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'I'm Going to Put on Bright Clothes now': The Process and Social Dimensions of Resilience Among Older Adults

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ABSTRACT

This article focuses on older adults' resilience following major losses. Interviews of seventeen older adults in Ireland illuminate the resilience process and its social dimensions – family, friends, social participation, formal supports, faith and spirituality. Becoming resilient is a process that develops through agential resolve contextualized by utilization of available resources. Those who had struggled to see themselves as resilient benefited from formal supports – such as counseling and social prescribing – that helped them to engage resilient agency. The resilience process presents as an internal resolution aided by social supports.

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Introduction

Resilience is a transformative concept because it rejects the circular notion that successful aging (Rowe & Kahn, 1997) necessitates remaining well. Resilience entails acknowledging that aging involves adversity such as illness, disability, and loss of loved ones. The ability to recover from adversity is the central focus in investigations of resilience. Recovery does not always mean returning to the previous state but also encompasses better than expected outcomes in view of the adversity faced. Resilience allows us to approach older persons as equals because the ability to recover is not based on ideas of (prior) high achievement as successful aging is, but rather it tends to approach all older persons as (in principle) capable of resilience: resilience therefore is an inclusive concept (Windle, 2011). Resilience is also an attractive concept for policymakers as it suggests that supports and resources in older persons' lives could be used to aid recovery from losses.

Although contextual and environmental aspects of resilience have featured in the literature (Cardenas & Lopez, 2010; Donnellan et al., 2015; Wild et al., 2013) and there is awareness of the importance of not ascribing resilience to

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individual attributes only, the social dimensions of resilience have remained somewhat nebulous. The aim of this research was to deepen the understanding of resilience processes, with emphasis on the social dimensions of resilience. The research context is Ireland, and we highlight the aspects of this context that are likely to resonate in other (liberal and familialist) welfare state contexts. We present findings from a qualitative study that examined the social dimensions in the process of resilience among older adults aged 70 and over who self-identified as resilient following the loss of a loved one or the loss of mobility.

Literature

Despite extensive research on factors that promote well-being in the face of adversities in old age, the need for conceptual clarity about what constitutes resilience in older age persists (Angevaare et al., 2020; Donnellan et al., 2015; Wild et al., 2013; Windle, 2011). Angevaare et al. (2020) systematic review identified that despite the lack of a unified definition of resilience in older age, descriptions of resilience shared three features: a stressor (e.g., adversities, losses), a response, and a mechanism by which the response is achieved. Hence, resilience manifests as a positive response to adversity; it "operates" between the occurrence of the stressor and the outcome of "bouncing back." Stressors are challenges to physical, psychological, or social functioning to which a resilient person responds better than expected (Hochhalter et al., 2010; Pruchno et al., 2015), returning to a level of well-being after a decline or reaching a higher level than before the event (Angevaare et al., 2020). Manning and Bouchard's (2020) study conceptualized resilience in older age as the process of coping and returning to an equilibrium. The notion of bouncing back is used by Donnellan et al. (2015) when identifying people who reverted to their prior level of well-being.

The dimensions underpinning the process of resilience are explained as resources that improve coping skills and diminish adverse effects on wellbeing (Windle, 2011). Personal coping styles, hope, faith, formal and informal networks, family, policies and professional support are some of the main resources identified as contributing to resilience (Cardenas & Lopez, 2010; Donnellan et al., 2015; Ungar, 2011; Wild et al., 2013). Community resources have been identified as critical, with Aldwin and Igarashi (2012) stating that resilience in older age is about shared relationships, engagement, and connection. Access to and use of resources have been examined in relation to differences among older people, such as variations in health, individual characteristics, and living conditions (Aldwin & Igarashi, 2012). In a study on widowhood and bereavement, Bennett (2010) showed that participants achieved resilience mainly through social support, participation, and personal features

such as their outlook on life and personality; this process occurred around one to two years after the loss. Other studies have also emphasized the relevance of time and context on how people cope with adversities (Manning & Bouchard, 2020; Windle, 2011). Manning and Bouchard's (2020) study found that participants described resilience as a state of being rather than something a person has. Thus, a resilient identity was influenced by early experiences and accompanied people throughout their lives. A resilient identity gave older people a resilient outlook, attitude, and practices that helped them manage adversities and protect themselves, but these needed to be maintained over time. Relationships and social support networks were identified as crucial for developing and maintaining a resilient identity, as well as having the ability to reframe adversities as opportunities for growth and being grateful.

From an ecological perspective, contextual dimensions have been identified as significantly contributing to resilience and encompassing both resources and adversities. These include structures, such as policies and institutions; cultural processes that yield meanings used by individuals to give sense to adversities; a mesosystem of interactions between individuals and family and community; and individual aspects, such as health, psychological and demographic characteristics (Aldwin & Igarashi, 2012; Cardenas & Lopez, 2010; Donnellan et al., 2015; Wild et al., 2013). Wiles et al. (2012) found that resilience is a contextualized process where personal characteristics that appear to be internal (e.g., being positive) are embedded in social and cultural contexts. Our study is located in the social and cultural context of (the Republic of) Ireland. Notable features of this context are that a.) population aging lags behind the rest of the European Union mainly due to relatively high fertility rates that were sustained until the 1980s, historical emigration, and immigration in recent decades (Organisation for Economic Co-operation and Development, 2023, p. 211; b.) expenditure on formal services for older adults is comparatively low, leading to reliance on family care (Organisation for Economic Co-operation and Development, 2023, p. 221, p. 229; c.) intergenerational conflict has not featured significantly in political or media discourse, and familial intergenerational relations are commonly relayed as solidaristic by younger and older adults, among other reasons due to reliance on intra-familial transfers of money, care and housing (Gray & Dagg, 2019). While these features are specific to the Irish context, they have resonance in other liberal and familialist welfare states; hence, there is scope to examine the transferability of the insights outlined here to other contexts that have one or more similarities with the Irish one.

