Chapter 4
What Do We Know About Resilience in Older Adults? An Exploration of Some Facts, Factors, and Facets

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Introduction

As the field of gerontology has become better established and developed more historical perspective and interdisciplinary depth, we can note a progression in thinking about concepts and theories of aging, what the experience of getting older means, and how it can be shaped as a process (e.g. Bengtson et al. 2008). Conceptual theses generate antitheses resulting in syntheses and new directions for research. So it is with the development of the concept of resilience with respect to older adults. Just as early research characterizing "normal" aging led to the excitement and enthusiasm surrounding the concept of "successful" aging, so, too, has this latter concept given way to the more recent concept of "resilience" in aging.

Similarly, conceptualizing the concept itself has presented unique potentials and pitfalls, as has been examined in the earlier chapters in this handbook. Is resilience a personality trait, a process, or both? Is it a single trait or actually part of a larger constellation of related personal characteristics? Does it remain constant or change over time? Seeking answers to these questions is both complicated and facilitated by the use of different disciplines and research methodologies to study the concept of resilience. This research effort has recently generated statements about the pressing need to deconstruct the essence of resilience and "interrogate the social, cultural, and economic dimensions that shape it" (Becker and Newsom 2005, 221).

As mentioned, in this context it is interesting to note how the early and subsequent articulation of the concept of "successful aging" (Rowe and Kahn 1987, 1997) gave way to criticism of its highly individualistic biases and disregard of the broader social, economic, political, and environmental dimensions and determinants of health in old age (Holstein and Minkler 2003). Some researchers now suggest that resilience might be a preferable concept to the more well-established one of successful aging, because it represents a more reasonable and attainable goal for most older adults (Hildon et al. 2010). The biopsychosocial approach to research

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on successful aging suggested by Inui (2003) includes studies of resilience and generativity.

Additionally, factors that influence or are, in turn, affected by resilience are also subjects for study and research. For example, what is the relationship between resilience and psychological well-being, physical health, social support, and economic resources? Additionally, how is our interpretation of resilience shaped by our understanding of factors both internal and external to the individual, as studied by different research traditions in gerontology (e.g. qualitative vs. quantitative)? It has been said that, "we don't see things as they are; we see things as we are" [Anaïs Nin, as cited in Baldwin (2000, xii)], and so it is with the concept of resilience and its interrelated facets.

The purpose of this chapter is to provide a framework for sorting out these complex and sometimes conflicting relationships, in a way that both broadens and deepens our understanding of the factors associated with resilience and its importance for older adults. In particular, we employ an interdisciplinary approach, highlighting the important contributions that different fields of study make to an understanding of the facts, factors, and facets surrounding this emerging concept. If, as suggested above, "we see things as we are," then differing views and perspectives are needed to assemble a complete and accurate understanding of any multifaceted and multidimensional concept.

Developing a Metaphor

Thinking metaphorically can be helpful in furthering our understanding of, and insights into, complex and complicated concepts. A metaphorical representation can provide new avenues of understanding to guide both research and application. Metaphor-based approaches may be particularly useful in gerontology, shedding new light on interdisciplinary correlations and connections (Kenyon et al. 1991).

Buffers of Old Age

Early research on resilience as a general concept suggested that it be thought of as a "buffer" between adversity and negative outcomes (Rutter 1987), a term that had already been used previously in epidemiological research in gerontology to interpret some significant health-related outcomes from the involuntary relocation of older adults in the community (Kasl et al. 1980; Ostfeld 1985). In this research, the "buffers of old age" included such external factors as social support (having a child living within a 50-mile radius) and internal factors as life meaning (having a sense of oneself as a religious person).

