interaction with foster care homes
- Society's irresponsible attitude towards the family placement problem of its little members (orphans)
- Low level of society's (including professional community) support for the new forms of family placement, misunderstanding and rejection of the idea of professional care for orphans
- Unwillingness of public organizations to make timely and flexible decisions, to respond efficiently on all the changes in the field of orphanhood
- Health organization's collecting and analysis of data, privacy of information and statistics on orphans, their placement, the adoptive families, rights violation, cases of illnesses, infections and etc.

As to the professional community, the problems are:

- A narrow "esoteric" circle of experts, who stick to the same models of the private orphanhood institutions
- Lack of scientific interest to the problems of orphanhood and professional impotence in rendering assistance to the orphans and adoptive families
- The absence of the special estimator of preferable form of family placement for each orphaned child
- The low level of expertise as far as the adequate training of adoptive and foster parents is concerned
- The absence of longitudinal psychological studies, providing both state and society with data on benefits and drawbacks of orphans' placement, peculiarities of different adoptive and foster families, the phenomenology of orphanhood in general.

Most of these questions are left unanswered, but time and again they are being discussed by the members of society, where the medical model is dominating over the social one. Hence, all the answers and decisions, both professional and non-professional, are rooted in the medical model of orphanhood.

Today in Russia, the two models coexist *inter alia* in orphanhood discourse. Based on discourse analysis, M. S. Astoyants concluded that orphans are regarded as subjects of social exposure and also as part of the modern culture or social entity and characteristic of a certain historical period. She identifies three types of orphanhood discourses: the discourse of *social danger*, the discourse of *social self-justification* and the discourse of *social integration*. We believe

that the first two types explicitly represent the medical model of orphanhood, while the last one represents the social model, including the subject relations between the orphan and the family (society). The discourse of *social danger* presents the orphan as someone excluded from society, as a potentially criminal element. The discourse of *social self-justification* is concerned with finding culprits, claiming that troubled families were guilty. The discourse of *social partnership* (social integration in solving the problems of orphans) acknowledges the problem of family's ill-being: "The child is considered to be a dynamic developing personality, while the problem of orphans is to be solved by the means of social integration and cooperation of public institutions, social agencies and organizations, professional unions and mass-media" (Astoyants, 2007). The understanding of one's orphanhood is a negative experience. It is known that the impact of experiences like that touches inner and outer determinants, which evaluate them. There, determinants become the markers of the discourse. A person's subjective attitude towards experiences and events is of great importance, as it can evaluate (mark) them as stress-producing or not in this or that setting (Dikaya & Makhnach, 1996). That is why the discourse of *social self-justification* sustains the medical model of orphanhood. In this context, the importance of life events in the investigation of the stress process in children from this focus seems very relevant. It connects with importance of developmental issues such as children's response to parental separation, coping in achievement contexts, repression or sensitization and developing resilience (Robson, 1997). This understanding of the role of negative experiences and events is especially important for adoptive families, both parents and children, as it can help to find the ways of coping with the aftermath by using orphan's individual and family's and society's in general collective resources. Children and parents learn new strategies for processing, managing and integrating their thoughts and feelings related to traumatic life events, leading to increased feelings of safety, improved communication, better parenting skills and healthier family relationships (Dorsey & Deblinger, 2012). This kind of work introduces adoptive families to the discourse of *social integration*, which is associated with the social model of orphanhood.

Both society and the orphan become the subjects of interaction. The research shows that in the field of orphanhood two types of discourse, the discourse of *social danger* and the discourse of *social partnership*, coexist and contradict each other. We believe that the shift from dominating the medical model towards the social model is almost absent in the phenomenology of orphanhood. It is noteworthy that the use of terms like *help* or *social service* is associated with the medical model and presupposes subject–object relationship. It means that the orphan as a person with special demands (physical, social) is in need of support. That makes him a problem, although the real problem lies in social barriers, created by the family and the public in general. The words *support*, *service* and *care* are often used by psychologists and social workers in their work with orphans and adoptive families. That is why the socialization of the orphan is a process of establishing his relations with the world around him by developing his life perspective, acquiring an education, specialization and finally self-fulfillment. For instance, it is important to take into account how the adoptive or foster family feels about the social support. D. Ghate and N. Hazel coined the notion of "negative support", emphasizing the subtle difference between aid and intervention, which can result in the loss of control over your own life and the life of a child (Ghate & Hazel, 2002). That's why many experts describe the instance of interaction between care services and substitute parents. The latter don't want to become the target of the intervention, as the rendering of assistance in this context means treatment in terms of deficiency, assuming that someone is "socially ill" and needs support (which is the typical medical model of the patient). Research associated with the social model of health focuses on actual social attitudes that are manifesting in stigmatization of children, orphans included (Mason, 1994). The process of the child's

