The Courage to be Resilient: A Paradigm Shift

A Literature Review

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Abstract

The author reviewed a selection of studies addressing the construct of resilience after traumatic events. The prevalence of resilience as a trajectory different from recovery, posttraumatic growth, or pathology was examined. Study samples reviewed in the literature consisted primarily of adult and adolescent participants exposed to traumatic or potentially traumatic events, either of a chronic or stress-related nature. A brief review of trauma typology and definitions of resilience is offered. Several risk and protective factors were affirmed in the literature including coping strategies, self-esteem/self-enhancement, emotion regulation/self-control, appraisal, previous adversity, gender, optimism, social support/social network, and purpose in life/spirituality. Cautions regarding risk factors are discussed and pose opportunities for further research. A paradigm shift from pathogenic-focused research to salutogenic-focused research is proposed, based on the work of Aaron Antonovsky. The compatibility of resilience-informed research with Adlerian theory and psychotherapy is also presented, as well as suggestions for trauma-competent practitioners.
# Table of Contents

Abstract .......................................................................................................................... 3

The Courage to be Resilient: A Paradigm Shift .......................................................... 5

Defining Trauma ............................................................................................................. 6

The Origin of Resilience Research .................................................................................. 8

Defining Resilience ........................................................................................................ 9
  Differential Definitions .................................................................................................. 11

The Nature of Resilience ............................................................................................... 13

Risk and Protective Factors ......................................................................................... 14
  Coping Strategies ....................................................................................................... 17
  Self-Esteem and Self-Enhancement ............................................................................ 18
  Emotion Regulation and Self-Control ........................................................................ 19
  Appraisal ................................................................................................................... 20
  Previous Adversity ...................................................................................................... 21
  Gender ......................................................................................................................... 22
  Optimism ..................................................................................................................... 22
  Social Support and Social Networks ......................................................................... 23
  Purpose in Life and Spirituality ................................................................................ 25

Cautions Regarding Risk and Protective Factors ....................................................... 25

Measuring Resilience ................................................................................................... 27
  Adult Rating Scales .................................................................................................... 28

Salutogenic Theory ....................................................................................................... 30

Alfred Adler’s Individual Psychology .......................................................................... 31

Therapy and the Trauma-Competent Practitioner ....................................................... 34

Discussion ..................................................................................................................... 36

Conclusion .................................................................................................................... 41

Areas for Further Study ............................................................................................... 42

References ................................................................................................................... 43
The Courage to be Resilient: A Paradigm Shift

Over the last fifty years, researchers have attempted to shed light on the ways in which individuals exhibit resilience after trauma. Some people flourish after adversity while others do not. The majority of those who experience a traumatic event fail to develop posttraumatic stress disorder. It is common for people to seem unaffected or even to grow after a traumatic event. Some people appear more resilient than others. Resilience is different than recovery. Resilience after trauma is common and not necessarily pathological. Resilience can be cultivated and is not generally considered an innate personality trait.

The majority of the research on trauma has focused on posttraumatic stress disorder (PTSD) and its symptoms in response to trauma, but recently researchers have started to focus on another concept: the prevalence of resilience after traumatic events. According to Wills and O’Carroll Bantum (2012), previous research “has indicated that a proportion of individuals who are exposed to stressful conditions do not show significant adverse effects” (p. 568). Many people continue to be able to achieve personal and interpersonal tasks even in the face of significant adversity (Westphal & Bonanno, 2007). Scholars agree with the notion that trauma research has focused too long on only the symptomatic trajectory; it is not surprising that dramatic reactions have flooded the loss and trauma research (Bonanno, 2005, p. 135). Bonanno (2005) has observed that the opposite response to trauma (the preservation of a relatively unchanged trajectory of functioning following a traumatic event) has rarely been studied, until recently. Researchers have generally conceptualized resilience as one of two extremes: either as a mark of extraordinary strength or as a deviation and an indication of extreme denial.

Numerous studies have confirmed the notion that resilience is actually a common and adaptive response following a potentially traumatic event. Almedom and Glandon (2007)
recognized resilience as a common reaction to disaster (pp. 128-129). Bonanno (2005) supported this notion and agreed that even though symptom levels varied according to traumatic event type, the most common outcome was consistently resilience (p. 136). Westphal and Bonanno (2007) also reported that a large number of studies have established that the majority of individuals who have experienced a potentially traumatic event demonstrated a “stable trajectory of healthy functioning, or resilience, in both personal and interpersonal spheres across time” (p. 420).

**Defining Trauma**

The word “trauma” receives frequent attention in literature surrounding resiliency. Trauma is commonly diagnosed as PTSD or posttraumatic stress disorder. According to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2013), PTSD is defined as:

1. exposure to actual or threatened death, serious injury or sexual violence  
2. presence of recurring, involuntary, and distressing memories, dreams, dissociative reactions (e.g. flashbacks);  
3. persistent avoidance of stimuli associated with the traumatic event;  
4. negative alterations in cognitions and mood associated with the traumatic event; and  
5. marked alterations in arousal or reactivity associated with the traumatic event (p 271-272).

PTSD was first classified in the late 1970’s to help understand the psychopathological aftermath experienced by a large number of Vietnam veterans, and later expanded early research on rape, domestic violence, and child abuse (Resick et al., 2012, p. 242). However, the PTSD diagnosis was not originally designed to distinguish between different types of traumatic events (Wamser-Nanney & Vandenberg, 2013, p. 672).
Trauma research and theory has broadly classified trauma into two categories, Type I and Type II trauma. Mahoney and Markel (2016) explain that Type I trauma refers to a single episode of trauma (p. 3) whereas Type II trauma (or complex trauma) refers to “repeated exposure to threats of violence, including social and political through war or torture, domestic violence (victim or witness), and childhood abuse” (p. 3). Posttraumatic stress disorder is often acute, resulting from exposure to a single-episode trauma (such as an automobile accident, natural disaster, etc.) (p. 1), whereas complex trauma (often referred to as CT), involves stressors that are prolonged and repeated (p. 1). Wamser-Nanney and Vandenberg (2013) defined complex trauma “as a traumatic event that is chronic, interpersonal” and added the stipulation that it “begins in childhood” (p. 672). They explained that traumatic events could include neglect, domestic violence, child sexual or physical abuse, life-threatening illness, the unexpected death of a family member or close friend, school or community violence, natural disasters, motor vehicle accident, or other serious accidents (p. 671). Alfred Adler conceptualized traumatic events in a very different way:

No experience is in it itself a cause of success or failure. We do not suffer from the shock of our experiences-the so-called trauma-but instead make out of them whatever suits our purposes. We are not determined by our experiences but are self-determined by the meaning we give to them. (Adler, 1931/2010, p. 24 as cited in Paige, DeVore, Chang, & Whisenhunt, 2017, p. 8)

Rutter (1987) proposed that in order to better understand resilience, we should ask why some individuals seem to maintain high self-esteem and self-efficacy despite facing the same adversities that lead others to give up or lose hope (p. 317). The quest to understand this discrepancy fueled the field of resilience research.
The Origin of Resilience Research

Clinical psychologist and researcher Norman Garmezy first noticed differences in the trajectories of children with schizophrenia, during his studies in the late 1960’s. His data suggested that clinical outcomes varied among participants, and that studying the development of participants predisposed to the disorder could also be valuable (1987). Masten, Nuechterlein, and Wright (2011) explained Garmezy was fascinated by cases of children he observed that were doing exceptionally well despite the prevalence of severe hardship in their lives (p. 140). Masten et al. explained, “his work took a dramatic turn toward the science of what would later become known as resilience” (p.141). Garmezy proposed that learning more about competence and resilience could inform approaches to preventing mental health problems and promote success in young children at risk (Masten, Nuechterlein, & Wright, 2011, p. 141).

