Silver Empowerment

Van Regenmortel, Tine, De Witte, Jasper

Published by Leuven University Press

Van Regenmortel, Tine and Jasper De Witte.
Silver Empowerment: Fostering Strengths and Connections for an Age-Friendly Society.

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Old age is all too often associated with dependency, passivity, unproductivity. These stereotypes influence how we feel about and deal with older persons. This ‘ageism’ can erode solidarity between generations and reduces the quality of life of older persons. In reality, older persons provide important social and economic contributions to society (such as looking after children or people who are ill). The World Health Organization (WHO) responded to this with its ‘active ageing’ concept: ‘active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age’ (WHO, 2002, p. 12). In this respect, the WHO emphasises society’s responsibility to provide these opportunities, for example by promoting a culture of lifelong learning for older persons. The WHO maintains that, through the regular involvement of older persons in social, political and economic activities, ‘active ageing’ can counteract social isolation and enhance an older person’s quality of life. In response to the 2002 WHO strategy, scientific discussions on active ageing started to boom at the beginning of the 2000s (Pfaller & Schweda, 2019).

Active ageing is often criticised for idealising ‘active’ and ‘successful’ ageing, which is not feasible for all older persons and may be accompanied by adverse side effects. It is also criticised for overemphasising physical activity and a productive model of active ageing, and for not sufficiently taking into account the heterogeneity of the older population. Indeed, it is important to provide sufficient room for alternative lifestyles for older persons (Foster & Walker, 2015) and to deviate from a singular ideal of how older people should live (see Chapter 8 in this volume).

Besides objections regarding theoretical and empirical shortcomings, the most prominent line of critique focuses on moral and political concerns
about exclusion at the intersection of age and social inequality. There are severe structural differences in the distribution of resources for successful and active ageing due to dimensions of social inequality (especially gender, ethnicity, class and sexuality). The effects of this social inequality unfold over the course of a person’s life and culminate in old age. Moreover, with advancing age, older people are also increasingly exposed to ageism and age discrimination. Thus, already existing discrimination is further aggravated (Katz & Calasanti, 2015). Against this backdrop, Ranzijn criticises active ageing as ‘another way to oppress marginalized and disadvantaged elders’ (Ranzijn, 2010, p. 716), as the concept devalues their life experiences. He advocates alternative conceptions of ageing that are more sensitive to the cultural diversity of ageing and that promote social inclusion (Ranzijn, 2010, p. 716). The active ageing discourse takes for granted that older persons are willing and able to become active. As a result, the active ageing approach tends to neglect frailty and limitations. Empirical research conducted by Jensen and Skjøtt-Larsen (2021) shows that inequality in ageing is conditioned by factors such as class and wealth, in other words, factors rooted in the social life biography. In this sense, active ageing is idealistic and unrealistic, and the concept ignores the life situation of large segments of older persons since active ageing opportunities are conditioned by factors such as one’s health and position in the social structure.

According to critical gerontology, the emphasis on personal responsibility functions as a mere alibi for dismantling the welfare state and shifting risks and costs to the individual. As a consequence, the attribution of responsibility is not accompanied by more agency (Emirbayer & Mische, 1998) and empowerment but only by the burden of negative consequences.

Therefore, we introduce the framework of empowerment for older persons, which takes into account these bottlenecks of the concept ‘active ageing’. The empowerment framework focuses on the strengths and potential of older persons, without neglecting their vulnerabilities and experiences of loss in the process. In fact, it is precisely out of a fundamental recognition of this vulnerability and the resulting state of mental suffering that empowerment arises and a person’s resilience can be appealed to. Hereby, empowerment recognises older people who are ill, frail and vulnerable, and stands up for their rights to receive care and security and for being heard in society. But of course, nothing should be done about them without them. Empowerment also promotes social inclusion and is sensitive to cultural diversity. Last but not least, empowerment focuses on structural barriers of exclusion. In this chapter, we first explain the empowerment framework, discuss its relation to vulnerability and resilience, and apply this framework specifically to older people.
Next, we zoom in on a key aspect for empowerment – namely, the concept of resilience. After defining this concept and describing its building stones, we give voice to the older persons themselves through resilient narratives. We conclude this chapter by discussing some implications for practice and policy.

1. The empowerment framework

Against the background of various social evolutions like deinstitutionalisation, person-centred care, ‘positive health’, and the emphasis on social inclusion and active citizenship, empowerment comes to the foreground as a useful framework. The framework of empowerment entails a different philosophy, a drastic shift in the way we look at vulnerability and the health and social care system. Empowerment is value driven and assumes values of social justice, solidarity and inclusion, and it strives for full citizenship and a high quality of life for everyone, especially for society’s most vulnerable groups. In the following, we describe the most important theoretical features of the framework of empowerment.

1.1 Theoretical features of empowerment

A central feature of empowerment is the focus on the strengths of individuals, the strengths perspective. A precondition of a strength-based approach is the recognition of both possibilities and vulnerabilities of individuals (Saleebey, 1996; Boumans, 2012). It is not just positive thinking, naïve reframing of deficits and misery, or ignoring or downplaying real problems (Janssen, 2013). Empowerment focuses on the strengths and capabilities of persons and groups, without neglecting their vulnerabilities. In fact, it is precisely out of a fundamental recognition of this vulnerability and the resulting state of mental suffering that empowerment arises. Strength and connection form the duality of empowerment. It brings together the ‘male’ (e.g. control, power, influence) and ‘female’ (e.g. cooperation, togetherness, alliances) sides of empowerment.

Empowerment supposes a relational picture of society, a second important characteristic. Empowerment does not try to realise maximal independency, but rather emphasises that vulnerability can go hand in hand with mastery over one’s life. Striving towards mastery, authenticity and identity can only be achieved in cooperation and connectedness with others. We speak about ‘interdependency’ in the lexicon of empowerment. According to the empowerment framework, people gain strength and grow through connections with others and their surroundings (informal and formal social supporting ties).
and, inversely, strength results in increased connectedness. To express the importance of this relational aspect of empowerment, different authors use the concept of ‘relational empowerment’ (Christens, 2011; Baur & Abma, 2012; Vanderplaat, 1999; Van Regenmortel, 2011).

Although most empirical work on empowerment has been on the individual/psychological level (Peterson & Zimmerman, 2004), the ecological nature of empowerment implies giving attention to the broader context within a community. Only focusing on individual empowerment could result in neglecting important social, structural and physical factors in the environment and the organisation (Maertens et al., 2015). This could create bias and a tendency to reduce problems to the individual dynamic whereby individuals are blamed and stigmatised, and interventions are mainly directed towards individual behaviour change (Peterson & Zimmerman, 2004). Empowerment always studies persons or groups in relation with their environment. Therefore, both individual and collective empowerment are essential. Another related and main theoretical characteristic of empowerment is its multilevel character, always involving micro (individual, psychological), meso (organisational, neighbourhood) and macro (society, policy) levels. These different levels are interconnected. We will explain these levels in more detail.

