

# *The importance of Resilience to Primary Care Practitioners: an Interactive Psycho-Social Model*

**Dr Robert Muller, Flinders University** (corresponding author)

[robert.muller@flinders.edu.au](mailto:robert.muller@flinders.edu.au)

**Associate Professor Paul R Ward, Flinders University**

[paul.ward@flinders.edu.au](mailto:paul.ward@flinders.edu.au)

**Professor Tony Winefield, University of South Australia**

[tony.winefield@unisa.edu.au](mailto:tony.winefield@unisa.edu.au)

**Dr George Tsourtos, Flinders University**

[george.tsourtos@flinders.edu.au](mailto:george.tsourtos@flinders.edu.au)

**Dr Sharon Lawn, Flinders University**

[sharon.lawn@flinders.edu.au](mailto:sharon.lawn@flinders.edu.au)

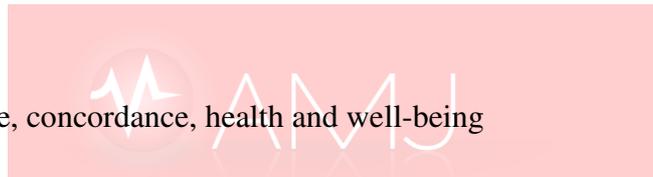
***Please cite this paper as:***

The importance of Resilience to Primary Care Practitioners: an Interactive Psycho-Social Model. Muller R, WardPR, Winefield T, Tsourtos G, Lawn S. AMJ 2009,1,1, 1-15. Doi 10.4066/AMJ.2009.23

## **ABSTRACT**

In this paper, it is argued that an understanding of the factors that make up resilience can enhance communication and concordance between practitioner and patient. A model is presented demonstrating that resilience is an interaction between factors in the internal domain, comprising psychological characteristics and resources, and the external domain, comprising the social environment surrounding the individual. As resilience manifests itself in different ways across the life-cycle, and according to individual circumstances, time is also an important part of the model presented in this paper. Understanding this model of resilience can lead to an insight that there are factors that can be influenced whereby the primary care practitioner can treat the patient, or refer them after a process of concordance through a deeper understanding of the factors that surround a patient's current health status. Underlying the model is the view that resilience is linked to the assets model of health, seeking to promote and maintain health and prevent illness. Therefore, primary care practitioners, through a deeper understanding of the circumstances of the patient, and through understanding the factors that promote resilience, may be better able to take action in health promotion and maintenance.

**Keywords:** resilience, concordance, health and well-being



## **Introduction**

Illness and disease causation, treatment and long-term management are multi-faceted aspects of health and are influenced by social, psychological, economic and cultural factors, in addition to biological, genetic and physiological ones. Whilst there is a great deal of literature about the social and economic determinants of health, this is often written for public health and health policy audiences, rather than being aimed at the primary care practitioner (PCP).

The purpose of this paper is to provide a synthesis of many of these literatures, as they relate to 'resilience'. We present a model of resilience which incorporates a number of the social, psychological, cultural and structural determinants of health, with the underlying philosophy being that we should be aiming to facilitate the development, maintenance and sustainability of resilient people (or patients) and communities, with the expectation that resilience is linked to promoting health and preventing illness (the assets model of health). Therefore, by understanding the various, and interacting factors that promote resilience in individuals and communities, PCPs can better understand their various roles in promoting and maintaining health. Some of these roles may be around treatment, some may be around helping patients to develop certain internal skills, and others may be around referring to a variety of other helping professionals (in health, social care and welfare agencies) whose time and skills are more suited to the task. Nevertheless, in order to be able to fulfill any of these roles, PCPs firstly have to understand the factors likely to lead to developing and maintaining resilience, and thus health. It is to this end, that the paper is focused.

