CHAPTER III
REVIEW OF LITERATURE

The investigation of factors contributing to positive adaptation in the wake of traumatic events, such as forced displacement, has been an appealing subject for research and theory. Research on resilience, thus concerns ‘the successful adaptation’ to life tasks in the face of highly adverse conditions (Bonnano, 2005; Khanlau & Wray, 2014), and has gained increasing attention from mental health professionals, as it is vital for survival in our challenging post-modern world.

Building upon the extensively acknowledged resilience theory, this chapter presents the emergence of the concept of resilience from its seminal foundations to the contemporary investigations in the area as well as the review of related literature about its antecedents and correlates.

Three waves of resilience research

For the purpose of convenience and understanding, literature on resilience has been demarcated into three distinct periods of research, often called ‘the three waves of resilience research’ (Richardson, 2002).

During the first wave, researchers were interested in phenomenological descriptions of the resilient qualities of individuals and associated support systems which predicted social and personal success. The focus was on defining and measuring resilience, and on the identification of marked differences between those who did well and those who succumbed in the advent of adversity or stressful life events. A surprising degree of consistency in intra-individual qualities, their relational and social resources which predicted resilience was revealed (Garmezy, 1971, 1991; Rutter, 1979, 1985; Werner, 1982). Hence, the concept of resilience originated and found its rightful place in the field of developmental and positive psychology.

In the second wave, researchers recognized that resilience was not merely a trait and moved beyond the mere description of the factors or variables associated with resilience to a process-focused approach so as to identify the underlying mechanism of resilient outcome. They aimed to understand specific processes.
particularly coping with stressors, adversities, or change, in a manner which resulted in the identification, fortification, and enrichment of protective factors that might lead to resilience (Richardson, 2002). Over a period of time, this kind of research has continued with increasing use of multiple levels of analysis and attention to neurobiological processes (Cicchetti & Curtis, 2007).

The third wave of resilience research had been marked by increased efforts to experimentally test and validate the ideas about resilience processes. While resilience achieved a multidisciplinary identification in context of motivational forces within individuals and groups, experimental processes were created for experiences which fostered the activation and utilization of the resilient forces (Richardson, 2002), and intervention based programs to promote resilience, by boosting protective factors, were introduced and tested. Some of these processes included positive parenting (Masten, 1999; Masten et al., 1990), positive emotion regulation (Fredrickson & Levenson, 1998; Ong, Bergeman, Bisconti, & Wallace, 2006) among others.

**Fourth wave of resilience research**

Other than the above mentioned three waves of research on resilience in human development (Richardson, 2002), a fourth wave is now under way (Masten, 2007; Wright & Masten, 2005). This fourth wave of resilience research is integrative in its approach and seeks to encompass rapid scientific advances in the field of genes, neurobehavioral development, and statistics for a better understanding of the complex processes that lead to resilience (Masten, 2007). Cross-disciplinary fourth-wave studies draw greater impetus from biosciences as well as behavioral sciences (Cicchetti & Blender, 2006), and tend to explore the role of genetic polymorphisms as moderators (vulnerability or protective influences) of risk or adversity in development (Kim-Cohen & Gold, 2009) and the role of neural plasticity in resilience (Cicchetti & Curtis, 2007).

**Seminal foundations of resilience research**

The knowledge of resilience and its associated factors reportedly originated in the early developmental psychology literature (Garmezy, 1971, 1991, 1994; Rutter, 1979, 1985; Werner, 1982; Werner & Smith, 1992) which laid the foundations for contemporary investigations.
One of the earliest studies to include a focus on resilience - the Kauai Longitudinal Study began in 1955 and followed all 698 babies born that year in Kauai with a goal of evaluating long-term outcomes associated with exposure to adverse rearing conditions (Werner & Smith, 1992). As the participants were followed from birth through adulthood (Werner & Smith, 2001), about one-third were designated as ‘high on risk’ due to factors including chronic poverty, parental mental illness, perinatal complications, or chronic family discord. Of these, the researchers noted that about one-third grew into competent, caring young adults despite considerable childhood adversity (Werner, 1993). Three main types of protective factors were identified: core resources, such as sociability, average intelligence, communication skills, having an internal locus of control, and attachment to parents; adaptive resources, such as emotional support from parents, siblings, spouse, or mate; and external support provided by an outside source such as school, work, or religious affiliation. Most of the participants who showed signs of resilience in adolescence remained resilient into adulthood (Luecken & Gress, 2010; Werner, 1993, 2012).

Since its inception, the scientific interest in the trait, process, and outcome of resilience has grown many fold (Cicchetti, 2003) with increasing numbers of studies attempting to identify the protective factors which are significant in specific contexts or groups of people (Masten & Wright, 2010). From adjustment to terminal disease (Taylor, 1983), long-term stress or adversity (Klein & McCabe, 2007), to being the victim of a violent act, such as a terrorist attack (Bonnano et al., 2006), studies have shown that a substantial number of people demonstrate rather high levels of resilience in response to such events and the extensive literature on resilience, which has resulted from the flurry of activity in the last 20 years, has identified a remarkably consistent set of factors associated with resilience (Masten & Obradovic, 2006). These factors are protective in nature (Luthar, 1993) and can be categorized as dispositional, relational, situational and/or philosophical (Polk, 1997).

Some of these factors are identified in lieu of the existing literature, from a diverse set of at-risk groups, and focal theme of the present study. Often observed in clusters, these include coping, physical and psychological health, social support, satisfaction with life, meaning in life, and self-efficacy (Atkinson, Martin, & Rankin, 2009; Luthar & Zelazo, 2003), and are presented in relation to resilience as follows:
Resilience, stress, and coping

Research to date suggests that those who typify psychological resilience do not discount the existence of stress in their lives, instead stressful conditions are appraised as opportunities for growth and development as opposed to threats to well being. Given this mindset, psychologically resilient persons make use of more proactive coping strategies and thus respond to stressful life circumstances more effectively (Kobasa, Maddi, & Kahn, 1982; Kobasa, Maddi, Puccetti, & Zola, 1985).

A host of studies tend to provide direction to the association between stress, coping, and resilience (Ong, Bergemen, & Bisconti, 2004; Wagnild & Young, 1993) across diverse samples and situations.

Protective factors established in early child researches on resilience identify the development and use of effective coping strategies (Garmezy, 1991). It is further likely that the coping strategies learned during childhood and adolescence have effects on the efficacy of adult coping (Patterson & McCubbin, 1987; Werner, 1993). Indeed, effective coping strategies, once learned, lead to a positive cycle of resilience that protects children and adolescents from stress into adulthood (Masten et al., 2004; Werner, 1993). On the other hand, lack of effective coping strategies increases the possibility of emotional and behavioral difficulties, even during periods of moderate stress (Albee, 1982).

Major, Richards, Cooper, Zubek, and Cozzarelli (1998) studied perceived stress, coping and resilience in a sample of adult females and found that high on resilience group reported low scores on perceived stress. Also, the resilient group showed more use of adaptive coping (including acceptance and reframing) and less use of maladaptive coping strategies like avoidance, denial, and venting. Similar findings were reported by Soderstrom, Dolbier, Leiferman, and Stienhardt (2000) as perceived stress was negatively correlated with resilience in corporate and university samples respectively, and by others like Norman (2001), Riolli, Savicki, and Cepani (2006), Riolli, Savicki, and Spain (2010), and Connor and Davidson (2003) across a range of clinical and non-clinical populations.

