

‘Keeping going’: chronic joint pain in older people who describe their health as good

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ABSTRACT

It is common for people with chronic conditions to report their health as good, although models of healthy ageing do not account for this. The concept of successful ageing focuses on overcoming problems, in contrast to the concept of resilience, which can acknowledge vulnerability. Osteoarthritis (OA) is the main cause of joint pain in older people, but research in this area has tended to focus on OA as an illness. Consequently, our research aimed to explore OA from the perspective of wellness. We undertook a longitudinal qualitative study to explore ‘wellness and resilience’ in a group of older people who reported chronic joint pain and considered themselves healthy. We interviewed 27 people and followed them up with monthly diary sheets, responding to reports of changes using their chosen contact method. This article focuses on how resilience relates to how people consider themselves to be well. Participants’ experience of the adversity of their pain varied, and was influenced by context and meaning. Participants described ‘keeping going’ in body, mind and everyday life. Flexibility and pragmatism were key aspects of keeping going. The findings support a broader version of resilience that incorporates vulnerabilities. In the context of health care we suggest that treating the frail body should not come at the expense of undermining an older person’s sense of a resilient self.

KEY WORDS—resilience, chronic pain, longitudinal qualitative method, osteoarthritis.

Introduction

The theory of ‘successful ageing’ has been influential in gerontology and in social policy (Kuh and the New Dynamics of Ageing Preparatory Network 2007), promoting continued physical, psychological and social activity as the ideal. Through being actively engaged in and with the world it is believed that older people will be healthier, have a better quality of life and

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be productive for longer. Definitions of what success means have also varied according to whether the concern is with biological, psychological or sociological aspects of growing older (Torres 1999). Baltes and Carstensen's (1996) view of psychological success is an older person being able to adjust their goals when faced with the kinds of challenges that tend to occur in old age. In this way, it is argued, losses are minimised and gains are maximised. Rowe and Kahn's (1997) view of success is more focused on the biological, and includes maintenance of physiological capabilities similar to those of a younger person; that is, 'successful ageing' as a kind of agelessness. The dominant western biomedical definition of 'successful ageing' resonates with Rowe and Kahn's model (Torres 1999) because of its emphasis on sound physical health (absence of disease and risk factors for disease) and good levels of physical and cognitive functioning. 'Successful ageing', according to these ideas, is healthy ageing (Bowling and Dieppe 2005).

Models of healthy ageing do not take into account the many older people who have chronic illnesses but who consider themselves to be healthy. It is common for people with chronic conditions to report their health as good (Blaxter 2004), including those aged over 85 (Collerton *et al.* 2009). Older people who have chronic pain have also been found to persevere in keeping up valued activities, roles and relationships (Sofaer-Bennett *et al.* 2007). General Household Surveys have found that 60 per cent of those aged over 65 reported some form of chronic illness or disability, and yet less than a quarter of these rated their health as poor (Sidell 2010). The starting point for our research was a longitudinal survey of older people with joint pain (North Staffordshire Osteoarthritis Project (NorStOP)) in which 58 per cent of older people with joint pain reported good, very good or excellent health in general. We undertook a longitudinal qualitative study to explore this phenomenon and the potentially connected concepts of 'wellness and resilience' in this group of people. In particular, we were interested in how the concept of resilience relates to how people consider themselves to be well. In doing this we also aimed to contribute to the understanding of the experience of resilience in later life.

Background

The original aim of our research was a deliberate attempt to take a salutogenic approach in the field of musculoskeletal pain through exploring wellness and resilience in older people with joint pain. A salutogenic approach, suggested by Antonovsky (1993) as an alternative to the pathogenic paradigm, is concerned with the question of how people learn to live (well) with stressors. The emergence of, and growing interest in,

a salutogenic approach has resulted in a number of psychological and sociological concepts being embraced under the ‘salutogenic umbrella’ (Lindström and Eriksson 2010). In presenting the background to this article we focus on resilience, given its status as a concept that is increasingly used in the field of gerontology (Wiles *et al.* 2012), but which, at the same time, lacks consistency in definition and use (Wild, Wiles and Allen 2013).

