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Bouncing Back Later in Life: Building Resilience with Older People
Final Report

Goetz Ottmann (PhD)
Margarita Maragoudaki

UnitingCare Community Options
Deakin University
Aims of the Report:

This report provides a summary of the findings generated by the Resilience Project. It explains how the research was conducted and provides an overview of the key insights.

Suggested Citation:
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Acknowledgements:
We would like to thank the older people who contributed their insights and wisdom collected over lifetimes. Without them this project would not have been possible. We would also like to thank Deakin University’s Quality and Patient Safety Research Centre for funding this project.
EXECUTIVE SUMMARY

The way resilience is fostered over the life course and particularly later in life significantly determines older people’s quality of life. This report explores the concept of resilience through the lens of 22 older people. It records how these older people view resilience and highlights strategies they employed to overcome significant obstacles and challenging situations. The report explores key themes as they emerge in the narratives and begins a dialogue with aged care professionals who would like to operationalize the concept.

The meaning participants assigned to resilience differed widely. Participants regard resilience as accepting change, endurance and flexibility, internal strength, confidence, cognitive or physical strategies, challenging yourself, and fighting against discrimination. Resilience-enhancing strategies employed by participants where shaped by their life course, available assets, and major adversities in their lives. Four key types of adversities were identified in this study: facing disabling circumstances, caring for an older person, facing challenging relationships, and facing discrimination. Although the sample size was too small to bring out resilience themes that resonate with all four of these adversities, it was possible to distinguish small but nevertheless significant differences between older people facing disabling circumstances and carers. Whereas older people facing disabling circumstances tend to focus more on cognitive or emotional strategies enabling them to expand the limits of what is possible in their lives, carers tend to emphasise stress management strategies and respite services, knowing what is available to them, and maintaining an emotional equilibrium.

In most cases, building resilience involved a mix of environmental, cognitive/emotional, social, and infrastructure resources. In many cases resilience emerged from a tension between having to accept one’s adversity and the need to challenge the limitations associated with it. A total of 56 resilience assets, strategies, or responses were recorded. The following resilience themes were identified by more than half of the participants:

- cultivating social networks and friends,
- friendship,
- cultivating a positive outlook on life,
- having and maintaining interests, being active,
• experience of previous crisis points or hardship,
• capacity building and support provided by case managers, nurses, or allied health,
• resisting and challenging one’s circumstances and limitations,
• acquiring knowledge,
• looking after yourself (Self-Care), and
• family support.

Some of these responses could be aggregated into thematic clusters. The most frequently mentioned clusters were:

• motivational strategies (present in 60 references),
• Friendship, family, and social networks (43 references),
• Capacity building and social support options (33 references),
• Problem solving and decision-making strategies (33 references),
• Stress Management Strategies (26 references), and
• Contestation Strategies (22 references).

Participants providing advice to others regarding how to build resilience agreed that a successful resilience strategy rests on a solid motivational foundation that restores people’s faith in their capacity and that taps into activities they regard as meaningful. In addition, cognitive and support strategies are viewed as valuable because they assist a person to re-develop their view of a life that is worth living. Allied health, health, and community care professionals have a crucial role in assisting older people to build resilience strategies.
INTRODUCTION

The way resilience is fostered over the life course and particularly later in life significantly shapes older people’s quality of life. In high and medium income countries, people live increasingly longer. Scientific and technological innovations, public health interventions, and access to quality health care have significantly extended life expectancy.\(^1\) In Australia, this trend has resulted in a marked growth in the numbers of people aged 85 or older. In 2006, people aged 85 and older made up 1.6% (double that of 1986 figures) of the Australian population, a figure that is projected to increase to 5.1% by 2050 (1). However, while life expectancy is increasing, so are the emotional and physical challenges older people face in later life (2-4). Well-developed resilience strategies can assist older people to mitigate these challenges and to gain a better quality of life.

This report explores the concept of resilience through the lens of 22 older people. It describes what meaning participants assigned to the term resilience, focuses on the range of resilience responses and strategies they employed to overcome significant obstacles and challenging situations, and brings out some key themes that might assist aged care professionals to operationalize a resilience approach.

**Conceptual Considerations**

The concept of resilience has a range of meanings. The word resilience stems from the Latin ‘resilire’ (to leap back, recoil). According to the Shorter Oxford Dictionary, the term resilience refers to ‘the act of rebounding or springing back’ or ‘the power of resuming the original shape or position after compression’. Resiliency, by contrast, refers to ‘the power of recovery’. In other words, resilience can be a process or a personality trait. This duality of meaning underpins a key debate in resilience research. Because it is very difficult to define and measure objectively personality traits such as internal strength – attempts say often more about social conventions and the values of the researcher than about the level of resilience of the people under study -, many prominent resilience researchers have come to agree that resilience should be regarded as a process (5, 6). However, a minority of mainly

\(^1\) The number of Australians and New Zealanders over age 65 is increasing more rapidly than that of the general population. In 2006, people aged 65 and older made up 13% of the Australian population. It is expected that this will more than double (to 24%) over the coming 30 years (1).
quantitatively-oriented researchers continues the pursuit of measuring resilience as a personality trait.

Aspirational Qualities of Resilience:
The concept of resilience holds aspirational qualities. Most people would like to be resilient, to ‘bounce back’ and ‘recover’ quickly. To be resilient is a desirable attribute. It is a testimony to our internal strength, to the fortitude and steadfastness of our character. Indeed, most of the participants talked about ‘internal strength’ as a core element of resilience. The aspirational qualities of resilience are important because they might motivate people to change their behaviour or life style and practitioner may find it useful to harness the motivational driving force of resilience. However, care has to be taken not to confuse aspirational qualities with the assets and strategies that underpin resilience responses and practitioners should be careful not to think of one client as ‘more resilient than another client’.

Beyond aspirations:
The term resilience has become a pivotal term in the positive psychology movement and particularly within Developmental Psychology where it has facilitated a shift in focus from pathological behaviour to positive adaptation in the face of adversity (7). Initially associated with research focusing on the personality traits and protective factors that enable children to survive hardship (8), resilience research increasingly expanded to explore the processes through which people develop coping resources (9) as well as the dynamic role of social, biological, and ecological factors in this process (10). Moreover, researchers began to critique studies that conceptualised resilience as extraordinary functioning and that restricted the application of the concept to a small elite. Researchers, such as Masten (6) argued that resilience was composed of ordinary rather than extraordinary processes (6) leading to a range of psychological outcomes – not just positive ones (11). In the eyes of these researchers, resilience should be a goal potentially attainable by anyone, not just a select few. Others added that the concept should include the possibility of personal ‘growth’ as a result of, not just in spite of, the experience of adversity (12, 13).

Psychological and psychiatric approaches tend to focus predominantly on cognitive and emotional factors as well as social connectedness. Such approaches are widely criticised by social scientists for not taking into account social, political, and cultural factors that produce
unequal access to resilience-enhancing resources and assets (14-17). Researchers that take a more systemic view have argued that resilience is a social and cultural good and that social policy is one of its key influencing factors (16, 18). Moreover, it is increasingly recognised that risk and protective factors are cumulative and linked in risk chains (16, 19). Indeed, life course theory researchers have argued for some time that policy initiatives have a crucial role in reducing vulnerabilities, ensuring that people have reserve capacity (human, social and economic capital) and are well-equipped to face adversity later in life but also offering them adequate compensatory supports as they age (20). They also emphasise the importance of age-friendly environments to facilitate resilience in older age.

Over the last two decades, the concept of resilience has been adopted by disciplines, such as environmental science, anthropology, gerontology, sociology, and health promotion. As a result, terms such as economic resilience, social and community resilience, or environmental resilience have become common place (17, 21). Within these disciplines, resilience is increasingly seen as an outcome of the availability of resources or assets, individual or communal competency or capacity, and personal and/or collective experiences enabling successful and sustainable resistance and/or adaptation to adverse events (22). Some researchers, employing a systemic conceptualisation of resilience, feature resilience as a negotiated process involving environmental, social, and individual factors. Within this context, resilience is ideally about striving towards a balance between a myriad of risks and protective factors, between collectively organised social assistance, family supports, and autonomy (see, for instance, 23). Figure 1 provides a graphic representation of the multi-layered factors that shape resilience as employed by more holistically inclined researchers.
While a more holistic approach adds important dimensions to the concept of resilience, most researchers gloss over negative aspect or systemic issues associated with resilience. Resilience strategies can have sub-optimal or even negative outcomes for individuals and for families. Maladaptive change is indeed a possibility. Moreover, an individual’s resilience strategies may undermine the resilience of a partner, friend, or family member. For example, a family’s resources may be focused on the needs of a member with a chronic illness leaving insufficient resources for other family members. More cathartic strategies may be illegal, anti-social, or socially unacceptable. Others may be legal, acceptable, and desirable but do not attract funding because they are not considered to comply with governmental guidelines.
More outspoken, resourceful, and uncompromising individuals or groups may be able to mobilise and attract social support services at the expense of other less vocal individuals or groups. In other words, people/groups have unequal access to resilience-enhancing resources and assets.

Social support – formal and informal – has the potential to eliminate some of this disparity. However, rather than encouraging older people’s resilience, some gatekeepers routinely generate obstacles. They tend to side with the outspoken, with the socially adept and tend to ignore or even discriminate against others. Resilience can be about relationships of power. It can be about empowering people to change power dynamics to build their own resilience. For instance, a woman facing an abusive relationship may benefit from formal social and psychological supports building her confidence and self-worth. This might enable her to become an actor and not merely to cope.

While power differentials may be an important aspect of resilience strategies, many older people will benefit from individually-focused approaches that enhance their emotional, cognitive, and social resilience strategies. Resilience strategies can moderate, mitigate, or transfer adversity or the risk of adversity. However, strategies that mitigate or transfer risk in the short run may not be sustainable in the long run and might even increase the risk of adversity over time. It is also possible that transferring one vulnerability may increase susceptibility to another vulnerability (17). While resilience strategies often lead to positive outcomes, they hardly ever give rise to outcomes that are entirely desirable or intended. It is therefore important to carefully consider the implications associated with resilience strategies.

To sum up the above, resilience strategies can have positive/desirable, negative/undesirable, unintended, or neutral outcomes. They can be

- Individual, community, or society focused
- Empowering or disempowering
- Proactive or reactive
- Short term or long term
- Sustainable or unsustainable
- Pre-existing or to be constructed (17)
A negotiated process involving environmental, social, and individual factors (23)

In this report resilience is regarded as developing and bringing to bear complex and multi-layered protective factors on vulnerabilities and adversities.

