Chapter 13
The Relationship Between Resilience and Motivation

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The word "resilience" comes from the Latin word "salire," which means to spring up and the word "resilire" which means to spring back. Resilience, therefore, refers to the capacity to spring back from a physical, emotional, financial, or social challenge. Being resilient indicates that the individual has the human ability to adapt in the face of tragedy, trauma, adversity, hardship, and ongoing significant life stressors (Newman 2005). Resilient individuals tend to manifest adaptive behavior, especially with regard to social functioning, morale, and somatic health (Wagnild and Young 1993), and are less likely to succumb to illness (Caplan 1990; O'Connell and Mayo 1998). Resilience, as a component of the individual's personality, develops and changes over time through ongoing experiences with the physical and social environment (Glantz and Johnson 1999; Hegney et al. 2007). Resilience can, therefore, be perceived as a dynamic process that is influenced by life events and challenges (Grotberg 2003; Hardy et al. 2002, 2004). Increasingly, there is evidence that resilience is related to motivation, specifically the motivation to age successfully (Harris 2008) and recover from physical or psychological traumatic events (Charmey 2004; Chow et al. 2007; Sanders et al. 2008).

Older women who have successfully recovered from orthopedic or other stressful events describe themselves as resilient and determined (Resnick et al. 2005; Travis and McAuley 1998) and tend to have better function, mood, and quality of life than those who are less resilient (Hardy et al. 2004). Resilience has also been associated with adjustments following the diagnosis of dementia (Harris 2008), widowhood (Rossi et al. 2007), management of chronic pain (Karoly and Ruehlman 2006), and overall adjustment to the stressors associated with aging (Ong et al. 2006).

Types of Resilience

Resilience has been differentiated into health resilience (Sanders et al. 2008), psychological resilience (Boardman et al. 2008), emotional resilience (Chow et al. 2007), and dispositional resilience (Rossi et al. 2007). Health resilience is the capacity to

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maintain good health in the face of significant adversity. Psychological resilience is focused on being able to maintain a positive affect regardless of the situation. Emotional resilience is described as the ability to maintain the separation between positive and negative emotion in times of stress. Dispositional resilience incorporates three personality characteristics including commitment to others, a sense of control over outcomes, and a willingness to learn from the current situation. All of these different types of resilience reflect being able to maintain a positive attitude and endure through any variety of health related, emotional, or social challenges. Moreover, it is anticipated that resilience translates across areas of physical and mental health.

Factors that Influence Resilience

Many factors or qualities within individuals have been associated with resilience (Table 13.1). These include such things as positive interpersonal relationships, incorporating social connectedness with a willingness to extend oneself to others, strong internal resources, having an optimistic or positive affect, keeping things in perspective, setting goals and taking steps to achieve those goals, high self-esteem, high self-efficacy, determination, and spirituality which includes purpose of life, religiousness or a belief in a higher power, creativity, humor, and a sense of curiosity (Boardman et al. 2008; Bonanno et al. 2007; Hegney et al. 2007; Kinsel 2005; Tedeschi and Kilmer 2005).

Positive Interpersonal Relationships

Interpersonal relationships include interactions with a network of family, friends, colleagues, and other acquaintances for enjoyment, or to provide psychological or physical assistance for in return. Involvement in interpersonal relationships and activities, whether receiving or giving the help, serves as a psychological buffer

Table 13.1 Resilient qualities or traits commonly noted in older adults

Positive interpersonal relationships
Strong self-efficacy
Positive self-esteem
A sense of purpose
Spirituality
Ability to use humor
Creativity
Acceptance of changes (physical and mental)
Maintaining a positive attitude
Ability to identify and utilize resources
Self-determination
Optimism

against stress, anxiety, or depression which commonly occurs with aging. Interpersonal activities also help individuals cope with losses, maintain a sense of belonging, and strengthen self-esteem and self-efficacy.