Zimmerman, one of the founders of psychological empowerment, distinguishes three components of empowerment on the individual (or psychological) level: the intrapersonal, the interpersonal and the behavioural dimension. The intrapersonal, cognitive component refers to how people think about themselves and includes domain-specific perceived control and self-efficacy, motivation to control, perceived competence, and mastery. (Zimmerman, 1995, p. 588)

It refers to the perceived control, the belief in one’s ability to influence a situation and environment (self-perception), and the motivation to exert influence. The interpersonal (or interactional) component involves critical awareness of societal norms and possibilities as well as the mobilisation of resources and the skills to use them. The behavioural dimension refers to involvement in the community, participation in society and organisations, and constructive behaviour (e.g. resilience, coping, assertiveness, solving) (Zimmerman, 1995).

On the organisational level, empowerment refers to organizational efforts that generate psychological empowerment among members and organizational effectiveness needed for goal achievement. (Peterson & Zimmerman, 2004, p. 130)
It concerns

processes that ensure that individuals get greater control within the organization, but on the other hand also that organizations, for their part, can also influence the policies and decisions of the wider community. (Maertens et al., 2015)

In this respect, a distinction is made between empowering organisations, which are ‘those that produce psychological empowerment for individual members as part of their organizational process’ and empowered organisations, which are ‘those that influence the larger system of which they are a part’ (Peterson & Zimmerman, 2004, p. 130). Empowering organisations need to give professionals sufficient discretionary space and support them in their process of self-empowerment (e.g. through education, stimulating critical reflection and vision) (Van Regenmortel, 2011; Janssen, 2010). The intra-organisational component on the organisational level refers to

the ways organizations are structured and function as members who engage in activities that contribute to individual psychological empowerment and organizational effectiveness needed for goal achievement. (Peterson & Zimmerman, 2004, p. 135)

It assumes connections between employees within the same organisation by stimulating collaboration between teams and groups (Janssen, 2010): ‘a good intra organizational structure should include good connections between internal units, leadership, a group-based belief system and have resolved ideological conflicts’ (Janssen et al., 2015, p. 6). The internal structure of a team can, for example, stimulate better coordination of care and reflection on ethical questions by supporting collective deliberation.

Further, mutual trust (between professionals, between professionals and management) and clear working routines are also empowering organisational features (Janssen et al., 2015). The interorganisational component ‘provides the infrastructure for members to engage in proactive behaviors necessary for goal achievement’ (Peterson & Zimmerman, 2004, p. 131). It involves exchanging information between organisations and the coordination of services between organisations (e.g. implementing networks that have a signal function for isolated older persons, multidisciplinary teams) (Janssen, 2010). Important empowering features on this level include improved linkages between participating organisations and gaining more insight into each other’s tasks (Janssen et al., 2015). The extra-organisational component refers to ‘actions taken by organizations to affect the larger environments
of which they are part’, such as policy change, creating alternative services or successful advocacy (Peterson & Zimmerman, 2004, p. 131). It involves the relation of the organisation with the broader environment and the way influence is exerted upon that environment (Janssen, 2010).

On the community level, empowerment includes ‘efforts to deter community threats, improve quality of life, and facilitate citizen participation’ (Peterson & Zimmerman, 2004, p. 130). An empowering community is ‘one in which individuals and organizations can use their skills to address their respective needs’ (Maertens et al., 2015). Empowerment on the community level refers to policy stimulating (or hindering) empowerment by employing the strengths of individuals, organisations and communities (Van Regenmortel, 2011, p. 29); policymakers should ensure people can participate in society by emphasising their strengths (Janssen, 2010). In this respect, first, a sense of community is important, which refers to a sense of belonging/connectedness. This is a subjective interpretation of identity where people share the same values, norms, needs, objectives and expectations. Important here is that communal needs and goals are recognised. Second, the social quality dimension refers to the quality and quantity of informal and formal interactions within the community that make sure that strengths are linked together and developed into human capital. Third, combined capacity refers to revealing and connecting the resources of people, groups and organisations, since the whole is more than the sum of its parts. Fourth, collective action means individuals use their combined strength to exert influence on community life and on social decision-making processes (Steenssens & Van Regenmortel, 2007). This community dimension is related to the power to institute social change: benefits, accessibility of resources and provisions, a better quality of care, influencing law and decision-making, among others (Van Regenmortel, 2011). Empowerment fights against stigmatisation and exclusion, stimulates a more positive image of vulnerable people, and encourages social solidarity in society.

Finally, empowerment is also an open-ended construct. Everyone can always continue to grow in their process of empowerment. Indeed, every person can continuously gain strength during the life course (Van Regenmortel, 2007), which is an important premise of a strength-based approach (Kisthardt, 1997). This means that empowerment is a continuous variable, not a dichotomous variable. It is not a question of having empowerment or not; there are gradations. The concrete empowering process is context determined, dependent on time (the trajectory should not be linear) and the specific population and differentiated according to life domains. Moreover, this process takes times and has peaks and vallies throughout life. These empowering processes are central in the empowerment framework, and empowerment outcomes are the results of these processes.
1.2 ‘Enabling niches’ and definition of empowerment

One cannot receive empowerment; empowerment cannot be given. This is the so-called paradox of empowerment. Everyone has to acquire it oneself because power that is given is actually a subtle form of control, of the ‘giver’ over the ‘receiver’ (Macaulay et al., 1998, p. 10 in Janssen, 2013, p. 22). Power concerns a personal as well a collective aspect. Jacobs distinguishes between three different levels of power: on the individual level, she refers to ‘the power from within’; on the collective or interactional level, she refers to ‘the power with’; and on the broader political-societal level, she describes the ‘power to’ (Jacobs et al., 2005). The environment, like professionals, can support and facilitate the individual empowerment process by creating enabling conditions.

These ‘enabling niches’ (as opposed to ‘entrapping niches’) are safe and warm places in which people are respected (not stigmatised) and encouraged to grow (Boone et al., 2020). Main characteristics of enabling niches are (Taylor, 1997, pp. 222–223):

– ‘People in enabling niches are not stigmatized, not treated as outcasts.
– People in enabling niches will tend to turn to “their own kind” for association, support, and self-validation. But the enabling niche gives them access to others who bring different perspectives, so that their social world becomes less restricted.
– People in enabling niches are not totally defined by their social category; they are accepted as having valid aspirations and attributes apart from that category. The person is not “just” a “bag lady”, a “junkie”, an “ex-con”, a “crazy”.
– In the enabling niche, there are clear, earned gradations of reward and status. People can work up to better positions. Thus there are strong expectations of change or personal progress within such niches.
– In the enabling niche, there are many incentives to set realistic longerterm goals for oneself and to work towards such goals.
– In the enabling niche, there is good reality feedback; that is, there are many natural processes that lead people to recognize and correct unrealistic perceptions or interpretations.
– The enabling niche provides opportunities to learn the skills and expectations that would aid movement to other niches. This is especially true when the enabling niche pushes toward reasonable work habits and reasonable self-discipline and expects that the use of time will be clearly structured.
– In the enabling niche, economic resources are adequate, and competence and quality are rewarded. This reduces economic stress and creates strong motives for avoiding institutionalization.’
A strengthening environment and sufficient resources are vital for the process of empowerment of individuals, families and groups. *Shared responsibility* is a keyword in the lexicon of empowerment. Social problems such as poverty are said to emerge because of a combination of factors on the micro, meso and macro levels. Indeed, empowerment supposes a circular causality that breaks through the classical linear cause-and-effect thinking and consequently avoids ‘blaming the victim’ and ‘blaming the system’. It implies a fundamental shift in the way social problems and their solutions are viewed (Van Regenmortel, 2011). Indeed, individuals, organisations and the system all have agency within certain boundaries and thus form part of the solution with respect to mechanisms of exclusion.