## **Models of Resilience**

In this section, a range of models of resilience expounded in the literature will be explored, however, a definition of resilience needs to be established initially as a starting point for discussion. The Oxford English Dictionary definition of resilience is "to be able to withstand or recover quickly from difficult conditions".<sup>1</sup> Such a definition is the basis of much of the work conducted on resilience over the last few decades and from here, the various models, including our own interactive psycho-social model take on the task of explaining the various aspects of resilience.

From an overview of the literature, it is apparent that there are a number of competing models of resilience,<sup>2-6</sup> however the majority of them do not have sufficient built-in complexity to reflect real-life situations and therefore have limited utility across a range of varying purposes. Previous models of resilience appear to have a number of inherent weaknesses, in

that they have neglected to include the dynamic interactions between the factors that make up resilience. Thus, sociologists and public health researchers have tended to look only at social and socio-economic determinants of resilience, while psychologists have tended to look only at the internal, psychological traits of the individual. As a result, previous models have perhaps not been seen as being as useful to primary care as they could be. These conceptualisations have assisted greatly in determining what constitutes resilience, but unfortunately, not how it operates. To establish a grounding for our model, and to begin to dissect the make-up of resilience and understand how it may actually operate, we first need to explore how the existing literature defines the internal and external domains within their conceptual models.

A number of researchers define the external social characteristics which develop or predict resilience as follows: supportive families and communities; warm but demanding relationships with parents; good educational opportunities and services; services delivered with consideration and respect; strong social relationships and community ties; having paid work; good, accessible and affordable public transport (to assist in overcoming social isolation); availability of opportunities at major life transition points; quality of the social and physical environment; and positive and supportive social policies.<sup>4 7-9</sup>



These characteristics are discussed in the social support literature. Social support is a major factor in resilience and has a number of interacting facets which help to underpin the external social characteristics discussed in the resilience literature. Stroebe<sup>10</sup> outlines five types of social support, namely emotional, esteem, instrumental, informational and appraisal support. Emotional support is based on receiving empathy, caring and concern. Esteem support is the reception of expressions of positive regard, including encouragement, agreement with feelings and so on. Instrumental support is when a person receives direct assistance such as money or help with childcare, and so on. Informational support is based on receiving advice, direction or suggestions. Finally, appraisal support is when information is received which assists a person with self-evaluation or appraisal of an event or situation.<sup>10-12</sup> In turn, there are four main sources of social support, community support (neighbours, church and so on), family support, support from friends, and professional support (medical advisers, social workers and so on). There are a range of studies that refer to the main sources of social support.<sup>13-18</sup>

The psychological research on resilience generally focuses on the internal traits that can enhance individual resilience, for example positive behavioural adjustment, enhanced cognitive functioning, the absence of psychopathology, the demonstration of behavioural

competence,<sup>3</sup> coping skills, self-efficacy, successful developmental processes in children who grow up in stressful environments, autonomy, self-regulation, problem-solving skills, an internal locus of control, critical problem-solving skills, and empathy.<sup>4 8</sup>

Critically for the argument put forward in this paper, there is little attempt made by previous authors to examine the interaction between the internal and external domains, or the social and psychological characteristics, that make up a person's life. The original research around resilience came from researchers and practitioners interested in childhood development – examining the factors involved in some children becoming resilient (or not) in the face a variety of life adversities. However, this paper is based more generally around a model of resilience which can be applied across the general population and therefore which may be more useful to the primary care practitioner (PCP) overall. Our proposed interactive model takes a more complex view, linking to the concept of holistic medicine (i.e. treating the whole person, rather than just the disease), and may be more useful for health promotion and illness prevention.

Before discussing our interactive psycho-social model of resilience, the following section will establish the differences between coping and resilience, as well as differentiating coping resources from coping strategies.