The concept of "buffers of old age" has reappeared again more recently in the gerontological literature (e.g. Wagnild 2003; Wagnild and Young 1993; Windle

et al. 2008) to describe protective factors that seem to mediate between stressful or adverse events and consequent behaviors or protective responses. This concept may be considered to capture both "intrinsic" factors, such as personality traits of flexibility, and "extrinsic" elements, such as social support. In terms based on Bourdieu's (1986) capital framework, resilience includes elements of both human capital (i.e. resources within the person) and social capital (e.g. social networks and support) that can be used to convert resources into adaptive responses (Harris 2008; Netuveli et al. 2008).

Resilience Repertoire

The metaphor we would like to propose in this chapter as a framework for exploring factors related to resilience in older adults is that of a "resilience repertoire," i.e. a supply of skills and resources that can be used to moderate "the bad things that happen" in the lives of older adults to reduce or blunt the negative consequences of those events, or even in some cases to lead to positive growth and development (Hardy et al. 2002). Individuals may have a variety of factors or elements in their repertoire and use them in differing ways at different times and in varying circumstances. There is thus a contextual and dynamic aspect to resilience over time and across an individual's lifespan (Kinsel 2005).

In addition, there can be cumulative or additive effects involved, such as when adverse events or challenges become compounded or chronic and create a greater element of risk for negative outcomes (Hildon et al. 2008). As Netuveli et al. (2008) suggest, "The resilient [are] ordinary people, without superpowers, as indicated by the fact that as adversities add up the probability of resilience decreases; resilience does not imply invulnerability" (p. 990).

Finally, there is a dimension to resilience suggesting that one's repertoire is a part of their life story or personal narrative, a theme of growing importance and relevance in gerontology generally (Birren et al. 1996; Kenyon et al. 2001, 2010). In this instance, the meaning assigned by individuals to life events and adversity, and how this meaning is incorporated into their ongoing development of self-identity to maintain constancy and continuity across their lifespan, can itself become a resource in the face of life's adversity (Collins and Smyer 2005; Hildon et al. 2010). As Windle et al. (2008) point out in the area of psychological resilience, such divergent theorists of aging as Erikson et al. (1986) and Kaufman (1986) both underscore the importance of the continuing development of the self across the life span and the emergence of life themes and wisdom as a key component of resilience in old age.

Meaning in life has been identified as an important dimension of resilience among adults and older adults in several studies. For example, Heisel and Flett (2008) identified perceived meaning in life as a factor related to resilience, and found that it explained significant variation in suicide ideation over and above physical and mental health problems. Having meaning and meaningful relationships

was identified as a theme in an exploratory study of resilience among adults who have experienced mental illness (Edward et al. 2009). Meaning-making was also found to be essential to resilience in Greene and Graham's (2009) study of Nazi Holocaust survivors, and in Gosselink and Myllykangas' (2007) research on older women living with HIV/AIDS. Overcoming loneliness through maintaining connections to others was found to be key to resilience for older widowers after the death of their spouses (Crummy 2002). Taken together, these studies support the earlier work by Burbank (1992) that meaning in life – especially meaning in relationships with others, spirituality, and activities – is key to health and resilience.

Research on the related and earlier concept of "stamina" by Colerick (1985) reinforces the importance of understanding an older individual's life history and how adversity has been addressed previously and incorporated into current experience. In this research, stamina is characterized by five different dimensions, based on the analysis of extensive interview data: (1) capacity for growth, (2) personal insight, (3) life perspective, (4) likelihood of functional breakdown, and (5) general competence. Both good physical health over the entire life history and greater levels of educational attainment were related to higher stamina. These findings are significant, because they emphasize the need for a life course perspective on resilience and suggest the possibility of a resilience "trajectory" in old age based on previous experiences of coping with challenges in one's life. Cumulatively, these life experiences may enrich and enhance one's repertoire for dealing with continued adversity as one grows older and faces the likelihood of increasing losses associated with advancing age.

These aspects of the "resilience repertoire" can be used as a conceptual framework for understanding the factors linked by research to an understanding of the adaptive responses to adversity that may help to protect adults from some of the losses and challenges of growing older.