Strong Internal Resources: Self-Efficacy, Self-Esteem, Determination, Problem Solving

Self-efficacy, which is described in detail below, is the belief in one's ability to organize and execute a course of action to achieve a specific outcome, and is thereby relevant to resilience. Different than self-efficacy, self-esteem is reflective of one's appraisal of his or her self-worth. Individuals who have a positive self-worth, accept and like themselves, and refrain from being "too hard on themselves" tend to be resilient and psychologically successful (Byles and Pachana 2006). The ability to accept oneself is particularly important in aging due to the many physical and mental changes that can occur, as well as the role losses. With age, for example, the older individual may note impairments in his or her ability to go up the stairs, carry grocery bags, complete a crossword puzzle, or remember how to get to a daughter's home. These changes can be devastating unless one has the resilience to accept the change and appreciate what he or she is still able to do. Self-esteem need not, however, decline with age despite the commonly experienced physical and mental changes that occur such as declines in strength and memory. Rather, self-esteem can be strengthened by helping older adults to recall prior successes and by exposing them to situations in which they can exceed and excel.

Determination, or hardiness, which may in part be a personality trait, can be strengthened by helping the older individual to focus on his or her abilities, current opportunities, and use of resources. Determined individuals tend to be more confident in their ability to cope and to take advantage of the resources, internal and external, that help them to adjust, accept, and cope with the challenges encountered in life. Strengthening determination and hardiness can be done by helping the individual to problem solve and stay focused on the positive rather than the negative – the "I can" versus "I can't" perspective. It is also helpful to remind the older adult how he or she handled stressful situations in the past and re-invigorate those prior strengths and abilities.

Optimism, Positivism, and Keeping Things in Perspective

Repeatedly it has been noted that focusing on positive outcomes and avoiding a focus on negative facts is critical to resilience (Greene and Graham 2009; Harris 2008). Positive emotions and the use of humor are recommended as a way to help eliminate, or cancel out, the impact of negative emotions. Older adults can be helped to manage negative emotions and negativism in the face of challenges, and to stay focused on positive events and feelings that may be occurring at the same time.

Spirituality

Spirituality, considered broadly, includes a sense of self and purpose, creativity, humor, and a curiosity and willingness to learn and experience new things. With regard to resilience spirituality is conceptualized more broadly. Spirituality includes establishing a sense of connection to others and a purpose. Spiritual activities that are reflective of resilience include such things as marching for world peace, exploring creative endeavors and taking art classes, and trying new activities (e.g, learning to play an instrument or speak a foreign language).

Motivation

Motivation, as previously described, is based on an inner urge rather than stimulated in response to adversity or challenge. Motivation refers to the need, drive, or desire to act in a certain way to achieve a certain end. Motivation is different from compliance in that compliance refers to doing what others want or ask rather than being truly motivated and driven by an inner desire. Ideally, health care providers want older adults to be motivated to comply with behaviors that are known to be effective in preventing disease and disability and improving overall health and quality of life.

Motivation is generally behavior or activity specific. An older adult may be motivated to spend the day lying in bed or to engage in physical activity, to learn a new language or creative skill, to take a prescribed medication or to skip the medication. Motivation has been conceptualized as a uni-dimensional concept focused on intrinsic personality components as well as a multidimensional concept that is influenced by many variables both intrinsic and extrinsic to the individual. The extrinsic factors include such things as social interactions with friends, family, and health care providers and the environment.

Factors that Influence Motivation

To comprehensively consider the many factors that influence motivation in older adults it is helpful to use a model of motivation (Fig. 13.1). As with resilience, these factors include traits of the individual as well as external resources that can be used to strengthen motivation in any given area. This model is based on social cognitive theory as well as empirical findings (Albright et al. 2005; Damush et al. 2005; Netz and Raviv 2004; Wilcox et al. 2005). According to social cognitive theory (Bandura 1997), human motivation and action are regulated by forethought. This cognitive control of behavior is based on two types of expectations: (1) self-efficacy expectations, which are the individuals' beliefs in their capabilities to perform a course of action to attain a desired outcome and (2) outcome expectancies, which are the beliefs that a certain consequence will be produced by personal action.

