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A Conceptual Framework for Assessing Social Resilience Community Scale: Focus on Ageing Populations and Primary Health Care

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Abstract

This study aimed to develop and validate the Social Resilience Scale, a tool designed to assess the ability of individuals particularly those with rheumatoid arthritis and hypertension to maintain social and emotional well-being in the face of chronic illness and adversity. Drawing on a comprehensive review of psychological and behavioral resilience literature, the scale was developed as a 25-item self-report instrument, rated on a 5-point Likert scale, with scores ranging from 30 to 180. The study sample comprised 400 participants (200 males, 200 females) aged 65 years and older from Gothenburg, Sweden. Participants were divided into four equal groups: individuals with hypertension, individuals with rheumatoid arthritis, individuals with both conditions, and a healthy control group. Also, demographic variables, including socio-economic status, gender, age, religion, education, and general health, were considered. Reliability analysis showed high internal consistency (Cronbach's alpha = 0.87). Content validity was confirmed through expert review, and construct validity was established via principal component analysis, which revealed three distinct factors explaining 77.818% of the total variance. The Kaiser-Meyer-Olkin (KMO) measure (0.794) and the determinant of the R-matrix (> 0.001) indicated sampling adequacy and the absence of multicollinearity. Inter-factorial correlations confirmed that the scale measures a unified construct of social resilience. Results demonstrated that while a high resilience score may indicate greater adaptive capacity, it should be interpreted alongside psychosocial variables such as social avoidance, emotional isolation, distress, and negative affectivity. Social resilience was found to play a crucial role in coping with chronic illness, influenced by factors such as social support, emotional regulation, positive beliefs, and problem-solving skills.

Keywords: *Social Resilience; Standardization and Norms; Aging Care; Primary Health; Rheumatoid Arthritis; Stress; Hypertension*

Introduction

Conceptualizing Resilience in Psychology and Aging Care

As Sweden's population ages and the prevalence of chronic diseases increases, the need for robust social support mechanisms and resilient healthcare systems becomes paramount. Social resilience the capacity of individuals and communities to cope with and adapt to social, health, and economic stressors is especially relevant in aging populations. In psychology, resilience is broadly defined as an individual's ability to cope with stress and adversity, involving adaptive responses to hardship shaped by a complex interplay of biological, psychological, social, and cultural factors. Adversity is considered the fundamental context of resilience, while positive adaptation represents its primary outcome. The American Psychological Association (APA, 2014) defines resilience as "the process of adapting well in the face of hardship, disturbance, disaster, threats, or even significant sources of stress." However, some scholars argue that the APA's definition does not fully capture the multifaceted and dynamic nature of resilience (Southwick, Douglas-Palumberi, & Pietrzak, 2014).

Resilience has traditionally been conceptualized within the field of positive psychology, where it is often associated with personal hardiness, emotional regulation, and the capacity to "bounce back" to a previous or even higher level of functioning after a crisis. According to Masten et al. (1990), resilience is "the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances" (p. 426).

Social resilience an extension of this concept emerges as an abstract but empirically supported notion, rooted in both individual intuition and systematic evidence. It encompasses the capacity of individuals, groups, or communities to withstand and recover from social stressors, such as isolation, inequality, or disruption of support systems. The development of resilience theory has evolved through three distinct periods:

1. **Phenomenological Phase**: Early research emphasized the observable traits of resilient individuals and their supportive environments, aiming to predict personal and social success.

2. **Process-Oriented Phase**: Resilience came to be seen not as a fixed personality trait but as a dynamic process of coping with challenges, emphasizing the identification and reinforcement of protective factors.

3. **Multidisciplinary Integration Phase**: Resilience expanded to encompass motivational, emotional, and social dimensions, highlighting how experiences activate and utilize internal and external resources (Kidd & Shahar, 2008). These evolving conceptualizations inform the assessment of resilience in clinical and community contexts, particularly in aging populations facing chronic illness, isolation, social anxiety, and system-level health disparities.