Cicchetti and Garmezy (1993) agreed that the roots of resilience research can be attributed to the groundbreaking work of Garmezy and his collaborators (p. 498). His writings were among the earliest efforts to highlight the importance of investigating protective factors in at-risk populations and Garmezy’s research “laid the groundwork for future work in the area of resilience” (Cicchetti & Garmezy, 1993, p. 498). Luthar, Cicchetti, and Becker (2000) also agreed that increasing empirical efforts to understand individual presentation in response to hardship were fueled by the evidence that many of the children Garmezy studied thrived despite their high-risk circumstances (p. 544). Luthar et al. (2000) added that the aim of his research was a systematic search for protective factors. Garmezy was among the first to examine the differentiation between children with healthy adaptation and those who were relatively less well adjusted (p. 544).
In his pioneering studies, Garmezy (1987) identified several risk factors associated with childhood psychopathology: “1) severe marital distress; 2) low social status; 3) overcrowding or large family size, 4) paternal criminality, 5) maternal psychiatric disorders, 6) admission of children into foster home placement” (p. 165). Subsequent studies added more risk factors, including socioeconomic disadvantage, parental mental illness, maltreatment, urban poverty and community violence, chronic illness, and catastrophic life events (Luthar et al., 2000). Norman Garmezy, his colleagues, and followers have transformed the field of resilience research across multiple disciplines, “from the molecular level to the global ecosystem, infusing a strength-based and recovery-oriented approach into psychology, education, social work, and psychiatry” (Masten et al., 2011, p. 141). While Norman Garmezy has been widely recognized for laying the foundation for current resilience research, he did not offer a clear definition of resilience. In order to effectively study and understand the concept of resilience, researchers must first agree on a definition.

**Defining Resilience**

Definitions of resilience vary depending on the researcher studying it. Cicchetti and Garmezy (1993) explained that researchers utilize different definitions of resilience that can range from “the absence of psychopathology in the child of a mentally ill parent to the recovery of function in a brain injured patient” (p. 499). With an increased interest in studying the concept of resilience, continuing research has expanded the scope of the concept itself. Cicchetti and Garmezy (1993) continued; the definition of resilience can vary and different conclusions can be drawn depending on how broad or conservative the definition is (p. 499). There is now increased interest in and a fast-growing body of experimental research on this alternative, resilience paradigm (p. 206). Nicoll (2011) explained that this research “is variously termed resilience,
positive psychology, wellness, health promotion, strengths-enhancement psychotherapy, and social emotional intelligence” (p. 206). Nicoll (2011) noted that over the past several decades, the field of mental health has leaned toward a biomedical-neurological paradigm (with a primary emphasis on the diagnosis of disease) and the construction of a symptom-reduction-focused treatment or intervention plan; however, we are now seeing a counter movement. This new paradigm “has been variously termed the resilience, positive psychology, or strengths-based paradigm in counseling and therapy” (Nicoll, 2011, p. 205).

Iacoviello and Charney (2014) concluded that resilience is commonly described as adaptive characteristics of a person to cope with and recover from adversity (and sometimes even thrive after adversity) (p. 2). Researchers Wills and O’Carroll Bantum (2012) proposed that the definition of resilience is being exposed to adverse circumstances (e.g. poverty, chronic illness, maltreatment) yet showing somewhat few negative symptoms in terms of problem behavior (p. 571). Southwick, Bonanno, Masten, Panter-Brick, and Yehuda (2014) defined resilience quite simply as a stable course of healthy functioning after an extremely adverse event (p. 2). They noted that a resilient course may contain a relatively short period of disequilibrium, but is then marked by continued wellness (p. 2). They found that this resilient outcome is very common. They asserted that it is not simply the absence of symptoms, and that it is different from other responses to potentially traumatic events (2014, p. 2).

Hames and Joiner (2012) proposed that resilient individuals are described by their ability to rebound back from negative life stressors and to adapt flexibly to the stressful demands after traumatic experiences (p. 642). Similarly, Seery, Holman, and Silver (2010) suggested that resilience involves a capacity to maintain a healthy outcome following a traumatic event, and the ability to rebound after a negative experience (p. 1025). Hjemdal, Friborg, and Stiles (2012)
agreed. They proposed that resilience refers to the maintenance of normal development, healthy adjustment or good functioning following a traumatic event (p. 174). Others considered the lack of psychopathological symptoms only part of the definition. Friborg, Hjemdal, Martinussen, and Rosenvinge (2009) explained, “successful adaptation has been considered as the direct opposite of a poor mental-health outcome” (p. 138), but on the other hand, “resilience is also considered as something more than just the absence of pathology since the adaptation process also may foster psychological growth, development of new competencies, or a new outlook on life” (p. 138). Friborg et al. (2009) echoed the definition set forth by other researchers, indicating a preservation of normal development or functioning despite being exposed to serious stress or adversity (p. 138). Illness is traditionally treated by removing something negative (e.g., pathogenic forces), and yet the promotion of resilience includes adding something positive (e.g., resources) (p. 148).

Rutter (1987) described resilience as “the positive pole of individual differences in people’s response to stress and adversity” (p. 316) and later expanded his definition to describe resilience as a multifaceted construct that necessitates an emphasis on social relationships and individuals (Rutter, 1999, p. 159). Luthar et al. (2000) agreed that resilience is much more than an individual trait. They posited that resilience refers to a dynamic process incorporating positive adaptation within the context of significant hardship (p. 543).

**Differential Definitions**

Resilience can commonly be defined as a dynamic process, marked by a relatively stable trajectory after exposure to potentially traumatic events. It differs from both recovery and posttraumatic growth (PTG). Bonanno (2005) reported that studies have now confirmed that resilience and recovery are separate and discrete outcome trajectories following a traumatic event
(p. 135). Recovery is marked by “moderate to severe initial elevations in psychological symptoms that significantly disrupt normal functioning and that decline only gradually over the course of many months before returning to pre-trauma levels” whereas resilience is characterized by “relatively mild and short-lived disruptions and a stable trajectory of healthy functioning across time” (pp. 125-126). Westphal and Bonanno (2007) agreed that although resilient individuals may experience “short-term dysregulation” and inconsistency in their emotional and physical well-being, their responses to traumatic events tend to be “relatively brief and usually do not impede their functioning to a significant degree” (pp. 420-421). Decidedly a major distinction between resilience and posttraumatic growth is the general sense of either equilibrium or disequilibrium during and immediately following the adversity. Individuals with resilient outcomes tend to experience little to no disruptions in their functioning following adversity, whereas individuals with posttraumatic growth experience a marked change in their ability to function normally following the adversity, followed by a period of growth.

In a study conducted by Levine, Laufer, Stein, Hamara-Raz and Solomon (2009) examining the connection between resilience and posttraumatic growth, researchers found that, high levels of resilience were associated with the lowest posttraumatic growth scores (p. 282). Although posttraumatic growth and resilience are both salutogenic constructs, the results implied that they are inversely related (p. 282). Their findings supported the notion that “resilience conceptualized and measured by a lack of PTSD following adversity is inversely associated with posttraumatic growth” (p. 285). Levine et al. concluded that individuals that displayed resiliency rarely experienced a drastic change in typical functioning, making them less likely to seek out opportunities for growth, explaining the correlation with low posttraumatic growth measures.
Westphal and Bonanno (2007) also identified this distinction and confirmed that a growing number of studies have confirmed that people exhibiting a resilient outcome trajectory are significantly less likely to search for meaning as compared to others, despite being exposed to the same event (p. 421). There is uncertainty as to whether resilient outcomes or posttraumatic growth is the preferred outcome. The notion that posttraumatic growth is the ideal reaction to traumatic experiences may unintentionally perpetuate the assumption that posttraumatic growth is a preferred or superior outcome compared to resilience (p. 425).

