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Resilience is an Adverse Event: A Critical Discussion of Resilience Theory in Health Services Research and Public Health

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Abstract

Resilience, the individual trait of being able to persist and cope with, often recurrent, negative experiences, has experienced an explosion in recent years as a topic of study. In this commentary, we critique this surge and problematize the co-occurring development of the "resilience as treatment" paradigm. We show that resilience is an expectation foisted primarily on historically and contemporarily oppressed and excluded populations often in response to systemic and structural forms of discrimination. We argue that this represents a fundamental mismatch of intervention and problem; offering an individual-level solution to a structural toxin. In doing so, we re-contextualize resilience as an adverse event, more analogous to scar tissue than a reliable treatment paradigm. Our essay concludes with offering alternatives to resilience that originate with the holistic trauma and liberation health frameworks. These paradigms are united in that, in contrast to resilience, they emphasize healing from structural violence, rather than adapting to it.

Keywords

resilience, systemic and structural discrimination, trauma, mental health

Introduction

In journals of public health, medicine, and allied health professions, resilience theory has proliferated rapidly, accompanying emergent frameworks for naming and addressing trauma at micro and macro levels. A Google Scholar search of the term "resilience" between 2003 and 2012 returned about 525,000 results; when restricted to 2013–2022, the same search returned about 927,000. The term's recent proliferation might be related to massive upticks in stress and distress in the wake of the COVID-19 pandemic, natural disasters, mass shootings, or police violence in the past several years. The proliferation may also be correlated with the emergence of new scholarly approaches to trauma stemming from studies like the late-1990s study of adverse childhood experiences.[1]

Given the growth in popularity of this concept, researchers and practitioners could benefit from a clear and critical understanding of resilience in context. Specifically, this article advocates for an understanding of resilience that is embedded within the context of adverse events, neoliberalism, and pathologizing impulses in medicine, allied health, and even social policy trends. Particularly when treating or studying patients who have experienced adversity, structural disadvantage, and traumatic life events, health practitioners and researchers have made use of resilience as a quantifiable construct, one with the capacity to predict positive outcomes or strengths-based traits at the individual level.[2] While resilience is, in many ways, a common-sense tool for scholars and clinicians seeking to uplift adaptive responses to harm, we argue that the concept of resilience should not be deployed without parallel measures and interventions focused on the harms that necessitate resilient traits in the first place.

Due to its rapid proliferation across disciplines, resilience is a keyword that may seem self-explanatory.[3] However, a more thorough definition can be derived from its usage in multiple academic contexts. At its most basic level, resilience can be defined as the ability to respond to stressful or traumatic situations in healthy or positive ways.[4] However, this definition risks the decontextualizing implication that

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resilience is an inherent trait possessed by individuals. Instead of functioning as an individual trait, resilience functions as the result of exposure to traumatic stimuli. A more critical definition of resilience might take into account the genesis and frequency of trauma and stress in an individual's life. Through a sociological lens, resilience is often conceptualized as a neoliberal technique of governance, placing the onus for posttraumatic adaptation on the individual rather than the systems through which trauma is transmitted.[2,3,5] As new quantitative measures of resilience have emerged,[6,7] some research has lost sight of the systemic, intergenerational, and collective means by which resilience is necessitated, neglecting to acknowledge or address harm-generating stimuli.

In this theoretical article, we expand the frame of resilience once again, redirecting attention toward the predisposing factors of resilience: material conditions of suffering, disadvantage, adversity, violence, and trauma. We approach this topic as a biracial Black cisgender woman in social work and a Black transgender woman in medicine and epidemiology, writing through our shared lens of Black womanhood and our distinct experiences as both researchers and practitioners. Building upon foundational interventions in health equity such as the social determinants of health,[8,9] we apply theories of cumulative disadvantage[10,11] to current understandings of resilience. We ultimately advocate for a broadened perspective on resilience that foregrounds collectivist and peer-centered models of survival and healing, rather than an individualized approach to promote coping.