Development of the Test: Social Resilience Scale

Social resilience refers to the capacity to maintain positive interpersonal relationships, overcome life's adversities and isolation, and adapt to or endure disruptions and emergencies. It reflects an individual's ability to effectively recover from difficult circumstances that threaten their well-being, personal development, and mental health (Reppold, Mayer, Almeida, & Hutz, 2012). According to Reppold et al. (2012), social resilience is best understood as a transactional process, shaped by ongoing interactions between the individual and their environment. Importantly, resilience is not static; an individual who demonstrates resilience in one situation may not necessarily do so in another (Windle, 2010). One of the widely recognized tools for assessing resilience is the Resilience Scale (RS-25), developed by Wagnild and Young (1993) to evaluate resilience in adults. In a Portuguese context, the RS-

25 was translated and adapted for adolescents by Felgueiras, Festas, and Vieira (2010). However, their study yielded inconsistent results, particularly in replicating the original single-factor structure proposed by Wagnild and Young (2009), suggesting a need for more contextually and developmentally appropriate tools. Our literature review indicates that the term "social resilience" has been explored across diverse domains. Nevertheless, its application and conceptual development within psychology remain relatively recent and underdeveloped. For instance, Connor and Davidson (2003) examined resilience in diverse populations including community samples, primary care patients, general psychiatric outpatients, and individuals involved in clinical trials for generalized anxiety disorder and PTSD highlighting a need for more targeted psychological frameworks. Rutter (1987) emphasized that resilience arises from multiple interacting processes, particularly interpersonal relationships and social support, suggesting that resilience is not solely an individual trait. The literature supports the urgent need to develop valid and reliable instruments to measure social resilience, particularly those suited to different age groups and sociocultural contexts (Windle, Bennett, & Noyes, 2011; Felgueiras, Festas, & Vieira, 2010).

Measures and Scoring

Social resilience plays a significant role in the context of chronic illnesses, such as rheumatoid arthritis and hypertension. As such, it is influenced by a range of factors including socialization processes, self-confidence, emotional regulation, personality traits, perceived stress intensity, and work-related distress. These factors and their impact on resilience may vary considerably across diverse lifestyles, cultures, and health conditions. The Health Social Resilience Scale consists of 30 items rated on a 5-point Likert scale, where:

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Neutral
- 4 = Agree
- 5 = Strongly Agree

The total score ranges from 30 to 180 points, with higher scores indicating greater levels of social resilience. Interpretation of total scores is as follows:

- 160–180: Very High Resilience
- 145–159: High Resilience
- 130–144: Moderate Resilience
- 120–129: Low Resilience
- Below 120: Very Low Resilience

Table 1: Scoring System

Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
1	2	3	4	5

Table 2: Dimensions and No. of Items

	Dimensions	Items	No. of Items
1.	Self- adjustment	8, 9, 10, 12	04
2.	Self- determination	1, 3, 5, 6, 11	05
3.	Self- confidence	2, 4, 7	03
Total			**12**

Sample Design

For the present study, a carefully selected sample of participants was drawn from individuals diagnosed with rheumatoid arthritis and hypertension in Gothenburg, Sweden, ensuring a balanced representation by gender and health care condition. The primary objective was to examine levels of social resilience among patients affected by these chronic conditions. A total of 400 participants were included in the study, with equal gender representation (200 males and 200 females). The sample was divided into four distinct groups: Group 1: 100 participants with hypertension (50 males, 50 females. Group 2: 100 participants with rheumatoid arthritis (50 males, 50 females). Group 3: 100 participants with both conditions (50 males, 50 females. Group 4: 100 participants in a control group with neither condition (50 males, 50 females). Participants were all aged 65 years and older, reflecting an age group commonly affected by these health conditions. Demographic variables considered in the study included ethnicity, socioeconomic status, race, religion, gender, age, mental health, cognitive, sensory, or physical disabilities, sexual orientation, gender identity, geographic location, to ensure a comprehensive analysis of factors influencing social resilience.

Administration of the Test

The Social Resilience Scale is a self-administered instrument designed to be completed individually. It typically takes 10 to 15 minutes to complete; however, there is no strict time limit, allowing respondents to proceed at their own pace. The scale consists of 25 items, each rated on a 5-point Likert scale. The self-report format ensures ease of administration in both clinical and research settings.

Reliability

The Social Resilience Scale was administered to the same sample over a period ranging from 20 days to 3 months, depending on participants' availability and convenience. Participants were randomly approached to complete the scale, and measures were taken to ensure the accuracy and consistency of their responses across all items. The scale demonstrated strong internal consistency, with a reliability coefficient (Cronbach's alpha) of 0.87, indicating a high level of reliability for measuring social resilience within the target population.