**Literature Review: Resilience and Ageing Research**

A number of gerontologists regard resilience as useful for exploring how older people negotiate adversities later in life (24) and resilience has become a small but growing research area within ageing research. Within gerontology, resilience is viewed as a further step away from pathology-focused research towards a strength-based approach, while also offering a more achievable aspirational goal than, for instance, the ‘successful ageing’ approach (25). Although still largely concerned with overcoming problems (26), the resilience approach has allowed researchers to highlight that many older people have learnt over the life course to deal with adversity and do well when they face challenges in later life. One group of influential resilience gerontologists borrows heavily from Development Psychology conceptualising resilience as personality traits that promote inner strength such as ‘internal hardiness’ placing emphasis on adaptability and realistic outlook (27-30), spiritual and social involvement and social support (31), or on sense of meaningful purpose, the belief to be able to influence your environment, and the ability to learn from positive and negative experiences (32). In general, these researchers focus on ‘positive psychological outcomes’ in the face adversity. More recently a new generation of researchers focusing on resilience later in life is applying a more holistic framework that takes into account a wider range of individual, social and environmental factors (24, 33, 34). However, the concept of later life resilience continues to be ill-defined and new approaches will need to emerge to integrate the micro, meso, and macro levels contained within the concept.

The following table (Table 1) provides an overview over the research literature focusing on resilience later in life. Since two extensive literature searchers were conducted as recently as 2011 (24, 34), the literature below was sourced through these existing searchers. In addition, a Google scholar search was conducted to identify research-based publications published between 2010 and 2012, a period not covered by the reviews in question. In order to be included in this report, publications had to report on research outcomes focusing on resilience in people aged 60 and over. Given the relative dearth of research in this area, we decided to
include both peer-reviewed publications as well as research reports published online.

**Table 1: Overview over the research literature focusing on later life resilience**

<table>
<thead>
<tr>
<th>Author(s) (Year of publication)</th>
<th>Method &amp; Country</th>
<th>Study population, Method &amp; Sample</th>
<th>Key Findings</th>
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<tbody>
<tr>
<td>Wagnild and Young (1990, 1993) (30, 35)</td>
<td>Qualitative, US</td>
<td>Interviews with 24 women aged 67-92</td>
<td>Qualities/traits: Equanimity (a balanced perspective of one’s life), perseverance (willingness to continue to reconstruct one’s life and to remain involved), self-reliance (belief in one’s capabilities), meaning making (the faith that life has a purpose), existential aloneness (belief that each person’s path is unique).</td>
</tr>
<tr>
<td>Laferrier and Hamel-Bissell (1994)[29]</td>
<td>Qualitative, rural US (Vermont)</td>
<td>Interviews with 6 women aged 87-93</td>
<td>Factors: Social support, living off the land, an attitude of perseverance and determination, and working hard</td>
</tr>
<tr>
<td>Talsma (1995)[36]</td>
<td>Quantitative, Netherlands</td>
<td>5,279, mean age 69.6 years, 3.4% aged &gt;85, homogeneous sample of men and women.</td>
<td>Three dimensions of resilience: physical functioning, psychological functioning, and well-being. Key insights: Resilient elders have high levels of physical functioning, are willing to take initiative and to expand behaviour, believe they have control over their life, and are generally satisfied with their lives.</td>
</tr>
<tr>
<td>Neary (1997)[37]</td>
<td>Qualitative, US</td>
<td>Interviews with 18 women aged 72-98 (2 African American, rest Caucasian)</td>
<td>Strategies: Taking action whenever possible, strategizing to maximise resources, focusing to deal with the emotional consequences of adversity Qualities: flexibility, tolerance, independence, determination, and pragmatism.</td>
</tr>
<tr>
<td>Felten (2000)[38]</td>
<td>Qualitative, US</td>
<td>Interviews with 7 women (various ethnicities)</td>
<td>Factors: determination, experience of previous hardship, knowledge of availability of assistive services, strong cultural and religious values, family and family-like support, self-care activities, care for others. Research participants experienced resilience as something very concrete (outcome of a planned process).</td>
</tr>
<tr>
<td>Bauman et al. (2001)[31]</td>
<td>Qualitative, US</td>
<td>Interviews with 10 people aged 86-94, 7 women, 3 men, 8 Caucasian, 1 Afro-American, 1 American Indian</td>
<td>4 Dimensions of resilience: Social: social support, maintaining friendships, cultivating social network Spiritual: faith, belief, values, meditation Emotional: behave in accordance with emotional rather than social expectations, emotional honesty Physical: regular exercise, healthy diet, self-care, remaining active Strategies: reframing, denial, flexibility, cultivating a positive frame of mind, remaining active, seeking information</td>
</tr>
<tr>
<td>Bonanno (2002 and 2005)[40, 41]</td>
<td>Quantitative, US</td>
<td>Measurements at T+6 and T+18 months (2002 study) and T+4 and T+18 months (2005 study)</td>
<td>Adversity: Bereavement. Factors: hardiness, self-enhancement, positive affect and humour, successful use of repressive coping The authors identify three manifestations of resilience: (1) present throughout the bereavement process, (2) gradual development of resilience, and (3) resilience after turning point.</td>
</tr>
<tr>
<td>Becker and Newsom (2005)[14]</td>
<td>Qualitative, longitudinal, US</td>
<td>Interviews with 38 Afro-Americans (12 men, 26 women), aged 65-91 over 10 years</td>
<td>Qualities: determination, perseverance, tenacity, independence. Strategies: faith, self-care, positive frame of mind, resisting in the face of discrimination – meaning making, acquiring knowledge, being informed, goal setting, cultivating interests, social engagement, Racism and oppression shapes people’s responses to adversity. This generates culturally specific philosophies. Resilience has to be understood within this context.</td>
</tr>
<tr>
<td>Nygren et al. (2005)[42]</td>
<td>Quantitative, Sweden</td>
<td>Umea 85+ Study</td>
<td>Testing various resilience and wellness scales. Significant correlations between Resilience Scale, Sense of Coherence Scale, Purpose in Life Test, and the Self-Transcendence Scale. The scales measure domains of internal strength. The oldest old have similar or higher levels of internal strength than younger cohorts.</td>
</tr>
<tr>
<td>Nakashima and Canda (2005)[13]</td>
<td>Qualitative, Japan</td>
<td>In depth interviews with 16 older palliative care patients</td>
<td>Key insight: resilience should be seen not only as ability to cope with adverse circumstances in ways that enable them to maintain normal functioning, but also in ways that facilitate continuing growth. Need for a balance between adequate care-giving resources and personal strengths carried over from previous life experience as well as importance of internal</td>
</tr>
<tr>
<td>Author(s) (Year of publication)</td>
<td>Method &amp; Country</td>
<td>Study population, Method &amp; Sample</td>
<td>Key Findings</td>
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<tr>
<td>Cohen et al. (2006)[43]</td>
<td>Qualitative, US</td>
<td>Narrative approach involving 24 multi-ethnic (Latino, Korean, African, Jewish, and Caucasian) older people (9 men, 15 women)</td>
<td>Key insights: narratives serve to create and reflect on personal meaning of events.</td>
</tr>
<tr>
<td>Yorgason et al. (2007)[44]</td>
<td>Qualitative, US</td>
<td>Interviews with 8 couples aged &gt;60 with a hearing loss.</td>
<td>Key insights: narratives serve to create and reflect on personal meaning of events.</td>
</tr>
<tr>
<td>Fuller-Iglesias et al. (2008)[46]</td>
<td>Quantitative, US</td>
<td>Interviews with subsample (n=99) of larger study of older men (37%) and women (63%) with a mean age of 74.5 years</td>
<td>Adversity: six or more adverse events over previous 12 years. Larger network size was associated with fewer depressive symptoms and greater life satisfaction, quality of spousal relationship impacts on life satisfaction. Social relations may be an important protective factor facilitating resiliency in later life.</td>
</tr>
<tr>
<td>Braudy Harris (2008)[47]</td>
<td>Qualitative</td>
<td>Older people with Alzheimer’s</td>
<td>Adversity: Alzheimer’s Focus: ability to balance recognition of impact of both individual and environmental resources.</td>
</tr>
<tr>
<td>Hegney et al. (2008) [23]</td>
<td>Participatory Action Methodology Qualitative and Quantitative</td>
<td>PAR with 14 community leaders involving 10 interviews and 1 focus group. Qualitative/Quantitative: 72 interviews with service providers, special needs groups, young people, commercial sector, farming families, resilient individuals.</td>
<td>Key insights: individual, physical and social factors are seen as working together informing resilience. Individual resilience contributes to community resilience and vice versa. Resilience strengthens over time. Factors: social networks and support, positive outlook, learning, early experience, environment and lifestyle, infrastructure and support services, sense of purpose, diverse and innovative economy, embracing difference, and leadership. Connection to land, family, culture, and being part of a rural community were both risk and resilience factors.</td>
</tr>
<tr>
<td>Author(s) (Year of publication)</td>
<td>Method &amp; Country</td>
<td>Study population, Method &amp; Sample</td>
<td>Key Findings</td>
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<tr>
<td>Brown et al. (2009)[18]</td>
<td>Qualitative, Hawaii</td>
<td></td>
<td><strong>Adversities</strong>: colonisation, wars, declining land affordability, changes to family structures, deteriorating health (obesity, hypertension, cancer, heart disease).&lt;br&gt;<strong>Key insights</strong>: resilience as collective, rather than individual good (process or resources) grounded in cultural values and tradition.&lt;br&gt;<strong>Protective factors</strong>: collective resilience – establishment of health, education and housing services by and for Hawaiians, the revival of Hawaiian culture and language, return of federal lands, partial self-determination.</td>
</tr>
<tr>
<td>Moyle et al. (2010)[49]</td>
<td>Qualitative, Australia, UK, Germany, South Africa</td>
<td>Interviews with 58 people aged &gt;65.</td>
<td><strong>Adversity</strong>: social isolation and loneliness, social worth, self-determination, security.&lt;br&gt;<strong>Strategies</strong>: maintaining community connections and relationships, keeping active, emotional, practical and spiritual coping.</td>
</tr>
<tr>
<td>Bennett (2010)[50]</td>
<td>Qualitative, UK</td>
<td>Re-analysis of 2 studies (15 men and 45 women)</td>
<td><strong>Adversity</strong>: Bereavement&lt;br&gt;<strong>Factors</strong>: worldview, self-enhancement, continuity of identity, continuing bonds and concrete aspects of self, expressed in roles and behaviours&lt;br&gt;<strong>Process</strong>: Some were resilient during bereavement (positive attitude towards life), some became gradually resilient (getting on with life) and some became resilient after experiencing a ‘turning point’ (receiving support).</td>
</tr>
<tr>
<td>Alex (2010)[51]</td>
<td>Qualitative, Sweden</td>
<td>Interviews with smaller sub-sample (n=24, 17 women and 7 men, aged &gt;85) of Umeå 85+ study (N=1250)</td>
<td><strong>Key themes</strong>: feeling connected, feeling independent and creating meaning. Gender shapes resilience responses.</td>
</tr>
<tr>
<td>Blane et al. (2011)[52]</td>
<td>Quantitative, qualitative, UK</td>
<td>Focus: social resilience-promoting factors. Reanalysis of English Longitudinal Study of Ageing, ELSA, the British Household Panel Survey, and a sub-study of Boyd Orr study.</td>
<td><strong>Adversities</strong>: ill health, financial deprivation&lt;br&gt;<strong>Resilience</strong>: defined as exclusive trait.&lt;br&gt;<strong>Key findings</strong>: resilience at older age is dependent on level of adversity. Resilience is either unrelated to or related only weakly to a person’s socio-demographic characteristics. Instead resilience is more strongly associated with a person’s inter-personal relationships, but only if they are present before or during exposure to adversity. Resilience is derived from using resources, primarily inter-personal, to stabilise the life change consequent to adversity.</td>
</tr>
<tr>
<td>Fredrikson-Goldsen et al. (2011)[53]</td>
<td>Multi-methods, US</td>
<td>Reanalysis of population based information and qualitative research involving community-based organisations in Washington State identifying risk and protective factors.</td>
<td><strong>Adversity</strong>: sexuality/gender-based social discrimination, isolation, and lack of support&lt;br&gt;<strong>Key findings</strong>: About ⅓ of LGBT participants have a disability, 1/3 reported depression, 91% engage in wellness activities, around 2/3rd have been victimised three or more times, 13% have been denied healthcare or received inferior care, 20% do not disclose their sexual or gender identity for health care. Lack of services: housing, LGBT-friendly care services, information, transportation, legal services, and social events.&lt;br&gt;<strong>Key Recommendations</strong>: cultural competency training for aged care professionals, facilitate legal planning, integration of LGBT competencies in education and training, and further research</td>
</tr>
<tr>
<td>Wiles et al. (2012)[33]</td>
<td>Qualitative, New Zealand</td>
<td>Interviews and focus groups with 121 older people, aged 56-92 (44 men and 77 women) living in 2 socially deprived, multi-ethnic communities</td>
<td><strong>Factors</strong>: internal resources: attitude, cultivating a positive frame of mind, counting one’s blessings, religious faith, working for others and society, making the most of things, having a purpose in life (work, pets, learning new things, cultural roles), keeping busy and engaged, challenging yourself vs. adapting and disengaging or selectively limiting activities, motivation, humour, adaptation.&lt;br&gt;<strong>Assets</strong>: supportive environment, urban and communal infrastructure (transport, health, clubs, associations), culture and social relations (friendliness), appropriate housing, assistive technologies, low traffic volume, quality of built environment (age-friendly places), health, family, friendships, social networks, communal and neighbourhood ties.&lt;br&gt;<strong>Key findings</strong>: gender and age shape resilience responses; resilience factors are interlinked; research definitions of resilience are narrow compared to views of participants; older people tend to compensate for resilience factors that are not within their reach.</td>
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</table>
The reviewed literature approaches resilience in terms of personality traits, cognitive strategies, social connectedness, as well as emotional and psycho-social and physical self-care strategies. Researchers focused on adversities such as bereavement, chronic or terminal illness, financial deprivation, negative health events, hearing loss, mobility issues, social isolation, and discrimination (social, cultural, sexual/gender). Authors can be assigned to two major camps: a) a theory driven body of research largely inspired by developmental psychology including a subgroup that seeks to empirically measure resilience and b) research inspired by hermeneutical phenomenology that explores the meaning older people assign to the phenomenon. Whereas the former tends to be bound by their respective academic discipline, the later tend to be more inter-disciplinary in scope. Few authors have begun to explore systemic aspects of crises and adversities and their impact on the resilience of older people.

