Chapter 9
Resilience in Aging: Cultural and Ethnic Perspectives

Darlene Yee-Melichar

This chapter shows that comprehensive research on resilience and aging would benefit from an examination and inclusion of cultural and ethnic perspectives relevant to older people. It shows the heterogeneity in resilience of older people as well as the cultural and ethnic perspectives in what older people will need addressed to be resilient in their lives. It also reveals that the older individual within a cultural or ethnic group is not a common stereotype, but still much their own person. Health and human service providers who interact with an older person must adjust their responses to that individual by taking into consideration the person's level of resilience, culture and ethnicity. More research in cultural and ethno-gerontology is required in order to better understand the diverse aging population and their current resilience and future needs. Forthcoming research on resilience and aging would benefit from a comprehensive and systematic approach by navigating the multidimensional perspectives of resilience at the individual, community, and cultural levels for intervention.

Resilience and Aging

The scientific community has begun to recognize resilience as a central component of success in later life. Although there is no consensus definition, resilience or the ability to recover from adversity and stress in life is a key factor of aging successfully. While resilience is often differentiated from coping and adaptation, how and why it is realized by some people and not others is still unclear. Resilience and aging has received inadequate attention; while some information is presented here, more research is required on the multidimensional perspectives of resilience in older people.

It is possible for older people to prevent or recover from physical decline. In a group of 213 people aged 72 and above who were living independently but needed

D. Yee-Melichar (✉)
San Francisco State University, San Francisco, CA, USA
e-mail: dyee@sfsu.edu

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assistance with at least one activity of daily living (such as bathing, dressing or going to the bathroom), it was noted that 28% of the participants 85 or younger had regained their ability to care for themselves (Gilbert 1999). This suggests that older adults have the power to help prevent or forestall the loss of independence with regular training and support. This type of behavior further suggests that resilience of individuals in later life is possible, but is often related to the individual and his/her willingness to recover.

A comprehensive review of the literature on resilience summarized key concepts and definitions as well as biological and psychosocial factors (Lavretsky and Irwin 2007). Treatment approaches to promote resilience, and implications for future research and interventions were discussed. The authors (Lavretsky and Irwin 2007, p. 309) indicated that "Successful aging is associated with a positive psychological outlook in later years, general well-being, and happiness… With global aging on the rise, many nations are developing and implementing healthy aging policies to promote quality and years of healthy life."

The processes and circumstances that create vulnerability among older people residing in Europe were examined by Grundy (2006). Vulnerability occurs when the balance between reserve capacity and environmental challenge falls below a level that ensures a reasonable quality and quantity of life. Vulnerable older people were defined as those whose reserve capacity falls below the threshold needed to cope successfully with the challenges that they face in life. The most vulnerable elderly are those who are lacking in autonomy, income, and social relationships. Preventive and compensatory interventions have been shown to be effective in preserving and/or restoring the reserve capacity and reducing the vulnerability of older people.

Grundy (2006) proposed various interventions to minimize vulnerability and increase resiliency; these interventions included promotion of healthy lifestyles and coping skills, strong family and social relationships, savings and assets; environmental improvements to reduce the risk of falls, social and policing programs to reduce street crime, influenza immunization programs; access to good acute care and rehabilitation, psychological and social work services, long-term assistance, and income support.

Although most interventions in Europe have evolved randomly and have not been thoroughly evaluated; some interventions have been shown to be effective in preserving or restoring the reserve capacity and reducing the vulnerability of older people. Grundy (2006) was careful to point out that more research is needed to learn about what is most effective in reducing vulnerability in different subsets of elderly individuals. Despite heterogeneity in age, there may be cultural and other differences in what each age cohort might need. In Europe, there are such diverse populations that understanding these differences are crucial. The same is certainly true here in the United States.

For example, in a recent study involving data from over 1,000 women related to the Women's Health Initiative, researchers aimed to understand how resilience might change over the lifespan. Research results indicated that resilience appeared to relate to other healthy aging determinants, and the way one ages (within a cultural and/or other context) may change the way that resilience is expressed (Vahia 2008).