The overall aim of empowerment is to provide social inclusion and full citizenship for each individual by supporting people in their searching process to gain mastery over the determinants of their quality of life (Janssen, 2013; Van Regenmortel, 2013; Steenssens & Van Regenmortel, 2007). Central to this empowerment framework is gaining mastery over one’s own situation and environment by gaining more control and insight into a situation and environment and by participation and influencing (Van Regenmortel, 2011). We use the following definition of empowerment, which is based on the theory from Julian Rappaport and Marc Zimmerman (Van Regenmortel, 2011, p. 12):

*empowerment is a strengthening process whereby individuals, organizations and communities gain mastery over their own situation and their environment through the process of gaining control, sharpening the critical awareness and stimulating participation.*

Mastery is said to positively influence various determinants of quality of life, such as physical, material and emotional well-being, and is itself operationalised by gaining control, sharpening critical awareness and stimulating participation.

*Control refers to perceived or actual capacity to influence decisions. Critical awareness refers to understanding how power structures operate, decisions are made, causal agents are influenced and resources are mobilized [...]. Participation refers to taking action to make things happen for the desired outcomes.* (Janssen, 2013, p. 20)
1.3 Empowerment and vulnerability

Whereas the active ageing approach tends to neglect vulnerability, empowerment certainly does not. However, from an empowerment perspective, we formulate a different perspective, one that contrasts with mainstream bioethical discourse which starts from the fully functioning, independent and autonomous individual. We do not see old age as a deficient and deviant mode of human existence. As human beings, we are embodied, interdependent persons, and we all share the fundamental experience of vulnerability, albeit to varying degrees depending on our specific situation. Following Bozzaro et al. (2018), we argue that old age should not be used as a marker of vulnerability, since ageing is a process that can develop in a variety of ways and is not always associated with particular experiences of vulnerability.

Bozzaro et al. (2018) make a distinction between ‘broad’ and ‘restrictive’ conceptions of vulnerability. As a broad concept, vulnerability describes a basic aspect of the human condition. In this sense, being vulnerable is a universal, inevitable feature of humanity. By contrast, restrictive concepts consider vulnerability as a specific context-dependent susceptibility to harm and exploitation as well as a limited capacity for autonomy. Restrictive concepts refer to particular persons or groups who – due to social injustice, dependencies or impaired capabilities – are presumed to be less able to protect themselves. There is a risk that persons or groups will be labelled ‘helpless’ without taking into account differences or changes within the identified group. Moreover, restrictive concepts can promote widespread paternalism in an attempt to prevent others from harm and meet their needs. This may lead to a systemic stigmatisation of and discrimination against certain groups that can ultimately even reinforce vulnerability. From an empowerment perspective, we define vulnerability not in terms of a failure to attain or retain full autonomous agency, whereby autonomy is defined as the individual’s capacity of rational self-determination, and the person is seen as an isolated, rational agent without any embeddedness in social relationships.

If we exclude special age-associated syndromes, such as frailty or dementia, and we do not define ageing itself as a disease but just as a normal biological process, the assumption that the elderly are per se vulnerable is simply no longer self-evident. Instead, the common categorization of the elderly as vulnerable rather seems to result from widespread deficit models and negative stereotypes of ageing and old age in terms of being miserable, helpless, and dependent. Labeling older people as vulnerable could thus further promote this kind of unwarranted ageism and ultimately lead to ethically problematic effects. For
example, empirical studies suggest that long-term care institutions with a paternalistic approach have a tendency to increase elderly people’s helplessness and need of care. (Bozzaro et al., 2018, p. 236)

Vulnerability has become an increasingly useful field of research for addressing risk reduction and the mediation of economic and social impacts. Moro et al. (2021) state that in the social sciences, vulnerability is associated with the risk of harm in the face of a possible eventuality and the ability to avoid or cope with a harmful outcome. Many definitions are available. The current debate shows that vulnerability captures various thematic dimensions, such as physical, economic, social and institutional aspects. Moro et al. (2021) propose a multidimensional approach to vulnerability and incorporate a personal dimension of vulnerability.

Schröder-Butterfill and Marianti (2006) developed a framework relevant to the study of ageing. This framework disaggregates vulnerability into its constituent domains – namely, exposure, threats, coping capacities and outcomes. Among those in later life, it is impossible to distinguish those who are vulnerable from those who are secure by examining only exposure factors or common threats, because vulnerability arises from interactions between advantages and disadvantages accumulated over the life course and the experience of threats in later life. Whether this interaction results in a better or worse outcome depends on the adequacy of the person’s coping resources. The study of vulnerability therefore requires attention not only to the ways in which exposure factors are created and distributed over time but also to the ways in which individuals manage or fail to mobilise social, material and public resources to protect themselves from bad outcomes.

Although a literature review has shown that there is no clear definition of vulnerability or vulnerable people, common denominators can be found in the literature about vulnerability and vulnerable populations. Usually, the use of vulnerability concerns people who do not enjoy full physical, psychological and social well-being and, as a result, they are at risk of falling behind in society or becoming socially isolated. Numans et al. (2021) argue that the concepts of self-reliance and social participation, promoted by social policy, are linked to the concept of vulnerability. People who do not meet these standards are labelled ‘vulnerable people’. This label is based on an outsider’s perspective. In line with empowerment, the authors explore an insider’s perspective; they question how persons who are classified as vulnerable perceive this definition. The data also reveals that the expressed feelings of powerlessness and lack of self-determination are linked to the feeling of being patronised. Moreover, by emphasising their competencies, respondents see
more potential in themselves to contribute to society: they count in society and must be taken seriously, despite their limitations and shortcomings due to illness and disease. In short, they accept being vulnerable, but they do not accept being of no value to society, as findings prove that the respondents are socially active in several life domains.

A prevailing misconception is that empowerment and vulnerability are opposed to each other, when in fact they are inherently intertwined. Moreover, it is precisely because of and in spite of the vulnerability that strengths are addressed (Van Regenmortel, 2010). It is the challenge to make these strengths visible and to connect them with the strengths of others, the environment and society. In this way, older persons can bear their vulnerabilities and a meaningful role in society can be taken up by the person involved. Paradoxically, strengths and vulnerabilities are thus at stake in empowerment. Empowerment gives broad recognition to the individual vulnerability, but does not individualise it so that the person or group involved is not culpabilised. There is attention for individual as well as for social and societal vulnerability. The psychological dimension, the relational dimension and the structural dimension of vulnerability are always in the spotlight. The paradoxical nature of empowerment also lies in the fact that it is about gaining control as much as it is about receiving support. A plea for more autonomy also goes hand in hand with a stronger sense of community and connectedness in society and care (social cohesion).