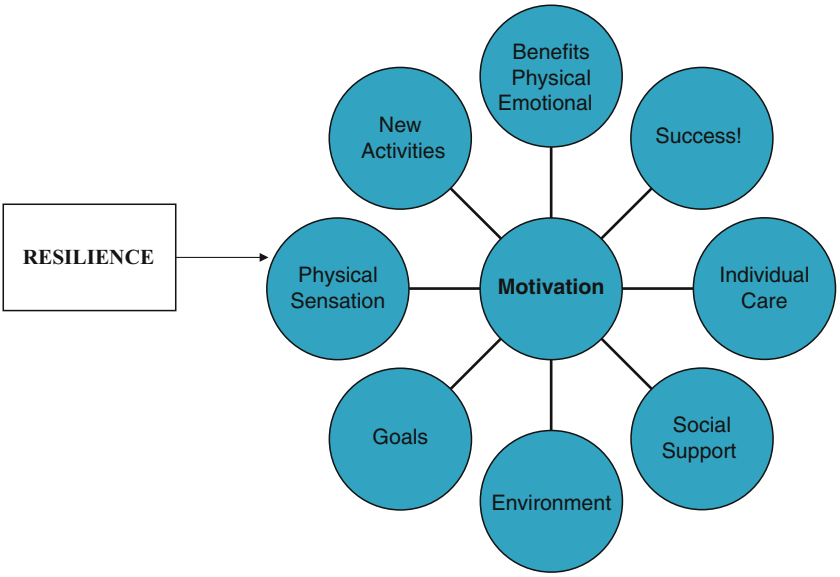

Fig. 13.1 A model of motivation and the relationship between resilience and motivation

Beliefs, both in relationship to outcomes (outcome expectations) and with regard to what older adults believe they are capable of doing (self-efficacy expectations), have been noted to influence motivation to engage in health promoting behaviors (Dohnke et al. 2005; McAuley et al. 2006; Resnick et al. 2008c). The benefits experienced by the individual such as improvement in blood pressure, ability to walk a longer distance without getting short of breath, or the improvement in mood associated with physical activity or adherence to a medication are critical to motivation in older adults. Pleasant or unpleasant physical sensations experienced by older adults are particularly relevant to motivation as with age there is a tendency to focus on immediate benefits (e.g., feeling good after exercising) associated with a behavior rather than remaining motivated to engage in the behavior for a long-term benefit (e.g., weight loss, decreased cardiovascular disease). Conversely, pain associated with an activity such as walking or climbing the stairs, or the belief that performing these activities will result in pain, will decrease the older adults motivation to engage in the activity. Alternating these beliefs and/or eliminating the negative sensations associated with the activity are critical to strengthening motivation and engaging the individual in the given activity.

Successful completion of an activity, particularly if this is done without experiencing unpleasant sensations, is one of the most effective ways to strengthen older adults' beliefs in their ability to perform the behavior and thereby increase motivation to continue to engage in the behavior. Being able, for example, to walk for 30 min or complete a dance class will increase the likelihood that the individual will return to the class another time and continue to engage in the activity.

Enhancing Motivation

Individualized care and demonstrating caring has an important influence on the older adults' motivation to perform a given activity. Individualized care includes recognizing individual differences and needs, using kindness and humor, empowering older adults to take an active part in their care, providing gentle verbal persuasion to perform an activity, positive reinforcement after performing (Resnick et al. 2006b, 2008a; Wilcox et al. 2005), and knowing when to confront the individual about his or her harmful health behaviors (e.g., not taking prophylactic medication or engaging in regular activity). An essential component of individualized care is letting the individual know *exactly* what it is recommended. This may be simple written instructions about what exercise program to engage in or what medication to take, why it is important, and exactly how the activity should be done or the medication should be taken. At each care interaction, it is critical to re-evaluate how the individual is doing with the behavior of interest. Checking with the individual and re-evaluating progress demonstrates that the provider cares about whether or not the activity is performed. Individualized care may initially be effective because the older adult simply wants to reciprocate for the care given to him or her by doing what the health care provider or family member requests (e.g., doing a certain exercise). Once the behavior is initiated, however, it is likely that the older individual will experience the benefit(s) associated with the behavior and thus continue to adhere for reasons beyond initial reciprocity for care received.