Bauman et al. (2001) examined resilience in the oldest-old. The authors reviewed three separate studies. One was a qualitative study of resilience in 18 women aged

72–98 years conducted by Neary (1997) who identified common strategies the older participants used to get through difficult times. These strategies were similar to the processes in the selective optimization with compensation model discussed by Baltes and Baltes (1990). Personal traits common to the resilient older women in this study included flexibility, tolerance, independence, determination, and pragmatism (Neary 1997). These traits are similar to those identified in the LaFerriere and Hamel-Bissell (1994) study.

The second study was conducted by Felten (2000) who examined seven women, representing a variety of ethnic groups, who had had serious physical impairments from which they had recovered. These older women displayed the traits of determination, previous experience with hardship, knowledge of available services, strong cultural and religious values, family support, self-care activities, and care giving for others.

The third study was conducted by Talsma (1995) who studied 5,279 people from the Netherlands with a mean age of 69.6 years. Three dimensions of resilience were identified including physical functioning, psychological functioning, and well-being. The conclusion was that resilient older people have high levels of physical functioning, are willing to take initiative and to develop behaviors, believe they have control over their current life and are generally satisfied with their lives. The Netherlands is a more homogenous society than the United States; hence, the applicability of this latter study to the diverse elderly residing in the United States has not yet been established.

Hawkley et al. (2005) summarized that resiliency is impacted partly by genetics but is also influenced by individual responses to stress. These differences include frequency of exposure to stress, nature and intensity of psychological and physiological reactions to stress, and the efficacy of restorative and preventative measures to stress. The authors explained the net impact of human frailties and strengths on physiological resilience and health during the aging process. They summarized how people might be genetically influenced by physiology, but that people have astonishing capacities to minimize or contain the long-term costs of stress, thereby maintaining a resilient physiology and helping them ensure a long and healthy life. This capacity comes from choices that limit exposure to stress, adapting coping strategies, and sleep and exercise patterns. Aging is inevitable, but limiting stress can considerably slow down the degradation of the body limiting even one's need to be resilient.

Fry (1997, p. 150) concluded that "Older people are people… Older people are people who have been here longer than others." In summary, it is apparent that resilient older people have shared and will hopefully continue to share similar circumstances and experiences that promote their security and/or decrease their vulnerability as they age.

Cultural Perspectives on Aging

Five issues have been noted, from a cultural perspective, to promote security or delineate increased vulnerability for older people. These include: (1) material factors, (2) health factors, (3) social linkages, (4) cultural values, especially those of independence,

and (5) cultural change (Fry 1997). Resilience is not examined specifically, but cross-cultural perspectives that impact an individual and how each may confront aging have been explored. Specifically, it was noted that growing older is not a uniformly "good" or "bad" practice; rather studies must look at culture, life experience, and local circumstance to demonstrate people's responses to aging.

Older people's experience and relationship to aging must not be separated from their earlier life stages. Younger life cannot be "divorced" from the stages of later life because that stage in life impacts later stages in life. The author explained that to understand someone's reaction to later life the overall picture of their individual experience must be examined.

Fry (1997, pp. 146–150) reflected that "Culture gives meaning to life. Values define what is good and what is bad. Aging has its valences… Independence is a dominant value orientation in American culture." However, the differences we see in other cultures are major differences in productive organization, family structures, political centralization, stratification, and worldviews.

Gunnestad (2006) examined resilience in a cross-cultural perspective with a study about: (1) protective factors, (2) different ways of creating resilience, (3) resilience and vulnerability from culture, and (4) minority and majority cultures, biculturalism and resilience. Although this discussion is not specific to older people, it examines cultural, familial, and social issues which both aid and hinder the development of resilience in children. The author outlined protective factors and processes which help to create resilience. These protective factors include: (1) Network factors (external support), (2) Abilities and Skills (internal support), and (3) Meaning, Values, and Faith (existential support).