Pole, Kulkarni, Bernstein, and Kaufmann (2006), in an adult sample, found that stress was significantly and negatively correlated with mental health and...
resilience in the wake of critical traumatic life events. Although no significant association was found between active coping and physical and mental health, and resilience, it was revealed that participants who used passive coping strategies were less resilient. A further examination of the specific passive coping strategies related to resilience revealed that both distancing coping and escape-avoidance coping were related to less total resilience, and that resilience was best predicted by less distancing coping, wherein, distancing coping accounted for about 34% of the variance in overall resilience.

Similarly, Caltbiano and Caltbiano (2006) reported that individuals low on resilience revealed low use of coping in totality as compared to those high on resilience. Those high on resilience scored significantly higher on problem solving coping while no significant differences were found between those high and low on resilience with respect to emotion focused coping.

Also, Vandsburger, Harrigan, and Biggerstaff (2008) found that positive communication, problem solving like taking and making decisions and sometimes avoidance behavior were used as coping strategies in a sample of poverty stricken women.

It is interesting to note that the trends in literature so far, had been recreated in action research as well, lending greater validity to the already existing resilience framework. In one of its kind study, Steinhardt and Dolbier (2008) examined the effectiveness of a four-week intervention program to enhance resilience, coping strategies, and protective factors, as well as decrease symptomatology in an adult sample of university students, who were randomly assigned to experimental and wait-list control groups. The resilience intervention imparted training on transforming stress into resilience, taking responsibility, focusing on empowering interpretations, and creating meaningful connections. Results of the study improve our understanding of the phenomenon by reporting significant differences between the experimental group and control group. The subjects who underwent the intervention program had significantly higher resilience scores, more effective coping strategies (i.e., higher problem solving, lower avoidant), higher scores on positive affect, and lower scores on symptomatology (i.e., depressive symptoms, negative affect, and perceived stress) post intervention than did the wait-list control group.
Specifically, there is strong evidence in the literature highlighting the relationship between resilience and the use of task-focused coping strategies rather than less effective emotion focused strategies (Everall, Altrows, & Paulson, 2006; Jones & Bright, 2001). Positive association between resilience and task oriented coping were reported by Hasui et al. (2009) in a sample of college going adults, and by Lee (2012) in a sample of female students.

According to Chappell and Dudeja (2008), and Smith, Tooley, Christopher, and Kay, (2010), resilience was found to be negatively associated with perceived stress and female gender, and resilience significantly predicted perceived stress. These results were in line with the longitudinal study of Dyrbyl et al. (2010) which reported that resilient individuals experienced fewer stressful life events, were less likely to be depressed, had a higher quality of life, and reported higher levels of social support.

In the same league, Patricia (2010) reported significant positive correlations between problem-focused coping and resilience, self-efficacy, and reappraisal emotion regulation, and significant negative correlations between resilience and avoidant coping and suppression emotion regulation. Significant gender differences were also reported on various dimensions of coping. Female adults used more social support coping than male adults.

However, quite contrary to previous research, Nishi, Uehara, Kondo, and Matsoka (2010), found a positive correlation between resilience and stress.

Recently, in a study conducted by Sattler, Assanangkornchai, Moller, Kesavatana-Dohrs, and Graham (2014) among survivors of natural disasters who were exposed to unprecedented horrors, loss of life and property, and who were forced to live in rebuilt homes, emotion-focused coping, somatic problems, and lack of social support was found to significantly contribute to posttraumatic stress and stress symptoms. On the other hand, resilient posttraumatic growth was positively associated with social support and problem-focused coping.

Hence, within the resilience literature the potential of problem focused coping, seeking social support and reappraisal as resilience factors to stress has been well established (Cederblad, Dahlin, Hagnell, & Hansson, 1994; DeLongis, Coyne, Dakof, 1988).
Folkman, & Lazarus, 1982; Lazarus & Folkman, 1984; Masten & Coatsworth, 1998; Taylor et al., 2000; Vedhara & Nott, 1996). These coping resources have been identified not only as correlates of resilient outcome but also have been shown to function as both moderator and mediator of stress-illness relations. Likewise, coping strategies like blaming others, wishful thinking and avoidant coping have been linked to negative social and health outcomes (Penedo et al., 2003; Swindells et al., 1999; Vitaliano, DeWolfe, Maiuro, Russo, & Katon, 1990). Research across gender, culture and race has exhibited similar patterns and associations (Lok & Bishop, 1999).

*Gender differences in stress and coping*

With respect to the general trend in gender differences, females have been reported to be higher on stress as compared to their male counterparts (Chapell & Dujela, 2008). Gender differences occur not only in outcome variable of stress but also in greater susceptibility to stress in females (Mancini & Bonanno, 2009), appraisal of threat and challenge associated with a stressful situation, and preferred choice of coping skills to counter the stressful situation. While males display use of adaptive problem focused coping, females tend to use emotion-focused coping (Ahern et al., 2004; Patricia, 2010).

Gender differences in stress reactions are reportedly a result of differences in cognitive appraisal as well as in acute reactions to trauma. It was surmised from the extant literature that women were more likely than men to perceive a situation as threatening, rate events as significantly more stressful, and endorse more loss of personal control. Additionally, women are more likely than men to experience acute psychological and biological responses to trauma including intense fear, avoidance, intrusive thoughts, horror, helplessness, panic, and anxiety (Olff, Langeland, Draijer, & Gersons, 2007). Moreover, women were more likely to accept responsibility for adverse situation (Siu & Watkins, 1997).

Patricia (2010) also observed that gender differences in response to trauma may be related to specific gender roles and the definition of ‘feminine’ and ‘masculine’ behaviors in society (Norris, Perilla, Ibanez, & Murphy, 2001). Lastly, men and women may not only differ in their reactions to traumatic stress but also perhaps primarily in their willingness to report those reactions (Bryant & Harvey, 2003).
**Health**

The complex and wide ranging epidemiology of IDPs’ health needs to be understood in the context of pre-migration and post-migration stressors. Even without the accompanying trauma, displacement is a wrenching event in itself; however, history provides evidence to the fact that displacement is not an isolated event but is accompanied by trauma of different types and intensities. Reports suggest that more than half of the IDPs are at risk of falling victim to physical violence threatening their lives (NRC, 2005). Often caught in desperate situations, they are exposed to human rights violations before, during and after their displacement. Women and children are particularly vulnerable to sexual and other forms of violence (Chatterjee, 2006). The trauma of forced exodus coupled with physical and psychological hardships in the period prior to resettlement (Ackerman, 1997) is immense and pose daunting challenges for many and is further compounded by exposure to an alien and hostile environment, problems of acclimatization, lack of basic amenities such as drinking water, drainage and sewerage, absence of proper lavatory facilities, poor housing, over-crowding, and extremes of climate, lack of healthcare, joblessness, idleness, depression, disease, and death (NRC, 2005).

