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# Resilience in the Study of Minority Stress and Health of Sexual and Gender Minorities

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Research in various populations has shown that, starting early in childhood, individuals often demonstrate resilience in the face of stress and adversity. Against the experience of minority stress, LGBT people mount coping responses and most survive and even thrive despite stress. But research on resilience in LGBT populations has lagged. In this commentary, I address 2 broad issues that I have found wanting of special exploration in LGBT research on resilience: First, I note that resilience, like coping, is inherently related to minority stress in that it is an element of the stress model. Understanding resilience as a partner in the stress to illness causal chain is essential for LGBT health research. Second, I explore individual- versus community-based resilience in the context of minority stress. Although individual and community resilience should be seen as part of a continuum of resilience, it is important to recognize the significance of community resilience in the context of minority stress.

*Keywords:* health, minority stress, resilience

In response to the experience of stress, LGBT people mount coping responses and most survive and even thrive despite stress. Resilience research has shown in various populations that, starting early in childhood, individuals mount significant, sometimes heroic, coping efforts in the face of stress and adversity. But research on resilience and, more generally, salutogenic, or health inducing processes in LGBT populations has lagged (Kwon, 2013). The present issue of *Psychology of Sexual Orientation and Gender Diversity* aims to fill this gap in the literature by offering a group of articles on various aspects of resilience in sexual and gender minority populations. But more than filling a gap, which any one issue can only begin to do, I hope that this special issue encourages researchers to incorporate resilience into their study of LGBT health.

In this commentary, I aim to briefly address two broad issues that, in my reading of the literature, I have found wanting of special exploration: First, I explore how resilience is related to minority stress: Is resilience antithetical to a stress focus? How is resilience different from coping? And, what is the role of resilience in the stress-to-illness causal chain? Second, I explore resilience in view of what I have termed minority coping (Meyer, 2003): How should we think of the differences between individual and community resilience in the context of minority stress and why does it matter?

## Resilience in the Minority Stress Model for LGBT Health

It is important to note that resilience is not in any way antithetical or an alternative approach to stress theory. It is, in fact, a very essential part of stress theory. According to stress theory, the impact of stress on health is determined by the countervailing effects of pathogenic stress processes and salutogenic coping processes. Similarly, resilience is an essential part of minority stress. Indeed, resilience really has meaning only in the face of stress, and therefore, it is an essential part of understanding minority stress. To state that is not the same as stating that research on resilience (or coping, for that matter) has progressed in lockstep with the study of minority stress processes. It has not, but a growing crop of studies on resilience—with a few published in this issue—is reversing this trend.

Minority stress is based on the premise that (a) prejudice and stigma directed toward LGBT people bring about *unique* stressors and (b) these stressors cause adverse health outcomes including mental and physical disorders (Meyer & Frost, 2013). The minority stress model shows that circumstances in the environment, especially related to stigma and prejudice, may bring about stressors that LGBT people experience their entire lives.

Although I originally developed minority stress in the context of sexual orientation, gender identity is similarly implicated. Recent research has shown how minority stressors impact the health of transgender and gender nonconforming individuals (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Hendricks & Testa, 2012; Testa, Habarth, Peta, Balsam, & Bockting, 2015). These writings suggest that similar minority stressors are applicable to gender minorities as has been described for sexual minorities. A unique source of stress concerns gender affirmation of transgender or gender nonconforming individuals in formal and informal social interactions (Sevelius, 2013; Testa et al., 2015).

I have referred to minority stress processes along a distal to proximal continuum, with distal stressors referring to events and experiences outside the person, and proximal stressors referring to stressors that are transmuted through socialization and experienced by the person through internalizing cognitive processes. Distal stressful experiences are life events, chronic strains, everyday

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discrimination or microaggressions (referred to as *daily hassles* in general stress research) and even nonevents (these are anticipated life course events that have been thwarted; Meyer, Ouellette, Haile, & McFarlane, 2011). Proximal stressors include internalized negative social attitudes, such as internalized homophobia and internalized transphobia, expectations of rejection and discrimination, or felt stigma, and concealment of sexual and gender identity. In turn, the minority stress model states that these stressors can lead to adverse health outcomes such as depression, anxiety, substance use disorders, suicide, and various physical health outcomes that are responsive to stress, such as asthma (Fredriksen-Goldsen, Kim, & Barkan, 2012; King et al., 2008; Marshal et al., 2008).

