2 Resilience and Well-Being

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The world breaks everyone, and afterward, some are strong at the broken places.

(Ernest Hemingway, A Farewell to Arms, 1929)

2.1 Introduction

The need to improve the treatment and management of long-term conditions is one of the most important challenges facing the NHS [1]. The idea of 'resilience' represents a paradigm shift to a treatment model that promotes positive adaptation, using an asset-based model of resilience, in the context of long-term health issues [2].

2.2 What Is Resilience?

In 2002, Ganong and Coleman suggested that we have entered the 'age of resilience' [3]. Indeed the term appears to have proliferated over the last 10–15 years: a quick Internet search reveals, for example, psychological resilience, ecosystem resilience and resilience in relation to peak oil, to the ability of a city to resist a terrorist attack and to a number of organizations dedicated to promoting resilience of individuals, cities and systems. A search for well-being produces similar, although perhaps not as prolific, results. Resnick et al. draw attention to the value of resilience as espoused through traditional adages and mythology [4], and, we would add, through now ubiquitous phrases that have entered popular culture (e.g. 'Keep calm and carry on'), that also espouse resilience.

Resnick et al. suggest that the popularity of the concept is due to the prospect that resilience can be fostered. (In fact, they go one step further and suggest that fostering of resilience can be used for primary prevention of chronic illness in at-risk

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populations.) [4] It is also likely that the proliferation of interest in resilience and well-being, at least in the developed world, is linked to demographics: larger numbers of people living longer, with greater expectations of their health, coupled with a decrease in public services, makes an emphasis on resilience and well-being very timely. A critical approach to resilience and well-being, however, means that there must be caution about blaming victims if they do not exhibit resilience and resisting the romanticization of resilience:

> How can we celebrate an individual's accomplishments and well-being in adverse situations without either blaming those whose lives show less cause for celebration, or dropping the critique of the contextual structures that promote the adversity. [5]

Given this background, the remainder of this chapter aims to provide a brief overview of resilience and well-being in the context of older people in primary care.

2.3 The 'Disability Paradox'

Many older people with chronic conditions describe themselves as healthy. General Household Surveys in the UK, for example, have found that although 60 % of those aged over 65 report some form of chronic illness or disability, less than a quarter rate their health as poor [6], sometimes referred to as the 'disability paradox' [7]. At the same time, doctors are generally working within a pathogenic paradigm, which emphasizes burden, disease and decline [8]. This tension has the potential to adversely influence consultations between doctors and older patients [9].

A salutogenic approach enables these paradoxes to be explored [10]. In the salutogenic approach, wellness (absence of morbidity) and illness (presence of morbidity) are seen as a continuum rather than a dichotomy; the focus is on factors that support health rather than factors that cause disease, and questions such as why some people manage better than others can be explored. Research adopting this perspective sometimes uses the idea of people 'beating the odds' or 'punching above their weight' (metaphors also used for resilience) [11–13]. Previous studies exploring why some people do better than others have compared, for example, healthy and unhealthy 'agers' in deprived areas (where no differences were found in terms of life histories and current circumstances) [14] or people whose self-reported health status differed from that predicted by a model derived from questionnaire responses [15]. The salutogenic approach thus has great potential for exploring health in later life [6].

An assumption is often made that resilience contributes to well-being; however, 'The Wellbeing and Resilience Paradox' report [16] suggests that this relationship is not always straightforward. The authors make a useful distinction between well-being as a complex concept that captures a 'psychological state at a point in time' and resilience, while no less complex, as being more dynamic and incorporating aspects of the past and future. Well-being is strongly related to resilience, and there is overlap in the factors that influence both, but there are also individuals and

communities for whom well-being is high but resilience is low. Communities with high well-being but low resilience tend to have larger numbers of older people. The authors suggest that the individuals and communities who exhibit this paradox are particularly vulnerable but perhaps not so easily identifiable as other groups, which has implications for health care for older people.