Materials and methods

We used the Grounded Theory (GT) method to explore the process of "bouncing back" among older adults aged 70 or older who had experienced the loss of a loved one and/or loss of mobility in older age. We adopted 70 as the minimum age (instead of the typical 65 based on normative retirement age) because experiencing loss of functional independence or life partner is not anchored in retirement age but rather these losses tend to accumulate at older ages (e.g., Rook & Charles, 2017). We sampled for cases where the loss(es) had occurred in the last 2–10 years to ensure participants' recollection of experiences of loss, while also allowing time for recovery after losses and reflection on this process. GT is suited to studying resilience in later life as its core tenet is to systematically study processes i.e. actions and interactions in response to events within contexts (Charmaz, 2014). The GT method helps to build theory grounded in data (Glaser & Strauss, 1967). In this study, the data were generated through interviews that were transcribed verbatim. Qualitative semi-structured interviews were selected to produce nuanced, multilayered talk data, grounded in the participants' renderings of their experiences, feelings, and reflections (Silverman, 2013).

Sample

Ethical approval was obtained from Trinity College Dublin in June 2023, and participant recruitment commenced thereafter. In keeping with GT methods, sampling was purposive and theoretical. In purposive sampling, participants are selected at the outset based on their knowledge, experience and characteristics related to the study topic. Theoretical sampling is key to theory building, requiring simultaneous data gathering and analysis, whereby as data collection proceeds, emergent topics are explored and developed further through sampling for participants, and more importantly, for conceptual saturation (Conlon et al., 2020; Corbin & Strauss, 2015).

We sampled for adults aged 70 and older who felt that they had bounced back from a major loss, and the recruitment strategy was accordingly focused on individuals self-identifying as resilient. Four main recruitment routes were utilized: invitation flyers circulated with the support of civil society organizations working with older people, flyers posted in key venues (e.g., public libraries, community centers), visits to older people's clubs, and notices published in local newspapers. The role of organizations was restricted to circulating invitations in their newsletters, social media, and e-mail lists, and they did not have any role in selecting participants. When a researcher visited a group, they discussed the study and answered questions. Potential participants contacted the team directly (by phone or e-mail) to express their interest. This first conversation proved crucial for clarifying the inclusion criteria, explaining

what participating in the study entailed and confirming the criteria of self-identifying as resilient. After this initial conversation and check on eligibility, prospective participants received the participant information leaflet with detailed information about the study and a time for the interview was arranged at least one week in advance.

Data collection and analysis

Seventeen community-dwelling older adults (13 women and four men) were interviewed between June and November 2023. Participants were mostly interviewed in their own homes at their request, with one interview conducted on university campus. Table 1 provides a summary of the sample and associated losses and timelines. The interviews lasted an average of 80 minutes, and were recorded, transcribed verbatim and pseudonymized. The interview guide was designed to prompt participants to share their experiences of loss, their process of coping and bouncing back, and the sources of support that aided/hindered the process. The interview guide is appended at the end of the article (please see Appendix 1). Participants were offered the opportunity to read their transcripts, but none availed of this option. Theoretical sampling and emerging concepts identified through continuous analysis informed the interviews as the study progressed.

Data collection and analysis were progressed in tandem whereby emergent and theoretically relevant aspects and dimensions of the process of resilience were identified and discussed by the research team (Timonen

Table 1. Participant characteristics.

Pseudonym	Gender	Age	Type of loss/time since loss
Mary	Female	74	Husband (cancer) – 4 years
Lucy	Female	88	Husband (dementia) – 4 years Son (cancer) – 2 years Sister (ill health) – 2 years Own mobility issues (walking)
Anne	Female	77	Husband (dementia) – 3 years
Rose	Female	73	Husband (cancer) – 5 years Own mobility issues (neurological illness)
Noreen	Female	88	Daughter (addiction) – 5 years Own mobility issues (walking)
Elizabeth	Female	72	Sister (cancer, cardiac) – 2 years
Bridget	Female	75	Multiple (husband main loss) – 4 years
William	Male	70	Mobility (wheelchair) and various health issues – 5 years
Jenny	Female	78	Son (sudden death) – 5 years
Linda	Female	88	Husband (dementia) – 4 years Son (addiction) – 4 years
Thomas	Male	77	Sister, Brother – 3 years Close friends – 2–10 years
Archie	Male	75	Wife (cancer) – 10 years
Michael	Male	77	Wife (illness) – 10 years
Bernie	Female	72	Husband (illness) – 3 years
Dorothy	Female	78	Mobility (wheelchair) – 4 years
Imelda	Female	81	Husband (dementia) – 2 years
Nuala	Female	78	Husband (illness) – 3 years

et al., 2018). Memo writing following each interview facilitated identification of key concepts (Conlon et al., 2020). Resilience as a process and social dimensions of resilience were early emergent concepts pursued across the full dataset.

