Developing and measuring resilience for population health

Sarah Cowley

Florence Nightingale School of Nursing and Midwifery
African Health Sciences 2008; 8(S): 41-43

Much research and writing about resilience focuses on extraordinary situations, which has two advantages. First, that acknowledges the depths of human suffering as well as the human capacity to survive despite extreme adversity, with some amazing individuals who are able to thrive or excel in the most shocking or dreadful situations. Second, for research purposes, extreme situations are often the most clearly defined, which helps with conceptualising, theorising and measuring. However, there are disadvantages. Human suffering, trauma and disruption can all suddenly affect people whose lives were previously stable and contented; so resilience needs to be 'everybody's business,' not an issue of concern for just a few. Suffering is also a very personal experience. Whilst health, social and economic inequalities create conditions where considerable resilience is needed, neither wealth nor absence of disease will guarantee happiness, social or mental well-being.

The late epidemiologist, Geoffrey Rose, pointed out that, although health needs may cluster in areas of disadvantage, they are widely distributed throughout the population[1]

To focus only on the most 'at risk,' would miss the majority of need in the population as a whole. This, it seems, also applies to resilience. The whole population has a need for resilience, even if it surfaces with the greatest clarity in times of high risk or suffering, so we need to understand mechanisms for developing resilience that are common to the whole population.

Rutter[2] offers a useful starting point when conceptualising resilience, which is that for all kinds of difficult circumstances people respond in a vast assortment of ways. Some succumb to pressure and others manage successfully in the most difficult of circumstances. Moreover, an individual's responses are not fixed or immutable, but dynamic and contextual; that is someone may react badly in one situation but cope well in another. Context and process are both central to studies of resilience, with resilience being defined as a:

- "a process or phenomenon reflecting positive child adjustment, despite conditions of risk." (page 10)[3] or
- "the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances" (page 426)[4].

Embedded within the concept of resilience are two component constructs: *risk* and *positive adaptation*[5,5] These lie at the heart of assessing resilience, which as a process cannot be directly measured, but needs to be inferred on the basis of these constructs. Positive adaptation points to outcomes that are better than would be expected following occurrence of the risk factor being studied. Garmezy[6] described three major categories of *protective factors* that would contribute to this adaptation. These are individual attributes, such as intellectual abilities, positive / optimistic outlook, high self esteem, family qualities, such as warm, caring and consistent parenting, family cohesion, positive expectations and involvement in family life and supportive systems outside the family, such as robust social networks and high-quality schools.

Such protective factors are largely developed within the early months and years of life, although clearly all of childhood and family life are important and intertwined with the wider community within which individuals live. These are the focus of interest for health visitors, who aim to work through the strengths of the family, developing a one-to-one relationship and providing a supportive and educative function so the best potential of each child can be reached. Cowley[7] identified that health visitors treated health as a process to be developed, focusing on key 'resources for health' that were both personal and internal to the individual or the family, or were external, arising in the current situation or context at the time. Further work with the clients served by health visitors[8] clarified that the

Correspondence author:
Sarah Cowley
Professor of Community Practice Development
King's College London
Florence Nightingale School of Nursing and Midwifery
150 Stamford Street, London, SE1 9NH
T: +44 (0) 20 7848 3030, F: +44 (0) 20 7848 3764
E: sarah.cowley@kcl.ac.uk

definition of what constitutes a 'resource,' and the distinction between 'internal' and 'external' lay within personal experience, rather than in observable factors or normative descriptors; this creates difficulties for measurement. However, the resources were conceptualised as lying within the practical and physical environment, emotional and social situation, or the field of understanding and development. These have a clear resonance with the three central components of a sense of coherence, identified by Antonovsky[9] [10]as manageability, meaningfulness and comprehensibility; also with social capital or community cohesion[11,12].

My methodological work focusing on the measurement of social capital included the validation of Antonovsky's sense of coherence scale for a UK audience[13] and a theoretical description of the process of social capital development[14], which identified key points for measurement of this contested concept. Like resilience, social capital is fungible; it is not fixed or immutable, but is constantly changing and dynamic. It is personally experienced and defined according to context. The method of identifying key transition points for development might, therefore, be worth considering in respect of identifying a scale for resilience, if indeed it is feasible to measure this concept.

Finally, an area of great personal interest for this resiliency workshop, would be to explore what effect, if any, practitioners might have on the development of resilience in infants and pre-school children. Parenting style and very early experiences have a clear influence on brain development and later responses to stress[15]. We hypothesise that positive approaches by the parent, and therefore likely development of resilience in infants, are encouraged by the presence of a practitioner/client relationship that mirrors the preferred parental style[16 17 18 19]

Unfortunately, organisational influences often act in opposition to the development of either personalised approaches to assessment,[20 21 22 23] or the development of partnership approaches to health visiting work[24] (Roche et al 2005). We are currently exploring the potential for measuring the nature of the professional/client relationship (Christine Bidmead, PhD student) and the mechanisms for evaluating self-efficacy[25] and parenting support within a real-world, ever-changing personal and service situation[26].