In addition to describing stressors, the minority stress model, consistent with general stress theory, also shows that coping and social support can buffer the effect of the stressors, so that negative health outcomes can be avoided or reduced. This is where the role of resilience is evident.

Distinguished from general stress theory, minority stress shows the relevance of minority identity in the stress process. Whether or not, and to what extent, one identifies with a sexual or gender minority identity (as opposed to not seeing sexual orientation and gender expression as an important part of one's identity) has impact on both exposure to minority stress and the coping and resilience opportunities one will have. Also relevant, but not discussed here, are the relationships *among* minority identities—gender, sexual orientation, ethnic/racial, and other—that the person has.

There are several important issues that concern identity—many of them are understudied in the LGBT minority stress literature. For example, is having a strong identification with a minority identity a protective or risk factor in terms of how it interacts with exposure to a stressor? On one hand a strong identity can make one vulnerable when a highly salient identity area is injured by a stressful prejudice event; but on the other hand, having a strong sense of identity can be a source of strength that inoculates the person against an assault in that area. Identity is especially important in the area of resilience, as I discuss below, because so much of the community resilience and social support depends on people affiliating with their sexual orientation and gender identity groups.

*Resilience* refers to the quality of being able to survive and thrive in the face of adversity. It includes anything that can lead to more positive adaptation to minority stress and thus, mitigates the negative impact of stress on health. Resilience is, thus, similar to coping in that they both can buffer the negative effect of stress on health. Coping refers to the effort mounted by the individual in response to stress—the effort to adapt to or defend against the stressor. One important difference between coping and resilience is that coping refers to *efforts* the person makes to adapt to stress, but coping does not necessarily indicate successful adaptation. Resilience does indicate success. Thus, resilience is inherently *inferential* because it depends on identifying adaptive functioning in the face of stress (Masten, 2007): We can see that someone is making a coping effort, but we identify resilience only by the impact it makes on health outcomes. Resilience is implied by the fact that the person withstood stress. Masten (2007) described several broad scenarios indicative of resilience: "(a) developing well in the context of high cumulative risk for developmental problems (beating the odds, better than predicted development), (b) functioning well under currently adverse conditions (stress-resistance, coping), and (c) recovery to normal functioning after catastrophic adversity (bouncing back, self-righting) or severe deprivation (normalization)" (p. 923).

In this context, it is also important to remember that the study of resilience is by definition a study of disease (or, more broadly, negative outcomes) causality. Like the general stress model, the minority stress model is a model of disease causality (Aneshensel & Phelan, 1999; Meyer, Schwartz, & Frost, 2008). Therefore, when investigators study resilience they are implicitly interested in how certain processes buffer the impact of stress on health outcomes—at its core, resilience is a process of stress buffering.

Wheaton (1985) has carefully laid out models of stress buffering and noted two primary causal models: (a) a *suppressor* effect where the stressor "activates" the buffer (e.g., an experience of antigay violence increases the social support the person receives), which, in turn, reduces the impact of the stressor on health outcomes (e.g., feeling depressed) and (b) a *moderator* (interactive) effect, where levels of the buffer, not activated by the stressor (e.g., high vs. low mastery) will alter the impact of stress on health outcomes (e.g., after an event of discriminatory job loss, a person with high levels of mastery will suffer less anxiety than a person with low levels of mastery).

As Wheaton has noted, researchers often confuse other processes with a buffering effect. For example, a direct effect of any factor on health outcomes independent of the presence of stress cannot properly be described as a buffer, or resilience, impact. Thus, noting a positive impact on well-being for the number of good friends one has, regardless of any exposure to stress, demonstrates a direct effect of friends on well-being but not a stress buffering, and therefore, resilience, effect. A different perspective is offered by Fergus and Zimmerman (2005), who included a direct effect model that they called *compensatory*. But I find this more expansive definition less directly related to resilience because, again, resilience can only be inferred in the presence of stress (Masten, 2007) and the direct effect model does not demonstrate that. As Luthar, Cicchetti, and Becker (2000) said, "The term 'resilience' should always be used when referring to the process or phenomenon of competence despite adversity" (p. 554).

