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Reframing resilience: Pilot evaluation of a program to promote resilience in marginalized older adults

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ABSTRACT

Resilience has been described as a paradigm for aging that is more inclusive than models that focus on physiological and functional abilities. We evaluated a novel program, Resilient Aging, designed to influence marginalized older adults' perceptions of their resilience, self-efficacy, and wellness. The multiweek group program incorporated an inductive definition of resilience based on group members' lived experiences. Outcomes evaluation for this pilot study included pre/postassessments on resilience, self-efficacy, and six wellness variables. Twenty-nine participants completed the program. Pre/post-assessment indicated a statistically significant multivariate change across the eight outcome variables. Increases in resilience, physical wellness, and emotional wellness, and decreases in social wellness and intellectual wellness accounted for most of the multivariate change. Resilient Aging is a participant-centered and strengths-based program that has potential for enhancing participants' perceptions of resilience and wellness. The program can be administered within community settings to promote resilience and wellness among marginalized older adults.

Resilient aging: Pilot evaluation of a program to promote resilience in older adults

Whereas the study of aging once focused on deficits and losses associated with later life, researchers are now studying how people age in a manner defined by health, wellness, and resilience. In fact, a growing number of gerontologists have argued that resilient aging should become the dominant paradigm for aging well. They argue that it is more inclusive, attainable, and attuned to diversity than models of successful aging that focus primarily on physiological and functional abilities (Harris, 2008; Hicks & Conner, 2014; Martinson & Berridge, 2015; Wild, Wiles, & Allen, 2013). Broadly defined, resilience research seeks to understand the variability of individual responses to adversity. Psychological resilience first became a subject of interest in the 1970s when researchers observed that many children growing up in high-risk environments managed to thrive (Luthar, Cicchetti, & Becker, 2000). When applied to older adulthood, use of a resilience framework illuminates how diverse groups of older people respond to adversity, including African Americans living with chronic illnesses (Becker & Newsom, 2005); individuals living with dementia (Harris, 2008) or HIV/AIDS (Emlet, Tozay, & Raveis, 2011); veterans (Pietrzak & Cook, 2013); and members of the LGBT (lesbian, gay, bisexual, transgender) community (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emlet, 2015). Increased resilience levels can buffer older adults from functional disability following chronic illness (Manning, Carr, & Kail, 2016), and perceiving oneself as resilient has been shown to enhance aging to a degree comparable with reduced physical disability (Jeste et al., 2013). Moreover, several studies have connected resilient aging with positive effects like coping, mastery, and positive adaptation (Earvolino-Ramirez, 2007); improved quality of life (Hicks & Conner, 2014); improved

coping for those living with HIV/AIDS (Emlet et al., 2011); mitigated impact of chronic disease onset on disability in later life (Manning et al., 2016); and reduced depression in prostate cancer patients (Sharpley, Bitsika, Wootten, & Christie, 2014). Due to the positive outcomes associated with the resilient aging paradigm, many gerontologists have called for strategies to promote resilience in older adults (Hochhalter, Smith, & Ory, 2011; Jeste et al., 2013; Manning et al., 2016). However, there is currently a dearth of resilience promotion programs described in the literature.

