Sociology of Health & Illness

SOCIOLOGY OF HEALTH & ILLNESS

ORIGINAL ARTICLE OPEN ACCESS

The Problem With Resilience: Individualisation, Reductionism and Relationality in Health Discourses on Resilience

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Received: 26 July 2024 | **Revised:** 18 February 2025 | **Accepted:** 12 March 2025

Funding: This work is supported by an Australian Research Council Future Fellowship awarded to Joanne Bryant (FT220100100).

ABSTRACT

Narratives of resilience are proliferating in health policy and research where they are used to address problems threatening individuals and communities. Resilience approaches are often considered alternatives to other models of intervention because they signal a shift away from deficit assumptions to more empowering ways of promoting health. To date, however, there has been a lack of scrutiny of the nature, assumptions and effects of resilience discourse within the health field. This paper critically analyses the logics that underpin the use of such discourse, and the implications of their allure. Findings show that resilience discourse is largely understood and operationalised in neoliberal, individualistic and reductionist terms. Such logics create normative standards for what counts as 'proper resilience' and, by doing so, engender experiences of guilt and shame when individuals are not 'resilient enough'. Seen differently, through the logics of social relationality, for example, resilience can engender new forms of subjectivity and practice for individuals and communities as 'expert' and 'knowing'. Relational resilience is especially evident in First Nations scholarship, where it is conceptualised in terms of collective values, practices and identities rather than the attributes of individuals, offering opportunities to advance thinking about resilience and its use in health contexts.

1 | Introduction

In recent years, concepts of 'resilience' have gained significant traction in health research, policy and practice, capturing the attention of policymakers and practitioners alike (Aranda and Hart 2015). Indeed, citations of the term resilience in health and medical journals has doubled since 2013 alone (Suslovic and Lett 2023). Interest in the concept derives from the belief that increasing the 'resilience' (of populations, patients and health care professionals) provides a solution to the range of problems threatening individuals, communities and contemporary health care systems. These include intractable forms of illness, rising health costs, high staff burnout and turnover.

The increasing attention given to resilience in health contexts follows similar patterns in areas of practice such as education and social work, where fostering resilience has been seen as an important objective for 3 decades or more (Bottrell 2009). In these fields, building the resilience of individuals is seen as a way of engaging with lived experience and working more effectively with disadvantaged and excluded populations (Ungar 2005; Suslovic and Lett 2023). In health contexts, resilience is seen as a preventive tool to promote health and wellbeing, to the extent that strengthening resilience is often seen as central to any planned programme of intervention (Aranda et al. 2012).

The rapid proliferation of resilience discourse in health triggers both optimism and concern: optimism about the potential opportunities to build innovative health policy, practice and intervention, but concern about the rapid growth of a concept that has, to date, lacked close scholarly scrutiny about its nature, assumptions and effects. Sociological and critical contributions to understanding 'resilience' discourse have been few and far between (but see Garrett 2016; Harper and Speed 2012; Aranda and Hart 2015; Suslovic and Lett 2023 for exceptions). Yet, as sociological scholars have noted (Bottrell 2009), how resilience is conceptualised matters greatly: it reveals how problems are understood and determines the kinds of programmes and interventions developed and implemented in response to them.

This paper is concerned with unpacking the assumptions and effects of resilience discourse in health. It has four sections. First, it describes the ways in which resilience has been conceptualised in relation to health and identifies how existing work tends to be focused on populations with histories of marginalisation and exclusion. Second, the paper considers the logics that underpin resilience discourse, arguing that, apart from a small literature that construes resilience in terms of relations and relationships, dominant conceptualisations are usually informed by neoliberal and biomedical logics of individualism and reductionism. Third, the paper considers the implications of these logics, including how they can produce (sometimes harmful) obligations to self-manage intractable problems, but also how, when understood in terms of social relations, they can engender new forms of subjectivity for health consumers as 'expert' and 'knowing'. In a final section, we draw on First Nations perspectives of resilience and related ideas of 'strengths' to provide a compelling example of what relational or 'collective' resilience looks like, and how it works to produce positive social change.

Overall, we hope to offer a clearer perspective on the limitations of the concept of resilience in health policy and practice, while being mindful of the opportunities it brings for shifting thinking towards greater attention to the agency and expertise of individuals and communities.

