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Impact of Psychological Resilience on Disease Recovery

A Systematic Literature Review

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Abstract: Psychological resilience is considered an important psychosocial factor in helping individuals cope with illness and adapt throughout recovery, yet research on the topic is spread across diseases, populations, regions, and methods. This systematic literature review examined the impact of psychological resilience on disease recovery and mapped research trends, methodologies, geographical patterns, key themes, and gaps in the literature. Selected academic databases were searched for studies published from 2016 to 2026, and 45 studies were included after screening guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses framework. Zotero and Microsoft Excel were used to manage bibliographic data, and VOSviewer was used to analyse keyword co-occurrence and author collaboration. The results show growing research interest, with a clear rise in output in recent years and a concentration of studies in China and the United States. Quantitative designs predominated, and the studies addressed diverse conditions including chronic disease, cancer, stroke, diabetes, inflammatory bowel disease, and COVID-19. Frequently identified themes were coping, adaptation, psychological well-being, social support, self-efficacy, and quality of life. Many studies reported favourable associations between resilience and recovery related outcomes, although some found no independent association with functional recovery. Gaps included limited longitudinal and intervention research, inconsistent measurement of resilience, and under-representation of some regions. Psychological resilience appears to be an important factor linked to disease recovery, and standardised, longitudinal, and intervention based studies are needed to clarify how resilience relates to recovery.

Keywords: *Psychological Resilience; Disease Recovery; Health Outcomes; Coping; Adaptation; Systematic Literature Review; Bibliometric Analysis.*

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I. INTRODUCTION

Disease recovery is a multifaceted process that extends beyond medical treatment and physical improvement. It is shaped by psychological and social factors that influence how individuals respond to illness and its associated challenges. People living with chronic or serious health conditions may experience emotional distress, physical restrictions, treatment-related pressures, and disruption to daily activities, all of which can affect quality of life, psychological well-being, coping capacity, and the ability to adapt to illness [1]–[3]. Consequently, growing attention has been given to psychosocial factors that may support individuals throughout recovery.

Psychological resilience describes an individual's ability to adapt effectively when faced with adversity, stress, or challenging circumstances and to maintain or regain psychological and functional well-being. In healthcare research it has emerged as an important concept for understanding how people respond to chronic illness, treatment demands, and changes in physical or social functioning. Research involving people with chronic conditions has linked resilience with quality of life, psychological well-being, coping, and daily functioning [4]–[7].

Associations between resilience and favourable outcomes have been reported across several conditions. In chronic obstructive pulmonary disease (COPD), resilience-related factors were important for health-related quality of life [2], and a similar relationship was found among adolescents with chronic health problems [4]. In inflammatory bowel disease (IBD), higher resilience was associated with lower disease activity, better quality of life, and fewer surgeries [8]. In first-episode schizophrenia, individuals who reached full recovery showed a significantly greater increase in resilience than those who did not [9].

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Associations between resilience, psychological well-being, and coping have also been identified in Crohn's disease [10] and among older adults living with chronic illness [3]. Resilience has also been related to functional ability and self-management, including activities of daily living in chronic kidney disease [6], self-care in COPD [11], and social support and self-efficacy after stroke [12].

The association is not uniform, however. A prospective study of acute ischemic stroke found that psychological resilience was not independently associated with functional recovery once relevant clinical factors were taken into account [13]. This contrasts with studies reporting positive associations with other recovery-related outcomes [6], [8] and suggests that the contribution of resilience depends on the disease, the type of recovery outcome, and other clinical and psychosocial factors.

The relationship may also involve interacting psychological and social factors. Social support, self-efficacy, depression, stigma, and coping have been identified as factors associated with resilience and quality of life in chronic illness [5], [12], [14]. Sleep quality and depression mediated the association between resilience and quality of life among hospitalised middle-aged and older adults with chronic diseases [7], and perceived social support and medical coping mediated the relationship between resilience and meaning in life among patients with COVID-19 [15]. Resilience may therefore act through interconnected psychological and social mechanisms rather than as a single independent factor.