According to Gunnestad (2006, pp. 2–3), "Network factors" include external support from family, friends, neighbors, teachers, etc. "Abilities" include internal support such as physical and mental strength, temperament and emotional stability, intellect and appearance. "Skills" include communication skills, social and emotional skills. "Meaning, Values, and Faith" include existential support such as perception of values and attitudes. The author pointed out that culture is contained in all three protective factors, and that these protective factors are interrelated. Culture affects the way we form external support and network systems. Culture decides what abilities and skills are appreciated. And, culture is an integral part of meaning, values and faith.

Gunnestad (2006, p. 3) described the need to create resilience. Resilience is created when the protective factors initiate certain processes in the individual. Identified different ways of creating resilience: (1) building a positive self-image; (2) reducing the effect of risk factors and (3) breaking a negative cycle and opening up new opportunities.

The author examined resilience and vulnerability in different cultures: (1) Latino youth; (2) North American Indian First Nation; and (3) South African youth. The author illustrates how the culture over a long period of time has developed ways of behavior that generate resilience within that setting. Culture can be said to be a way of living facing the challenges in a certain environment with both extrinsic and intrinsic factors (Gunnestad 2006, p. 10).

Gunnestad (2006, p. 17) studied minority and majority cultures, biculturalism, and resilience. Culture relates to the meaning of life of a group of people, it relates to how they live and work (skills), what they hold as right and important for them (values) and it also goes with faith and religion. Culture is a vital part of the identity. Identity is a central part of our personality; it may be seen as the core.

From the perspective of resilience, it can be seen that if you take the culture from a people, you take their identity, and hence their strength – the resilience factors. If people are stripped of what gives them strength, they become vulnerable, because they do not automatically gain those cultural strengths that the majority culture has acquired over generations.

Stutman et al. (2002) report on resilience among immigrants and people from minority cultures. Immigrants and people from minority cultures who master the rules and norms of their new culture without abandoning their own language, values and social support seem more resilient than those who just keep their own culture and cannot acclimate to their new culture or those who become highly acculturated.

Cultural Differences in the Expression of Resilience

Katzko et al. (1998) examined the self-concept of the elderly in a cross-cultural comparison. A sample of elderly Spanish participants (n = 83) and elderly Dutch participants (n = 74) were compared to gain an idea of the cross-cultural content of self-concept. The research required participants to provide information through the use of the SELE-Instrument. The SELE Instrument is a sentence completion test with a set number of stem questions. The test determines whether the statements made by participants are either motivational or dispositional statements. Motivational statements are beliefs or perceptions while the dispositional statements are self-evaluations of the physical and mental self. The SELE-Instrument maintains specific procedures and coding methods to examine the differences and similarities of the responses between the elderly Dutch and Spanish participants.

Katzko et al. (1998) analyzed and discussed the research results; they acknowledged that the most striking differences were questions related to the "Family" and "Activities" categories. It appears that the elderly participants are looking for new ways to continue to lead meaningful lives after previous goals related to family, marriage, and career are met. In terms of Planning, it appeared that the elderly Spanish participants were more concerned about "Family" while the elderly Dutch participants were more concerned about "Activities." In terms of Possible, it appeared that the elderly Spanish participants were more concerned about "Family, Habitation and Helping" while the elderly Dutch participants were more concerned about "Autonomy and Activities."

Questions related to "future possibilities" (personal expectations and goals of the participants) also exposed differences in personal desires between the two cultures. Additional responses to various questions exposed the differing goals, plans, and desires of the two cultures. Overall, the results of the study indicated that in both

cultures, the elderly participants maintain a "still-healthy" image of themselves and often look for opportunities with which to fill their day-to-day existence with meaningful activities.

Katzko et al. (1998) examined the self-concept of the elderly Dutch participants to elderly Spanish participants. They looked at what made these groups age well. They found that each cultural group chose to fill their time differently; the elderly Spanish participants spent more time with family while the elderly Dutch participants spent more time on activities. However, either way, finding fulfillment in their choice was crucial in being content and satisfied as they aged.