2 | Defining Resilience in Health Contexts

As Bottrell (2009) notes, one of the main challenges in writing about resilience is the diversity of ways in which the term is conceptualised and used. Resilience has been defined as the capability to 'bounce back' from adversity (Harrison 2013) or a positive adaptation despite adversity (Ungar 2005). Thus, it can be any characteristic or feature that enables one to withstand difficulty. In health research, policy and practice, resilience is often understood as a capability of *both* individuals and systems. It may be described as a response of individuals, reflecting perspectives from psychology and medicine, and usually articulated in terms of emotional, cognitive and interpersonal qualities and characteristics (Harper and Speed 2012). Borrowing from ecological perspectives (Lentzos and Rose 2009; Evans and Reid 2013), resilience is also described as a response of health systems to recover from disturbance and disaster. Although the existing health literature engages with both forms of resilience, the key area of application is most usually in relation to individuals: medical patients, consumers of health services, health professionals and marginalised or 'at risk' members of communities. Here, resilience is largely understood as personal and psychological characteristics: for example, emotional regulation, self-esteem, self-efficacy, perseverance and hope (Larkins et al. 2021). However, resilience may also be seen to be located in the social environments of individuals, including families, for example, as parenting styles, positive caregiving, and family cohesion (Larkins et al. 2021). Thus, the cognitive and emotional features of resilience (e.g., self-esteem) are characterised as things that can be learnt in the correct environment (e.g., through positive parent–child interaction) (Zolkoski and Bullock 2012).

Resilience is a concept that is typically applied to consumers of health services, but it may also be used in relation to health professionals, such as nurses, physicians and allied health care providers. In respect to health professionals, building resilience is seen as a means to manage staff burnout and improve the quality of care provided to patients (Epstein and Krasner 2013; McCann et al. 2013). Developing 'resilience-promoting' environments in hospitals and other health care settings is viewed as a preventive measure to reduce staff stress (McCann et al. 2013). Well cited resilience-promoting strategies include the promotion of mindfulness, self-monitoring and limit setting (Epstein and Krasner 2013).

In relation to medical patients and the consumers of health services, efforts to 'foster resilience' tend to have focused on populations with histories of economic and/or social marginalisation (Suslovic and Lett 2023). These include homeless people, people with mental health problems (Hu et al. 2015), Indigenous and other racialised populations (Tsey et al. 2007) and children and adolescents in difficult circumstances (Craig et al. 2021). In these contexts, building resilience is viewed as a strategy to address a variety of health problems across a wide range of populations: for example, alleviating distress among young people leaving foster care (Greeson et al. 2024), managing stigma and discrimination among people who identify as gender and sexuality diverse (Meyer 2015) and reducing 'infertility-related distress' among couples with infertility (Herrmann et al. 2011).

Thus, when used in health contexts, resilience is a concept seen to have salience and versatility. Indeed, its versatility is such that it is often seen as central to any planned social or health-related intervention. Building resilience is seen to increase the capacity of health professionals to manage burnout, the capacity of patients to deal with health problems and the capacity of marginalised groups (such as young people and gender and sexuality diverse people) to manage the social factors producing their distress (such as volatile family histories and social discrimination). This 'flexibility and elasticity' (Gill and Orgad 2018), and its potential for myriad applications across a range of contexts, makes resilience an attractive 'solution' to a range of health and social problems.

Part of this attraction derives from the fact that resilience is seen as a useful response to the dominance of pathology-focused biomedical approaches, and narratives of resilience have been taken up and used by health consumer and advocacy groups, most notably in the mental health field (Harper and Speed 2012). Pathology and/or risk-oriented discourse is integral to the production of medical knowledge: its focus on identifying and describing risk and problems enables the development of a range of interventions and solutions (Shim 2002). Yet, as advocacy groups and critical health scholars have identified, this mode of thinking produces and perpetuates deficit understandings of health consumers and marginalised communities—as 'ill', lacking the volition to solve their own problems and in need of expert help. Within this context, narratives of resilience offer a useful political means of problematising negative stereotyping by drawing attention to the skills, capacities and agency of communities of health consumers. Resilience narratives have been used in this way by consumers of mental health services (Harper and Speed 2012; Howell and Voronka 2012), maternal and perinatal services (Hannon et al. 2023), and in general health and medical service decision making in emergency situations (Shih et al. 2022; Hallam 2020). In this regard, the uptake of resilience discourses goes some way in addressing the social injustices produced through medicalised discourses of deficit, which cast health consumers as inexpert and vulnerable.

Importantly, and despite its widening popularity and its seeming potential to transform policy and practice, the concept of resilience has received little critical analysis in health scholarship. We therefore unpack some of the logics and assumptions that underpin resilience discourse and the implications of its widespread allure.

