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Experiences of Resiliency and Family Support in Older Women With Mental Illness

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Walden University
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Abstract

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MA, Webster University, 2009

BA, Anderson University, 2007

Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Psychology

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Abstract

Lack of a support system for older females with mental illness may cause reduced resiliency skills and an increase in mental illness symptoms while they attempt to manage independent living. The purpose of this qualitative study was to explore the individual stories of older women living independently who suffer from a mental illness and have a support system. Social learning theory and self-efficacy theory provided the framework for the study. Data were collected from face-to-face interviews with 8 women ages 65-80 years who are in treatment at a mental health center in South Carolina. Findings from coding analysis showed that having a family member providing support inside or outside the home gave older females with a mental illness a more positive outlook and enabled them to have good hygiene, clean clothing, something to believe in, and someone to look forward to seeing on a regular basis. The findings may serve professionals striving to gain knowledge of how mental illness impacts the daily functioning of older females while also suggesting that there is a relationship between family support and resiliency.

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Dedication

First, I would like to thank my committee members: Dr. Elizabeth Weinbaum, Dr. Leslie Barnes-Young, and Dr. Jonathan Cabiria. This team was instrumental in helping me get to the finish line resulting in a dissertation that I am very proud of. Thank you to my past chairs: Dr. Susan Randers who died during my first 2 years in the program, Dr. Diane Blyler, Dr. Donna Mayer, and Patricia Metoyer who for reasons beyond my control had to leave me and move on to other projects. I thank you for your contributions and encouragement that this can be done. Thank you to Dr. Ivan Elder, my supervisor during my internship at Bryan Psychiatric Hospital and Morris Village Drug and Alcohol Treatment Hospital. I am forever in your debt and you will always be a part of my life. Thank you to my IRB committee, Dr. Monica McConnell, and Dr. Patricia Handley, for all your help ensuring my study was safe and the well-being of the participants were addressed, and for your enthusiasm for my topic and helping me lock in my site. Thank you to Dr. Al Edwards for allowing me to conduct my interviews at the mental health center. To April Simpson for overseeing the study and to Courtney Hudson for all her efforts to find participants and assist with coordination of interviews. Thank you to my brother, Dr. Douglas Masini at Armstrong State, who tirelessly edited and made suggestions while also continuously reminding me why I started this in the first place. He always addressed me as if he were a committee member himself and gave me the speech that time will pass either way: "You can be accomplishing something or not, either way time will pass. It is your choice." To my computer savvy brother, David Masini, who was always available for 911 emergency technical assistance that I consistently had to deal with while trying to get this project completed. To my daughter and best friend, Kathleen Harbin Black, who always reminded me that you have to take

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Chapter 1: Introduction to the Study

Resiliency is specific to an individual and is based on that individual's personal experiences including how they interpret seeing other older adults managing their life and stressors. Resilience was defined by Masten (2014) as "the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability development" (p. 6). Resilience is also combined with the effort to be more positive while experiencing difficult life events while aging (Alex & Lundman, 2011). Some older adults may define their specific qualities of resiliency differently than other older adults. Resilience is also assessed in accord with the individual's lifestyle and their learned ability to manage their daily living especially when those individuals try to take care of themselves and are more able to adapt (Masten, 2014). As family members age, resiliency can become a major factor in their ability to maintain independence. This study focused on the lived experiences of older adult females who have a diagnosis of a mental illness and live independently in the community.

A person who wishes to continue living independently may need extra help from outside the home. According to Qualls (2016), families provide more than 75% of all long-term care provided to older adults. A strong family member who elicits a positive attitude and is willing to become a caregiver could make the difference in whether the older person continues to live independently. To assess the needs of the person living independently, the caregiver begins a needs analysis, which begins with how the older person views their abilities and needs. Caring for loved ones and ensuring they have what they need to live can be as basic as food, electricity, and medications. Conducting a needs

analysis may reveal a deficiency that can be rectified with a family member offering to step in and provide basic assistance to the older person (Qualls, 2016).

Family support is defined as an "individual family member or members who volunteer as a continuation of the health care system, and who out of love and caring will oversee their loved one's daily routine" (Public Interest Directorate Reports, 2014, p. 1). Family support is an important aspect of an older person's life; as they age, an older person living independently without this type of support could become more vulnerable and subject to greater life problems and symptoms of mental illness. According to Gaffey, Bergeman, Clark, and Wirth (2016), older adults have shown preferences for their support systems to contain individuals who are known to the older adult. Older adults suggested that they want their support to be provided by a small group of people to avoid becoming overwhelmed or suffering increased symptoms.

Many reports and estimations of how fast the older adult population will grow have surfaced. The population of older adults age 65 continues to grow at a rapid pace and is expected to reach over 72 million by 2030 (Dillip et al., 2016). Baby boomers are largely responsible for this increase in the older population as they began turning 65 in 2011 (Ortman, Velkoff, & Hogan, 2014), with the older population projected to double from 36 million in 2003 to 72 million in 2030, and to increase from 12% to 20% of the population in the same time frame. Ortman et al., (2014) projected that "by 2050, the older population numbers will be closer to 83.7 million" (p. 2) with increases continuing through 2060. Ortman et al., organized categories by age, sex, race, and other indicators of ethnic origin and included expected changes in the populations such as death

projections, births, and immigration. According to Mather, Jacobson, and Pollard (2015), the population of older adults over age 65 is estimated to more than double "from 46 million in 2015 to more than 98 million by 2060" (p. 3). Mather et al., also estimated that "between 2020 and 2030 numbers of older adults will increase by almost 18 million as the last of the large baby boom cohorts reaches age 65" (p. 3), and those 85 and older are projected to "more than triple in size from 6 million in 2015 to nearly 20 million by 2060" (p. 3). With older adults living longer, those ages 100 and older are also expected to increase in numbers to around 600,000 by 2060 (Mather et al., 2015, p. 3).

Kontis et al., (2017) published a population report stating that by the year 2030 older females will live to be 90 or more years of age. Kontis et al., stated that this increase should result in concern about assessing the ability of older adults to live independently and have appropriate health care. With older adults living longer (Gaffey et al., 2016; National Alliance for Caregiving, 2015; Qualls, 2016). The American Association for Retired Persons (2015) reported that the average age of older adults who require some level of care is now 69.4 years; this population is mostly female with 47% being over the age of 74. The Centers for Disease Control and Prevention (2011) reported that the United States has 34 million caregivers, and most are family and friends who are unpaid for their services. Qualls (2016) reported that half of older adults who received some type of support from family continue to live in their own home, with around 35% living with the caregiver.

These facts and this statistic emphasize the need for further research on this topic. Because knowledge is limited about how older adults with mental illness live

independently, this study first focused on how older adults define their resiliency and also how family support (or the lack of support) predicts the ability of these older adults to live independently. The study also addressed the effect of mental illness on the individual's capabilities and the value of family support in promoting resiliency.