Despite this growing body of work, existing systematic reviews have tended to concentrate on particular diseases or populations, such as colorectal cancer and cardiovascular disease [16], [17], while individual studies have examined many different recovery-related outcomes. Medical care focuses mainly on treating the physical condition, whereas resilience may help people cope with illness, overcome emotional challenges, and adjust to treatment; its contribution to recovery across diseases nevertheless remains inadequately understood. A broader synthesis is therefore needed. This systematic literature review synthesises evidence from 45 studies published between 2016 and 2026 and addresses three research questions. What are the main trends, themes, and geographical patterns in research on the impact of psychological resilience on disease recovery? What research gaps and limitations exist in the current literature? Who are the most influential authors and what are the most impactful journals?

Correspondingly, the objectives were to determine the predominant research trends, methodologies, and designs; to analyse geographical distribution, international collaboration, and journal impact; and to identify recurring themes, key concepts, research gaps, challenges, and limitations. The findings may help patients understand the importance of psychological well-being during recovery, assist nurses, doctors, psychologists, and other healthcare professionals in recognising psychological factors as part of patient care, support healthcare organisations and policymakers in developing patient-centred recovery and psychological support programmes, and give researchers and nursing students evidence for identifying knowledge gaps.

II. RESEARCH METHODOLOGY

➢ *Search Strategy and Study Selection*

The review involved the methodical identification, selection, organisation, analysis, and synthesis of published studies. Scholarly databases were searched using terms including “Psychological Resilience,” “Resilience,” “Disease Recovery,” “Recovery,” “Health Outcomes,” “Chronic Disease,” “Cancer,” “Stroke,” “Cardiovascular disease,” and “Mental Health,” and the search was limited to English-language publications from 2016 to 2026. Selection followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework, as shown in Fig. 1.

The search of five databases (PubMed, Scopus, Web of Science, CINAHL, and PsycINFO) identified 200 records. After 30 records were removed before screening (20 duplicates and 10 marked ineligible by automation tools), 170 records were screened and 95 were excluded as incomplete articles. Of 75 reports sought for retrieval, 5 could not be retrieved and 70 were assessed for eligibility. Twenty-five were excluded because they were not directly related to resilience and disease recovery (9), the full text was not accessible (4), they were not in English (6), they provided insufficient information (4), or relevant recovery outcomes were not reported (2). Forty-five studies were included.

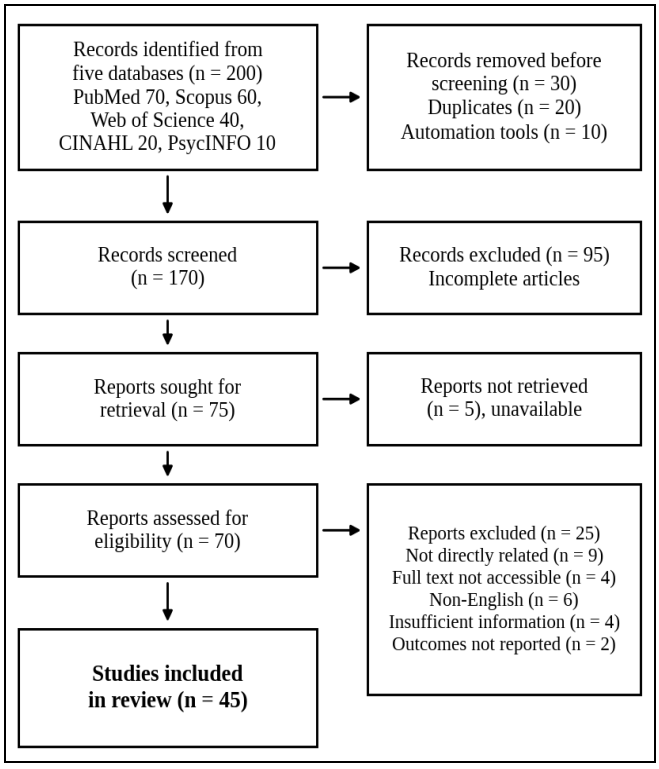


Fig 1 PRISMA Flow Diagram of Study Identification, Screening, Eligibility, and Inclusion.