3 | Logics of Resilience Discourse

Narratives of resilience make particular assumptions about the nature of social world and the character and composition of the human subject. Logics of rationality and self-management dominate these narratives and, as several scholars have noted (Gill and Orgad 2018; Garrett 2016; Suslovic and Lett 2023), these accounts share an affinity with the broader logics of neoliberalism, which seek to organise individual practice in ways that manage and minimise dangers in an increasingly insecure world. However, alternative logics exist including those that would have us understand resilience in terms of social relations. Within these, resilience is seen in social practices and identities that are uniquely configured in relation to time, place and collective knowledges (Aranda and Hart 2015; Aranda et al. 2012; Bottrell 2009).

3.1 | Risk-Laden Environment

Concepts of resilience advance a view of a social world as characterised by risk, instability and adversity. Resilience suggests that individuals have the capacity to positively adapt to risk, and by doing so promotes a view of life as a process of continued 'adaptation to dangers said to be outside our control' (Evans and Reid 2013). This view of the risk-laden environment and the vulnerable human subject is clearly evident in the mainstream health literature where the social world is typically described in terms of (1) the risks confronted by vulnerable and high-need populations (of adolescents and the elderly, Indigenous and other racialised groups), (2) socioeconomic and other hardships of poverty and homelessness, (3) pandemics of viral infection and diseases of affluence and (4) overburdened and burnt-out professional workforces.

The attention given to risk in heath contexts reflects wider shifts in social organisation documented by sociologists such as Beck (1992) and Giddens (1991), whereby human practice is presented as being increasingly organised in relation to recognising and minimising risk. The focus given to risk management has occurred as a response to the rapid industrialisation and globalisation of society and the accompanying increase in environmental pollution, natural disasters and new illnesses. Increased environmental risks have been paralleled by a weakening of 'protective' social institutions such as heterosexual marriage, the nuclear biological family and religion which had previously set the normative standards through which life trajectories were guided (Lupton 2006). In consequence, and in the absence of such traditionally scripted life trajectories, social life has been reframed to focus on the individual making judgements about potential harm, and shaping or constructing self and destiny. In this way, resilience narratives may be viewed as a logical response to social imperatives to individuals to continually adapt to the 'challenges of an increasing turbulent environment' (Gill and Orgad 2018) since the responsibilities to manage risk trajectories are placed squarely upon them.

3.2 | Resilient Subject: Rational Versus Relational

Implicit in the logic of the turbulent social environment is the assumption that individuals actively navigate the environment as rational and disciplined subjects who can identify and predict potential threats and take steps to minimise them. This is evident in the health literature that positions health care professionals as skilled in managing the intensity and complexity of their workplaces and/or health consumers as capable of shaping and determining their personal wellness/illness trajectories (Suslovic and Lett 2023).

Within this framing, resilience is seen as enshrined in purposeful and individual 'practices of choice, self-control and personal transformation' (Harper and Speed 2012) that create positive change for the person and their environment. The emphasis within this framing is on the actions of the subject, which are seen to derive from individual attributes, skills, and values, rather than from the environment in which the subject lives. Aranda et al. 2012 call this version of the subject

> .... the Cartesian subject, in possession of a unified coherent identity, whose actions are the result of individual agency and rational choice and whose behaviours are taken as evidence of a priori psychological states acting as causal mechanisms.
>
> (Aranda et al. 2012, 551)

This is a very familiar discourse in health and biomedicine. Indeed, perhaps the majority of health interventions rest on assumptions of rational choice and self-management. For example, information-based health education rests on the belief that, provided with sufficient information, people will order their thoughts, choices and practices in ways that promote their health (Harwood 2009). Campaigns for healthy eating, for example, assume that better knowledge about food groups, nutrient requirements, energy needs, and food preparation necessarily leads to behaviour change about food choice. By means of such a logic, the contextual and relational factors that shape food availability and affordability (such as poverty, cultural values or geographic access to food) are erased (Rail and Jette 2015). Importantly, people who can regulate their food choice and adopt 'healthy lifestyles' are not only viewed as being more responsible but also more resilient to the adversities that bring about unhealthy body weight in the first place (Nishimi et al. 2022).

However, alternative logics exist that construe the resilient subject using logics of relationality. For example, Aranda et al. (2012) engage with resilience as a subject position 'generated relationally, whose subjectivity is negotiated through embodied, affective and historically and culturally situated biographies' (p. 554). Likewise, Ungar (2008) and Bottrell (2009) describe resilience in terms of specific forms of practice generated through negotiations between identities, local meanings and relationships with others. As one example of this, in her study of teenage girls in social housing in Australia, Bottrell (2009) describes the acts of resilience that enable young women to cope within austere living conditions—pooling funds for a night out or a meal, sharing clothes or household goods, providing babysitting services to one another or a place to stay. She also sees truancy from school as a resilient practice: girls avoid school in order to avoid the negative stereotyping they receive from teachers and other students because of their status as social housing tenants. In Bottrell's framing of resilience as relational social practice, truancy becomes an act of resilience that is context and meaning specific. It is action that emerges in relation to the specific social values and identities in a local settings, and is not an a priori or an 'after-the-event' psychological state.