Wild, Wiles and Allen (2013) make a useful distinction between work on successful ageing, which, while moving away from a pathogenic approach, is still focused on overcoming problems, and work on resilience, which focuses on the ‘experience of vulnerability’ and how this relates to older people feeling well despite having a chronic condition. The starting point for our research is, therefore, the idea that people living with a chronic condition can be understood to be resilient (Wiles *et al.* 2012).

Resilience

Two dimensions have been proposed for the resilience construct – exposure to adversity and showing signs of positive adaptation to this adversity (Luthar, Cicchetti and Becker 2000; Masten 2001; Schoon 2006). According to this definition, identifying resilience requires two judgements: is there now or has there been a significant risk of adversity to be overcome and is the person ‘doing okay’? In many studies ‘doing okay’ is measured by assessing mood, wellbeing or quality of life before and after being exposed to adversity (Hildon *et al.* 2010; Netuveli *et al.* 2008; Windle, Woods and Makland 2009). Maintained or increased psycho-social wellbeing and quality of life are indicative that the person is doing okay and is therefore resilient.

Those with resilient outcomes to adverse situations have been reported to draw on a broader range of social and individual resources than those with vulnerable outcomes. As a consequence, these people were better able to maintain continuity of their previous lives, were more in control and, therefore, more able to transform an adverse event into a benign one (Hildon *et al.* 2008). Drawing on previous experiences of loss and coping to create a sense of oneself as resilient has been found to help women deal with challenges from current ill health (Gattuso 2003).

Kuh and the New Dynamics of Ageing Preparatory Network (2007) make a case for studying not only physiological but also social and psychological resilience alongside frailty in older people, raising the prospect of being able to be physically frail but psychologically and socially resilient. This suggests that resilience may offer an appropriate framework for understanding wellness in the context of chronic joint pain.

Kralik, van Loon and Visentin (2006) draw on the idea that living well with chronic illness involves establishing order and making sense of the

turbulence caused to established ways of living. They argue that ‘making sense’ involves reconstructing the self in the light of changes imposed by illness, and that narration facilitates this process. Several researchers have drawn attention to the importance of personal narratives in achieving continuity in the sense of self (Gattuso 2003; Hildon *et al.* 2008; Kralik, van Loon and Visentin 2006; Williams 1984).

Sense of coherence

Antonovsky observed that the stories of patients included not only risk factors (psychological stressors) but also protective factors that help a person to cope well no matter what the stressor. His Sense of Coherence (SOC) model includes three elements: sense of comprehensibility – a belief that the stimuli from one’s environment make sense and are ordered and predictable; a sense of manageability – a confidence that resources are available that will enable a person to cope well with the demands made by the stimuli; and a sense of meaningfulness, connected to motivation and a wish to cope.

Albrecht and Devlieger (1999) take the three components of Antonovsky’s SOC model and apply them in a corresponding ‘balance’ model of mind, body and spirit, with all components being interrelated. Thus, a good quality of life for people with disabilities involves acknowledging the impairment, having a degree of control, being able to fulfil roles, having a ‘can do’ approach, having purpose and meaning in life, and engaging in reciprocity. Albrecht and Devlieger (1999) suggest that one dimension of the self (comprised of mind, body and spirit) may compensate for a lack in another dimension. This is similar to Wild, Wiles and Allen’s (2013) model of areas of resilience in later life, which acknowledges that people may be resilient in one area but not in others. This is also important for exploring the potential relationship between resilience and vulnerability.

Osteoarthritis

Osteoarthritis (OA) is the main cause of chronic joint pain in older people. Pain from OA has been linked to depression/anxiety as both cause and effect, either directly or mediated through physical functioning (Bookwala, Harralson and Parmelee 2003). A mediated explanation argues that activity may be restricted because of joints being stiff and painful or because of low motivation when feeling anxious or depressed. Not moving joints sufficiently can cause an increase in symptoms of OA and might result in reduced social contact, putting people at risk of mental distress (Chapman, Fast and Keating 2005; Machado, Gignac and Badley 2008). However, the majority

of older people with OA do not succumb to mental distress, and continue with their normal life. Previous research in this area has tended to focus on OA as an illness, with ‘coping’ (in the sense of learning how to tolerate) as a minor area of interest. Consequently, our research consciously aimed to explore OA from the perspective of wellness.