The Nature of Resilience

Resilience differs from both recovery and posttraumatic growth. Understanding the nature of resilience can shed light onto how resilience operates, how it is fostered, and how it may be inhibited. Researchers sought to understand if resilience is an inherent personality trait or a complex process with multiple variables. Bonanno (2005) proposed that there are multiple and sometimes unexpected factors that may foster a resilient outcome. Several of the same characteristics that help foster healthy development should also nurture adult resilience (p. 136). Such characteristics would include both situational factors, (such as supportive friendships), and individual factors, (such as the capacity to adapt easily to changes) (Bonanno, 2005, p. 136).

Southwick at al. (2014) agreed with a multi-dimensional approach to deconstructing resilience, and they cautioned a need to examine resilience and its determinants from “multiple levels of analysis, including genetic, epigenetic, developmental, demographic, cultural, economic and social” (p. 11). Cicchetti and Garmezy (1993) stressed the importance of acknowledging that resilience is not a static trait. It is possible that new vulnerabilities or assets may emerge during highly stressful periods or during developmental transitions throughout the life course (p. 499). Rutter (1987) agreed with Cicchetti and Garmezy’s position that resilience should not be
viewed as a fixed characteristic of the individual. He explained that when circumstances change, resilience too, may change. People who cope successfully with difficulties at one point in their life may respond differently to other stressors given different situations (Rutter, 1987, p. 317). Luthar, Cicchetti, and Becker, (2000) also agreed that resilience should not be considered a static state (p. 552). While literature has traditionally focused on resilience as a personality trait, Masten (2015) highlighted that current research is helping to rid the misconception that resilience is a simply a personality trait.

Luthar et al. (2000) added the importance of understanding underlying protective processes instead of just identifying protective factors (p. 544). They noted, “researchers are increasingly striving to understand how such factors may contribute to positive outcomes” (p. 544) instead of simply studying which person, family, or environmental factors are associated with resilience (Luthar, Cicchetti, & Becker, 2000). Luthar et al. (2000) highlighted that paying attention to underlying processes is “essential for advancing theory and research in the field, as well as for designing appropriate prevention and intervention strategies for individuals facing adversity” (p. 544).

**Risk and Protective Factors**

Resilience is a dynamic process marked by a relatively stable trajectory after exposure to potentially traumatic events. Researchers have aimed to deconstruct it further to help explain differences in adaptation, specifically why some people adapt positively following exposure to adversity whereas others adapt negatively (Sandler, Wolchik, & Ayers, 2008). Sandler, Wolchik, and Ayers (2008) explained that a common approach to studying resilience has been to identify risk and protective factors that predict varied functioning in those exposed to adversity. Factors affecting resilience can be found at the individual, family, community, or cultural level (p. 61).
In their work studying bereaved children they found that healthy and maladjusted outcomes are best predicted “not from any single factor (e.g., caregiver mental health, traumatic death) but from the accumulation of multiple risk and protective factors” (p. 61). Their research established support for risk and protective factors at the family (e.g., parenting, caregiver mental health problems, stressful events) and individual (e.g., coping efficacy, threat appraisal, control beliefs, self-esteem) levels (p.69). Sandler et al. added that resilience is shaped by environmental factors as well as individual and protective factors, and that resilience is seen as a process that occurs over time (p. 60). Luthar et al. (2000) highlighted that research concerning resilience appears to be in good standing, they added “reviews of the relatively small though burgeoning literature have indicated synchronous evidence regarding many correlates of resilience (protective factors) across multiple studies” (p. 545). Shahar (2012) agreed, adding that research “has largely focused on identifying the factors which render individuals particularly vulnerable to stress, primarily under the influence of the stress-diathesis model” (p. 537). They added that more recently, more attention has shifted to the possibilities that resilience research can shed on presenting protective, stress-resistance factors that promote health (Shahar, 2012, p. 536).

Garmezy (1987) identified several risk factors associated with childhood psychopathology, “1) severe marital distress; 2) low social status; 3) overcrowding or large family size, 4) paternal criminality, 5) maternal psychiatric disorders, 6) admission of children into foster home placement” (p. 165). Galatzer-Levy, Burton, and Bonanno (2012) found that response patterns vary in regard to unique individual differences due to a number of unique personal and contextual factors (p. 547). Similarly, literature has shown that resilient individuals can be differentiated from others by factors such as gender, age, level of education, personality traits, (including affectivity, self-efficacy, self-enhancement, and optimism), social and economic
resources, past and current stressors, positive world views, and the ability to process positive emotions (Galatzer-Levy, Burton, & Bonanno, 2012, pp. 547-548).

Hjemdal et al. (2011) noted that previous research on resilience has highlighted the presence of protective factors that are believed to moderate the effects of stressors and may essentially add to promoting mental health and also prevent the development of negative symptoms despite being exposed to stressful situations (p.314). Hjemdal et al. (2011) also offered “neuroticism or negative/pessimistic cognitions are well-known vulnerability factors of depression, while emotional stability and optimism are generally protective” (p. 139). Garmezy (1987) identified three general variables that appeared repeatedly across studies, the personality dispositions of the individual, a supportive family environment, and an encouraging external support system (p. 168). Westphal and Bonanno (2007) indicated that many individual differences could affect outcomes. These differences include distinctions in dispositional optimism, hardiness, ego resiliency, threat appraisal, emotion regulation, and the ability to successfully seek out social support (p. 424). A review of literature by Shahar, Elad-Strenger, and Henrich (2012) highlighted three major factors separating resilient and pathological adolescents; relatedness (i.e., positive interactions with others), agency (a conviction that one can intervene effectively with one’s own life), and reflectiveness (curiosity about one’s inner thoughts and feelings) (p. 620).

A study by Seery, Holman, and Silver (2010) found that following major medical problems, individuals reported “improved social relationships, new and valued life priorities, and developing greater patience and courage” (p. 1038). Seery et al. (2010) noted that self-enhancement, positive emotions, and directing attention away from negative emotions have been associated with resilience after hardship (p. 1038). After compiling numerous studies and
personal interviews, researchers identified six psychosocial factors that promote resilience in individuals: 1) optimism, 2) cognitive flexibility, 3) active coping skills, 4) maintaining a supportive social network, 5) attending to one’s physical well-being, and 6) embracing a personal moral compass (Iacoviello & Charney, 2014; Nugent, Sumner, & Amstadter, 2014). Iacoviello and Charney (2014) confirmed that an assortment of factors, (including cognitive, behavioral, and existential elements) have been verified in the literature as contributing to resilience in response to hardship (p. 9).

It appears that a combination of various factors have been demonstrated to influence and shape resilience in individuals after traumatic events. Literature regarding each of these factors is gradually growing and helps to construct a better understanding of the mechanisms supporting and inhibiting resilience.

Coping Strategies

According to Galatzer-Levy et al. (2012), there is support from the coping literature that resilience can be fostered by the ability to flexibly move between multiple coping behaviors (p. 542). The highlighted clinical research indicates, “one potential factor is the way that people cope with adversity” (p. 547). Galatzer-Levy et al. (2012) reviewed previous literature studying stressful life events and transitions and found different responses, yet the most common outcome “consistently has been shown to be positive adaptation characterized by little or no disruption in functioning, or resilience” (p. 544). They explained that the majority of research concerning resilience and the ways people cope with extreme adversity has accentuated two seemingly paradoxical sets of strategies (p. 548). One view is that “a healthy response to loss or trauma was assumed to require focused processing of personal thoughts and feelings associated with the event and a deliberate and effortful kind of trauma focus or working through” (Galatzer-Levy et
al., 2012, p. 548). Conversely, “expression of positive emotion, staying active and socially engaged are some of the components of this form of coping that, in contrast with the prior strategy, rely upon interpersonal functioning” (p. 548). For this reason, researchers have shifted toward a more holistic perspective that emphasizes both dimensions through the concept of coping flexibility (p. 548).