Background of the Study

An older person's resiliency is an important factor to consider for those wanting to live and maintain an independent lifestyle. The U.S. Census Bureau (2012) indicated that between 2012 and 2050, the United States will experience considerable growth in its older population according to the 2012 Census. 13.7 % of the population in the United States are older adults aged 65 and up. In 2050, the population aged 65 and over is projected to be 83.7 million, almost double its estimated population of 43.1 million in 2012. (, p.1). This fact is being addressed in the United States and continues to be a concern in other areas of the world. According to Lacruz et al., (2010), resiliency was researched in Berlin and Hawaii using a literature review. This review found that the Honolulu Aging Study reported older adults who survived life to age 85 were considered to be exceptional. Reviewing literature on the Berlin Aging Study the researchers found that there was a difference in how a physician reported that older adults appeared sickly versus the older adult believing they were healthy for their age. Parslow, Lewis and Nay (2011) reported that Australian researchers also saw the importance of studying an older person's independent living and mental health in the context of their support system. The Chinese have also recognized the need to research resiliency in connection to functioning independently during aging. Lima et al., (2015) conducted a study on older adult Chinese

resilience and late life resilience as a possible buffer against depressive symptoms after a stressful life event. The researchers reported non-health stressors such as a death of a partner, conflict with another individual, loss of a pet, a partner having a serious illness, death of spouse, or financial troubles as major contributors to depressive symptoms. It was noted that late life depression can also be a contributing factor for ill health, so it is important that protective factors against late-life depression remain at the forefront of research. The current study focused on what contributes to resilience.

Masten (2014) pointed out that resilience is the idea or belief that individuals can handle or cope with the stressors that result from unplanned changes in daily life. Resiliency has been defined as "doing well despite adversity or risk" (Masten, 2011, p. 494) and "as the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development" (Masten, 2014, p. 6). Masten reported that the word *resilience* came from the Latin verb *resilire*, meaning to bounce back. Masten also reported that *resiliency* is used in many ways by researchers, including those in the ecology field, where the term is used to indicate how systems that are not human are able to adapt to unexpected changes. Masten also reported that social scientists agreed that the term resilient referred to individuals who were interested in learning how they are able to survive adversities, implement new coping skills, and move forward after an event.

A resilient person has the ability to handle situations as they arise while not letting one specific situation cause disruption in their lifestyle regardless of how difficult that may be and can put into motion their skills to overcome stressors (Van Wormer, Sudduth,

& Jackson, 2011). According to Zeng and Shen (2011), "resilience is a construct" (p. 489) that is found in literature from previous studies on resiliency that focused on older adults trying to cope while not giving up when life becomes stressful. Madewell and Ponce-Garcia (2016) agreed with Masten (2011) when they stated that "even during emerging adulthood (ages 18 to 25), resilience can be seen by evidence of cognitive flexibility, inhibition control, and executive functioning capabilities," (p. 250) including the time when mental illness may first surface.

As interest in resiliency has increased, researchers have looked at positive influences in people's lives as a source of resilience, rather than negative influences, in an effort to enhance an individual's lifestyle for better functioning and development. There are many definitions of resilience presented in the literature. Madewell and Ponce-Garcia (2016) discussed individuals being flexible and applying skills to their everyday life while not giving up when times become difficult. Some definitions are short and do not explain how resilience is supposed to work for older adults. Aburn, Gott, and Hoare (2016) conducted a literature review on the term resilience and what it means. Aburn et al., reviewed 100 articles and found that there is not one definition accepted overall, but a combination of different definitions that all connect to the same idea that many individuals who suffer a traumatic event are able to return to their lives and continue living. Aburn et al., also revealed that the term resilience is now applied to "patients, professionals, and family caregivers" (p. 981) when their abilities or lack of are being discussed.

Krause and Hayward (2015) reported that resilience has been studied as one factor in relation to the stressors of living independently. Individuals who were unable to work through their day-to-day problems were considered less resilient and in need of more support. Because change is inevitable, the older population must learn to change in order to survive and protect their ability to live independently (Cicchetti, 2010).

Older women were discovered to be happier and report fewer physical ailments when living independently, even when they have multiple health issues and normal everyday problems that involve socializing and financial issues (Weissman & Russell, 2018). Weissman and Russell (2018) reviewed data from the National Health Interview Survey from 2009-2014 that was collected for the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics on individuals who were living in a community independently in the United States. Weissman and Russell found that older adult females had reported that they were happy and in very good health living independently compared to their counterparts who had spouses or partners. Weissman and Russell also found that the older adults who opted to live with family reported that they had poor health and needed a support system to implement and promote their coping skills. Zeng and Shen (2011) reported that, even in developing countries, the older person must learn coping skills to be more resilient due to limitations they face from independent living and what is considered a support system.

The older adult may become more vulnerable after the occurrence of a health or financial issue (Seery, 2011). The individual then has to rely on what coping skills they have learned to enable them to deal with life's adversities. The higher the stress and

difficulty with independent living, the more an individual relies on these protective factors and constructs to enable them to move forward after a situation (Seery, 2011).

Cummings and Kropf (2011) noted that some older adults with mental illnesses have demonstrated that they have sufficiently high self-esteem and strong skills to maintain an independent lifestyle. Family support can be a welcome addition to independent living and can enhance the quality of living by reducing levels of stress (Johansson, Long, & Parker, 2011). Fortinsky, Tennen, and Steffens (2013) reported that resilience stems from perceived control over life, and as older adults age they may have to resort to others to assist in day-to-day functioning. This change from primary control to secondary control may become necessary and involves new strategies to avoid disrupting an independent lifestyle.

Wiles, Wild, Kerse, and Allen (2012) found attitude to be an important element of older adults living independently and that the definition of resilience had more details than just bouncing back. The presence of a support system encourages a better quality of life and a generally more positive outlook for older adults (Czaja, 2016). McMurtrie (2013) reported that a good support system allows an individual to be able to function better when there are life changes, making those changes easier to accept and manage. When discussing quality of life, it is important to understand that older adults may see how they live and their quality of life differently. It is important that those who may be caring for an older adult take into consideration how that older adult defines happiness and quality of life. This issue of categorizing all older adults as having the same issues and needing the same support was a topic that was addressed at the White House

Conference on Aging (2015). All older adults should not be categorized the same because they are different, and their personal needs are different. This fact was highlighted as an issue that will require more research because it is one of the most important issues for older adults and their families who provide support. The number of older adults with unique care-related issues is increasing, raising concerns about cost of care and the availability of qualified caregivers (White House Conference on Aging, 2015).

According to Hayman, Kerse, and Consedine (2016), quality of life may be enhanced or reduced according to the issues the older adult faces and the available resources they have at their disposal. Family support can allow for monitoring and timely reassessing of the older person's issues and resources combined with their ability to live independently. These assessments can include not only resiliency levels but also health and social connections (Hayman et al., 2016).

Based on my experience working with an older population, I began questioning why some individuals were more resilient than others and why some were able to live independently with outside support and others were not. I looked at the use of a support system inside or outside of the home and its effect on day-to-day living in older American females who have a mental illness. I used Krause and Hayward's (2015) definition of support: "recurrent patterns of interaction with other individuals" (p. 259). Krause and Hayward found that support and social relationships were used in conjunction with the individual needing some social time with another person while that same person provided some type of support. Relationships may be therapeutic to provide support, or they can be for socializing. An assessment would need to be conducted to understand

what the older person needs in terms of support before moving forward with any type of intervention. Krause & Hayward noted that relationships can be difficult and cause undue stress, so this clarity will help everyone involved in the older adult's life. Krause & Hayward also attempted to understand why some older adults with a mental illness can adjust to stressors such as illness, loneliness, aging, or other possible variables, and how this would differentiate them from others. Learning to adapt to life changes, including mental illness, or the person's ability to interpret that more help is needed may assist a caregiver in measuring the presence or absence of resiliency in those who are able to live independently. In the current study, family support was one of the questionable predictors of resiliency. If the older person did not possess resiliency, it could be due to lack of family support outside the home.