Resilience researchers focusing on older people draw on a range of coping and life course theories. Two ageing theories are worth mentioning as they are cited more widely: (1) the *Selective Optimisation with Compensation* or SOC theory developed by Baltes and Baltes (54) and the (2) *Response to Transitions and Crises* or RTC framework by Moos and Schaefer (55).

1. The SOC theory essentially holds that in older age, people select from their sphere of activities those of the highest priority (those allowing for satisfaction and personal control) effectively reducing their expectations. In turn, they optimise their functioning in certain domains by accessing their reserve capacity. Furthermore, they compensate for losses by drawing on additional resources.

2. Moos and Schaefer’s RTC framework developed in the mid-1980s proposes that:
   - Crisis or transitions are not necessarily harmful but can provide a catalyst for positive development and
   - An individual’s responses are shaped by demographic and personal characteristics, the nature of the crisis or transition, and features of the physical and social environment.

Moos and Schaefer further propose five adaptive tasks that individuals have to master if they are to successfully face crises or transitions:

1. Being able to turn an adverse event into something meaningful and of personal significance,
2. Realistically address the requirements of the adverse event,
3. Sustaining relationships with individuals,
4. Managing the feelings aroused by the event, and
5. Preserving a satisfactory self-image and sense of competence.

Moos and Schaefer argue that three groups containing nine types of coping skills are utilised:

1. Appraisal-focused coping
   a. Logical analysis and mental preparation
   b. Cognitive re-definition
   c. Cognitive avoidance and denial

2. Problem-focused coping
   a. Seeking information and support
   b. Taking action,
   c. Identifying alternative rewards

3. Emotion-focused coping
   a. Affective regulation
   b. Emotional discharge
   c. Resigned acceptance

Several among the researchers focusing on resilience in later life regard storytelling, the continuous re-narration of life events, as a crucial building block of resilience. Turning the narration of the past into a constructive process that provides a thread of continuity between the past and the present allows older people to reconcile themselves with loss and discover their own ability to overcome adversities and see themselves as resilient (13, 25). Seen as a psychological cumulative that occurs over a lifetime, this process contributes to the maturity older people require to deal better with adversity. At this point, resilience research meets up with contributions to ‘lifespan theory’. The work of Staudinger, Marsiske, and Balter (28), for instance, highlights that older people have better developed coping strategies and reserve capacity than younger people and are therefore better able to deal with loss and grief in later life.

Evidently, there are enormous gaps in the still very embryonic literature focusing on later life resilience. In particular, there are few studies that systematically explore how older people build and draw on resilience resources at the micro, meso, and macro level to face
challenging circumstances. Moreover, there is a dearth of studies focusing on how adversities shape resilience responses. This study provides some evidence to address these gaps in the literature.
The aim of this research project was to (a) explore strategies that older people employed in the face of adversity and to (b) extrapolate implications for aged care professionals. The project was designed as a preliminary study aimed scoping a resilience approach for community aged care. A qualitative methodology is customarily used in such exploratory research. In this case, it involved a focus group meeting and semi-structured interviews. Ethics approval was obtained from Deakin University. Financial governance (disbursing and payment of accounts) was provided by UnitingCare Community Options and Deakin University.

Two Phases
The project was conducted in two phases. Phase 1 consisted of a summative literature review as well as a focus group meeting involving older people (aged 60 and older) and carers. The purpose of Phase 1 was to identify likely themes that would be generated by the semi-structured interviews in order to construct meaningful interview questions. A convenience sample of 8 focus group participants was recruited in March 2009. The group formed part of a reference group to another project. They were approached by the research team, given a summary of the research aims, and provided with a plain language statement. The group unanimously agreed to participate in the project and informed consent was obtained before the group meeting.

Procedure: The focus group session (53 minutes) was conducted in mid April 2009. Three questions accompanied by prompts were posed during the focus group meeting:

1. What does ‘resilience’ mean to you?
2. Have you ever been in a situation where your own resilience helped you to manage difficult times?
3. How would you go about building resilience?

In addition, focus group members were asked whether they found the questions meaningful. Responses served as a basis for the development of the interview schedules.
Data Analysis: Focus group responses were recorded in note form only. A content analysis was conducted focusing on how participants responded to the questions. The results from this process in conjunction with the insights derived from the literature review shaped the development of the interview schedule for Phase 2. The final interview schedule was tested by 5 older people volunteering for the task.

Phase 2 involved data collection and analysis. A convenience sample of 23 older people and 8 carers were recruited and interviewed. Participants were drawn from a pool of approximately 260 clients of a Melbourne-based community aged care brokerage provider. In order to be eligible to participate they had to be aged 60 or older, had to be able to participate in a face-to-face interview lasting around one hour, and to give informed consent. Moreover, they had to be interested in the topic of resilience. Potential participants were selected and approached by their case managers. If interested in the project, their contact details were, with their permission, forwarded to the research team. A research team member contacted potential participants and gave them an overview of the project. If the person was willing to participate, informed consent was obtained and a face-to-face semi-structured interview was conducted. A total of 31 people agreed to participate in the project. Table 2 below displays demographic information of participants.

Procedure: Interviews took place between June 2009 and December 2011. The following questions served as a template during the interviews. They were adjusted depending on the situation and the responses provided by the interviewee:

- What does resilience mean to you?
- Can you give me an example based on a life event that highlights what resilience is for you?
- Do you think that resilience still can be actively fostered?
- What other factors do you think contribute to your resilience?

Prompts:
- Self-Care: Physical Exercise, healthy eating, medication management, lifestyle.
- Building reserves (physical, cognitive, social, emotional, material)
- Leisure
- Sense of control, having control over services
- Making sense of difficult circumstances
- Awareness of stressors and protective effects/minimising risk
- Stress Management/Coping Strategies
- Planning ahead
- Being well informed

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- Social network/family
- Collective action/advocacy
- Social services/income support
- Assistive technology
- Built physical environment
- Having an emotional ‘home’
- Treasuring values and certain regularities in life
- Successfully overcoming of difficulties in the past
- Outlook on life

If someone would like advice on how to foster resilience, their ability to withstand difficult events, what would you advise them to do?