Social support networks including family, friends, peers, and health care providers are important determinants of behavior (Jackson 2006; Kim and Sobal 2004; Thrasher et al. 2004). Repeatedly, motivation to exercise, for example, has been found to be influenced by the social milieu of the individual and/or the care setting. Social interactions can alter recovery trajectories by disrupting the progression of functional limitations to disability. The influence of any member of the individual's social network, however, can have a positive or negative influence depending on his/her philosophy and beliefs related to activity of interest. Social supports can directly serve as powerful external motivators by (1) providing encouragement; (2) helping the older adult feel cared for and cared about; and (3) helping to establish goals such as regaining self-care abilities, and being able to return home alone. Social supports can also indirectly impact motivation by strengthening the individual's beliefs in his or her ability to participate in rehabilitation activities, for example, or engaging in a regular exercise program.

The environment can also influence motivation. Environments that offer opportunities for physical activity (e.g., parks or wide open clutter free hallways), access to staircases, or heart healthy food options can increase motivation to adhere to the recommended activity (Booth et al. 2000). The ability to develop personal goals and evaluate one's performance toward that goal can influence motivation to engage in a given behavior (Bandura 1997). Articulated goals give older adults something to work toward, and help motivate them to adhere to a specific health promoting activity. Short-term goals provide the older individual with exactly what he or she should do on a daily basis (e.g., walk for 20 min; do ten sit to stands). Long-term goals focus on what the individual wants to achieve such as being able to ambulate without an assistive

device, being able to care for oneself, being able to walk to the grocery store, or to go on a trip. Goals are most effective when they are (1) related to a specific behavior; (2) challenging, but realistically attainable; and (3) achievable in the near future (Bandura 1997).

Exposure to new and different activities, such as Tai Chi classes or creative art classes, tends to motivate older adults to adhere to these classes and be willing to expand and try additional new activities (Resnick et al. 2005). Lastly, the individual's personality and self-determination have an important influence on motivation. Older adults report that it is their own personality, that is, determination, and their own firm resolutions and adherence to those resolutions, that motivates them to perform specific tasks (King et al. 1992).

Relationship Between Motivation and Resilience

Similarities Between Motivation and Resilience

There are some similar factors that are associated with both resilience and motivation such as determination, self-efficacy, being open and willing to experience new things, and social supports. The capacity to be resilient and/or motivated is present in everyone and choices are made in the face of routine and challenging situations to be motivated and/or resilient. Motivation related to engaging in physical activities is high in some people while others are highly motivated to sit in a chair or lie in a bed. Conversely, some older adults are motivated to take classes in a senior center while others refuse to even consider this and are motivated to sit daily and watch television alone. Some individuals are resilient with regard to physical challenges but cannot cope with challenges associated with finances or cognitive changes. Both resilience and motivation can be strengthened through appropriate interventions and exposure to life experiences. Strengthening factors that influence motivation and resilience such as self-efficacy, self-esteem, positive relationships with others, sense of purpose, and learning to keep things in perspective are all ways in which older adults can strengthen motivation and resilience (Bandura 1997; Newman 2005; Tedeschi and Kilmer 2005). Thus, there are traits and characteristics of individuals associated with resilience and motivation as well as external factors that can impact resilience and motivation as individuals respond to challenges or activities within their lives.