1.4 Empowerment in old age

No matter how old we are, we can still play our part in society and enjoy a better quality of life. The challenge is to make the most of the enormous potential that we harbor even at a more advanced age. (European Commission, 2018)

From an empowerment view, ageing is not a problem, but a global challenge today and even more for generations to come. Both Europe and Belgium are characterised by an ageing population, of which the two main causes are the low birth rate and increasing life expectancy (Börsch-Supan et al., 2013). In 2060, about 30 per cent of the total European population will consist of people sixty-five years or older, and 12 per cent will consist of people eighty years and older (Niedzwiedz et al., 2016). Figure 1.1 shows a similar trend for Belgium: while in 2020 there are about 2.2 million older persons of sixty-five years or older and 330,000 older persons of eighty-five years and older, this increases to respectively 3.3 million and 830,000 in 2070. In line with this trend, not only the absolute number but also the proportion of older persons in the total population increases.
The ageing of our society implies that more people will be dependent on ‘the active population’, which could pose challenges for health and welfare systems across Europe. Over the last few decades, a number of social trends – like rising health and social care costs, budget cuts, workforce issues in the healthcare sector, increasing chronic illnesses and the wish of older persons to live as long as possible in their own house – have led to the belief that the health and social care system for older people needs to be restructured and improved by developing an alternate philosophy or paradigm (Janssen, 2013).

The societal response to population ageing will require a transformation of health systems that moves away from disease-based curative models and towards the provision of older-person-centered and integrated care. […] It will require a coordinated response from many other sectors and multiple levels of government. […] Although these actions will inevitably require resources, they are likely to be a sound investment in society’s future: a future that gives older people the freedom to live lives that previous generations could never have imagined (WHO, 2015, p. 223).

The contemporary organisation of the health and social care system is still directed towards one-sided practical support to remedy problems in functioning that threaten self-reliance. In this respect, the current policy vision sees vulnerability mostly from a medical point of view where the accent lies on physical vulnerability, whereas psychological and societal functioning are not included (Machielse, 2016). This is problematic in the light of increasingly ubiquitous concepts in the health and social care sector, such as quality of life,
positive health and frailty. All those concepts emphasise the importance of the interconnectedness of various life domains (physical, social, economic, psychological) when assessing health and healthcare, and they thus surpass the one-sided focus on the physical domain. In short, a restructuration of the health and social care system and a shift in paradigm, in which more attention is paid to vulnerability with respect to the physical, psychological and social domain, seems necessary (Gobbens, 2017).

In addition, the informal resources of older persons are important for improving and maintaining their quality of life. Research has made clear how the process of individualisation negatively affects the available informal support for older persons: family structures evolve, people live farther from each other, networks become smaller and less diverse, and family and neighbourhood relationships are less evident (Machielse, 2016, 2015). Furthermore, changes in social structures (e.g. the increased labour participation of women) also led to a decrease in the availability of informal support (De Koker et al., 2007). In this respect, research shows that the social network of older persons has become less diverse and that older persons increasingly have mostly vertical contacts due to a strong focus on the nuclear family (Cantillon et al., 2007). These modifications in the social network of older persons make it more complicated for them to sustain a supportive social network, which is already difficult given numerous age-related adversities such as deteriorating health. Maintaining supportive social capital is important because everyone, not least older persons, needs social capital to realise goals that give meaning to life.

A positive environment is vital for empowering processes and empowerment outcomes of older persons. The degree to which older persons are enabled to feel in control of their lives, solve their own problems and make choices for themselves seems likely to promote happiness and a feeling of well-being, which is reflected in both health and longevity (Buie, 1988 in Lloyd, 1991). Much depends on the way in which older persons experience the provision of services and care. Older persons need to be encouraged to manage their own health and life within their home environment – of course supported by family, neighbours, friends and professionals. A shift is taking place

from cure to a balance between cure and care by strengthening the sense of mastery of older people and to support them to activate and/or enlarge their social network. Professionals are, in other words, expected to support care recipients in making the right choices that is in accordance with their wishes and expectations and on overcoming paradoxes that are inherent to human life. (Janssen, 2013, p. 15)
As mentioned before, empowerment assumes values such as social justice, solidarity and equality, and it strives for full, relational citizenship and a high quality of life. Consequently, the primary focus of empowerment is on society’s most vulnerable groups, the so-called silenced voices. Considering this, extra attention ought to be given to the underprivileged and impoverished older persons. To address social problems (e.g. poverty), it is important to pay attention to the psychological dimension of living in adverse circumstances and to provide care and support to underprivileged older people that is in line with their coping strategies and contributes to the development or strengthening of their sense of mastery. Of course, in addition to the individual-psychological level, there is always a more structural, societal-political level in the concept of empowerment.

Empowerment as a positive concept emphasises society’s responsibility to use the strengths and capacities of vulnerable older persons more. Community building and community care come to the foreground (see also Chapter 4). It denotes not only care in the community but also care by the community. The key components of community care should be to respond flexibly to individual needs, to give consumers a range of options, to foster independence (with no more intervention than is necessary) and to concentrate on those with the greatest needs (Lloyd, 1991). Similar to the proverb ‘it takes a village to raise a child’, we argue that it takes a whole community to support the empowerment processes of older persons. In this respect, the concept of age-friendly communities seems appropriate. The WHO’s movement of ‘age-friendly communities’ aims to develop infrastructure and facilities that support and value older persons as well as promote their active participation (Gobbens, 2017). The WHO defines ‘age-friendly cities and communities’ as

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a good place to grow old. Age-friendly cities and communities foster healthy and active ageing and, thus, enable well-being throughout life. They help people to remain independent for as long as possible, and provide care and protection when they are needed, respecting older people’s autonomy and dignity. (WHO, 2015, p. 161)
\end{quote}

Finally, the empowerment framework encompasses a shift from the problem of ageing into positive ageing. Many models have already tried to discover the variables that result in successful ageing. These studies emphasise individually modifiable health promotion behaviour, excluding many older people, especially those with disabilities and impairments. From an empowerment perspective, we consider a more holistic concept of ageing well, including,
for example, a spiritual component and taking into account the value of wisdom, a total life history perspective and, last but not least, the limiting social, structural and cultural context. Empowerment, and more specifically the resilience framework, covers these aspects and does not marginalise vulnerable older persons.

As Janssen et al. argue, resilience is positively related to empowerment:

*the outcomes of these resilience processes may ultimately contribute to the stabilization or the improvement of a (general) sense of mastery and that those with a greater sense of mastery are able to show resilience in times of crisis and hardships.* (Janssen et al., 2012, p. 344)

Resilience helps us understand the processes and mechanisms through which individuals strive to maintain or regain mastery over the determinants of the quality of their lives (Janssen et al., 2012).

### 1.5 Empowerment and resilience

Empowerment and resilience are widely employed concepts in community psychology and other social sciences. Both are potent processes for responding to adversity and oppression. They both take a strengths-based approach that recognises, respects and promotes local capacity by attending to resources that are inherent or able to be developed within an individual and community (Brodsky & Cattaneo, 2013; Buckingham & Brodsky, 2021). Empowerment and resilience have the potential to facilitate each other. They have been conceptualised and operationalised in various, often overlapping ways. Both concepts have been critiqued for lacking clear consensus regarding definition, operationalisation and measurement (Luthar et al., 2000).

Brodsky and Cattaneo (2013) developed a transtheoretical (or transconceptual) model of empowerment and resilience. This transtheoretical model shows shared outcomes (maintenance, self-efficacy, knowledge, community resources, skills) and processes (awareness and goal setting, action, reflection) and then lays out differences between resilience and empowerment. The aims of empowerment and resilience differ.