Yet, debate about how to define resilience has resulted in a “contested discourse” (Harris, 2008, p. 43). Current debate about how to define resilience reflects the ongoing dialogue between proponents of Rowe and Kahn’s theory of successful aging and its critics. In Rowe and Kahn’s (1997) theory of successful aging, resilience describes older adults who overcome stress and retain high levels of physiological health or functional ability (Rowe & Kahn, 2015). In effect, resilience is subsumed under the successful aging paradigm as a trait that is used by some older people to attain the criteria for successful aging. However, critics of the successful aging movement have argued that Rowe and Kahn’s theory excludes the majority of older adults from the ranks of aging well and fails to account for the diversity and plurality of the aging experience (Harris, 2008; Martinson & Berridge, 2015; Young, Frick, & Phelan, 2009). In contrast to Rowe and Kahn’s (2015) description of resilience, some gerontologists have argued that (a) most or all older adults possess resilience (Harris, 2008; Hicks & Conner, 2014); (b) resilience can be demonstrated regardless of sociocultural backgrounds or physiological or functional deficits (Harris, 2008); and (c) marginalized populations may possess resilience that is overlooked by traditional definitions of the concept (Wild et al., 2013). For instance, low-income older adults and their families may have many years of experience in navigating social service systems and relying on kinship networks. When a health crisis occurs, these individuals may have an advantage compared to older adults who are unfamiliar with community resources or unwilling to seek assistance from extended family (Wild et al., 2013). Therefore, resilience programs should use an inclusive, culturally-nuanced definition of resilience, particularly when working with older adults who have been marginalized due to age, race, socioeconomic status, health, ability status, or sexual orientation (Becker & Newsom, 2005; Emlet et al., 2011; Fredriksen-Goldsen et al., 2015; Harris, 2008; Manning et al., 2016; Wild et al., 2013). The remainder of this article will describe a novel program designed to promote the growth of resilient attitudes and behaviors in marginalized older adults. We will then present results from a pilot study and discuss the implications for future resilience practice and research.

Previous resilience research

Resilience research has evolved from a focus on descriptions of the personal attributes of resilient individuals to an emphasis on the dynamic processes that occur when resilience is enacted. For instance, early resilience research focused on which traits were possessed by resilient individuals. Across age groups, resilience is associated with traits that include (a) high expectancy, or a sense of purpose and achievement; (b) self-determination; (c) positive relationships/social support; (d) flexibility; (e) sense of humor; and (f) self-esteem/self-efficacy (Earvolino-Ramirez, 2007). Specific to older adults, resilience consists of three core attributes: (a) coping abilities, (b) hardiness, (c) and positive self-concept (Hicks & Conner, 2014). However, many researchers have argued that resilience is a dynamic process and not merely a set of attributes. Descriptions like “rebounding,” “flourishing despite adversity,” and “the ability to navigate adversity in a manner that protects well-being” indicate that resilience is an active process that can be used to counteract the negative effects of significant adversity (Earvolino-Ramirez, 2007, p. 76; Hildon, Montgomery, Blane, Wiggins, & Netuveli, 2010, p. 36; Manning et al., 2016, p. 514).

Recognizing that resilience is malleable and can be promoted in later life, current research focuses on the positive benefits of resilience and exploration of how to promote resilience through the use of programs and interventions. Research indicates that resilient aging can result in improved health and quality of life. For instance, increased resilience levels can buffer older adults from functional disability following chronic illness (Manning et al., 2016). The effect of perceiving oneself as resilient has been shown to enhance

perceptions of aging to a degree comparable with reduced physical disability (Jeste et al., 2013). However, although researchers have called for an expansion of resilience-enhancing programs (Hochhalter et al., 2011; Jeste et al., 2013; Manning et al., 2016), there is currently a dearth of resilient aging interventions (Jeste et al., 2013). Nonetheless, several recommendations have been provided to guide the development of resilient aging programs. Programs should be tailored to the specific needs and social locations of older adults (Hicks & Conner, 2014; Hochhalter et al., 2011; Jeste et al., 2013; Manning et al., 2016), and they should include strategies that focus on individual resilience and promoting resilience within the context of families and in the community (Hochhalter et al., 2011). Resilience programs should use resilience-building curricula and resilience enhancement techniques, should be grounded in theory and research, and should promote quality of life. In particular, these programs should be patient-centered, focused on the whole person, and concerned with providing tangible skills for navigating adversity (Hicks & Conner, 2014; Hochhalter et al., 2011; Manning et al., 2016). Finally, the discovery that resilience can be taught has prompted some gerontologists to suggest that resilient aging can be applied universally to older adults regardless of age, ability, or health status (Hicks & Conner, 2014).