Table 3: Reliability of the Social Resilience Scale on Three Dimensions

	Dimensions	Items	No.	Cronbach α
1.	Self- adjustment	8, 9, 10, 12	04	.974
2.	Self – determination	1, 3, 5, 6, 11	05	.875
3.	Self – confidence	2, 4, 7	03	.833
	Total		**12**	**.871**

Table 4: Descriptive Statistics of Scale and Reliability (Cronbach's Alpha)

Mean	Variance	Std. Deviation	Cronbach's alpha	No. of Items
47.61	56.654	7.470	.871	12

Validity

The content validity of the Social Resilience Scale including both face and logical validity was established through expert evaluation by ten professionals in the field of psychology and health sciences. To assess construct validity, exploratory factor analysis (EFA) was conducted using varimax rotation. Prior to factor extraction, data were screened to address potential issues of multicollinearity and singularity. The determinant of the R-matrix was found to be greater than 0.001, indicating the absence of problematic multicollinearity.

The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was calculated at 0.794, which exceeds the acceptable threshold and is statistically significant at the $p < 0.001$ level. Furthermore, all individual sampling adequacy values were above the minimum criterion of 0.40, supporting the appropriateness of factor analysis. These findings collectively support the scale's construct validity, confirming that the items meaningfully reflect the underlying dimensions of social resilience.

Table 6: Inter-factorial Validity

Dimensions	**Self-Adjustment**	**Self- Determination**	**Self-Confidence**
Self-Adjustment	1		
Self- Determination	.249**	1	
Self-Confidence	.139*	.427**	1

** Correlation coefficient is significant at the 0.001 level (2-tailed)

The inter-factorial correlations clearly demonstrated that all factors were significantly correlated with one another, indicating that they collectively measure the same underlying construct social resilience. This strong inter-correlation among factors reinforces the unidimensionality and conceptual integrity of the scale, supporting its use as a reliable tool for assessing social resilience.

Table 7: Factor Structure of the Social Resilience Scale (RS)

Item no.	**Resilience Dimensions**	**Factor 1**	**Factor 2**	**Factor 3**
RS9	Self-Adjustment	.965		
RS8		.963		
RS12		.953		
RS10		.938		
RS5	Self- Determination		.896	
RS1			.874	
RS3			.869	
RS11			.768	

RS6		.483	
RS2	Self-Confidence		.889
RS4			.831
RS7			.796
Percent of variance	39.891	25.239	12.688
Cum.percent of variance	39.891	65.132	77.818

A Principal Component Factor Analysis (PCA) was conducted using a structured method to explore the underlying dimensions of the Social Resilience Scale. The analysis resulted in the identification of three distinct factors. Items with factor loadings of ≥ 0.41 were retained, as this threshold was considered indicative of a meaningful contribution to the factor structure. The three extracted factors accounted for a cumulative total of 77.818% of the total variance, with individual contributions to the variance ranging from 12.688% to 39.891% across the factors. This high percentage of explained variance supports the robustness of the factor structure and provides strong evidence of the construct validity of the scale. A detailed summary of factor loadings, individual percentage of variance, and cumulative variance for each factor was compiled to facilitate further interpretation and scale refinement.

Item/ Statistical Analysis

Table 4: Descriptive Statistics of items scale and Cronbach`s Alpha

Descriptive Statistics for items					**Descriptive statistics for scale**		
Item no.	**Range**	**Mean**	**SD**	**Variance**	**Scale Mean if Item Deleted**	**Corrected Item-Total Correlation**	**Cronbach's Alpha if Item Deleted**
RS-1	4	4.12	1.034	1.069	43.40	.596	.846
RS-2	4	4.03	.881	.776	43.48	.477	.854
RS-3	4	4.13	1.056	1.116	43.38	.590	.847
RS-4	4	4.02	.901	.812	43.50	.409	.858
RS-5	4	4.08	1.006	1.011	43.43	.579	.848
RS-6	4	4.01	.984	.967	43.50	.401	.859
RS-7	4	3.97	.862	.743	43.55	.411	.858
RS-8	4	3.78	.986	.973	43.73	.594	.847
RS-9	4	3.72	1.046	1.093	43.79	.595	.846
RS-10	4	3.74	1.019	1.039	43.77	.581	.848
RS-11	4	4.22	.993	.986	43.30	.627	.844
RS-12	4	3.71	1.066	1.136	43.81	.586	.847

Results and Discussion

The social resilience scale provides a high-indexed scoring system, with total scores ranging from 30 to 180. Interpretation of the scores allows for classification of resilience levels as follows: 160–180: Very High Social Resilience and 145–159: High Social Resilience, 130–144: Fair Social Resilience, 120–129: Low Social Resilience, Below 120: Very Low Social Resilience. While these classifications offer a useful overview of an individual's resilience, they should not be considered in isolation as risk indicators for chronic illness. A more comprehensive interpretation must also consider underlying psychosocial factors such as social inhibition, avoidance behaviors, negative emotional responses, anxiety, psychological distress, and negative affectivity. Interestingly, a high resilience score does not necessarily imply an absence of stress or chronic illness. Rather, individuals with such scores may still face significant challenges but possess coping mechanisms that enable them to navigate adversity more effectively.