## **Resilience and Coping**

The literature on coping is voluminous and inconclusive, and in fact resilience and coping are often conflated in the literature. To distinguish between resilience and coping, a definition of coping is necessary. Coping is defined in the Online Oxford English Dictionary as “dealing effectively with something difficult”.<sup>19</sup> As a starting point for discussion, it needs to be pointed out that ‘something difficult’ is in fact quite different to ‘facing adversity’ (adversity is what is overcome by the resilient person). Facing difficult situations is not necessarily the same as facing adversity. In addition, efforts to cope do not always lead to solutions to a problem. This issue was examined in the mid-1980s,<sup>20-23</sup> and more recently by Harvey and Delfabbro<sup>3</sup>. The argument put forward by these authors is that resilience involves an active shaping of the individual's environment in order to insulate themselves from adverse situations. On the other hand, coping can involve passivity through dealing with a situation through avoidance. As resilience and coping are different, we argue that coping (strategies and resources) is one of the many factors that comprises resilience, and is part of the internal ‘toolbox’ that a person may draw upon in their attempts to overcome adversity.

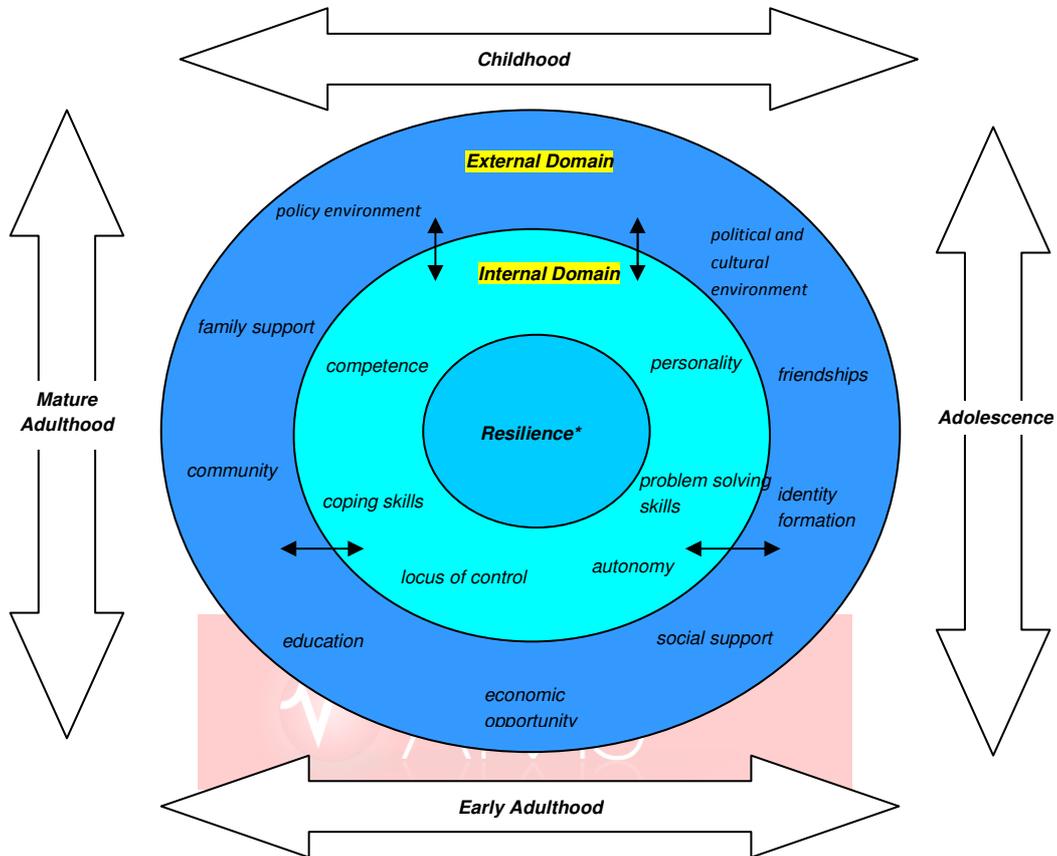
Alluded to here is the distinction between coping strategies and coping resources. This is an important distinction as they are often conflated and confused in the literature. Coping strategies can be referred to as those techniques that are used in everyday situations to overcome specific situations or circumstances. These may also be characterised as coping skills.<sup>24</sup> Coping resources are what a person draws upon, that help them deal with situations. These may include such factors as general health, employment, and social support, which influence the enactment of coping strategies.<sup>24</sup> In other words, coping resources are what a person draws upon in order to implement coping strategies. The availability of the resources will enable or restrict the ability to implement particular strategies, therefore those who have fewer coping resources will have fewer strategies to use to deal with adversity.