Differences Between Motivation and Resilience

Resilience, unlike motivation, relies on the individual experiencing a life challenge or some type of adversity. These challenges may be developmental challenges such as those associated with normal aging (e.g., vision changes), or they maybe social

and/or economic challenges such as those experienced by the loss of employment, the loss of a spouse, or a move into an assisted living facility. Conversely, motivation is not dependent on an adverse event or challenge; rather motivation is a necessary component for all activity. Routine personal care activities such as bathing and dressing require motivation, as do making plans to have dinner with a friend or play cards. Resilience would be required, however, when the individual is faced with bathing and dressing challenges following a wrist fracture. It is only when an activity does not occur that questions are raised as to the level of motivation of the individual. Resilience is a process of coping with stressors, adversity, change, or opportunity. The individual is forced to pass through stages of biopsychospiritual homeostasis (i.e., adaptation physically, mentally, and spiritually to a set of circumstances), disruption, and finally reintegration. Resilience, or successful reintegration, involves coping with the adversity such that there is personal growth, an increase in knowledge and self-understanding, and an increased strength of his or her resilient qualities. Unfortunately, resilient reintegration does not always occur. Some individuals may recover from a challenge with a permanent loss, such as the loss of function due to a stroke. These individuals may give up hope of recovery and may not return to a state of optimal homeostasis. There is also the possibility that dysfunctional reintegration will occur and the individual might resort to use of alcohol or other destructive behaviors, become depressed, and isolate him or herself as a way to cope with the challenge.

Interaction of Motivation and Resilience

The current work in resilience theory and understanding of this concept is focused on the individuals' response to challenges and the use of resilience. It is believed that all individuals have the innate ability to return to homeostasis successfully and to transform, change, and grow, regardless of age (Werner and Smith 1992). The individual must summon the motivation, in the face of adversity, to be resilient. Thus, motivation may be present independent of resilience, but resilience depends on the individual being motivated to successfully reintegrate. Resilient reintegration requires increased energy, or motivation, for resilience to successfully occur.

Empirical Evidence of the Relationship Between Motivation and Resilience

Prior research has repeatedly demonstrated that resilience, or the factors that are reflective of resilience such as vitality and extraversion, were predictive of the factors that are generally conceptualized as indicative of motivation such as self-efficacy, physical activity, and active coping (Engel et al. 2004; Fredrickson 2001; Ingledew et al. 2004). Moreover, there is evidence that motivation serves as a mediator for resilience in older adults. As part of the KNEE study (Wright et al.

2008), a longitudinal intervention study aimed at reducing levels of pain and disability in a sample of community dwelling older adults with knee osteoarthritis, participants completed a comprehensive baseline survey including multiple psychosocial measures such as negative and positive affect, self-efficacy, and health status, as well as reports of physical activity. The sample included 275 older adults with degenerative joint disease. Resilience was conceptualized in this study as positive affect, vitality, and extraversion. Motivation was conceptualized as self-efficacy and measured using the arthritis self-efficacy scale which addresses self-efficacy for function, pain management, and the ability to control other arthritis symptoms. The relationship between resilience, motivation, and physical activity was tested using structural equation modeling. As hypothesized, resilience was mediated by self-efficacy and thus resilience was indirectly related to function through self-efficacy.

In a study that included 163 older adults living in a continuing care retirement community, the mediating effects of motivation on resilience and the impact of motivation and resilience on physical activity were also tested (Resnick and D'Adamo manuscript submitted). Data were collected for this study as part of an annual health promotion survey and residents completed interviews that included measures of physical activity (Dipietro et al. 1993), self-efficacy related to physical activity (Resnick and Jenkins 2000), and the 14-item Resilience Scale (Wagnild 2009). As demonstrated in the KNEE study, the relationship between resilience and physical activity was mediated by self-efficacy (Resnick and D'Adamo manuscript submitted).