Methods

In order to explore people’s own perceptions of what being well in the context of chronic joint pain meant to them, and how this might change over time, the study was designed as a qualitative longitudinal study. Participants were interviewed in-depth at baseline and then sent a monthly contact sheet (*see* below) for 11 months, making a total participation time of 12 months.

Recruitment

Participants were recruited from an ongoing cohort study (the NorStOP study; *see* Thomas *et al.* 2004 for further details) in which they completed a general health and joint pain questionnaire. The questionnaires of cohort participants who had reported OA/pain in peripheral joints and who had agreed to further contact were assessed in order to find participants from across the age range of 55–90 who rated their health as good/very good or as fair in the presence of moderate/severe pain and physical limitations. Those who reported no health problem and/or no limitation and/or mild pain were excluded. Out of the 60 people approached, 27 agreed to take part. In only two instances were reasons given for declining to participate – bereavement and being too old (90 years).

Baseline interviews

An in-depth interview was carried out at baseline with the 27 participants who had agreed to take part. The life-grid approach (Richardson *et al.* 2009) was used for the interview, which helps participants to talk about their current health circumstances within the broader context of their whole life. Participants talked about their family, and about work, leisure and health throughout their lifecourse. In addition, they were asked about their current daily life, the impact of joint pain, how they saw their present and future health (and why), their use of health and social services, and whether they had any advice for others with similar joint pain/OA about how to stay well. Baseline interviews lasted between 30 minutes and two hours; the average length was just over an hour, but most lasted between one and one-and-a-half hours.

Monthly contact

Each participant was sent a monthly contact sheet for 11 months following the interview. The sheet asked about changes in their health (*e.g.* whether they were feeling more or less well than normal), changes in their problem joint(s) and changes in personal circumstances which affected how they were coping or felt in themselves. Participants could respond simply by answering the questions on the contact sheet, or could ask for further contact that month. Participants used the contact sheet to indicate whether or not they wanted further contact with a researcher. In this way participants were able to drive their involvement with the study in terms of which format they preferred (face-to-face follow-up interview, telephone conversation, email or letter) and the frequency of contact.

Of the 27 who initially agreed to take part in the study, six withdrew over the course of the year – three in response to the first contact sheet (for unknown reasons), one after the fifth contact sheet (due to her husband's illness) and two were withdrawn after they did not reply at all to two consecutive contact sheets. In relation to the remaining 21 who stayed in the study for the whole year, the number of responses to contact sheets ranged from two to 11 per person. Most of these responses included brief notes or longer letters/email exchanges. Ten participants did not request contact, while others asked for one phone call or one interview, or a combination of phone calls and face-to-face contact. The maximum contact requested for any one participant was four interviews (two face-to-face, two by phone).

Analysis

Interviews were digitally recorded and fully transcribed. A thematic analysis was carried out (Charmaz 2006), facilitated by the qualitative software package NVivo8. A coding framework was drawn up by the lead author, which was refined following independent coding by the second and third authors. All three authors met to organise the codes into themes, which categorised the data so that conceptual analysis could be developed.

It is important to note here that although the study was designed to explore 'wellness and resilience' in older people, we attempted to avoid imposing these concepts on the data from the outset, not least because these are not usually terms used by participants themselves (although Wiles *et al.* 2012 use this to their advantage in making resilience the topic of discussion in their focus groups). We acknowledge, however, that the thematic analysis was conducted from our standpoint as researchers of people's experience of living with chronic musculoskeletal pain, which sensitised us to particular themes. The initial coding frame was generated from the data in this study, but also reflected other studies of living with chronic illness. Commonly used

codes therefore included: self-management, social relationships, independence, self and identity, coping, strategy and style, keeping going/carrying on, valued activities, experience and explanations of illness, and health service use. These were then grouped into overarching conceptual themes, including wellness and resilience.

All names used here are pseudonyms. All research was carried out in accordance with the ethical approval given (Ref. 08/H1203/52) and in line with the British Sociological Association Statement of Ethical Practice (British Sociological Association 2002).