Stressors and Adversities

Perhaps not unexpectedly, the research on resilience seems to emphasize the responses by older adults to life events more than the specific, in-depth understanding of the dimensions of these events themselves. This may not be surprising, given the fact that research on stress has suggested that it is not so much the event itself that may be stressful, as the meaning or significance of the event to the individual and the larger context in which it occurs (Hardy et al. 2002; Masuda and Holmes 1978).

Ryff et al. (1998) have suggested that resilience in later life be focused on the potential of older adults to maintain their mental health in the face of threat or risk. Some gerontological research has specifically been directed toward determining the types of adversities that can be expected with increasing age and that therefore may serve as the basis for stressors. For example, Hildon et al. (2008) suggest that "adversity [centers] on limited circumstances and opportunities brought about by physical, mental, or social losses" (p. 737), which are most often related to

the death or illness of a loved one, one's own poor health, or circumstances in retirement. They also propose a temporal dimension to understanding adversity, and recommend capturing changes in these domains over multiple years and based on deteriorating health, increased stress, and worsening life circumstances. There is some suggestion that resilience may be more prevalent among the old–old than among young–old adults (Mehta et al. 2008; Seplaki et al. 2006).

In this research in particular, health issues play a central role. For example, Netuveli et al. (2005, 2006) have reported that poor or declining health reduces the quality of life of older adults, particularly when it results in physical impairment or functional limitation. Hildon et al. (2010) extend this insight by demonstrating that the experience of adversity is magnified by the more limiting effects of health problems, such as impacts on activities of daily living (ADL). In addition, they may be less easily managed and be experienced as problems that have become compounded and gotten worse over time.

Hardy et al.'s (2002) research specifically assessed stressful life events among community-dwelling older adults, and it was found that among their subjects 18% identified a personal illness or injury, 42% the death of a family member or friend, 23% the illness or injury of a family member or friend, and 17% a nonmedical event over the previous 5 years. The last category included such events as victimization and changing residence, as well as events affecting another family member (such as divorce or the unemployment of a child). A significant finding from this research is that medical and nonmedical events may be of equal importance in their impact on the lives of older adults.

More recent research by Hildon et al. (2010) defined the adversities examined as "being limited by ill health or (in the past 5 years) deteriorating health, having more stress, changing life circumstances, being worse off financially, and experiencing a negative or difficult event such as bereavement" (p. 39). Importantly, they also suggested that negative life events, including both bereavement and retirement, may be acute or chronic. For example, the death of a spouse can continue to interfere with the daily routine of the survivor, serving as a constant and ongoing reminder of the loss. In their research, they found that 34.5% of respondents had experienced worse health, 33.3% more stress, 23% worse life circumstances, 40.8% limiting illness, 19.5% worse finances, and 71.3% had had a negative life event in the past 5 years.

Enriching these results and insights into the circumstances of adversity are studies focusing on specific types of stressors. For example, the experience of illness has been explored in the context of dementia (Harris 2008) and serious chronic conditions (Becker and Newsom 2005). Importantly, the latter study added the dimension of ethnicity to the need for a complete understanding of the role of a life course perspective within the broader cultural, social, and economic context of adversity, a theme also captured in other research (e.g. Felten 2000). Still other studies have gone into more depth in exploring the circumstances surrounding adversity in bereavement and widowhood (e.g. Bonanno et al. 2004).

The collective importance of these studies is that they draw attention to questions about the nature or types of stressors, the possibility of additive or cumulative

effects of adversity, and its duration and whether it is acute or chronic. Each of these aspects may create very different and challenging experiences for older adults, depending on their total set of life circumstances and resources for coping.

Specific Components of the Resilience Repertoire

The focus of this discussion will not include the personality- or trait-related factors in one's resilience repertoire, as these are topics considered by other authors in this book. Rather, this chapter focuses on those elements related to the two broad categories of health and social and economic factors that can be characterized as part of the individual's personal supply of resources for coping with adversity.