**Data Analysis:** Interviews were digitally recorded. Of the 31 recordings, 6 were not transcribed (5 due to media failure and 1 due to poor sound quality or slurred speech). The remaining 22 interviews were de-identified and transcribed. A copy of the transcript was sent to participants to give them an opportunity to revise their statements. Six participants made use of this offer. Transcripts were imported into a qualitative analysis software package (NVIVO) and thematically coded. A hybrid approach of inductive and deductive coding and theme development integrating data- and theory-driven codes was used to interpret raw data (56). Whereas insights derived from the research literature provided a starting point for the development of the codes, initial code categories were reshaped in light of the data generated. In other words, code categories were not entirely derived organically from the ‘ground up’ drawing exclusively on field work materials but were, at least initially, shaped by our knowledge of the research literature.

**Table 2: Demographic Overview of Participants**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Adversity</th>
<th>Interview Transcribed</th>
<th>Focus Group</th>
<th>Ref.</th>
</tr>
</thead>
<tbody>
<tr>
<td>m</td>
<td>85</td>
<td>Anglo-Australian</td>
<td>Minor mobility issues</td>
<td>x</td>
<td>RES026</td>
<td></td>
</tr>
<tr>
<td>m</td>
<td>100</td>
<td>Anglo-Australian</td>
<td>Mobility Issues</td>
<td>x</td>
<td>RES029</td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>78</td>
<td>Anglo-Australian</td>
<td>Mobility Issues due to accident</td>
<td>x</td>
<td>RES028</td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>60</td>
<td>Italian-Australian</td>
<td>Life-long chronic illness</td>
<td>x</td>
<td>RES016</td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>78</td>
<td>Anglo-Australian</td>
<td>Disability, mobility issues</td>
<td>x</td>
<td>RES021</td>
<td></td>
</tr>
<tr>
<td>f &amp; m</td>
<td>mid 80s</td>
<td>Chinese</td>
<td>f: disability, vision impairment; m: carer</td>
<td>x</td>
<td>RES027</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>Age</td>
<td>Ethnicity</td>
<td>Health Problem</td>
<td>Caregiver</td>
<td>Proxy</td>
<td>ID</td>
</tr>
<tr>
<td>--------</td>
<td>-------</td>
<td>--------------------</td>
<td>-----------------------------------------------------</td>
<td>-----------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>m</td>
<td>mid 80s</td>
<td>Anglo-Australian</td>
<td>Stroke, disability, mobility issues</td>
<td>x</td>
<td>x</td>
<td>RES010</td>
</tr>
<tr>
<td>m</td>
<td>mid 70s</td>
<td>Anglo-Australian</td>
<td>Disability, amputation, acquired brain injury, stroke</td>
<td>x</td>
<td></td>
<td>RES022</td>
</tr>
<tr>
<td>f</td>
<td>65</td>
<td>Anglo-Australian</td>
<td>Parkinson’s, disability, mobility issues</td>
<td>x</td>
<td></td>
<td>RES014</td>
</tr>
<tr>
<td>m</td>
<td>81</td>
<td>Anglo-Australian</td>
<td>Medical accident, disability, mobility issues</td>
<td>x</td>
<td></td>
<td>RES012</td>
</tr>
<tr>
<td>m &amp; f</td>
<td>81</td>
<td>Anglo-Australian</td>
<td>m: carer; f: chronic Illness</td>
<td>x</td>
<td></td>
<td>RES011</td>
</tr>
<tr>
<td>f &amp; m</td>
<td>87</td>
<td>Anglo-Australian</td>
<td>f: carer; m: acquired brain injury, disability</td>
<td>x</td>
<td></td>
<td>RES003</td>
</tr>
<tr>
<td>f (f carer proxy response)</td>
<td>mid 70s</td>
<td>Greek-Australian</td>
<td>Stroke, disability, mobility issues</td>
<td>x</td>
<td></td>
<td>RES020</td>
</tr>
<tr>
<td>m</td>
<td>78</td>
<td>Anglo-Australian</td>
<td>Carer (dementia, bereavement)</td>
<td>x</td>
<td>x</td>
<td>RES015</td>
</tr>
<tr>
<td>f</td>
<td>79</td>
<td>Anglo-Australian</td>
<td>Carer (dementia, bereavement)</td>
<td>x</td>
<td></td>
<td>RES009</td>
</tr>
<tr>
<td>f</td>
<td>70</td>
<td>Italian-Australian</td>
<td>Carer (disability, mobility issues)</td>
<td>x</td>
<td></td>
<td>RES030</td>
</tr>
<tr>
<td>f</td>
<td>80</td>
<td>Anglo-Australian</td>
<td>Carer (disability, mobility issues)</td>
<td>x</td>
<td></td>
<td>RES001</td>
</tr>
<tr>
<td>f</td>
<td>Mid 80s</td>
<td>Anglo-Australian</td>
<td>Carer (disability, mobility issues)</td>
<td>x</td>
<td></td>
<td>RES024</td>
</tr>
<tr>
<td>f</td>
<td>80</td>
<td>Anglo-Australian</td>
<td>Abusive relationship</td>
<td>x</td>
<td></td>
<td>RES018</td>
</tr>
<tr>
<td>f</td>
<td></td>
<td>Anglo-Australian</td>
<td>Abusive relationship</td>
<td>x</td>
<td></td>
<td>RES007</td>
</tr>
<tr>
<td>f</td>
<td>81</td>
<td>Anglo-Australian</td>
<td>Abusive relationship</td>
<td>x</td>
<td></td>
<td>RES023</td>
</tr>
<tr>
<td>m</td>
<td>96</td>
<td>Anglo-Australian</td>
<td>Hearing loss, mobility issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>m</td>
<td>80</td>
<td>Anglo-Australian</td>
<td>Stroke, Cancer</td>
<td></td>
<td></td>
<td>RES019</td>
</tr>
<tr>
<td>m</td>
<td>76</td>
<td>Anglo-Australian</td>
<td>Carer (dementia)</td>
<td></td>
<td></td>
<td>RES012</td>
</tr>
<tr>
<td>f</td>
<td>77</td>
<td>Italian-Australian</td>
<td>Stroke, Arthritis</td>
<td></td>
<td></td>
<td>RES018</td>
</tr>
<tr>
<td>f</td>
<td>74</td>
<td>Serbian-Australian</td>
<td>Carer (dementia)</td>
<td></td>
<td></td>
<td>RES007</td>
</tr>
<tr>
<td>m</td>
<td>79</td>
<td>Ukrainian-Australian</td>
<td>Arthritis, mobility issues</td>
<td></td>
<td></td>
<td>RES023</td>
</tr>
<tr>
<td>f</td>
<td>75</td>
<td>Sri Lankan-Australian</td>
<td>Stroke</td>
<td></td>
<td></td>
<td>RES019</td>
</tr>
</tbody>
</table>
RESULTS:

Meaning of Resilience:
Participants provided us with a wide range of definitions of resilience. A total of 17 thematic responses were offered to the question ‘what does resilience mean to you’. They included personality traits, emotional and cognitive factors such as confidence and competency and strategies. The most frequent responses were ‘accepting change’, ‘endurance, flexibility, elasticity, and rebound’, ‘internal strength’, ‘confidence and trust in one’s own ability’, and ‘developing strategies’. A number of participants researched the meaning of the concept in a dictionary before the interview leading them to define resilience in terms of endurance, flexibility, elasticity, and rebound. The following table (Table 3) provides an overview of the definitions given and the number of interviews the theme occurred in.

Table 3: Resilience: Definition

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting Change</td>
<td>11</td>
</tr>
<tr>
<td>Endurance, Flexibility, Elasticity, Rebound</td>
<td>11</td>
</tr>
<tr>
<td>Personality trait, internal strength</td>
<td>10</td>
</tr>
<tr>
<td>Confidence, trust in one’s own ability</td>
<td>9</td>
</tr>
<tr>
<td>Developing Strategies</td>
<td>7</td>
</tr>
<tr>
<td>Being able to ask for help</td>
<td>6</td>
</tr>
<tr>
<td>Being in Control</td>
<td>6</td>
</tr>
<tr>
<td>Demanding (Social) Justice</td>
<td>4</td>
</tr>
<tr>
<td>Challenging yourself, to be courageous</td>
<td>4</td>
</tr>
<tr>
<td>Allowing yourself to be sad</td>
<td>3</td>
</tr>
<tr>
<td>Response to feeling discriminated against</td>
<td>3</td>
</tr>
<tr>
<td>Excitement</td>
<td>1</td>
</tr>
<tr>
<td>Faith</td>
<td>1</td>
</tr>
<tr>
<td>Feeling stronger later in life</td>
<td>1</td>
</tr>
<tr>
<td>Fit to look after yourself</td>
<td>1</td>
</tr>
<tr>
<td>Hope</td>
<td>1</td>
</tr>
<tr>
<td>Strength as result of weakness of other</td>
<td>1</td>
</tr>
</tbody>
</table>
Several of the participants were members of a minority group (cultural or disability) and/or a lower socio-economic stratum of society. These participants saw resilience more in terms of ‘demanding social justice’ and a ‘response to feeling attacked’.

“I’ve always been a fighter. If they say it can’t be done, I think, yes it can. One way or another, it will get done. And so have a go at it.” (RES010)

“ Battlin’ your way through things.” (RES022)

“… don’t try to screw me over and any loved one of mine. Because, I don’t like it … I will fight. It’s just naturally built in me, that if I get angry, or I see something is not right, it’s the logical part of it, it’s the humanitarian part of it … the justice (Greek: dikio) of it. … Once it’s a battle that’s where your resilience comes out … Resilience comes from hurt, comes from anger, from anxiety it comes from your own self-worth and what you value … how you want to see them treated… Being just. That’s all it is.” (RES020)

“[Resilience] is people getting up and having a go when things happen to them or in their family, the going gets tough and it seems that people get resilient, the tough keep going.” (RES021)

“And this doctor looked across the desk and said “what would you expect with a mother like you? And her reaction was ..., because she had a tough upbringing, she said ‘tell Sue don’t let that bugger beat ya!’ Well I think that people, who are resilient, may use another phrase but they’re going to get on top of it.” (RES021)

Adversities:
Moose and Schaefer propose that an individual’s resilience responses are shaped, among other factors, by the nature of the adversity or transition. Only major adversities highlighted by participants were recorded in this study. Four most frequently mentioned types of adversities included:

1. Facing an illness, accident, or disability,
2. Caring for another person,
3. Abusive relationships,
Other types of adversities mentioned within the narratives included ‘financial deprivation’, ‘drugs and substance abuse’, ‘political circumstances’, and ‘arranged marriage’. Table 4 provides an overview of the types of adversities and the number of interviews the adversity was mentioned in. Most of the participants faced more than one single adversity.