## Individual Versus Community Resilience

An important distinction, especially in the context of minority stress, is between individual- and community-based resilience. On the individual side are qualities best illustrated by the concept of mastery (Pearlin & Schooler, 1978) that Turner and Roszell (1994) described as indicative of *personal agency*. These are qualities that the person may possess, which can help or hinder her or him in coping with stress, making the person more or less resilient. In addition to mastery, we can include among these qualities such constructs as a sense of powerlessness (Seeman, 1959), effectance motivation (White, 1959), locus of control (Rotter, 1966), helplessness (Seligman, 1975), hopelessness (Abramson, Alloy, & Metalsky, 1989), and fatalism (Wheaton, 1985). Other personal resilience constructs are personality traits (e.g., extroversion) and even what Turner and Roszell (1994) call "world view" constructs, such as sense of coherence (Antonovsky, 1979), hardiness, which includes commitment, control, and challenge (Kobasa, 1979), and potency (Ben-Sira, 1985). All of these constructs represent quali-

ties of the person that have been described as associated with resilience.

But there are some limitations or even hazards when researchers and policymakers focus only on individual-level, or personal resilience. Cultural analysis would suggest that such an individual focus is rooted in western, and even more so, American, ideology that highlights meritocracy and individualism (Hobfoll, 1998). American ideology about meritocracy and individualism exalts personal triumph over adversity—the very essence of resilience. But such ideology can itself lead to negative health impacts on disadvantaged populations. This is because despite our thinking of personal resilience as an attribute of the person, not everyone has the same opportunity for resilience when the underlying social structures are unequal. As Merton (1968) has noted, the *opportunity structure*—the social, economic, and political structures that make success possible in society—are not equally distributed. Racism, homophobia, sexism, socioeconomic inequality, and other social disadvantages limit individual resilience. When individual resilience becomes an ideal, it can lead to adverse health outcomes through both its policy implications and actual increase in stress exposure to disadvantaged social groups (Kwate & Meyer, 2010).

A focus on resilience can lead to a "blame the victim" attitude: By noting that individuals *can* be resilient we risk expecting that individuals *ought to be* resilient. It is easy to slip into assuming that everyone who is exposed to stress can, and therefore should, survive and thrive by virtue of their own resilience—as the idiom goes, pulling themselves up by their bootstraps. Resilience becomes perceived as "ordinary magic," not something extraordinary and rare (Masten, 2001). I find this attitude creeping in many ways into general discourse, including, for example, our growing distaste of the term "victim," which critiques say disempowers individuals, but I believe sometimes accurately connotes social realities. If no one is "allowed" to be a victim even when victimized, then we may begin to expect everyone to be heroically resilient.

I say that a focus on individual resilience is hazardous because, from a public policy perspective, it can remove or reduce social responsibility to protect disadvantaged populations as it creates expectation of individual resiliency. Moreover, as we shift our discourse to individual resilience we risk focusing on the individual *response* to stress rather than the stressor itself. This shifts the policy implications that is at the origin of the stress concept generally and minority stress specifically. Minority stress aims to draw our attention to social events and conditions related to stigma and prejudice that harm population health, for example, causing health disparities. As we begin to focus on individual responses and resilience we risk a shift from interventions that attempt to correct the pathogenic social environment to interventions that focus on individuals so that they can become resilient in coping with the environment.

The concept of community resilience realigns these priorities. Community resilience refers to "how communities further the capacities of individuals to develop and sustain well-being" (Hall & Zautra, 2010). We can think of community as providing the resources that can help individuals cope with stress (Fergus & Zimmerman, 2005). This approach to resilience, Fergus and Zimmerman (2005) say, emphasizes social environmental influences on health and helps place resilience theory in a more ecological context, moving away from conceptualizations of resilience as a static individual trait. This conceptualization of resilience also focuses on social resources as a target of intervention.

