

Building Resilience With Mindfulness-Based Stress Reduction

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Abstract

Resilience is the capability to adapt effectively to stressful or traumatic environments. Understanding how to develop resilience is of significant import because of the adversity that living through the COVID-19 pandemic has engendered, especially for low-income racial and sexual minority groups. Mindfulness-based stress reduction (MBSR) is an intervention program that offers mindfulness training to assist individuals in coping with depression and anxiety. Emerging literature on mindfulness-based stress resilience and its associated salutogenic benefits will be analyzed to determine MBSR's efficacy in building resilience. Furthermore, a multi-step process for initiating widespread understanding of and access to resilience resources will be provided. In schools, students will receive resilience education complementary to their pre-existing health programs and opt to participate in MBSR. To determine if resilience has been developed, students should demonstrate a statistically-significant improvement in their scores on the Connor-Davidson Resilience Scale before and after MBSR intervention.

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Defining Resilience

In April of 2003, while descending the lower stretches of Utah's Bluejohn Canyon, Aron Lee Ralston dislodged a stone boulder which crushed his right hand against the wall of the canyon (Ralston 2004). Ralston spent five days attempting to withdraw his right hand from the boulder's pressure, but after his meager water supply had diminished, not expecting to survive, he videotaped his goodbyes to his family (Ralston 2004). During the night, he had visions of playing with a future child while missing a section of his right arm (Ralston 2004). Crediting this as the motivation to live, Ralston amputated his forearm and was eventually rescued (Ralston 2004). Years later, Ralston's traumatic experience was modified into the movie *127 Hours* to, as director Danny Boyle suggested, tell the story "not for its horrific nature but for Ralston's resilience" (Here and Now 2010). This quality of resilience is described by the American Psychological Association as "the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress" (APA 2012). It occurs when one effectively leverages their available resources to sustain personal well-being and positively engage with their struggles (Rudzinski et al. 2017). For those with mental health difficulties including PTSD or depression, increasing resilience usually is within the scope of treatment plans.

While such operational definitions are effective for consistency and the prevention of subjective impressions as an influence on observations, they fail to reflect the complexity of resilience ("Critical Thinking" n.d.). There are multiple psychological, biological, and social factors that act in tandem to determine an individual's response to stress or trauma ("Critical Thinking" n.d.). For example, shyness may be operationally defined as the "total amount of time that a person avoids eye contact in a conversation with another person" ("Critical Thinking" n.d.). However, shyness entails multiple different behaviors, including feelings of insecurity or

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fears of negative evaluation, in a wide variety of situations (“Critical Thinking” n.d.). Since operational definitions rely on the existence of observable and measurable conditions under which phenomena occurs, it is difficult to characterize psychological concepts like resilience through an operational lens (Southwick et al. 2014). An effective definition for resilience must encapsulate the entirety of the term. For instance, resilience may be present to varying degrees since an individual who adapts constructively to stress in a personal relationship may simultaneously fail in the workplace setting (Southwick et al. 2014). Furthermore, resilience may change over time as a function of development and one’s interaction with the environment. Our responses to stress and trauma occur in the context of “interactions with other human beings, available resources, specific cultures and religions, organizations, communities and societies” which are all capable of impacting our resilience (Southwick et al. 2014).

Cultures are composed of the values, norms, rules, and ways of life that previous generations have left behind and how new generations interpret and adapt these to their social lives. In this manner, cultures across the world have diverse perspectives and divergent values, indicating that it may be difficult to apply a homogenous definition of resilience across cultural and community barriers (Gunnestad 2006). An example of how different cultures may have different resiliencies is the comparison between victims of childhood bullying in Sudan versus in Norway. In Sudan, the victim seeks support from classmates or friends who confront the bully, developing a child’s resilience through friendship and cooperation (Gunnestad 2006). On the other hand, in Norway, the victim talks to parents or teachers who establish rules for behavior, developing a child’s resilience through communication with a powerful authority figure (Gunnestad 2006). Both victims utilized a protective network to solve the issue, making use of different aspects of the network in regard to cultural norms. Similarly, Muslim girls abstain from