Table 4: Types of Adversity

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring, Terminal Illness</td>
<td>9</td>
</tr>
<tr>
<td>Accident, Illness, Disability</td>
<td>9</td>
</tr>
<tr>
<td>Financial Deprivation</td>
<td>7</td>
</tr>
<tr>
<td>Discrimination</td>
<td>4</td>
</tr>
<tr>
<td>Spouse</td>
<td>4</td>
</tr>
<tr>
<td>Drugs</td>
<td>1</td>
</tr>
<tr>
<td>Political Circumstances</td>
<td>1</td>
</tr>
<tr>
<td>Arranged Marriage</td>
<td>1</td>
</tr>
</tbody>
</table>

Resilience Responses:
Resilience responses were obtained by analysing participants’ answers to subsequent interview questions. These questions asked participants to explain on the basis of a lived experience how they overcame a crisis point or respond to prompts. The resulting narratives provided us with a wide range of resilience strategies. We identified a total of 57 distinct strategies that were assigned to the following four main categories:

- Environmental factors,
- Human factors,
- Social factors, and
- Infrastructure.

We tested a range of classification schemes drawing on the existing literature but found that this Bourdieu-inspired (57) classification provides the most meaningful headings.

Resilience Strategies by Cluster:
When examining the results in terms of clusters containing similar items, the by far most popular clusters of resilience strategies were

- motivational strategies (60 references)
- Friendship, family, and social networks (43 references)
- Capacity building and social support options (33 references)
- Problem solving and decision-making strategies (33 references)
- Stress Management Strategies (26 references) and
- Contestation Strategies (22 references)

Resilience Responses by Adversity:
When analysing the resilience responses by adversity focusing on the top 11 themes it is possible to highlight minor differences between two of the groups. The data suggests at a level of a hypothesis, bearing in mind the small sample size, that carers place greater emphasis on ‘knowing your options’, ‘support, understanding, and encouragement’, ‘relaxation’, and ‘respite’ (see Table 5 below) than the total sample population.

Table 5: Resilience Response by Adversity – Carers

<table>
<thead>
<tr>
<th>Theme</th>
<th>Total Sources</th>
<th>Carers (n=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HC - Problem Solving - Previous Crisis Point, Hardship</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>SC - Cultivating Social Networks and Friends</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>HC - Stress Management - Looking after yourself</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>SC - Family Network</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>HC - Stress Management - Relaxation</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>HC - Spirituality - Religion</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>SC - Friendship</td>
<td>16</td>
<td>5</td>
</tr>
<tr>
<td>PC - Social Support - Case Management</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>HC - Decision Making - Knowing your Options</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>HC - Motivational Strategy - Having and Maintaining Interests, being active</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>HC - Motivational Strategy - Support, understanding, encouragement</td>
<td>9</td>
<td>4</td>
</tr>
</tbody>
</table>

When compared to the total population, older people facing disability, chronic illness, or accidents, on the other hand, mentioned more frequently the ‘capacity building’ potential of social services (see Table 6 below).

Table 6: Resilience Responses by Adversity: Disability, Illness, Accidents

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sources</th>
<th>Illness (n=11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC - Friendship</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>HC - Motivational Strategy - Having and Maintaining Interests, being active</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>HC - Motivational Strategies Positive frame of mind</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>HC - Knowledge</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>SC - Cultivating Social Networks and Friends</td>
<td>16</td>
<td>7</td>
</tr>
</tbody>
</table>
Resilience Responses by Individual Strategy:

When focusing on individual participants’ resilience strategies, the interviews show that participants’ resilience responses are enormously diverse. Indeed, while several of the themes coincide, their strategies are as diverse as their life histories and the situations they find themselves in. Table 7 overleaf provides an overview over the range of resilience strategies employed by participants.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC - Clean Air</td>
<td>RES001 RES003 RES007 RES009 RES010 RES012 RES014 RES015 RES016 RES018 RES020 RES021 RES022 RES023 RES024 RES026 RES027 RES028 RES029 RES030</td>
</tr>
<tr>
<td>EC - Nature</td>
<td>1</td>
</tr>
<tr>
<td>HC - A S - Making Sense of What is Happening</td>
<td>2 x x x x</td>
</tr>
<tr>
<td>HC - Assimilative Strategies - Role Creation</td>
<td>5 x x x x x</td>
</tr>
<tr>
<td>HC - Assimilative Strategy - Resourceful, Content, Modest</td>
<td>4 x x x x</td>
</tr>
<tr>
<td>HC - Contestional Strategies - Expanding what is possible</td>
<td>3 x x x x</td>
</tr>
<tr>
<td>HC - Contestional Strategies - Resisting</td>
<td>11 x x x x x x x x x x x x</td>
</tr>
<tr>
<td>HC - Contestional Strategies - Sense of Purpose</td>
<td>6 x x x x x x</td>
</tr>
<tr>
<td>HC - Decision Making - Involvement in Decision Making</td>
<td>1 x x x x x x</td>
</tr>
<tr>
<td>HC - Decision Making - Knowing your Options</td>
<td>7 x x x x x x x x</td>
</tr>
<tr>
<td>HC - Decision Making - Knowing your weaknesses</td>
<td>1 x x x x x x x x</td>
</tr>
<tr>
<td>HC - Know ledge</td>
<td>11 x x x x x x x x x x x x</td>
</tr>
<tr>
<td>HC - Motivation - Motivation (unspecified)</td>
<td>4 x x x x x x</td>
</tr>
<tr>
<td>HC - Motivational - Hope</td>
<td>2 x x x x x x</td>
</tr>
<tr>
<td>HC - Motivational Strategies Positive frame of mind</td>
<td>14 x x x x x x x x x x x x x x x x</td>
</tr>
<tr>
<td>HC - Motivational Strategy - Having and Maintaining Interests, being active</td>
<td>12 x x x x x x x x x x x x x x x x</td>
</tr>
<tr>
<td>HC - Motivational Strategy - Support, understanding, encouragement</td>
<td>9 x x x x x x x x x x x x</td>
</tr>
<tr>
<td>HC - Motivational Strategy - Values, commitment</td>
<td>5 x x x x x x x x x x</td>
</tr>
<tr>
<td>HC - Motivational Strategy - Working for the greater good</td>
<td>3 x x x x x x x x x x</td>
</tr>
<tr>
<td>HC - Problem Solving - Careful Rational Analysis</td>
<td>3 x x x x x x</td>
</tr>
<tr>
<td>HC - Problem Solving - Controlling Emotions</td>
<td>1 x x x x x x</td>
</tr>
<tr>
<td>HC - Problem Solving - Goal Setting</td>
<td>4 x x x x x x x x x x</td>
</tr>
<tr>
<td>HC - Problem Solving - Previous Crisis Point, Hardship</td>
<td>12 x x x x x x x x x x x x x x x x</td>
</tr>
<tr>
<td>HC - Problem Solving - Pro-active aging - Planning ahead</td>
<td>1 x x x x x x x x x x x x</td>
</tr>
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<td>HC - Problem Solving - Creating Positive Routines, Planning the Day</td>
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<td>HC - Spirituality - Religion</td>
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<td>HC - Stress Management</td>
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<td>HC - Stress Management - Hobby, Creative Outlet</td>
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<td>HC - Stress Management - Looking after yourself</td>
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<td>HC - Stress Management - Meditation, Sensory Experience, Nature</td>
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<td>HC - Stress Management - Sense of Humour</td>
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<td>PC - Physical Infrastructure - Ageing-friendly environment</td>
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<td>PC - Support Services - Capacity Building</td>
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<td>PC - Support services - Capacity Building - Allied Health, Nursing</td>
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<td>PC - Support Services- Home and Personal Care</td>
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<tr>
<td>PC - Cultivating Social Networks and Friends</td>
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<td>SC - Family Network</td>
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<td>SC - Friendship</td>
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<td>SC - Spirituality - Sense of Belonging</td>
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<td>SC - Trust, Sharing with others</td>
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<td>SC - Work Experience</td>
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All participants employed a narrative strategy, re-telling life events in which they feature as 'resilient'. Indeed, some of the participants mentioned that the process of narrating their stories within the context of the research had helped them to better understand their own resilience. Re-remembering may be an important resilience-enhancing activity.

At an individual strategy level, a number of key themes were identified that occurred in more than half of the interviews. They included

- cultivating social networks and friends,
- friendship,
- cultivating a positive outlook on life,
- having and maintaining interests, being active,
- experience of previous crisis points or hardship,
- capacity building and support provided by case managers,
- resisting and challenging one’s circumstances and limitations,
- acquiring knowledge,
- looking after yourself (Self-Care), and
- having family support’.

In other words, the ten most frequently mentioned resilience responses **consisted of a mix of human, social, and physical support factors.** For a complete list of resilience themes identified in the narratives see Table 7 above.

Resilience Themes in Details:

Environmental Factors:

Environmental factors feature in a number of ways in the narrative. For one person with a family history of respiratory problems, the quality of air was important. This enticed the family to move from Port Melbourne to the inner east.

“We didn't move on my account, we moved on Father's account. He had some chesty troubles in the winter and the doctor said look, I think you'd be wise to get over to the other side of Melbourne away from the sea. So that's how it was. One of his closest friends lived in Box Hill. He said if you're going to move you've got to come to Box Hill. He drove us round to see places that were available. It worked with him too, he didn't have any serious health problems after that and I certainly never had asthma since I came here. So it was partly environment, that's one thing, I suppose.” (RES029)
The other participant loved nature and relied on memories of nature as a source of relaxation and strength:

“And the memories of what you have done! How wonderful I find the memories are so strong that in my mind I can see and feel and hear um, sitting right on just below the very peak of um, I forgotten the name of the Mountain Kosciusko just below the peak there’s a lake in an Alpine meadow and rocks. And I was sitting on some rocks in this cold, it was a summers day and the air was cold, the wild flowers were beautiful, the view just below the lake and then it gone down and I could not see. But I could get a glimpse of Mount Buffalo. I could still smell the wildflowers and feel that air and hear that water moving through the ground, which is a silly thing to say, but that what it was. It was not a creek, not as big as a creek not even a tiny river just, it was just moving, the sound of moving water.”