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➢ *Eligibility Criteria*

Studies were included if they (1) focused on psychological resilience or resilience in relation to disease recovery or health outcomes; (2) involved populations experiencing a disease, illness, health condition, or recovery process; (3) examined the relationship or influence of resilience on recovery, health outcomes, coping, adaptation, well-being, or related outcomes; (4) used quantitative, qualitative, mixed-methods, or systematic review approaches; (5) were published in English; (6) were published between 2016 and 2026; and (7) provided sufficient information relevant to the research questions. Studies that did not address resilience, did not link it to recovery or pertinent health outcomes, were not available in full text, or were published in other languages were excluded.

➢ *Literature Management and Analysis*

Zotero was used to gather, store, and organise the selected articles and to identify duplicates. Bibliographic data, including title, authors, year, journal, DOI, methodology, country, university, publisher, keywords, and citation details, were recorded in Microsoft Excel. Descriptive analysis was used to examine publication growth, journal and publisher distribution, regional and university representation, methodology, and influential authors. Methodologies were classified as quantitative, qualitative, mixed-methods, or systematic literature review.

VOSviewer was used for keyword co-occurrence analysis, to visualise the frequency of keywords and the links between frequently occurring concepts, and for author co-occurrence analysis, to examine collaboration among researchers. Citation counts were used to identify influential articles and authors where citation data were available. Bibliometric approaches of this kind have also been applied in related areas such as mental health [18].

➢ *Synthesis of Results*

Findings were synthesised according to the research questions and objectives, with attention to recurring themes, methodological trends, and regional patterns. The evidence was further analysed to identify knowledge, empirical, methodological, population and geographical, theoretical, evidence, and practical gaps. The findings of the systematic review and the bibliometric analysis were then combined to describe the state of research on psychological resilience and disease recovery.

III. RESULTS OF THE BIBLIOMETRIC ANALYSIS

➢ *Publication Growth*

Studies on psychological resilience and disease recovery were published throughout the review period of 2016 to 2026 (Fig. 2). Output increased gradually and became more prominent from 2021. The fewest publications appeared in 2016 and 2017 (one each), annual output peaked at six in 2021 and settled at four or five between 2022 and 2025, and 2026 recorded the highest count (eight). Overall, the pattern indicates increasing scholarly attention to resilience and illness recovery.

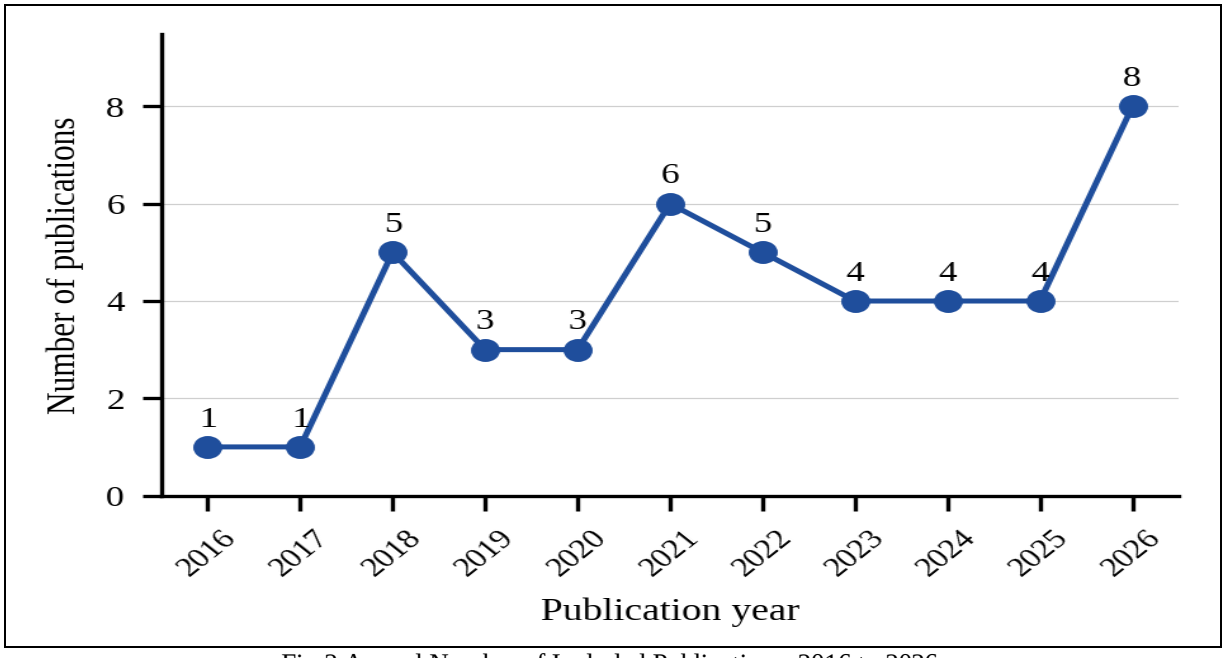


Fig 2 Annual Number of Included Publications, 2016 to 2026.