Lewis (2008) defined "culture as a shared, learned, symbolic system of values, belief, and attitudes that shapes and influences perception and behavior – an abstract 'mental blueprint' or 'mental code'." Defined "resilience as the strengths that people and systems demonstrate that enable them to rise above adversity" and described ways to build resilience. According to, "cultural resilience refers to a culture's capacity to maintain and develop cultural identify and critical cultural knowledge and practices." Defined "community resilience as the ability of a community to establish, maintain, or regain an expected or satisfactory level of community capacity in the face of adversity and positive challenge." Lewis (2008) summarizes the role of Alaskan elders in the cultural resilience of Native communities.

Cultural Resilience

Lewis (2008) comments on cultural resilience, examining the obstacles that specific societies face in establishing and maintaining their various traditions and social norms. He explores resilience and cultural resilience within the elderly community and defines the typical roles of elders (i.e., grandfather, mentor). "Cultural Identity" is an important topic since the elderly relies upon it to maintain status within their community. It is a social support system that allows them to share their culture with younger generations.

Lewis focuses upon maintaining a community's level of resiliency, highlighting the peoples of Native Alaska to provide examples of how a specific culture maintains its identity. Examples he includes are the Alaskan natives' effort to speak and teach their native language and share traditional stories. Lewis also points out issues such as Alaska's reliance on imported goods and out-migration of youth, as variables which decrease that community's resiliency. Lewis turns to issues of the elder community within the Alaskan Native people and remarks upon the challenges they face such as: younger generations moving away and leaving elders to support themselves. Tensions between personal and communal resilience address the elders' desire to maintain independence while maintaining a valuable and useful identity within their culture. Lewis concludes his presentation by emphasizing that the issue of resilience sparks innovative efforts within a specific culture to maintain its identity.

Culture and Aging

Moody (1998) cites the differences among cultures in regards to aging. He describes how different cultures view, and tend to, elders in geriatric medical care. His article features a case study of a family who is taking care of their aged Chinese family member who is still currently a citizen of China, but is residing in the United States. The family is tending to their elder family member and making medical decisions on her behalf. The scenario is the Chinese elder complains of increasing pain and the family takes her to the hospital. The family learns that the elder family member in fact has cancer. The family asks the doctor not to tell the Chinese elder that she has cancer and opts for herbal remedies instead of traditional remedies such as radiation. The family is adamant about their decision citing their cultural values, but this leaves the healthcare team shocked about the family's decision and in disagreement with their choices.

Moody (1998) portrays the increasing complexity of "ethnic ethics" in the medical community in relationship to the aging population. The idea of "ethnic ethics" rests on the idea that as elders of different cultures age, there are different practices that varying cultures abide by. Moody depicts some of the most common arguments that arise when discussing differences in cultural medical care. First, there is the argument that rights and values are relative to the culture in which are expressing them. Some cultures value familial solidarity in later age; whereas other cultures, like the United States, value individualism and independence. Others believe that certain rights are universal and should not be questioned among cultures. Some believe that the argument of the "right thing to do" must be looked at on an individual basis and not in larger context. These viewpoints set the stage for the complexity of different cultures within the American healthcare system.

Moody (1998) also describes a study by the Fan Fox and Samuels Foundation. This study brought together different elders of different ethnicities and surveyed them about their views on aging. Although many of the predicted different responses occurred, there were also many similar statements across different cultures. Some ideas that were similar among cultures included: shared belief of fatalism, reluctance to communicate with healthcare professionals, and the belief that healthcare professionals did not want their opinion in relationship to care. The study predicted they would find differences among cultures, but were not prepared for the similarities they found.

It is clear that there are cultural differences that medical professional should be aware of and consider when having to provide care. In fact, future medical care might include the need to "negotiate differences" or to understand differences of cultures and look for ways to incorporate compromises between cultures. Despite a family's wish to use an alternative or less scientific intervention, doctors should still work hard to try and educate the family about the benefits of tested medicine. In summary, no matter the ethnic group, they all share "a concern for the dignity of elders."