Human Factors:

Human factors constituted the largest category comprising emotional, cognitive, and spiritual factors. Based on the themes identified in the narratives, the following sub-categories emerged:

- Assimilative Strategies,
- Contestation Strategies,
- Decision Making,
- Acquisition of General Knowledge,
- Motivational Strategies,
- Problem Solving Strategies,
- Spirituality, and
- Stress Management Strategies.

Assimilative Strategies included resilience responses that emphasised adaptation. It included themes such as ‘making sense of what is happening’ (2 responses), ‘role creation’ (5 responses), ‘resourcefulness, content, and ‘modesty’ (4 responses). Role creation often appeared in the context of confidence building. The following interview excerpts provide a flavour of these themes:

“So I think that all comes into… it’s meaning in what is happening to you, and that’s where people’s outlook on life is so important”.

“I suppose... I think it made me have a role in life, ... Your role, your job, your position in society, and having to be organised, which again doesn’t come naturally to me... So I
suppose it improved my self-esteem, and didn’t think that everything was going downhill – I was learning a few new skills, in a way.”

“She has a very serious eye sight problem, but I’m letting her do lots of things instead of letting her feel that she is useless. She is doing all the cooking. She does the cooking. She knows where the oils are and soy sauce is. So I’m letting her do the things and building up her confidence.”

“But I think it’s the point of being able to keep going and make the most of what you’ve got. What my mother used to say, “it’s better to be content with what you’ve had” That’s one of her sayings which is quite true. Yeah.”

“But …, look, if there’s anything round the place I can do it, I’ll do it, if I can’t do it, I’ll get someone else in who can do it. It’s a matter of knowing your limits.”

Contestation Strategies were mentioned frequently by participants and particularly by people facing disability, chronic illness or accidents. The category included themes such as ‘expanding what is possible’ (3 responses), ‘having a purpose in life’ (2 responses) and ‘resisting the circumstances’ (11 responses). The following excerpts highlight these themes:

“The ones that are resilient are the ones that realise their capabilities and they will work hard to those capabilities and beyond them if they can, but if they can’t beyond it, they will ask for help. But the people that aren’t resilient, they won’t ask for help. They just try and do [it] themselves – so-called stubbornness, but resilience is different.”

“It is not by standing up to him and yelling at him or anything I am just strong within myself and no matter what he throws at me I am strong enough to sort of resist it really.”

“I’ve always been a fighter. If they say it can’t be done, I think, yes it can. One way or another, it will get done. And so have a go at it.”

“But if you are positive and if you’re bright about it, they are bright in return and the encouragement you get will make you do something you haven’t done before and you go to the top of the building and look at Melbourne or you go to the football and see the Grand Final in a wheelchair. You can do it. And see I can tell other people that I went to the top of Melbourne. That’s good, I’ve ticked the box. They’re all pleased for me and I’m pleased I’ve done it. So that’s good, positive. Positive thinking. Reinforcement.”

Motivational Strategies was the single most frequently mentioned category in this study. It included themes such and having a ‘sense of purpose’ (6 responses), ‘motivation’ (4), ‘hope’ (2), ‘positive frame of mind’ (14), ‘having and maintaining interests, being active’ (12), ‘support, understanding, encouragement’ (9), and ‘values, commitment’ (5).

“Sense of purpose: that’s important, always.” (RES012)
“Yes I wanted to be there for my friend that was the motivation behind that goal. I think you have to have a strong motivation. And if you don’t believe in yourself or believe the reason for doing something the goal is not worth while doing. Well it’s not going to be strong enough for you.” (RES028)

“...support and encouragement and introduce them to things which might give them something to live for. But it comes back to you - it certainly is a tricky one. ... I think the more interests you've got, and filling your time and your mind, that's what makes life worth living, isn't it. ...” (RES029)

“They’ve got to take the initiative really. Because, some are very private; some are very depressed I think, you know. And they do not know how to deal with it. I am only making suggestions.” (RES026)

“The person who goes through you know a tragedy like a stoke or something like that, whatever it is, always need to be given the hope that there is hope for them to have some sort of life even if it’s different, that they have life ahead of them in the future.” (RES020)

“Well I have learnt as I have gone through life that you've got to take the glass being as half full and not half empty.” (RES018)

“I think resilience is mainly a mental attitude. Once you get people to believe that they can do something, when they believe themselves – the mental attitude – that’s where they get their resilience from.” (RES010)

“And you don’t get anywhere much if you just say yes this is bad, I’m not going to get better, of course, you won’t. But if you so need it’s happened and I can’t reverse it but, by Jove, I’m going to do something. And if you are bright the other people are bright. My carer is nice and she’s, we have a bit of fun together, I think I can make her laugh as much as she does me. So in personal relationships you have to feel happy and you’ve got to use that to sort of help you in your determination to move on. Um, if you’re unhappy you can’t communicate with somebody like you or like my carer, or the man down the street or the fellow who rings up on the phone or whatever.” (RES012)

“And I thought I need to do something to make myself feel better, more positive, get into a different frame of mind. And I think that’s um of being part of resilience. That’s how I act out my resilience or put strategies into place to be resilient.” (RES028)

“I mean, you’ve got to be active. You’ve got to be active – Heavens! [Wife: Yeah... You’ve got to be active...if you can]. Well, if you can be, you know. Physically, if you can do it, you do it. Physically, if you can’t do it, you do something else. Keeping the mind active so you’re not sitting there dribbling out of the corner of your mouth sort of thing...” (RES011)

Interviewer: “Do you think that resilience can be ‘built’ for a person who just has faced a major disaster in their lives do you think resilience still can be built, can be actively fostered?” “Sure it can. What you have to do is restore their faith in themselves. Instead of being depressed and defeated they have to be alert and understanding and determined to reverse or to improve the situation.” (RES012)
Decision Making was another important theme. It included ‘being involved in the decision-making process’ (1), ‘knowing your options’ (7), and ‘knowing your weaknesses’ (1). ‘Knowing your options’ was an important theme, frequently mentioned by carers.

“Unless you’re in the know, you can’t really make the best of it.” (RES014)

“... five Years ago I was naïve. Five Years down the track I’ve learnt the system enough and go in and dictate to people what I need done.” ... “It’s value for information. If you don’t get the information you just don’t know.” (RES020)

“And that’s strengthening well I feel strength and resilience is um, knowing your weakness and recognizing your weakness and it’s a double wedged sword ... Unless you know your weakness and how weak you are you can’t be resilient and strong. Does that make sense?” (RES028)

“..., in this good country that we live in, there are an awful lot of things to help you. The main thing is to find out what’s available. And lots of people I meet tell me they’ve suddenly discovered “you know I discovered that I can get this that or the other”. For instance, I’m veteran and I’ve discovered that I can get all my hearing free of charge now, aides and all the rest of it. I mean I never knew that, I was never into that. So there is a lot of help you can get, is getting to know what help is available. So I would say people living alone try and find what help is available.” (RES026)

Knowledge or the acquisition of general knowledge featured in eleven interviews. And particularly people facing disability, illness, or accidents reported on the theme. Although, statements were often general, they appear to be related to the above theme of ‘knowing your options’.

“The more you can learn the better. The more you can learn the better.” (RES018)

“And that is part of positive outlook isn’t it and learning and learning from your experiences and you try and find ways of bettering your understanding (pauses)” (RES003)

“Learning: You can always learn and we get better and we do things better” (RES012)

Absolutely, I think ... that is what gives my life meaning. The fact that I’ve really put the time and effort into graduating as a doctor and having a knowledge of health in a holistic sense and trying to build on that with the theology study ....” (RES016)
Problem Solving Strategies formed another important body of resilience responses. The category included themes like ‘careful rational analysis (3 responses), controlling emotions (3), creating positive routines, planning the day (3), goal setting (4), learning from previous hardship or challenges (12), and planning ahead (1).

“Taking a broad attitude initially at the problem [...] centre, it then highlights um, possible options and you make a mental decision. Concentrate and very often achieve it. ... I still put it down to accepting the fact and seeing what you can do um, to improve the situation, you can do within yourself to control emotions.” (RES003)

“I think really you can’t think straight unless you don’t control your feelings. You know what I mean. If you let your feelings take over you’re lost it in some ways. Now I’m not trying to be judgmental in any way. Again it comes back to giftedness plus training. I mean you can only train people where there is something you can train.” (RES026)

“And I think that’s the other thing about being resilient. Every situation you have to look at openly and you have to think through things very carefully and in very truthful way without all that emotional stuff. ... And making sure that my emotions were not influencing the decision in a bad way.” (RES028)

“Yes, you make goals for yourself, yes.” (RES010)

“I think goal setting is very important but it has got to be time-related. All of these are important.” (RES012)

“I want to go back dancing. That’s my long term goal that I would hope I could achieve. How do I get there? Ok I can I can focus on my time in hospital. And that’s what I did. I focused on short stages and set myself very small goals and um each time achieved one of those goals I celebrated somehow or another.” (RES028)

“When you’re brought up not having much, it’s in the first place, not hard to continue a line like that.” (RES011)

“Yes, well that was my downfall – I was too proud to ask for help. I grew up that way – I was what they called a Depression child. So you learnt to look after yourself within your family group but that’s it – I come from Sydney so all my family’s up there, I couldn’t call on them.” (RES015)

“If everything gets handed to you on a silver platter you don’t have resilience because you don’t feel those emotions. You don’t get to the end stage which is resilience.” (RES020)

“I suddenly felt unhappy on the road so I got out of the car. But I had this feeling, particularly once coming from my sister’s - so I got out of the car and I didn't drive it out again. I thought better to ... go out when I wanted to go, not have an accident.” (RES029)
**Spirituality** was an important category. It included the themes of religion (10 responses) and sense of belonging (3).

**Stress Management** is a category made up of sub-themes such as ‘hobbies, having a creative outlet’ (6 responses), looking after yourself (self-care) (11), ‘meditation and sensory experiences’ (2), ‘relaxation’ (6), and ‘sense of humour’ (3) – a theme principally mentioned by carers.