In spite of the potential that a resilient aging paradigm holds, there is a great deal of debate about how to define resilience. Although much scholarly discussion has focused on whether resilience is a trait or a process (Luthar et al., 2000), a growing number of gerontologists have expressed concern that resilient aging has been conflated with Rowe and Kahn's theory of successful aging (Harris, 2008; Hicks & Conner, 2014; Wild et al., 2013). In Rowe and Kahn's theory of successful aging, resilience describes older adults who overcome stress and retain high levels of physiological health or functional ability (Rowe & Kahn, 2015). In effect, resilience is subsumed under the successful aging paradigm as a trait that is used by some older people to attain the criteria for successful aging. However, critics of the successful aging movement have argued that Rowe and Kahn's theory excludes the majority of older adults from the ranks of aging well and fails to account for the diversity and plurality of the aging experience (Harris, 2008; Martinson & Berridge, 2015; Young et al., 2009). These gerontologists have described resilient aging as an alternative paradigm that differs substantially from successful aging (Harris, 2008; Hicks & Conner, 2014; Wild et al., 2013). For instance, they have argued that (a) resilience is possessed by most or all older people, although to varying degrees (Harris, 2008; Hicks & Conner, 2014); (b) resilience can be demonstrated regardless of sociocultural backgrounds or physiological or functional impairments (Harris, 2008); (c) and marginalized populations may possess hidden resilience resources that are easily overlooked by traditional definitions of the concept (Wild et al., 2013).

Resilient aging program

The ongoing debate about successful and resilient aging informs the theoretical underpinnings of the approach we used in the Resilient Aging program. First, we developed the curriculum according to the core assumption that all older adults possess at least some degree of resilience. This assumption has been substantiated by other researchers who have suggested that most or all older adults possess at least some of the core components of resilience (Harris, 2008; Hicks & Conner, 2014; Wild et al., 2013). Viewing resilience as a universal characteristic allows both practitioners and older adults to seek out evidence of resilient behavior and mindsets. By assuming that each older adult client has a reserve of resilience to draw on, practitioners can challenge the narrative that older adulthood is characterized primarily by deficits and decline. Previous research indicates that assuming a broad, inclusive definition of resilience may result in older adult clients reflecting on their life histories and looking for occasions when they were resilient (Emlet et al., 2011; Gattuso, 2003). Therefore, we began the group with the working hypothesis that all participants had personal examples of resilience that could be incorporated into the program's weekly content.

An inductive definition of resilience, developed by both program facilitators and group members, was used in the program curriculum. Our intent was to identify a working definition of resilience

that reflected the group members' collective understanding of resilience including what it was, how it manifested in their lives, and what could be done to promote it. Therefore, at various points throughout the program participants were asked to describe how they understood resilience. Although we assumed all participants possessed at least some degree of resilience (Harris, 2008; Hicks & Conner, 2014), we did not assume that each participant would begin the program with the same understanding of the term. Therefore, the facilitators and participants constructed the program's definition of resilience through an ongoing dialogue that was grounded in the paradigm of social constructionism. Social constructionism explains that words, concepts, and experiences are perceived through interpretive lenses that have been constructed by the society in which one lives (Gubrium & Holstein, 1999). Because language plays a substantial role in the interpretive process, social constructionist research attends to discourse, or the way that language is used within a group of people to orient them to reality. By incorporating the definitions provided by our participants, we intended to make Resilient Aging more personalized, client-centered, and culturally responsive.

Finally, we provided opportunities for participants to explore how they experienced resilience across a broad range of life domains. Resilient aging research indicates that older adults may be more likely to identify forms of resilience when domains unrelated to physiological or functional abilities are included (Becker & Newsom, 2005; Earvolino-Ramirez, 2007; Harris, 2008; Hicks & Conner, 2014; Hildon et al., 2010; Wild et al., 2013). Similarly, when asked to define optimal aging, older adults use multidimensional definitions that are related to the biological, psychological, social, and spiritual domains (Reichstadt, Depp, Palinkas, Folsom, & Jeste, 2007; Young et al., 2009). Therefore, we structured the Resilient Aging program according to a whole person approach to defining and promoting resilience. The facilitators prompted discussion of both physical and nonphysical definitions of resilience by introducing a multidimensional wellness model. The participants identified examples of resilience across several domains including physical limitations related to chronic disease, disability, or functional impairment, as well as nonphysical domains such as relationships, emotional well-being, and spirituality.