Acknowledgement: This paper draws on an earlier working document prepared by Sandra Dowling, research associate, King's College London, Women's and Family Health Research, Florence Nightingale School of Nursing and Midwifery.

References

1 Rose G. Rose's Strategy of Preventive Medicine, with commentary by Kay-Tee Khaw and Michael Marmot. Oxford University Press, Oxford. 2008

2 Rutter M. Genetic influences on risk protection: Implications for understanding resilience. In: Luthar S S. (ed) Resilience and Vulnerability: Adaptation in the context of childhood adversities. Cambridge, Cambridge University Press. 2004, pages 489-509

3 Luthar S S and Zelazo L B. Research on resilience: An integrative review. In: Luthar S S. (ed) Resilience and Vulnerability: Adaptation in the context of childhood adversities. Cambridge University Press. Cambridge. 2004, pages 510-550

4 Masten A S, Best K M and Garmezy N. Resilience and development: Contributions from the study of children who overcome adversity. Development and Psychopathology. 1990, Vol. 2, pages 425-444.

5. Luthar S S. (ed) Resilience and Vulnerability: Adaptation in the context of childhood adversities. Cambridge University Press, Cambridge. 2004

6 Garmezy N. Stress-resistant children: The search for protective factors. In: Stevenson J E. (ed) Recent research in developmental pathology: Journal of Child Psychology and Psychiarty Book Supplement #4. Pergamon Press, Oxford, pages 213-233, 1985

7 Cowley S. Health-as-Process: a health visiting perspective. Journal of Advanced Nursing 1995., 22: Vol. 3 pages 433-441

8 Cowley S & Billings J. Resources revisited: salutogenesis from a lay perspective Journal of Advanced Nursing. 1999, Vol. 29: 4 pages 994-1005

9 Antonovsky A. Unraveling the Mystery of Health: How people manage stress and stay well. Jossey Bass, San Francisco, 1987

10 Antonovsky A. The structure and properties of the sense of coherence scale Social Science and Medicine 1993, Vol. 36: 6 pages 725-733.

11 Wilkinson R. Unhealthy Societies: The Afflictions of Inequality. Routledge, London. 1996

12 Putnam R. Bowling alone: the collapse and revival of American community. Simon and Schuster, NewYork. 2000

13 Hean S., Cowley S., Forbes A. & Griffiths P . Theoretical development and social capital measurement. *In* Social capital for health: Issues of definition, measurement and links to health (eds. Morgan A & Swann C) Health Development Agency, London 2004, pages 41-68

14 Hean S., Cowley S., Forbes A., Griffiths P., & Maben J The M-C-M ' cycle and social capital Social Science and Medicine 2003, Vol. 56., pages 1061–1072

15 Gerhardt S (2004). Why Love Matters: how affection shapes a baby's brain. Brunner-Routledge, Hove

[16] Bidmead C, Cowley S A concept analysis of partnership with clients in health visiting. Community Practitioner. 2005, Vol. 78: 6, pages 203-208

[17] Bidmead C, Davis H. Partnership working: the key to public health. *In* Policy and Practice in Community Public Health: a sourcebook (ed. S. Cowley) Bailliere Tindall, Elsevier. Edinburgh 2008, pages 28-48.

[18] Bidmead C, Whittaker K. Parenting and family support: a public health issue. *In* Policy and Practice in Community Public Health: a sourcebook (ed. S. Cowley) Bailliere Tindall, Elsevier. Edinburgh 2008, pages 68-107

[19.] Bidmead C & Cowley S. Partnership working to engage the client and health visitor. In The carrot or the stick? Towards effective practice with involuntary clients. (Editor: Martin C Calder), Russell House Publishing, Lyme Regis, Dorset. 2008. pages 172-189 .

[20] Houston A & Cowley S. An empowerment approach to needs assessment in health visiting practice Journal of Clinical Nursing. 2002, Vol. 11: 5 pages 640-650

[21] Cowley S & Houston A. A structured health needs assessment tool: acceptability and effectiveness for health visiting. Journal of Advanced Nursing 2003, Vol. 43: 1, 82-92

[22] Mitcheson J & Cowley S. Empowerment or control? An analysis of the extent to which client participation is enabled during health visitor/client interactions using a structured health needs assessment tool. International Journal of Nursing Studies. 2003, Vol. 40, pages 413 –426

[23] Cowley S, Mitcheson J & Houston A. Structuring health needs assessments: the medicalisation of health visiting. Sociology of Health and Illness 2004, Vol. 26: 503-526

[24] Roche B, Cowley S, Salt N, Scammell A, Malone M, Savile P, Aikens D, Fitzpatrick S. Reassurance or Judgement? Parents 'Views on the Delivery of Child Health Surveillance Programmes. Family Practice. 2005 Vol. 22 pages 507 - 512.

[25] Whittaker K. Cowley S. Evaluating health visitor parenting support: validating outcome measures for parental self-efficacy. Journal of Child Health Care. 2006, Vol. 10: 4, pages 296-308

[26] Whittaker K. A realistic evaluation of how parents experience the process of formal parenting support. PhD thesis, King's College London. 2008