Such conceptualisations, we believe, are better placed to reveal the political nature of resilience, how its meanings are specific to the culture and values of particular settings and how dominant definitions of resilience are imposed upon, and used to regulate, already marginalised peoples. However, relational understandings of the resilient subject are rarely seen (and even more rarely used) in health contexts where logics of individualism, reductionism and rationality predominate, limiting the usefulness of resilience as a practical tool in health policy and practice, a point we will return to later.

3.3 | Classificatory Practices: Categorising, Associating and Reducing

Health research, policy and practice is dominated by practices of categorising, measuring, associating and predicting. This preoccupation also exists in the study of resilience in health, where risks and resilience are categorised and mapped, often in terms of 'risk' and 'protective' factors seen as 'proximal' and 'distal' to a person's health. Such factors are frequently understood to be present at the individual level in terms of knowledge, attitudes and beliefs; at the interpersonal level in terms of relationships with friends, family and communities and at the organisational level in terms of the way social structures, public institutions and policies affect individuals (Bryant et al. 2021). Often, risk and resilience 'factors' are understood using binary logics as the positive and negative materialisation of the same attribute: for instance, high quality of life versus low (Herrman et al. 2011), more versus less minority stress (Meyer 2015), constructive engagement with work-related stress rather than withdrawal from the work-place (Epstein and Krasner 2013; McCann et al. 2013).

Ultimately, these categorisations are epistemological practices that work to reduce complexity and identify what are presumed to be the fundamental sources of resilience. For example, in their study of infertile couples, Herrman et al. (2011) use a 'resilience scale' (Wagnild and Young 1993) to explain how couples cope with childlessness. In this scale, resilience is measured by asking individuals to respond to 25 questions such as, 'I am determined' and 'my life has meaning', using a Likert scale. Their responses are then codified into 'factors' such as self-reliance, determination, adaptability and positive outlook, which are then themselves arranged into a single psychometric score. Here, Likert scales and psychometric score construction have a translating function: they are used to collapse and codify human experiences (in this case, determination and meaning of life) from the 'chaotic complexity' of human experience (Mol and Law 2002) into 'factors' and components. These categories are then ordered in relation to each other as signifying less or more of the seemingly same characteristic. In this way, resilience becomes translated into sets of characteristics and factors that are said to be located within individuals, in the form of largely decontextualised emotional responses and choices.

The classificatory logics used in much resilience research strongly align with biomedical reductionist epistemologies and methods, and the techniques that these use to identify and solve problems. They assume that knowledge of resilience can be garnered from empirical epistemologies and through reductionist research methods of scaling and scoring. This devolution grossly oversimplifies the complexities of the social world, representing it via 'smaller, presumably independent units of observation' (Shim 2002, 132) without attention to how specific units of observation coalesce and relate to each other and wider social processes. These reductionist logics would have us understand social context in narrow terms whereby individuals are understood as being able to control and change their environment by making the 'right' choices in decision-making. Importantly, however, this false logic of being able to reduce, simplify and locate the root sources of resilience within the individual contributes to the concept's sense of versatility. This is what makes 'resilience-fostering' interventions an attractive solution to a wide range of health and social problems.

3.4 | Neoliberal Affinities and Other Forms of Governance

The emphasis on self-management, risk-reduction and problem-identification in dominant forms of resilience discourse reveals its links to sociocultural logics of neoliberalism (Gill and Orgad 2018; Garrett 2016; Suslovic and Lett 2023), and the rapid proliferation of resilience discourse can likewise be, at least partially, explained by these. 'Profit logics' (Connell et al. 2009) of rationalisation and itemisation drive neoliberal practice and are valued by institutions and policy makers under pressure to improve quality of services and reduce economic waste in increasingly austere funding environments. Such logics of enterprise colonise multiple spheres of social life by organising how individuals relate to the social world through the identities that are most valued (rational and self-managing), and through the practices (of predicting, calculating and coping) that are associated with these. In this regard, resilience narratives and practices are aligned, with imperatives that 'encourage people to individually respond to *collective* instabilities and uncertainties engendered by neoliberal economics' (Garrett 2016, 1920).

However, alternative logics that construe resilience as a form of social practice and subjectivity reveal the partialities of neoliberal agendas and how these articulate with other cultural and political processes (Kingfisher and Maskovsky 2008). When resilience is understood through logics of relationality, it reveals the 'actually existing' (Bell and Green 2016; Brenner and Theodore 2002) social processes through which neoliberal individualising imperatives act upon and through people. This was lucidly revealed by Bottrell (2009) in her study of the resilience of teenage girls who 'lived' resilience differently through their practices of sharing limited resources (meals, clothing and places to stay), as well as through their unique identities (as social housing tenants).