Having established that coping strategies and coping resources are part of the make-up of resilience, the following section will provide an overview of our interactive psycho-social model of resilience.

### **An interactive psycho-social model of resilience**

Our model adds to the understanding of resilience by examining the interactions between the internal and the external domains that are drawn upon in adapting to adverse circumstances, as can be seen in Figure 1 below. The internal domain represents the psychological traits and resources of the individual, while the external domain represents the social environment that surrounds the individual. In our proposed model, and in order to understand how resilience manifests over the lifespan, time also becomes a crucial aspect of the model as resilience may be built, lost, re-structured, destroyed, accumulated, and so on, over time, not in a linear fashion, but somewhat unpredictably over the lifespan.

**Figure 1: An interactive psycho-social model of resilience**



**Note:** The small arrows in this model represent the two-way interaction between the internal and external domains. The large arrows represent the passage of time represented through life phases.

In order to understand resilience, it is necessary to recognise that there are certain health issues where inequitable outcomes are apparent. This may be for a host of social, psychological, genetic, or lifestyle related reasons. There are also many cases where there appear to be few explanations available to distinguish the differences in outcomes between individuals despite their similar situational circumstances. Could the explanatory factor be that some individuals or agents have certain internal traits or external supports that make them resilient?

If these individuals are resilient, then it is necessary to take as many factors as possible into account in looking for possible explanations. Therefore to have a model of resilience that only considers one set of factors (e.g., social or psychological) creates only a partial explanation. In such a model, the effectiveness of resilience is undermined as an explanatory concept as it does not seek to look at the interaction of factors, only factors in themselves. To examine, for example, the interaction between strong family support and self-esteem and self-efficacy delivers a greater explanatory power in understanding a person's circumstances. An examination of the interplay between the internal psychological domain and the external social domain may be the key to resilience, and therefore one of the keys to understanding health and preventing illness.



Time is also a critical factor in the proposed model as resilience is not constant. In fact, it appears to change over time. So, for example, people may learn strategies for dealing with future events from the experience of past events. Strategies may be learnt, or people may know what to expect as future issues arise. Without time built into the model, again the explanatory power remains only at a shallow level. However, time also invites unpredictability into the equation, as resilience does not necessarily grow automatically as a result of past experiences. A person who demonstrates resilience at one point in their life may not show resilience at a particular time in the future for a whole host of reasons. Perhaps they have not learnt to deal with a situation they have never faced before, and therefore may be unable to apply old solutions to new problems. Perhaps the social supports that were in place in the past have lessened, leading to a lowering of resilience. A range of adverse situations, for example ill-health, financial difficulties, marriage breakdown, or the sheer weight or number of pressures, may be involved in a person's inability to remain resilient over time. The critical point however is that resilience manifests itself in a person's life in a variety of ways and at various times, and thus may be characterised as a 'toolbox', or a set of strategies that a person has (or lacks) at their disposal when facing adverse circumstances. The 'tools in the toolbox' can be added to through learning strategies via adaptation over time.

## **Why primary care practitioners should consider this model**

A critical question for the practitioner is: If patients can be assisted to be more resilient, will patients become healthier? Practitioners can have a major effect on the internal domain of the individual in seeking to enhance their resilience. Recognising and understanding the individual's psychological make-up can be critical to better health outcomes. The external domain can also be affected by the practitioner in a positive way. With a deeper understanding of the social determinants of health, encompassed within the social external domain, the PCP may be able to advocate for positive change in the social environment and/or refer the individual to social service or welfare organisations and agencies. One of the best ways to achieve these beneficial outcomes would be through listening to, and understanding, the narratives of the patient, which would lead to a greater potential for concordance between practitioner and patient.