Community resilience can be conceptualized at different levels and contexts—we can think of local or national level, the general LGBT community or more specific sexual and gender minority communities, and so forth. In the context of minority stress I have referred to community resilience as *minority coping* (Meyer, 2003). Hobfoll, Jackson, Hobfoll, Pierce, and Young (2002) introduced a similar concept of *community-mastery* as distinct from individual-mastery. They noted that community-mastery is "a sense that individuals can overcome life challenges and obstacles through and because of their being interwoven in a close, social network" (p. 856). This is distinguishable from *individual-mastery*, which refers to the sense that individuals "can overcome obstacles and challenging circumstances based on their own effort" (p. 856). It is also distinct from *social support*, which refers to the receipt of help from others. In communal-mastery there is of course the potential that one will receive support from others but it is not required. The authors (p. 856) explain, "Communal-mastery entails the belief that being part of a closely knit social fabric in itself generates successful confrontation with life problems (i.e., 'I succeed because I am part of a social group that values me')."

In the context of minority stress, minority coping and community resilience refer to norms and values, role models, and opportunities for social support. Community-level resilience includes tangible and intangible resources in the community. Tangible resources include, for example, access to an LGBT community center, specialized clinics and support groups, hotlines, information (knowledge), role models, as well as affirmative laws and policies that stem from community mobilization and advocacy (e.g., same-sex marriage, antibullying campaigns). Intangible resources include reframing of social values and norms and applying minority perspectives to them, such as redefining life goals and measures of success (Crocker & Major, 1989).

It is important to note that community resilience, or minority coping, is related to social identity as a sexual or gender minority and affiliation with the LGBT community. Although some community resources—such as a change in law or policy—could reach anyone regardless of their identification, many resources require the individual to access them. To activate such resources, the individual LGBT person must tap into the community to reap the benefits of minority resilience. In that, identification with a community is an essential vehicle to benefiting from community resilience. In the most basic sense, to connect with others like you, you need to see yourself as similar and connected with them. A man who has sex with other men but who does not identify as gay or bisexual could be exposed to some similar stressors as those experienced by a gay- or bisexual-identified man, but he will not be able to benefit from significant sources of strength that the gay or bisexual man could access. Research has shown the importance of belonging to the community, finding strong connections with others, and finding positive role models (Riggle, Whitman, Olson, Rostosky, & Strong, 2008; Riggle, Rostosky, McCants, & Pascale-Hague, 2011; Rostosky, Riggle, Pascale-Hague, & McCants, 2010).

At the same time, however, individuals are limited by the structure of the community. Individual LGBT persons can only benefit from whatever resources are available from the community. (And, again, by access I mean both tangible and intangible

forms of access and identification). This means that to the extent that the community as a whole has not achieved resilience—for example, to the extent that homophobic and stereotypical attitudes prevail—those will be transmitted as well.

Also this means that all segments of the LGBT community will not benefit equally because of structural inequalities within the LGBT community. Even if a person is identified as LGBT, of course, they may face obstacles to connecting to community-based resilience resources. Racism, classism, sexism, biphobia, and transphobia, among other exclusions, will limit many in the LGBT community in identifying and affiliating with the community and, by extension, will deprive them of community resilience.

Still, it is also important to remember that the concept "LGBT community," which often erroneously connotes White middle class, and urban LGBT people, should not refer to one particular LGBT community. It is a general construct that includes—and historically has always included—many sexual and gender minority communities that achieve resilience on their own terms (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Moore, 2010). Thus, variation in identification and participation in an LGBT community related to race/ethnicity, social class, age cohort, sexual and gender identities, among others, are important to consider as we study community resilience.

Finally, in the many years of research on minority stress, one of the areas most lagging has been intervention to enhance resilience. The resilience concept offers great promise for intervention research but has been underused in developing interventions (Herrick, Egan, Coulter, Friedman, & Stall, 2014).

My comments here should not suggest that we should abandon individual-based resilience interventions or research. On the contrary, individual resilience is important in determining health outcomes. When we look at the minority stress model, it is important to consider interventions across the entire model (Meyer & Frost, 2013). Rather than think about individual and community interventions as opposites, we ought to think of them along a continuum. This notion is, of course, consistent with social psychological theories that view the person within a social environment (Ungar, 2011). We should look at sites for intervention along the continuum of individual to community resilience. For example, we should look at changing laws and education systems to make them more LGBT affirmative, but also continue to develop effective approaches to increase individual resilience.

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