Within this alternative framing, resilience is seen to be configured differently at different times, in different places, using different shared knowledges. As we return to in the final section of the paper, this perspective provides a useful foundation for understand resilience as underpinned by sets of shared values, identities and collective practices rather than the cognitive, emotional and interpersonal qualities of individuals.

4 | Implications and Effects

Informed by the above analysis, we now move to consider how the logics of specific resilience discourses function within the everyday subjective experiences of individuals, bringing about particular implications and effects. We argue that dominant narratives of resilience as an individual technique of self-management reify normative ways of living, setting up criteria for what counts as 'proper' resilience and governing individual and social identities in relation to this. We identify the role of classificatory research practices in sustaining individualised narratives of resilience. But we also consider how attention to social context and processes, as enabled through relational logics of resilience, can make space for new forms of subjectivity and practice that give authority to the expertise and agency of individuals and communities.

4.1 | Resilience as Responsibility: Being 'Resilient-Enough'

The framing of resilient subjects as purposeful and rational actors, engaged in choice and self-transformation, is in line with larger imperatives that shift responsibility for problems and problem solving onto individuals and away from the state and the structural inequalities that are implicated in their production (Connell et al. 2009; Bottrell 2009; Garrett 2016). Through a logic of 'personal responsibilisation', problems of illness, disease and social inequality become transformed into problems of self-care (Harper and Speed 2012), and individuals become obliged to change their attitudes and behaviour to improve their health. Thus, while dominant ideas of resilience may be thought of as offering an alternative to medicalised discourses of deficit, which cast health consumers as vulnerable and inexpert, their framing of resilience in terms of personal responsibility and action means that resilience discourse can offer little more than an 'individualised reading of empowerment, rather than an actual redistribution of power' (Harper and Speed 2012, 483).

When resilience is viewed in this way, a sense of failure and personal responsibility can arise when resilience is not sufficiently enacted. Harper and Speed (2012) in their analysis of resilience discourse in mental health, describe how this happens to people who do not 'recover' from mental illness, and in consequence continue to be viewed negatively by health providers. Similar effects have been documented for other marginalised populations, such as drug users (Gowan et al. 2012), where logics of self-management and responsibility promote deficit views of people and communities as lacking in self-control, incapable of reason, and not being 'resilient enough' to manage their health and social problems when they do not stop using drugs. Having a sense of failure can serve to further entrench the marginalisation of already excluded groups when they are seen to lack the discipline, skills and volition needed to take proper advantage of the solutions offered to them (Bryant et al. 2021; Brough et al. 2004; Moreton-Robinson 2013).

4.2 | Reifying Normative Ways of Being: Setting Criteria for 'Proper' Resilience

A key effect of individualising discourse is its reification of normative codes of living (Connell et al. 2009). In the case of resilience, as previously described, what counts as appropriately resilient practice rests on culturally dominant assumptions about the nature of the social world (as inherently risky) and human subjectivity (as acting with intention towards the 'external' social world). In this framing, resilience becomes normatively coded as practices of self-regulation, the capacity for action and attitudes of positivity and preparedness.

Ryan's (2023) analysis of new discourses on the 'biology of resilience' provides a useful example. These are scientific discourses focused on children living in conditions of poverty and neglect, that claim that such early experiences get 'under the skin', become embodied physiologically and lead to negative outcomes in later life. Ryan (2023) details how such discourses operate to produce normative expectations of what counts as 'appropriate' development for children: '*what* develops, *how* development happens, and *why* development is "derailed"' (Ryan 2023, 32). Together, they imply a normative developmental trajectory for childhood in which some children are seen to be primed, physiologically, towards negative or positive life outcomes, depending on their early experience. In this way, as Ryan (2023) explains, the biology of resilience scripts a future for children in which trajectories are almost pre-decided and guided by normalising codes focused on producing 'healthy, industrious, and law-abiding citizens' (p. 47).

Yet, these normative expectations of resilient behaviour can work against socially excluded young people, such as street-involved young people, where violence is seen as a *necessary* form of negotiation that solves problems and strengthens relationships (Barker 2013). In street contexts, violence is an *act of resilience* that is context and meaning specific. Thus, ultimately, what is considered resilient practice on the street may not always align with normative models of resilient practice and, in fact, is typically viewed as delinquent and in need of intervention.