2.4 Definitions and Dimensions of Resilience and Well-Being

The 'salutogenic umbrella' incorporates a number of resilience-related psychological and sociological concepts, including resilience and well-being, for example, hardiness, assets, inner strength and coping [17]. The concept of resilience is increasingly used in the field of gerontology but lacks consistency in definition and use [18]. It has had numerous meanings in the literature, but generally refers to a pattern of functioning indicative of positive adaptation in the context of significant risk or adversity [19]. But beyond that common understanding, there are different views on (a) whether resilience is a personality trait or a process, (b) the dimensions of resilience, (c) the validity of resilience as a concept and its consistency over time and (d) the relationships of resilience with adaptation and whether it adds something new in developmental and life course theories [20]. Research into resilience was originally developed in the domain of developmental psychology, dealing with childhood and adolescence, and has only recently been extended to other periods of the lifespan, including old age.

Looking in more detail at the construct of resilience, two dimensions have been proposed – exposure to adversity and showing signs of positive adaptation to this adversity [20, 21]. According to this definition, identifying resilience requires two judgements: is there now or has there been a significant risk of adversity to be overcome and is the person 'doing okay'? In many studies, 'doing okay' is measured by assessing mood, well-being or quality of life before and after being exposed to adversity [22–24]. Maintained or increased psychosocial well-being and quality of life are indicative that the person is doing okay and is therefore resilient.

Those with resilient outcomes to adverse situations have been reported to draw on a broader range of social and individual resources than those with vulnerable outcomes. As a consequence, these people were better able to maintain continuity of their previous lives and were more in control and, therefore, more able to transform an adverse event into a benign one [25]. Drawing on previous experiences of loss and coping to create a sense of oneself as resilient has been found to help women deal with challenges from current ill-health [26].

Kuh makes a case for studying not only physiological but also social and psychological resilience alongside frailty in older people, raising the prospect of being able to be physically frail but psychologically and socially resilient [27]. This suggests that resilience may offer an appropriate framework for understanding wellness and well-being in the context of older age and/or chronic conditions. This also comes

across in Windle's proposed definition of resilience, developed from a review and concept analysis:

> Resilience is the process of effectively negotiating, adapting to, or managing significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate this capacity for adaptation and 'bouncing back' in the face of adversity. Across the life course, the experience of resilience will vary. [28]

In this definition, 'bouncing back' and adaptation are both seen as part of resilience, which, I would suggest, make it more appropriate to older people. Adaptation also distinguishes resilience from stoicism, which, although often lauded as a positive response, has no elements of flexibility, which are key to resilience [29].

However, the notion of bouncing back, at least in the context of older people with chronic conditions, could also be seen as flawed. Chronic conditions, by definition, persist and might get worse rather than better, and resilience here may mean that a person 'keeps going' despite the adversity, rather than returning to a pre-adversity state. Some research uses comparison of measures such as well-being and quality of life before and after adversity to determine resilience, with the focus on bouncing back rather than keeping going. It is difficult to measure adversity 'objectively', and people may experience the same adversity differently. This demonstrates the importance of looking at older people's own definitions of adversity, well-being and resilience [18]. These are important because they will shape the actions they take, and have taken, over their lifetime. It is important for healthcare professionals to consider older people's own definitions of resilience (or perhaps rather 'keeping going') as part of a patient-centred approach.

2.5 Measuring Resilience

The measurement of resilience is problematic: a recent review of resilience scales found no current 'gold standard' amongst 15 measures of resilience [30]. This review reported that a number of scales are in the early stages of development, but all require further validation work. The authors identify the lack of attention paid to family and community resources as a major weakness of existing attempts to create a valid measure of the concept. A further problem, particularly for those wanting to adopt a salutogenic approach, is that measures for older people often focus on deficits, such as challenges of living with chronic illness, pain, loss and loneliness [31]. The growing literature on optimal ageing [32] yields more positive measures, for example, Wagnild and Young developed a resilience scale measuring positive attributes (including equanimity, perseverance, self-reliance, existential aloneness and spirituality/meaningfulness) through interviews with 'resilient' individuals [33].