Resilience refers to ‘successful adaptation despite risk and adversity’ (Masten, 1994, p. 3) and is operationalised as ‘more than the absence of pathology, as exemplified by not only surviving, but thriving, sometimes even with enhanced functioning, and as a dynamic process rather than a stable trait’. Persons can adapt to and withstand adversity and oppression through resilience processes. Empowerment spurs external change, a meaningful shift
in the experience of power attained through interaction in the social world. Power refers to influence at any level of interaction, including in personal relationships, settings and systems, and the broader society. Resilience in the absence of empowerment may uphold oppressive power structures. Resilience always occurs within a context of fundamental risk endemic to the context in which an individual is situated, while empowerment may or may not. Resilience is focused on internally focused goals – adapting, withstanding, resisting – while empowerment is aimed at power-oriented, external change. Empowerment is a bridge between the intrapersonal and social realms. Articulating this dynamic bridging aspect of empowerment is very important.

Unless we understand that empowerment is not only experienced internally but also enacted socially, requiring a response from the social world, we risk laying the blame for disempowerment at the feet of marginalized communities. (Brodsky & Cattaneo, 2013, p. 337)

The ultimate goal of empowerment is second-order change which influences the status quo by shifting power dynamics and imbalances between the target individual or community and the larger system. Brodsky and Cattaneo (2013) note that the differentiation between the transformative, external focus of empowerment and the adaptive, internal focus of resilience is in no way a criticism of resilience. The ability to cope with the situation as it is can be a pivotal step towards gaining the strength, consciousness and resources necessary to ultimately work towards empowerment goals that will change the status quo. Empowerment builds on resilience to provide the bridge that connects individual power to social power.

2. Resilience: The (hidden) capital of older persons

The true quest as we age should not be for successful aging, but our goal should be for resilience, an undervalued and not fully examined concept in aging. (Harris, 2008, p. 43)

2.1 Framework and definition of resilience

Since the 1990s, there has been broad attention for resilience. Research about resilience is rooted in positive psychology (Seligman & Csikszentmihaly, 2000) and was originally developed in the domain of developmental
psychology dealing with childhood and adolescence (Garmezy, 1991; Werner & Smith, 1982; Rutter, 1987). Today, resilience has been extended to other periods of the lifespan including old age (Ryff et al., 1998; Masten & Wright, 2009). Resilience research can be situated within the broad shift from the ‘damage’ to the ‘challenge’ model where the focus is shifting from the damage of adversity to how people positively overcome adversity (Van Regenmortel, 2006, 2002). Resilience originally comes from the discipline of ecology and can be defined as ‘an ecosystem’s ability to absorb and recover from the occurrence of a hazardous event’ (Akter & Mallick, 2013, p. 114).

Resilience research (Janssen et al., 2011) focuses on ways to improve well-being and stimulate health (Van Regenmortel, 2009). The belief in the potency and strengths of people, even among the most vulnerable, is an important aspect of resilience. However, resilience is not a synonym for invulnerability (Werner & Smith, 1982; Rutter, 1993). People can be vulnerable and hurt even though they are able to manage challenging circumstances – in short, they are ‘vulnerable but invincible’ (Werner & Smith, 1982; Van Regenmortel, 2002).

Resilience not only relates to empowerment; it is also essential with respect to the newer concept of ‘positive health’, which was introduced by Machtelt Huber. ‘Positive health’ emphasises ‘the resilience or capacity to cope and maintain and restore one’s integrity, equilibrium, and sense of wellbeing’ (Huber et al., 2011, p. 344), with respect to the physical, mental and social domains. Huber regards health as a dynamic balance between opportunities and limitations, which are affected by external conditions (Huber et al., 2011). Therefore, not surprisingly, high levels of resilience in later life correlate with reduced vulnerability to depressive symptomatology and mortality risks, better self-perceptions of successful ageing, and increased levels of mental health, well-being and quality of life (Gerino et al., 2017).

Resilience research holds on to a holistic view in which attention is directed to the complex interplay between adversities, sources of strength and adaptation processes, and the variations of this according to individual, familial and contextual factors (Van Regenmortel, 2006). While coping refers to the abilities to handle certain circumstances, resilience serves as a framework for understanding healthy development in the face of risk (Janssen, 2013). It refers to the ability to maintain a stable and good way of psychological and physical functioning during difficult circumstances and even to become stronger by learning from adversities (Geraerts, 2013). On a conceptual level, resilience is considered the bridge between coping and development (Greve & Staudinger, 2006; Leipold & Greve, 2009).
Resilience is often defined as ‘patterns and processes of positive adaptation and development in the context of significant threats to an individual’s life or function’ (Janssen, 2013, p. 21). Two coexisting concepts are central to resilience: first, the presence of a significant (developmental) threat or risk to a given person’s well-being; second, the evidence of a positive adaptation in this individual despite the adversity encountered (Fraser et al., 1999; Luthar et al., 2000; Van Regenmortel, 2002).

Although old age is often accompanied by feelings of loss (e.g. the death of partner or friends, divorce) and other developmental stressors (e.g. physical or cognitive impairments, functional limitations, changing residence, health problems), many older persons are capable of moderating the impact of these distresses (Hardy et al., 2002, 2004). The ‘life course theory’ states that older persons are faced with adversities that can be both cumulative, lifelong (e.g. poverty) and age-specific (Fuller-Iglesias et al., 2008, p. 182). People make use of their ‘sources of strength’ or ‘protective factors’ to deal with adversity (Earvolino-Ramirez, 2007). Besides personal attributes (e.g. positive self-concept, self-efficacy beliefs, internal locus of control, optimism), external factors like families, communities and wider contextual circumstances influence people’s reactions to stressful situations (Neimeyer, 1997). This means that protective factors are context-specific, and both the amount and type of resources may differ at different times across the lifespan (Hochhalter et al. in Resnick et al., 2011). Moreover, they can lead to different outcomes for different individuals. Every individual experiences challenges through a particular lens, which is formed and framed by personal history and specific individual, social, cultural and environmental characteristics. Moreover, in dealing with adversity, people can age successfully and be resilient in some domains (emotional, spiritual, social, cognitive and physical), but not in others (Hochhalter et al. in Resnick et al., 2011). Therefore, it is essential to understand life stories and how previous adversity was dealt with and incorporated in recent experience. Consequently, a narrative research approach is valuable for investigating resilience processes.

In common with empowerment, resilience encompasses a positive and appreciative perspective on human functioning.

Resilient individuals have a sense of active and meaningful engagement with the world. Their positive and energetic approach to life is grounded in confident, autonomous, and competent functioning and a sense of mastery within a wide range of life-domains. (Greve & Staudinger, 2006, p. 812)
In addition, resilience is a relational and dynamic concept, in which persons are studied in a complex interplay with their environment (Van Regenmortel, 2006). The (social and societal) environment has an important role to play in supporting the resilience of older people. In this respect, it is important to acknowledge both internal and external sources of strength, and thus also a shared responsibility of both older persons and their social environment with respect to their resilience (Janssen et al., 2012). Indeed, resilient people do not take on a subordinate position or see themselves solely as a victim, nor do they seek to internalise adversities. It is important not to put adversities each time out of the personal responsibility because this could result in alienation and a lack of bonding. On the other hand, acknowledgment of contextual factors can allow social actions to emerge, and people can protect themselves from negative self-evaluation. Hence, it is appropriate to regain grip on one’s own life without feelings of self-reproach and without neglecting structural causes (Van Regenmortel, 2013).