➢ *Publication Sources*

Table 1 lists ten of the publication sources of the included studies, each of which contributed one study. Brain, Behavior, and Immunity recorded the highest H-index (221) and impact score (7.28) among them. The sources span neuroscience, immunology, oncology, psychiatry, geriatrics, nursing, and gastroenterology, demonstrating the multidisciplinary nature of the literature. These indicators should be interpreted alongside publication type and other quality criteria rather than as definitive evidence of journal credibility.

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Table 1 Selected Publication Sources of the Included Studies

Journal	Publisher	H-index	Impact score	Subject area
Brain, Behavior, and Immunity	Elsevier	221	7.28	Neuroscience, immunology, behavioral sciences
BMJ Oncology	BMJ	11	4.07	Oncology
Inflammatory Bowel Diseases	Oxford University Press	192	5.03	Gastroenterology, hepatology
Comprehensive Psychiatry	Elsevier	134	5.49	Psychiatry and mental health
Journal of the American Geriatrics Society	Wiley	282	3.41	Geriatrics and gerontology
European Journal of Psychotraumatology	Taylor & Francis	85	4.22	Psychiatry and mental health
Journal of Clinical Nursing	Wiley	138	4.47	Nursing
BMC Geriatrics	Springer Nature	124	4.46	Geriatrics and gerontology
International Journal of Molecular Sciences	MDPI	365	5.82	Biochemistry, genetics, molecular biology
Journal of Advanced Nursing	Wiley	193	4.86	Nursing

➢ *Authors, Countries, and Institutions*

Jia-Su Wang recorded the highest citation level in the selected literature, followed by H. J. Kim and Yen-Da Chen, and the cited authors came from a range of health-related disciplines. China was the leading country of publication with 13 studies, followed by the United States with ten and the United Kingdom with three, while many other countries contributed one or two studies each. Asia was the most represented region, followed by North America and Europe, indicating an uneven geographical distribution of research. Authors were affiliated with universities in China, the United States, the United Kingdom, Australia, Spain, Germany, Canada, Japan, South Korea, and other countries, across public health, nursing, medicine, psychology, rehabilitation, geriatrics, and psychiatry. The co-authorship network showed that several research groups, rather than a single team, contribute to the field.

➢ *Disease and Population Coverage*

The included studies covered chronic diseases, cancer, cardiovascular diseases, neurological disorders, kidney disease, diabetes, IBD, COVID-19, and mental health conditions [7], [16], [17], [19]. Kidney disease was examined in several studies [20]–[22], as was cancer, including breast and gastric cancer [23]–[26], with randomised trials combining resilience training and nutritional support in gastric and colon cancer [27], [28]. Other studies addressed diabetes [29], [30], stroke [31], multiple sclerosis [32], spinal cord injury [33], postsurgical and cardiovascular surgery recovery [34], [35], and psychiatric conditions [36]–[38]. Further work considered concept and definition [39], [40], immunity and inflammation [41], [42], mental health in the somatically ill [43], and psychological interventions for long-term conditions [44].

➢ *Keyword Co-Occurrence and Themes*

Keyword co-occurrence analysis identified the most frequent terms in the included papers (Fig. 3). Resilience, patient, and psychological resilience were the most prominent terms, and related terms such as social support, self-efficacy, mediating effect, quality, recovery, outcome, and anxiety appeared in connected clusters. The analysis also identified recurring concepts such as coping, quality of life, psychological well-being, social support, adaptation, and disease-related outcomes, which shows that resilience research is closely connected with psychological adaptation and the ability to manage the challenges of illness.