Other examples of measuring resilience include Martens et al., who used 'mastery' as a proxy measure, or marker, of resilience [34] and measured it using the 'Personal Mastery Scale' [35]. They suggest that having a high level of mastery helps older people to cope with and adapt to living with a chronic condition. They also suggest that further longitudinal research is necessary to unravel the long-term

effects of mastery, income and social support on 'relatively successful functioning' in chronically ill patients. Lamond et al. suggest that the CD-RISC is an internally consistent scale for assessing resilience amongst older women and that greater resilience as assessed by the CD-RISC related positively to key components of successful ageing [36]. The strongest predictors of CD-RISC scores in this study were higher emotional well-being, optimism, self-rated successful ageing, social engagement and fewer cognitive complaints. Janssen et al. conducted a qualitative study and suggest that the main sources of strength ('to improve resilience') identified amongst older people were constituted on three domains of analysis; the individual, interactional and contextual domain and thus proactive interactions need to help older people build on the positive aspects of their lives [37].

This resonates with Wild et al.'s [18] model (Fig. 2.1) of the different levels of resilience, including individual, family and community [18].

2.6 Alternatives to Resilience

The salutogenic umbrella can also be referred to as an 'asset-based approach' – identifying the protective factors that create health and well-being and in contrast with the deficit-based approach described earlier. Resilience can be seen as an asset. Clearly in health care, a deficit model is necessary to identify need, priorities and so on, but an asset-based approach would seem more acceptable as a complement to this deficit-based approach. However, as with resilience, the focus of much research in this area has been personal factors and cognitive resources, and there is a need to

Fig. 2.1 Levels of resilience (From: Wild et al. [18] with permission)

extend this further. The scales of resilience (individual, household, family, neighbourhood, community, societal), seen in Fig. 2.1, can also be applied to an asset-based approach, as can the different domains of resilience, shown in the second model above, for example, financial, environment, physical, social, psychological, mobility and so on.

2.7 The Importance of Resilience in Context

Wild et al. acknowledge the potential for applying the concept of resilience to older people, acknowledging as they do that it can incorporate and balance vulnerability alongside strength across a wide range of contexts [18]. Locating resilience within these broader contexts removes the focus from individual characteristics and the associated blame for those who do not 'achieve resilience' [18]. The model also acknowledges that people may be resilient in one area but not in others (Fig. 2.2).

Older people, particularly those with chronic conditions, might not consider themselves to have a medical condition but simply to be getting older; nevertheless, they have to face up to changes in their physical abilities and their perception of themselves. Being 'resilient' (in the sense suggested by Wild et al. [18] and Windle [28] above) means being able to accommodate and adapt to physical changes and fluctuations in health and well-being in order to sustain what is important in life and for a valued sense of self.

Windle draws attention to the 'normal, everyday' nature of resilience, echoing Masten's evocative phrase 'ordinary magic' and suggesting that 'the opportunity for positive adaptation should be an option for everyone' [28]. Perfect physical health

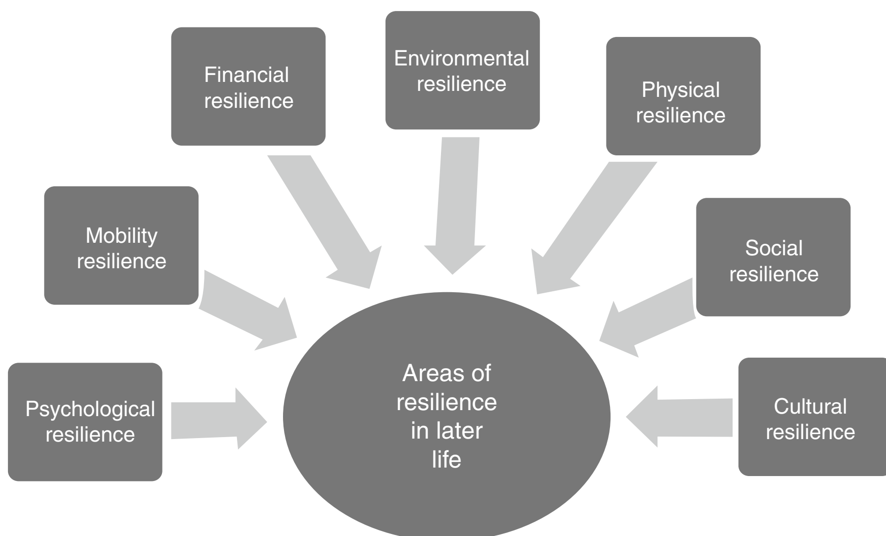

Fig. 2.2 Areas of resilience (From: Wild et al. [18] with permission)