The findings are divided into three sections. First, we discuss how participants articulated their process of becoming resilient. Second, we describe the five major sources of support (social dimensions of resilience) identified in participants' accounts. Third, we detail the sources of support that proved significant for participants who initially had struggled to recover from losses.

Results

The losses the participants had experienced were life changing and their circumstances gave context to the process of coping. Where the death of a spouse came as the culmination of a long illness it had involved the *"lovingly difficult"* (Linda, 88) task of caring for the spouse, typically at home and followed, in some cases, by relocation to a nursing home. Caring entailed acknowledging the loss ahead. For these participants, the loss of a loved one unfolded gradually and the experience of caring helped them to prepare for the loss and develop a sense of acceptance afterward. Where spouses were cared for in a nursing home or hospital to end of life, this prepared participants for living alone. By contrast, others were confronted with unexpected death, such as the death of a healthy adult child, or multiple deaths of loved ones within a few years. Loss of mobility brought radical changes into participants' lives, particularly for those who had lost their ability to walk, which involved emotional and practical adjustments to their new reality.

The interview prompted participants to revisit their steps and to give meaning to their journey to resilience following major loss(es). Participants' accounts showed their process of resilience progressing at different rates, or traveling different distances, with some drawing on skills acquired during previous experiences of coping. Accounts across the sample spoke of making choices and decisions and implementing changes that fostered the process of resilience. Looking back, participants often recognized a turn or a milestone that signaled awareness of overcoming the most challenging period.

The process of resilience

This section portrays participants' accounts of *becoming resilient* by identifying a moment of resolve, seeing no choice, and connecting to earlier life experiences. Even though participants rarely pinned their resilience on any single factor, many identified *a moment of resolve* that brought the realization of having *no choice* but to move forward. This resolve prompted entry to a new

stage in the resilience process marked by the decision to introduce changes, exemplified by Imelda's (81) words:

> The brain definitely closes down to a certain extent, to protect the body and gives you time. But *there does come a point* when you turn around and say, well, I've had enough of that. Now, *what's the next step*? And the next step was I'd ring friends. *Instead of waiting* for them to ring me, I'd ring them and say, come up and have a cup of tea or I'll meet you. [our emphases]

The next step, as Imelda explained, revealed an awareness of reaching a turning point powering the readiness to act. Similarly, Mary (74) identified the moment when she decided to start moving forward:

> You're getting through each birthday, each holiday, each, you know, without them. But it wasn't until last year that *I decided*, I think was New Year's Eve. I was here with dogs, talking to them (laughs), I decided that *I've got to make a new life now*. I've got to try new things (. . .) I just said, *I've got to start doing something that I enjoy* outside of my house. [our emphases]

After spending much time *"trying to make sense of what happened"* following her husband's death, Bernie (72) recounted becoming more proactive and introducing changes:

> I did realize that being on my own is a lonely place, and I needed to finish it if I was to survive. So, and I did every online course that I could find (. . .) I joined a walking group (. . .) And I didn't know whether this was wise or not and not knowing what the future would hold but I did decide to go ahead and get a dog.

The decision to take "*the next step*" was a manifestation of the process of resilience, which, as the above quotes illustrated, advanced gradually and materialized through actions such as resuming social life. These actions made participants' progress visible to others who could see them "moving on." Resilience therefore presents as a process that evolves gradually and incrementally but also entails personal effort and resolve at certain moments that were quite memorable for participants.

Reaching the moment of resolve entailed resilient agency gradually recovering control over emotions and regaining enjoyment. Mary (74) recounted her journey from a "*foggy period when I was only existing*", after her husband's death up to a point where she felt enjoyment again and had "*things to look forward to*." Regaining control over one's life, underpinned by the resolve to move forward, meant applying self-discipline, will, and pragmatic strategies to move through daily life. Bernie (72) explained, *"I make myself get up and do anything rather than mope to stay active and engaged,"* while Rose (73) recalled:

> It was really quite difficult. So, I kind of made a list of important things, and I go, okay, I'm going to do those three things this week, like I broke a chunk it into small pieces, and that was the only way I found I could deal with it. I just kept telling myself, you have to do it, you have to do it, there's no other alternative.

The decisions and resolutions ensuing from participants' resilient agency were contoured by the context and personal circumstances. Not allowing the loss of mobility to define her was the resolve that kept Dorothy (78) focused and self-aware:

> It's important not to let people put you in a little box as this old lady who has all these things wrong with her and that is you. It is not. You know, and then you think back to when you were living your best life and you're still that person inside.

Often, resilient agency meant acting upon the realization of *having no choice but to come to terms*. Anne's (77) words summarized the agential dynamic of understanding one's situation, facing the options, and acting to preserve well-being:

> How do you cope with any loss? There's no way of doing it, you know, a loss is a loss. So, okay, what's your life from now on? *You basically have to make something out of it yourself*. There's no one going to do it for you. (. . .) you could sit here, and. . . you could just be so overwhelmed by it, but at the end. . .you do have to face it, and you do have to cry, but *you do have to do something then*. (. . .) *you actually have to, you have to just move on*. [our emphases]

The data contained participants' descriptions of how some people, when faced with losses, *choose* not to move on. They portrayed this as the opposite of resilience and used it as a counterpoint to portray themselves as resilient, sometimes criticizing those who had *"the poor me syndrome"* (Imelda, 81). Thomas (77) summarized this view:

> It's only natural [feeling sad after a death] I don't think that's depression. I think that's reacting appropriately to the circumstances (. . .) But a couple of people have taken it to themselves as a sort of a badge that they won't let go, and they wear it as a sort of a comfort blanket, "this is me, the bereaved person."