In adopting such an approach based on an understanding of resilience, PCPs may be able to offer a more holistic understanding of the circumstances that have led to the patients' current health status. It may also lead to a greater understanding of the ways in which good health may be maintained. How this can be of benefit to practitioners is discussed below in the following three points. Above all, the following discussion leads to a common point: that the interactive model of resilience outlined in this paper allows questions to be asked that can lead to in-depth understandings of people's lives, and therefore to better understandings of their health status.

**1) An interactive model of resilience provides a focus on health and well-being:** Often in primary care, there is a tendency to focus primarily on the 'curing of illness'. Our model presents a perspective on resilience which focuses on health and well-being, through the assets model of health, such as that presented in the work of a number of researchers.<sup>25-28</sup> This stands in contrast to the medical model which focuses primarily on illness and treatment of symptoms.<sup>29,30</sup> This salutogenic focus was established early in the genesis of resilience research which originally concentrated on examining disadvantaged communities and individuals, particularly children, within those communities. When it was found that certain individuals fared better than others despite having similar circumstances and backgrounds, resilience research was born, focusing on the reasons why these resilient people were better able to cope with, adapt to, and resist their circumstances. This is the focus of research such as that produced by the UK-based **Research Unit in Health, Behaviour and Change (RUHBC)**.<sup>2</sup> Such an assets-based approach, based on preventative health and well-being, can only benefit the healthcare system, and indeed, the individual.

## **2) An interactive model of resilience allows examination of risky and/or unhealthy behaviours:**

An interactive model of resilience can assist in providing a different perspective on particular behaviours which are considered to be unhealthy or risky. For example, tobacco has a negative effect on health and well-being, yet it also provides benefits for some individuals who smoke. Research affirms that some smokers perceive that tobacco assists them to cope with difficult situations, stress, depression, poverty and a whole range of issues.<sup>8 31</sup> An interactive model of resilience can allow us to examine such trends by analysing various groups with high rates of smoking such as people living in low socio-economic status (SES) areas, refugee groups, indigenous groups, and people diagnosed with a range of mental illnesses. All of these groups generally have more to cope with than other population cohorts in society explaining, to some extent, their high prevalence of smoking. As the RUHBC<sup>2</sup> point out, the resilience perspective does not deny that smoking is bad for one's health, however the strength of the perspective is that it allows us 'to see the importance of context for re-evaluating the meanings and value of these risky practices' (p.3). The complexity of the interactive model of resilience may allow the practitioner to be able to understand why someone is choosing a particular lifestyle behaviour, and the benefits or perceived benefits that someone gets from that behaviour. In order to improve health, it may be useful to understand the benefits that people derive from risky behaviours and lifestyle choices.



**3) An interactive model of resilience is holistic:** Lloyd<sup>32</sup> points out that “the primary aim [of everyday primary practice situations] is to provide a feeling [for the patient] of being understood; one that gives the reassurance for the individual strengths and self-management potential of the person to be launched” (p.64). Our interactive model of resilience allows the inner dialogues of the patient to be tapped into, as the perspective allows for a holistic view of the patient's life, one of the best ways of achieving this being through listening to the ongoing narratives of the patient themselves. This would move primary care practice back to a more traditional model based on a ‘relationship of understanding’ between patient and practitioner. In addition, as Lloyd<sup>32</sup> argues, a deeper understanding of people's own stories can often provide the impetus for a range of self-healing processes (p.64).