Findings

We present findings which contribute to answering our question of how the concept of resilience relates to older people with joint pain who see themselves as well. Our findings therefore focus on two areas: was joint pain experienced as an ‘adverse event’ and were people ‘doing okay’ with joint pain?

Was joint pain experienced as an adverse event?

Severity of joint pain. It is important to explore whether people simply described themselves as well because their joint pain was not serious enough to have an impact on them. As described above, we selected participants who indicated on cohort study questionnaires that their musculoskeletal condition was chronic and problematic. The questionnaire, by imposing a particular framework on participants, steered some to present their symptoms as more severe than subsequently indicated during the first interview in our qualitative study. Three participants were aware of a mismatch. Carol felt that it was completing the NorStOP questionnaire that had led to the construction of herself as a person with severe OA.

I feel a fraud, because I don’t feel as though I’m an arthriticky person. I mean, when you said you were coming, I thought, ‘Oh God, you know, she’ll walk in and look at me and think, “There’s nothing wrong with her”, you know.’ I do, I feel a fraud but until you fill these things in [referring to NorStOP questionnaire], you don’t really put your finger on it and think, ‘Yes, I am having that trouble with that knee’ and, ‘Yes, my neck does hurt and this shoulder does give me a bit of gyp and my hip is a pain’, but, you know, you don’t feel like it [is arthritis]. (Carol)

During the interview, six participants described symptoms that could be interpreted as being severe, for example, frequent spells of troubling joint pain and difficulty in using the affected joint(s). Five of these also had other health problems which compounded the effect of their joint problem on their ability to function. At the other extreme, two participants said that they

only experienced a twinge in their joints. The remaining 19 fell in between these two extremes. If we only consider OA symptoms then we might take participants at the two extremes as indicative of adversity *versus* no adversity. What about the 19 participants in between? Could they be said to be experiencing OA as an adversity?

Lewis, for example, like several of the 19 participants, said he could work through the pain and stiffness in his joints. He knew that usually after about 40 minutes of walking the pain would lessen, though occasionally he had to change his plans because of severe symptoms which did not resolve after moving about. When asked whether he considered himself to be a well person he gave no indication that he considered his physical decline to be an adversity.

I feel well, yes. I don't know if I give the impression but I feel that my mind is clear, my memory's okay; so, my body is not as good as it was, I'm aware of that, but all in all, putting everything, you know, into perspective, being 80 next month, I feel pretty good. (Lewis)

In relation to his age he feels he is doing well. Is it because participants like Lewis have successfully adapted to their symptoms that this results in their downplaying the adversity of these, *i.e.* they are demonstrating resilience? We return to this question in the discussion.

Context of the adversity In some quantitative studies of resilience in older people, adversity was decided *a priori* and assumed to be equivalent across participants sharing that life event or experience (Hildon *et al.* 2010; Netuveli *et al.* 2008; Windle *et al.* 2009). In our study the impact of OA symptoms depended not only on the degree of the severity of the symptom ('objectively' determined) but also the context. Carol, who was divorced and had paid National Insurance contributions for only a few years, needed to continue working at her portfolio of cleaning jobs into her late sixties, or beyond, in order to fund her retirement. A small loss of grip strength was of major significance to her.

Had a problem at Aldi [supermarket] with shopping trolley tokens. My mum who's 84 couldn't remove her token, so she asked me. I couldn't remove it so I assumed it was faulty and fetched the attendant. He removed it with ease, and seeing my shocked look he replaced it back in a trolley for me to try again. I still couldn't remove it. I feel as though I am putting pressure on my fingertips but my grip is getting poorer. Until this incident I didn't realize my finger tip grip was getting worse. It's just made me realize some things are going to get harder to do. (Carol, in response to fifth monthly contact sheet)

Not being able to remove a shopping trolley token was a minor inconvenience when it happened; its significance was what it heralded for the future. Carol needed good grip strength to continue her work as

a domestic cleaner. Her situation demonstrates that the degree of felt adversity is contextually contingent. Wiles *et al.* (2012) point to the importance of older people's own understanding of resilience as being embedded in social and physical contexts.