“No, music would have carried me through. I can tune out, I suppose it would be the thing.” (RES023)

“It’s beautiful. The music. The movement. It’s the closest thing to heaven on this earth!” (RES001)

“Having my own, my own passions because I love the theatre and I love writing and having creative outlets.” (RES003)

But I have always sort of watched what I eat. Mainly I am a lover of fruit and veggies. ... If I get down I go for a walk. It does not happen that often. I usually have a weep, then pull myself up. The after a while he is ok. But walking is good. You know out in the fresh air, talk to people that pass by.” (RES018)

“... preserve my own strength, both physical and mental – continue with my usual social and exercise activities as far as possible, and plan treats.” (009)

“Yesterday I walked down to Peter Mac in Box Hill and walked home again. Which I suppose is about an hour and a quarter all up. Oh yeah, I do a bit. We’ve got a treadmill in there but being a Tasmanian, which I am, hot weather, I sweat like a piglet, in the sun. If I get on the treadmill for any length of time, I’m soaking.” (RES011)

“Well, you know, when you’re a paraplegic and you’re trying to make the most of it and you’re doing exercises at the gym and you’re in a wheelchair and you haven’t yet ventured out onto the streets.” (RES012)

“And we are doing the exercises as well. My husband and I go to the swimming pool every week and my husband can swim one thousand five hundred metres in one hour and he is 81 years old.” (RES027)

[About hypnotherapy] “The complete relaxation. And I had no pain and I had to practice at home and I had the same picture. I don’t remember, a number of times a day, three times I think. You had to make yourself relax. COMPLETELY relax. EVERYTHING within you, you’ve got to relax. It was wonderful. I used it a lot.” (RES003)

“What I would like to say in conclusion is that you ABSOLUTELY have to have a sense of humour it gets you out of a lot of situations. It’s, it’s, it’s not that you are laughing at anybody otherwise you will let yourself be dragged down.” (RES0018)
“Having fun is part of that too and having a sense of humour. And having a good laugh. You have to have a laugh. A laugh is so healthy.” (RES028)

“I try and if I can get a massage every now and then, I will, if I had the money I’d have one every week.” (RES030)

Social Factors:

The category of social factor includes tremendously important themes such as ‘cultivating social networks and friendships” (16 reference), ‘family network’ (11), ‘friendship’ (16), ‘having a trusted GP’ (1), ‘trust, sharing with others’ (5), and ‘volunteering’ and ‘work experience’ (5, 6).

“One, you’ve got to make an effort, don’t isolate yourself. You need to be relating with people and ready to listen to their problems and you believe in perhaps you can tell them yours.” (RES003)

“Well... Make sure... Accept invitations to be with people, such as one son ..., I now go there every Monday night for tea. And that’s a regular invitation – so that’s arranged. Take up some invitations – people say “we must have a meal or go to the pictures” but take a bit of initiative myself, to say, yes I’m ready. Not just leave it to people ... – I should make the effort to say, “well, what about next week”... (RES009)

“Now networking is important. It is important in business and in everything. I have a network with my own friends. I have a network here; I am not going on to the committees here because I don’t want to do that.” (RES026)

“Well social network and support, well thinking about the fall you had I wouldn’t of survived being home, if my I did not have more social networks and support and they weren’t around me. They were fantastic, just did much more than I ever asked.” (RES028)

“I suppose I’m lucky. I’m so lucky. Because I have wonderful family – they’re so good to me – they’re so affectionate. It’s lovely. Because you need that – or I need it when my [head’s a mess]. Because I feel better if I feel their love, and I feel it so strongly.” (RES014)

“And resilience well there are so many avenues towards resilience: friendships; talking to people...” (RES001)

“... because if you trust people and you are willing to share more of yourself, good times and not so good times, that they will be honest back to you and, ... you do communicate with each other and I think that’s where my supports come from.” (RES021)

“I always enjoyed my work. I have always worked. I have always worked. It’s helped you know...!” (RES018).
Physical Support:

Physical support includes categories such as ‘age friendly environment’ (4 references), ‘supportive bureaucracy’ (2), ‘place of residence’ (7), as well as ‘social services’ (home and personal care, respite, transport, housing, etc.) and ‘social support’ (case management, allied health, nursing, psychologist, and peer support). It is important to point out that several participants mentioned that it was tremendously important to have someone to provide information about the availability of care and to coordinate care arrangements during times of crisis. Participants stated that without the assistance of nurses, allied health personnel, and case managers, they could have ended up in nursing homes well before their time.

I find it’s very good – there are a lot of places that will provide access for wheelchairs. Surprisingly enough [...] the places that are not all advertised, but there is a lot – if you look around there’s lifts everywhere.” (RES014)

“But then I have a great team of maxi taxi drivers. What I’ve learnt and have told others but if you find a driver you like and his happy to exchange mobile phone numbers - my team certainly are. That you can ring them directly and make a time for whatever appointment you’ve got to go to. It suits them.” (RES021)

“And the friend whose birthday it was made sure the restaurant did not have stairs and that sort of thing and the toilet was accessible.” (RES028)

“I didn’t have close contact there with people apart the ones just around us but I have here. . Here I walk up the shops and you know you talk to the different ones. You see them. Um, and even the house you know is good to suit. That makes a difference.” (RES018)

“[Respite] is vital to me. Ye, ye you’ve got to have a little break from reality of life um, see I do leave him to go on mass on a Sunday, but it’s an hour or a bits o or something, it’s in the morning and he is usually sleeping and that but I am always glad to come home. ....” (RES001)

“And she would be much better if she had a long weekend away with her daughter and a couple of her daughter’s in law. Why don’t they have a women’s weekend. A long weekend where they can go to Port Fairy and enjoy a few restaurants, a few walks and came back and had another week or so off. I went into care and then came back. I recognise that I’m not the only one needing sustenance. She did. And she was much stronger and brighter for it.” (RES012)

My, our lovely case manager, that wonderful lady. I think she just sits there and thinks “What more can I do to help you?” (RES001)
“My case manager is there at a call, whenever I want anything urgent, if I have to go taxi or whatever. And she’s very good – she’s always looked after me.” (RES010)

“They taught him to speak, and taught him manual dexterity a bit.” (RES003)

“So then you get down to the social services support, you get physio support. Yeah, they’re all helpful but it’s the others that resonate at a personal level. They give you a bit of extra fire.” (RES012)

“She [a nurse] was great she, she was great right from the beginning was fantastic she was the only one on my side. And even when my mum had her fall and had broken her hip, shoulder and wrist, and she went back to Kingston, she actually had heard that mum was going back there and asked to get put onto her case, and um for me, because she knew everything that I had gone through in terms of Southern Health and Monash Medical Centre she was the main person to talk to... So if I had any problems I would say to her and then she would go and sort it out.” (RES020)

“So every time there was an issue or a problem I might have freaked out about it emotionally and then I would think what can I do about it? Every time, what can I do about it? What can I do about it? How can I change it? How can I make a difference? What can I do to alter it? And move on in a positive way every time. And in fact my physio and my exercise physio said gone on holidays and once left and they both said to me that they thoroughly enjoyed the long rehab with me because every time I came in each week I said guess what I’ve done this week? Guess what I’ve done this weekend? Guess what I’m trying to do and I can do? And they said it was marvellous working with me because I kept pushing and trying out and prepared to have a go at things. And kept ticking things off and that’s what I’ve done.” (RES008)

“Well I have someone who comes and showers John every day, which is amazing for me. It is just (whispers) because he’s incontinent. So I get that, every day.” (RES001)

How can one build resilience? Participants give advice

When asked what advice participants would give to others regarding how resilience can be built, their responses reflected their other statements. In this sense, their advice consists of a mix of human, social, and physical factors. They thought the key task of a friend or care professional would be give encouragement and build capacity. In addition, they emphasised the need to have a positive mind set aimed at improving the situation as much as possible.

“A lot of it is encouragement when you are young not to be self-pitying and dwell on what might not be right for you, whatever it might be.” (RES003)

“What you have to do is restore their faith in themselves. Instead of being depressed and defeated they have to be alert and understanding and determined to reverse or to improve the situation.” (RES012)
Another theme that came through clearly was the need to identify activities that were meaningful to the person, to give them a goal they could work towards. Support services clearly have a role to play in encouraging someone to focus on and work towards an identified goal. There was also an acknowledgement that the task of identifying such meaningful activities was not an easy one.

“I think I’d explore with the person what’s meaningful for them. ... It’s tricky really, but I think you’ve just got to start where a person is and then see what might enrich their lives, to give them meaning. ... Living in the now, making the most of life.” (RES016)

“Yep, you’re actually giving that person encouragement because they can stay at home and that’s where the resilience will come. Hang on! I can stay at home and guess what there are all these services available to me! Rather than feeling worse right from the onset and saying right the option left for me is to go into a nursing home. And everything that I’ve known in my life is out the window. And I can’t participate in society and I can’t do this and I can’t do that. ... Yes, what drives them, some people it’s easy for them to recognise other people it may take them 50n or 60 Years to find it.” (RES020)
DISCUSSION & CONCLUSION:

The Meaning of Resilience:

The question regarding the meaning of resilience yielded personality traits, positive, coping behaviour, as well as confidence, and stress management skills. Social justice themes, such as ‘demanding justice’ and ‘response to feeling discriminated against’ were clearly audible within the sample and resonate with the literature focusing on ethnic and cultural minorities (14, 18, 33, 43). There a large gaps in this research literature. Firstly, there is a scarcity of research focusing on how different minority groups deal with different aspects of discrimination. Secondly, we were unable to identify any literature that deals with the interface between older people who interpret resilience in terms of social justice and the health and social care environment where such individuals are often regarded as ‘disruptive trouble makers’.

A large number of participants facing illness or disability equated resilience with ‘acceptance’. Several people stated that individuals have to accept adversities before they would be able to deal with their challenges. This in essence resonates Moos and Schaefer’s RTC highlighting the importance of being able to turn an adverse event into something meaningful and significant (55). Similarly the frequently-mentioned theme of having confidence in one’s own ability resonates closely with Moos and Schaefer’s theory.

Some of the personality traits that were mentioned, such as ‘internal strength’, ‘endurance’, ‘flexibility’, ‘elasticity’, and ‘rebound’ resonate well with the coping-focused literature on resilience in older age (14, 29, 30, 32, 35, 52). Respondents who circumscribed resilience in this fashion were often better educated. Indeed some of these respondents had searched for the term in a dictionary before being interviewed.

In addition research participants offered a list of cognitive and emotional strategies reminiscent of the literature on coping.

Interestingly, resilience was always interpreted as the resilience of an individual and not that of a family, group, or community.
Adversities:
Most of the research into later life resilience focuses on a limited number of adversities and explores how older people deal with them. Taking a life-course approach, the findings of this scoping study suggest that resilience is to some extent a response to the particular context of an adversity. Moreover, the results also indicate that some traumatic events experienced earlier in life may have a lasting impact on a person or family potentially enhancing or limiting the repertoire of resilience responses to future challenges. Most of the participants dealt with a range of adversities when we interviewed them. Yet the research literature generally glosses over multiple adversities and their potentially compounding effect.