Problematizing Resilience

The recent wave of transdisciplinary resilience research that has evolved in public health, psychology, social work, healthcare, and allied fields, has included an emphasis in identifying factors associated with resilience.[12] Underlying this emphasis is a through-line of "resilience as treatment"; whereby investigators seek to identify factors that foster resilience as a way to "trigger" more robust resilience in response to trauma. However, this arm of investigation actually exposes the fallacy of the resilience treatment regime as we identify the unequal expectation of resilience across populations, and injurious stimuli. Specifically, these studies disproportionately occur in racialized populations, and in response to traumas that are driven by social-structural processes that function as intervening pathways between systemic discrimination and adverse health. Examples are numerous: Investigators and mental health practitioners have attempted to identify resilience factors for ethnoracially minoritized groups (such as positive feelings towards one's own racial or ethnic group) in response to racial microaggressions[13] or overt racism.[14] These studies call for individuals who experience systemic racism (interpersonal and structural[15] to adapt to this exposure by becoming resilient. Similarly, resilience has been studied as a potential response to and treatment for exposure to heterosexism and cisgenderism among affected queer communities. An examplar study of LGBTQ college students identified microaggressions and victimization (unwanted sexual contact, harrassment and abuse) as risk factors for depression and suicidality and identified resilience as a modifier for these relationships and a protective factor against the negative mental health outcomes.[16] Similar work has been done studying resilience in response to economic deprivation,[17] and for individuals who lie at the intersection of multiple oppressive structures.[18]

Through these examples we see that resilience is an expectation of the historically and contemporarily oppressed and excluded groups; that they (we) are required to become robust to the structural, institutional, and interpersonal forms of discrimination that are pervasive in our society. In this way, with the development of therapeutic programs targeted at increasing individual resilience,[19] the "resilience as treatment" paradigm places the locus of intervention for structural harms within the marginalized individual, a fundamental "mismatch" that facilitates maintenance of the status quo. This paradigm normalizes the experience of structural harms and demands the construction of resilient subjects, obfuscating the impact on social inequities on individual outcomes. Structural harms require structural interventions that work outside of the individual and intercede along multiple levels of society (interpersonal, institutional, structural), and across multiple sectors (policy, economic, education).[20,21]

Given that resilience is a disproportionate expectation of the marginalized, a more appropriate framing for it in the administration of healthcare is a marker of health *inequities*; an adverse event in response to structural harm that manifests within the individual. We argue that we should reframe "resilience as treatment" to "resilience as scar tissue." This metaphor is useful for two reasons. Firstly, resilience can only occur in response to harm. In this way, it is more aptly considered an adverse event in and of itself; a signifier of exposure to noxious stimuli. Secondly, as scarring results in dysfunction,[22] the development of resilience may also indicate the loss of normal function. For instance, consider the Superwoman Schema (SWS), a theoretical framework that captures how Black women respond to gendered racism, *misogynoir*,[23] and cope with related stress.[24] While linked to the ability to cope with noxious stimuli, SWS is also characterized by Black women as a suppression of emotion and difficulty with accepting emotional support in service of presenting a strong image.[24,25] Here, the scar tissue metaphor is particularly apt because adoption of this role prevents expression of the full range of human emotion; thereby exhibiting the dysfunction characteristic of fibrosed tissue. Further, SWS also supports the framing of resilience as an adverse event, as the schema is also associated with increased risk for stress-related illness.[26,27] The specific case of SWS highlights the duality of resilience, as a coping mechanism and source of dysfunction and sign of harm, limiting its utility as a treatment paradigm.

While uncritical approaches to resilience in research and practice can be harmful, especially to marginalized populations, we hesitate to denounce resilience frameworks entirely. We recognize that while resilience is an adverse event, there are individuals who thrive in the face of trauma. Our "scar tissue" metaphor also works in the context of post-traumatic thriving or post-traumatic growth—similar to research on scarring that asks questions about how to prevent scarring after injury, research efforts could be directed toward deepening our understanding of how to prevent traumatogenic processes in the first place. Future research that uses resilience as a central paradigm should focus on the individual and collective mechanisms by which harm is mitigated and prevented, rather than focusing on the aftereffects of harm.

Alternatives to the Resilience Framework

As a framework and a measure, resilience fails to account for the events that necessitate or predicate it. While we are not advocating for the outright replacement of resilience theories with alternative approaches, we are indeed in favor of a more complicated approach to resilience in theory and practice. Complex engagement with resilience requires a clearer understanding of cumulative disadvantage, grief, and loss as key experiences within many resilient individuals' lives.[28] Complex engagement also requires a de-centering of individualism in approaches to public health and collective wellbeing. With a clear understanding of the social and economic forces that generate trauma and disadvantage, practitioners and researchers alike can benefit from pursuing alternative paradigms to supplement their resiliency work.

