

## **Resilience and Resistance: Addressing Acute and Chronic Adversity in Communities of Color**

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### **Problem and Concerns**

#### **I. Definitions of Resilience**

The term *resilience*, derived from the Latin word, *resalire*, (meaning to spring back) has been used in many different contexts and a variety of disciplines including physics, psychology, ecology and economics. Explanations of the term vary widely and offer contrasting views of the ways individuals and communities respond to crises. Some definitions interpret resilience as an attribute (Brown & Kulig, 1996; Pfefferbaum, 2005) that is inherent and dynamic (Rose 2007). Others argue that resilience is a process (Sonn & Fisher 1998; Norris, 2008) that emerges when responding to adversity, or that appears only in the wake of crisis (Butler, 2007). Through a disaster lens, resilience is often described as, “the capability of a community to face a threat, survive and bounce back, or... bounce forward into a normalcy newly defined by the disaster related losses and changes,” (Cox & Perry, 2011, p. 395-396). This concept of ‘bouncing forward’ is especially important, as older definitions of resilience focused on a return to the status quo, rather than on post-disaster growth of individuals and their communities.

Resilience is also a critical concept for individuals and communities that struggle with long-term stresses outside of disasters. As noted by Ganor & Lavy (2003), resilience is the ability of individuals and communities to deal with a state of continuous long term stress and to find inner strengths and resources in order to cope effectively. As persons and communities of color face chronic stressors at higher levels than other groups, this view of resilience is useful to highlight the value of resistance to harmful environmental forces.

There is growing interest in understanding factors that predict successful coping mechanisms during traumatic events such as natural disasters or war, and when individuals are exposed to chronic adversities such as family violence or social marginalization. Processes of successful coping are now understood to be attributable to a range of biological, psychological, relational, and socio-cultural factors in circumstances, particularly where there are high levels of exposure to environmental adversity (Ungar, 2015). Conceiving resilience in this way focuses on a process of complex interaction, which includes environmental characteristics and actions in the home, neighborhood, school, community and contexts (Schoon, 2006) that influence development over the life course (Sroufe, Egeland, Carlson, & Collins, 2005).

A classic study conducted by Werner and Smith (1992) examined the resilience of children and identified protective factors at three levels: within the individual, the family, and the community. This approach examines the extent to which interpersonal, community and institutional factors facilitate access to resources for individual and collective coping in culturally meaningful ways (Ungar 2008). A definition that includes these factors replaces the notion of ‘successful adaptation’ to adversity as a measure of personal fortitude with a constellation of core concepts that define resilience as: 1) a multidimensional process that can be predicted; 2) a reflection of individual capacity formed over a lifetime of exposures and experiences; 3) an outcome of a given physical and social ecology to provide the resources necessary to sustain wellbeing; and 4) an expression of the sociopolitical context in which individuals live and communities are formed. When applying this definition to people of color, signs of resilience and intentional acts of resistance to oppression are often intertwined.

## **II. Trauma, Recovery & Resilience from a Historical Perspective**

Resilience literature is now being applied to disaster preparedness and response, models of treatment for those suffering from post-traumatic stress disorder, and interventions to reduce negative psychosocial consequences for children and adolescents exposed to potentially traumatic events. However, *historical trauma*, the legacy of chronic trauma and unresolved grief across generations (Brave Heart & DeBruyn, 1998) is frequently overlooked in the assessment of individual and community resilience.

Historical trauma is cumulative and collective and manifests itself emotionally and psychologically in members of different cultural groups (Brave Heart, M.Y.H., Chase, J., Elkins, J., & Altschul, D.B. 2011). Proponents of historical trauma as a public health concern argue that the intergenerational transmission of trauma eventually leads to social dysfunction, including interpersonal and domestic violence, child maltreatment, unemployment, and poverty; all of which contribute to the breakdown of community, family structures, social networks, and the loss of resources.

Dr. Joy DeGruy Leary (2005) documents the effects of historical trauma on the descendants of African slaves, when she defines *post traumatic slave syndrome* as a condition that exists among African Americans in the present day due to multigenerational trauma resulting from centuries of slavery, continued oppression, and institutionalized racism. The biologic impact of such trauma is linked to psychological and physical disorders, resulting from the impact of the chronic release of stress hormones. Health diagnoses from the slavery era acted to support cultural dominance over the enslaved by, "labeling acts and thoughts of self-preservation as dysfunctional" (Goodman & West-Olatunji, 2008, p. 56).