is neither necessary nor sufficient for successful ageing as defined by the older adults themselves. Their holistic self-appraisal involves strong emphasis on psychological factors such as resilience, optimism and well-being, along with an absence of depression.

2.8 Implications of Taking Account of Resilience

Most of the public discourse on population ageing involves dire predictions and negative stereotypes. This negative view of old age has been contrasted by empirical research on older adults who continue to function well and are ageing 'successfully'.

Health and welfare services may be part of the environment of many older people, particularly those with chronic conditions, but those who provide care need to appreciate that a frail body is not indicative that the cared-for person lacks a resilient sense of self or is not able to draw on other domains or levels to achieve resilience.

Clinicians can help reduce societal ageism through their optimistic approach to the care of seniors. Treating the frail body should not come at the expense of undermining an older person's sense of self. In order to balance professional perceptions of an individual's 'frailty' with an individual's embodied and lived experience, we suggest that health and social care providers take an individual's own approach to managing their condition as the starting point for any support.

Further research on how older adults develop and maintain positive self-appraisals in the presence of biological decline may also inform similar adaptations across the lifespan.

2.9 Suggested Activity

Think about a particular patient using a salutogenic approach and using the models shown above. Is it possible to identify different levels of resilience that the patient can draw on/could be helped to draw on, outside of his/herself? Are there other domains in which the patient is resilient that can be used to support an area of difficulty? Does the patient have valued activities? How can they be supported to continue with these? How could any treatment given to a patient be used to support rather than undermine a positive sense of self? Are there opportunities for fostering resilience in older people with current high levels of well-being?

References

1. Coulter A, Roberts S, Dixon A. Delivering better services for people with long-term conditions. London: The King's Fund; 2013.
2. Jeste DV, Palmer BW. A call for a new positive psychiatry of ageing. Br J Psychiatry. 2013;202:81–3.