There is a mounting evidence that displacement and its sequelae have great negative impact on the health, both physical and psychological, of the IDPs (Porter & Haslarr, 2005), such that compared to non-displaced populations, they often report greater physical and psychological distress (Pumariega, Rothe, & Pumariega, 2005). Commonly reported problems among IDPs are cold-cough, fever, diarrhea, tiredness, lack of appetite, giddiness, weight loss, stomach pain, hip pain, headache, pain in the neck, swelling of legs and hands, hair loss, skin diseases, injuries, chest pain, eye problems among others (Jeyaranjan & Swaminathan, 2000). Specifically, the low health status of women has been indicated with factors such as antenatal care coverage, prevalence of anemia and reproductive tract infections (Kundu & Kanitkar, 2002). At the same time, psychological and mental disorders have been reported to be epidemic in proportion (Steel et al., 2009). Stress induced disorders like cardiovascular stress, psycho-trauma, endocrine stress, musculo-skeletal stress, stress-belly (ulcers etc.), cranial stress (tension headaches and migraines), hypertension and stress
diabetes are widely prevalent. Reactive depression especially overt depression in men
and retarded depression in elderly, and nervous breakdown are very common coupled
with constant uncertainty which leads to chronic, impending, and ongoing phobias.
Cases of neurological disorders are also commonly reported in the resettlement sites
(NRC, 2005). As illustrated by Roberts and Browne (2010) in a review of 15
quantitative studies on general psychological health of adult conflict-affected persons
in low- and middle-income countries, exposure to violent and traumatic events, forced
displacement, separation of families and communities, and deprivation of basic goods
and services in internally displaced people were found to be associated with poor
health status and these rates are observed even decades after their subsequent
resettlement (Marshall, Sehll, Elliot, Berthold, & Chun, 2005).

Displaced Kashmiri pandits exhibit similar trends, typical of internally
displaced people. For instance, Chowdhary (1997) reported that Kashmiri migrants
had aged physically and mentally by 10-15 years with symptoms ranging from
premature aging, premature decline in mental faculties to premature deaths. A health
survey conducted among them revealed that the affected population showed multiple
signs of deteriorating health like high incidence of serious and potentially fatal
diseases (NRC, 2005). There were reported cases of premature menopause in women,
hypofunction of reproductive system, delayed reproduction or infertility, malnutrition,
and stroke. Psychiatric disorders including depression and generalized anxiety were
reported to be in nearly double the numbers than non-displaced population (Banal et
al., 2010).

The review so far has been designed to enumerate upon the potential somatic
and psychological health problems that are contingent upon forced displacement and
its associated trauma. However, the ‘never say die’ human spirit exemplifies itself
among these traumatized migratory populations such that many do not develop
physical or mental disorders, despite the higher than average risk (Abramson,
Steihling-Ariza, Garfield, & Redlener, 2008; WHO, 2003); and even if they do, the
amount of pathology is lesser in proportion to the trauma (Pupavac, 2002). Further,
while symptoms of distress such as sadness, depression, feelings of social isolation,
and other somatic problems often exist, most of the time among IDP’s there is a sense
of resiliency, and a desire to regain control of their lives. Thus, resilience acts as an integrative construct that provides an understanding of how internally displaced people achieve and sustain health and well-being in the face of adversity. Some initial psychological distress following stressful experience, often referred to as ‘emotional scars’ is expected and may even be potentially beneficial for adaptation, however, from a resilience perspective, the speed and thoroughness of recovery from harm are the key outcomes that need to be observed (Zautra, Hall, & Murray, 2008).

Literature is rapt with studies that provide evidence for relationship between resilience and health. While some studies promote health as predictor of resilience, others report health as an outcome of resilient personality. Overall, resilience scores have been demonstrated to be closely associated with physical and mental health in general as well as high-risk populations like IDPs and other migrants.

In one of the earliest longitudinal studies on resilience, Werner (1993) reported that cohorts of at-risk children who grew into resilient adults were typically quite healthy. They had few illnesses both in childhood and adulthood, a robust physique, and better than average energy. (Brown & Rhodes, 1991; Felsman, 1989; Heinzer, 1995; Murphy, 1987; Werner, 1993). Subsequent well-designed prospective studies have consistently supported this conclusion (Cooley, 1990; Klaas, 1989; Wagnild & Young, 1993).

Holtz (1998) studied a retrospective cohort of refugee Tibetan nuns and lay students who were arrested and tortured in exile and found that resilient outcome was negatively related with health symptoms such as anxiety, affective disturbance, somatic complaints, and social impairment.

Belmont (2000) reported that individuals high on resilience, when exposed to a range of environmental stressors, remained healthy (i.e., reported lesser health symptoms and less frequent visits to physician) and continued to perform well despite high stress levels. Those low on resilience, on the other hand, tended to become ill and suffered performance breakdowns under stress.

Friborg, Hjemdal, and Rosenvinge (2003) supported the association between resilience and health in clinical as well as non-clinical population. Results conclusively showed that health symptoms were negatively associated with all the
dimensions of resilience, viz. personal competence, social competence, family coherence, social support, and personal structure in both the samples.

In the presence of stressful life events, having good to excellent self-rated health and its indicators such as high grip strength, independence in instrumental activities of daily living (IADLs), and having few depressive symptoms were associated with high resilience (Hardy, Concato, & Gill, 2004). Similarly, O’Rourke (2004) found that psychological resilience had significant negative association with psychiatric symptoms and positive association with physical health in a sample of adult bereaved females.

A strong negative association between symptoms of illness (e.g., common cold, flu, headaches, upset stomach, feeling nervous or tense) and resilience was also reported by Dolbier, Smith, and Steinhardt (2007) in their research on university students and corporate employees.

In line with the previous research, Smith et al (2008) examined data collected from different samples i.e., undergraduate students, cardiac rehabilitation patients, and women who had fibromyalgia and found significant negative correlations between three different measures of resilience and health related measures of anxiety, depression, and physical symptoms. Similar results were reported by Bartone, Roland, Picano, and Williams (2008).

Taking our understanding further, a study conducted by Riolli, Savicki, and Spain (2010) examined a sample of U.S. military personnel under traumatic stress conditions. Resilience was reported to be negatively related to a host of physical and psychological symptoms including somatization, obsessive-compulsive thoughts, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid suspiciousness, and psychoticism. Similarly, a strong negative association was observed between resilience and psychological distress, and empathetic personal distress in a study conducted by Kinman and Grant (2011).

While the above mentioned studies establish the directional relationship between resilience and health, other studies have explored the contribution of physical and mental health towards resilience output and also how resilience ameliorated the
negative effect of adverse events on health and well-being. For instance, Windle, Woods, and Markland (2008) discovered that psychological resilience moderated the negative effect of chronic illness on subjective wellbeing.

In a study on adult survivors of violent trauma, Connor, Davidson, and Lee (2003) found that greater scores on resilience were associated with better health. Also, negative correlations were found between resilience and physical and psychological symptoms. Further, resilience was identified as a strong predictor of physical and mental health. Similarly, Friborg, Hjemdal, Rosenving, and Martinussen (2006) proposed resilience as a significant predictor of mental health i.e., it acted as a protective factor that buffered the development of psychiatric symptoms during the encounter with stressful life events.

Lamond et al. (2009) reported similar trends in a large sample of community-dwelling women over age of 60 years. Not only were resilience scores positively correlated with emotional health score and physical functioning, emotional health was upheld as a significant predictor of resilience. On similar lines, psychological distress and somatic symptoms were upheld as significant predictors of resilience by Baldwin, Jackson, Okoh, and Cannon (2011) in a sample of African American migrants living in the United States.

However, a small number of studies provide divergence to the above trend in literature. For instance, Nygren, Bjorkman-Randstrom, Lejonklou, and Lundman (2005) reported no correlation between scores of resilience and physical health in an elderly sample across gender. Similarly, Choowattanapakorn, Alex, Lundman, Norberg, and Nygren (2010) found no contribution of experienced good health to resilience scores in an adult Thai sample.