Our emphasis is on understanding and researching resources and mechanism that allow older persons (also organisations and communities) to grow and to develop in a positive way.

In this chapter, we focus on individual resilience, not on resilient families (see Paddock, 2001) or resilient communities (see Atlantic Health Promotion Research Centre, 1999).

2.2. Building stones of resilience

We state that resilience is not a fixed personality trait, but a social construct which results from a dynamic, non-deterministic, context-related (multi-layered) process of development (Van Regenmortel, 2006; Peeters, 2012). Many factors contribute to personal resilience, which is in part based on bonding and engagement with significant others and an informal social network, as presented in the casita or ‘house of resilience’ (Peeters, 2012). In the literature, we find a number of global building blocks for resilience, such as secure attachment, internal locus of control, meaningfulness and humour.

From the scientific literature, we find that the sources of strength that give rise to resilience are situated in the individual, interactional and contextual domain and that they are all inherently linked to each another (Van Regenmortel, 2013). Indeed, an optimal climate for development and resilience requires that these three domains interact favourably. Specifically for older persons, based on narrative research, the following sources of strength give rise to resilience among older persons (Janssen et al., 2011).
Sources of strength on the individual domain

The individual domain refers to

the qualities within older people and comprises of three subdomains, namely beliefs about one’s competence, efforts to exert control and the capacity to analyze and understand one’s situation. (Janssen et al., 2011, p. 145)

Sources of strength in this domain include the following (De Witte & Van Regenmortel, 2019):

– beliefs about one’s competence:
  • pride about one’s personality: having an easy-going or down-to-earth, for example, character which results in people not being embittered or that they blame others;
  • acceptance and openness about one’s vulnerability: this takes time and is difficult but is said to result in people not being too susceptive to others’ negative views of their limitations.

– efforts to exert control:
  • anticipation of future losses: taking action to influence outcomes of their situation, e.g. moving to a neighbourhood with shops close by, in appropriate housing;
  • mastery by practising skills: staying active and practising knowledge and skills;
  • acceptance of help and support: this takes time and is difficult (e.g. using a wheelchair).

– capacity to analyse and understand one’s situation:
  • having a balanced view on life: this helps to put things in perspective;
  • not taking on the role of a victim: emphasising strengths instead of vulnerabilities;
  • having the perspective of wanting to seize the day.

Older persons more frequently display positive, low-arousal emotions and fewer negative emotions of either high or low arousal, which suggests that older persons regulate their emotions better than younger people do. This allows them to better adapt to negative life events. In addition, older persons do not demonstrate a diminished sense of control:

they display strengths such as more nuanced understanding of emotion, better ability to regulate that emotion, and are more likely to accept circumstances as being out of their personal control. (Mlinac et al., 2011, p. 71)
Older persons behave more in accordance with their feelings than with social expectations. Although in later life people are perhaps more dependent on external resources (Greve & Staudinger, 2006), some research finds that resilience and a sense of coherence is more present among the oldest old than the younger old (Clark et al., 2011).

**Sources of strength on the interactional domain**

The interactional domain is defined as ‘the way older people cooperate and interact with others to achieve their personal goals’ (Janssen et al., 2011, p. 145). It concerns how people interact with significant others like relatives and friends, neighbours and professionals to achieve goals and to endow meaning to their lives (Mlinac et al., 2011). Sources of strength in this respect are as follows (De Witte & Van Regenmortel, 2019):

- empowering informal relationships with family: this helps older persons to make sense of their situation, offers practical and emotional support, and contributes to their feeling of agency.
- empowering formal relationships with professionals: commitment, reliability and interest are important characteristics of these relationships.
- the power of giving (‘reciprocity’).
- societal responses: society acknowledging and valuing older persons.

Both the quantity and quality of social relations are important with respect to resilience.

> Optimally, as the needs and circumstances of individuals change, and when confronted with stressful life events, social relations in the form of social networks and high-quality relationships, facilitate their ability to meet the challenges they face. (Fuller-Iglesias et al., 2008, p. 184)

Having close, affectional relationships within the family, broader family and external environment is an important protective factor that stimulates resilience in later life because these conditions make it easier to receive help and guidance (Van Regenmortel, 2006). People receive information through social relations, which also encourages coping behaviour and enhances self-esteem and instrumental support (Fuller-Iglesias et al., 2008). Hence, integration into the community – having friendly neighbours, people looking out for each other, a good community spirit and a good mix of people – is important.
This community integration is strengthened by paid work, voluntary work and community organisations (Clark et al., 2011).

We found that there were differences depending on the personal characteristics of the individual (i.e. age, gender, and race), and social relations (i.e. network size and spousal relationship quality), in the presence of resilience in old age. […] Our findings indicate that a larger social network and a higher quality of relationships with spouse predicted fewer depressive symptoms and greater life satisfaction despite experiencing a significant number of adversities. (Fuller-Iglesias et al., 2008, p. 190)

Sources of strength on the contextual domain

The contextual domain refers to ‘a broader political-societal level including the efforts on this domain to deter community threats, improve quality of life and facilitate citizen participation’ (Janssen et al., 2011, p. 149). From this, it is clear that the environment plays a significant role in gaining resilience, by offering possibilities and by stimulating collective and individual participation
(Van Regenmortel, 2013). The contextual domain includes the following sources of strength (De Witte & Van Regenmortel, 2019):
- accessibility of health and social care,
- availability of social and material resources (e.g. mutual self-help groups) and
- social policy (e.g. the possibility to go to a nursing home, income) (Janssen et al., 2011).

In sum, various environmental factors (e.g. care delivery) which are not in direct control of older persons also determine their resilience (Van Kessel, 2013). The different domains are interrelated; for example, openness about one’s vulnerability is closely linked to accepting help, which may stimulate interaction with the social environment, and participation, which may in turn result in acquiring more resources and skills. Accepting help and support is not always easy for older persons because it can be in conflict with feelings of ‘wanting to take care of yourself’ (Janssen, 2013). Ideally, the individual, interactional and contextual domains interact favourably, as a gearwheel.

2.3 Resilient narratives

Using this Janssen’s framework (2013), we conducted narrative interviews with fifteen vulnerable community-dwelling older persons in Belgium who were selected through a ‘purposive sampling’ strategy between May and July 2019 (De Witte & Van Regenmortel, 2019). In narrative research, stories of experience are created in a dialogue with the respondent. Although researchers may use a topic-based schedule (as we did), they are not governed by it. Interviewers take on an informal and friendly stance to create a climate of trust; the interviewer is non-judgemental and takes the time to ‘really listen’ (Fraser, 2004; Moen, 2006). We contacted various organisations in Belgium who work with Dutch-speaking older persons (55 years or older) with limited financial means or other vulnerabilities that affect their well-being and who are able to give informed consent. A relatively diverse group of respondents – with respect to gender, age, household status and migration background – was selected with the aid of three organisations. The interviews were recorded and transcribed verbatim, and thematic content was analysed. We used ‘sensitizing concepts’ from the literature, especially from the Janssen’s framework (2013).