Problem Statement

This qualitative study addressed the experiences of older adult females who are living independently with a mental illness and family support. The first problem was lack of knowledge about what skills the older adult female has or uses to maintain independent living. The second problem was not knowing what the family support system does, whether this support is used as needed, and whether the older adult female depends on this assistance on a daily basis.

Lack of a support system for older females may cause reduced resiliency skills and an increase in mental illness symptoms while they attempt to manage independent living. The lack of a support system may promote difficulties in the form of health issues such as sadness and depression which can also include poor appetite, weight loss, fatigue,

sleeping problems, absence of emotion, loss of interest in daily activities and resentment (Clark et al., 2012). Isolation can also increase depressive symptoms, reduce self-esteem, and increase poor decision-making. Lack of a support system continues to be a problem (Levine, Halper, Peist, & Gould, 2010). Levine et al., (2010) reported that the current care systems available to older adults are limited. This problem was also reported in literature from non-U.S. countries (Czaja, 2016; Hayman et al., 2016; Lacruz et al., 2010; Parslow et al., 2011).

Older adults who receive care from someone other than a family member may initiate the discussion of defining who the expert is and who can make decisions of care or treatment for the older adult. This also promotes the idea that the family should be the expert in the older adult's medical and mental health needs. In cases where the mental health issues are severe, older adults may not know who is in charge of their care or what care they receive and why. Levine et al., (2010) reported that it was necessary that family members be active not only in a background supporting role but also in being at appointments. This involvement in discussing treatments and monitoring changes provides an advocate for the best possible care for the older adult, including understanding medications and how to dispense them properly. Family support is vital in ensuring family members are receiving appropriate treatment and care through monitoring by those who know them the best (Levine et al., 2010).

One in three older adults fall each year, and 20% to 30% sustain an injury that can be severe enough to result in an emergency room visit and possible early death (CDC, 2014). The CDC (2014) also reported that emergency rooms treated 2.4 million nonfatal

falls in older adults. Costs associated with independent living accidents come not only from falls but from the long-term care associated with rehabilitation (CDC, 2014). Czaja (2016) reported that 2.5 million older adults visit an emergency room each year due to falls; it is also likely that many other falls are not reported due to a lack of a support system or the older adult fearing they may lose their independence. A support system may provide needed encouragement of the ability to function independently, which may promote resiliency-related skills and heighten positive thinking. This system can encourage the older adult to want to remain in an independent living status.

The Department of Health and Human Services (2012) reported that "one in every eight, or 13.3%, of the population is an older American" (p. 1) and "about 28% (11.8 million) of noninstitutionalized older adults live alone (8.4 million women, 3.5 million men)" (p. 1). The Department of Health and Human Services also reported that "in 2009, approximately 2.7% of the elderly lived in senior housing with at least one supportive service available" (p. 5). This supportive individual could be a grandchild or another individual who assists them, reinforcing the fact that support is very important to sustain an independent lifestyle for older women.

Masten (2014) reported that resilience is always changing in people. There may be a decline with age or with other systems the individual comes into contact with that may cause a reduction in the ability to function in their daily living. According to Landeweer, Molewijk, Hem, and Pederson's (2017) study on older adults who have an onset of mental illness earlier in life, these older adults become more reliant on family members as they age. I attempted not only to fill the gap in the literature on support in the

home but also to clarify issues related to observed resiliency skills of older persons. A support system may reduce the impact of life changes and provide socialization and comfort for those living alone. The problem addressed in the current study was older adult females who have no support system may experience reduced observable resiliency skills and a possible increase in mental illness symptoms while they attempt to manage independent living.

Purpose of the Study

This qualitative study addressed resilience factors in older adult females with a mental illness who live independently. I explored whether their support system enables them to be more independent and whether this support encourages their innate skills that allow them to live independently. The goal of this research was to understand through phenomenological interviews how older adult females with a chronic mental illness manage living independently with a support system. If there was no support system reported during the interview, then I inquired about the older adult female's resiliency skills; their ability to handle situations, stressors, and problems in their life; and where their resilience comes from.

I looked at support systems inside and outside of the home of older adult females in South Carolina who are in outpatient treatment at a local mental health center and how these women manage their day-to-day living. I used a demographic survey followed by a face-to-face interview with questions to explore resiliency skills that the older adult females use in their day-to-day life and how they manage to live independently. The study focused on the lived experiences of older adult females with mental illness and how

they describe their abilities to manage day-to-day living with a support system in place. I also explored what the support system allows them to do and what they may not be able to accomplish without a support system. These interviews also allowed participants to share their experiences regarding what it takes for them to live their life each day and what support they may need to do this.

Initially, I planned to use the Folstein Mini-Mental State Examination to assess whether the participant could understand the nature of the study and what their role would be if they chose to take part in the study. By signing the consent form, the indicating they understood what they agreed to participate in. However, after consultation with colleagues at the host center, the Folstein Mini-Mental State Examination (Folstein, Folstein, & McHugh, 1975) was changed to the St. Louis University Mental Status Examination (SLUMS, 2006), as suggested by the South Carolina Department of Mental Health Institutional Review Board (IRB) due to the scoring being based on the participants education level (high school education or less than high school) versus their age. The SLUMS would increase retention of participants and provide a more equitable analysis regarding observable resiliency skills. The SLUMS was administered to each participant to provide information about the cognition of the participants and their ability to provide informed consent to participate in the study. There were no participants who did not meet the selection criteria, and none were excused from the study.

Research Questions

This study focused on the lived experiences of older adult females who live independently with a mental illness and participate in treatment at a South Carolina

mental health center. This research has one main question and two subordinate questions. The overarching question for this study was the following: What does family support do for the participant and does that support comes from someone living inside or outside the home? The subordinate questions that were explored were the following:

1. What does family support mean to older female adults who have chronic mental health issues and receive outpatient care in their local communities?
2. What resilience skills are used by older adult females to be able to remain in independent living?

Theoretical Framework for the Study

Several theories are important to consider when researching resiliency in older females. The methodology of this study was qualitative. The study was designed to address whether family support inside or outside the home encourages or promotes resilience for older females who live independently and who are in mental illness treatment. The theories of social learning, self-efficacy (Bandura, 1991), and resilience (Holling, 1973) provided the framework for this research because they helped me explain what was involved in having resiliency. Information gleaned from the theories also supported older adult females returning to normalcy after some type of event and living their life independently while having the inner motivation to want to return to life as it was prior to the event. Motivation and self-regulation also important parts of the theories supporting this study and also play a role in older adults' decisions to remain as independent as possible in the place of their choosing. This decision also encompasses

the skills to monitor an individual's personal progress combined with a positive mindset and feeling responsible for one's lifestyle.