In this way, rather than offering an alternative to deficit discourse, or 'challenging the ontology of the deficit model' (Harper and Speed 2012, 15), resilience discourse can reproduce normative obligations: by setting up and perpetuating the criteria through which 'real' and 'proper' resilience is to be understood, and governing individuals, communities and their life trajectories accordingly (Ryan 2023). Ultimately, dominant resilience discourses work to reify difference between those who can and cannot 'do' resilience in line with these normative conditions, offering positions as 'responsible' and 'resilient-enough' to those who can meet such requirements, and casting those who cannot as lacking personal discipline and volition. It is for these reasons that Garrett (2016) and others (Neocleous 2013; Harper and Speed 2012) borrow from Foucault et al. (1988) to claim that resilience discourse may best be understood as constituting a new technology of the self, operating as a tool of social control that demands one to 'be resilient', and in the process hides other ways of responding to adversity. This is why Neocleous (2013) declares that 'resilience is by definition against resistance' (page 7) because it demands acquiescence to social control rather than resists it.

Yet, as we have argued already, the individualising tendencies within resilience discourse manifest in impartial and unstable ways. The responsibility to meet the normative standards of 'proper' resilience and to be 'resilient enough' is not totalising, nor is the personal responsibilisation experienced in everyday life necessarily negative. Importantly, in some health contexts, resilience discourse can carry the political authority that has enabled advocates and activists to insist upon their collective participation and inclusion in health services and policymaking (Hallam 2020).

4.3 | Resilience as Authority and Belonging

Resilience narratives have appeal to health advocates and activists because they carry with them a sense of agency, expertise and authority. Resilience discourse also has the potential to question medicalised discourses of deficit that cast health consumers as inexpert and vulnerable, and gives authority to health consumers to insist their agency is acknowledged and to demand accountability from policymakers and providers. Informed by these developments, consumer participation initiatives have grown in relation to mental health (Howell and Voronka 2012), HIV (Coren et al. 2021) and drug and alcohol services (Bryant et al. 2008), among other health issues. In some cases, they have led to more inclusive styles of health service provision that take better account of the experience and knowledge of consumers. Consumer participation activities take a range of forms—from the use of suggestion boxes and feedback forums to consumer involvement in high level decision-making (Bryant et al. 2008; Tritter and McCallum 2006)—but all such initiatives rest on a view of health consumers as knowledgeable, self-managing and capable, a subject position that itself aligns closely with resilience discourse.

Moreover, as lived experience research studies have shown, personal responsibilisation is not always and necessarily experienced negatively. Participants in Stonehouse et al.'s (2022) study of lived experience of homelessness, recounted how accepting personal responsibility, at least in part, for their homelessness was seen as both reasonable and necessary. Rather than fully accepting or rejecting responsibility, participants narrated stories revealing both the social constraints affecting their negative housing experiences, and their capacity to actively navigate such constraints (Stonehouse et al. 2022). For these participants, narratives of personal responsibility were appealing in that they communicated a sense of self-determination, disrupted internalised assumptions of failure and deficit and offered subject positions as responsible and capable of self-management. These were attributes and identities that had hitherto not been available in the contexts of their lives.

Thus, the responsibilising imperatives of resilience discourse are not always experienced as damaging, as is often argued in existing critiques of resilience (see Garrett 2016; Neocleous 2013). Indeed, in some settings, and for some advocates and activists, resilience discourse carries political authority enabling advocates to insist on excluded peoples' inclusion in governance practices in health service provision and policy-making, and to problematise overly medical and psychologistic perspectives on lack and vulnerability. It also has an impact on the everyday lived experiences of marginalised people when identity-positions such as 'responsible' disrupt prior assumptions about the self organised around notions of deficit (see also Bryant et al. 2021).

4.4 | Simplification and Reduction Practices: Re-Establishing the Cultural Authority of Scientific Notions of Resilience

Much of the existing research literature on resilience is characterised by simplification and reduction practices. As we have described, this happens both at the level of epistemology and method in everyday research practice, for example, by simplifying resilience into 'protective' and 'risk' factors and into 'levels' and 'domains' that are 'proximal' and 'distal'. These classificatory imperatives have important governance effects. In particular, they conceal the social processes that produce resilient practice and marginalisation and establish resilience as reducible, quantifiable and intervenable, setting up the conditions for 'resilience fostering' interventions to be seen as legitimate solutions to complex health problems.