These studies provide some empirical support for the premise that resiliency is present in everyone but when faced with a challenge, at least a physical or functional challenge, motivation is needed so that physical recovery or predetermined goals (e.g., being able to walk a certain distance) can be achieved. Both resiliency and motivation are necessary for optimal recovery to occur. Understanding the similarities and differences between these two concepts and their relationships provides important background for the development of appropriate interventions to innervate resilience and strengthen motivation and thereby improve recovery across a variety of clinical situations.

Practical Applications of Resilience

Assessment of Resilience

Increasingly resilience is believed to be a human ability that can be developed over time. Older adults, by virtue of surviving through decades of life experiences, tend to be resilient (Nygren et al. 2005). These individuals have lived through losses including physical changes such as declines in vision, hearing, or physical abilities, social losses such as loss of parents, siblings, spouses, and in some cases children, and role-related losses. Although they may not have been successfully resilient in

all of these experiences, they have accrued some positive experiences in which they were resilient and motivated and thus recovered from the challenge experienced. Thus, when working with older adults it is particularly helpful to explore prior challenges and establish strengths with regard to recovery that suggest resilience and motivation.

Talking with individuals about past experiences may be the most comprehensive way to establish prior evidence of resilience. However, the stories provided may be difficult to interpret. As an alternative to a qualitative assessment of resilience, scales reflecting individual correlates of resilience such as self-efficacy, coping, optimism, vitality, or self-esteem can be utilized. Table 13.2 provides examples of

Table 13.2 Measures of resilience used among older adults

Measure	Description
The 25- and 14-item Resilience Scale (Wagnild and Young 1993)	The 25- and 14-item Resilience Scale was developed as a general measure of resilience for adults across the lifespan. Initially, the measure included 25 items reflecting five interrelated components that constitute resilience: Equanimity reflecting the ability to "go with the flow"; perseverance or determination; self-reliance reflecting a belief in one's ability to manage; meaningfulness or a belief that life has meaning; and existential aloneness or a sense of uniqueness. Participants respond by either agreeing or disagreeing with the statements on a scale of 1 (disagree) to 7 (agree). The responses are summed and a higher score reflects stronger resilience. Prior research has demonstrated evidence of internal consistency (alpha coefficient of 0.91), test–retest reliability, and construct validity of the measure based on a significant correlation between resilience and life satisfaction, morale, and depression when used with older adults (Wagnild and Young 1993)
The Resilience Scale (Hardy et al. 2004)	To complete the resilience scale participants identify the most stressful life event they experienced in the past 5 years and respond to a series of nine questions about their response to that event. There was evidence of internal consistency with an alpha coefficient of 0.70, and test–retest r eliability with an intraclass correlation of coefficient of 0.57. Validity was based on a significant correlation between resilience and having few depressive symptoms, and good to excellent self-rate(d?) health (Hardy et al. 2004).
Dispositional Resilience Scale (DRS) (Rossi et al. 2007; Friborg et al. 1997)	The DRS is a 45-item questionnaire that includes 15 commitment, 15 control, and 15 challenge items. There is a 4-point scale response used to rate participant agreement with items ranging from 1 (completely true) to 4 (not at all true). A total dispositional resilience score is created based on responses. The original DRS was modified to be appropriate for older adults (Rossi et al. 2007). There was evidence of internal consistency with an alpha of 0.83, and validity based on a statistically significant relationship between sense of coherence and Hopkins symptom checklist, and a statistically significant difference in Dispositional Resilience among patients and healthy volunteers (Friborg et al. 1997)

some of the more commonly used measures reflective of resilience. In addition, there are several measures that address different aspects of resilience including dispositional resilience, physical resilience, psychological resilience, or a measure of general resilience. These measures can be completed during a clinical assessment of a patient to gain insight as to the strength of his or her resilience.

Interventions to Strengthen Resilience

Interventions to stimulate and build resilience are focused in three areas: (1) developing disposition attributes of the individual such as vigor, optimism, and physical robustness; (2) improving socialization practices; and (3) strengthening self-efficacy, self-esteem, and motivation through interpersonal interactions as well as experiences.