One such alternative lies in a holistic trauma framework created by Alvarez and Farinde-Wu.[29] This framework, accompanied by approaches such as collective healing, de-individualizes the impetus to withstand and adapt to violent conditions of living. Responding specifically to colonial violence, Alvarez and Farinde-Wu's holistic trauma framework promotes epistemic justice, acknowledging and valuing multiple ways of being and knowing. This is something that often gets lost in resilience-based approaches, which tend to underscore the importance of adapting to trauma instead of questioning the conditions that facilitated traumatic events in the first place. Interventions such as the Advance Peace Model offer a holistic trauma-informed response to structural harms–in this case, responding to urban gun violence.[30] In particular, this approach prioritizes the community-level interventions that are needed to interrupt gun violence and prevent it from continuing, refusing to take for granted that gun violence will happen in certain urban spaces.

Another approach that accounts for multiple levels of violence and trauma is the liberation health framework.[31] Building upon the legacies of Martin-Baro's liberation psychology and Freire's popular education, Dawn Belkin Martinez and Ann Fleck-Henderson apply a radical social work lens to the biopsychosocial model taught to most social workers in the United States. In doing so, they articulate that work with clients and patients should happen on multiple levels: the individual, the cultural, and the institutional. By conceptualizing a patient's presenting problem on multiple scales, practitioners must account for the harm-generating institutions, structures, and sociocultural norms that inform problems that might otherwise be addressed on a solely individual scale. A liberation health approach pushes practitioners to conceptualize cases with an eye toward power. This kind of formulation encourages practitioners to pursue social justice alongside their patients; after naming the institutional and cultural factors that have contributed to their patients' presenting problems, practitioners are implicitly motivated to more actively resist racist or classist policies, a white supremacist culture of professionalism in medicine, or bureaucratic restrictions that limit patients' access to care.

Most notably, paradigmatic alternatives to resilience prioritize healing from violence over adaptation to violence. This holistic lens is compatible with existing frameworks for understanding violence at a structural level; the social determinants of health, for example, offer a mechanism for attending to multiple needs in an individual's life through an anti-individualist approach.[9] A social determinants-informed approach to research and practice is one that considers the kinds of social change needed to prevent health disparities in the first place, rather than placing the impetus for adaptation on individual patients. These kinds of paradigmatic shifts focus not only on healing but also on liberation.[32] Addressing vulnerability through a de-individualized lens requires alternatives to resiliency theory. By departing from approaches that fail to challenge social inequality, researchers and practitioners stand to enhance existing resiliency models by infusing them with a greater awareness of the social determinants that inform poor health outcomes.

Conclusion

The proliferation of a resilience framework in health services has offered an important tool for conceptualizing and measuring the strengths of patients who endure trauma and oppression. However, as we have demonstrated, this framework is imperfect; it has the potential to normalize structurally-induced suffering. Writing from a Black queer and trans feminist perspective, we are committed to troubling the assumptions inherent in a resilience framework, as these assumptions reinforce the very health inequities that stem from white normativity, toxic individualism, and false objectivity in the health sciences. Cumulative disadvantage and the social determinants of health are conceptual tools that help to complicate mainstream notions of resiliency among marginalized populations most impacted by health disparities. When we fail to account for the traumatogenic structures and institutions in our patients' lives, we do them a disservice.

Health services and public health must infuse social justice values and principles in all aspects of research and practice. We advocate for a justice-oriented interdisciplinary approach to trauma, risk, and vulnerability in health care, public health, and health services research; one that makes use of existing approaches such as the liberation health framework, which was coined by two social workers. This is a mechanism for resisting the status quo and articulating an overlooked truth: that race, class, disability, gender, and sexuality, among other social identities that are used to stratify society, play a role in determining who must *become* resilient in the first place.[33] Addressing the root causes of violence, trauma, and vulnerability is imperative for practitioners and researchers alike, lest we obscure these injustices with an individual strengths-based approach. While resilience has proven itself to be a useful theoretical and practical tool, we caution against its overuse and misapplication.

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