Internal conversations featured in several accounts. The exercise of self-talk allowed participants to work through the realization of their new situation and to develop responses to it. Linda (88) explained her use of internal conversation as a crucial part of her process of coping: *"I sort everything out of here* [touches her head]. *I talked to myself a lot."* Self-awareness guided some to practice self-care and allow themselves the time they needed, as Bernie (72) explained:

> I knew to kind of proceed slowly with what was going on in my life, and to try and be kind to myself, and like, if I wanted to sit and just think and be a bit sad, well, there was no harm in that. And then you just brushed yourself off.

The process of resilience outlined above centered on agency and resolution in a way that resonates with the psychological approach to resilience, but the data also reveals the resilience process as almost *forced upon* a person to take action to continue living, not just surviving: becoming resilient

involves personal effort but also acceptance of the new reality. Further, the process of resilience needs to be understood within the framework of participants' contexts and circumstances, among them earlier life experiences.

Prior life experiences provided a foundation for resilience that helped some participants to cope with loss. Rose (73) drew strength from her experience of coping as the parent of a child with mental health problems. Noreen's (88) experience of the death of a sibling, husband and daughter helped her to understand that *"it will pass. . .you will go on living"* and contributed to her readiness to *"move on. . .from this"* and *"put on bright clothes."* Linda (88) had cared for her husband for nearly a decade before his death and faced the unexpected death of an adult child. She attributed her coping skills to her childhood experiences:

> . . . [Only one session of counselling] was sufficient because I have my own coping skills, I have my own way to cope with whatever is thrown at me. . .. that's from a very early stage in my life. (. . .) I am a very independent person. [Childhood] is where I would say all that came from. (. . .) [With specific reference to coping after her husband's death:] *I was strong and I am strong.* (. . .). [our emphases]

Lucy (88) recalled the difficult period after her husband's and son's death. At some point, the memory of her mother having "given up on life" in widowhood mobilized Lucy's willingness to realize *"I'm not that kind of a person* [inclined to withdraw]" and to act accordingly:

> I just wanted to stay in bed (. . .) she'd [daughter] say, mom, are you coming down? And I'd say, no, leave me here, you know, I was taken to the bed. And *then it hit me*. That's what my mom was doing when my dad died, you know, *and I said, no, I'm not going to be like my mom*, you know. She gave up her life. She just stopped living. [our emphases]

Earlier challenging experiences provided a foundation for resilience that afforded some participants confidence about their ability to cope successfully when faced with adversities. Together with childhood, the prior experiences of coping with personal health difficulties and caring for an ill partner featured in these participants' accounts. In one case earlier experiences during working life were mobilized. Michael (77) explained how he had developed a coping "strategy" based on his experience in a field of work where trauma was dealt with not by taking time off but by relying on routine. Michael decided that, for him, this meant recovery through marrying again following the death of his wife.

Overall, participants recounted resilience as the progressive recovery of well-being and ownership of a self-concept as a resilient person overcoming loss. The next section discusses the sources of support – the social dimensions of resilience – that paved the way toward resilience.

Social dimensions of resilience

The process of resilience was underpinned by sources of support that helped participants to cope better, such as counseling or the presence of supportive relationships. These social dimensions – their presence or absence – emerged in connection to participants' contexts and circumstances, and their personal experience of loss and coping. Participants made decisions and introduced changes that fostered the process of resilience. Consequently, the interviews sought to "map" the role and significance of various potentially supportive social connections in each participant's life. Participants described these supports but rarely attributed their resilience to any single factor. The following sub-sections briefly describe the most relevant dimensions identified by participants: family, friends, social participation, formal supports, and spirituality and faith. These dimensions are not ranked in a hierarchical order as their presence and significance varied among participants.

Family

For most participants, family represented an established and positive support structure while others had challenging or estranged relationships with one or more family members (e.g. Nuala, 78 and William, 70). Adult children and siblings featured frequently in participants' accounts. Most participants lived alone, while some lived with an adult child. In our sample, the latter group reported that living with a relative helped them cope better. Dorothy (78), who used a wheelchair, acknowledged the support of her social worker, and her son and daughter-in-law who had moved in with her. These supports were integral to Dorothy's ability to remain in her house, and she was emphatic in her acknowledgment of the social worker's role in endorsing her wish to continue living independently. Noreen (88) referred to caring for the grandchild after her husband's death as a *"lifesaver."* Established close relations with extended family were also drawn on as sources of support. Mary (74) found mutual support from a cousin, also a widow. Bernie (72), Nuala (78) and Anne (77) were close to their brothers and visited them frequently. In contrast, participants who had little or no support from close family members felt their absence. Elizabeth (72) resented the lack of communication from her siblings after the death of a sister while William (70) had no relationship with his daughter and his only sibling.