These three areas are not necessarily mutually exclusive and the interventions that can strengthen physical robustness may improve socialization practices and strengthen self-efficacy. For example, encouraging an older adult to participate in a dance class because he or she enjoys dance and has previously excelled in this activity may also increase socialization and strengthen self-efficacy and self-esteem.

It is important not to oversimplify interventions to strengthen resilience or ignore the larger context in which the individual lives. For example, recommending participation in a dance class for an individual who lives in a community in which such activity is considered frivolous or an insufficient source of physical activity may result in decreasing self-esteem and can have a negative impact on resilience. Thus, multifaceted approaches to optimizing resilience are needed. Risk-oriented strategies should be considered with all interventions to help assure that older adults are not exposed to experiences that might decrease resilience. Environmental interventions such as chairs, beds, and toilets that facilitate successful transfers are needed to assure that resilience is not undermined. Social networking systems that help disseminate opportunities for successful activities and increase reach to older adults are likewise important and useful interventions to consider when trying to strengthen resilience. The Strength-Focused and Meaning-Oriented Approach to Resilience and Transformation (SMART) Intervention (Chan et al. 2006) is another example of a multifaceted approach to strengthen resilience in response to trauma that incorporated Eastern spiritual teaching, physical techniques such as yoga, and psycho-education that promoted meaning reconstruction.

Interventions to Strengthen Motivation

Motivation is necessary for resilience to be activated following a challenge. Although it may be difficult to motivate older adults to engage in certain activities (e.g., exercise, medication adherence), there is evidence to support that interventions, particularly

those based on the theory of self-efficacy, are effective (King et al. 2007; Resnick et al. 2007, 2008b). Likewise, effective interventions include those that are guided by a social ecological model (Fleury and Lee 2006; Gregson et al. 2003) which considers intrapersonal, interpersonal, environmental factors and policy.

Table 13.3 describes specific interventions that can be used to motivate older adults to engage in specific activities. First and foremost, it is critical to establish whose motives are being addressed in the motivational interaction. If goals are established without the input of the older individual it is not likely he or she will be willing to participate in the activities needed to achieve the goal. For individuals who are cognitively impaired and cannot articulate goals, it is useful to review old records and speak with families, friends, and caregivers who have known the individual previously. Goals can then be developed based on their prior life and accomplishments (Galik et al. 2008). Further it is important that the goals established be realistic and achievable so as to assure feelings of success.

Demonstrations of caring on the part of the interventionist are central to motivating older adults. Care can be demonstrated by behaviors and activities perceived by the individual as expressions of love, attention, concern, respect, and support (Boynton and Boynton 2005; Resnick et al. 2005). Another important aspect of caring is setting some guidelines or limits with regard to behaviors. This does not relate to punishment or threats. Rather, it is focused on being firm and informing the individual of the activity they need to do and why they need to do it. For example, an older individual may need to get up and walk to the bathroom to prevent skin breakdown, optimize continence, and regain strength and function.

Examining the setting in which behaviors are expected to occur is also important to motivation. Simple interventions such as eliminating background noise and speaking slow, low, and loud can help with the communication that is needed between an older adult and the interventionist. Altering the physical environment so that the older individual can perform successfully is an important first step in motivation. Continued alteration in the environment maybe needed, however, to assure that physically the individual is challenged in such a way as to optimize function and provide the ongoing goals for motivation. For example, initially motivating an older adult to be independent with toileting might mean putting a commode chair right by the bedside. Once successful, the distance between the bed and commode could be extended with an ultimate goal being to walk all the way to the bathroom.