Galatzer-Levy et al. (2012) sought to test whether flexible coping (as defined as the ability to both focus attention on distressing material and the ability to focus attention away from that same material) would predict resilience in individuals adapting to college (p. 549). They found that the ability to utilize flexible coping strategies predicts greater degrees of resilience within the context of exposure to a PTE [potentially traumatic event] (Galatzer-Levy, et al., 2012, p. 561).

**Self-Esteem and Self-Enhancement**

According to Bonanno (2005), trait self-enhancement is the tendency toward self-serving biases in perception and attribution (overestimating one’s own positive qualities) (p. 137). It has been positively correlated in individuals with resilience. In samples of individuals dealing with stressful events, “trait self-enhancement was positively associated with ratings of functioning made by mental health experts” (p. 137). Iacoviello and Charney (2014) also found that “efforts to create positive statements about oneself and one’s situation” compromise a behavioral or action-oriented component necessary for positive outcomes (p. 3).

Research by Hames and Joiner (2012), suggested that factors that confer resilience to individuals with low self-esteem may differ from the factors that confer resilience to individuals with high self-esteem (p. 641). Their review of previous research indicated that “for individuals with high self-esteem, repeating positive self-statements was an effective means of improving
self-esteem and mood” however, for “individuals with low self-esteem, repeating positive self-statements led to a decrease in self-esteem and mood” (p. 642). This research however, only tested one type of positive self-statement, a stable/global one. Stable/global self-statements are enduring and likely to affect many outcomes. In contrast, unstable/specific positive self-statements are not enduring and are not likely to affect many outcomes. An example of a stable/global positive self-statement is “I’m a lovable person” whereas an example of an unstable/specific positive self-statement is “People seem to like me today” (Hames & Joiner, 2012). After presenting participants with a laboratory stressor and various positive self-statements, Hames and Joiner (2012) found that individuals with low self-esteem got the most benefit from thinking about doing the things they enjoy (versus thinking about positive aspects of themselves) (p. 658). Interestingly, the condition that was most beneficial for individuals with high self-esteem was the least beneficial for individuals with low self-esteem (p. 658). In summary, researchers found that individuals with low self-esteem benefit more from thinking about the things they enjoy doing, whereas individuals with high self-esteem benefit more from using stable/global positive self-statements following a stressor (2012). Hames and Joiner (2012) cautioned practitioners and advised, “caution should be used when advocating the use of a resiliency technique across individuals, as the efficacy of the technique may differ as a function of attributes such as self-esteem” (p. 660).

**Emotion Regulation and Self-Control**

Wills and O’Carroll Bantum, (2012) explained that there are two distinct domains of regulation processes, defined as good self-control and poor regulation. These co-exist within each individual and have different antecedents and different consequences (p. 569). Good self-control is described as “a set of correlated abilities involving a tendency to acquire and evaluate
information, think ahead about situations, and achieve goals through self-monitoring performance and persist in completing tasks” (p. 570), whereas poor regulation is described as “a tendency to be impatient and act without thinking, to like to switch tasks, and to be easily irritated or frustrated” (p. 570). These domains have different implications, with a higher level of good self-control contributing to resilience and a higher level of poor regulation making individuals more vulnerable to the repercussions of life stress (p. 569). People with better emotion regulation were better able to dampen arousal, manage negative emotions, and use cognitive-management strategies to avoid contemplating negative experiences even after the event (p. 577). Additionally, having accessible support from others contributes to aspects of self-control involving both behavioral action (planning how to stay the course of a treatment program) and cognitive control effects (finding positive purpose during difficult circumstances) (p. 583).

**Appraisal**

Iacoviello and Charney (2014) stressed the importance of the ability to reappraise one’s perception of a traumatic situation instead of being inflexible in one’s perception (p. 3). Researchers have recently begun to question whether it is the stressful event itself, or how one interprets (or appraises) it that determines outcome. Reappraisal involves an effort to find meaning and positive outcomes, while also acknowledging the negative and painful consequences. Traumatic experiences can be reevaluated, altering the perceived value and meaningfulness of the event (p. 3). Iacoviello and Charney continued, “acceptance and assimilation of a traumatic experience into one’s life narrative involves acknowledging that experiences with stress, or even trauma, can provide opportunities for growth” (p. 3). Iacoviello
and Charney noted that being mindful of one’s thoughts about a situation and actively minimizing the appraisal of threat without denying it (p. 3) can also be beneficial.

Westphal and Bonanno (2007) noted the importance of flexibility in the ways individuals perceive and organize highly aversive life events (p. 424). They explained further, an ability to maintain a separated view of positive as well as negative information is believed to enable people to manage difficult life events in a manner that is both flexible and effective (p. 424). This appraisal-based flexibility fosters resilience because it fosters “feelings of mastery, competence, commitment, and other aspects of positive self-perceptions” (p. 424) which helps to maintain or restore self-esteem after traumatic events (p. 424). Rutter (1987) agreed wholeheartedly, explaining “protection does not reside in the psychological chemistry of the moment but in the ways in which people deal with life changes and in what they do about their stressful or disadvantaged circumstances” (p. 329).

While employing appraisal strategies has been shown to be beneficial to outcomes, measuring appraisal and traumatic events can be problematic. Seery et al. (2010) cautioned that attempting to rate the severity of traumatic events objectively could be difficult because not everyone experiences adversities unanimously (p. 1036). Luthar et al. (2000) agreed and proposed that the meaning of any traumatic event to the individual experiencing it can differ greatly from the interpretation of the resilience researcher. Scientists may define a life circumstance as being highly stressful; while individuals may see themselves as being relatively well off (p. 550).

**Previous Adversity**

Seery et al. (2010), proposed, “resilience involves having psychological and social resources that help people tolerate adversity, but coping with adversity may itself promote
development of subsequent resilience” (p. 1037). In their multiyear longitudinal study of a national sample, they found that participants with a history of some lifetime adversity reported better mental health and well-being outcomes than participants with a high history of adversity, as well as participants with no history of adversity (p. 1025). They concluded that experiencing adversity in moderation can help foster the development of resilience (p. 1036) and that experiencing low levels of adversity can help foster coping skills, social support networks, and create a sense of mastery over previous adversity (p. 1037). This helps to foster beliefs in the ability to cope successfully in the future, and create psychophysiological toughness (p. 1037).

Gender

In their research study testing resilience and pathological symptoms in adolescents, Hjemdal et al. (2011) tested the Resilience Scale for Adolescents, and found that “overall levels of resilience were unrelated to gender differences” and that “the differences obtained may be an indication of gender-related differences of characteristic styles for good adaptation” (p. 319). Hjemdal et al. (2011) noted that previous research has also shown some general gender differences in larger samples; Females generally report more social and interpersonal resources compared with males, and males rate themselves higher on personal dispositions than females (p. 315). Their research confirmed gender differences only on resilience subscales; “Female pupils reported significantly lower scores on Personal Competence, but higher scores on Social Resources and Family Cohesion, than males” (p. 319) confirming previous research indicating slight gender differences.

Optimism

Iacoviello and Charney (2014) explained that optimism denotes the maintenance of positive expectancies for significant future outcomes (p. 3) and found that optimism has been
associated with well-being after adversity (p. 3). Galatzer-Levy et al. (2012) stressed that more research “has emphasized optimism, and a focus toward the future, and away from extremely distressing events lead to better outcomes” (p. 548).