## **Conclusion**

It appears that it would be advantageous to the PCP-patient relationship if there were greater levels of mutual understanding leading to concordance, or shared decision-making. We have proposed a model of resilience in this paper, and argued that this model may lead PCPs to a greater understanding of the issues that surround health and illness. The model represents the

interaction between the internal psychological domain, and the external domain represented by the social environment of the individual. We also argue that the proposed model provides a positive focus on health and well-being, allows for a deeper examination of risky and/or unhealthy behaviours, and represents a holistic approach to health.

In terms of the benefits of the model, it has been argued that although there are a number of areas in which PCPs may be able to have little direct influence, an understanding of the model may lead them to recognise ways in which they can have a positive effect on these wider social issues, such as acting in an advocacy role for example. In the areas of life in which PCPs may be able to affect change, an understanding of the resilience model may lead to understandings through a process of concordance, which in turn may result in more accurate recognition of symptoms, leading to better health outcomes. This may lead to another avenue of health improvement through referral to health, social care and welfare agencies in appropriate cases.

Overall, it can be seen that better health outcomes are intricately linked to better communication between practitioner and patient. In order to achieve this, concordance is vital as there needs to be communication between practitioner and patient leading to understanding of symptoms, treatment and the general conditions of a person's life. Our proposed interactive model of resilience may be an important vehicle through which to realise such a scenario.

### **Acknowledgements**

The authors would like to acknowledge SA Health as the funding partners of the Smoking and Resilience project, through their strategic health research program (SHRP), for their valuable contribution to the Smoking and Resilience project.

We would also like to acknowledge the contribution made to the conceptualisation of the project and to the resilience model by those members of the Project Management Group who are not included as authors of this paper – Professor Fran Baum, Professor John Coveney, Karen Wyld, Alwin Chong, Roslyn Miles and Associate Professor Paul Delfabbro.

Finally, we acknowledge the efforts and again, the contribution made to the development of the resilience model by all members of the Reference Group for the Smoking and Resilience

project who are not included as authors of this paper – David Edwards from QuitSA, Wendy Keech from the Heart Foundation, and Wendy Lawrie and Della Rowley from SA Health.

**Declaration of competing interests**

The authors declare that they have no competing interests.



## References

- [1] Oxford Online Dictionary [accessed on 30 September 2008]:  
[\[http://www.askoxford.com/concise\\_oed/orexxsilient?view=uk\]](http://www.askoxford.com/concise_oed/orexxsilient?view=uk)
- [2] RUHBC: Health and resilience: what does a resilience approach offer health research and policy? *Research Findings* 2006; 11.
- [3] Harvey J, Delfabbro PH: Psychological resilience in disadvantaged youth: a critical review. *Australian Psychologist* 2004; 39: 3-13.
- [4] Bartley M, Schoon I, Mitchell RDB: Resilience as an asset for healthy development. In *Health Assets and the Social Determinants of Health*. Edited by Ziglio E, Morgan A. Venice: WHO European Office for Investment for Health and Development, 2006.
- [5] Luthar SS, Cichetti D, Becker B: The construct of resilience: a critical evaluation and guidelines for future work. *Child Development* 2000; 71(3): 543-562.
- [6] Ungar MT: A constructionist discourse on resilience. *Youth Society* 2004; 35(3): 341-365.
- [7] Bartley M, editor: *Capability and Resilience: Beating the Odds*. London: University College London, Department of Epidemiology and Public Health, 2006.
- [8] Braverman MT: Research on resilience and its implications for tobacco prevention. *Nicotine and Tobacco Research* 1999; 1: S67-S72.
- [9] RUHBC: Greater expectations: the parts of Britain where people live longer than expected. *Research Findings* 2003; 4.
- [10] Stroebe W: *Social Psychology and Health* (2<sup>nd</sup> edn). Buckingham, Open University Press, 2000.
- [11] Matud MP, Ibanez I, Bethencourt JM, Marrero R, Carballeira M: Structural gender differences in perceived social support. *Personality and Individual Differences* 2003; 35: 1919-29.
- [12] Smith TW, Ruiz JM: Psychosocial influences on the development and course of coronary heart disease: current status and implications for research and practice. *Journal of Consulting and Clinical Psychology* 2002; 70: 548-68.
- [13] Shute R, De Blasio T, Williamson P: Social support satisfaction of Australian children. *International Journal of Behavioural Development* 2002; 26(4): 318-326.
- [14] Hogan BE, Linden W, Najarian B: Social support interventions: do they work? *Clinical Psychology Review* 2002; 22(3): 381-440.