This research is based on a limited number of narratives of vulnerable community-dwelling older persons in Flanders who are all active in at least
one organisation. As a result, the research results cannot simply be transposed to contexts other than the one described here.

However, our findings correspond closely with the results of scientific research conducted in other countries (e.g. Janssen, 2013). Our narratives show that various life domains and sources of strength are indeed strongly interconnected and need to interact favourably in order to create an optimal climate for resilience and empowerment.

Various respondents are proud of their personality (e.g. being honest and courageous, having a good heart and meaning well), the activities they undertake (e.g. editing a book, meeting politicians to discuss social issues, helping others, counteracting injustices) and their knowledge (Respondent 4, 5, 6, 9, 13, 14). Respondent 5 says that although it is important to talk about specific problems (e.g. cancer, death of partner) with friends or family, it is essential not to complain too much (Respondent 3, 11, 15).

People don’t always sympathize [with someone’s health problems]. They themselves also have their issues, so they don’t always want to hear from other people what’s wrong with them. (Respondent 11)

The narrative of Respondent 15 shows the detrimental influence of stigmatisation, the blaming-the-victim mechanism and the lack of basic resources (e.g. decent income). On the other hand, we observe the empowering force of participation. Respondent 15 lived in poverty for a long time because his invalidity made him unable to work and led to high medical costs. This negative spiral made him feel angry and even resulted in social withdrawal. By engaging in social organisations and being asked to come back, he regained pride in himself and a sense of self-worth:

that is more for a human being than you would think. That is how I started again. […] At the time, they [people from that poverty organization] asked me to come back. During those five years [when his financial difficulties were very high], nobody has asked me that. I was so little approachable that nobody was waiting for me. So that was pleasant, and I went back. That’s something; from time to time they ask you something, and people take into account what you say. That is very different from when you always need to talk about those debts and when they say it’s your own fault all the time. (Respondent 15)

From our narratives, it becomes apparent that acceptance of one’s own limitations – which is a process that takes time – is an important source of strength which helps older persons to deal with adversities. Indeed, accepting one’s
own vulnerabilities makes it easier to accept support from others. However, various respondents do not seem to accept their limitations and are sometimes even ashamed of their situation, which negatively affects their resilience. For example, Respondent 12 states ‘that would be a big step for me to give things out hand. Even groceries I still want to do myself’. Respondents describe how they try to preserve their mastery over their situation by practising their skills. Respondent 13, for example, states that he performs physical exercises during his morning ritual in order to maintain a good physique.

Various respondents also seem to have a balanced view on life, which helps them put negative encounters into perspective. They talk about both the positive and negative things they encountered during their lives.

_I think that I already had the best behind me. And I am grateful, because I had a beautiful time. […] I think that I am very realistic. […] My mother taught me not to look up to all those who have more. Look down to all those who have less. That is something that still works [to be positive]._ (Respondent 5)

Various respondents who have a rather optimistic view on life also do not adopt the role of a victim. In this respect, Respondent 9, for example, always tried to counteract injustices, which clearly gives her a sense of self-worth and general courage. On the other hand, we find that Respondent 15 explicitly blames ‘the system’ for the long period he lived in poverty. Taking the role of a victim allows him not to feel guilty for his situation and to be able to feel well again.

Most respondents indicate that they don’t know what tomorrow will bring; through this sentiment, they do not anticipate much on future losses, try not to worry a lot and live in the moment and enjoy as much as possible (Respondent 1, 4, 6, 11, 12), as exemplified by Respondent 6:

_I think every day has its value. I am very aware that time will never return. […] That’s is a sort of philosophy of life I try to follow since long. […] I try to live in the present. […] I life day by day. I know from experience that when things come closer, that they are often easier to solve than when you think of them in advance. That is my experience in life._

On the other hand, the awareness that every day can be one’s last can also have negative implications with respect to future life projects. Most respondents find it important to continuously realise certain (small or big) goals, despite difficulties such as health problems and pain (Respondent 3, 5, 6, 7, 9, 12, 13): performing certain household tasks such as cleaning and doing groceries,
giving this interview, writing a book, doing physical exercises every day and going outside are all included in these goals.

Based on these fifteen narratives, we find that people with a lot of interests and activities have a more positive outlook on life and seem to be more resilient. As Respondent 13 says, ‘If you go sit down, it’s over’. Various respondents indicate they never get bored and have various interests and activities such as engagement in organisations, volunteering, maintaining a household, communication with friends and family, reading, cooking, walking dogs, and participating in culture, food, alternative medicine, painting or gardening (Respondent 1, 4, 5, 6, 8, 9, 11, 12, 13, 14, 15). These activities not only give them energy and courage and help them to maintain a good physique, but the social aspect is also very important.

Respondents explain that positive relations with family and friends are a source of strength which helps them to maintain mastery over the determinants of their lives (Respondent 4, 5, 6, 7, 8, 11, 12, 13, 15): ‘I get my energy from other people. [...] I need that; I need people’ (Respondent 5). Although positive relations offer both practical and emotional support, which reduces stress levels, the respondents state that they are somewhat hesitant to appeal to their family and friends because they do not want to burden them too much. Further, it is important that those family members and friends live nearby so that they are able to help them with small practical problems.

An intimate relationship with a partner is especially important because it can create a feeling of love and belonging. A lack of close relations is associated with feelings of (emotional) loneliness. Indeed, respondents who explicitly indicate that they do not feel lonely often still have a partner, contact with various family members or friends (Respondent 5, 6, 8), and people who feel lonely foremost lack an intimate relationship with someone, and some of them live a socially withdrawn life (Respondent 2, 3, 7, 10). Respondents give various reasons why they do not succeed in having a new intimate relationship, despite feeling lonely. One respondent explains that he does not want to start a new relationship because of the love and affection for his deceased partner: ‘I still hold dear to her. That was the best woman in the world’ (Respondent 13). Another respondent states that his psychological problems make him afraid of being rejected by others and make him think that nobody wants him: ‘nobody wants me anymore. [...] I don’t know. Maybe I am too fat [laughs], or not attractive enough’ (Respondent 10).

Some narratives demonstrate the important role professionals can play in the respondents’ lives with respect to practical, emotional and relational issues (e.g. trust). A respondent states that thanks to the support of a specific
professional and her psychologist, she has found the courage to take up contact with her grandchildren again (Respondent 3).

Some respondents mention the impact of how society perceives them on their well-being. One respondent states that he no longer has a professional identity since his retirement:

*you have the awareness that you no longer count as before. In the past, I had to gather legislation and vulgarise it and speak about it and handle that, I am a jurist, and now that is all a lot less.* (Respondent 7)

We find that numerous useful services exist: social housing, service flats, recreational activities, debt mediation, social restaurants, transport, and so on. Nevertheless, the cost of and lack of access to some of these services prevent respondents from receiving the desired and needed support. Most of our respondents cannot afford a taxi. This is problematic because their health makes it difficult to get by on public transportation. As a result, they go out less than they would like to (Respondent 3, 5, 15). In addition, various respondents indicate that they would like to have some professional psychological support (e.g. to deal with grief or traumatic experiences), but they no longer make use of it because of the financial cost (Respondent 2, 3). Nevertheless, some respondents seek support by participating in group discussions of the organisations in which they are active, which offers them perspective and lets them know they are not alone with their problems (Respondent 2, 10).