The theoretical basis for this study was social learning theory as proposed by Bandura (2001). Bandura's (2001) theory states that individuals need to self-regulate their behaviors to deal with the demands of life. Social learning theory was also used to show that older persons have the capability to be "self-reactors with a capacity for self-direction" (Bandura, 2001, p. 3). I assumed, according to Bandura (2001), that people have the ability to self-regulate not only when an event prompts this regulation. Bandura (2001) explained that motivation is the use of setting personal goals followed by the use of "available resources, skills, and effort to fulfill them" (p. 3). The older person uses self-regulation to monitor progress of the goals. Self-regulation requires the individual to be motivated, and this motivation must come from within the self. Bandura (2001) stated this motivation is a key component in an individual being self-driven to attain goals. Older adults may perceive their inner strength and abilities to achieve these specific goals as differing from other older adults (Bandura, 1991). As goals are met, older adults increase their motivation, and this develops into self-efficacy, which is an individual's belief in their ability to accomplish their life goals such as living independently. People are confronted with situations that necessitate decisions, and older persons are no different. Individuals learn from direct experiences, according to Bandura (1977), and the observation of others. This reinforcement allows individuals to select the behaviors they like and discard the others. Bandura (1977) explained that social learning theory reinforcement not only promotes new behaviors but also incorporates strengthening those

new behaviors for use on a daily basis. This is further explained by understanding that people have learned capabilities; older adults learn that they have limits and, by observing others, they see that they need to add more skills and expand these capabilities to remain independent. Bandura (1977) noted that "behavior, other personal factors, and environmental factors all operate as interlocking determinates of each other" (p. 10). Learning which one of these determinates is more powerful is the key to initiate changes in behavior. An older adult living in an apartment that requires a lot of work to keep clean compares themselves to a friend who has less to maintain and seems happy. This experience may influence older adults to start thinking their apartment may be too large and they may also be happy living in a smaller, more manageable apartment. Social learning reinforces self-regulation as older adults make decisions on their behalf that reinforce self-efficacy and a positive attitude. Bandura (1991) also noted that "most theories of self-regulation focus on negativity whereas he feels people are proactive and aspiring organisms" (p. 250).

The second theory that supported this study was resilience as proposed by Holling (1973). Holling's theory states that having resilience means that the environment flourishes by using what it has to replenish and maintain itself during problems/irritations on a day-to-day basis. Holling related the ability or skills of an environmental system to humans. Holling explained that when the system (or life stressors) attempt to drain resources and the ability to survive, that system maintains its original structure and function by not allowing the stressors to cause a collapse or an increase in symptoms. Holling noted that humans survive in this world by having learned resilience skills in

place when they are needed allows individuals to continue living as best as they can; in that way, humans can accept and deal with stressors without losing control of their situation. Also, those who can use these learned skills are understood to be more capable of managing and anticipating life changes and accommodating those changes without increasing problems. Gunderson and Holling (2002) looked at resilience and adaptive cycles and noted that when an event occurs, learned skills are implemented to manage and adapt to that event. Humans do not always know when an event may occur, so they have to build their skill set and be ready to adjust as needed (Gunderson & Holling, 2002). This adjustment will return them to their equilibrium or balanced state. Different outcomes may occur when individuals are not ready for an event and are left with situations they cannot alter, which may make them more vulnerable (Seery, 2011).

The two theories provided a foundation for the study. Social learning theory as proposed by Bandura (1991) provides the idea that observing others promotes individuals to adjust their behaviors and may promote interest in changing their lives to live more independently. Resilience, according to Holling (1973), was the second theory used to frame the research questions. When the environment changes for older adult females, their learned skills enable them to get back on track and not allow these situations to disrupt life for the long term. More detailed explanation of these theories and how they supported this study is found in Chapter 2. The two theories were selected to support and answer the research questions addressing what family support means to older female adults who live independently with a mental illness, and what the older adult gains by

having family support. These questions combined with what support is provided by the family and how this support promotes independent living were the basis of this research.

Nature of the Study

The nature of this study was qualitative. I used a phenomenological design to explore the lived experiences of older females ages 65 to 80 who live independently, have a mental illness, and receive support from family members or other sources. Taylor, Bogdan, and DeVault (2016) noted that qualitative researchers should approach their study with understanding and sensitivity to how their subjects view their world. The current study began with participants signing consent forms to show understanding of what they were going to participate in, to consent to participate, to consent to audio recording for accuracy of the interview, and to consent to completing a demographic questionnaire and the SLUMS. The consent to participate also included three questions that ensured the participant understood what the study was about, how the researcher would keep their information confidential, and how they would meet the criteria to participate. The consent forms also included a statement that there was no monetary compensation but that they were contributing to the research by sharing their personal stories as they experienced life on a day-to-day basis as an older adult female with a mental illness and family support. The consent form was followed by the SLUMS and a face-to-face interview including open-ended questions. The interview provided an opportunity for the female participants to share how they viewed their world and their needs or day-to-day problems. Phenomenological interviews were used to explore the lived reality of the participants. Confidentiality and consent for participation were

explained and documented before I began any interaction with participants. I gained approval from the institutional review board (IRB) committees through Walden University, as well as the local mental health center where I was employed prior to beginning the study. The interview process was completed in approximately 60 minutes for each participant. The interviews were recorded for validation and reviewed by the participant to confirm their answers were accurate (also known as member checking). The recordings were then transcribed to compare the Dragon® recording to the digital recorder. The specific themes that emerged were categorized as the most often repeated theme and then by how often the other themes were repeated.

I used interview questions that prompted the individuals to share experiences; their responses were then categorized into themes and compared. The interview questions are included in Appendix A. The phenomenological design combined with the qualitative data collection was the most effective method for gathering information and reporting the participants' lived experiences. I focused on the experiences of older female adults to understand and record their common themes. The data for this study derived from the older adult females who agreed to take part in this study, and the responses were coded by hand to identify categories and then analyzed to find themes. I found relevant information about older females' meaning of life, resiliency skills with a mental illness, and ability to manage independently from their point of view, referred to as phenomenology (see Manen, 2014).

Definition of Terms

Age stigma: "An attribute that is deeply discrediting, with three categories of stigma: abominations of the body (physical deformities), blemishes of individual character (mental disorders/dementia), and tribal stigma (group membership)" (Chasteen & Carey, 2015, p. 100).

Appraisal: The method that an individual uses to measure another individual's lifestyle, chance of becoming involved in some type of harm, safety, attitude, and skill level to live independently (Lazarus, 1990).

Coping: The use of cognitive and behavioral strategies to manage the demands of a situation when these are appraised as taxing or exceeding one's resources or to reduce the negative emotion and conflict caused by such demands (APA, 2016).

Cost of living alone: "Local cost of living is captured by a new measure of cost of living, the Elder Economic Security Standard Index, which summarizes the expenses associated with living independently, albeit at a modest standard of living, for older adults" (Mutchler, Lyu, Xu, & Burr, 2017, p. 2498).

Family: A group or unit of individuals who are related by blood, marriage, or other situations that cause them to be referred to as a family member (VandenBos, 2007, p. 366).

Family support: A unit of individuals or several family members who assist through volunteering to continue health care as needed for a family member (Public Interest Directorate Reports, 2014).

Independent living: The ability of an individual to perform without assistance from others all or most of the daily functions typically required to be self-sufficient, including those tasks essential to personal care and to maintaining a home or job (APA, 2016).

Living alone: "A single older adult was the householder of a one-person household" (Mutchler et al., 2017, p. 2499).

Mental illness/mental disorder: "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above" (Diagnostic and Statistical Manual of Mental Disorders, 2013, p. 20).