Program delivery

Consistent with recommendations offered in previous resilience research, the Resilient Aging program was designed to promote the growth of resilient attitudes and behaviors using a 9-week curriculum that was (a) delivered in a group format, (b) participant-centered, (c) focused on the whole person, and (d) intended to influence participants' self-concepts (Hicks & Conner, 2014; Hochhalter et al., 2011) (Table 1). The use of nine weekly sessions, each lasting approximately 1 hour, provides adequate time to introduce the concept of resilience, formulate a broad definition of the construct by pairing it with each of six wellness domains, synthesize the emergent definition of resilience developed by the group, and conclude with a discussion of how the program impacted the participants. The 9-week duration of the program also provides sufficient time to measure changes from pretest to posttest without participants beginning to experience fatigue. Our primary research question was this: What is the impact of the Resilient Aging group program on the combination of participants' perceived resilience, self-efficacy, and multidimensional wellness? We hypothesized that over the course of the program participants would see themselves as more resilient, experience higher levels of self-efficacy, and rate themselves as more well on a variety of wellness domains.

Group format

The program was delivered in a group format due to the strategic delivery format that groups provide. Group formats are commonly used to promote mental health and wellness because they highlight the universality of particular problems, cultivate altruism, instill hope, and allow participants to learn from the experiences of others (Yalom, 1995). The group format allowed participants to learn about the adversity their coparticipants had experienced and how

Table 1. Resilient Aging program curriculum.

Session 1:

- Lead facilitator introduced the term resilience and asked participants to identify initial definitions of resilience
- Lead facilitator introduced the six domains of wellness and asked participants to identify connections between the domains (ie., physical & emotional are connected; social & spiritual are connected)

Session 2:

- Facilitators and participants reviewed key concepts from previous week
- Participants expanded their definition of resilience by providing examples and personal stories of adversity & resilience
- Facilitators and participants collaboratively defined emotional wellness
- Participants identified connections between resilience and emotional wellness

Session 3:

- Facilitators and participants collaboratively defined psychological wellness
- Facilitators elicited examples of personal adversity & resilience to change self-concept of participants
- Participants identified connections between resilience and psychological wellness

Session 4:

- Facilitators and participants collaboratively defined social wellness
- Facilitators elicited examples of personal adversity & resilience to change self-concept of participants
- Participants identified connections between resilience and social wellness

Session 5:

- Facilitators and participants collaboratively defined physical wellness
- Facilitators elicited examples of personal adversity & resilience to change self-concept of participants
- Participants identified connections between resilience and physical wellness

Session 6:

- Facilitators and participants collaboratively defined intellectual wellness
- Facilitators elicited examples of personal adversity & resilience to change self-concept of participants
- Participants identified connections between resilience and intellectual wellness

Session 7:

- Facilitators and participants collaboratively defined spiritual wellness
- Facilitators elicited examples of personal adversity & resilience to change self-concept of participants
- Participants identified connections between resilience and spiritual wellness

Session 8:

- Facilitators and participants synthesized emerging group definition of resilience.
- Participants reflected on what they had learned about resilience and whole person wellness throughout the program

Session 9:

- Summative discussion of the major themes that participants had discovered about resilience and wellness
- Participants reflected on how the group had impacted them
- Facilitators provided certificates indicating that group members had completed the program

coparticipants had exhibited resilience. The use of a group may be particularly beneficial when discussing resilience within a group of individuals who have experienced marginalization. Within the group, participants were given the opportunity to pool their collective expertise, develop

solidarity, and consider how they could support one another's efforts to develop resilience (Wild et al., 2013). As one participant stated about the program, "It has really helped me because you know your situation but you find that others—we're different but we're all alike. I've learned a whole lot, and it's just a blessing being together and everybody sharing what's happened to them or what is happening to them and to know that you're not alone."

Additionally, a group format is a practical and efficient use of staff resources that allows similar programs to be delivered in community settings.

Participant-centered

Throughout the program we asked participants to define resilience. This ensured that the term would become familiar, culturally relevant, and linked to personal examples. First, we invited members to describe the qualities that they associated with resilience while the lead facilitator recorded participant responses on a large board located in the front of the room. Next, we asked group members to identify occasions when they had witnessed others demonstrate resilience. This created an opportunity to identify key behaviors or actions that were associated with resilience. When participants began to describe personal examples of their own resilient behavior, the facilitators encouraged other group members to express their reactions. Frequently, participants responded in agreement by confirming that the examples provided by peers were, in fact, examples of resilient attitudes or behaviors.