Our respondents use various primary and secondary control processes to deal with adversities they encounter in life. Primary control is considered to be a constant and universal motive (Janssen et al., 2012), whereby people use their resources to influence outcomes in the environment and to realise personal goals (e.g. constructing a large social network) (Janssen, 2013). An example is an older person who actively engages in a social organisation in order to meet people and create new relations. Secondary control processes come to the foreground when people are unable to realise certain goals (e.g. enlarging their social network). At that moment, they apply psychological processes (e.g. adjusting goals, expectations and preferences) to bring themselves in line with their specific context (Janssen, 2013; van Tilburg, 2005):

*adaptations of the system of personal values and preferences, reinterpretations of stressful problem situations, changes in perspective and deliberate (downwards) comparisons are typical examples of processes that contribute to resolving the actual/ought discrepancy.* (Greve & Staudinger, 2006, p. 818)
That way, older persons can disengage from goals that are no longer attainable and select goals that are more realistic to achieve (Greve & Staudinger, 2006). An example is older persons who learn to accept that their contact possibilities decrease because of severe mobility limitations.

To counter memory problems, some of our respondents write things down in a notebook as reminder. Physical health problems affect their daily life. When they go out, they think carefully about which routes and busses they can take (so as to walk as little as possible) and where there are benches on which they can rest (Respondent 7, 12, 13, 15).

Older persons are sometimes compelled to use secondary control processes through which they adapt goals and accept their vulnerabilities. Financial limitations force them to live economically, for example by not eating a warm meal every day (Respondent 1, 4, 6, 10). Furthermore, the respondents try to accept these limitations and focus on what they can still do, as Respondent 1 describes, for example:

> I find that I have a luxurious life. People always want so much more and more, and sometimes I think: but we already have a luxurious life where we can do what we want, eat what we want. [...] I live well I think, and for example in the winter I put the heat on 18 degrees: for a lot of people that is very low, but I put on a big sweater. So in that way, I think that I live economic but I find that I live well.

### 3. Implications for practice and policy

By thoroughly depicting the resilience processes of vulnerable older persons, we are able to make a number of relevant observations and formulate recommendations for practice and policy.

First, a global observation is that resilience is a process that takes time, not in the least because older persons themselves need to understand and be able to express their problems.

> Accepting one’s vulnerability or accepting the use of medical devices is not something that the majority of the older people easily deal with. Often, a period of having doubts, being insecure and considering one’s options precedes such a more or less stable situation. (Janssen, 2013, p. 62)

Although some problems can be dealt with relatively quickly, numerous (age-related) difficulties take a significant amount of time to deal with. This
is especially the case when it concerns changes in social networks (e.g. due to divorce, death of a partner) or when it concerns emotions (e.g. feelings of loneliness) which require psychological adjustments. Therefore, we think that both professionals and the social network of older persons should try to enhance older persons’ sources of strength and bear in mind that older persons often go through various stages when dealing with their problems, which takes time. Further, many respondents indicate that they find it difficult to accept certain vulnerabilities that cannot be overcome (e.g. health problems, memory problems), and often continue to struggle with them. In this respect, we are of the opinion that many older persons could benefit from some psychological help to learn to accept vulnerabilities that cannot be overcome. In general, much more attention should be given to the mental health of older persons. This was especially the case in the current Covid-19 pandemic, when many older persons indicated that they were lonelier (De Witte & Van Regenmortel, 2020). In accordance with other scientific literature (Plantinga, 2019), it is essential that older persons who live in poverty are supported not only materially but also emotionally and socially. Policy and practice should guarantee accessible, affordable and tailored psychological services for older persons.

Second, since older persons are more aware that they are in their last life phase, they seem to anticipate less specific problems they might face in the future. Although this awareness makes them enjoy the moment more (carpe diem), it can also pose difficulties when those problems do occur. Hence, it seems that older persons should at least already think about possible problems they might face in the future and how they would deal with them. That way, older persons would be mentally and emotionally better prepared the day they are faced with those problems. In the same vein, it is essential that the social network, professionals and society in general detect various hinge moments in the lives of older persons such as the death or divorce of a partner, retirement or severe health problems such as cancer. The detection of those junctures at the moment they present themselves is essential, since they are often accompanied by severe stressors that threaten the quality of life of older persons.

Last but not least, our narratives demonstrate that the power of giving has enormous beneficial effects on both older persons and society in general. In line with other research (Janssen et al., 2011), we find that doing things for other people (individually or through volunteering, practical or moral support) and looking to be meaningful to others is a crucial source of strength. Moreover, it has numerous positive effects on the quality of life of older persons; it results in increased feelings of self-worth and self-esteem, and it
makes older persons feel good, useful, needed, valued and proud of themselves. Since the power of giving often includes social contact, other benefits can be constructing a social network, coming out of one’s own comfort zone and having a challenge and engaging activities which distract from the own sorrows. Stimulating reciprocity and participation in daily life and in care are fruitful pathways for the resilience of older persons. How society, family, friends and professionals can trigger the give-take balance and tailor-made forms of participation is an important aspect in facilitating processes of resilience and empowerment. At present, it seems like the strengths of older persons are not fully made use of. For instance, by offering the necessary and personalised support (e.g. moving to more suitable home, psychological support, practical aid to stimulate mobility), escalation of those problems and their side effects (such as loneliness and social withdrawal) can be prevented. To this end, a more positive image of old age, exploring the numerous sources of older persons’ strengths through authentic listening to the older persons themselves and embedding their experiential knowledge in practice and policy are of utmost importance.

In sum, it is essential that society invests more in seeking how older persons can contribute to and participate in society, by helping them find out what they can do. Furthermore, it is equally important that policymakers take away the contextual, structural barriers that impede older persons from participating to society by increasing their mobility and access to health and social services, for example. By creating ‘enabling niches’ in which older persons can further develop themselves and are no longer stigmatised and by investing in warm, empowering, reciprocal formal and informal relations, resilience in old age is strengthened.

4. Conclusion

The paradigm of empowerment focuses on the strengths of older persons without neglecting their vulnerabilities. It recognises older people who are ill, frail and vulnerable, and stands up for their rights to receive care and security and for being heard in society. Empowerment takes into account the pitfalls of ‘active ageing’, promotes social inclusion and focuses on structural barriers of exclusion. A strengthening environment (e.g. by creating enabling niches) is necessary to realise empowerment. If meaningful relations are stimulated, the resilience of older persons will improve. Rooted in positive psychology, resilience focuses on how people can positively overcome adversity and vulnerabilities and how they can manage challenging circumstances. Our
resilient narratives of older persons show that various sources of strength on the individual, interactional and contextual domains are interconnected. For an optimal climate for resilience, these resources need to interact favourably. The importance of the power of giving, warm and positive relationships, strengthening community care and community building, and increasing access to health and social services are important ways to facilitate resilience and empowerment.

Older persons are full citizens and, in line with empowerment, co-creation seems to be the positive approach for policy, practice and research for cooperating with them. This benefits both older persons and society as a whole, and brings us another step closer in realising Silver Empowerment.

References