Phenomenology: Phenomenology is a method of abstemious reflection on the basic structures of the lived experience of human existence (Manen, 2014, p. 26).

Resilience: The ability of an individual to adapt to stressful events and regain positive adaptation of life despite an adverse event or events (Hermann et al., 2011).

Stress relationship: A relationship in which the demands of that relationship exceed a person's ability to participate as an active member of that relationship (Lazarus, 1990).

Support: An individual or a group of individuals who supply assistance to an older adult as needed. This assistance can be in the form of administering medications, assistance in educating about mental illness, assisting with a physical illness or disability, or obtaining other support services for older adults (Cummings & Kropf, 2011).

Assumptions

The following assumptions framed this study. I assumed that all participants recruited through the mental health center staff would be open, honest, and forthcoming in responding to the interview questions. I also assumed that the participants would feel comfortable to share positive and negative experiences of managing life independently, self-regulating behaviors, and making changes while facing stigma and discrimination. I assumed that the face-to-face phenomenological interviews would provide new information about how older adult females use newly learned skills, where they learned these specific skills, and how they put them to use during a transaction or event. I also assumed that the participants would share strengths and how they see themselves and their abilities during disruptions in day-to-day living and whether this strength was due to family support. With a large population of older persons living longer, there needs to be greater awareness about their specific abilities to live independently with or without support. These assumptions were based on the supporting theoretical frameworks that

were chosen to explore how the older adult female learns, implements, and manages her life living independently with family support.

Scope and Delimitations

The population used in this study was limited to older adult females who live independently, who are ages 65 to 80 years, who have some type of support system in place, and who are being treated for a mental illness. Males were not included in this study because I had a higher number of older adult females as clients while working at the mental health clinic and wanted to focus on this population. The theories of social learning, self-efficacy, and resilience provided the background to understand how an older female may view herself, her world, where she learns skills, and how she reports her personal resilient abilities. The experiences shared by these older adult females' stories revealed what it takes for this population to incorporate their learned skills into managing day-to-day independence. This information, combined with new knowledge (talents, thoughts, or ideas), may be used to problem solve with the older adult female, professionals, and family members. Quantitative and mixed methods were considered but rejected because they would not permit an in-depth examination of the specific experiences and opinions of the participants. A more detailed discussion of the study's methodology is found in Chapter 3.

The interview questions that were used in this study were structured for this particular group of older female adults who have a mental illness and live independently. Questions focused on their lived experiences and the nature of their coping skills. Older adult females and males who live independently may rely on specific support systems to

fulfill needs such as picking up prescriptions or going to doctor appointments, mental health appointments, church, or other social functions. A new study, structured using the same, criteria from this study but changing the population to older adult males, may allow for transferability.

Limitations

The study focused on older females who live in South Carolina and did not include males or any other adults inside or outside this state. Findings may change if the population was expanded to include other groups or ages. If expanded to include males, this might change the outcomes because a male's perception or experience with a support system may be different than a female's (Chatters, Taylor, Woodward, & Nicklett, 2015). Another limitation was the use of purposeful sampling versus random sampling, which limited participants to those who are in mental health treatment. In this study, purposeful sampling was used. Although I used a limited number of participants, the results may be applied to other older females who met the same criteria (65 to 80 years of age, have a mental illness, have family support, and live independently). Findings may not be generalizable to a younger female population. Another limitation was asking participants to discuss their current lifestyle rather than how they lived in the past and what skills they used in years past to manage. I also limited participation to women who have some type of support from inside or outside the home. I included older women who suffer from a mental illness and who receive care in their homes to discover whether support in the home enhances resiliency or results in no changes in their current lifestyle.

To address bias at the start of participant selection, I made clear to staff at the mental health facility that there could not be any previous relationships with me for a client to be considered a participant. I was mindful not to use participants I had a previous relationship with either in therapy or clients I knew while I was a supervisor in senior adult services. I followed all criteria to avoid "study design bias, selection participant bias, data collection bias and how themes are drawn from the data" (Smith & Noble, 2014, p. 3). Bias in a study design could include using questions that lead a participant to answer in the manner that supports the researcher's beliefs. Questions were designed in a manner that allowed the participants to understand what was being asked and to provide accurate answers about the topic (see Podasoff, MacKenzie, & Podasoff, 2012). In selecting participants, I explained the criteria, which included age, having family support, receiving treatment at the mental health center, living independently, and having had no relationship with me. Questions were asked from the interview protocol (Appendix A) in the same manner and tone for each participant, not using any type of emphasis on words to influence the response. Changing the tone could have suggested to the participant that I wanted certain answers and not the truth, which may be considered a bias. Also, I did not ask any yes or no questions to allow the participant to share her story as she lived it and not as I assumed it was lived. I used the Dragon® recording system and a digital recorder to record interviews to ensure accurate transcripts when identifying themes from participants' stories (see Smith & Noble, 2014). If bias surfaced, I addressed it immediately with the staff that oversaw the study; if needed, I discussed it with the office of patient affairs who oversaw protection of the participants (see Smith & Noble,

2014). I understood that there is some type of bias in every research project, but I did my best to minimize it and document it to continue being aware of it.

de Casterlé et al., (2011) discussed researching lived experiences and that these lived experiences (as explained in the words of the participants) are how participants perceive their personal lives and events. The intent of using a qualitative research method was to compare stories looking for commonalities in the specific population. When discussing research methods for use with older adults, Jeste et al., (2013) stated that there is limited information on older persons suffering chronic mental illnesses and their service needs. I attempted not only to fill the gap in the literature on support in the home but also to clarify issues related to resiliency of older persons. The limited amount of literature on this topic was one reason for this study in addition to the exploration of the participants' views on resiliency. With the numbers of older adult females continuing to rise, the population of available older adult females with a mental illness available for future studies may outnumber the eight participants in this study. This small number can only be a starting point for research in this area.

Significance

The significance of this study included understanding the barriers the older adult female faces and what it may take to reduce those barriers. It was important to understand how older females think and how they perceive their life (see Bandura, 2001). Everyone ages, so if these barriers are identified and solutions put in place, other aging adults may have the opportunity to deal with these barriers earlier and suffer less impact. Barriers include acceptance of a mental illness (Mizock, Russinova, & Millner, 2014) and

acceptance of other challenges such as aging, loneliness, mental illness symptoms, isolation, treatment, previous maltreatment, and support issues (Rodin & Stewart, 2012) as well as limited income and lack of transportation. Then there are the physical problems such as difficulty walking, resulting in having to learn how to use a walker or cane for overall stability. Other physical barriers may include shakiness or trouble breathing. Difficult walking increases the possibility of falls and the cost of treatment. The mental illness could be considered a barrier in that the older female may not trust doctors or professionals to treat them. The physician may not have a good understanding of mental illnesses and may not treat the older female with understanding and compassion. This may cause another barrier that must be addressed. The cost of physical injury treatments and lack of a support system in place to address these barriers could cause a community to have to absorb the costs resulting in increased costs for everyone else. Older adults may feel like giving up on life, family, and overall living when life becomes difficult.