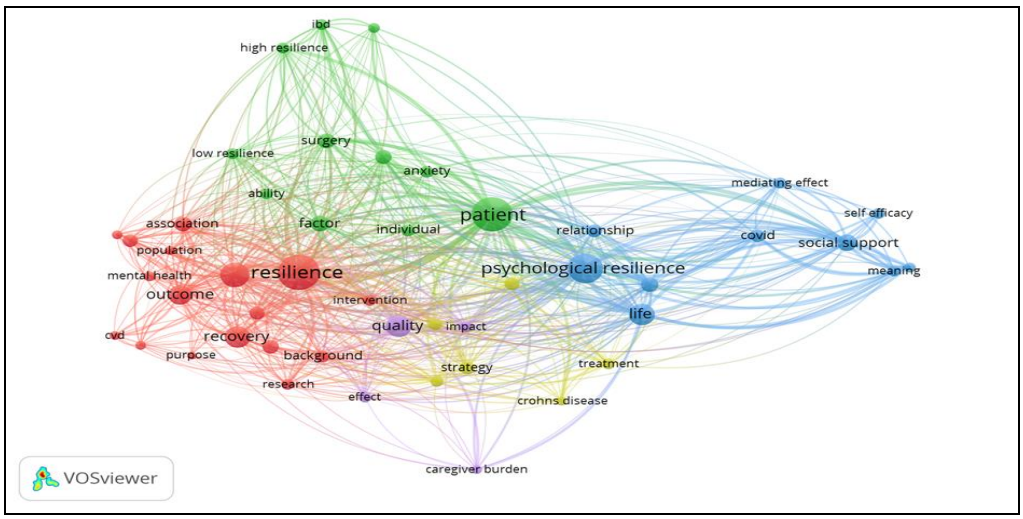


Fig 3 Keyword Co-Occurrence Network Generated with VOS Viewer.

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➢ *Thematic Radar Analysis*

Fig. 4 presents the thematic radar profile of the literature across five dimensions: resilience and psychological well-being; disease activity and quality of life; social support, self-efficacy, and coping; functional recovery; and resilience interventions. Each dimension is plotted on a scale of 0 to 10, where higher values indicate greater research emphasis. Resilience and psychological well-being, and disease activity and quality of life, received the greatest emphasis, whereas functional recovery and resilience interventions were the least emphasised. The profile reflects the relative emphasis of research rather than effect sizes or strength of evidence, and it highlights areas where further investigation is most needed.