Focused on the whole person

We also introduced the concept of whole person wellness and identified six domains of wellness for use in the program. These included emotional, psychological, social, physical, intellectual, and spiritual wellness (Adams, Bezner, & Steinhardt, 1997). The lead facilitator explained that these domains were interactive and that resilience could be found within each domain. Throughout the program, the lead facilitator asked participants to consider how resilience would be manifested in each of the wellness domains. For instance, during the week in which emotional wellness and resilience were featured, the group facilitators asked participants to (a) review their collective understanding of resilience, (b) identify the primary features of emotional wellness, and (c) discuss how they had demonstrated resilience related to emotional wellness. Participants frequently identified connections between the wellness domains and discussed how resilience in one domain could be employed when adversity occurs in another domain. For instance, group members suggested that the loss of forms of physical functioning resulted in deficits in their emotional well-being. When asked how they were able to cope during times of physical and emotional duress, some participants identified the spiritual or social domains as sources of resilient attitudes that could be drawn upon to overcome adversity.

Influencing participants' self-concepts

We intended to influence participants' self-concepts by using their own definitions and examples of resilience. The notion that an individual's self-concept can be changed is based on the principles of narrative and cognitive behavioral approaches to psychotherapy. Both forms of therapy have been used successfully with older adults (Gardner & Poole, 2009; Knight, 2004). In accordance with narrative therapy, we encouraged participants to share examples of resilience found within their own or another person's personal narrative. Previous research indicates that bringing to mind past examples of coping may influence older adults' current self-concepts (Gattuso, 2003). In accordance with cognitive behavioral therapy, we hypothesized that group members would use the principle of reframing to develop a new schema based on an emerging definition of resilience. Reframing allows an individual to consider a circumstance from a new perspective, and it is a core element of cognitive behavioral therapy. By considering examples of adversity in light of a group dialogue about resilience, we assumed that some participants would reframe negative circumstances as opportunities

to use personal reserves of resilience. In sum, we hypothesized that participants would begin to see themselves and their circumstances differently after participating in the 9-week Resilient Aging program.

Method

Implementation of the Resilient Aging program should be categorized as action research (Johnson & Christensen, 2012). Action research is conducted within in vivo settings, uses methodological pluralism, and actively seeks to incorporate the views and opinions of participants. Although the results of action research may be generalizable to a population of people, its primary focus is addressing problems faced by a specific group of people.

Sample

We piloted the program within an adult day health center that is located in a large, midwestern city. This particular site was selected for action research due to the preponderance of attendees who participate in the state's Medicaid waiver program. More than nine million individuals in the United States are eligible for both Medicaid and Medicare, and these beneficiaries are more likely to be frail, have functional or cognitive impairments, and live with multiple chronic conditions (Kaiser Family Foundation, 2012). The center has a daily census of between 100 and 120 clients. Because of the size of the center, the facility is subdivided into three group areas, each consisting of a distinct set of clients and staff. Our consultation with staff revealed that two of the three areas included clients who were cognitively intact and more likely to benefit from the program. The third area consisted primarily of individuals with moderate-to-severe cognitive impairment and was excluded from the current study. These assignments were made by site staff as a result of the use of a cognitive screening instrument, clinical judgment, and consultation with client family members. Consistent with action research, we aligned delivery of the program with the specific needs of the research site. The Resilient Aging program was added to the weekly schedule that was announced each morning to the adult day health center clients and delivered within the large gathering rooms where clients were accustomed to attending. Because the groups of participants were divided into two different rooms, we offered the program at separate times to each of the two groups, once in the morning and once in the afternoon. Each session lasted approximately 1 hour. The general structure of the program consisted of the 9-week curriculum referenced earlier (Table 1). Although the format and topics were identical for the two groups, each set of participants identified slightly nuanced definitions of resilience and wellness, which we expected due to the use of inductive definitions of resilience and wellness. The program was delivered by two cofacilitators. This allowed one facilitator (first author) to lead the program while the other facilitator (second author) contributed additional perspectives and made field observations related to the group process.