Addressing outcome expectations associated with an activity, particularly the immediate unpleasant sensation that may be occurring is critical to motivation in older adults. Sensations such as fear of falling or fear of exacerbating underlying medical problems, pain, and shortness of breath or fatigue associated with an activity are likely to decrease motivation to engage in the activity. Interventions to overcome these sensations such as graded activity or graded exposure treatments (Jong et al. 2005; George et al. 2008) have been shown to increase individuals' willingness to persist with an exercise program. Graded activity starts by finding out how much activity the individual can do before the unpleasant sensation occurs (e.g., pain or fear). The training starts at that level of exercise or activity. The individual is

Table 13.3 Interventions to strengthen motivation

Focus of intervention	Examples of intervention techniques
Beliefs	Interventions to strengthen efficacy beliefs are as follows: 1. Verbal encouragement of capability to perform 2. Expose older adult to role models (similar to others who successfully perform the activity) 3. Decrease unpleasant sensations associated with the activity 4. Encourage actual performance/practice of the activity 5. Educate about the benefits of the behavior and reinforce and underline those benefits 6. Teach realistic beliefs 7. Relate behavior to outcomes (e.g., exercise reduces blood pressure and causes weight loss)
Elimination of unpleasant sensations (e.g., pain, fear)	1. Facilitate appropriate use of pain medications to relieve discomfort 2. Use alternative measures such as heat/ice to relieve pain associated with the activity 3. Cognitive behavioral therapy: (a) Explore thoughts and feelings related to sensations (b) Help patient develop a more realistic attitude to the pain, that is, pain will not cause further bone damage (c) Relaxation and distraction techniques (d) Graded exposure to overcome fear of falling
Individualized care	1. Demonstrating kindness and caring to the patient 2. Use of humor 3. Positive reinforcement following a desired behavior 4. Recognition of individual needs and differences such as setting a rest period or providing a favorite snack 5. Clearly and simply write out/inform patient of what activity is recommended
Social supports	1. Evaluate the presence and adequacy of social network 2. Teach significant other(s) to verbally encourage/reinforce the desired behavior 3. Use social supports as a source of goal identification
Goal identification	1. Develop appropriate realistic goals with the older adult 2. Set goals that can be met in a short time frame (daily or weekly) as well as a long range goal to work toward 3. Set goals that are challenging but attainable 4. Set goals that are clear and specific 5. Identify and use rewards that have meaning to the individual
Successful performance	1. Review prior times challenges overcome and skills and techniques utilized 2. Expose the individual to activities in which he or she can be successful 3. Continue to build challenges into the activity so that new successes can be incorporated

guided in a way that will help build tolerance to the unpleasant sensation by slowly increasing duration, intensity, and frequency of the exercise or activity that was noted to cause the pain or the fear. In contrast, graded exposure treatment involves presenting the individual with anxiety-producing material (e.g., having him or her engage in an activity that causes pain) for a long enough time to decrease the intensity of their emotional reaction. Ultimately, the feared situation no longer results in the individual becoming anxious or avoiding the activity.

Managing Apathy

Apathy or a lack of interest, concern, or emotion has been conceptualized as the opposite of motivation (Marin 1991). Although not pervasive among all older adults, apathy is common particularly among those with dementia and depression (Marin 1991). Interventions include the use of pharmacological agents including amantadine, amphetamine, bromocriptine, bupropion, methylphenidate, and selegiline (Marin et al. 1995), cholinesterase inhibitors (Whyte et al. 2008), and selective serontonic reuptake inhibitors (Padala et al. 2007), and focus on structure and stimulation such that the individual is encouraged to engage in activities that he or she can easily do successfully. It may be necessary to persistently encourage and actually accompany the apathetic individual to an activity and provide one-on-one encouragement to keep them engaged.

Conclusion

Resilience and motivation are related but separate concepts and together serve as keys to successful aging. Resilience emphasizes the older individual's capacity to respond to a challenge or adversity and motivation provides the impetus to engage in the behaviors needed to recover. A focus on resilience and motivation is an innovative way to optimize aging and buffer many physical and psychosocial losses. Helping older adults sustain their resilient characteristics and implementing motivational intervention in times of physical, emotional, social, or economic crises can result in helping the individual through the challenging situation and facilitating personal growth beyond the immediate event through the posttraumatic or postchallenge period.

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