Health Resources

There are five aspects of health that are relevant to a discussion of resilience: (1) health status, (2) health promotion, (3) physical activity, (4) nutrition, and (5) medication compliance and personal medicine.

Health Status

Older adults are sometimes quoted as saying, "if you have your health in old age, you have everything," based on the insight that good health is a major instrumental resource in achieving other important life goals and outcomes. Poor health and resultant functional limitations can, indeed, become a barrier and a challenge in reaching a whole host of other objectives in one's life as an older adult.

Consequently, in much of the current resilience research, (poor) health tends to be addressed more as a factor in causing adversity than as a response to it. An exception is the early research on stamina by Colerick (1985), suggesting that high levels of self-reported physical health that extend back over one's life history are correlated with increased levels of stamina in old age. A "life pattern" of self-perceived good health seems to equip an individual with important resources for facing some of the potential challenges of growing older.

Additional studies extend this insight by suggesting that it is not so much the level of health status or absence of health problems, but rather how health is defined and viewed by the individual that is important. This finding is consistent with the now widely recognized phenomenon that older adults "overestimate" their self-reported health compared to "objective" measures of their health status. Even under these circumstances, however, there does not seem to be a clear-cut correlation between resilience and self-reported or perceived health.

For example, Nygren et al. (2005) found that there was no correlation between scores on a variety of psychological measures of resilience, sense of coherence, purpose in life, and self-transcendence in relation to perceived physical health. In contrast, Hardy et al. (2004) determined that good to excellent self-rated health was associated with high resilience. Interestingly, in their study Hildon et al. (2008) found that participants with resilient outcomes rarely talked about health-related limitations and did not dwell on them.

In summary, it seems not to be the case in every instance that health status constitutes a major resource in an older adult's resilience repertoire; rather, it is the way in which health problems are viewed and given meaning by the individual that is important. More research is certainly needed here to clarify apparent opposite findings and to shed more light on the role that health plays as a component of the resilience repertoire.

Health Promotion

A focus not found in the previous research literature on resilience, yet one having increasing importance for the future in terms of reducing the prevalence of chronic disease and functional impairment, is that of health promotion with older adults and its interrelationship with reducing risk and increasing resilience (Smith et al. 2004). This topic draws on a life course perspective, suggesting the importance of a long history of established healthy behaviors, a point emphasized earlier in the literature on stamina (Colerick 1985). An emphasis on health promotion is based on the assumption that appropriately designed interventions can improve or maintain health status and thereby enhance resilience in older adults (Luthar and Cicchetti 2000).

For example, pilot research by Clark et al. (2009) suggests that interventions may be successfully developed for older adults to maintain key elements of healthy lifestyle – such as exercise and diet – and thereby buffer them from "going off track" in these behaviors in response to a range of setbacks associated with aging. Anchored in the concepts and methods of selective optimization with compensation (Schulz and Heckhausen 1996) and goal-setting (Gebhardt and Maes 2001), such interventions may promote and support the internal processes used by individuals to acquire or maintain healthy behaviors (Prochaska et al. 1992; Prochaska and Velicer 1997).

Initial findings from this intervention research suggest that there may be different types of trajectories of maintaining positive behavioral patterns in the face of risks for "going off track" (followed by their relative proportions in the participant pool): (1) those older adults readily maintaining behaviors (50%), (2) those benefiting from guidance in coping with adversity (25%), (3) those stymied by adversity (15%), and (4) those with low motivation to maintain behaviors or participate in the intervention (10%). Identifying those vulnerable individuals for whom resilience to adverse events might be strengthened has important implications for targeting future interventions.

Physical Activity

A geriatrician colleague of the authors talks to his patients about the importance of their "making daily deposits into their exercise account" to build up their physical reserve capacity upon which to draw if they become sick or hospitalized – much like financial deposits in a bank account provide needed resources in an economic downturn. This expression captures the importance of physical activity in one's resilience repertoire.