The purposive sample was derived based on the following criteria. First, only individuals who were assigned to one of the two program areas designed for individuals with moderate-to-good cognitive functioning were included. Next, only individuals who attended the center on the days when the program was offered were included. A total of 51 individuals met these initial criteria. These individuals were then screened based on their willingness to provide informed consent to participate in the study and their ability to accurately complete several quantitative scales, as evidenced by the clinical judgment of the staff and research team. Four individuals elected not to participate and 11 were unable to complete the scales. Although these individuals were excluded from data analysis and reporting, they were allowed to observe the Resilient Aging program. This resulted in 36 individuals who participated in the study. Finally, seven individuals failed to attend a majority of the sessions (five out of nine) and were excluded from data analysis. In total, 29 adults met full inclusion criteria and were included as participants in the study. A post hoc power analysis

revealed that the sample size was adequate to avoid Type II error ($=.788$). All procedures for the research were approved by the Institutional Review Board at our university (Protocol Number: 2014B0512).

Measures

To measure the impact of the Resilient Aging group program, we collected quantitative survey data at two time points: first prior to the program, and then again following its completion. We measured resilience using the 12-item Simplified Resilience Score (SRS), which was adapted from Wagnild and Young's (1993) Resilience Scale ($\alpha = .85$; Manning et al., 2016). We measured self-efficacy using the 10-item General Self-Efficacy Scale (GSE) ($\alpha = .76$ to $.90$; Schwarzer & Jerusalem, 1995). We measured multidimensional wellness using the 36-item Perceived Wellness Survey (PWS) (Adams et al., 1997; $\alpha = .91$; Foster & Levitov, 2012). The PWS measures physical, psychological, emotional, social, intellectual, and spiritual wellness domains. To better identify which forms of wellness were impacted by the program, each of the six wellness domains was calculated as a separate variable.

Data analysis

We calculated group means at pre- and posttest on measures of resilience, self-efficacy, and multidimensional wellness. A total of four participants were absent or unavailable when pretest data were collected. Because they met all inclusion criteria, we imputed missing values so that maximum participant data was retained. We ran five iterations of the random imputation procedure and aggregated their results to ensure that the final imputation was accurate (Tabachnick & Fidell, 2013). A one-way repeated measures MANOVA was conducted to compare participants' pretest and posttest scores. Data analysis was completed using IBM SPSS Statistics for Windows version 22.0 (Aramonk, NY).

Results

Participants ranged in age from 59 to 94, with an average of 78 years old. They were primarily African American (79%) and enrolled in Medicaid (62%) (Table 2). Anecdotal remarks by participants indicated that many of the older adults who participated in the study suffered from chronic health conditions and physical disabilities. Regarding levels of resilience prior to participation in the Resilient Aging program, participants scored considerably lower ($M = 7.44$, $SD = 2.07$) than a national norm group of older adults drawn from 2006–2010 waves of the Health and Retirement Study (HRS) ($M = 9.19$; $SD = 1.77$; reported in Manning et al., 2016).

Statistical analysis indicates that participants experienced both positive and negative changes between pretest and posttest. A repeated measures MANOVA (multivariate analysis of variance) was calculated to demonstrate the overall impact of the program. Regarding the change in resilience, self-efficacy, and wellness between pretest and posttest, there was a significant effect, Wilk's Lambda = .505, ($F(1,28) = 2.575$, $p = .039$), with a large effect size (partial $\eta^2 = .495$) (Table 3). Follow-up univariate analysis revealed that the primary contributors to this change included increases in resilience (partial $\eta^2 = .079$), physical wellness (partial $\eta^2 = .109$) and emotional wellness (partial $\eta^2 = .022$), and decreases in social wellness (partial $\eta^2 = .093$) and intellectual wellness (partial $\eta^2 = .100$) (Table 4).

Discussion

The results indicate that participants' perceptions of their resilience and wellness changed following the implementation of the Resilient Aging program. Although the effect sizes associated with any single variable were small, due primarily to the modest number of participants included in the study,

Table 2. Demographic characteristics of the sample.