- [15] Lakey B, Lutz CJ: Social support and preventive and therapeutic interventions. In Pierce GR, Sarason BR, Sarason IG, Eds: *Handbook of Social Support and the Family* 1996; Plenum, New York: 435-465.
- [16] Booth RJ, Cameron LD, Schlatter M, Ziginskas D, Harman JE: Effect of a psychosocial support intervention on NK cell numbers in women with breast cancer. *Brain, Behaviour, and Immunity* 2005; 19(4) Supp 1: e5.
- [17] Cohen AN, Hammen C, Henry RM, Daley SE: Effects of stress and social support on recurrence in bipolar disorder. *Journal of Affective Disorders* 2004; 82(1): 143-147.
- [18] Boutin-Foster C, Charlson ME: Getting to the heart of social support: a qualitative study on the mechanisms of action of social support among patients with coronary artery disease. *Journal of Clinical Epidemiology* 2002; 55(6): 629.
- [19] Oxford Online Dictionary [accessed on 30 September 2008]:  
[\[http://www.askoxford.com/concise\\_oed/cope\\_1?view=uk\]](http://www.askoxford.com/concise_oed/cope_1?view=uk)
- [20] Gruen RJ, Folkman S, Lazarus, RS: Centrality and individual differences in the meaning of daily hassles. *Journal of Personality* 1988; 56: 743-762.
- [21] Lazarus RS, DeLongis A, Folkman S, Gruen, R: Stress and adaptational outcomes: the problem of confounded measures. *American Psychologist* 1985; 40: 770-779.
- [22] Lazarus RS, Folkman, S: Transactional theory and research on emotions and coping. *European Journal of Personality* 1987; 1: 141-169.
- [23] Rutter, M: Resilience in the face of adversity: protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry* 1985; 147: 598-611.
- [24] Sabina C, Tindale, R Scott: Abuse characteristics and coping resources as predictors of problem-focused coping strategies among battered women. *Violence Against Women* 2008; 14(4): 437-456.
- [25] Sen A: *Development as Freedom*. Oxford: Oxford University Press, 1999.
- [26] Fleischer NL, Weber AM, Gruber S, Arambula KZ, Mascarenhas M, Frasure JA: Pathways to health: a framework for health-focused research and practice. *Emerging Themes in Epidemiology* 2006; 3.
- [27] Rak C, Patterson L: Promoting resilience in at-risk children. *Journal of Counselling and Development* 1996; 74(4): 368-373.
- [28] Ward PR, Coates A: Health and happiness in a materially deprived, ethnically-mixed locality. *Journal of Epidemiology and Community Health* 2005; 60(87).

- [29] Rudge T, Morse K: Re-awakenings? A discourse analysis of the recovery from schizophrenia after medication change. *Australian and New Zealand Journal of Mental Health Nursing* 2001; 10(2): 66-76.
- [30] Tsang S, Anderson J: Human agency and the process of healing: lessons learned from women living with chronic illness – ‘rewriting the expert’. *Nursing Inquiry* 1999; 6(2): 83-93.
- [31] Siahpush M, Carlin JB: Financial stress, smoking cessation and relapse: results from a prospective study of an Australian national sample. *Addiction* 2005; 101: 121-127.
- [32] Lloyd M: Resilience promotion: its role in clinical medicine. *Australian Family Physician* 2006; 35(1/2): 1-4.