Also, literature reveals that certain populations exhibit resilience even in absence of good health, in the wake of chronic health conditions, and terminal disorders like cancer (Kun, Qin, Ming, & Bei, 2013; Cohen, Baziliansky, & Beny, 2014).

*Gender Differences in Health*

Within the trauma and resilience literature, researchers have revealed gender differences in the incidence of various physical and psychiatric problems, with men
being more vulnerable to some disturbances and women being more vulnerable to others (Ai-Issa, 1982; Dohrenwend & Dohrenwend, 1976; Kessler & McRae, 1981; Khaled, 2008).

A host of studies report female gender to be particularly indicative of poor physical and psychological health, women being more susceptible to physical and sexual torture during the pre-migration, transition, and resettlement phases of displacement, lower stress tolerance threshold, poor coping, and greater internalization of problems (Chatterjee, 2006; Kundu & Kanitkar, 2002; Shepperd & Kashani, 1991).

For instance, in a sample of mass displaced adults, Ekblad, Prochazka, and Roth (2002) provided a gender sensitive picture and reported that psychiatric symptoms and poor coping were associated with being female. Women had a significantly higher mean on measures of post-traumatic stress disorder, depression, anxiety, and lower mean on manageability than their male counterparts.

Similarly, Samaddar (2003) reported that in refugee camps, as compared to males, females reported greater number of mental problems and physical symptoms like skin diseases, nutrition syndromes, incidence of tuberculosis, renal stones, renal failure, and asthma. Consistently over time, female gender had been negatively associated with mental health outcomes among migrants and refugees (Bean, Derluyn, Eurelings-Bontekoe, Broekaert, & Spinhoven, 2007; Cardozo et al., 2004; Steptoe, O’Donnell, Badrick, Kumari, & Marmot, 2008).

Nevertheless, some investigations examining health in males and females have produced equivocal results. For example, Rhodewalt and Agustsdottir (1984) found no gender difference in psychological distress in response to stressful life events and quite contrary to the general trend in gender differences in health, Vishevsky and colleagues (2010), in a meta-analysis comprising of 70 studies to examine the direction and magnitude of gender differences in self-reported posttraumatic growth and health, revealed lesser health problems and greater posttraumatic growth in women than men (Vishevsky, Cann, Calhoun, Tedeschi, & Demakis, 2010).

**Social Support**

A person’s social world provides the meaningful structures and supportive resources that enable him to meet adaptation challenges. Several key longitudinal
child development studies identify that social settings play determinable roles in providing opportunities for acquisition of both internal and external protective factors associated with resilience (Gore & Eckenrode, 1994; Howard, Dryden, & Johnson, 1999). Werner (1993) in her classic longitudinal study on resilience followed all children born in 1955 on a Hawaiian island from postnatal period to ages 1, 2, 10, 18 and 32 years. The essential nature of social support was reported by those who exhibited resilience. All resilient youth in the study had at least one person in their lives, who accepted them unconditionally, regardless of temperamental idiosyncrasies, physical attractiveness, or intelligence, and most established such a close bond early in their lives, if not with a parent, then with another family member such as a grandparent or favorite aunt or uncle. Some of the high-risk youth who had problems in their teens, but staged a recovery in young adulthood gained a more positive self-concept in the context of an intimate relationship with a spouse or a mate. Werner’s research and that of her American and European colleagues (Berkman & Glass, 2000; Garmezy & Rutter, 1983; Morrow, 1999; Werner, 1993) who had followed resilient children into adulthood has repeatedly shown that informal and personal ties to kith, kiln, and community, exposure to a warm, caring, and supportive environment, and social cohesion act as protective factors (Werner, 1993), and play critical roles in determining physical and mental well-being, within a socio-environmental framework to health promotion (WHO, 2003).

Similar to findings in the childhood resiliency research, multiple studies have confirmed the association between social support and resilience in general as well as traumatized adult population (Koenen, Stellman, Stellman, & Sommer, 2003; Perry, Difede. Musngi, Frances, & Jacobsberg, 1992), thereby, delineating a crucial role for social resources in the ways adults cope with stress (Hobfoll, 2002; Holahan & Moos, 1991; Murrell & Norris, 1983).

Valentine and Fienauer (1993) found that supportive relationships outside the family (friendships, support from church settings, and good marriages) were crucial in overcoming the experiences of sexual abuse in adult women. It acted as a buffer against stress and symptomatology in adults who were victims of childhood physical and sexual abuse. Individuals exhibited higher levels of resilience and well-being
when they had persons available who would help them in difficult situations (Perrig-Chiello, 1997) and also resilient individuals were reported to seek and receive substantial social support from within and outside the family (Bonanno et al., 2002).

In a sample of Vietnam veterans, King, King, Fairbank, Keane, and Adams (1998) found that several factors, including higher levels of both perceived (functional) and structural (i.e., membership in organizations) social support were associated with a lower likelihood of post deployment stress reactions and greater resilience.

In one of the limited research evidence on the enhanceability of resilience, Neil and Dias (2001) reported that perceived social support was positively related to the growth in resilience during a 22-day ‘Outward Bound program’ comprising of intensive physical, emotional and social training aimed at improving resilience in the participants. Social support accounted for 24% of growth in resilience, and more specifically, the perceived support from the least supportive group member was the best predictor of growth in psychological resilience and had a big impact on participants’ growth.

Similarly positive association between resilience and social support were reported by Carbonell et al. (2002) and Connor and Davidson (2003) across different age groups and samples.

In the context of trauma and catastrophic events, studies on risk following such events have also highlighted the particular importance of social resources and social support (Bonanno et al., 2002; Bonanno, Boerner, & Wortman, 2008). The resilient people clearly had more support from friends and relatives before the loss than others (Bonnano et al., 2002) and individuals with more support were reportedly less likely to develop long-term traumatic reactions (Berwin, Andrews, & Valentine, 2000; Ozer et al., 2003).

In Bonanno et al.’s (2007) study on survivors of 9/11 terrorist attack on New York city, adult individuals reporting low levels of social support were less likely to be resilient. Compared with participants with high level of social support, participants with medium support were about 30% less likely to be resilient. The same was true
for participants with low social support (Bonanno, Galea, Bucciarelli, & Vlahov, 2007).

These findings are similar to those of a later study by Wilks (2009), which reported support derived from family and friends to be strongly associated with resilience and inversely related to stress in an adult sample. Compared to those reporting lower resilience, individuals with higher resilience were 4.9 times more likely to experience higher familial support and 1.8 times more likely to experience higher friend support.

Smith et al. (2010) combined results from two subsequent studies and found that instrumental, informational, and/or emotional assistance provided by significant others was strongly associated with resilient outcomes. Availability and adequacy of social support has been reported to be a part of resilient response to loss such that these resilient outcomes tend to be significantly affected by social support both in terms of number and satisfaction (Nishi et al., 2010).

With respect to displacement, studies into the complexity of various aspects of social support such as support seeking behaviours, assessment of support received, and the means by which support works for diverse groups of displaced people have also reported social support to act as buffer for acculturative stress and associated traumatic sequelae (de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009).

For instance, Schweitzer, Melville, Steel, and Lacharez (2006), in a study on African migrants from the Sudanese community found that social support at an emotional and instrumental level was found in family, extended family, and social groups within their cultural context and was of particular salience in determining psychological wellbeing. Further, this social support was found to play a protective role and buffered the effects of high acculturative stress on anxiety and depressive symptoms associated with migration (Crockett et al., 2007).