development is being linked to the degree of social acceptance of his advantages and disadvantages. This factor becomes crucial for the child's future.

In Russia, the system of guardianship causes a strong feeling of dependence among children from the very moment they come to the orphanage. Little orphans are told again and again that the state will take care of them. This results in gradually increasing dependence. According to M. Mason (1994), the medical model focuses on illness and boosts labeling, while the estimation, monitoring and therapy are imposed. That is true for orphans being treated paternalistically by orphanage workers and other public caretakers. It is known that orphans develop a special psychological pattern, the so-called "we of the orphanage". According to A. Prikhozhan and N. Tolstykh, child orphans divide world between "us" and "them". Orphans detach themselves from others, tend to act aggressively and have separate groups even within the orphanage (Prikhozhan & Tolstykh, 2007). In after-orphanage life, they reproduce the same patterns. They usually rent a flat or marry with their kin. In other words, they reproduce the model of segregation imposed to them by society. The closedness of the social institutional space, the limited access to social connections and the imposed social role (orphan's role) result in a specific asocial and sometimes even criminal way of life for the orphans or, on the contrary, push them to become the victims of various offences. The closedness of orphanages also limits the professional perspectives of the orphans. This is backed by the low self-rating as compared to normal children of the same age (Abelbeysov, 2011). This situation indicates the predominance of the discourse of *social danger*. That's why we believe that interrelations as an environmental factor are number one for orphans' resilience (Laktionova & Makhnach, 2009). A life in an orphanage doesn't require certain personality functions necessary for a normal life (Prikhozhan & Tolstykh, 2007). That's why, not having the skills of social behavior, necessary for successful adaptation and formation of socially acceptable behavior, orphans can take on only the patterns of their peers. The social environment beyond their group of peers doesn't suggest them a proper pattern of interaction, so socially stigmatized orphans fail to establish appropriated relation with other people on different levels. That's why the role of significant others (neighbors, incidental acquaintances, schoolmates, teachers, guardians) is crucial for orphans, as with their help they fill, by pity or support, the empty gaps in their emotional and social personality structures (Radina & Pavlycheva, 2010). This environment can be a risk factor or a defense factor, depending on who and to what extent becomes a significant other. Thus, the environment becomes a relational factor of resilience. The role of peers and schoolmates is important because it can promote positive socialization. An orphan can also take on the set of rules for his future life by following the only example taken from social interaction. Orphans, like any other teenagers, create their subculture that helps them to conceptualize the world and their lives. They tend to idealize certain phenomena, which are regarded by them as portals to the normal civilized life. We have already shown that orphans tend to support informal youth movements and to communicate with those addicted to alcohol. Unfortunately, this kind of behavior stands for a defensive response, which is a marker of inability of their subculture to form resilience (Laktionova & Makhnach, 2009).

It is known that only a few can discard overprotection and hothouse conditions by themselves as it requires certain inner and outer conditions. By inner, we mean character traits, for example the inner locus of control that helps to move towards one's resilience. Our research shows that teenage orphans with emotional and behavioral problems have their inner locus of control associated with social adaptation and resilience, but only in case of their *positive attitude towards oneself and others*. Only in this case can they feel emotionally at ease and can admit responsibility for what is going on (inner locus of control); they long for achievements (motivation) and dominance

(Makhnach & Laktionova, 2013). The mere fact of losing contact with habitual environment and establishing relations not only with peers show the potential resilience. Unfortunately, however, the social orphanhood system isn't aimed to encourage independent life attitude. It's not just the absence of everyday social skills but the inability to act and make decisions independently. As a result, orphans cannot lead an autonomous life; they are unable to foresee the consequences of their deeds, plan their activity, predict future, set an aim and gradually move towards its attainment (Iovchuk, Severnyy, & Morozova, 2008). This leads to incomplete or insufficient socio-psychological adaptation, inadaptability, school disadaptation and deviant behavior (Prikhozhan & Tolstykh, 2007).