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unwanted sex by dressing modestly and staying indoors while Norwegian girls know to say ‘no’ to a man and acknowledge their bodily rights (Gunnestad 2006). Muslim girls demonstrate resilience through the protective value of faith while Norwegian girls do so through their self-confidence skills (Gunnestad 2006). However, if a girl from a strict Muslim environment adopts the Norwegian dress code without understanding the deeper values and skills that exist alongside it, she may be more vulnerable to unwanted sex (Gunnestad 2006). In this manner, it is challenging but nevertheless required to take culture and other vectors of identity such as religion and race into account when defining resilience. For this reason, I concur with the definition of resilience as a “multi-dimensional characteristic that varies with context, time, age, gender, and cultural origin as well as within an individual subject to different life circumstances” (Herrman et al. 2011). Although there is a lack of consensus on the operational definition of resilience, most definitions realize the significance of the biopsychosocial approach to resilience (Herrman et al. 2011).

From a psychological level, personality traits including extraversion, congeniality, high self-esteem, altruism, and an optimistic cognitive appraisal all contribute to an internal locus of control which evidently improve an individual’s display of resilience (Joseph & Linley 2006). Furthermore, from a social standpoint, relationships with friends and family, social support, and demographic factors such as age, gender, and ethnicity all impact one’s resilience. For instance, family stability and good parenting are associated with “better psychological well-being in maltreated children” (Herrman et al. 2011). Biological mechanisms of resilience are still emerging, but there is strong evidence that the hypothalamic-pituitary-adrenocortical (HPA) system is involved in exhibition of resilience during stressful events (Sippel et al. 2015). In an experimental model with rats, maternal care of rat pups reduced the HPA response to stress

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because maternal actions such as increased licking increased release of oxytocin within rat pups, suppressing the HPA axis and reducing stress and anxiety (Sippel et al. 2015). On the other hand, exposure to childhood trauma produces permanent alterations in the HPA axis, increasing vulnerability to mood and anxiety disorders (Sippel et al. 2015). Resultantly, resilience can be shaped by psychological, social, and biological factors (Levine 2003).

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Developing Resilience

Salutogenesis is a medical approach coined by Dr. Antonovsky, professor of medical sociology, which primarily centers on determinants of human health and well-being rather than on disease (Super et al. 2016). According to salutogenic theory, people exist along a health ease/dis-ease continuum (Super et al. 2016). If people deal successfully with stressors, they move toward the ‘health-ease’ state, but if they unsuccessfully cope with stressors, people move toward ‘dis-ease’ (Super et al. 2016). Generalized resistance resources (GRRs) are internal resources such as attitudes or self-efficacy values or external resources such as social support or cultural stability that are used by people in the health ease/dis-ease continuum to counter stressors (Super et al. 2016). A core construct within the model, sense of coherence (SOC), is defined as “the extent to which one has a pervasive, enduring though dynamic feeling of confidence” (Super et al. 2016). Those with a strong SOC see the world as more comprehensible, manageable, and meaningful, so they better understand stressors and can identify GRRs to cope with difficulties (Super et al. 2016). On the other hand, those with a weak SOC are vulnerable to poorer lifestyle choices, reduced mental health and quality of life, and increased mortality risk (Super et al. 2016). Studies have demonstrated that SOC is significant in the development of stress-related resilience, suggesting that interventions that increase SOC levels may promote psychological resilience (McGee et al. 2018).

Mindfulness-based stress reduction (MBSR) is one such intervention developed at the University of Massachusetts Medical Center (Dutton et al. 2013). The program uses techniques such as mindfulness meditation, body awareness, and exploration of behaviors and feelings to assist those with high levels of stress or anxiety (Dutton et al. 2013). For example, in one lesson, participants practice ‘choiceless awareness’ in which they consciously note sensations, emotions,

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or thoughts from moment to moment without rumination (Dutton et al. 2013). MBSR is of considerable interest to resilience development because of its ability to increase SOC and its convenience (Weissbecker et al. 2002). For instance, women with fibromyalgia who participated in MBSR reported significantly higher increases in SOC than waitlisted controls (Weissbecker et al. 2002). Since it does not require a mental health professional for effective use, MBSR potentially reduces the stigma associated with mental health treatment (OSG et al. 2001). Since standard exposure-based cognitive therapy can be expensive and difficult to access, the cost-effective and sustainable MBSR is, thus, more accessible to the general population (OSG et al. 2001). Furthermore, magnetic resonance imaging studies have indicated several functional and structural changes within the brain in response to 8 weeks of MBSR training (Gotink 2016). MBSR was associated with the increased activity of the prefrontal cortex and its more efficient inhibition of the amygdala, improving emotion regulation and an individual's psychological resilience (Gotink 2016).