Similarly, in the first three years of resettlement in their host country, a group of youth reported social support and social inclusion to be strongly associated with well-being and resettlement (Correa-Valez, Gifford, & Barnett, 2010).
In a review of literature on social support and resilience, Sousa, Haj-Yahia, Feldman, and Lee (2013) found that in majority of studies, social support played an important role as a resource of resilience. Two studies which underscore the power of social support over time require special mention here. In a cohort of adult survivors of Croatian war, Kuterovac-Jagodic (2003), found that even though social support did not affect stress symptoms during active fighting, but social support was protective over time. Another study by Punama-ki, Komproe, Qouta, El-Masri, and de Jong (2005) illustrated the importance of participants’ satisfaction with their social support in protecting adults from the mental health effects of exposure to political violence. High social support partially mediated the relationship between military violence and mental health: military violence increased social support, which decreased mental health symptoms.

Moreover, social support has also been associated with other significant variables in resilience literature, like reduced morbidity and mortality (Berkman & Glass, 2000; Cohen & Syme, 1985), positive affective states (Baldassare, Rosenfield, & Rook, 1984; Cooper, Okamura, & Gurka, 1992; Lyubomirsky, Tkach, & DiMatteo, 2006; Pinquart & Sorensen, 2000), and coping strategies (Costa & McCrave, 1992; Sinha & Watson, 2007).

Social support as a variable has gained prominence both as a means for individuals to gain access to emotional support as well as a source of increased information and accurate appraisals of stressful situations (Aspinwall & Taylor, 1997; Hobfoll, Mancini, Hall, Canetti, & Bonanno, 2011). However, there is a very small proportion of research which does not recognize the association between resilience and social support (Hyman, 2004) and provides interesting diversion to work in this area. Another emergent direction in research examines the costs as well as benefits of social relationships and support-giving. Despite the positive connotations of the concept of ‘social support’, the social ties are not always or even necessarily positive influence on well-being or life in general (Rook, 1984). This is particularly true in case of obligatory social ties which create stressful demands and tend to cancel or outweigh these roles’ positive consequences. While supportive social ties enable one to lead a positive and productive life in the face of adversity and stress, it has also
been found that problematic social ties lead to downward comparison and decrease in resilience (Tood & Worell, 2000).

Nonetheless, social groups are important psychological resources that have the capacity to protect health and well-being, but that they are only utilized effectively when individuals perceive themselves as socially apt and competent, and they share identity with other individuals or groups (Jetten, Haslam, Haslam, Dingle, & Jones, 2014). Literature deems it probable that resilient individuals have greater social skills, which in turn enhances their likelihood of having a support system in place and/or perceiving that support is available. These resilient personality resources and social support resources supplement each other additively, interact and augment, or simply substitute for one another (Thoits, 1995).

Especially in case of forced migration, this understanding of well-being is directly tied to the broader social environment within which the displaced individuals have been living their lives and maintaining social relations and social networks, and which may expand sources of social support (Berndt & Ladd, 1989; Felsman, 1989; Werner, 1993; Werner & Smith, 1992, 2001).

**Gender Differences in Social Support**

Variations in social distributions of perceived support have been reported with respect to gender. While the general trend shows that women report more perceived support than men (Bultmann, Kant, Brandt, & Kasl, 2002), there is also a substantial body of research which advocates that men and women don’t differ in this resource (Turner & Franko, 1994). However, men tend to have larger networks than women and women tend to exhibit greater investment and intimacy in their relationships (Belle, 1987; Werner, 2012), social network of males being more ‘extensive’ while those of females being more ‘intensive’ in nature.

There have also been reports of difference in dominance of one kind of support in males and another kind of support in females. For example, King et al., (1998) reported that in the face of stressful life events, women scored high on functional social support and men scored high on structural social support. Similar findings have been reported by Kawachi and Berkman (2001). However, there has been one consistent finding in the literature that resilient women tend to elicit and
provide more social support than their male counterparts such that social support acts as a great source of resilience in women (Werner, 2012).

**Positive Affect and Negative Affect**

The field of positive psychology is rapt with literature testifying for close association between resilience and emotions. It has been found that resilient people have optimistic, zestful, and energetic approaches to life, are curious and open to new experiences, and are often characterized by high positive emotionality (Block & Kremen, 1996; Klohnen, 1996). While Block and Kremen (1996) propose that positive emotions are an outcome of resilient coping, there are others who suggest that resilient people may, in fact, use positive emotions to achieve effective coping (Anthony, 1987; Masten, 2007; Murphy & Moriarty, 1976; Werner & Smith, 1992), and demonstrate the ability to cultivate one or more positive emotions, such as amusement, interest, contentment, or hope, respectively. Research further provides evidence for reciprocal causality between resilience and positive emotions. Rather than being a simple by-product of resilience, the experience of positive emotion exudes adaptive benefits in the coping process (Folkman & Moskowitz, 2000, 2004). It has also been proposed that resilient people not only inculcate positive affect in their own lives, but are capable at eliciting positive emotions in those around them (Demos, 1989; Kumpfer, 1999; Werner & Smith, 1992), thereby creating a ‘ripple like effect’ of positivity. Facial and vocal behavioral markers of positive emotional experience, such as smiling and laughing have also been associated with better adjustment and stronger social relationships over time (Bonanno & Keltner, 1997; Keltner & Bonanno, 1997).

Resilience coupled with positive emotions and their associated functionality serves to strengthen resistance to stress by affording greater access to positive emotional resources (Ong & Bergeman, 2004; Tugade et al., 2004), thereby providing respite from ongoing stressful experiences (Folkman & Moskowitz, 2000; Zautra et al., 2005) and this is specifically relevant in terms of internally displaced persons (Porter & Haslam, 2005).

A host of empirical research reports a robust relation between positive emotions and psychological resilience through an array of multiple methodologies.
like laboratory studies, self-report, observation, longitudinal studies, etc. A few of these researches are quoted here for the benefit of creating a sound database and to guide framing of hypotheses.

In a 2002 study, Tugade and Fredrickson reported that people who scored high on a self-report index of psychological resilience reported experiencing more positive emotions in response to stressors, both in the laboratory settings and in daily life. More importantly, the experience of positive emotions partially mediated the beneficial correlates of resilience.

Sinclair and Wallston (2004) found that resilience was positively correlated with positive affect and negatively correlated with negative affect even in the face of acute stress and physical disability.

Bonanno et al. (2005) in their study on high exposure survivors of the September 11, 2001 terrorist attack, found that subjects adjudged as high on resilience by their peers and friends scored high on positive emotions and low on negative emotions. Similar results were reported by Bux and Coyne (2009) in individuals exposed to July 2005 London bombings.

In a landmark effort consisting of three studies, Ong et al. (2006) investigated the functional role of psychological resilience and positive emotions in the stress process. While the first two studies explored naturally occurring daily stressors, the third study examined data from a sample of recently bereaved widows who took part in a pre- and post-interview and completed self-report questionnaires at the initial and post interviews as well as at 8, 12, 16, 20, 24, 36, and 48 months. In addition to the interview and questionnaire data, the target widowed group also maintained a daily record of their stress and emotions. Across all the three studies, resilience was found to be positively related to positive affect, negatively related to stress and negative affect. It was found that higher levels of positive emotion interacted with stress to weaker its influence on negative emotion such that the occurrence of daily positive emotions served to moderate stress reactivity and mediate stress recovery. Resilience moderated the relationship between daily stress and negative emotion such that increase in resilience led to decrease in negative emotions associated with stress and findings also indicated that differences in psychological resilience accounted for
meaningful variation in daily emotional responses to stress. Finally, findings indicated that over time, the experience of positive emotions functioned to assist high-resilient individuals in their ability to recover effectively from daily stress.