Resilience Across Ethnic Groups

Consedine et al. (2004) explain that there are a variety of ways that older adults employ in adapting to the changes that aging brings. The authors explain that as individual's age, they come to resemble each other less, rather than more. What is known is that older adults engage in a diverse range of self-care efforts and different attempts to anticipate future difficulties related to aging.

Consedine et al. (2004) considered socioemotional adaptation among individuals from six ethnic groups: African Americans, Jamaicans, Trinidadians, Bajians, US-born Whites, and Immigrant Europeans, predominantly Russians and Ukrainians from the former Soviet Union. The study examined a sample of 1,118 community-dwelling older adults from Brooklyn, New York based on data from the Household Income and Race Summary Tape File 3A of the 1990 Census files. The mean age of the sample was 73.8 years. Data were collected during face-to-face interviews that lasted about one and a half hours in the respondent's home or in a location of their choice such as a church or senior center.

Consedine et al. (2004) used the following measures to look at ethnic constraints on later life adaptation: Demographics, Resiliency, Quality of Social Networks, Stress, Trait Emotions (Negative vs. Positive), Emotion inhibition, Religiosity, and Interpersonal conflict. For the purposes of the study, resiliency was defined as functionality relative to health impairment. Data were analyzed and results were reported. Consedine et al. (2004, pp. 124–125) concluded that "later life is associated with both gains and losses; aging brings with it a variety of challenges in coping with losses in physical, social, and economic realm."

The data also suggested that resilient members of African descent (African Americans, Jamaicans, Trinidadians, and Bajians) were more likely to manifest patterns of adaptation characterized by religious beliefs, while resilient US-born Europeans and immigrant Europeans were more likely to benefit as a result of a nonreligious social connectedness. Social networks, religion, emotions, and emotion regulation are among the key proximal components underlying ethnic difference in later life adaptation.

Aging and Culture

Holzberg (1982) described how little is written about the cultural factors that differentially affect the aging individual or social group. She explained that most contemporary literature focuses on the biological, psychological, and sociological factors of aging, but not on the cultural perspectives of aging. The author gave details on some of the anthropological perspectives to ethnicity and aging. First she explained that "cultural patterning of the human life cycle" is an effort to demonstrate how dominant societal values may structure, facilitate, or hinder individual and group adjustments to aging. Through understanding these patterns, one can better understand the diverse ways individual's age separate from the overall age group.

It is important not to place all "old" in group such as AARP or NCSC, but rather look at elders more closely. Holzberg (1982) criticized research as often placing minority elderly in the category of impoverished or attributing them with unemployment, low levels of education, and high dropout rates. She explained that it does impact the aging experience, but cannot be the only thing that is viewed as important. She gave specific examples of ethnicities including Asians, Native Americans, and Indians and how each group ages differently. Holzberg (1982) explained that understanding the nature of cultural experiences can aid us in our search for explanations of why certain people age differently from others.

Woehrer (1978) has said "The fact that people of different cultural backgrounds put their social worlds together differently means that their needs and resources as well as the ways in which they use the services available to them will vary." Holzberg (1982) concludes with a call for more research in cultural and ethnic gerontology in order to better understand the diverse elder populations and their current and future needs.

Nandan (2007) examined three "waves" of Asian Indian Elderly (AIE) immigrants. The author asserted policy makers and helping professionals have lumped the Asian Indian Elderly (AIE) immigrants with other Asian groups without considering the specific needs and unique perspectives of this population. The author detailed the time periods and numbers in which Asian Indian Elderly immigrated to the United States. Tracing the Asian Exclusion Acts of the early twentieth century, Nandan (2007) stated that the Asian Indian Elderly immigrants did not make much of an impact on the country's population demographics until well after the US repealed these laws. Therefore, the biggest immigration stages took place in the mid-1963s, during the economic boom in 1970s and mid-1980s, and during the 1990s after the "Family Reunification Act of 1990" was passed. Nandan noted that most of these Asian Indian Elderly are aged 55 and over, and therefore have specific needs based upon the circumstances surrounding their particular time of immigration.