The short term benefits of 'adaptation' to social inequalities and historical trauma have measurable health consequences which raise questions about the concept of coping with adversity and its cost to wellbeing. Research documents the relationship between traumatic events, impaired neurodevelopmental and immune system responses, and subsequent health risk behaviors resulting in chronic physical and behavioral disorders. Unaddressed trauma significantly increases the risk of mental illness, substance abuse disorders, chronic physical diseases, and early death. As Cox & Perry (2011) note, in the past, "the dominant discourse of recovery from traumatic events and disaster tended to reinstate the status quo and prescribe a preferred version of recovery in which suffering was privatized and individualized and positioned as something to be managed effectively and moved beyond as quickly as possible," (p. 401). Such an ahistorical view of resilience is inadequate when addressing the legacy of trauma that exists in communities of color.

Goodman and West-Olatunji (2008) assert that while encounters with interpersonal and institutional racism may happen regularly, they meet Carlson's criteria (1997) of a 'traumatic event' because there is a lack of control over when these encounters and experiences occur. Carlson identifies three defining elements of traumatic events: a lack of control over what is happening, the perception that the event is a highly negative experience, and the suddenness of the experience. Though an experience must be sufficiently uncontrollable, negative, and sudden to be potentially traumatizing, "even extremely uncontrollable, negative, and sudden, events may not cause traumatization if the effects are moderated by favorable individual and situational pre and post-traumatic factors (Carlson & Dalenberg, 2000, p.10).

### **III. Allostasis, Weathering, Toxic Stress and Social Determinants of Health**

Social conditions play a major role in determining the health of individuals and their communities and social stressors are among the most commonly studied social determinants of health. As Pearlin (1989) notes in his overview of stress research, social science divides stressors into two broad categories, *life events*, or acute traumatic experiences, and *chronic strains* which are recurrent and enduring life problems. Studies show that if individuals are repeatedly forced to adapt to psychosocial stressors and adverse environments, the cumulative, negative effect—deregulates homeostasis (Seeman, Singer, & Horowitz, 1997). Exposure to chronic stressors and a proliferation of stressful events over the life course are shaped in large part by people's race, gender, income, and socioeconomic status in society (Pearlin, Schieman, Fazio, & Meersman, 2005).

The World Health Organization defines social determinants of health as, “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels”. Similarly, social determinants of health are also defined by The Centers for Disease Control as, “the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities”. Both institutions adopt an intersectional lens, allowing for the understanding of, “race, class and gender as relational concepts: not as attributes of people of color, but as historically created relationships of differential distribution of resources, privilege and power” (Mullings, 2005, (p., 79-80). Examining the many ways that social injustice and health inequalities intersect allows for a fuller, more comprehensive understanding of community and individual resilience that reflects the powerful influence of social stressors on health.

Physical sciences offered some of the earliest definitions of resilience by quantifying the ability of a system to endure strain and elastically deflect forces with the potential to break or deform it (Gordon, 1978). When considering the impact of prolonged burdens on individuals and communities, scientific definitions offer insight into the exploration of chronic stressors. In physics, *stress* is defined as force divided by area. When materials are stressed below their ‘yield point’, they deform elastically and return to their original shape when the stress is removed. However, when materials are stressed beyond their yield point, they deform plastically and some fraction of the deformation is permanent and irreversible. The yield point is referred to as the ‘yield strength’ of the material; the ultimate tensile strength of a material refers to the amount of pulling and stretching that it can take before it fails (or breaks).

In the child development field, ‘toxic stress’ is defined as an extreme form of stress that results from strong, frequent and/or prolonged adversity—such as chronic poverty, exposure to violence, or child neglect—without adequate adult support to buffer the stress. It can cause disruptions in brain development, including the development of executive function, which affects inhibitory control and cognitive and mental flexibility (National Scientific Council on the Developing Child 2011, 2012). More generally, the theory of *allostasis* was introduced by Sterling and Eyer (1988) to explain the physiological basis for disparate patterns of morbidity and mortality, especially amongst African Americans. Allostasis is defined as the process by which the body maintains homeostasis (i.e., adapts to stressful situations by creating ‘stability through change’). However, if the mediators of allostasis --adrenal hormones, neurotransmitters, or immuno-cytokines- are released too often or are insufficiently managed, the cost is ‘allostatic load’, which is the cumulative wear and tear on the body.