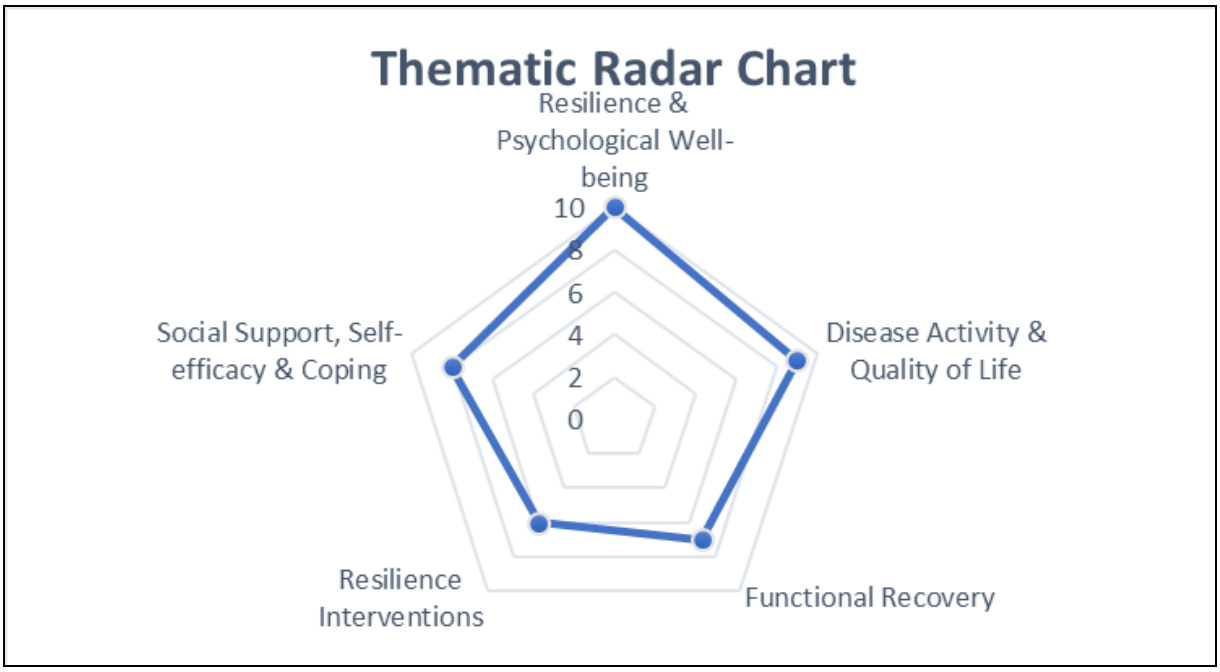


Fig 4 Thematic Radar Profile of the Included Literature Across Five Dimensions.

➢ *Methodologies Used*

Quantitative studies accounted for 78 percent of the literature, qualitative studies for 13 percent, and mixed-methods studies for 9 percent (Fig. 5). The predominance of quantitative research indicates that most studies used numerical data and statistical methods to examine relationships between resilience and recovery outcomes, whereas relatively few focused on patients' experiences, perceptions, and coping.

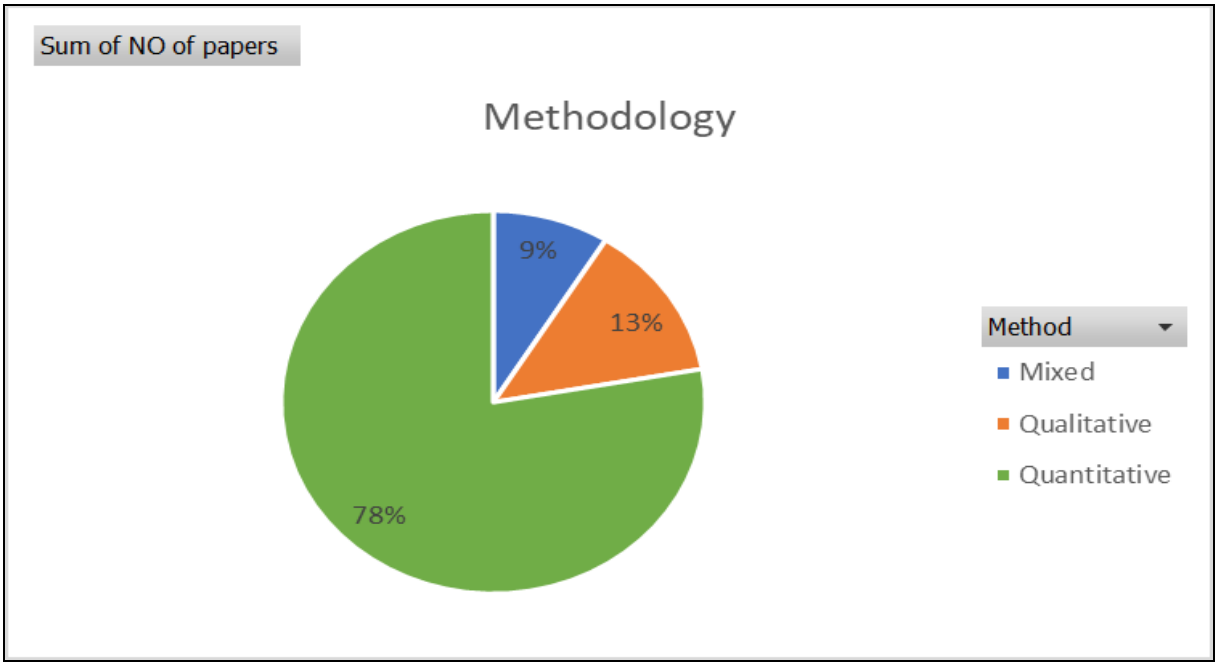


Fig 5 Methodological Distribution of the Included Studies.

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➢ *Identification of Research Gaps*

Seven types of research gap were identified from the synthesis of the included studies, summarised in Table 2.

