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. 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 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 process or phenomenon reflecting positive child adjustment, despite conditions of risk.” (page 10)
- “the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances” (page 426).

Embedded within the concept of resilience are two component constructs: risk and positive adaptation. 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 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 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 clarified that the
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, 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. 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.

Unfortunately, organisational influences often act in opposition to the development of either personalised approaches to assessment, or the development of partnership approaches to health visiting work (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 and parenting support within a real-world, ever-changing personal and service situation.

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