A study conducted at the Georgetown University Medical Center employed MBSR as a community-based mindfulness intervention for low-income, predominantly African-American women with histories of intimate partner violence and post-traumatic stress disorder (Dutton et al. 2013). Participants reported positive benefits such as increased self-acceptance and self-empowerment (Dutton et al. 2013). One woman remarked “the group helped me get through my problems and believe in myself” while another stated she could now put her “mind to anything ... and accomplish things” (Dutton et al. 2013). The mindfulness practices the participants learned through MBSR promoted healing from trauma and overall reduced their everyday stress, developing the quality of resilience. The study, however, has some limitations that may impact its generalizability to a larger population. Firstly, researchers did not assess

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changes in participants' use of traditional or complementary mental health services after MBSR treatment; this introduced the confounding variable of other treatments that may have worked side-by-side with or by itself to induce the noted increase in resilience (Dutton et al. 2013). Furthermore, researchers identified a selection bias in their experiment since only women who wished to participate were chosen (Dutton et al. 2013).

During the COVID-19 pandemic, many of us have had to change how we live and work, creating a 'new normal' (Behan 2020). Healthcare workers are overwhelmed and fearful, worried that their occupation may put family at increased risk of contracting the virus. Children and adolescents have lost the structure provided by their school environments and support external to family. Older people and those with pre-existing conditions, having been deemed vulnerable to COVID-19, become anxious as to what will happen if they develop the illness. Also taking into account the increased systemic racial disparities and financial instability, our conventional world has most certainly transformed into one without a foreseeable future. The introduction of an MBSR program during the pandemic may serve an effective strategy to develop stress-based resilience among the populations most severely impacted by the coronavirus (Behan 2020). In fact, the University of Virginia School of Medicine Mindfulness Center offers an eight-week MBSR program to develop resilience during this pandemic (Miller 2021).

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Implementing Resilience Interventions

Minority stress refers to the chronically high levels of stress faced by members of stigmatized minority groups (Denato 2012). With regard to sexuality, stressors embedded in the social position of sexual minority individuals can cause health-related conditions such as mental health disorders or psychological distress (Denato 2012). These stressors include the structural exclusion of LGBTQ from resources and advantages available for heterosexual people and internalized homophobia (Meyer & Frost 2013). For instance, there are many nations which have barred individuals from same-sex marriage (Meyer & Frost 2013). The right to marriage, an important status and highly-valued goal for many, is denied to lesbian and gay individuals, excluding them from full participation within society (Meyer & Frost 2013). Because of such stigma, prejudice, and discrimination, LGBTQ individuals experience more stress than heterosexuals which leads to mental and physical illnesses (Meyer & Frost 2013). Likewise, a study conducted by the Fenway Institute and funded by the National Institute for Minority Health and Health Disparities determined that over forty percent of LGBTQ youth in the United States reported symptoms of depression or anxiety while nearly one in five youth attempted suicide within 12 months prior to participation in the survey (Conron et al. 2015).

Furthermore, racial disparities contribute to minority stress. Black Americans are twenty percent more likely than the general population to experience serious mental health problems, and in 2017, suicide was the leading cause of deaths among young Black adults (“Mental and” n.d.). Similarly, Latino immigrant families residing within the United States experience high rates of poverty, inadequate health care, low-wage employment, and language isolation (Cardoso and Thompson 2018). These negative effects are further exacerbated by one’s residence in a low-income or poor neighborhood. During the COVID-19 lockdown, those living in households

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with low financial stability have had a lack of availability of material resources, impacting their ability to survive and delaying efforts for developing self-efficacy (Buheji 2020). Those in low-income situations often are characterized by low utilization of social support or natural assets, resulting in intense emotional pain and mental trauma during the pandemic (Buheji 2020). These social stigmas that LGBTQ individuals and racial traumas that Black and Latino Americans are subject to, coupled with the intersectional difficulties of low socioeconomic status, increases their risk for adverse developmental outcomes and illuminate the necessity to develop resilience within these communities. Maintaining equitable access to MBSR for low-income, racial and sexual minority groups may strengthen their resilience in the face of stress and trauma.