Beyond this, however, the classificatory imperatives through which resilience is conceptualised set up a particular ontological framing of the social world and its relationship to the individual. This too has governance effects in that it encourages us to misread the social processes through which resilient acts are made, obfuscating the difference between the 'individualised resilience' imposed on already marginalised persons and the forms of 'collective resilience' that derive from this, and prefigure, social change. By framing the social world in terms of 'levels' of proximity to the individual (e.g., at family, community, structural 'levels'), and by codifying and reducing human experience into binaries, psychometric scales and scores of 'risky' or 'resilient', the capacity to explain *why* individuals and groups act in the way they do disappears (Williams 2003). Instead, explanation is forced to fall back on popular logics in which individuals are seen as being able to exert control over their circumstances through their choices and practices, if only they are strong enough to do so (Bottrell 2009). Within this ontological framing, human choice and action are seen to derive from psychological processes within individuals (Stone-Jovicich 2015) and the social world is viewed in limited terms of how it adds to individual experience but is thought to have little productive power in producing such choice and action in its own right.

Such a framing offers no tools with which to understand the social processes at work in how resilience is enacted and produced (through practice, subjectivity and social meaning systems over time); how these processes work to create desired health outcomes and how resilience might be differently enacted across diverse communities and local settings. This more detailed description and analysis is necessary to develop 'resilience building' programmes that are both context specific and relevant to the populations they seek to work with, and engage.

Classificatory imperatives to establish resilience as reducible, measurable and intervenable, perpetuate the assumption that 'resilience building' interventions are a useful and versatile policy and practice approach. But there are problems with this assumption. Sociological critiques of scientific knowledge provide insight into this by showing how 'simplification practices' can establish and stabilise an object of study, constituting it as 'real' and 'coherent', when neither may be the case (Law and Mol 2002).

For example, critical drug studies scholars have shown how the screening and diagnostic tools used in addiction medicine, through their quantification and ordering of the extent and scale of drug problems, establish and stabilise the characteristics of 'addiction' itself in terms of compulsion and impaired control (Fraser et al. 2014; Dwyer and Fraser 2015). Similarly, youth sociologists reveal how 'scientism'—in the form of reductionist methods for the collection and treatment of data—have worked to establish understandings of the 'adolescent brain' common in developmental psychology and medicine (Bessant 2008). Within these framings, young people's brains, as assessed by medical technologies such as magnetic resonance imaging, are treated as the source of the 'risky' cognitions and behaviours that supposedly characterise young people's choices (Bessant 2008; Kelly 2012). By such means, youth capacity is reduced to brain structure and function, and the complex interaction of emotion, experience and context disappear from view (Kelly 2012). As Bessant (2008) argues, through these reductionist methodological practices, it becomes a 'well known fact' (p. 348) that young people have different and immature brains, and thereby risky behaviour.

Seen from this perspective, classificatory practices of categorising, reducing and connecting things together do not objectively document reality, but rather are part of the epistemological process of constituting a 'truth'. The classificatory practices at work in resilience research govern our understanding of 'resilience' in similar ways. The epistemological and methodological practices of such research produce what we have come to understand as 'resilience'. They codify, arrange and reduce the complex and often collective character of resilience to all but a few main features—self-regulation, self-improvement, positivity and preparedness—and fix these as the realities of resilience.

These are almost always seen as the characteristics of the individual, and not as the collective forms of resilience and resistance that have the capacity to bring about social and structural change (such as those evident in consumer advocacy and collective actions that seek to better align health governance with the lived experiences and relational knowledges of health consumers).

5 | Relational Resilience and the Potential for Social Change

The dominance of individualising logics in resilience discourse obscures the value of other potentially more useful understandings of resilience, including the relational understandings referred to throughout this paper. These alternatives would have us understand resilience in terms of the social practices and subjectivities that are uniquely made in, and through, different contexts and collective knowledges. In the final section of the paper, we draw on scholarship from First Nations scholars who, through their engagement with concepts of resilience and related ideas of 'strengths' and 'strengths-based approaches', provide a compelling example of what relational or 'collective' forms of resilience might look like, and how they can bring about positive social change.

In countries such as Australia, Canada and the USA, First Nations communities have frequently been the target of interventions to 'foster resilience' (Askew et al. 2020; Van Uchelen et al. 1997; Kana'iaupuni 2005), although First Nations scholarship offers an ambivalent perspective on many of these efforts (Askew et al. 2020). Resilience is embraced by some First Nations researchers as a means of drawing attention to the social and environmental conditions in which First Nations people experience health (Wright et al. 2016; Young et al. 2019). They thereby offer perspectives on how health and wellbeing are shaped by forces beyond the biomedical and the personal. Other writers, however, argue that the concept of resilience pays insufficient attention to the harmful historical, economic, social and political factors that shape Indigenous peoples' lives. They argue instead that advocacy for resilience is a colonial and colonising project (Askew et al. 2020) that operates to further entrench First Peoples' dispossession and marginalisation when they are seen to lack the volition needed to take advantage of 'well-meaning' programmes and interventions (Moreton-Robinson 2013).