The results of this study may help older adult females with a mental illness and the professionals who deal with them by providing information about how older adult females perceive their support systems and their abilities to live independently with a chronic mental illness. The study findings may reveal issues or talents the older adult female may have that were not previously known. Learning more about these issues or talents may help the support system and the professional to find solutions for each issue, which may promote resiliency. Older adult females may have computer talents, storytelling skills, craft skills, or some other skill that may be educational in the community. The implementation of talents may provide positive feelings of worth in the

community, may increase socialization and self-esteem, and may inform women that they have something to give back no matter how simple they may believe their skills are. Having this knowledge may contribute to a smoother transition in the community and may enable women to make decisions earlier that may promote an older adult to continue to live in their own home independently, with a mental illness, and continue to be involved in a social lifestyle. No hidden issues or talents were uncovered or brought to my attention.

Matthews (2012) suggested that a good support system may increase an older adult's self-esteem by increasing their confidence that they can change their life, adjust to barriers, and not add to the community debt due to limited income and insurance. Open discussions with family, the older female, and the practitioner may enable practitioners treating these older females to learn more about their lives and what they want, enabling possible changes in practice and policies to serve this population better. The implications of this study to social change may also be seen in less money and time being used in emergency room visits that may be avoided by using the support system for assistance, more involvement in the community and church resulting in more knowledge and skills to educate others, and more positive feeling of their believed abilities and accomplishments, which will also provide a better lifestyle. Further, this study supports the idea that those with family support have the increased feeling of a loved one caring for them and the hope is this will add to the older adult females' interest in maintaining an independent lifestyle. This study's outcomes may show that having a family member providing support or some type of support outside the home gives the older female a

more positive outlook, something in which to believe, and someone to look forward to on a regular basis. This study also impacts social change by adding to the body of limited knowledge regarding not only older adult females but also how they see themselves managing independent life on a day-to-day basis with or without a support system combined with a mental illness and other medical comorbidities.

Working with older persons has shown me that, as this population ages, their physical and mental issues can become more difficult to handle. The result may be the older person is no longer able to see a purpose to their life. They may begin to feel alone, and the decisions made are not positive to their existence. Older people may make the unconscious decision to give up. Support or something to believe in may change this (Kasen, Wickramarantne, Gameroff, and & Weissman, 2012). Locating, educating, and using solutions/coping skills to improve specific issues can enable older persons to deal with their problems and not turn day-to-day problems into disabling situations. The findings may provide an opportunity for education and social change while being a catalyst for future research.

Summary and Transition

With a large population of older persons living longer, there is a need for these people to be aware of their abilities (or inabilities) to live independently with an outside support system or in a situation with support inside the home. This study showed that a lack of support for older females caused reduced resiliency and an increase in mental illness symptoms while managing independent living. Older adults are living longer and when possible prefer to live independently in their own homes (Ganong et al., 2013).

Some examples of barriers were discussed, including how those barriers are reduced by having a good support system in place. Removing the barriers and encouraging independent living enhances older adults' belief in themselves, builds coping skills, and reinforces dignity in the elderly. Also, sharing the knowledge learned about older adult females from this study may enable family members and practitioners who treat them to understand more about how they see themselves, their abilities or coping skills, and what support may be needed to live on their own.

Literature was reviewed on the aging population, including statistics from the U.S. Census Bureau and resiliency on older adults in other countries. Resiliency, along with aging, adaptability, income, coping skills, and the acceptance or nonacceptance of a mental illness, are factors that affect this population. Additional factors uncovered were the presence of a support system, the ability to live independently, and presence or lack of resiliency.

This study began with a demographic survey followed by an interview using questions that focused on the problem statement and provided a direction to explore the participants' lived experiences. The Folstein Mini-Mental State Examination (Folstein et al., 1975) was changed to the SLUMS (2006) developed by the South Carolina Department of Mental Health IRB due to the scoring being based on the participants' education level (high school education or less than high school) rather than their age. The SLUMS was administered to each participant to provide information about their cognition and their ability to provide informed consent to participate in the study. There were no participants who did not meet the criteria to participant, and none were excused

from the study. The interview provided an opportunity for each female participant to share her view of everyday life, how she sees herself, how she observes other older adult females and their skills in facing day-to-day problems. Phenomenological interviews addressed the lived experiences of the participants. Confidentiality was explained at the start of the study and documented before any data collection began. Bias in this study was addressed and was monitored throughout the study. I gained approval from the IRB committees through Walden University on July 11, 2019, as well as the South Carolina local mental health center (SCDMH) #IRB 2019-6-21 prior to beginning the study. The interview process was completed in 30-40 minutes for each participant. The interviews were recorded for validation, hand transcribed, and checked for accuracy. The themes that emerged were categorized and organized by three main themes.

This research focused on the lived experiences of older adult females who live independently with a mental illness and participate in treatment at a mental health center. This study had one main research question and two subordinate questions. The overarching question this study addressed was the following: What does family support do for the participant and does that support comes from someone living inside or outside the home? The subordinate questions that were explored were the following:

1. What does family support mean to older female adults who have chronic mental health issues and receive outpatient care in their local communities?
2. What resilience skills are used by older adult females to be able to remain in independent living?

The literature review in Chapter 2 includes topics of resilience (i.e., defining the concept of resiliency, influences on resiliency among adult populations, psychobiological factors, positive attitudes and emotions, family and community, population aging, studies of resiliency among older adults, levels and perceptions of resilience among older adults, response to stressors, influences on resiliency among older adults, multifactor influences on resiliency, cognition and memory, state of mind and coping abilities, relationships to family and community, independence and dignity, and mental illness and resiliency) based on peer-reviewed articles.

Chapter 2: Literature Review

Chapter 2 includes a discussion of the relevant research pertaining to resiliency, older adult females, and their support systems. This review of research, including the outcomes of interview and survey research as well as the conclusions of systematic literature reviews, provides a background for the current study on what is needed to help older adult females to live independently with support from inside or outside the home.

First, the initial problem is restated, then the theories that back up the research are explored in more detail, including how they are associated with the overall research. The review begins with a discussion of early studies about resiliency that focused mainly on children, as these provide a historical foundation for later studies about resiliency among adults in general and among older adults in particular. Questions such as whether children who suffer some type of trauma or adversity become older adults with symptoms of mental illness and/or lower resiliency are also explored. Varying definitions of resiliency found in the literature are then examined, followed by a discussion of literature on the main influences on resiliency among adult populations in general along with an understanding of what older females believe about themselves. The theories of self-efficacy (Bandura, 1991) and changes in life (mental illness, income, loss of spouse, injuries) provide a backdrop for discovery of resilience skills that allow the older adult female to maintain an independent lifestyle (Gunderson & Holling, 2002; Holling, 1973).

Along with the increasing numbers of older adults living longer, there has also been an increase in issues involving aging (Cohen, Kampel, & Verloo, 2016). For older adults to live independently, these issues must be addressed, and solutions must be found

to ensure that the older adult lives in a safe environment. Cohen et al., (2016) found that older adults prefer to age in their homes rather than other arrangements, and that researchers should be putting more effort into learning, including studies on how these older adults age, tools they need to be successful, where they prefer to live and be involved (communities, church, families), and what this involvement does for how they see and feel about themselves. The remainder of the literature review addresses research that was conducted on resiliency among older adults, including information about the various factors that influence resiliency in this population, followed by an overview of the literature relating to mental health and resiliency among older adults.