In their study of resilience and prisoners of war, Segovia, Moore, Linnville, Hoyt, and Hain (2012), found that optimism was the best predictor of resilient outcome thirty-seven years later. They found that the variable that had the strongest association with resilience was a measure of optimism–pessimism. Optimism was a stronger predictor of resilience than traumatic experience type (such as torture variables like solitary confinement) (p. 334). Their results indicated that it was not specifically the severity or duration of trauma that determined an individual’s resilience, but the individual’s level of optimism, as higher scores were associated with resilience (p. 334).

**Social Support and Social Networks**

Iacoviello and Charney (2014) reported that resilient individuals use “active rather than passive coping skills; they act and create their own resilience” (p. 3). Action-oriented and cognitive components are both needed for successful outcomes. “Efforts to create positive statements about oneself and one’s situation, and active efforts to seek the help and support of others, comprise the behavioral or action-oriented components” (p. 3)

Similarly, Panzarella, Alloy, and Whitehouse (2006) concluded that social support “may reduce the likelihood of maladaptive inferences for particular negative events” (p. 310). This buffering effect “may occur either before the subjective experience of stress (after a potentially stress-inducing event has occurred) by influencing event appraisal” or “after the experience of stress but prior to the onset of hopelessness and depression by influencing appraisal of coping abilities or resources” (p. 310).
Westphal and Bonanno (2007) highlighted the connection between social supports and well being: “The idea that helping others is what best bestows beneficial meaning on people’s traumatic experience has strong intuitive appeal and also fits with the well-documented link between social supports and adjustment” (p. 419). They also added “measures of individuals’ social engagement and support networks reflect social functioning over time and thus may be more reliable indicators of adjustment than self-reports about growth that were obtained at specific points in time” (p. 419).

In their research studying college students and social support, Galatzer-Levy et al. (2012) found that “social networks are of most utility in adaptation among those under the most stress” (p. 560). For the most distressed students, Galatzer-Levy et al. (2012) found that “increases in social network size predict high levels of functional instability throughout college while increases in social network embedded-ness appears to have a stabilizing effect on these students” (p. 562), leading them to believe that “social network quality may have a stronger impact on adjustment than the gross quantity of people in one’s social network” (p. 549).

Wills and O’Carroll Bantum (2012) found that “social support is widely recognized as a protective factor. It is related to lower levels of psychological and physical symptomatology in a variety of adult populations” (p. 569). Wills and O’Carroll continued to explain, “the availability of emotional or instrumental support has been shown to reduce the impact of negative life experiences on psychological and physical symptomatology, termed a stress-buffering effect” (p. 569). Social relationships “can support a person’s feelings of competence and optimism and hence motivate persons with problems to take an active (rather than helpless) approach to problems” (p. 574).
Wills and O’Carroll Bantum also noted the role that the social network has on its own members. Members of social networks “can engage in problem solving together with the distressed person through suggesting alternative solutions to problems and providing feedback to help persons self-monitor their progress toward the goal of resolving the problem and regulating negative emotions.” (p. 574). Being a part of a social network can be a “motivating force to utilize self-control skills because of a greater awareness of normative considerations and because a sense of mutual obligation in which a person is both helped by others and helps them in return” (p. 574).

**Purpose in Life and Spirituality**

Iacoviello and Charney (2014) proposed “positive religious coping has been associated with better physical and mental outcomes in response to a range of situations” (p. 4). For example, in a study of “psychosocial factors associated with resilience and recovery from the experience of a traumatic event in primary care patients, purpose in life emerged as a key factor associated with both resilience and recovery” (Alim et al., 2008, as cited in Iacoviello & Charney, 2014, p. 4). Additionally, in a study of Pakistani earthquake survivors, “purpose in life was associated with lower posttraumatic and depressive symptom levels” (Feder et al., 2013, as cited in Iacoviello & Charney, 2014, p. 4). Lastly, a meta-analysis of the “association between religious coping and psychosocial adjustment to stress found that positive religious coping had a moderate positive association with positive psychological adjustment” (Ano & Vasconcelles, 2005, as cited in Iacoviello & Charney, 2014, p. 4).

**Cautions Regarding Risk and Protective Factors**

Although the aforementioned factors have all been found to affect resiliency after trauma, it is wise to consider some of the cautions regarding risk and protective factors. Paradoxically,
many of the factors that foster resilience, cannot alone explain it. Garmezy (1971) cautioned, “a simple declaration of physical, psychosocial or sociocultural resources cannot explain divergent paths to adaptation or to deviance” (p. 102). Others echoed his sentiment, “mental disorders are likely to be caused by multiple risk factors and processes rather than singular causes” (Cicchetti & Sroufe, 2000, as cited in Hjemdal, Vogel, Solem, Hagen, & Stiles, 2011, p. 315).

Shahar et al. (2012) noted, “clinical experience working with adolescents and young adults has taught us that the tendency to classify psychosocial factors into clear-cut risk vs. resilience categories is in need of a serious reexamination” (p. 618-619). They continued, “most, if not all, psychosocial factors include elements of both risk and resilience” (p. 620). Rarely do resilience researchers “consider the possibility that a construct might actually serve as both a risk factor and a resilience factor” (p. 620). Rutter (1987) agreed, “any one variable may act as a risk factor in one situation but as a vulnerability factor in another” (p. 317). Perhaps it is better to propose that both psychopathological symptoms and protective factors create resilient outcomes (Hjemdal et al., 2011). Westphal and Bonanno (2007) conferred, “multiple pathways to resilient outcomes undoubtedly vary in adaptive value across different people, situations, and cultural contexts” (p. 425). Southwick et al. (2014) also agreed, “specific determinants generally serve as relatively weak predictors of resilience by themselves and explain a relatively small piece of the puzzle.” (p. 11).

Masten (2015) explained, “resilience, whether it is defined in terms of capacity, processes, or outcomes of positive adaptations in contexts of risk, will depend on the co-action of multiple systems as they come together in the function or development of the individual” (p. 187). The development of any one individual’s resilience “will be influenced by many interactions within the individual (genetic, neural, immunological, cognitive, etc.) and also
between the person and the environment, including interactions with family, peers, school, community, and the natural and built environment” (p. 187). Shahar et al. (2012) agreed with Masten and suggested that relevant research should focus on “a host of psychosocial factors (e.g., dependency, self-concept, social support, positive life events, coping strategies)” to better understand resilience (p. 618). Despite the fact that many factors make resilience a problematic construct to understand, researchers have sought to standardize resilience, by measuring it using various methods. These methods include various measurement scales for children, adolescents, adults, and older adults.

**Measuring Resilience**

Since resilience is more than just the absence of pathological symptoms, researchers go about measuring resilience in different ways. Researchers have recently begun to create ways to try and capture resilience using measurement scales. Various measurement scales currently exist for children, adolescents, adults, and older adults. Smith-Osborne and Bolton (2013) reviewed available literature on existing resiliency measurement scales and found that, “currently validated instruments measure specific populations and vary in length and format” (p. 111).

**Child and Adolescent Rating Scales**

Smith-Osborne and Bolton (2013) identified four scales for children and adolescents: the Resilience Scale for Adolescents (READ), the Resilience Scale for Children and Adolescents (RSCA), the Adolescent Resilience Scale (ARS), and the Resilience Skills and Abilities Scale (RSAS).

The Resilience Scale for Adolescents (READ) is a 28-item scale rated using a 5-point Likert scale. It is comprised of five factors: Personal Competence, Social Competence,
Structured Style, Family Cohesion, and Social Resources. It has been tested for validity in Norwegian and American populations.

The Resilience Scale for Children and Adolescents (RSCA) consists of three scales: Sense of Mastery (20 items), Sense of Relatedness (24 items), and Emotional Reactivity (20 items), all on a 5-point Likert scale. It has been tested for validity in various populations.