Characteristics	Participants (<i>N</i> = 29; % or mean)
Age (range = 59 to 94)	78 years
Gender	
Female	69%
Race/ethnicity	
African American	79%
Caucasian	21%
Medicaid-eligible	62%

Table 3. Multivariate analysis of Resilient Aging program.

		Value	<i>F</i> statistic	<i>p</i> -value	Partial η^2	Observed power
Change from pretest to posttest	Pillai's trace	.495	2.575	.039*	.495	.788
	Wilks' lambda	.505	2.575	.039*	.495	.788
	Hotelling's trace	.981	2.575	.039*	.495	.788
	Roy's largest root	.981	2.575	.039*	.495	.788

Note. **p* < .05.

Table 4. Descriptive statistics & post-hoc univariate analysis.

		Preintervention (<i>N</i> = 29); Mean (<i>SD</i>)	Postintervention (<i>N</i> = 29); Mean (<i>SD</i>)	<i>F</i> statistic	<i>p</i> - value	Partial η^2	Observed power
Change from pretest to posttest	SRS ^a	7.44 (.207)	8.10 (.213)	2.397	.133	.079	.321
	GSE ^a	3.15 (.55)	3.13 (.53)	.056	.814	.002	.056
	PWS ^a						
	Emotional wellness	4.24 (.64)	4.35 (.79)	.628	.435	.022	.119
	Psych. wellness	4.02 (.65)	3.98 (.73)	.100	.754	.004	.061
	Social wellness	4.29 (.62)	4.04 (.77)	2.866	.102	.093	.373
	Physical wellness	3.68 (.85)	3.98 (.91)	3.443	.074	.109	.433
	Intellectual wellness	4.49 (.64)	4.28 (.81)	3.108	.089	.100	.399
	Spiritual wellness	4.31 (.85)	4.31 (.92)	.000	.999	.000	.050

Note. SRS = Simplified Resilience Scale; GSE = General Self-Efficacy Scale; PWS = Perceived Wellness Scale.

^aHigher scores indicate improvement.

the total effect of the program was robust. Regarding the use of an inductive definition of resilience, participants were responsive to the lack of an externally imposed definition of what it means to be resilient. For instance, with minimal prompting from the facilitators, some participants quickly identified times in their own lives when they had overcome adversity. Similarly, the use of a broad and inclusive definition of resilience allowed participants to draw on a wide range of lived experiences to reframe their self-concepts as resilient people. Although group members expressed a limited understanding of the term resilience at the outset of the program, by its conclusion many group members were referring to themselves or others in the group as resilient. This seems to coincide with previous research indicating that older people are able to view themselves as resilient when they draw on personal stories of coping (Gattuso, 2003). In fact, from a social constructionist perspective, resilience is not merely a trait or a process, but rather it is a subjective reality that is formed within a community of people (Gubrium & Holstein, 1999; Wild et al., 2013).

The use of an inductive definition of resilience is consistent with the recommendations made by a growing number of gerontologists. Many gerontologists have recommended that subjective definitions of optimal aging and resilience should be used in both intervention and services research (Jeste et al., 2013; Reichstadt et al., 2007; Wild et al., 2013). Older adults' subjective ratings of constructs like health and quality of life have been shown to have powerful predictive value and accuracy that is superior in some cases to the use of objective ratings instruments (Blazer, 2008). Furthermore, allowing participants to contribute to the operational definition of resilience enhances the program's generalizability to participants in a variety of cultural or geographic regions. Given the heterogeneity of the older adult

population, the use of subjective definitions allows researchers to account for both personal differences and cultural, social, and environmental contexts that may influence how key outcome criteria are perceived (Phelan, Anderson, LaCroix, & Larson, 2004). Within the literature, qualitative studies have demonstrated that definitions of resilience are defined somewhat differently in diverse contexts (Becker & Newsom, 2005; Emlet et al., 2011; Harris, 2008). Moreover, older adults' definitions of resilience tend to be more multidimensional, contextual, and nuanced compared to the definitions typically used by researchers (Wild et al., 2013).