Research Strategy

This research began by researching literature in 2010 via the Walden University Library; the Greenville Hospital System Medical Library, Greenville, South Carolina.; Anderson University Library, Anderson, South Carolina; University of South Carolina Library, Columbia, South Carolina; and the Academic Search Premier Databases using the following key words: *resilient*, *resiliency*, *older adults with mental illness*, *resiliency with older adults and mental illness*, *independent living*, *older adults*, *mental illness*, *family support*, *support systems* and *older adults*, and *resiliency* and *older adults*. This search was expanded to ERIC, Academic Search Premier, Academic Search Elite, ProQuest, Psych ARTICLES, PsychINFO, SAGE, PubMed, and Google Scholar with assistance from Walden Library staff in researching this topic.

Overall, a fairly small number of primary research studies was found about the topic of resiliency in older populations. The search was therefore expanded with the

assistance of the listed university libraries to include relevant literature reviews and systematic reviews of previous and current studies, the conclusions of which have been incorporated into the discussions in the sections that follow. Direct contact by email or phone was also made with some of those researchers who had published research on resiliency in the past (regardless of the area) in order to seek ideas and suggestions to guide the search for relevant literature.

A phenomenological research design was implemented with the idea of finding and understanding themes and daily life management skills supplied by the participants. Manen (2014) stated “Phenomenology is more of a method of questioning than answering, realizing that insights come to us in that mode of musing, reflective questioning, and being obsessed with sources and meanings of lived meaning “ (p. 27). The research strategy resulted in many historical articles that may be considered dated. However, they actually provided the researcher with useful information and motivated the researcher to search in other areas that involved or connected to resiliency issues, including material about the effects of environmental changes as they relate to changes in life and how people may manage what they cannot control.

Studies regarding newborns, adolescents, teenagers, or adults under the age of 65, and their issues, regardless of gender, were not the focus of the searches and were not included in the review. A number of key studies on resiliency among children and on the factors influencing resiliency among adults in general, were appropriately added to the background context of this study.

Theoretical Framework

This chapter used the integration of two theories, Social Learning Theory (Bandura, 1991) and Resilience (Holling, 1973) in order to explore how older adult females manage life with a mental illness when using resiliency skills and family support. Later researchers commented that early studies defined resilience in simple terms such as "doing well despite adversity or risk" (Masten, 2011, p. 494), and were focused mainly on children who had endured psychological trauma (Andel, 2011; Pietrzak & Cook, 2013), and individuals with mental illness or traumatic experiences. Cicchetti (2010) observed that "the historical roots of resilience can be traced back to early programs of research about individuals with schizophrenia and on persons exposed to parental mental illness, extreme stress and poverty; as well as on the functioning of individuals who experience traumatic occurrences earlier in their lives" (p. 146). Past research has shown that older adults have experienced many events associated with some type of trauma, including veterans (Pietrzak & Cook, 2016) and that it should continue to be a goal of researchers to study how they manage to have resiliency and where their strengths lie to live independently. When specifically talking about older females, it is also important to consider how these older females see and think about themselves. The two theories served as a base for collecting data in line with the research questions.

Social Learning Theory

This section will first outline social learning theory by Albert Bandura who specifically stated that individuals are caught between their behaviors and how the environment may promote self-regulation. Social Learning Theory is based on the

premise that watching others and learning what they do, and then taking what was observed and integrating these behaviors into daily life may promote changes. Practicing these changes promotes a healthier and happier life regardless of circumstances that the individual is having to manage. Bandura (1991) also informed us that the skill of observing others could be combined with the "self-monitoring of personal competence and self-esteem" (p. 250) and that we must know one's limitations in order to implement new behavior. This knowledge may be used as a guide to avoid problems that may occur when going beyond the abilities of an older adult (Bandura, 1971). Bandura (1991) stated the actions taken to change behavior help us adjust or change, and that this is a continuous pattern in life to allow us to be stronger by reinforcing and practicing new behavior. According to Bandura (1991), these newly reinforced behaviors are the desired results. His theory could be applied to the circumstances of the older adult female population in this study learning to self-regulate herself to maintain independent living. It is possible that the older female can obtain newfound confidence in making her own life decisions while also using the opportunity to implement learned power to choose activities she enjoys participating in. Some of these activities may include going to church, social gatherings, and being involved in the community or volunteering. Bandura did not specifically write about older females, but his theory can be expanded from his specific ideas to this new arena of how older adult females see their life and believe in their abilities as compared to others. Bandura's (1991) theory also support this study by helping us understand how participants believe they are capable of living independently and how they adjust behaviors to remain independent.

Understanding more about this population gave this me the opportunity to understand therapeutic options that build strength from within and reinforce the client's belief that they are stronger than they believe, and that they can achieve the same behaviors and milestones that others achieve. Bandura (1991) stressed that changes can be implemented only if the individual is willing and interested in learning and applying through practice. In other words, there must be some type of motivation or an interest in wanting to begin implementing changes before these changes can take place.

Kalkstein, Kleiman, Wakslak, Liberman, and Trope (2016) reported that we learn from experience and actually performing a skill can reinforce that ability. It was noted that people also can learn from observing someone else perform that same skill. They discussed that Social Learning Theory reinforces the idea of learning through modeling a behavior and that this modeling can reinforce more understanding of the skill so that it can be repeated again and again with the intended result being mastery of that skill. Kalkstein et al., (2016) also reminded us that a major finding in the social learning literature is that people tend to learn better in social situations than from direct experience and that these social situation can vary depending on who is modeling the behavior or skill. Rosenstock, Strecher, and Becker (1988) informed us in their historical study on models of behavior change that social learning theory is based on "expectancies and incentives" of an individual and how strong their characteristics are to manage their environment (p. 176). Expectancies are what an individual anticipates when the environment changes and an understanding of how events cause changes to that specific environment. Some possible environmental changes may be a decline in health, income, a

fall, or a decrease in memory. Expectancies also include what action the individual takes when the environment changes, the consequences of those actions and how this affects the individual's expected outcomes. These changes are also combined with an understanding of one's competence and ability to make changes as needed to live independently. These expectations can include awareness and ability to take care of one's own health and anything involving ability to adapt to changes in family dynamics. This theory supports the proposed research questions about support and what older adult females may have that reinforce their ability to live independently; by seeing others live independently, they better manage their life, improve problem solving, and strengthen their resiliency skills.