Emotional and practical support from adult children was significant for most participants, but sometimes characterized by ambivalence. For example, when needing support with the *"tsunami of paperwork"* after her husband's death, Rose (73) felt conflicted about asking her daughter for help:

> I don't have anybody to delegate. My daughter is away. My son isn't really able to help [due to illness]. And my other daughter, she lives here, and she, you don't want to burden her with everything either. You're conscious, like, she has her own life.

After the loss of a spouse, the parent-child relationship could become what Anne (77) described as *"a balancing act"* in search of an equilibrium between wanting the children's support, asking for help, and keeping one's independence. Paradoxically, while expecting and receiving their children's support and concern, some participants also felt they could not openly share their feelings (especially grief) in the interest of protecting their children. They did not want to burden their children and preferred talking to friends.

Friends

Old and new friends were sources of emotional support and opportunities for social engagement. Dorothy (78) had an established network of friends and emphasized their importance in helping her with practical tasks and keeping her engaged; she had daily phone conversations with two childhood friends, while other friends brought her books and accompanied her for strolls in the park and medical appointments. Mary (74) valued the support of friends and neighbors during difficult moments, such as helping her to overcome the emotional hurdle of returning for the first time to a church where she used to go with her husband. She emphasized the significance of friends who had experienced similar losses:

> [S]he's a great friend who's there, and you never have pressure from her. It was always like, now, if you don't feel like going, it's no big deal. . .with her there was no pretense. How are you? And you would tell her, you know, because she knew.

Archie (75), a widower, talked about going on a short holiday with two close (previously bereaved) friends who *"understood what I was going through"*. However, there were also some accounts of friends who were not helpful or served as cautionary examples, as recounted by Rose (73):

> I have a friend whose husband is dead about ten years, and she just never stops talking about [husband] as if he died yesterday. I remember thinking "I'm not going to do that" because that puts people off.

Rose's decision to act differently conveys again the element of agency and active decision-making outlined in the previous section. When established friends were not supportive following loss of mobility, Rose decided to join groups that did not require a high level of mobility where she could meet new people while re-gaining a degree of control over her new situation: "*I know what I need to do. I need to get out and meet people that will make me feel happier.*" Self-awareness of one's needs featured as a significant element of

resilience. Similarly, Thomas (77), when facing the loss of close friends, focused on forging new friendships:

> Well, unfortunately, you reach a point where suddenly everybody is bloody dying . . . now we realize that you only have friends if you make them . . . So the practical impact is that we have set out to make friends with other people.

While many participants valued and invested in friendships, others preferred and benefited from social interactions that centered around organized groups and activities.

Social participation

Attending groups and social activities fulfilled needs contextualized by the changes participants were experiencing. For those who had lost a spouse, joining activities and meeting people was a way of addressing the loneliness of living alone. Rose (73) explained how *"weekends are the loneliest because people do things with their families at weekends"*. Personality (being introverted or finding socializing difficult) was the reason given by some participants who defined themselves not as "people persons" but as enjoying social activities that reflected their interests and dispelled feelings of loneliness. Michael (77) did not enjoy meeting new people but liked cultural groups. He had joined a group and the committee of a club, which suited his interests and personality:

> I wanted to get involved in something, something regular (. . .). I'm purely a committee person, not a member person. I look after safety and do things like that. I don't go on any of the social events that they have. They're just not my cup of tea. I enjoy their meetings. I mean, most of the meetings.

Similarly, Bernie (72) preferred cultural activities, courses and volunteering. She was happy to have formed an interests-based relationship with three women she knew through a course and met for cultural outings. Archie (75) joined a walking group after his wife's death and found comfort in this shared outdoor activity. Participation in interests-based groups warded off loneliness while not demanding the formation of close relationships.

Other participants had built long-term resources around a myriad of social activities. Following the death of her husband, Noreen (88) quickly resumed her activities in volunteering, attending social clubs, and choir. Years later, when faced with the death of her daughter, Noreen found these long-established activities to be a source of support and positivity that she cherished. Similarly, Lucy (88), Jenny (78) and Linda (88) advocated the benefits of social participation. Lucy affirmed, "*I live for the club"*, which she attended three days per week. Jenny referred to the various groups she frequented (cultural, walking, life-long learning) as sources of positivity, encouragement,

and support, while Linda volunteered in community organizations for several years, which helped her through her husband's illness and death. As Imelda (81) explained, participation in groups provided a space for communicating and connecting that was valued more highly than the specific activities:

> It's not what you're doing there, it's what you're doing afterwards. You're having the cup of tea, you're having the chats, you're meeting people, you're listening to people.

Social participation held different meanings for participants. While most designated social participation as providing support, motivation and routine, others were not inclined to frequent or intensive involvement. Decisions about social participation contributed to the resilience process; many and varied interactions for some and activities that dispelled loneliness but did not overreach their less sociable personality for others. Self-awareness in choosing activities that reflect their personality and needs is illustrated by Bernie's words "*I'm not going to suddenly go out and be a people person. I don't knock on people's doors . . . I'm happy with people but not necessarily engage with people. I don't like being alone. I am in the middle*". Rose's reflection exemplifies participants' agency and will to have control over their decisions and do what felt right for them:

> [Daughter] says, Mom, I think you're a bit depressed (. . .) Maybe if you take such and such a medication and I said, giving me antidepressants, if I haven't taken them until now, I don't think I need them, because that's only plaster on symptoms. I know what I need to do. I need to get out and meet people. That will make me feel happier.