Here, I highlight a two-step process to make the psychological concept of resilience available to individuals from these diverse communities. First, it is quintessential to inform individuals of the significance of resilience and emerging literature and research on the development of resilience. To achieve this, schools should implement a chapter on resilience within their health curriculums which addresses the need for resilience through a series of lessons similar to the pre-existing exercises in drug awareness and suicide prevention. Then, schools should offer the cost-effective MBSR for students interested in increasing their resilience after having been educated about its advantages. In this manner, schools serve as the vehicle for resilience development for adolescents from all walks of life who will utilize this education throughout a lifetime to cope in traumatic and stressful environments.

Children spend more time in school than in any other formal institutional structure, and so, the social interactions, peer relationships, and the cognitive progress that occur in school play a significant role in children's development (Fazel et al. 2015). Because of the increased

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diagnosis of children with severe mental illnesses and psychological distress, mental health services embedded within the school classroom have been studied to determine if they promote mental health awareness and healthy emotional development in students (Fazel et al. 2015). In one study, students aged 9-10 at several schools received the classroom-based cognitive behavior therapy prevention program FRIENDS which resulted in significantly lower rates of anxiety and improved levels of self-esteem among students (Stallard et al 2005). Since 81% of participants thought they had learned new skills through FRIENDS and 41.1% helped someone else using their new skills, mental health intervention in schools have been shown to be an efficacious manner of promoting awareness of mental health and emotional resilience (Stallard et al 2005). As suggested by these results, introducing the psychological concept of resilience to students through school may be an effective manner of making psychology's understanding of resilience more available to individuals (Manassis 2014).

Health education is required by forty-six states in the United States for all grade levels. The topics included in many school health curriculums are bullying, violence, and suicide prevention which all revolve around social and emotional well-being (Chriqui et al. 2019). As such, introducing a chapter on resilience within the school health curriculums may be easily achieved and have a widespread educative effect. The chapter on resilience would include thoughtful discussion on defining resilience, activities to understand the mechanism by which resilience acts, and guided reading of research experiments which illustrate how resilience enables individuals to cope with stress and overcome hardship. For instance, one such activity incorporates positive, self-regulatory coping (Lew 2018). Students identify their stressors, the causes of unhappy or upsetting feelings, and verbally share stressors with peers to build a community of trust where their voices are heard (Lew 2018). Then, students must identify how

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they usually act when presented with stressors and rate them by their effectiveness (Lew 2018). Finally, students brainstorm alternative manners to respond to stressors, ready to exercise these new coping strategies in genuine situations (Lew 2018). What education ultimately stimulates is a widespread understanding of resilience, making individuals more open-minded to building their personal resilience through a school-based MBSR intervention.

Without providing education before proceeding to actions like offering MBSR, individuals may be skeptical of how beneficial building resilience may be. For instance, in my parents' rural Indian community, there is a lack of understanding and knowledge about the nature of mental illnesses. This contributes to the perpetuation of mental health stigma and the reluctance of mentally ill to seek help or utilize programs designed to treat them (Mayo Clinic Staff 2017). For this reason, it is vital to inform communities about resilience and spread psychology's understanding of the concept before introducing MBSR to build resilience (Weiner 2019). This process had been implemented with a sample of students recruited for MBSR intervention from a Catholic Gymnasium for girls in Germany (Gouda et al. 2016). Beforehand, the teaching staff and the participating students in grade 11 were educated about the MBSR project's rationale and contents in a detailed presentation (Gouda et al. 2016). Once participants completed the MBSR course, there were significant improvements in perceived stress and self-efficacy, suggesting that students' resilience improved (Gouda et al. 2016).

To measure the progress that students have made through the MBSR programs offered at their schools, we must operationalize the concept of resilience. Operationalization is the process by which abstract conceptual ideas such as resilience are transformed into measurable observations. For instance, the concept of resilience cannot be directly measured, but it can be operationalized through the identification of representative indicators. Indicators of resilience

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may include relatively low levels of perceived stress and higher self-esteem ratings. Furthermore, measures such as the Connor-Davidson Resilience Scale are utilized to psychometrically evaluate one's resilience as a function of personal competence, control, and acceptance of change. To best determine whether the schools' employment of MBSR is beneficial, the Connor-Davidson Resilience Scale should be administered to students before and after intervention and tested for statistically significant difference.

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