The direct relationship between resilience and positive affect and inverse relationship between resilience and negative affect has been validated across clinical and non-clinical populations (Singh & Yu, 2010; Smith et al., 2008) and has been found to be stable over a time period of 30 years (Burns & Anstey, 2010).

In the context of bereavement specifically, resilience has been reported to play an important role in explaining variability in widowed persons’ levels of positive emotion following loss as it was found to be associated with higher positive affective states post conjugal loss (Ong, Fuller-Rowell, & Bonanno, 2010). Research has also found resilience to be positively related to homeostatic protected mood, i.e., an object free biologically determined positive mood, with no cognitive component (Cummins, 2013).

Some studies investigating the association between resilience and structural components of affect had found that not only is trait resilience related with general positive and negative affect states but it is also associated with discrete emotions. In this league, Fredrickson, Tugade, Waugh, and Larkin (2003) assessed people exposed to September 11, 2001 terrorist attacks. Resilience was positively correlated with pleasant mood and negatively correlated with the frequency of negative emotions experienced in the aftermath of the attacks. Also, resilience was negatively correlated with experiences of two negative emotions, namely, anger and sadness while it was positively correlated with experiences of six positive emotions, including interest, joy, hope, sexual desire, pride, and contentment. Similarly, in an experimental study the behavioral expression of genuine smiles during laboratory induced sadness tasks were found to be especially adaptive in the context of adversity (Bonanno & Keltner, 1997). Philippe, Lecour, and Beaulieu-Pelletier (2009) also reported resilience to be significantly associated with presence of discrete positive emotions such as alertness and determination while negative emotions were not highly correlated with psychological resilience.
There is also a small yet substantial amount of studies which report independence in the presence of resilience and negative affect, and positive affect and negative affect. For instance, in the 2009 study conducted by Cohen and colleagues, positive and negative emotion scores were found to be independent of each other. Significant correlations between resilience and positive emotions were reported and while resilience was directly predicted by positive emotions, negative emotions indirectly affected resilience by reducing the predictive value of positive emotions. Under extreme stress, people who show resilience do not deny the presence of negative emotions but they do emphasize on the presence and cultivation of positive emotions for posttraumatic growth (Ong et al., 2006; Cohen et al., 2014). As Ong, Bergeman, and Chow put it, high-resilient individual’s positive emotions appear to ‘sit side-by-side’ their negative emotions in relatively independent fashion, implying positive emotions of resilient individuals are not so easily erased by the negative emotions experienced by them in the wake of stressful life events (Ong et al., 2010).

**Gender differences in positive affect and negative affect**

While the general trend in literature proposes that women report more negative affect and less positive affect (Fujita, Diener, & Sandvik, 1991), some researchers tend to diverge from it. They report no gender differences with respect to emotion experienced (Tugade & Fredrickson, 2004). Further, researchers owe these gender differences to gender roles, social effects, and/or greater priming of emotions in females as compared to males (Eagly & Wood, 1985; Gohier et al., 2013).

**Satisfaction with Life**

The association between resilience and satisfaction with life is supported by a network of correlates of resilience discovered across a range of self-report, observational, and longitudinal studies. Satisfaction with life, the ‘cognitive judgmental’ component of subjective well-being (Diener, Emmons, Larsen, & Griffin, 1985), has been consistently and positively associated with psychological adjustment and negatively associated with depression and other forms of distress (Pavot & Diener, 1993). The positive nature of resilience, and the success and growth it can facilitate also suggests the presence of a positive relationship between resilience and life satisfaction (Luthans & Youssef, 2007).
Researchers report that resilience contributes to life satisfaction especially by building upon resources (Cohen et al., 2014) and these resources in turn lead to greater resilience. The reciprocal dependence between resilience and satisfaction with life is observed in general as well as at-risk populations (Christopher, 2000; Karairmak, 2007), and is well-established in early empirical work of Klaas (1989), Cooley (1990), Killien and Jarett (1993), and Wagnild and Young (1993), wherein, significant positive association between resilience and life satisfaction were reported across various samples.

Christopher (2000) used a descriptive correlation study to explore the personality construct of resilience and life satisfaction in relation to psychological well-being in migrants of Irish origin. Resilience and satisfaction with life were positively correlated and together they significantly contributed to psychological well-being of this displaced populace.

Similarly, Wagnild (2003), in a cross-sectional study used data from three different samples of low and high income adults. Resilience was found to be significantly and positively correlated to life satisfaction across the various socio-economic groups.

The fact that resilience leads to positive outcomes and appreciation of life, even in the wake of physical disability and pain, has been endorsed in a study by Sinclair and Wallston (2004), wherein significant positive correlations were found between resilience and life satisfaction in adult females with physical handicap due to rheumatoid arthritis.

Heilemann, Lee, and Kury (2003) studied a sample of underprivileged adult females of Mexican descent and found that resilience was positively correlated with life satisfaction, and intrinsic strengths such as mastery and resilience, and satisfaction with life accounted for 31% variance in depressive symptoms; satisfaction with life being negatively correlated with suicide ideation. These results were similar to those of a study sample of American Indian migrants (Belcourt-Dittloff, 2006).

Other than providing evidence for strong association between life satisfaction and resilience, literature also boasts of studies which provide evidence for the
ameliorating effect of one on another. For instance, in an adult sample, Chappell and Dujela (2006) revealed that for life satisfaction, resilience came out to be a strong predictor explaining 8% variance.

Utsey, Hook, Fischer, and Belvet (2008) reported similar trends in a sample of young adults. Resilience was found to exert a positive indirect effect on life satisfaction through the associated variable of optimism.

The relation between resilience and satisfaction with life has also been found to be stable across various age groups ranging from adolescence to old age such that resilience emerged as the strongest predictor of life satisfaction across the life span and across gender (Beutel, Glaesmer, Decker, Fischbeck, & Brehler, 2009).

Studies have also reported close association between satisfaction with life and other variables in resilience research like positive cognitive appraisal (Karairmak, 2007), hope and optimism (Utsey et al., 2008), psychological distress (O’Rourke, 2004), perceived stress and health (Windle, Woods, & Markland, 2010).

**Gender Differences in Satisfaction with Life**

When it comes to gender, studies pertaining to satisfaction with life report equivocal results. While some studies report no gender differences (Huebner, 1991; Pavot & Diener, 1993), there are others which found that compared to females, males scored higher on life satisfaction (Chipperfield & Havens, 2001).

Results are variable not only in terms of degree of life satisfaction experienced but also in the source of this satisfaction. While males are reported to generate greater life satisfaction from work/employment and success related factors (Kossek & Cynthia, 1998), females tend to judge their level of satisfaction in terms of relations, giving and receiving of social support (Ma & Huebner, 2008).