Nandan (2007) described the differences in present experiences, legal status, reasons for marriage, adaption and challenges, and pre-immigration culture and values, of each wave of immigrants. The author noted that unlike the second and third wave immigrants, first wave immigrants may not as often visit family members in India because much of their family has already migrated to the US or other countries. Also, the support and community life in India is vastly different from the time they left, and therefore they do not recognize their native homeland. On the contrary, second wave immigrants do visit their native India to see family and friends, and seem to hold closer ties with their native culture as they are more often settled in rural areas in the USA (unlike the first wave immigrants who migrated to large cities for work). In addition, the second wave of Asian Indian Elderly seems to have retained specific cultural and religious customs of their native homeland, fueling their desire to make visits.

Nandan (2007) remarked upon the loneliness and alienation experienced by third wave immigrants, coupled with the financial and medical burden of caring for their elderly parents. These burdens are compounded by their parents' (immigrants as well) status as "permanent residents" rather than citizens, which makes them

inapplicable from benefiting from most public services. In some situations, children may send their elderly parents back to India in order to give them better care.

The author discussed the proper approach a "helping professional" should take in regards to Asian Indian Elderly, stating that those "competent" persons will keep in mind the specific cultural change, age group, and migration experience during the past 50 years of Asian Indians, rather than grouping their research and goals within the larger Asian Immigrant group. Nandan (2007) has 11 propositions in which helping professionals should engage with Asian Indian immigrants based upon the different time in which each group came to America, including the age group in which they now belong.

For example, the first wave of AIE immigrants should be viewed very similarly to United States-born citizens. They are familiar with American values, and often have retired with substantial financial security. Second wave AIE immigrants are in their 50s with college/marriageable age children and, more often than first wave immigrants, come from a variety of countries: India, Kenya, South Africa, along with Guyanese cultures and might have adapted faster to American custom than those who directly migrated from India. Many of the third wave immigrants may not be legal citizens, coming after the reunification clause of the American immigration policy. Nandan (2007) concludes that helping professionals must receive ongoing training to adequately address the specific differences within the three waves of Asian Indian Elderly immigrants in addition to not grouping this specific culture within the larger group of Asian Immigrants.

Nandan (2007) described the increase of Asian Indian Elderly Americans since the mid-1960s. The author discussed the three distinct waves of immigration since 1960 and what services and or resources each may need as they age. Recently in the 2000 US Census, Asian Indians ranked fourth highest with regard to number of immigrants over the age of 55. The author explained that the country is experiencing a "browning" and "graying" of America. Since the needs and experiences of three waves of AIE immigrants are different because of the time, age, and stage in life of their migration to the U.S., their needs will be different.

Example of Impact of Culture on Resilience

Yin (2006) described how elderly white men are most afflicted by high suicide rates. Overall, in the U.S. population, there are 11 suicide deaths per 100,000; however, white males commit suicide three times the existing national average, and are eight times more likely to kill themselves than women of the same age group.

The author described the high suicide rates of elderly white males and why they seem to be at substantially greater risk for suicide than females. Some researchers claim that the lack of resilience in males is from weak coping abilities. For example, men are accustomed to asserting their will and taking charge; however, later in life, as they age, men have unrealistic expectations and are less likely to ask help from others, making aging more isolating. Also, the author explained how much of the

research around male suicide explains an elderly person's act of suicide as "tragic but rational," making it seem normal and acceptable.

The author explained that women have lower suicide rates because of their existing physical and role changes they experience through life making them more apt to accept change when it happens in later life. Further, women also tend to build more robust social networks with family and friends which is necessary for resilience. Suicide is found to be less common in those with strong social networks. In addition, race might affect resilience in males. Researchers noted that the lower suicide rates in male Hispanics and non-Hispanic whites might be because of "familism" or their increased emphasis on close relationship with extended kinship. The author indicates that lower suicide rates in older male African Americans might be due to more connectedness to social institutions such as family, church, and social-support systems. Researchers found in interviews that African American Pastors in the south viewed suicide as a "white thing," and furthered this by saying that their community had developed a culture of resilience in which suicide was counter to the black experience. The author explained that culture, tradition, and family connections seem to lower suicide rates because of increased resilience.