Secondary and ongoing adversities It is not just the individual meaning of adversity that poses a problem for the first judgement (in determining resilience) but also that adversity in chronic illness is not necessarily a discrete event. Thus overcoming it is not a one-off happening. Secondary adversities can arise. For example, Miles had severe pain in his ankle on standing and very limited mobility. He was prescribed a 'boot' to immobilise his ankle, which he was very hopeful would help prevent the pain when standing up. The boot, a type of inflatable splint designed for short-term immobilisation of an acute ankle injury, however, proved to be a problem in its own right. Miles could not get his trousers over the boot and would have found driving difficult; his car was essential for his mobility. He had already decided against the only other available treatment—replacing the ankle joint—because rehabilitation would take two to three months and he lived alone. So the prospects of a 'cure' diminished and he realised he would have to continue as before. Those treating his ankle problem did not appreciate that they were adding to his adversity.

Experience of joint pain as disruptive The meaning that participants attached to their joint pain affected their experience, in particular whether it was experienced as a disruption, an expected part of growing older or, as in Sanders, Donovan and Dieppe (2002), a combination of the two. Many of our participants, whose joint problems came on gradually and not unexpectedly in later life, did not appear to experience 'chaos', and they adjusted their lives almost imperceptibly to accommodate their symptoms. It was the interviewer's questions, for example, that made Anne aware of the adjustments:

I just moved a moment ago because my back was hurting a bit and my hip, because I'm sitting; whereas, normally, if I was just on my own, you'd get up and do something different, so that the pain then alters. But yes, you do, you know, you don't think about it in actual fact, it's only when people ask you about it that you think, 'Yes.' (Anne)

Other participants, whose joint problems came on suddenly and severely, and/or who had a co-existing chronic condition and/or had experienced a life event such as bereavement, did talk about how their lives had radically altered. In their accounts they gave examples of drawing on the past to make sense of the present. This increased their optimism about the future and helped create a sense of self as resilient. Arthur, for example, placed his

current health problems as just one more in a line of health and other problems stretching back to his childhood. In his quotation below, the sense of the strength he has gained from overcoming those adversities in dealing with his current (and future) problems is palpable:

I've had health problems all through my life and I remember my mother, when I was younger, saying to me, 'You've beaten it before, you can do it again,' and she seemed to give me an inner strength that way, you know, and it's stuck with me. There have been many obstacles in my life that I've had to overcome and I have done so. So this, in a way, is my latest challenge, you know, and when I start thinking to myself I'm fed up, I've got to stop that and think positive, and it comes from an inner strength. (Arthur)

Inner strength is identified as a key component within the salutogenic umbrella (Lundman *et al.* 2010). Antonovsky's SOC model recognises shifts in feelings of 'inner strength' over time as different factors that influence SOC wax and wane. Miles describes an occasional and temporary sense of despair when he first wakes with a diminished sense of motivation, which is restored as everyday routines kick in:

Some mornings I wake up and wish I hadn't woken up, but once I'm out, up and about, that feeling goes. (Miles)

This can be compared with Arthur's perception that he might not always be able to rely on his daughter to give him the help he needs to continue living at home. This produces a less transient sense of vulnerability, and yet, at the same time, this vulnerability is countered by high motivation, the sense of having an inner strength and the acceptance that he will probably have to make a difficult decision about where to live in future. Most of the participants in our study did not face the extreme challenges faced by Miles and Arthur and did not talk explicitly of a resilient self but rather of 'keeping going', and it is to this that we now turn.

Keeping going or 'doing okay' with joint pain

Several studies have examples of how 'keeping going' structures older people's narratives about staying well and getting on with life despite having a chronic condition (*e.g.* Busby 2000; Paterson 2001, 2003; Sofaer-Bennet *et al.* 2007; Wray 2003). We did not ask people to define resilience, but we did ask them to focus on what they felt enabled them to see themselves as well despite having a chronic joint problem. The notion of 'keeping going' best describes this for our participants. Keeping going has a particular poignancy for people with OA since it can be hard to keep going physically.

Keeping going in body, mind and everyday life. A common strategy for keeping the limbs going was to improve joint mobility through physical movement.