Socialization plays a critical role in shaping cognitive functioning, belief systems, personality traits, and attitudes all of which influence social resilience. Various psychosocial factors, including emotional isolation, negative affect, perceived stress intensity, occupational distress, fear of failure, and social withdrawal, interact dynamically with an individual's resilience level. Social resilience is best understood as an adaptive capacity the ability to rebound from adversity and regain psychological well-being. Resilient individuals do not allow setbacks to define them; instead, they demonstrate optimism, emotional regulation, perseverance, and a growth-oriented mindset. These individuals often view failure not as defeat but as constructive feedback for personal development. The scale indirectly reflects key components of resilience, such as: i. the ability to make realistic plans and take action. ii. Confidence in one’s strengths and competencies. iii. Effective communication and problem-solving skills. iv. The capacity to regulate strong emotions and impulses. These qualities help mitigate the tendency toward emotional suppression and avoidance during social interactions, which is often observed in individuals with lower resilience. As such, the social resilience scale can serve as a meaningful tool for identifying both strengths and vulnerabilities in individuals coping with chronic and primary health conditions.

Conclusion

With the global rise in cases of rheumatoid arthritis, hypertension and age-related problems, it has become increasingly important to adopt psychological approaches that help identify individuals who may be more psychologically vulnerable to the impact of these chronic conditions. Contemporary behavioral research has shifted in focus from examining only the pathological aspects of mental health (such as psychological, behavioral, social, and psychiatric disorders) to investigating the protective characteristics that enable individuals to maintain well-being in the face of adversity. Rather than viewing individuals as passive recipients of stress, the research now emphasizes the adaptive qualities that protect against mental maladjustment during challenging life experiences (Patterson, 2002). It is recognized that not all individuals develop psychological disorders in response to distressing or chronic life situations (Rak & Patterson, 1996). This variability is often attributed not to rigid psychological defenses, but to the capacity for flexible adaptation in the face of stress a trait commonly referred to as resilience.

Therefore, the development and application of the social resilience scale provides a valuable tool in understanding and identifying these adaptive qualities, particularly among aging populations coping with chronic illnesses. It supports a strength-based perspective, highlighting the role of protective factors such as emotional regulation, optimism, and effective social functioning in promoting psychological well-being despite age health-related challenges.

In this context, the need for efficient and reliable methods to assess psychosocial risk factors is critical particularly in the development of digital care platforms, raising awareness, and enhancing

primary and preventive health services. Tools such as standardized questionnaires and single-item screening questions have proven to be both time-efficient and psychometrically reliable, making them practical for routine use in both general and clinical settings.

The social resilience scale, alongside established tools like the Resilience Scale (RS-25), offers a valid means to assess an individual's level of resilience across a continuum from strongly disagree to strongly agree. As demonstrated in the current study, the adaptation of the social resilience scale yielded high construct validity and reliability, it as a quick, reliable, and minimally burdensome instrument suitable for diverse healthcare contexts. Importantly, this research is set against the backdrop of what may be considered a new global epidemic a growing mental health crisis, age related problems disproportionately affecting different countries, where resources, modern technologies and preparedness are often limited. The compounded challenges posed by aging populations, neurological and behavioral health conditions, and escalating psychosocial stressors are expected to result in increased demand for long-term care and associated societal costs.

As such, there is an urgent need to prioritize effective prevention strategies through a multifactorial, life course approach. This involves focusing on at-risk groups such as care consumers, older individuals, family caregivers, and individuals facing identity and psychological vulnerabilities. Investment in accessible services, community-based support systems, and early screening tools like the social resilience scale will be essential to delay disease onset, reduce care burden, and promote healthier aging.

Ultimately, interdisciplinary research, policy reform, and the active participation of society are indispensable in addressing this emerging crisis and building a foundation for more resilient populations in the years to come.