Some participants needed the encouragement from an external party, such as a friend or health professional, to instill the motivation to "go out" and initiate social interactions to regain well-being. Bridget (75) and Elizabeth (72) talked about their experience participating in groups for the first time, following the recommendation of social prescribing professionals. Elizabeth was experiencing a "second chance" at socializing which she had been unable to do earlier in life (because of family circumstances), while Bridget explained how talking and listening to other women had made her feel more confident and outgoing since joining a group. William (70) talked about the weekly attendance at a social club, suggested by his social worker and counselor, which had become a vital part of his routine:

> I do four days a week [at the club] and it really is a lifesaver. It gets me out, it means I'm meeting people. It's fantastic atmosphere here, it's always good fun, it cheers me up. It really does help me.

Social participation emerged as a significant component of resilience that provided adaptable support. This support was modulated by participants' needs, interests, and personalities. Becoming engaged in social activities, even when prompted by the advice of a health professional, had a positive impact on these

participants' well-being. The next section will elaborate on the role of formal supports that often entailed advice on how to become more socially engaged.

Formal supports

Formal support materialized mainly through services, such as doctor's, counselor's and social worker's appointments or care packages for participants with mobility loss and other illnesses. Dorothy (78) was satisfied with her care package that involved formal carers assisting with daily tasks. Noreen (88) was also happy with the daily assistance with tasks that her declining mobility did not allow, and trips to a daycare center once a week.

Counseling was assessed as beneficial by some participants. William (70) emphasized the role of counseling in improving his subjective well-being while coping with the loss of mobility and the loss of key family members (through death or estrangement). William spoke highly of the support his counselor had provided:

> [S]he [counsellor] kept me going, kept on telling me, look, you've done this, you've done that, you're fighting (. . .). I thank her that I'm still here, she says, no, it's you that's done it. But I couldn't have done it without her help even to this day.

As mentioned in the previous section, William's counselor prompted him to join a social club, which he evaluated as very beneficial in helping him to cope better. At the same time, William felt supported by the social worker handling his case, who had provided him with temporary accommodation and met him regularly to assess his evolving needs. A social prescription service referred Bridget (75) and Elizabeth (72) to groups and activities that helped them to improve their subjective well-being. These three participants had gone through a difficult process of coping with their losses and had felt, in their own words, depressed. The supports they received from health, counseling and social work professionals were substantial and marked a juncture where they started to feel ready to make changes and move forward, echoing the moments of resolve described in the earlier section.

The role of counseling in building resilience was also mentioned by participants who spoke of having attained coping skills from counseling sessions they had attended in the past. This was the case for Rose (73), who had found in counseling (to cope with her son's illness) a source of strength that was now, many years later, helping her to cope with her losses:

> I think I just went for three sessions. I knew what I needed to do because I had had a lot of counselling before in relation to my son and, you know, how to deal with issues.

While some participants benefited from counseling, others felt that this service was not relevant to their coping process. Michael (77) recalled the time when the hospital invited him to bereavement group sessions:

> I felt they were actually being unhelpful because what they were saying was, look, there is no way out of this. This has happened to you, learn to befriend grief. It was almost encouraging people to be utterly self-indulgent. Instead of saying, look, would you ever get up?

In addition to receiving counseling, Jenny (78) joined a bereavement group where she found a safe place to grieve. She progressed to becoming a volunteer helping other parents with the loss she had experienced (sudden death of an adult child). Rose (73) and Linda (88) recalled similar experiences in progressing to become volunteers in the support groups that had helped them. These experiences enabled them to find a sense of purpose and mastery by channeling their experiential understanding to helping others, which was conducive to resilience. In Jenny's words:

> I feel so proud that when parents come into the organization, into the meetings so heartbroken, that I can say, you'll be okay again. It'll take time, the grief gets lighter. So, I feel very proud that I can do that.

This process of finding a source of support and evolving in that setting to take an active part in extending support to others constitutes a distinctive resilience trajectory.

The support of encouraging health professionals was relevant for some participants as it provided an impulse that nurtured resilient agency. Noreen's (88) personal resolve to move on was aided by a health care professional who presented Noreen with an alternative image of herself, something that she then "*had to live up*" to:

> [Doctor] came over and I [asked] how am I going to go on living now [after husband's death]? I saw the road ahead of me as a big, long, lonely road. And he said. . .of course you'll go on living. He said, you're *not the kind of a woman who'd sit down and be at home*, you'll be up and doing in no time. And *I felt I had to live up*. And y*ou do have to say one day to yourself, move on*. [our emphases]

Formal supports, such as care packages, counseling, social prescription and social services helped participants practically and emotionally. The role of counseling and social prescription in encouraging changes conducive to recovering wellbeing was spontaneously and emphatically acknowledged by the participants who had availed of these services. Some also identified their spiritual beliefs as a source of resilience, as the last sub-section will briefly depict.

Religion and spirituality

Faith and spirituality featured as sources of comfort and hope for participants who spoke of practices such as prayer, attendance at (Catholic) mass, and

spiritual meditations. In Lucy's words, *"you have to have something to hang on to"*, referring to her faith and constant prayer. Similarly, a few women in the sample found consolation in the belief in the afterlife that kept them connected to their loved ones, as Noreen (88) explained:

> I think the big important thing is your religious faith. (. . .). I believe we'll see our loved ones in the next life. I don't know how anyone would manage, anyone that doesn't believe in the next life.