**Meaning in Life**

In recent years, the construct of meaning in life has received renewed attention and legitimacy as an important theme of resilience, in conjunction with a growing focus on positive traits and psychological strengths (Ryan & Deci, 2001; Seligman & Csikszentmihalyi, 2000). Frankl (1963, 1984) argued that to find meaning in life is an
innate drive in humans, and the failure to do so results in psychological distress. Meaningful living has been directly equated with authentic living (Kenyon, 2000), and is held in great importance in the premise of eudemonic theories of well-being as a critical component (Ryff & Singer, 1998) or as a result of maximizing one’s potentials (e.g., Ryan & Deci, 2001; Maslow, 1971). While attainment of life meaning is associated with positive outcomes, such as positive affect (Zika & Chamberlain, 1992), life satisfaction (Lin, 2001; Shek, 1993; Zika & Chamberlain, 1987, 1992), work enjoyment (Bonebright, Clay, & Ankenmann, 2000), and happiness (Debats, van der Lubbe, & Wezeman, 1993) among other measures of healthy psychological functioning, having less meaning in life has been associated with greater need for therapy (Battista & Almond, 1973; Lent, 2004), depression and anxiety (e.g., Debats et al., 1993), and suicidal ideation and substance abuse (e.g., Harlow, Newcomb, & Bentler, 1986), as well as other forms of distress.

According to Wong (1998, 2011), “One’s life purpose depends importantly on one’s overall life orientation or the mindset with which one looks at life and makes significant choices. Without a strong sense of life purpose, one is likely to lose one’s way and see one’s life derailed by making a wrong turn. A good and right purpose will be constructive, realistic, achievable, consistent with one’s gifts and strengths, and, more important, congruent with the best values for the person and society” (p.599).

The author further propagated a meaning-centered approach to resilience by advocating that without a strong sense of constructive, realistic, and achievable life purpose, one’s life gets ‘derailed’. Meaningful living accentuates resilience by the means of purposeful life goals, freedom and responsibility, by differentiating between the right and wrong pathways to happiness, courage and acceptance, faith, commitment to growth, discovering of dimensions of self and life not explored before and positive thinking (Wong, 2011).

Life meaning may be particularly salient to displaced people with history of trauma. It has been observed that intense traumatic experiences often change a person’s world view, his enduring beliefs and life purpose (Janoff-Bulman, 1992), while the broad literature on adversity and stress outlines the utility of finding
meaning in life, especially when confronting life’s challenges, as a mechanism underlying resilience (Fine, 1991). The ability to find meaning in life may act as resource and facilitate effective recovery from stress and trauma (Schaefer & Moos, 1992). In turn, enhanced ability to recover from negative events may allow a person to achieve or maintain a feeling of greater purpose in life over time and maintain healthy psychological functioning (Taylor et al., 2000).

The initial spurt to empirical work on resilience and meaning in life was provided by a 1993 study conducted by Wagnild and Young, which aimed at identifying and describing characteristics of successful adjustment following a recent major loss. Using grounded theory approach, meaningfulness i.e., an understanding that life has a purpose was identified as an important theme to constitute resilience. Over a period of time, the extant literature has provided evidence to this association across wide range of populations and situations (Harlow, Newcomb, & Bentler. 1986). Meaning in life has been reported to be an important factor in long-term adjustment and resilient outcome among adult female survivors of childhood sexual abuse (Valentine & Feinbaur, 1993), individuals suffering from terminally progressive disease (Taylor et al., 2000), holocaust survivors (Greene, 2002), clinical and non-clinical populations (Friborg, Hjemdal, Rosenvinge, & Martinussen, 2006), and during financial and natural adversities (Hegney et al., 2003).

Taken together, the research suggests that meaning acts as resource, which may not only preserve mental health in the context of traumatic or life-threatening events but be protective of physical health as well (Taylor et al., 2000).

Pinquart (2001) in a meta-analysis of 70 studies on meaning in life synthesized a strong association of meaning with better physical and psychological health, everyday competence, lower levels of depressive symptoms post-loss, better adaptability, and overall psychological well-being.

Also, finding meaning in the event of bereavement or loss of a loved one had significant effect on long-term adjustment. For instance, in a longitudinal study, Davis, Nolen-Hoeksema, and Larson, (1998) studied adults coping with the death of a hospice-residing family member and reported that those who found meaning in life at 6-13 months post-loss were less distressed at subsequent assessments, after controlling for pre-loss levels of distress.
Bonanno, Wartman, and Nesse (2004) in an analysis based on 185 widowed persons, assigned these participants to one of three categories: not searching for meaning; searching for but not finding meaning; or searching for and finding meaning based on their search for meaning at 6 months and 8 months post loss. Search for meaning differed significantly by bereavement group and it was found that resilient individuals searched for meaning less than all other groups except depressed-improved individuals. The proportion of those who ‘searched for but did not find meaning’ was significantly smaller among resilient individuals.

It has been reported that those who felt their life to be more meaningful were less depressed and felt greater satisfaction with their lives, greater self esteem and optimism, and more positive affect than those who searched for meaning in life (Steger & Frazier, 2006). Also they tend to score high on resilience, social support and low on negative affect, stress and physical symptoms (Smith et al., 2010). Further, in the wake of adverse and stressful life events, the positive impact of meaning in life has been found to be sustainable over long-terms (Maschi, Baer, Morrissey, & Moreno, 2012).

Werner (2012) in a review of studies that had explored the effects of trauma, violence and war around the world found that survivors who exhibited the essence of resilience reportedly shared an affirmation and appreciation of the value of life. They believed that their world was meaningful, and they were committed to alleviate the suffering of others. The processing of their traumatic experiences, although painful, contributed to their personal growth and their strong sense of coherence in later life (Werner, 2012).

From the early classic Kauai study by Werner and Smith (1982) to recent studies of well-being (e.g., Holland, Currier, & Neimeyer, 2014), it has hence been established that the resilient individuals deeply held conviction that life has meaning and under great stress, it is this meaning that provided with feelings of transcendent hope and kept them going.

Gender differences in meaning in life

Literature tends to vary with respect to gender differences in meaning in life. While some researchers report women to have greater meaning in life (Evangelista, Kajawa-Singer, & Dracup, 2001), others report men to score higher on measures of
meaning (Bryant, 2007), or no gender differences at all (Polantsky & Esprey, 2000; Steger, Frazier, Oishi, & Kaler, 2006). These variances in findings are rooted in postmodern movements of ‘constructivism and deconstruction’ (Hare-Mustin & Marecek, 1988), and feminist epistemologies and research which challenge the idea of a single meaning of reality for men and women based on associated differences in social experiences, cultural assumptions, and experience with religion and spirituality (Bryant, 2007; Hare-Mustin & Marecek, 1988).

**Generalized self-efficacy**

A resilient personality is characterized by a belief in one’s own abilities to manage life’s challenges and situations effectively. Self-efficacy is thus linked to stress resilience in the face of anything from minor hassles to major tragedies (Bandura, 2002) and hence, it has been acknowledged as a prerequisite for resilience (Lin, 2001; Rutter, 1987).

Werner and Smith’s (1982) seminal research had emphasized on the purposeful nature of self-efficacy in the development of resilience. Children with learning disabilities, whose progress had been closely monitored over a longer period of time right into adulthood, showed greater acceptance of their disability and possessed a strong sense of self-efficacy towards goal attainment. Working towards goal attainment, they were able to find suitable employment and matrimonial alliance in adulthood.

Over a period of time, self-efficacy has been operationalized in resilient individuals who showed physical independence despite accidents like horrific burns (Holaday & McPhearson, 1997), sexually and physically abused women who achieved academic as well as relationship success (Humphreys, 2001; Turner, 2001), holocaust survivors (Baron, Eishman, Scuello, Veyzer, & Lieberman, 1996; Greene, 2002; Sigal & Weinfeld, 2001), and refugees (Sulaiman-Hill & Thompson, 2012).