My husband and I walk two miles every morning after breakfast – really to get my limbs going. (Gwen)

Keeping going was also presented as an attitude of mind that has a psychological benefit, and as a moral enterprise – particularly in comparison to other people (Rosenfeld and Faircloth 2004):

I'm working 39 hours; it's only low paid but it keeps you occupied. It occupies your mind because I think if you stop in, if I finished work, you get fed up and you deteriorate, I think. (Peter)

Don't give up, keep going. Don't give up. Don't let it get on top of you, which a lot of people it does. (George – has very painful hip and knee joints, asthma and only one lung)

There are some days when you can't [live with the pain] so ... if I'm sitting there feeling sorry for myself, I think, 'Come on, snap out of it, you could be worse.' ... Don't get me wrong, I'm not a martyr but I do try [to cope]. (Jessie)

Lastly, keeping going concerned maintaining the continuity of everyday life. This involved fulfilling the daily routine; keeping up valued roles and relationships, for example as grandparents, friends or church members; and engaging in pastimes and leisure interests, which included voluntary work, paid work, housework, dancing, swimming, art and gardening. Through these things participants also maintained a continuity of their identity.

Flexibility in keeping going. Keeping going was not about unwavering adherence to past activities; flexibility and adaptation were part of the positive function of these valued activities:

A few days after we met I had a fall ... It was enough to upset my neck and hip all on the right side. So the cleaning got left for a few days until I felt more like it. We made more of an effort to get out for a walk, and back home I picked up the paintbrushes and the oil paints (I've not done any oil painting for about 8–10 weeks) and the picture came together quite well and quickly – photos enclosed. ... But I've done something I've been promising myself to do for a long time and that is take stock of all my drawings, *etc.* They total drawings, water colours and oils to 1,170. I invited the family to Sunday lunch and they all chose a picture. What a busy but enjoyable day; and there was lots of help and I've many cards of thanks from them for the pictures. (Penny, by letter)

Other participants described changing their activities to accommodate physical changes, for example, going fly fishing rather than walking, playing golf rather than football and doing more reading and less gardening, or doing a different type of gardening, but still doing all of these activities with an underlying continuity of self.

Joint pain and stiffness can compromise keeping up valued roles and activities and several of our participants made reference to a 'use

it (the joint) or lose it (functioning)’ approach to self-management (Grime, Richardson and Ong 2010):

Keeping mobile [is very important], because even though we’re, sort of, disabled, it’s a case of use it or lose it. If you want to keep your mobility you’ve got to move, even if you’re in pain, you’ve got to move. (Vida)

Participants were prepared to innovate in order to ‘use it’; for example, some had started going to gyms or had bought treadmills which they used at home. Such innovations were not extraordinary magic (Masten 2001) but examples of positive adjustments to try to achieve optimal functioning (Schoon 2006) – they were part of keeping going.

However, our participants were also pragmatic; they accepted that part of being human was having off days, when you might feel sorry for yourself. Feeling a bit down was not incompatible with being able to keep going, as seen above in the examples of Miles, Arthur and Jessie. In the context of a chronic condition, understanding that the condition will fluctuate and that there will be ‘good days and bad days’ (Charmaz 1993) is also part of keeping going.

Discussion

Deciding whether having a chronic condition is an adversity poses several problems. A stressor, such as loss of mobility or grip strength due to OA, might be experienced with different degrees of adversity, depending on the perceived severity and the meaning and significance of the loss for the individual. One loss can trigger other losses so that there is a cascade of adverse events, and felt adversity might fluctuate over time. It is difficult to disentangle felt adversity from the process of coping with adversity; that is, is one person doing better than another following an adverse event because the stressor was more benign or because he or she was more resilient? The two participants who said that their joint problems were minor both had spouses who had dementia. The wider setting in which the individual lives also has the potential to affect the experience of adversity (Wild, Wiles and Allen 2013).

Roisman argues that ‘the fact that some adults deal well with loss and traumatic exposure and others do not might reveal less about the adaptive capacities of individuals experiencing these life events and more about the nature of the putative stressors’ (2005: 264). Roisman is making a case for not applying resilience to experiences which might be unpleasant and frustrating but do not require the mobilisation of extraordinary resources in order to cope. In the commonly used resilience metaphor, their weight does not extend the spring. Applying this principle to the case of OA means that

people should only be described as resilient if the symptoms and physical limitations they experience as a result of OA are sufficiently 'out of the ordinary' to be considered adverse, thus requiring an extraordinary response.