Geronimus (2001) applied the theory of allostatic load and developed the *weathering framework* to demonstrate the particular burdens of racial inequality on women's health regardless of socioeconomic

status. Calculations of allostatic load scores have shown African Americans to score higher than whites, even when poverty levels are controlled for (Geronimus, Hicken, & Keene, 2006). African American women show excessive levels of chronic morbidity, disability and early health deterioration. Geronimus points out such poor health outcomes are not attributable to unhealthy behaviors alone but are instead, “a consequence of the cumulative impact of repeated experience with social, economic or political exclusion. This includes the physical cost of engaging actively to address structural barriers to achievement and wellbeing,” (2001, p. 133). Positive social experiences, however, are associated with a lower allostatic load, leading researchers to conclude that social experiences can affect biological systems that affect a wide variety of physical and mental health outcomes. Thus, historical trauma can have a lasting effect on multiple health issues, as does *toxic stress*.

Applying the concept of *allostatic load* to historical and intergenerational trauma, it is possible to hypothesize that the sum total of individual levels of African American allostatic load is mirrored in the African American culture, which in turn cumulatively contributes to collective degradation and wear and tear, i.e. *culturostatic loading*. Arguably, there are critical African American cultural norms that appear unable to transcend harmful environmental exposures to create new health promoting strategies that can mitigate the amplification of health crises. The key to survival of the human species is the ability to respond to rapidly changing conditions through the elasticity of culture, which enables groups to access shared wisdom, memory, and ways of coping with diverse patterns of existence (Rodrigues and Fortier, 2007). The loss of cultural elasticity suggests that the culture might be moving closer and closer to the ‘yield point’. For example, culturostatic loading could be a contributing factor (though not causative) to the disparate burden of lifestyle diseases such as cardiovascular disease, certain cancers, HIV/AIDS, diabetes, violence and mental health disorders among African Americans (CDC, 2013).

The tension between chronic adversity and building collective efficacy in communities bearing the burden of unaddressed historical trauma requires access to effective use of culturally relevant resources. As noted by the National Scientific Council on the Developing Child (2008), toxic stress can also impact resiliency if there are no buffers. This is of dire urgency, given that disasters, whether natural or man-made, can “further aggravate pre-existing concerns related to systemic oppression and erode... coping skills,” (Goodman & West-Olatunji, 2008, p. 51-52). Acute trauma of this kind adds an even higher level of stress to individuals already bearing a high allostatic load in the face of collective culturostatic load.

#### **IV. Youth and Resilience**

Exposure to adversity and trauma increase the impact of social and ecological factors on mental health and effective coping, especially for youth. As Ungar (2013) notes, in studies of populations that are chronically exposed to higher levels of stress, such as maltreated or racially marginalized children, environmental factors have greater influence than individual characteristics on positive developmental outcomes (Chandler & Lalonde, 1998; DuMont, Ehrhard-Dietzel, & Kirkland, 2012; Klasen et al., 2010; Ungar, Liebenbuerg, Armstrong, Dudding, & van de Vijer, in press).

At the individual level, youth resilience can be thought of as the ability to withstand adverse circumstances and master age-appropriate developmental tasks despite serious threats to adaptation (Masten 2001). Elasticity, at a cultural and an individual level, is an important concept because, “exposure to trauma causes the brain to become reorganized to accommodate the demands placed upon it”, (Perry et al., 1995, p. 278). However, these exposures make children malleable, but not necessarily resilient.

Research has shown however that there are five types of resources, or capital, that children need in order to, “buffer the impact of stress or help them recover when their mental health has deteriorated,” (Obrist, Pfeiffer, & Henley, 2010; Ungar, 2011). These five types of capital include: 1) Social capital (relationships with caregivers, feelings of trust); 2) Human capital (ability to learn, play, and work); 3) Financial/Institutional capital (social welfare programs, health care, specialized supports at school, mentoring programs); 4) Natural capital (land, water, biological diversity), and the 5) Built environment (safe streets, public transit, recreational facilities, housing, schools). Each of these types of capital is interdependent, and places the impetus for recovery, resilience, and well-being on environmental factors.

Elevated exposure to violence, police brutality, lack of community cohesion, and limited physical and social mobility can have disastrous effects on health outcomes, especially for children. Unequal opportunities for education and housing create further health inequalities for youth and communities of color. Without equal access to educational opportunities, children lose the health and social benefits that an education provides. As Hammond (2004) notes, “education has the potential to enhance all health outcomes through enabling individuals to see their lives in a broader context... and enables individuals to cope more effectively with ill health and other types of adversity,” (p. 566).