Recommendations for a National/International Strategy

The scientific community plays an essential role in addressing the complex challenges posed by population aging and the increasing number of individuals affected by chronic illnesses, psychosocial stressors, and neurodegenerative conditions. The implications of societal aging extend across economic development, labor markets, retirement systems, family dynamics, healthcare infrastructure, and the growing demand for disease-related care and social support. A coordinated national strategy is needed to respond effectively to these challenges. This strategy must involve state institutions, healthcare managers, policymakers, and the general public. Through targeted investment in research, education, and care infrastructure, we can improve the quality of life for older adults and enhance public health outcomes. Below are key recommendations:

1. **Promote Public Awareness, Education, and Family Support:** Expand national campaigns to educate the public on aging-related diseases, especially dementia, in alignment with global calls from WHO and Alzheimer's Disease International (ADI). This includes providing informational resources, caregiver support programs, and community-based initiatives that reduce stigma and promote social inclusion.

2. **Strengthen Research Across All Domains**: Invest in multidisciplinary research focusing on biomedical factors, risk factors, quality of life, and service development. Advancements in neuropsychological testing, genetics, neuroimaging, and biomarker technologies will enable earlier diagnosis, more effective interventions, and long-term care planning.

3. **Expand Specialist Availability in Primary Health Settings**: Integrate multidisciplinary geriatric care teams into primary care, including professionals from mental health centers, rehabilitation

units, and day care centers. Training healthcare workers in gerontology and chronic disease management is crucial, as is supporting the development of community and home-care programs tailored to older adults' needs.

4. **Implement Good Clinical Practice (GCP) Guidelines for Chronic Disease Management**: Adopt evidence-based GCP guidelines that incorporate community outreach components, focusing on early detection, patient education, and self-management of non-communicable diseases (NCDs). These guidelines should be adaptable to the diverse needs of local populations.

5. **Prioritize Prevention and Early Diagnosis**: Shift the national healthcare focus toward preventive care and early screening, particularly for conditions that impair resilience and quality of life in older adults. Promote routine psychosocial assessments and the use of standardized screening tools (such as the Health Social Resilience Scale) to identify at-risk individuals early in the disease trajectory.

These recommendations aim to create a proactive and sustainable framework for managing the challenges of aging and chronic disease. Through integrated efforts in research, education, service provision, and policy development, nations can better support their aging populations and foster resilient, inclusive communities. We concluded that, the social resilience scale offers a valid and reliable measure for assessing resilience in older adults with chronic conditions. It underscores the importance of psychological and social factors in health outcomes and provides a foundation for future interventions and support programs targeting this vulnerable population.

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Resilience Scale

Listed below are a series of statement that represent possible feelings that individuals might have about him/her & his/her surrounding? Please indicate the degree of your agreement or disagreement with each statement in the bracket ( ) provided against each statement.

Strongly Disagree (SD) Disagree (D) Neutral (N) Agree (A) Strongly Agree (SA)

Items	SD	D	N	A	SA
I can easily manage all of life's problems.					
I consistently adhere to my plan, ensuring that I stay on track to achieve my goals.					
Managing all financial issues can be quite challenging.					
I am resilient in the face of challenges and navigate tough times with confidence and strength.					
I have more faith in my own abilities than in those of others.					
I navigating challenging family situations can be incredibly tough, but it's essential to confront these issues head-on for the sake of personal growth and harmony.					
I can easily handle all the challenges in my life.					
I refuse to let failure discourage me; instead, I see it as an opportunity for growth and resilience.					
Social reactions are not significant to me.					
I can successfully eliminate all obstacles in my life.					
I embrace all changes and challenges, viewing difficult times as opportunities for growth.					

I possess the energy and resilience to tackle any challenge that comes my way.					
I am capable of solving all problems on my own.					
I refuse to accept hopelessness.					
In challenging times, it's essential to trust in your own strength rather than depending on others.					
All changes can be easily adopted.					
I am confident that I can easily address all social issues.					
I often find it quite challenging to stay engaged with social plans.					
I can manage both acute and chronic illnesses effectively.					
I can firmly handle many social activities and things at a time.					
I cultivate a resilient mindset, embracing positivity and prioritizing my primary health as I navigate through any adversity.					
I respond to all situations in my life in a very controlled manner.					
I find it challenging to manage social and emotional situations concerning my family matters.					
It took a significant amount of time to recover from both acute and chronic illnesses as well as stressful events.					
I find it challenging to bounce back after experiencing any setback.					