3. Ganong LH, Coleman M. Family resilience in multiple contexts. J Marriage Fam. 2002;64(2): 346–8.
4. Resnick B, Gwyther LP, Roberto KA, editors. Resilience in aging: concepts, research and outcomes. New York: Springer; 2011.
5. Massey S, Cameron A, Ouellette S, Fine M. Qualitative approaches to the study of thriving: what can be learned? J Soc Issues. 1998;54(2):337–55.
6. Sidell M. Older people's health: applying Antonovsky's salutogenic paradigm. In: Douglas S, Earle S, Handsley S, Lloyd CE, Spurr S, editors. A reader in promoting public health. 2nd ed. London: Sage; 1995/2010. p. 27–32.
7. Albrecht G, Devlieger PJ. The disability paradox: high quality of life against all odds. Soc Sci Med. 1999;48(8):977–88.
8. Bowling A. Lay perceptions of successful ageing, findings from a national survey of middle aged and older adults in Britain. Eur J Ageing. 2006;3:123–6.
9. Bowling A, Dieppe P. What is successful ageing and who should define it? BMJ. 2005; 331(7531):1548–51.
10. Antonovsky A. Health, stress and coping. San Fransisco: Jossey-Bass; 1979.
11. Bartley M. (Undated, accessed online July 2012). Capability and resilience, beating the odds. ISBN 0-9527377-9-5 ISBN 978-0-9527377-9-7. www.ucl.ac.uk/capabilityandresilience.
12. Dupre ME, George LK. Exceptions to the rule, exceptional health among the disadvantaged. Res Aging. 2011;33:115–44.
13. Canvin K, Marttila A, Burstrom B, Whitehead M. Tales of the unexpected? Hidden resilience in poor households in Britain. Soc Sci Med. 2009;69:945–54.
14. Gilhooly M, Hanlon P, Mowat H, Cullen B, Macdonald S, Whyte B. Successful ageing in an area of deprivation, part 1 – a qualitative exploration of the role of life experiences in good health in old age. Public Health. 2007;121:807–13.
15. Bryant LL, Corbett KK, Kutner JS. In their own words, a model of healthy aging. Soc Sci Med. 2001;53:927–41.
16. Mguni N, Bacon N, Brown JF. The wellbeing and resilience paradox. London: The Young Foundation; 2012.
17. Lindström B, Eriksson M. The Hitchhiker's guide to salutogenesis. Salutogenic pathways to health promotion. Helsinki: Folkhälsan Research Center; 2010.
18. Wild K, Wiles JL, Allen RES. Resilience: thoughts on the value of the concept for critical gerontology. Aging Soc. 2013;33(1):137–58.
19. Schoon I. Risk and resilience. Adaptation in changing times. Cambridge: Cambridge University Press; 2006.
20. Luthar S, Cichetti D, Becker B. The construct of resilience: a critical evaluation and guidelines for future work. Child Dev. 2000;71(3):543–62.
21. Masten A. Ordinary magic. Resilience processes in development. Am Psychol. 2001;56(3): 227–38.
22. Netuveli G, Wiggins RD, Montgomery SM, Hildon Z, Blane D. Mental health and resilience at older ages: bouncing back after adversity in the British Household Panel Survey. J Epidemiol Commun Health. 2008;62(11):987–91.
23. Hildon Z, Montgomery SM, Blane D, Wiggins RD, Netuveli G. Examining resilience of quality of life in the face of health-related and psychosocial adversity at older ages: what is "right" about the way we age? Gerontologist. 2010;50:36–47.
24. Windle G, Woods RT, Makland DA. Living with ill-health in older age: the role of a resilient personality. J Happiness Stud. 2009;11(6):763–77.
25. Hildon Z, Smith G, Netuveli G, Blane D. Understanding adversity and resilience at older ages. Sociol Health Illn. 2008;30(5):726–40.
26. Gattuso S. Becoming a wise old woman: resilience and wellness in later life. Health Sociol Rev. 2003;12(2):171–7.
27. Kuh D, the New Dynamics of Ageing (NDA) Preparatory Network. A life course approach to healthy aging, frailty and capability. J Gerontol: Med Sci. 2007;62A(7):717–21.

28. Windle G. What is resilience? A review and concept analysis. Rev Clin Gerontol. 2011;21(2): 152–69.
29. Moore A, Grime J, Campbell P, Richardson J. Troubling stoicism: sociocultural influences and applications to health and illness behaviour. Health (London). 2013;17(2):159–73.
30. Windle G, Bennett KM, Noyes J. A methodological review of resilience measurement scales. Health Qual Life Outcomes. 2011;9:8. doi:10.1186/1477-7525-9-8.
31. Langer N. Resilience and spirituality: foundations of strengths perspective counseling in the elderly. Edu Gerontol 2004;30(7):611–17.
32. Baltes PB, Baltes MM, editors. Successful aging: perspectives from the behavioral sciences. New York: Cambridge University Press; 1990.
33. Wagnild GM, Young HM. Development and psychometric evaluation of the resilience scale. J Nurs Meas. 1993;1(2):165–78.
34. Martens VC, Bosma H, Groffen DAI, van Eijk JTM. Good friends, high income or resilience? What matters most for elderly patients? Eur J Public Health. 2011;22(5):671–6.
35. Pearlin LI, Schooler C. The structure of coping. J Health Soc Behav. 1978;24:2–15.
36. Lamond AJ, Depp CA, Allison M, Langer R, Reichstadt J, Moore DJ, Golshan S, Ganiats TG, Jeste DV. Measurement and predictors of resilience among community-dwelling older women. J Psychiatr Res. 2008;43(2):148–54. Epub 2008 May 1.
37. Janssen BM, Van Regenmortel T, Abma T. Identifying sources of strength: resilience from the perspective of older people receiving long-term community care. Eur J Ageing. 2011;8(3): 145–56.