We explored how people with joint pain 'keep going' and whether this can be equated with the 'doing okay' criterion of resilience. Most participants accepted their joint problems as a normal part of growing older. Pain interfering with sleep, pain and stiffness making it difficult to get going after rest, or needing to change the way of doing everyday activities were seen as consequences of having an older body and were tolerated and worked around. This leads to the issue of judging what constitutes 'doing okay'. Any verdict will be relative to the norm of the social group to which the person who does the judging belongs. What constitutes positive adjustment has been contested (Schoon 2006). Health-care professionals are frequently critical of patients who accept their joint problem as part of ageing (Hurley *et al.* 2010) and many would not judge acceptance to be a resilient outcome. A resilient outcome would be actively treating joint symptoms as a medical problem, for example, undertaking exercise programmes and possibly losing weight, preferably after consulting a health-care professional. This highlights a tension between resilience as defined by a professional and as defined by a patient. Wild, Wiles and Allen (2013) draw attention to the importance of considering older people's own definitions of resilience. These are important because they will shape the actions they take, and have taken, over their lifetime. It is important for health-care professionals to consider older people's own definitions of resilience (or perhaps rather 'keeping going') as part of a patient-centred approach.

Trying to decide if a person has bounced back after experiencing adversity by making two judgements about adversity and doing okay appears flawed in the context of older people living with chronic joint pain. Conceptualising resilience as being able, like a spring, to bounce back to a pre-adversity state is a badly chosen analogy in the context of chronic conditions, which, by definition, persist, and might get worse rather than better. A resilient person does not 'bounce back' having shed the adversity but, rather, finds a way of 'keeping going' despite it. Making the two judgements of adversity and doing okay to identify resilience is not specific to the idea of bouncing back; they can equally relate to keeping going. However, in practice some researchers have compared measures such as wellbeing and quality of life before and after adversity to determine resilience. So they are looking for bounce back, not how well the person is doing now given that they are experiencing these difficulties. The weight of adversity is hard to pin down, and what is observed from the outside might not be the same as that experienced on the inside.

Even if the flaws are addressed by more nuanced questions, the premise behind the questions – that older people can be categorised as resilient or not resilient – remains. Yet, as we have shown, the participants in our study could appear both resilient and vulnerable; Antonovsky's approach can accommodate this finding, and SOC might offer a more apt model than the spring for several reasons. Since the model assumes that the normal state is for people to be subject to stressors, the first judgement becomes redundant. To be resilient is to keep everyday life going despite the adversities which might threaten to cause disorder, and SOC therefore implies that resilience is part of the human condition. The question is, 'why do some people do better than others?' The senses of comprehensibility, manageability and meaningfulness which make up SOC are dynamic, so the ability to live well – to be resilient – is also dynamic.

Wiles *et al.* (2012) and Wild, Wiles and Allen (2013) bring back the potential for applying the concept of resilience to older people with chronic joint pain, acknowledging as they do that it can incorporate and balance vulnerability alongside strength across a wide range of contexts. Locating resilience within these broader contexts removes the focus from individual characteristics and the associated blame for those who do not 'achieve resilience' (Wiles *et al.* 2012).

Older people who have joint pain and stiffness might not consider themselves to have a medical condition but simply to be getting older; nevertheless, they have to face up to changes in their physical abilities and their perception of themselves. Being 'resilient' (in the sense suggested by Wiles *et al.* 2012, above) means being able to accommodate and adapt to physical changes and fluctuations in health and wellbeing in order to sustain what is important in life and for a valued sense of self. Health and welfare services are an important element of the environment of many people with chronic conditions, but those who provide care need to appreciate that a frail body is not indicative that the cared-for person lacks a resilient sense of self. Treating the frail body should not come at the expense of undermining an older person's sense of self. In order to balance professional perceptions of an individual's 'frailty' with an individual's embodied and lived experience, we suggest that health and social care providers take an individual's own approach to managing their condition as the starting point for any support offered.

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