The Adolescent Resilience Scale (ARS) is a 21-item scale rated using a 5-point Likert scale. It contains three factors: novelty seeking, emotional regulation, and positive future orientation. It differentiated groups into vulnerable, resilient, or well adjusted. It has been validated on a Japanese population sample.

The Resilience Skills and Abilities Scale (RSAS) consists of 35 items, each rated on a 5-point Likert scale. It has three subscales: Active Skill Acquisition, Future Orientation, and Independence/Risk Taking. It has been tested for validity on high school population samples. Only the READ appeared to be both reliable and valid in Smith-Osborne and Bolton’s (2013) review.

**Adult Rating Scales**

Smith-Osborne and Bolton (2013) also identified several scales for adults: the Resilience Scale (RS), the Connor-Davidson Resilience Scale (CD-RISC), the Baruth Protective Factors Inventory (BPFI), the Resilience in Midlife Scale (RIM), the Resilience Scale for Adults (RSA), and the Brief Resilient Coping Scale (BRCS).

The Resilience Scale (RS) is a 25-item scale rated using a 7-point Likert scale. The scale has two factors: personal competence and acceptance of self and life. It has been tested for validity on numerous populations of different ages and backgrounds.
The Connor-Davidson Resilience Scale (CD-RISC) is comprised of 25-items rated on a 5-point Likert scale. It contains five factors: personal competence/high standards/tenacity, trust in personal instinct, positive acceptance of change/secure relationships, control, and spiritual influences. It has been tested for validity in six different population samples, and can distinguish between greater and lesser resilience (Connor & Davidson, 2003; Ahern, Kiehl, Sole, & Byers, 2006).

The Baruth Protective Factors Inventory (BFPI) contains 16 items; each rated using a 5-point Likert scale. It examines four factors: adaptable personality, supportive environment, fewer stressors, and compensating experiences. It has been tested for validity on one sample population, but further testing is needed to establish both reliability and validity (Ahern, et al., 2006).

The Resilience in Midlife Scale (RIM) is a 25-item scale, rated using a 5-point Likert scale. It consists of several factors: self-efficacy, family/social networks, perseverance, internal locus of control, coping, and adaptation. It has been tested for validity in one population sample.

The Resilience Scale for Adults (RSA) contains 33 items, and factors six components: positive perception of self, positive perception of future, social competence, structured style, family cohesion, and social resources. It has been tested for validity on several population samples.

The Brief Resilient Coping Scale (BRCS) is a very brief scale consisting of four items, each rated using a 5-point Likert scale, designed to measure active coping.

Smith-Osborne and Bolton (2013) noted that discriminant and convergent validity were established for all scales except for the BPFI and RS. The RSA, CD-RISC, and BRCS also established predictive validity. More studies are needed to replicate results for the BPFI, BRCS,
and RIM. Smith-Osborne and Bolton (2013) concluded that, “the need for an analytical approach to measuring resilience is long overdue” (p. 111).

Salutogenic Theory

As research in the field of resilience and trauma has steadily increased, so too have the ways in which practitioners view mental illness. In the past several decades many practitioners and researchers have adopted a strengths-based approach highlighting the promotion of health (rather than focusing on the treatment of disease). The aim of this unconventional shift is to understand wellness rather than disease, and “not only how people recover or cope but also how individuals and communities thrive and flourish” (Seligman, 2011, as cited in Hamm, Carlson, & Erguner-Tekinalp, 2016, p. 254). Garmezy (1971) noted, “Most psychiatric studies focus on pathology, not on the delineation of degrees of normal psychological health” (p. 102). Consequent researchers and practitioners have used Garmezy’s pioneering work in the field of resilience research to further broaden our understanding of mental illness.

One such researcher was sociologist Aaron Antonovsky. Antonovsky was a practitioner who believed there was merit in studying the origins of health (versus the popular disease model). He coined the term salutogenesis (the origin of health in Greek) to accompany his model of health. His theoretical model examined the relationship between life stresses and health by what he called sense of coherence (SOC). Antonovsky and Sagy (1986) explained:

SOC was defined as “a global orientation that expresses the extent to which one has a pervasive, enduring, though dynamic, feeling of confidence that one’s internal and external environments are predictable and that there is a high probability that things will work out as well as can be reasonably expected.” (Antonovsky, 1979, as cited in Antonovsky & Sagy, 1986, p. 214)
Antonovsky (1996) elaborated, “The strength of one’s SOC, I proposed, was a significant factor in facilitating the movement toward health” (p. 15). He continued, “these components will sound familiar to those who know the coping literature, for they are close to concepts like optimism, will to live, self-efficacy, learned resourcefulness, hardiness, etc.” but, he added, “it is the particular combination of the cognitive, behavioral and motivations which is unique” (p. 15). Antonovsky was honest in his assessment of his work; “I have none the less been highly critical, in emphasizing that the basic flaw of the field is that it has no theory” (p.18). Even though Antonovsky’s model was without an obvious foundation, the salutogenic orientation has been helpful in “providing a direction and focus” and “allowing the field to be committed to concern with the entire spectrum of health ease/dis-ease, to focus on salutary rather than risk factors” and “always to see the entire person (or collective) rather than the disease (or disease rate) and collaborator” (p. 18). Perhaps Antonovsky’s model of salutogenesis is compatible with positive or strengths-based psychological orientations such as Alfred Adler’s theory of Individual Psychology.

**Alfred Adler’s Individual Psychology**

There has been an increasing interest in “focusing on strengths, solutions, resilience, and thriving of individuals even after traumatic experiences. Alfred Adler has been considered as the forefather of such strength-based approaches” (Hamm et al., 2016, p. 254). Hamm, Carlson, and Erguner-Tekinalp (2016) continued, “Although not given credit by positive psychology researchers, Individual Psychology is the original positive psychology” (p. 256). They confirmed that “current research in this area supports what Adler realized a century ago, that one of the best ways to remedy problems is to focus on identifying and developing client strengths, rather than focusing exclusively on their pathology” (p. 255).
Nicoll (2011) agreed that Adler’s theory is “consistent with the emergent paradigm shifts toward positive psychology and resilience” (p. 206). He continued that both Adler’s theory and positive psychology “all advocate an optimistic and proactive approach to counseling and therapy” (p. 206). Further, “both Individual Psychology and the resilience paradigm seek to promote more effective parenting and family interaction patterns. Healthy personalities develop best within healthy social environments” (Nicoll, 2011, pp. 206-207). Nicoll (2011) explained, “Adler (1937) theorized that all those who experience adjustment problems in life do so as a consequence of an inadequately developed sense of social interest, his concept for healthy psychological adjustment or mental health” (p. 206).

Griffith and Powers (2007) expanded, “The more developed the community feeling [social interest], the more diminished the inferiority feeling...therefore, the effectiveness of psychotherapy or counseling depends upon increasing and strengthening the discouraged person’s community feeling and social interest” (p. 11). Adler believed that each person yearned to find “belonging in the human community” and had a responsibility “for the way the life of the community is being shaped by his or her actions” (Griffith & Powers, 2007, p. 11).

Nicoll (2011) affirmed the holistic nature of Adler’s theory, when he wrote “[Adler’s] holistic, social-psychological view of humankind” inclined individuals to care for others and suggested that “a sense of compassion for others and attitudes of hope and optimism are associated with mental, physical, social, emotional, and spiritual well-being” (p. 207). Adler believed that the thoughts, feelings, beliefs, and actions of the individual were unified. Griffith and Powers (2007) further explained that Adler’s view that the individual was indivisible, “With every individual we must look below the surface. We must look for the underlying coherence,
for the unity of the personality. This unity is fixed in all its expressions” (p. 55). This idea of holism was in stark contrast to Freud’s contemporary psychoanalytic view at the time.