Table 2 Research Gaps Identified in the Literature

Gap	Summary
Knowledge	Resilience is linked with several favourable outcomes, but its relationship with actual disease recovery is not fully understood, and evidence remains distributed across individual conditions rather than integrated.
Empirical	Few studies directly evaluate recovery outcomes; many examine adjustment, coping, quality of life, or mental health instead. Evidence is limited for some diseases and patient groups.
Methodological	Quantitative designs predominate, and designs, resilience instruments, and outcome measures vary. Many studies assess resilience at a single time point, so longitudinal evidence is limited.
Population and geographical	Studies are concentrated in a few countries, with little evidence from low- and middle-income countries, underrepresented groups, and regions such as South Asia, Africa, the Middle East, and South America.
Theoretical	Resilience is conceptualised inconsistently, as a personal trait or as a dynamic process, and the mediating psychological and social mechanisms are insufficiently explained.
Evidence	Study quality, populations, disease contexts, resilience measures, and outcomes vary, making it difficult to determine the extent and direction of the influence of resilience on recovery.
Practical	Little is known about how resilience-building interventions can be integrated into routine patient care or which interventions work.

IV. DISCUSSION

This review examined evidence on the relationship between psychological resilience and disease recovery across health conditions and patient populations. Overall, resilience was frequently associated with more favourable recovery-related outcomes, particularly quality of life, psychological well-being, coping, adaptation, and participation in disease management. The strength and nature of these associations differed by disease, population, measurement tool, and outcome assessed. Resilience therefore appears to be an important factor in recovery, but its relationship with recovery cannot be considered uniform across all diseases and outcomes.

One of the most consistent findings was the association between resilience and quality of life. Higher resilience was related to better health-related quality of life in COPD [2], to quality of life among middle-aged and older adults with chronic diseases, with sleep quality and depression contributing to the relationship [7], and, in insulin-treated type 2 diabetes, to a pathway involving diabetes distress, self-efficacy, and quality of life [5]. These findings suggest that resilience may be particularly relevant to how patients adapt psychologically and socially to long-term illness.

Resilience was also related to clinically important outcomes. Among patients with IBD, higher resilience was associated with lower disease activity, better quality of life, and fewer surgeries, and high resilience was observed in 27 percent of patients with ulcerative colitis and 21.5 percent of those with Crohn's disease [8]. The association should nevertheless be interpreted cautiously, because the presence of resilience does not demonstrate that resilience itself produces better clinical outcomes.

Evidence from cancer studies further supports the relevance of resilience during recovery from serious illness. A systematic review of patients with colorectal cancer related resilience to coping, hope, social support, and quality of life [16], and studies of breast and other cancer populations have highlighted resilience as a potential protective factor during treatment and rehabilitation [23], [25]. These findings suggest that resilience may help patients adapt to the emotional, physical, and social challenges of diagnosis and treatment.

Resilience was frequently examined alongside coping, self-efficacy, social support, psychological well-being, depression, sleep quality, and self-care. Relationships between resilience, activities of daily living, and well-being were identified in chronic kidney disease [6], and self-efficacy mediated the relationship between social support and resilience in patients recovering from stroke [12]. Resilience may therefore operate within a broader psychological and social process rather than as an isolated factor, with supportive relationships, confidence in managing illness, effective coping, and emotional adjustment shaping how it is expressed during recovery.

The literature also showed inconsistencies. In a four-year follow-up of 28 individuals with first-episode schizophrenia, 55 percent were fully or partly recovered, and those who recovered showed a greater increase in resilience [9]. In contrast, resilience was not independently associated with functional recovery after adjustment for clinical factors in acute ischemic stroke [13]. The relationship thus differs by disease and by how recovery is defined and measured, and resilience should not be interpreted as a universal predictor of every form of physical or functional recovery.

The bibliometric findings show expanding interest in the topic across chronic, oncological, neurological, cardiovascular, renal, metabolic, inflammatory, and COVID-19 related conditions. Research was concentrated in particular countries, led by China, followed by the United States and the United Kingdom. This may limit the applicability of findings to other cultural, social, and healthcare environments, because resilience can be influenced by social support systems, cultural expectations, healthcare access, economic circumstances, and community resources. Influential authors and journals came from

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nursing, psychology, psychiatry, medicine, oncology, geriatrics, and related disciplines, indicating an interdisciplinary field. The involvement of nursing journals is particularly relevant because nurses provide continuous physical, emotional, educational, and supportive care throughout recovery, although interdisciplinary contributions may also produce differing theoretical approaches and measurement practices.