### **Solutions: The Importance of Multi-dimensional Processes**

To begin, resilience as a concept must be problematized to more effectively address social inequality. Any investigation of the mechanisms for individual and collective coping with acute or chronic adversity must begin by interrogating pre-existing power structures. Environmental factors that contribute to weathering, illness and cultural degradation (culturostasis) must also be identified and addressed to support mental and physical health. After a disaster, equitable policies and activities should be prioritized as recovery and rebuilding strategies are developed and resources are allocated. Though the circumstances facing those who have experienced a disaster differ from those exposed to day-to-day adversity, in the case of New Orleans many individuals and communities still grapple with the multiplicative effects of both. As Goodman and West-Olatunji (2008) note, recovery and rebuilding efforts in communities of color must, “address symptoms of disaster-related stress as well as the systemic stressors influenced by [inequalities such] racism and classicism” (p. 57). When an individual or a community is faced with recovery after a disaster or after a series of long-term stressors, there are several ways in which building and improving resiliency can be supported.

### **The Social-Ecological Model**

Attempts to build resilience should be focused on multiple systems and institutions in order to maximize effectiveness. In addition, the transformative role of culture must be harnessed to promote emotional release and realignment, as well as optimism and hope. The Institute of Women & Ethnic Studies (IWES) employs the Social Ecological Model (SEM) as its framework for multi-level approaches. The SEM approach seeks solutions that address the intersection of interpersonal relationships, community norms and environments, and the effect of societal policies upon individual behaviors. As Cox and Perry (2011) have shown in their research on disaster recovery, oftentimes the driving forces behind recovery and rebuilding process can leave important social-psychological processes unaddressed. The SEM approach reveals rather than obscures the unmet psychological, emotional and material needs that can undermine long-term sustainability and community resilience.

### **Culture as a Transformative Resource**

Ungar notes that how people mitigate risks is dependent on the ways people understand their circumstances and identify the essentials needed to cope. In other words, how people respond to

traumatic events is dependent on the ways people resolve tensions to attain healthy functioning; this process is culturally embedded, and may not align with subjective points of view or normative judgments on how people should react in specific contexts (Ungar 2004). In a study of resilience-related beliefs and positive child development in Chinese youth in Hong Kong, Lee et al (2010) hypothesize that cultural beliefs significantly influence how people perceive, experience and approach adversities in life. They found that the value of resilience beliefs embedded in Chinese culture that children acquire through cultural transmission was helpful in mitigating harmful effects of adversity upon child development.

Communal norms are invaluable to capitalize on the collective power of individuals striving to cope with adversities. Intentional opportunities for social interaction and cultural expressions are necessary to help to dislodge deeply held reactions to traumatic events (such as fear and sadness). This work must be done at the neighborhood level to override culturostasis and help jumpstart the transformative journey to healing (Shervington, 2011). In the aftermath of Hurricane Katrina, it was love of the city's culture that brought New Orleanians back home in spite of the difficulties of living in a place that suffered immense destruction and offered little recovery support for communities of color. Cultural expression was often used to facilitate emotional release and realignment, by sending positive messages to the community, promoting optimism and hope, and directing people how to celebrate life and respect death.

It is critical to give adequate time and space for healing to affected individuals. Children exposed to trauma cannot exhibit the markers of resilience if their environments do not provide them with resources, familial and community supports and culturally affirming experiences. IWES data (n=1184) collected among New Orleans youth age 11 to 14 (87 % African American, 42% male and 58% female) reflect the legacy of social inequity and chronic adversity in the aftermath of disaster. Almost ten years after Hurricane Katrina the young people surveyed report symptoms of PTSD that are nearly three times the national average and symptoms of depression that are more than double the national average. These youth are participants in IWES post- Katrina programs focused on healthy decision-making, positive youth development and reducing sexual risk behaviors. In the New Orleans context, culturally relevant interventions, including art, music, role plays, and celebrations have become an intrinsic part of supporting emotional well-being and envisioning individual and community wellness.

### **Renegotiation of Identity**

Interventions must be developed to assist the renegotiation process by emphasizing the, "relevance of place, social capital, and identity formation in the psychosocial recovery process of disaster survivors and their communities," (Cox & Perry, 2011, p. 408). This is particularly true of the lingering effects of trauma that are commonly overlooked in efforts to recover from immediate crises. Post-trauma and post-disaster, individuals and communities are often disoriented. Disturbance in identity might take the form of identity confusion, feelings of passive influence, or confusion over one's desires or personal goals (Carlson & Dalenberg, 2000). An essential component to healing and building resilience is allowing for the 'reorientation' process, during which individuals and communities collectively navigate, negotiate, and reconstruct identity and belonging.