Resilience Strategies:
The interviews managed to capture a total of 56 approaches and strategies grounded in participants’ life experience. A number of these strategies could be combined into clusters. These clusters highlight common, frequently encountered resilience domains. ‘Motivational strategies’ were most frequently mentioned and made up the most important cluster. Throughout their accounts, participants emphasised the importance of motivational strategies. Indeed, the importance of motivation came also to the fore in participant’s advice to others. Given the importance assigned by participants to ‘motivational strategies’, it appears that a successful resilience strategy rests on a solid motivational foundation that restores people’s faith in their capacity and that taps into activities they regard as meaningful. Other clusters whose content was frequently mentioned included ‘Friendship, family, and social network’, ‘capacity building and social support’, ‘problem solving and decision-making’, ‘stress management’, and ‘contestation strategies’. Interestingly, ‘capacity building’ themes, although regarded as important by our participants, rarely feature in the research literature.

The resilience responses of individuals tend to be context dependent. However a number of resilience responses occurred in more than half of the accounts. These were ‘cultivating social networks and friends’, ‘a positive outlook on life’, ‘having and maintaining interests and remaining active’, ‘re-remembering previous hardship’, ‘capacity building and support provided by care professionals’, ‘resisting and challenging one’s limitations’, ‘acquiring knowledge’, ‘self-care’, and ‘having family support’. In most people’s accounts, resilience responses consist of a mix of individual, social, and physical support elements. Interestingly, the theme of ‘having and maintaining interests’ while frequently voiced by participants,
features in only a few select phenomenological studies that involved older people in scoping the concept of resilience (14, 33, 49). Themes, such as ‘social connectedness’, ‘friendship’, and ‘trust’ are mentioned in the more socially-focused literature (13, 31, 33, 43, 46, 47, 49, 51, 52). Emotional and cognitive strategies, such as ‘accepting change’, ‘being in control’, ‘stress management’, meaning making’, ‘motivation’, ‘role creation’, ‘hope’, and ‘sense of humour’ (30, 33, 35, 39-41, 44, 45, 49, 51) resonate with the above-reviewed mainstream literature and particularly with the more coping-focused literature. ‘Financial resources’, ‘self-care’, and ‘social support’ were regarded as important by many participants. References to these protective factors appear also in the research literature (14, 18, 29, 31, 33, 38, 45, 47).

A number of participants who experienced adverse health events highlighted the importance of having someone who helped them to map pathways out of the crisis. They stated that without the assistance of one specific nurse, allied health professional, or case manager, they would have ended up in a nursing home or would not have been able to ‘get their lives back’ to the point they did. Hence, allied health, nurses, case managers, psychologists and other community aged care professionals represent an important resilience asset for older people and play an important role in some of these accounts.

Several participants actively planned ahead for older age. They ‘downsized’ in time, installed assistive devices, and bathroom railings. None of the participants mentioned this as a resilience strategy.

Resilience as resisting, strategic goal setting, and accepting:
Interviewees who faced disabling circumstances emphasised the importance of cognitive and psycho-social, and emotional strategies to regain or maintain aspects of their lives they treasured. Their resilience approach depended largely on the form and intensity of the adversity (34). Moreover, participants who looked back upon the adversities they had faced appeared to draw on that experience as a source of self-confidence (13, 25). People who had suffered an accident but had a realistic prospect that they would be able to retain much of their mobility and/or lifestyle, employed a very concrete goal setting approach that enabled them to get through rehabilitation and ‘to get their lives back’. For people who experience permanent disability, the task often seemed to involve finding a balance between ‘resisting’ and ‘accepting’. Although they had to accept their disability and some of the limitations it
imposes on their lives, they emphasised how important it was to challenge these limitations and to expand the boundaries of what is possible (see also 13, 33, 36, 44).

Cognitive, psychosocial, and emotional strategies were valued as they assisted people to find this balance (33). Participants often talked about the need to challenge themselves, to remain active, and to cultivate and maintain interests (13, 30, 33, 35, 36, 45). Knowledge regarding the availability of social services as well as encouragement and capacity building generating trust in the ability to succeed were extremely important to this group (23, 29, 31, 33, 38, 43, 45). The importance of emotional support in the form of family and a circle of friends was also frequently mentioned (23, 33, 46, 47, 52). Interviewees in this group tended to regard self-care as an important part of resilience.

Resilience as a sense of emotional balance:
For most carers, maintaining an emotional equilibrium stood in the foreground. They appeared to aim for a balance between the high physical and emotional demands on them and the maintenance of a little bit of their former lives. They tended to draw on experiences of hardship they managed to overcome in the past as a source of resilience and emphasised the importance of respite or short breaks. Moreover, they tended to actively cultivate friendships and social networks allowing them to obtain encouragement and understanding as well as a little ‘treat’ in the form of a life outside their carer roles. They thought it important to cultivate interests and to look after themselves - emotionally and physically. The importance of knowing their limits as well as stress-management strategies were often mentioned.

They talked about emotional strategies such as the need to accept change and to have a strong sense of purpose. However, the interviews also demonstrated that caring as the main sense of purpose in one’s life could lead to a dependency that, in the absence of other balancing factors, could easily turn into an adversity. Moreover, they highlighted the importance of the place of their residence which was ideally located close to medical services, shopping and other amenities, surrounded by good neighbours. Some highlighted the need to provide financial assistance to carers. Bereavement is another important adversity some of the carers had to face. Interestingly, bereavement features in few of the narratives as a ‘significant adversity’. This may be the case because the majority of participants who faced bereavement had moved on.
To date, the literature on resilience in later life has largely failed to engage with caring as an adversity as long as it does not involve bereavement. This study suggests that caring represents a substantial adversity that often culminates in and is emotionally interlinked with and compounded by bereavement.

Resilience and Facing Abusive Relationships:
Because of the small number of cases in this group, the themes developed for this group are advanced at a hypothesis level only. Although the three cases were very different involving different backgrounds, different timelines, social locations, and resulted in different outcomes, none of the women who experience abusive relationships managed to emotionally extract themselves completely from the events. The adversity marked them for life and at the time of the interviews they were still engaged in rebuilding their confidence. While on the surface the women appeared to be very resilience, as they have managed to cope most of their lives, their stories suggest that they still faced significant psychological issues as a result of the abuse. All three seemed to battle against low self-esteem.

For the three women contributing to this study, resilience consisted mainly of coping and endurance strategies such as cultivating (at the time hidden) social networks and support structures, engaging in activities outside the home, cultivating a positive frame of mind, looking after themselves, and, knowing their options. Some of the women appeared to draw on the physical and mental decline of their partners as a source of strength and resilience. None of this has been explored in the literature on later life resilience. Indeed, the topic of trauma in later life has received but scant attention by researchers (58). This is curious since war-related and other traumas are a common occurrence in this population.

Differences in Resilience Repertoires:
Whereas some of the participants made use of a wide range of resilience responses, others employed far fewer strategies. In fact, some participants seemed to compensate for using only a few resilience responses by relying much more heavily on one or two strategies (see also 33). RES007 and RES023 provide examples of this. RES023, for instance seemed to live for her music. Music appears to gives her meditative stress relief and the break from everyday pressures that other people seem to get from a variety of sources. RES007, on the other hand, seems to derive her purpose in life from her daughters. Older people with very limited
resilience responses may benefit from an intervention that potentially broadens their resilience repertoire. A summary of assets, strategies, and resilience responses identified in this study that might be of value to older people can be found in Appendix 1.

Strengths and Weaknesses of this Study:

This study contains strengths and weaknesses. Its strength lies in the extraordinary depth with which the interviews elucidate a wide range of aspects related to resilience in later life. Readers interested in accessing a condensed version of these interviews, are referred to the companion volume to this report (59). The key limitation of this study is its relatively small sample size. Although 31 interviews are generally regarded as a respectable sample within qualitative research (60), due to the heterogeneity of the sample, data saturation was not reached in some domains and further research is required to explore these domains in more detail. Although the study does not provide an exhaustive overview of resilience strategies, it generated sufficient data to identify several generalizable themes that can inform a community care pilot intervention.
Appendix 1: Summary of Resilience Assets

1. Environmental Factors
Having access to clean air, water, food etc.
Access to unspoiled nature.

1. Human Factors
a) Assimilation Strategies
Accepting Change
Adapting to Change
Being able to see meaning in what happens to you

b) Motivational Strategies
Cultivating a positive frame of mind
Hope
Identifying and cultivating interests
Learning that one still has a useful role in life
Trust in one's ability to succeed/confidence building
Seeking understanding and encouragement
Previous hardship builds resilience (narrative strategy)

c) Contestation Strategies
Challenging yourself
Cultivating values and commitment
Fighting for a fair go
Knowing your weaknesses/turning them into strengths
Learning to be resilient
Remembering that you are in control
Resisting
Remembering one’s sense of purpose

d) Knowledge, Skills, health, physical ability/capacity.
Decision making
Being truthful to yourself
Knowing your options
Self-help literature

e) Problem Solving
Keeping emotions in check/rational analysis/careful deliberation
Being comfortable to ask for help
Creating goals and working towards them
Active Day Planning
Strategies to deal with disability

f) Stress Management
Self-care (Exercise, Nutrition, Emotional)
Creative outlet (music, art, writing)
Knowing your limits, Being Flexible
Planning treats, social activities
Positive routine
Stress management strategies, meditation
Sense of humour

g) Spirituality
Religion, spirituality
Working for the greater good
Sense of Belonging

3. Social Factors
Being able to trust and share with others
Being aware of and accepting different viewpoints
Cultivating social network and friends
Family network
Friendship, social network
Having a trusted GP
Peer support
Fellowship (Church, Clubs)
Work
Volunteering

4. Infrastructure
a) Physical Infrastructure
Well-designed buildings and cities
Place of residence (access to transport and services, proximity to family, access to health, shopping facilities, good neighbours, etc.)

b) Social Infrastructure
Respite care, carer relief
Support services (Housing, pension, case management, psychologist, allied health, nurses, etc.)
Home and personal care services
Quality health care
Capacity building (Allied health, case management, etc.)
Supportive Bureaucracy

c) Economic Infrastructure
Access to work, financial resources
Carer support schemes
Subsidised health and aged care
Retirement benefits
Access to banking, shopping, leisure facilities
REFERENCES:


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