Sinclair and Wallston (2004) reported that self-efficacy was positively correlated with resilience in the face of physical disabilities and was also closely related to coping. The authors reported that self-efficacious people had stronger incentive to face the adversities, hence they engaged in problem solving coping. It is these efficacious beliefs that tend to help people to develop a sense of self-worth and sense of control, which in turn gave them confidence and influenced their ability to
cope (Bromley, 2005). Also, people high on self-efficacy reported to have lower levels of negative emotions and cognitions, and made use of more active coping with greater persistence (Luszczynska & Schwarzer, 2005).

Further, the direct and indirect influences of self-efficacy on problem-focused coping and resilience were examined by Li and Yang (2009) in a sample of young adults. Resilience scores were found to be positively associated with self-efficacy and problem solving coping, and negatively associated with stress and avoidance coping. Stress was reported to contribute negatively to self-efficacy, self-efficacy had a unique contribution to resilience, while resilience had the strongest unique contribution to problem solving coping and avoidance coping. Also self-efficacy indirectly affected avoidance coping via resilience.

Similarly, Patricia (2010) reported self-efficacy to be positively associated with resilience, problem-solving coping and reappraisal emotion regulation, and negatively associated with avoidant coping.

In another study by Gan, Xie, Wang, Rodriguez, and Tang (2012), self-efficacy was found to be related to post-adversity psychological adjustment in people severely affected by natural disasters like earthquake and who had witnessed casualties in their families. Participants who score high on self-efficacy reported greater use of social support, and exhibited the emotive component of resilience, which was negatively related with psychological symptoms following stress.

Similarly, D’Amico, Marano, Geraci, and Legge (2013) found that self-efficacy was integral in coping with negative emotions associated with an emotionally and socially critical traumatic event and expression of positive emotions among young males and females.

Although, literature provides sufficient evidence for close relationship between resilience and self-efficacy, quite contrary to expectations Todd and Worrell (2000) studied a sample of 50 females in the varied age range of 19 to 54 years and found that generalized self-efficacy was unable to predict resilience, thus providing a singular example of such deviance from general trends.

**Gender differences in generalized self-efficacy**

While the general trend reports a significantly higher amount of self-efficacy being reported by males as compared to their female counterparts (Pompili et al.,
2007, Li & Yang, 2009), there also exist some studies like those of Leganger, Kraft, & Roysamb (2000), and Cody (2013), which reported no significant gender differences in generalized self-efficacy.

**Gaps in the review of literature**

The review of literature has been an attempt to present a comprehensive picture of the empirical and theoretical work conducted in the line of risk and resilience research. While it provided information about general trends in the field, it also brought forward certain gaps, inconsistencies, and deficits.

Firstly, there is a lack of uniformity in defining the very concept of resilience (e.g., Bonanno, 2004; Connor, Davidson, & Lee, 2003; Friborg et al., 2006; Masten et al., 2004; Richardson, 2002). There is also a lack of consensus among researchers about the nature of resilience as trait, process, or outcome (Mancini & Bonanno, 2010). Despite voluminous research on the role of resilience in maintaining positive mental health, a systematic examination of its various causal models is conspicuous in its absence. These inconsistencies in defining, approaching, and operationalizing resilience is suggested to cause confusion and undermine the comparability of study findings, and have significant implications for developing research designs, for identifying factors contributing to resilience, and for using empirical findings to develop and evaluate resilience based interventions. Also, depending on the approach employed to conceptualize resilience, the population studied and the decisions about the criterion level for resilience, rates of resilience and or the factors thought to comprise resilience tend to vary widely within and across, therefore making comparison difficult and limiting the ability to draw meaningful conclusions (Wald et al., 2006).

Second, although many of the resilience theories (e.g., Richardson 2002; Richardson et al., 1990; Rutter, 1985, 1987, 1990; Ungar, 2013; Wagnild & Young, 1993) have received modest empirical investigations, findings from these studies are limited by various methodological shortcomings. Measurement of resilience and associated protective factors is integral to this field of research (Gillespie, 2007); however, an over-reliance on static methods involving retrospective self-report measures has proven to be a deficit. As these measures rely on global rating of overall functioning, they tend to miss the more subtle aspects of functioning of affected
populations in their daily lives (Luecken & Gress, 2010). Another measurement issue concerns the dichotomous categorization of individuals as either resilient or non-resilient. Although it has the economy of simplifying statistical analyses and interpretation, dichotomy of continuous variable of resilience is discouraged as it leads to loss of precision and may give misleading results (Cohen et al., 1983; Mac-Callum, Zhang, Preacher, & Rucker, 2002).

While the existing literature predominantly focuses on identifying traits and correlates of resilience (Haskett, Nears, Ward, & McPherson, 2006), and reports use of cross-sectional studies, there is a growing need for resilience research to move beyond its limited focus on single factors towards considering developmental processes through prospective longitudinal studies that explore process of resilience (Rutter, 1990). Further, the lack of multi-level analysis, comprising of multiple methods, measures, and their convergence has been observed throughout the literature. As Ungar, Liebenberg, and Brown (2005) put it, ‘there are any number of drawbacks to resilience research that relies solely on one method or another’, qualitative and quantitative methods, by themselves they cannot yield a complete picture of the complex relationships among risks, protective factors, and outcomes (Creswell, 2013), and hence need to be integrated so as to yield resilience in its totality.

A third apparent gap in the research base is with regard to the lack of variability of samples studied, thus limiting the generalizability of results. Most of the studies in the related literature have a developmental focus, while resilience in adults has been waiting for to be more fully investigated (Bonanno, 2004). Resilience studies among high-risk civilian populations are also limited, and by far have focused primarily on general coping responses and adjustment (Bartone, Roland, Picano, & Williams, 2008; King et al., 1998; Sutker, Davis, Uddo, & Ditta, 1995), rather than resilience. There is an urgent need to extend resilience research to a broader range of adult populations, especially other at-risk populations who are at heightened risk of directly experiencing or witnessing traumatic events involving human suffering and death as in the case of internally displaced persons.

Fourth, empirical issue that needs attention is the widespread absence of culturally sensitive investigations of resilience, the investigation of what is universal and what is unique to different populations. By assuming construct homogeneity,
studies generally tend to overestimate the appropriateness of western models of resilience research, and overlook cultural and contextual norms, and variations in people’s physical and social ecologies outside Euro-western settings (Ungar, 2010).

Lastly, review of literature shows that refugees and internally displaced persons in different parts of the world have high rates of psychological and emotional problems, however, there is limited existing research exploring the resilience and positive outcomes in these displaced populations (Aroian & Norris, 2000; Hooberman, Rosenfeld, Rasmussen, & Kaler, 2010; Sandquist, Bayard-Burfield, Johansson, & Johansson, 2000). Further less is the amount of studies which explore resilience in relation to post-displacement factors. Moreover, most of these studies come from western culture and little is known as to whether these theoretical formulations can account for the experience of displaced populations in Asia especially Indian subcontinent, given the unique cultural, political, and historical context in which they are located.

Given the gaps in literature, additional empirical research is needed to help clarify the construct of resilience, its factors, and underlying processes. Resulting new theories in future may need to use more sophisticated methodologies and measurement strategies, which can be validated across a range of populations, age groups, and across cultures (Wald et al., 2006), along with a consideration for changes over time. Resilience is an important concept; however, the current state of knowledge in terms of theoretical models and clinical as well as practical application remains very much a ‘work in progress’ (Atkinson, Martin, & Rankin, 2009) and deserves further exploration.