A lifetime of regular physical activity strengthens a broad range of physiological systems in older adults, which influence health and well-being, chronic disease development, and functional capacity. Regular physical activity provides many health benefits, including reduced coronary risk, higher bone density, greater muscle mass, lower risk of falls, less body fat, and slower development of disability in old age (American College of Sports Medicine 2009). Research also suggests that physical activity levels are associated with cognitive resilience, including faster reaction times, improved psychological well-being, and reduced risk of cognitive decline and dementia (Hogan 2005).

With regard to the effects of acute care, hospital stays impose a degree of immobility on patients, often resulting in functional decline that begins as early as the second day (Hirsh et al. 1990). In a study of over 1,200 community-dwelling older adults hospitalized for acute illnesses, 31% experienced a decline in their ability to perform ADL between preadmission and time of hospital discharge (Sager et al. 1996). During hospitalization, those with the greatest loss in ADL are most likely to be admitted to a nursing home (Rudberg et al. 1999). Individuals who are physically active have higher levels of functional ability and may be better able to tolerate a hospital stay with no loss in the ability to perform ADL.

Indeed, research findings suggest that "prehabilitation," a program to enhance functional exercise capacity in older adults before surgery to minimize postoperative morbidity, is feasible (Carli and Zavorsky 2005). Moreover, other research indicates that walking more than four hours per week is associated with a significantly reduced risk of hospitalization for cardiovascular disease in older men and women, allowing individuals to avoid the negative functional outcomes of hospital stays (LaCroix et al. 1996).

Physical activity also contributes to resilience via psychosocial pathways. It is associated with improvements in psychological health and well-being, including reduced levels of perceived stress and a lower risk of depression and anxiety (American College of Sports Medicine 2009; Starkweather 2007; Taylor-Piliae et al. 2005). Social support may also play an important role in improvements in overall well-being. In one study, improved social relations were related to increased satisfaction with life and reductions in loneliness in sedentary older adults who participated in an exercise program (McAuley et al. 2000). In another study of community-dwelling older adults by Talsma (1995), physical function, psychological function, and well-being were all supported as dimensions of resilience. Physical activity, aerobic exercise, and community involvement were significantly related to resilience and moderated the effects of chronic conditions on resilience.

Finally, the relationship between physical activity and self-efficacy is also well established. In a literature review, McAuley and Katula (1998) concluded that most exercise intervention studies in older adults result in improvements in both self-efficacy for physical activity and physical fitness. Self-efficacy contributes to the maintenance of physical activity and physical function, particularly in those who are at risk for functional decline, allowing them to carry out basic self-care activities when their ability to do so is challenged (Mendes de Leon et al. 1996).

Nutrition

Healthful dietary and activity patterns have been associated with a reduction in mortality among the elderly as well as a reduction in the rate of cognitive decline (Feart et al. 2009; Knoops et al. 2004; Mitrou et al. 2007). Dietary patterns characterized by consumption of a variety of such nutrient-dense foods as fruits and vegetables appear to be most protective. This pattern could be conceptualized as building up a "nutritional bank account." The 2005 Dietary Guidelines for Americans (USDHHS/USDA 2005) recommend that older adults select a variety of nutrient-dense foods. On the other hand, inadequate dietary intake (protein-energy undernutrition) can lead to a loss of muscle mass with a negative effect on the performance of ADL (Sharkey et al. 2004) as well as an increased risk of mortality (Mahan and Escott-Stump 2008). Age-related loss of taste sensitivity (Shaffer and Tepper 1994), depression, lack of access to food, social isolation, and bereavement are other factors associated with inadequate intake (Mahan and Escott-Stump 2008). Simple interventions such as providing an additional meal or a companion at meals have been effective in increasing intake in homebound older adults (Locher et al. 2005).