IWES developed a division of post-disaster, community mental health, emotional resiliency and wellness after Hurricane Katrina, the Collective for Healthy Community. The initiative is a collaborative, multi-disciplinary approach to promote community level, non-clinical approaches to individual and collective recovery, resiliency and healing. One of the activities undertaken was the creation of *Red Tent* gatherings to provide a dedicated space for healing and unrestricted communication. These gatherings

are intergenerational events that are free and open to the public and designed to promote community wellness, healing and resiliency. IWES continues to host Red Tents with collaborative partners that wish to co-create safe spaces where affected community members come together to tell their stories, discuss the impact of trauma, learn and practice positive thinking and self-care techniques, and engage in calming activities to manage stress (i.e. massage, acupuncture, art, poetry, and other forms of cultural expression).

### **Interpersonal and Community Level Interventions**

Environmental forces and experiences over the life course have been repeatedly shown to have more influence on effective coping than individual will. Ungar (2011) makes that point that resilience outcomes are best promoted by “changing the odds stacked against the individual” rather than “changing the capacity of individuals themselves to change,” (p. 1176). Family level interventions, for example, buffer stress for individuals, and contribute to stronger community networks. Similarly, interpersonal and community level interventions can have a great impact on the resiliency of children, especially at the school level.

For vulnerable populations, healthy relationships with caregivers and community institutions contribute to individual resilience in direct ways. Children who experience a sense of belonging at school are more likely to show signs of resilience (Shin, Daly, & Vera, 2007; Theron & Engelbrecht, 2012), and resilient children often have teachers who accept, respect, and trust them, and provide children with opportunities to express themselves in institutional settings (Bernat, 2009; Ungar, 2009; VanderVen, 2004). It is critical to focus on providing culturally appropriate interventions in schools that promote positive relationships and self-expression. IWES does this through *Photo Voice* and *Art Voice* programs, which encourage young people to utilize artistic expression in response to trauma, can promote individual and collective resilience. Other examples of IWES’ commitment to multidimensional strategies to build youth resilience include: 1) conducting workshops for youth-serving and family support organizations on trauma; 2) creating an advisory team of parents and caretakers to discuss of the impact of stress on risk-taking behavior, and; 3) providing trainings for educators and health professionals on the recognition, primary management and referral of youth presenting symptoms of emotional distress. Vulnerable youth are often exposed to potentially traumatic events in their homes, neighborhoods and community settings. These are important sites of potential intervention rather than ‘adaptation’. IWES is currently developing a city-wide public will campaign to address the need for compassionate trauma-informed approach to working with vulnerable youth.

### **Providing Necessary Material Resources**

In disaster situations, market principles alone cannot meet the needs of people. Cooperation between politicians, administrative authorities and community members is expected. For an individual, a community, a city or region, attempts to address traumatic events must integrate survivors’ emotional, psychological, and social recovery needs into the planning and allocation of recovery funds and resources (Cox & Perry, 2011). Decision-makers that celebrate the value of ‘bouncing back’ after disaster must also allocate resources for the express purpose of keeping communities intact and supporting human recovery. Necessary resources may include, but are not limited to, mental and physical health services, social programs, public transit, recreational facilities, food and housing assistance, job training and placement initiatives, and schools with specialized supports and mentoring programs. If given the knowledge, affected community members have the power to collectively act in their best interest and simultaneously persuade policymakers and other gatekeepers to do what is right (Shervington, 2011).

In the case of chronic stressors and other traumatic exposures, a sense of safety and protective relationships are critical for confronting the event(s) that threaten emotional wellbeing. Resilience is more evident among individuals and groups that successfully navigate the resources that support them by negotiating for services in ways that affirm their priorities, lived experiences, and culture (Ungar, 2008). Actively working to influence institutional decision-making in this way intentionally addresses the social inequality and builds efficacy. One of the ways that IWES engages in this work is through participation in a city-wide community health improvement committee directed by the city's health department to address mental and physical health inequalities.

### **Distributive Leadership**

Another way to build resiliency is to promote the concept of distributive leadership, which is based on less-hierarchical decision making (Usdin, 2014). When leaders are willing to distribute the responsibility and authority for making decisions throughout impacted areas, community and individual resiliency are strengthened (Usdin, 2014). The spread of power to those most affected by trauma, disaster, or long-term stress builds self-esteem, self-efficacy, and ownership of solutions. IWES is currently implementing a *Youth Participatory Action Research* (YPAR) initiative designed to engage community members in a process of studying the social problems affecting their lives and impacting their ability to be resilient. By demonstrating that those needing support and resources should not be solely studied, but should be a part of finding solutions to the problems they face, inclusive leadership can be facilitated through community-led research and action.



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