Above all else, First Nations health scholarship focuses on relational ways of knowing and being (Watego et al. 2021; Gardner et al. 2024) and strengths-based practice that resists oppression and gives voice and political power to Indigenous communities and their leaders (Askew et al. 2020; Kana'iaupuni 2005). First Nations activists and scholars describe strengths relationally in terms of the shared values, practices and identities that matter to communities, rather than the qualities of individuals (Van Uchelen et al. 1997; Kana'iaupuni 2005; Yap and Yu 2016; Gardner et al. 2024). By doing so, 'strengths' become a feature of locally-specific *social relations* and, by defining them in this way, the process by which certain forms of resilience discourse may produce social change becomes more evident.

For example, characteristics such as 'parenting style', 'positive caregiving' and 'family cohesion', which are commonly understood as forms of resilient behaviour, in First Nations terms are better understood as relations of kinship responsibilities (Kirmayer et al. 2011). Family and kinship are central organising principles in First Nations communities (Gardner et al. 2024). They govern the social exchanges that take place between individual members of a community but also reinforce connections to land and culture (Yap and Yu 2016). Studies of Indigenous social movements note how these networks and kinship systems are central to distributing knowledge and shared values in ways that mobilise communities to act against racism and injustice, thereby facilitating positive change (Lupien 2020; B. Carlson et al. 2017).

Similarly, ideas such as 'self-esteem', 'self-efficacy' and 'perseverance', which may be taken to be indicators of resilience in psychological and public health formulations, in First Nations frameworks are instead understood as collective identities linked to pride and belonging to community, as well as to shared histories and futures (Van Uchelen et al. 1997; Kana'iaupuni 2005; Gardner et al. 2024). Strong collective identities are an integral part of what drives political change for First Nations people and their communities (Rice 2012; Lupien 2020). For example, Askew et al. (2020) describe how First Nations health workers in Australia understand 'strengths-based approaches' as conscious emancipatory practices, and draw on strengths discourse to reject laying blame on First Nations peoples for the structural conditions that produced poor health.

In this way, a strengths approach may give rise to 'a radical rethink of Indigenous peoples, communities and capabilities to enable [a] different way of working with' rather than 'on' First Nations people (Askew et al. 2020, 105). Collective identities of strength, resistance and self-determination (B. L. Carlson et al. 2017) rewrite and resist Colonial and neo-colonial narratives of deficit. When understood in relational terms, as collective identities and shared values and practices, resilience can therefore become a *disruptive tactic* with which to reframe dominant thinking about First Nations peoples' health and social conditions.

First Nations perspectives align in a number of ways with the ideas of relational resilience referred to throughout this paper (Bottrell 2009). The advantage of understanding resilience in relational rather than individual terms is that, unlike more determinist approaches, it reveals the social processes that are involved in generating exclusion and inequality, and producing movement and change. Importantly, for First Nations peoples, as for marginalised and disenfranchised groups, resilience and 'strengths' narratives are deeply political. They draw attention to the capacity and humanity of First Nations people and their pursuit of self-determination and sovereignty in relation to their health and wellbeing.

6 | Conclusion

Notions of resilience have increasing traction in health and healthcare settings. Yet, the manner in which resilience has been operationalised to date, largely through the logics of personal responsibilisation and reductionism, has not only limited the concept's impact and relevance, but has been damaging to populations and groups who are seen as not 'resilient-enough' to manage what in reality are structurally-rooted health and social problems. Yet, in the right conditions, as First Nations scholars and activists have shown, resilience discourse has power to shift narratives away from deficit-based biomedical framings of health by giving authority to lived experience, promoting alternative forms of expert knowledge, drawing attention to inequality and exclusion, and enabling reframing and resistance. In this regard, relational understandings of resilience, such as those articulated by First Nations scholars, where the emphasis is placed on collective forms of resilience as values, practices and identities rather than individual attributes, bring with them the opportunity to produce positive and meaningful social change for marginalised peoples.

Author Contributions

Joanne Bryant: conceptualization (lead), formal analysis (lead), funding acquisition (lead), writing – original draft (lead). **Peter Aggleton:** conceptualization (supporting), formal analysis (equal), writing – review and editing (equal).

Acknowledgements

This work is supported by an Australian Research Council Future Fellowship awarded to Joanne Bryant (FT220100100) *Reimagining strengths approaches to drug and alcohol care for young people*. The authors wish to thank the two anonymous reviewers for their thoughtful and constructive advice. Open access publishing facilitated by University of New South Wales, as part of the Wiley - University of New South Wales agreement via the Council of Australian University Librarians.

Ethics Statement

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The authors have nothing to report.

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