Another factor is the presence of chronic diseases leading to dietary restrictions often related to inadequate dietary guidance provided by health care providers (Shatenstein 2008). The dietary pattern associated with inadequate intake is one of low dietary variety and limited consumption of nutrient-dense foods (Roberts et al. 2005). Although there has been little research focusing on nutrition-related resilience in older adults, a qualitative study by Greaney and colleagues found that disruption in routine, illness, and loss were cited as reasons for relapse. Those who were resilient cited determination and willpower as important in returning to healthful eating patterns (Greaney et al. 2004).

Medication Compliance and Personal Medicine

For older adults, the analysis of medications taken to manage chronic illnesses can serve as a proxy measure of complex and overlapping medical conditions that threaten independence. Adherence to complex medication regimens is presumed to be all-important to managing a person's chronic conditions, causing recovery or stabilization from disease symptoms and helping to promote well-being. However,

an approach to a patient with a chronic illness that focuses on sickness alone will oftentimes miss adaptive strategies that individuals use to maintain good health.

The adaptive steps individuals take to maintain health and well-being have been referred to as "personal medicine" (Deegan 2005). Personal medicine includes activity that gives meaning and purpose to one's life, such as participating in hobbies, helping others, and performing one's work and family role. Personal medicine is also a self-care strategy when individuals perform activities, such as exercise or socializing, that they recognize help them to feel better.

The concept of personal medicine also includes noncompliance to medication when the person believes that the medication interferes with life activities that are meaningful. For instance, a medication used to treat hypertension that causes dizziness and impairs mobility so that an individual can no longer complete a meaningful activity in his or her life may not be accepted. Medication nonadherence, as a coping skill and a component of self-efficacy, is an important example of resilience in adults. Unfortunately, the concept of individual nonadherence to medications that is consistent with health promotion is not well developed or well studied. Health care providers must try to incorporate a person's treatment and health goals into the medical care plan. Understanding activities that individuals value, as well as self-initiated interventions that people use to control disease and disease symptoms, will identify important outcomes of treatment.

Social and Economic Resources

There are three aspects of social and economic resources that are relevant to a discussion of resilience: (1) social support, (2) activities, and (3) finances.

Social Support

Social support has emerged consistently as a major component of resilience. The term "social capital" has been used to describe the resources involving social support and networks that can be employed to buffer older adults from adversity (Netuveli et al. 2008). For example, these same researchers found that, "The only variable that was consistently related to resilience was social support, measured in terms of having people who can be trusted and who will offer help, comfort, and appreciation, especially in a crisis" (p. 989). Importantly, it appeared that support before and during adversity, rather than after and in response to it, was the important factor. Earlier research on stamina has also highlighted the importance of support available from close family members, such as spouses and confidants (Colerick 1985).

The specific element of personal relationships as a factor in social support has also been highlighted. Hildon et al. (2008) suggest that a key factor in weathering life events is the recognition of the availability of help and those who can be relied on for it. In their study both resilient and nonresilient groups, in fact, relied on family, friends, and neighbors for socializing and sometimes practical support.

The key difference between the groups was related to the nature of the impacts of the loss of a loved one or the consequences of health problems.

In addition to relationships, integration into the community, suggesting placement of the older adult within a web of supportive relationships, has emerged as an important variable. In the research by Hildon et al. (2010), a good sense of community was related to "having a lot of friendly neighbors," "people looking out for each other," "a good community spirit," and "having a good mix of people." Community integration was also captured through involvement in paid employment, voluntary work, or community organizations. Expanding on the theme of webs and networks, Netuveli et al. (2008) state that, "resilience is to be found in the warp and woof of family and civic society" (p. 990), suggesting through a weaving metaphor the importance for resilience of an integrated and interwoven set of relationships that make up the very fabric of a community.