The infusion of a multidimensional wellness model appears to have had mixed results. It is unclear why participants experienced both increases (physical wellness, emotional wellness) and decreases (social wellness, intellectual wellness) in multidimensional wellness over the course of the program. The increase in emotional wellness was least surprising, as participants spoke openly during the program about how experiences with adversity and loss had impacted their emotional well-being. Likewise, given how many participants had chronic health conditions or functional impairments, the increase in perceived physical wellness at posttest was somewhat expected. For example, one participant stated, "I think that my disability and all our disabilities—we have lost an important part of our life (sic) that we lived prior to the disability and to be able to operate now and feel good about ourselves means that we have been resilient and grown with the disability to do that." Another participant told the group that he had been practicing resilience in physical therapy by reflecting on the group's dialogue about overcoming adversity. He stated that he had been able to walk a longer distance due to focusing on what he had learned in the group.

However, we did not anticipate the subsequent decreases in participants' intellectual and social wellness domains. Regarding intellectual wellness, it is possible that participants enjoyed the intellectual stimulation provided by the resilience program and felt dissatisfied that additional programs did not exist at the adult day health center. It is equally possible that some participants rated themselves as less intellectually well because of difficulty understanding the discussion about resilience in the program. Additional evaluation would be needed to identify what prompted the change. Regarding social wellness, a possible explanation is that participants responded more openly about their frustrations with family at posttest. Therefore, given the small sample size, social wellness scores could have shifted substantially as a result of several respondents expressing frustration with family members at posttest. For instance, during the program some participants shared frustration about a lack of perceived support from family members. In some cases, this was contrasted with feeling more normal and less alone within the group. In fact, several participants stated that participation in the program had given them a greater acceptance of their illnesses and disabilities and an enhanced sense of solidarity with others facing similar challenges. Another possible explanation is that some participants may have had trouble following along with, or feeling connected to, the group discussion; and this may have resulted in decreases in intellectual or social wellness scores. In sum, the use of a multidimensional wellness framework provided a helpful structure for guiding participants' understanding of resilience. Nonetheless, future iterations of the program should address the possibility that participants may become less satisfied with certain aspects of their wellness.

Limitations

There are several limitations to this study that should be considered. First, the internal validity of the study is limited by the lack of a control or comparison group. Although we speculate that increased resilience scores were related to the weekly group discussion that focused on activating resilience, a control or comparison group is needed to validate this assumption. Next, the results of this program are limited by the use of a small sample size. Although the study had adequate statistical power for multivariate analysis, the study was underpowered at the level of individual variables. Therefore, the use of a larger sample would provide greater clarity about changes to resilience and wellness variables. Additionally, results are limited by the use of only one program site. Although the sample

was diverse in regards to race, gender, and socioeconomic status, it would be helpful to collect additional demographic variables, such as education level, and expand the sample size by replicating the study at multiple program sites. Finally, the use of self-report measures limits the conclusions that can be drawn from these results. For instance, although participants rated themselves as more resilient, it is unclear that this perceptual change will translate to differential attitudes or behaviors after the expiration of the program. Therefore, replication of these results, preferably with a comparison or control group and a stronger longitudinal design, is needed to confirm the pilot program's findings and identify whether this program's framework can be used to develop additional resilience-enhancing programs.

Conclusion

Resilient aging is a promising paradigm with a growing literature base. Provided that a broad and inclusive definition of resilience is used, resilient aging has the potential to improve the quality of life and well-being of all older adults—in spite of the adversity they may face. The Resilient Aging program provides a template for how to promote resilience in a manner that is empirically supported, intended to impact participants across multiple life domains, and constructed in conjunction with older adult participants. Although the program's use of an inductive definition of resilience is novel, this strategy was well-received by participants; and it may be particularly empowering for marginalized older adults who possess resilience that has not been recognized by traditional definitions (Wild et al., 2013). By inviting participants into group dialogue about how they have bounced back from adversity, the Resilient Aging program encourages participants to reframe their experiences. As one participant concluded, "I think whenever someone else mentions it to you about your resilience, I think that's when you see it. You don't see it until someone mentions it to you."

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