Noreen and Linda (both 88) had volunteered in their parishes for years and attended mass regularly. A few participants, like Mary (74), were not religious, but their husbands had been. Going back to mass was an important step for Mary, a ritual that kept her close to her deceased husband. A few participants referred to themselves as spiritual. For Imelda (81), spirituality meant a positive attitude that gave logic to life events, and death - *"I do believe we are here for a pause. Some pauses are shorter, some pauses are longer"* - while Jenny (78) detailed how her spirituality kept her connected to her son:

> I'm spiritual . . . I'm in the now and I feel my son is up there over the rainbow. And his presence was very strong after he passed away, you know, the white feather would appear somewhere. I might be doing something with the [grand]children and, like, I could feel him saying, well done, Mum, well done. Thank you.

This section has outlined the five social dimensions of resilience: family, friends, social participation, formal supports, and religion and spirituality. The journey to resilience was a process that participants reconstructed in research interviews as they recounted actions that had contributed to their recovery from the loss(es) they had experienced. The next section focuses on the social dimensions of resilience that fostered resilience in participants who felt they had benefited from formal or structured supports.

Fostering resilience

As discussed in previous sections, becoming resilient was a process where, supported by various social dimensions, the timing and the distance traveled varied among participants. Some participants lacked resources that had allowed others to build the foundations of resilience prior to the loss, such as earlier experiences conducive to resilient self-image and supportive friends. These participants acknowledged that they had needed an external party to initiate and enable the process of moving forward, and in their case the role of formal supports and guidance by doctors, social workers, counselors and other health and social care professionals proved substantial. In all cases, the processes of resilience were powered by agential resolve and decisions to adopt actions that would introduce changes conducive to resilience and wellbeing.

The process of coping after loss was particularly challenging for participants with weaker social engagement and fewer support networks. These participants benefited greatly from the support of professionals and participation in social groups. The absence of other close and supportive relationships following her (very close) sister's death led Elizabeth (72) to conclude: *"I lost everything when she died. . .the loneliness was killing me because I didn't know what to do with myself"*. Having been prescribed sleeping pills that did not help, Elizabeth followed the suggestion of seeing a counselor whose advice helped her to get out of the house, take regular exercise and join a group:

> I got great confidence and great encouragement out of it because I was afraid to go out, so he [professional] encouraged me to go. I was afraid to do things.

Leaving the house to meet new people and to take up activities on her own was a challenging but momentous turn in Elizabeth's life:

> I used to put my coat on and walk to the door and say, no, I'm not going, and take my coat off and come back and sit down. I'll do it tomorrow. I'll do it next day (. . .) he [counsellor] said to me, Elizabeth. . .you have to push yourself out that door. After the third or fourth time . . . *I felt confident enough and kept going*. I know at one stage, I remember saying to me, now, Elizabeth, look, like this, go out the door, and if you feel you're having a panic attack, just tell yourself you can't have it and go because you can't go back in, tell yourself you have no key, you locked yourself out. *I told myself*, don't come back in. [our emphases]

The failed attempts and hesitation expressed by Elizabeth were addressed through the ongoing support of the counselor. While this formal support instilled motivation and a sense of direction, Elizabeth's internal talk reflects the development of a resilient agency that moves her to act and results in a significant change. The resolve to talk herself into taking the first step, facing her fear, formulating a plan and acting accordingly led to a new phase in Elizabeth's life. Elizabeth evaluated her progress and spoke of change and gaining self-confidence and enjoyment:

> I used to say, what am I going to do now? (. . .) I'm feeling better now, thank God . . . I'm getting up and I'm doing stuff that I didn't do before. And I'm not afraid of going out like I was. It's a big change, much better.

Bridget (75) had experience multiple deaths of loved ones (grandchild, sister, mother, husband), some of them in tragic circumstances, and a serious illness, and was leading a life mostly within the confines of her house and children's visits. Like Elizabeth, Bridget received the encouragement of a social prescribing professional to start social and physical activities, which she followed through. Attending a women's group and activities was transformative for Bridget, *"I'm a new woman. . .we help each other"* and helped her to realize she was bouncing back: *"I'm delighted with myself. I'm quite happy now with it. I'm getting used to being on my own"*.

Participation in social groups and activities was crucial for both Elizabeth and Bridget, and instrumental in their journey to well-being and self-confidence. These supports along with health professionals acted as a springboard into resilience. Literally *getting out of the house* is a phrase that featured in several participants' accounts of their journey to resilience.

Discussion and conclusions

The aim of this research was to gain a deeper insight into the social dimensions of resilience as recounted by older adults who had experienced one or more major age-related losses, and who self-identified as resilient. The journeys to resilience that emerged from participants' accounts reflect a process that is neither solely psychological nor exclusively triggered by social factors, but rather something that develops at the interface of agency and social supports. The process unfolds as older people make decisions as to what sources of support they can access and how they decide to use them. Participants positioned themselves at different junctures within the process of "bouncing back" after loss. Some participants' accounts portrayed them as individuals who had built a measure of resilience throughout their lives that helped them to cope with their recent losses. These participants spoke of life experiences, relationships, and building an outlook on life that framed their self-identification as resilient. Others relayed a more recent awareness of resilience and explained how health, social and other professionals' support and advice had been crucial in their progress toward resilience.