Yin (2006) described why there are such obstacles in detecting depression in the elderly. The author explains that in later life depression can manifest into fatigue and or other physical systems, making the diagnosis of depression much more difficult. The author also explains that there is the persisting public view that suicide in the elderly is less tragic and more acceptable than in youth, even viewed as part of the natural aging process. Finally, the author concludes with whatever the reasons are that treating depression in later life is treatable and should be treated as aggressively in later life as in youth. The elders are an important and critical part of society and need to be treated that way.

Yin (2006) included a graph that shows suicide by age and sex (which shows elderly white men having a significantly higher number of suicides). The next chart shows male death rates for suicide by race, Hispanic origin and age. It shows how White males have the highest number of suicides per 100,000 later in old age. Some researchers argue that elderly white males lack the resilience and coping mechanisms that make white women and older black people less prone to suicide. Researchers show that Hispanic males might have a significantly smaller percentage of suicides because of the cultural emphasis on close relationships with extended kinship. The author concluded that social institutions such as family, church, and social support systems might serve to protect against things that may influence suicide. The author showed how resilience is probably stronger in culturally rich minorities.

Next Steps in the Area of Cultural Impact on Resilience

This chapter shows that comprehensive research on resilience and aging would benefit from an examination and inclusion of cultural perspectives and ethnic variations relevant to the sample population of older people. Information on resilience

and aging indicate that the elderly have the power to help prevent or forestall the loss of independence with regular training and support; successful aging is associated with a positive psychological outlook; some interventions have been shown to be effective in preserving or restoring the reserve capacity and reducing the vulnerability of older people; and the way one ages may change the way that resilience is expressed.

Research on resilience in aging and cultural perspectives reveal that studies must look at culture, life experience, and local circumstance to demonstrate people's responses to aging; culture affects the way we form external support and network systems, decides what abilities and skills are appreciated, and is an integral part of meaning, values and faith; culture over time has developed ways of behavior that generate resilience within that setting; immigrants and people from minority cultures seem more resilient than those who cannot acclimate to their new culture or those who become highly acculturated; differences in goals exist between cultures yet cultures look for opportunities with which to fill their existence with meaningful activities; need for individual resilience as well as cultural resilience and community resilience and need for ethnic ethics in cultural medical care to address differences and similarities in cultural perspective.

Studies on resilience in aging and ethnic variations suggest that as individuals age, they come to resemble each other less; social networks, religion, emotions, and emotion regulation are among the key components underlying ethnic difference in later life adaptation; little is written about the cultural factors that differentially affect the aging individual or social group; understanding the nature of cultural experiences can aid us in our search for explanations for why certain people age differently from others; culture, tradition, and family connections seem to lower suicide rates because of increased resilience; and resilience is probably stronger in culturally rich minorities.

This review of the literature shows the heterogeneity in resilience of older people as well as the cultural and ethnic perspectives in what older people will need addressed to be resilient in their lives. It also reveals that the older individual within a cultural or ethnic group is not a common stereotype, but still much their own person.

A "strengths perspective for social work practice" indicates that "people have untapped, undetermined reservoirs of mental, physical, emotional, social and spiritual abilities that can be expressed. The presence of this capacity for continued growth and heightened well-being means that people must be accorded the respect that this power deserves. The capacity acknowledges both the being and the becoming aspects of life." (Weick et al. 1989, p. 352).

Health and human service providers who interact with an older person must adjust their responses to that individual by taking into consideration the person's level of resilience, culture and ethnicity. More research in cultural and ethnogerontology is needed in order to better understand the diverse aging population and their current resilience and future needs. Forthcoming research on resilience and aging would benefit from a comprehensive and systematic approach by navigating the multidimensional perspectives of resilience at the individual, community, and cultural levels for intervention.

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