Activities

In addition to social support, the concept of activities in which older adults may be engaged seems relevant to resilient responses to adversity. For example, using activities diaries, Hildon et al. (2008) found that study participants with resilient outcomes reported nearly twice as much involvement in leisure or household activities that took place alone than those in the vulnerable outcome group. In related research on successful aging, a higher level of daily activity (e.g. reading, listening to the radio, and visiting with family) was associated with greater self-reported levels of successful aging (Montross et al. 2006), and ultimately with increased happiness, better functioning, and lower mortality (Menec 2003).

Finances

Hildon et al. (2010) specifically studied the role that financial or economic resources (including home ownership) might play in moderating adversity or enhancing quality of life among older adults. Somewhat paradoxically, their research determined that worsening financial circumstances were not significantly related to negative changes in quality of life in their older adult cohort, nor were adequate or more than adequate financial resources considered a protective factor in facing adversity. Their conclusion was that "insufficient income may not be as threatening and indeed sufficient income may not be as protective as other, perhaps less tangible, circumstances" (p. 9), such as social support.

Discussion and Conclusions

It is clear that the concept of resilience is multifaceted and multidimensional, a dynamic relationship between, on the one hand, stressors and adversities in the environment and, on the other, responses and reactions to them from an older

adult. In understanding this complex interplay of factors and forces, it is essential that we approach the topic of resilience from an integrative and interdisciplinary perspective, much as the field of gerontology in general deals with the issues of aging.

Research on the stress and adversity side of the equation includes consideration of health and mental health status and maintenance, and includes losses and changes in these factors over time. In particular, impacts creating impairment and functional limitation in ADL are important. Additionally, such losses as those associated with bereavement and relocation represent nonmedical factors that may be as important as those related to health. In all these stressors, it is essential that we consider the broader social, cultural, and economic contexts represented by gender, ethnicity, and class. Additive or cumulative effects over time, as well as acute vs. chronic conditions, are also aspects that must be taken into account. Finally, resilience has temporal and developmental aspects, and depends on the individual's interpretation of his or her life situation, experience, and resources.

On the other side of the resilience equation, the metaphor of resilience "repertoire" has been suggested as a way to understand the supply of skills and resources that can be used to moderate the impacts of stressors and adversities on the individual, and even lead to positive growth and development. The emergence of the meaning of life events for the individual, set against the backdrop of their own personal story or narrative that gives life continuity and meaning, is especially relevant here. In this regard, the skills and resources in one's repertoire are organized, selected, and wielded in unique ways that depend on the individual's values and themes that give his or her life integrity and meaning in a very personal way.

As an element in the resilience repertoire, health status may be important as a factor filtered through the individual's perception, but the research on its importance seems to be mixed in understanding its relationship to resilience. However, a life course perspective on healthy behaviors and health promotion does seem to be relevant to reducing risk and increasing resilience, suggesting a way of examining the concept through a life trajectory approach introducing the possibility of intervention to change its slope and even direction. In particular, physical activity and nutrition have a strong research base of evidence linking these two health behaviors to the development of a "reserve account" upon which the individual may draw when such health-related events as illness or hospitalization occur. In addition, the concept of "personal medicine" as an extension of individual health behavior captures elements of activities that give one's life meaning and purpose, linked to self-efficacy and self-care, in support of feeling well.

Finally, there is a substantial and well-documented literature on the importance of social support for an individual's ability to weather life's crises. Turning to friends, family, neighbors, and others during such times has consistently been shown to provide critical resources for an older adult in coping with life's adversities. In a larger sense, being part of a community, of a web of supportive relationships, is the essential ingredient in support. Having meaningful activities on a daily basis, whether pursued alone or with others, is another facet of the psychosocial factors related to resilience.

In conclusion, investing in one's human and social capital may be seen as a critical element in supporting an individual's ability to weather life's crises and to cope with adversities. An understanding of the different factors that go into one's resilience repertoire can suggest areas for potential interventions to support and enhance it. In this sense, examining the facts, factors, and facets of resilience in older adults can lead to designing ways to develop and enhance it to promote an individual's quality of life into old age – a worthy goal, indeed!

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