Adler’s view of human nature stressed the importance of autonomy and self-determination in life’s outcomes. Hamm et al. (2016) explained, “Adlerian theory emphasizes that nature or nurture is inadequate in explaining the development of problems or coping. Rather, there is an emphasis on one’s ability to influence, interpret, and create events as people have the capacity to transform the events and determine their own destinies” (p. 255). Hamm et al (2016) continued, “in Adlerian therapy, just like in positive psychology, the focus is on how individuals overcome difficulties and what they gain out of such challenges” (p. 255). Adler stated, “meanings are not determined by situations, but we determine ourselves by the meanings we give to situations” (Adler, 1980, p. 14 as cited in Griffith & Powers, 2007, p. 97). Adler believed that our responses to life’s challenges were more influential than the specific challenges themselves. Shahar et al. (2012) agreed with the importance of assigning meaning to individual experiences and proposed “that underlying the risk/resilience dialectics is a developmental process through which individuals actively structure and interpret their experiences, including those with adversity, to construct goals that bring meaning to their lives” (p. 635). Adler’s theory emphasized that all movement was purposeful and behavior operated in conjunction with a final or end goal. Each individual had a creative power that “expresses itself in the desire to develop, to strive, to achieve, and even to compensate for defeats in one direction by striving for success in another.” This power is “teleological, it expresses itself in the striving after a goal” (Griffith & Powers, 2007, p. 100).

Adler’s theory of human nature influenced his model for therapy accordingly. He believed that individuals were able to shape their destiny and increase their own social interest,
allowing them to become healthy contributors to their communities. Adler’s model of therapy embodied respect for the client, optimism, and encouragement toward change. Adler believed that establishing a therapeutic relationship, investigating the client’s lifestyle, providing opportunities for the client to gain insight, and reorientation were necessary for growth (Dreikurs, as cited in Griffith & Powers, 2007, p. 1). Hamm et al. (2016) described these principles in action: “As Adlerian-based group counseling, the group’s process was seen as a psychoeducational process helping participants develop awareness and meet life’s tasks in better ways, emphasizing a growth mindset, personal responsibility, equality, encouragement, and social interest” (p. 257). For Adlerian therapists, “the core intention and goal is to help increase the client’s social interest” (Paige, DeVore, Chang, & Whisenhunt, 2017, p. 24).

**Therapy and the Trauma-Competent Practitioner**

Therapists provide trauma-competent therapy as Adlerian practitioners. Paige, DeVore, Chang, and Whisenhunt (2017) emphasized that trauma-competent clinical practice is “a term we use to describe clinical practice informed by the knowledge, skills, and attitudes essential to healing from the effects of traumatic stress” (p. 9). They proposed that “Adler was perhaps the first trauma-competent clinician” due to his core beliefs in social interest, encouragement, lifestyle and holism (p. 29). Paige et al. (2017) cited evidence “that Adlerian psychotherapy, when paired with current trauma-specific knowledge and skills, is empirically supported through qualitative research as trauma-competent clinical practice” (p. 9).

Therapists should provide core conditions of the therapeutic alliance such as “nonjudgment, respect, acceptance, establish collaborative therapeutic alliance, and develop therapeutic relationship” (Paige et al., 2017, p. 24). The therapist should guide the client toward “mutually agreed-on treatment goals” while providing “support, structure, [and] emotional
stability” (p. 24). When assessing the lifestyle of a client, practitioners should assist clients to reprocess traumatic memory and address traumatic beliefs, while they provide a safe place for clients to learn a healthy sense of control. It is important for practitioners to remember, “clients are the authority and that we as clinicians are not to impose our own meanings on their narratives” (p. 29). During all stages of therapy a practitioner should use “confidence, demonstrate a strengths-based approach with affirmative language, and demonstrate lightness and humor” (p. 25). As believers in holism Adlerian practitioners make “self-care is a priority” (p. 28) and encourage their clients to do the same.

As trauma-competent therapists, practitioners should understand the “neurobiology of trauma, demonstrate foundational trauma knowledge, demonstrate foundational knowledge of trauma-competent clinical skills, effects of trauma on functioning, current trauma literature, provide psychoeducation on neurobiology of trauma and its treatments, demonstrate trauma-focused clinical skills, demonstrate assessment skills, and demonstrate diagnostic skills” (Paige et al., 2017, p. 29) including the caveat that trauma symptomology may vary based on age, gender, and a host of other factors. Most importantly the therapist should “know how to gauge readiness for processing through the trauma” (p. 29) and always provide encouragement to the client.

Iacoviello and Charney (2014) proposed “that understanding these factors can help promote resilience in individuals before they even encounter trauma, can inform psychosocial intervention strategies to treating trauma survivors, and can aid in the development of resilient communities” (p. 2). An encouraging note is that “these factors can be cultivated even before exposure to traumatic events, or they can be conceptualized and targeted in interventions for individuals recovering from trauma exposure” (p. 9).
Other research by Ruini and Fava (2012), indicated that “flourishing and resilience can be promoted by specific interventions” which lead to a “positive evaluation of one’s self, a sense of continued growth and development, and the belief that life is purposeful and meaningful, the possession of quality relations with others, the capacity to manage effectively one’s life and a sense of self-determination” (p. 291).

Ruini and Fava (2012) proposed a newer model of therapy based on Ryff’s cognitive model of psychological well being (Ryff, 1989) called Well Being Therapy (WBT). It encompasses “six dimensions of positive functioning and eudaimonic well-being: autonomy, environmental mastery, personal growth, purpose in life, self-acceptance and positive interpersonal relationships” (p. 293) and well being therapy “appears to be more suitable for addressing psychological issues that other therapies have left unexplored, such as the promotion of well-being” (p. 301). Ruini and Fava (2012) expanded, “well-being therapy may have a preventative role in general populations and particularly in children” as “a decreased vulnerability to depression, mood swings, and anxiety has been demonstrated after WBT in high-risk populations” (p. 291).

Discussion

The research referenced in this literature review supported resilience as a common and adaptive response to adversity following a traumatic event (Almedom & Glandon, 2007; Bonanno, 2005; Westphal & Bonanno, 2007). The pioneer of resilience research, Norman Garmezy, helped to launch a new strengths-based approach to treating individuals after trauma (Masten et al., 2011; Cicchetti & Garmezy, 1993; Luthar et al., 2000). Although the field of resilience has been identified by many names, (resilience paradigm, positive psychology, wellness, health promotion, strengths-based approach, salutogenic model), researchers have
agreed that resilience is commonly defined as an ability to experience negative events and continue to manage with little to no disruption in functioning (Iacoviello & Charney, 2014; Wills & O’Carroll Bantum, 2012; Southwick et al., 2014; Hames & Joiner, 2012; Seery et al., 2010; Hjemdal et al., 2012; Friborg et al., 2009).

Researchers agreed that resilience is a multifaceted, and dynamic process, requiring both individual intention and social relationships (Rutter, 1987; Luthar et al., 2000). It is distinguished from both recovery and posttraumatic growth. It is separate from recovery; as recovery entails a marked period of significant disruption follow the traumatic event, followed by a gradual decline in functioning (Bonanno, 2005; Westphal & Bonanno, 2007). Resilience is inversely related to posttraumatic growth. Individuals who display resilient outcomes show less disruption in functioning, and are less likely to search for meaning or growth after the traumatic event (Levine et al., 2009; Westphal & Bonanno, 2007). Further research is needed to clarify if resilient outcomes are preferable to posttraumatic growth. Current literature refuted the misconception that resilience is an innate characteristic, rather it operates on multiple levels and is based on situational factors (Bonanno, 2005; Southwick et al., 2014). It is not a static trait and can even fluctuate over time and depending on the circumstance (Cicchetti & Garmezy, 1993; Rutter, 1987; Luthar et al., 2000; Masten, 2015).