We can't say that this situation is acceptable for the actual Russian social care system. But any system can preserve itself only by increasing inactivity of its elements. Each one, who wants to break through the limits of the system, constitutes a potential threat. That's why orphans' training can be oriented towards the independent attitude, as only inactive children can guarantee the system's stability. The orphan can hardly become independent and responsible in the context of passive consumption of services (educational, health-preserving). This system isn't aimed at producing socialized individuals; it forms a passive, dependent child that cannot survive without support and guardianship of the medical model.

If we consider adoptive families, they can also become the part of medical model after adopting an orphan. The families must always remember that orphans constitute a marginalized group. This image is most likely the fruit of predominance of the medical model. So, the adoptive family can become a special element, thus an excluded one (the medical model pattern again). So the members of adoptive family and those who render them professional assistance should look for intrafamilial and environmental resources as the social model presupposes. Thus, our research showed that successful family placement highly depends on the individual resilience of adoptive parents, fruitful intrafamilial communication, advanced skills of problem solving, reasonable resource management and a realistic view of the financial situation. All these factors reduce the risk of psychopathology in both parents (for example depression associated with adoption difficulties) and a child; they also provide for interaction, closer communication and proper adaptation of the orphan (Makhnach, Laktionova, & Postylyakova, 2015).

It is also important to realize that the former orphans reproduce the system of closedness in their subculture, importing them to the new family, especially when they have siblings. Sibling adoptions are often unsuccessful and lead to so-called de-adoption. T. Reilly and L. Platz showed that biological siblings adopted by the same family are more problematic that separated ones (Reilly & Platz, 2003). In a comparative study, R. Hegar showed that factor of joint sibling placement stays highly problematic (Hegar, 2005). R. Stryker made an interesting observation, having attracted attention to one peculiarity of orphans:

> It didn't ever cross my mind to ask an adult to help me with things. If you needed help it meant that you were dumb. Stupid, because I didn't want to be put in a worse place, I asked (friends) Sergei and Erik to help. We helped each other get what we wanted.
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> *(Stryker, 2000, p. 82)*

This idea, articulated by the American, who had adopted a Russian child, demonstrates that orphans are not used to turn to their family for help, while familial help and support is one of the major factors of resilience. The "we of the orphanage" determines orphans' deeds and their life in general. The fact of being associated with an impotent and resourceless "we" demonstrates the social frailty of orphans (Prikhozhan & Tolstykh, 2007). There is the same phenomenon as we can observe, in another vulnerable group – a segregated ethnic one. Kumar, Mukherjee, and

Parkash (2012) analyzing the social perspective emphasize the fact that the opposition of "us" and "them" can lead to segregation and then even to the involvement in terrorism. They find that, often, perceived or existing socio-economic differences create "ethnicity-based conflicts" and results in "us vs. them" groups, which often take recourse to conflict (Kumar et al., 2012). In our case the opposition of "us" and "them" also causes social conflict, the distance between "us" and "them", which determines the whole subsequent life of the individual.