The predominance of quantitative designs supports the measurement of associations but may leave patients' experiences of developing, maintaining, and using resilience less explored, and greater use of qualitative methods could deepen understanding of the individual and contextual factors involved. Taken together, the gaps in Table 2 show that the evidence is distributed across individual conditions, measured inconsistently, concentrated geographically, and weighted toward associations rather than interventions. Fewer studies examine whether resilience-focused interventions can be incorporated into clinical care and whether they produce measurable improvements in recovery.

V. LIMITATIONS OF THE STUDY

Several limitations should be considered when interpreting the findings. The 45 included studies varied widely in diseases, patient groups, settings, and stages of recovery, and disease recovery was not defined uniformly, with outcomes ranging from quality of life and disease activity to functional recovery and self-care. This limits direct comparison. Studies also used different resilience scales and conceptual frameworks that may capture different aspects of the construct, such as coping capacity, adaptation, emotional regulation, and personal strengths. Quantitative designs predominated, and cross-sectional and prospective designs differ in how relationships between resilience and recovery can be interpreted.

Geographical representation was uneven, and participant characteristics varied, so findings from one population cannot be assumed to apply to others. Most research examined associations rather than causal effects, and other variables such as social support, depression, coping, self-efficacy, disease severity, treatment factors, and socioeconomic circumstances may also influence recovery. The findings should therefore be understood as observed relationships rather than a direct causal effect of resilience on disease recovery.

The review did not use a formal critical-appraisal or risk-of-bias tool, so studies were not weighted by methodological quality. The sources also differed in type, comprising peer-reviewed primary studies, systematic and scoping reviews, a doctoral dissertation, and a preprint. The thematic radar analysis relied on an interpretive classification into five broad themes and reflects relative research emphasis rather than strength of evidence. Finally, restricting the review to English-language publications from 2016 to 2026 may have excluded relevant evidence.

VI. FUTURE RESEARCH DIRECTIONS

Future studies should extend to a broader range of diseases, patient groups, and healthcare settings that are currently less represented, particularly in South Asia, Africa, the Middle East, and South America, to test whether the observed relationships hold across clinical and cultural contexts. Clearer conceptual definitions and validated, consistently applied resilience measures are needed so that differences between studies reflect real differences rather than differences in measurement.

Longitudinal and prospective designs should assess resilience repeatedly to examine whether changes in resilience precede changes in recovery. Randomised controlled trials could test whether structured interventions, such as resilience-development programmes, counselling, coping-skills training, mindfulness-based interventions, and social-support programmes, strengthen resilience and improve recovery. Because resilience interventions and functional recovery were the least emphasised themes, trials should test resilience-building programmes against objective endpoints such as activities of daily living, physical function, and disease activity, reported alongside psychological outcomes.

Qualitative and mixed-methods research should explore how patients perceive, develop, and sustain resilience during illness. Studies should also examine whether social support, self-efficacy, coping, depression, sleep quality, and health behaviours act as mediators or moderators, and should consider cultural, social, and economic influences, including through cross-cultural validation of measures and interventions. Future systematic reviews should incorporate newly published studies, classify resilience measures and recovery outcomes more clearly, and consider meta-analysis where studies are sufficiently similar.

VII. CONCLUSION

This systematic literature review highlights the important role of psychological resilience in disease recovery. Individuals with greater resilience may be better able to cope with the psychological and emotional challenges of illness, and resilience is linked with positive coping, adjustment to illness, continued involvement in treatment and rehabilitation, and the ability to manage difficulties during recovery. It is shaped by personal, social, and environmental factors, including support from family and healthcare professionals, coping strategies, self-efficacy, and psychological well-being, which suggests that it can potentially be strengthened through appropriate support and interventions.

At the same time, differences in research methods, populations, measurement tools, and geographical representation make comparison across studies difficult, and some studies do not show an independent relationship between resilience and functional recovery. Further research using consistent measurement and longitudinal designs is needed to understand how resilience develops over time and

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how resilience-focused interventions influence recovery in different conditions and populations. Considering psychological resilience alongside physical treatment may help patients strengthen their coping abilities and adapt to the physical, psychological, and social challenges of illness.

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