Our findings suggest that many older adults who have experienced losses will benefit from gentle but persistent professional advice and prompting to take up activities outside their homes. Hence, similar to Bennett (2010), we found that some participants could bounce back by drawing on available (internal and social) resources, while others needed external intervention in the form of professional help, the implication being that individual agency is not the sole condition for resilience for all older adults. Bennett's (2010) examination of the timing of moving on, identifying specific moments where participants felt ready to move toward resilience, also resonates with our findings, again emphasizing that resilience is not solely an individual process based on internal resources but one that draws on social, institutional, professional, and community resources. Considering the role of agency, Aldwin and Igarashi (2012) observed that environmental dimensions offer resources and opportunities but cannot create resilience by themselves, pointing to the significance of the interaction between individuals and resources which is also evident in our findings. Donnellan et al. (2015) identified personal willingness to access support as essential to resilience, and Manning and Bouchard (2020) identified people being strategic and activating

specific sources of support at different moments of the coping process, as also evidenced in our findings.

Our findings align with previous research on early life experiences influencing resilience in later life (Gattuso, 2003; Pruchno et al., 2015). Like Gattuso's (2003) study of how older women nurtured their present resilient selves by drawing on past adverse experiences they had overcome, we argue that holding onto narrations of past personal conquest helps people to construct themselves as resilient in the face of changes and losses. While not everyone has such a store of previous resilience experiences to draw on, their relevance was evidenced by several accounts in our study.

Sources of support – the social dimensions of resilience – were contextualized by participants' circumstances and held different degrees of significance in fostering resilience. It is important to acknowledge that some older adults have several resilience-promoting resources available to them, ranging from positive social relationships to past experiences that are conducive to coping. Others need to acquire or cultivate sources of support, a task that is not easy and may necessitate professional help and formal supports. Social participation and counseling yielded remarkably positive outcomes for those who had decided to take recourse to them, sometimes following persistent prompting by professionals. The "distance traveled" in the process of becoming resilient is significant in explaining how these participants built their self-identification as resilient.

Regarding the limitations of this research, we want to sound caution around drawing strong universal recommendation from these findings. It is not possible to provide a "recipe" for resilience as sometimes the journey to resilience is long and hard even in propitious circumstances, and quite adverse circumstances with relatively few supports can still lead to a favorable outcome. In accordance with the sampling criteria outlined earlier, the sample consisted of self-selecting individuals who *identified as resilient* at the time of their research participation. Several participants in this study could be characterized as "joiners" who had thrown themselves into different activities following their losses and to aid their recovery, including participation in social activities, clubs, and provision of care to others. Even those participants who needed to work hard at their coping and resilience, had volunteered to take part in the research and hence evinced the kind of openness and inclination toward "trying things out" that others who struggle to become resilient might lack.

Many participants described in quite vivid terms a turning point where they resolved to cope. This was usually a distinctly agentic moment, but it could also have an element of surprise or sudden awakening: one had reached a turning point, sometimes without being aware of it, and sometimes as the last option, prompting resilience by default or as a paradoxical resignation: *one had no choice but to choose to become resilient*. The participants in this research

combined independently *resolving* to cope with *asking* others for some help or *accepting* help where it was offered. Hence, our findings indicate that at the heart of the resilience process is this merging of an internal resolution, and the act of seeking or accepting support from others, including formal service providers. Resilience therefore presents as a story that we tell ourselves in the moment of coping, and retrospectively. Further, it is a story that others can hint at or help to initiate for the person dealing with loss. The main implications of this research accordingly relate to the need for further research on social interventions that encourage resilient responses, including social work practices that identify formal services (such as counseling) and community-based supports (such as peer support groups and organized social activities) for older adults who express the need and willingness to receive such supports to help them cope with age-related losses.

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Ethical standards

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Appendix 1

Resilience project (Ireland) interview guide

As a preamble to the interview, interviewer reminds participant of the focus of the research and confirms consent to participate.

Opening question

(1) Tell me a bit about yourself and your life up to this point?

Main part of the interview - The event

(2) Tell me about the loss you experienced and how this has impacted on your life (*OR changed your life*)?
(3) What were the main sources of help and support you drew on immediately at the time of [the event]? *(note to interviewer: probe here for formal supports and social network supports)*
(4) As time has gone on how have you adapted to [the event]? *(note to interviewer: Allow an open-ended answer and then probe for both formal supports and social network supports using prompts below)*
- What new health and social services, if any, did you receive to help adjust to [the event]?
- What help and support, if any, did you receive from voluntary organizations to help you adjust to [the event]?
- What help and support, if any, did you receive from friends or family to help you adjust to [the event]?

(5) What is everyday life like for you now? *(note to interviewer: Allow an open-ended answer and then probe using prompts below)*
- How have the benefits, services and supports you receive changed since [the event]?
- How has your participation in social activities and networks changed?
- Do you think people view you differently since [the event] and does this impact on your day-to-day life?

(6) Thinking back on how you have adjusted/are adjusting to life after [the event], did you draw on experiences of overcoming difficulties in your earlier life to help you cope? And do you think your personality has played a role?

Closing questions

(7) Thinking about how your life as a whole, how would you say [the event] changed your life? Has it shaped your expectations or hopes for the future?
(8) Is there anything else I have not asked you about that you would like to tell me?