Russian folklore, acting as a container of discourses in their historical perspective, is of great interest in this context. As far as orphanhood is concerned, folklore, expressing a traditional philosophy of life, contains many proverbs and sayings that reflect the whole range of attitudes towards this social phenomenon. It is known that proverbs are cultural clichés that explain general laws and prescribed patterns of behavior. Out of the whole range of generalized, culture-bound principles, the individual "privatizes" only a few, which don't contradict each other and would lay a foundation of his behavior (Leontiev & Tarvid, 2005). In this respect, individually experienced proverbs that constitute an image of orphans and orphanhood reflect the attitude towards this social phenomenon. We choose twenty-five Russian proverbs about orphans and orphanhood. Then we grouped them according to the type of discourse they represent. Thus, nine proverbs were associated with exclusion of orphans from the society, eleven justified orphanhood and only five of them suggested that society itself is responsible for current state of affairs. In Russian proverbs, the terms used to define an orphan and orphanhood include loss of parents, the rupture of social bonds, lack of family support, the process and situation of deprivation and want and the lack of money or means of livelihood. Some of these are, indeed, the effects of orphanhood. However, the Russian equivalents of orphanhood treat these as integral parts of the totality of the process of orphanhood. Proverbs, advocating this viewpoint, we associate with the discourse of *social danger* (an orphan's childhood is a life-long heritage; the orphan is not noble). *Social self-justification*, which translates into orphanhood, is stretched to include poverty, physical and mental weakness and society's irresponsibility and is reflected in the following proverbs: "God granted the orphan a mouth, so he will give him some food as well" and "Only God would come to the orphan's defense". Proverbs like "Orphan's childhood is a life-long heritage" and "Orphan is not noble" fix the viewpoint that stigmatized orphans are not full members of society. The stigmatization of children and teenagers, who are enjoying a period of acquiring social skills, suspends this process and leaves no chance to quit the medical model of orphanhood. Orphanhood is regarded as a negative fact, as the *status quo* of an orphan's life with the discourse of social danger permanently looming nearby. The fixation of this fact in the orphan's personal discourse and the adoptive family's discourse leads to the consolidation of the discourse of social danger. This evidently doesn't add to the resilience of the child, his family or society in general. We believe that the proverbs reflecting the discourse of *social integration* ("The one who takes pity on the orphan will be rewarded by God", "The world still exists due to the orphans") are associated with the social model that correlated to society's resilience and its responsibility for its illnesses orphanhood included.

Conclusion

We believe that U. Bronfenbrenner's theory of ecological systems provides us with the best possible methodology for studying resilience. A gradual shift from the medical model of deficiency towards the social model has determined the principles and accents: more and more studies are focused on inner and outer factors of person's resilience, including well-being, hope, potential resources and meaning of life, which constitute the basis for positive socialization. This change also touched the socially inadaptive group of teenage orphans. However, the emerging discourse

of *social partnership* embedded in the social model is far from being predominant in Russia both in public and professional circles. Problems of orphanhood are still examined in the context of the medical model. Inner and outer factors are rarely regarded as important for resilience, though the role cultural, familial impact, as well as the role of "significant others", can be crucial. The example of orphans as an inadaptive group can be the case for the shift from the discourse of social danger and the discourse of social self-justification towards the discourse of social partnership. This, however, can lead to the misunderstanding and underestimation of the role of significant others in orphans' resilience.

Present psychological developmental theories (psychogenetic, biochemical and stress theories) are based on the medical model of subject–object interaction between the agent and the recipient. The rejection of this model in favor of the social one leads to the subject–subject interaction between people.

The comparison of two models of orphanhood made us conclude that the medical approach is historically traditional for Russia. The medical model of deficiency is indispensable at certain stages of an orphan's education as it helps to diagnose this or that developmental deficit. But we must be aware that the paradigm of the medical model imposes a one-sided approach: the deficient proves to be sufficient. In fact, by using the deficiency model, the social caretaker limits himself. The social model examines orphan's resources, those personality characteristics that can be used as guidelines and call for further development. An orphan, as any other person, has both deficiencies and potentialities. The notion of resilience unites these opposites as we begin to examine, not only risk factors in the context of bigger family, society, peers and culture, orphan's health and personal behavioral features, but also the factors of resilience in above-named areas. Thus, the resilience approach in fact unites two models, the medical and the social. If resilience factors compensate for risk factors, the child will pass through each and every step of positive socialization. Moreover, as is known from the longitudinal experiments, it is not true for every developmental context (Anthony, 1987; Fergusson et al., 1989; Garmezy, 1976; Rutter, 1979; Sroufe, 2005; Ungar et al., 2008; Werner, 1993). This approach allows us to expose deficiency in an orphan's development and intentionally compensate for it, basing on his inner resources and resources of the family, society and culture. This can be considered the most balanced, reasonable and efficient strategy in the process of orphans' positive socialization.

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