Several risk and protective factors were affirmed in the literature review, and the majority of literature confirmed that there is no one factor that can determine resilience. Rather, it is more likely an accumulation of different risk and protective factors (Sandler et al., 2008). These factors include both individual and environmental factors (Luthar et al., 2000; Shahar, 2012) and require a combination of unique personal and contextual factors (Galatzer-Levy et al., 2012; Hjemdal et al., 2011; Garmezy, 1987; Westphal & Bonanno, 2007; Shahar et al., 2012; Seery et
al., 2010). Flexible coping, the ability to focus both inwardly and outwardly, was affirmed in the literature to be beneficial (Galatzer Levy et al., 2012), as well as self-esteem and self-enhancement (Bonanno, 2005; Iacoviello & Charney, 2014; Hames & Joiner, 2012). Emotion regulation and self-control were also reported to contribute to resilience, as high levels of each can buffer stressors (Wills & O’Carroll Bantum, 2012).

Appraisal, the ability to changes one’s perception of an experience, correlated with better resilience outcomes (Iacoviello & Charney, 2014; Westphal & Bonanno, 2007; Rutter, 1987). However, since individual perception is subjective, it may be harder to accurately measure (Seery et al., 2010; Luthar et al, 2000) and requires further study to substantiate. Previous adversity, in moderation, predicted better adaptations after trauma, even when compared to no adversity (Seery et al., 2010). Gender differences could not be determined based on the literature sample and further research is necessary to investigate any possible correlations (Hjemdal et al., 2011).

Optimism was associated with psychosocial well being, and was the strongest predictor of resilient outcomes (Iacoviello & Charney, 2014; Segovia et al., 2012). Social support and social networks predicted better well being and less symptomology (Iacoviello & Charney, 2014; Panzarella, et al., 2006; Westphal & Bonanno, 2007). The quality of friendships was more beneficial than sheer social network size (Galatzer-Levy et al., 2012; Wills & O’Carroll Bantum, 2012). Spirituality was correlated with positive psychological adjustment and better physical and mental outcomes, and purpose in life was associated with both lower levels of PTSD symptoms and depression (Iacoviello & Charney, 2014).

While much has been done to promote the field of resilience research, there are still many obstacles to consider. Resilience research is still relatively young in the field of positive and
Individual Psychology. Improvements can be made to many dimensions of resilience research including clarifying terms and definitions, expanding research studies, understanding the mechanisms of resilience, and examining the potential for more compatible foundational resilience theories. Luthar et al. (2000) noted that “ambiguities in definitions and terminology” are concerning as well as the “instability in the phenomenon of resilience” itself (p. 543). Luthar et al. also “reiterate the need for greater precision in terminology” (p. 548) to collectively establish valid and reliable findings.

McCleary and Figley (2017) highlighted that resilience concepts have “gained widespread use in scholarship and practice, yet definitions, measures, and uses of resilience remain complex and multifaceted” (p. 1). They continued, “Scholars have also critiqued resilience theories and practice models as being difficult to define, too heavily focused on individual psychometric properties, and obscuring structural causes of adversity” (p. 1).

Sandler et al. (2008) agreed, as they noted “there is an increasing emphasis in resilience theory and research in moving beyond prediction of adaptation to understanding the processes underlying adaptation” (p. 62). They expanded, “Theoretical models are useful to articulate the processes that lead to resilience” however, “because processes that are theorized to be helpful may operate in unexpected ways, research is needed to test the hypothesized relations” (p. 69).

Friborg et al. (2009) proposed that, “The construct of resilience has been criticized for being operationalized as a positive, yet not independent counterpart of vulnerability” (p. 147) and suggested that further research is necessary to tease out their convergence. Similarly researchers need to refine the distinction between resilience, recovery, posttraumatic growth and pathology.

Practitioners also contend that trauma diagnoses are still lacking in their effectiveness. Wamser-Nanney and Vandenberg (2013) asserted, “survivors of traumatic events often present
with symptoms not specifically captured in the PTSD diagnosis, such as affect regulation
difficulties, impaired self-concept, interpersonal problems, sexualized behavior, and somatic
complaints” (p. 672), and that PTSD may be “insufficient to fully capture the potential
debilitating consequences of complex trauma in children” (p. 672).

Trauma-competent practitioners should be able to foster the therapeutic relationship,
understand foundational trauma knowledge, remain current in reading trauma literature,
demonstrate trauma-focused clinical and assessment skills, comprehend diagnostic criteria, and be willing to process through trauma with clients while constantly providing encouragement.

Adlerian practitioners in particular should recognize the compatibility of Adlerian therapy with resilience-informed research. Adler’s emphasis on self-determination and the ability of individuals to influence, interpret, and create meaning for themselves, parallels the findings concerning appraisal and the benefits of reframing traumatic experience.

Similarly, Adler’s belief in the social embeddedness of community feeling is echoed in the research indicating better outcomes for individuals who have a network of quality friendships and interactions. “The idea that helping others is what best bestows beneficial meaning on people’s traumatic experience has strong intuitive appeal and also fits with the well-documented link between social supports and adjustment” (Westphal & Bonanno, 2007, p. 419).

Adler’s view of human nature as holistic (or indivisible) compliments the findings that resilience is a multifaceted, layered and dynamic process comprised of unique individual and environmental factors in specific combination. Additionally, Adler’s opinion of encouragement resonates with the concepts of optimism and self-enhancement, providing ample opportunity for practitioners to help clients find new ways “to increase an individual’s courage to meet the problems of life” (Adler, 1964, p. 362 as cited in Griffith & Powers, 2007, p. 20).
Conclusion

The literature reviewed for this discussion confirmed that resilience is a common and adaptive response following a potentially traumatic event (Almedom & Glandon, 2007). Symptom levels may vary depending on the type of traumatic event, however resilience prevails as the most common outcome (Bonanno, 2005). The literature reviewed conferred that resilience is a multifaceted, and dynamic process, requiring both individual and social components (Rutter, 1987; Luthar et al., 2000). It is different from both recovery and posttraumatic growth. It is not a static trait or characteristic but is a unique dynamic and fluid process. The origin of research in resilience is credited to Norman Garmezy and his work in the late 1960’s. He began the search for protective factors leading to health promotion, and started a new wave in psychological theory, consequently leading to the emergence of theories called the resilience paradigm, positive psychology, wellness, health promotion, strengths-based, and salutogenesis.

Many protective factors have been identified in the literature reviewed such as coping strategies, self-esteem (self-enhancement,) emotion regulation (self-control), appraisal, previous adversity, gender, optimism, social support (social network), and purpose in life (spirituality). There is no one factor that can determine resilience. Measurement scales exist for children, adolescents, adults, and older adults, however currently validated instruments measure specific populations and vary in both length and format (Smith-Osborne & Bolton, 2013).

Alfred Adler’s Individual Psychology is highly compatible with resilience-informed research. Adler’s view of human nature stressed the importance of autonomy and self-determination in life’s outcome, a holistic view of human nature, a penchant for optimism, encouragement, and social interest, or community feeling.
Trauma-competent practitioners are encouraged to foster the therapeutic relationship, understand foundational trauma knowledge, stay current in the trauma literature, demonstrate appropriate clinical and assessment skills, understand diagnostic criteria, and be willing to process through trauma with clients while providing encouragement.

Areas for Further Study

Further study is needed in the field of resilience research. Improvements can be made in many aspects regarding the resilience field. Further research is needed to clarify terms and definitions. Future studies need to reflect increasing cultural diversity in the population samples selected. The specific mechanisms of resilience need further identification and study in order to inform further theory development.
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