Extrapolation from basic social learning theory can be utilized to describe the experiences of older adult females who live independently with family support. The opposite may also be true; the lack of a family support system may show later evidence of disengagement, where the older adult female may stop paying attention to others, lose interest in maintaining her appearance, relationships, or worse just give up on herself. Once a person stops being involved in the community, combined with a lack of a support system, the older adult female may begin to believe she cannot manage on her own and may stop maintaining skills necessary to live independently. This theory also supports the nature of the study. By using this theory, the researcher will conduct interviews as the basis for what she is interested in finding out. These lived experiences are best explained and clarified by the older adult female who actually experienced this life and is willing to open up and share. Rosenstock et al., (1988) also stated that incentives are what drives

the individual to make changes while being aware of the value of the specific change or outcome. Incentives can be in the form of the ability to continue independently, physical appearance, caring for one's health, self-esteem, and pride to achieve set goals while not relying on family members except when needed (p. 176). When studying resilience in older females, it is also important to consider how an individual sees themselves and their abilities. Bandura (1971) refers to the awareness or ability to manage life as "self-regulation of motivation" which is the inner driving force that pushes individuals to want to learn to have stronger skills and live independently while experiencing success in setting and achieving their goals (p. 3). He stated that individual behaviors come from the "inner forces in the form of needs, drives, and impulses, often operating below the level of consciousness" (Bandura, 1971, p.1). One example would be an individual setting the goal of living independently by using this independence as a driving force, along with motivation to find appropriate resources, initiate the action to use these resources while exerting the effort needed to live independently. Bandura (2001) also stated that, after the goals are accomplished, an individual is given a feeling of competence leading to setting a more significant goal and the outcome is higher levels of achievement. People are continuously confronted with situations that require inner strength to make decisions. Bandura reported that individuals learn from direct experiences and observing how others handle their day-to-day life (Bandura, 1977). For this to be accomplished, Bandura believed individuals should have the ability to not only assess what they can and cannot do (abilities) but also to be able to recognize their behaviors. This recognition leads to changes either positive or negative in their daily living (Bandura, 1991). This type of

reinforcement is not only informational but also has response strengthening capabilities. This reinforcement allows individuals to select the behaviors they like and discard the others by making changes to their lifestyle (Bandura, 1991). These changes should also increase self-efficacy (what you expect outcomes to be after behavioral changes are implemented) and should not be confused with locus of control (Rosenstock, Strecher, & Becker, 1988). The researchers also explained that according to Bandura, locus of control is a "generalized concept" (p.178) that focuses on the self and your beliefs about yourself compared to self-efficacy which is considered more situational (Rosenstock et al., 1988). Environmental changes are a natural occurrence for all people but the reaction to those changes are a concern for the older population as supported by Resilience Theory (Holling, 1973).

Resilience Theory

Resilience was created by C.S. Holling in 1973 with the idea of adaptive cycles and living things which included, not only the environment but humans and our capacity to adjust when an unexpected event occurs. He also included consideration of what may be the duration of time to return to a normal state and what that may involve. These unexpected changes were what Holling (1973) was most interested in. During his research, he found that he could also apply how changes in an individual's environment-initiated changes in the reaction to that event. These reactions were then observed to see how long it took to get back to what was considered normal. Holling and Gunderson (2002) expanded this theory in an attempt to better understand the changes in environments and humans and how they also manage to survive and continue thriving

even though they suffer extreme changes that many times cannot be controlled. They were interested in the "persistence" (p. 8) of environments not to allow large changes to make extreme changes, but could accommodate smaller, undaunting changes and incorporated these changes into their systems with little adjustments. When a system suffers unexpected changes, that system may weaken causing reinforcers to do their part to promote that environment or individual to return to a steady state. Gunderson and Holling (2002) termed the name "Panarchy" (p. 8) which came from the Greek god "Pan" (p. 8) who the researchers explained captured the idea of life as "an image of unpredictable change and upon notions of hierarchies across scales to represent structures that sustain experiments, test results, and allow adaptive evolution" (p. 8). This image helped them see that, the environment and support systems do change and that many times this change is unexpected and must be managed to allow a return back to the steady (normal) state. Resilience Theory (1973) suggested that changes in environments are many times unplanned or unexpected, yet individuals have shown the ability to survive, adjust, and maintain their level of a steady state with the use of learned resiliency skills and a support system. The researchers stated that when resources run short it is the failure of management of the system (in this study, management would be the family support) that becomes the culprit (Gunderson & Holling, 2002). After conducting an exhaustive search, the researcher found little to no studies on resilience theory and older adults.

These two theories support the questions that this study proposed to answer about older female adults who live independently with a mental illness. First, by explaining what type of support system the participants have and how these older adult females see

themselves using Social Learning Theory (Bandura, 1991). Second, by discussing their learned skills to manage changes in their environment using Resilience Theory (Holling, 1973) in connection with how they utilize these skills, and what skills enable them to remain independent using Social Learning (Bandura, 1991). Third, by learning what the support system exactly does to enable the older adult female to manage changes whether they be expected or unexpected. Finally, by exploring how the older adult females believes the support system allows her to have experiences that she may not if she did not have this support system. These theories also support the problem of what is not known about what specific skills the older adult female with a mental illness has or uses to maintain independent living and what exactly the family support system does for them and if this support is used as needed on a daily basis.

This theory also supports the nature of the study with the design of using phenomenological interviews to explore lived experiences resulting in themes about how the older female looks at herself, thinks of herself, thinks about her mental illness, aging, and what she believes her abilities are to live independently. One advantage of using the phenomenological method is the researcher collects true lived experiences directly from the older adult females and directly from their point of view. Another advantage to this method is that the interviews are structured and propose to answer the research questions.

Literature Review Related to Key Variables

In much of the research about resiliency completed in the 1970s, the goal was to "understand and prevent psychopathology" in children (Masten, 2011, p. 493) with the thoughts of what happens as these children age. Researchers began by looking at children

who suffered different types of experiences or circumstances that should have left them with some type of a mental disturbance that would affect their future as they become older adults. Yet their ability to manage these experiences without any problems encouraged the researchers to explore further (Rodin and Stewart, 2012). This exploration was driven by the idea that they could use more studies and information to further develop theories and interventions (Masten, 2011).

Maercker, Hilpert, and Burri (2016) reported that there has been a wide range of research conducted on young and middle-aged adult's resilience leaving the older population almost completely unaddressed. The researchers were concerned that there was substantial needed information about the older adult population missing which may have caused gaps understanding their resilience and how they were able to either display or explain resilience that has been learned as a result of some type of childhood experience. They stated that we in the research community remain limited to the much needed knowledge about older adults and how they have been able to manage their lives without giving up during the aging process. Also, we lack knowledge of how we can predict resilience in the older population which would be beneficial to family members and those who care for this population. Maercker et al., (2016) also reported that it is believed that individuals must experience some type of trauma to be resilient when in fact resilience comes from the ability to adapt regardless of the event.

Fahy et al., (2017) was interested in how adults who grew up in some type of stressful situation or neglect (either by the parents or another adult) were able to either manage or not manage their adult life and responsibilities. Fahy et al., reviewed data from

The National Child Development Study which was a longitudinal study that collected data from 18,558 individuals that were followed through their lifetime up to age 55. The data from this study focused only on 9,137 of the participants aged 55 and only data from the year 2013. The participants were 48% males and 52% females. Definitions of childhood adversity were listed as "illness, abuse, paternal absence or in care" (p. 82). Focus was on how the adult reported if they felt they had suffered adversity as a child and if this adversity may have had some connection to their work status. Participants reported their work status as "working full time, part-time, unemployed, permanent sickness or disability, retired, or "homemaker or other" of whom 82% (n=533) were homemakers (defined as looking after home or family) and a small minority were temporary sick (p. 82). Fahy et al., (2017) reported they found 38.5% were not working full time jobs, 19.7% worked only part time, 2.8% were unemployed, 5.2% were on permanent sickness or disability pension, 3.3% were retired and 7.5% reported they were in "homemaking/other" activities. Childhood neglect was reported in 9.8% while 6.3% reported childhood physical and/or sexual abuse by a parent. Females reported more physical or sexual abuse by a parent versus neglect (pg. 82). They also added that these children that grew up with adversities may also have to now managing adult symptoms of "increased attention to negative stimuli, difficulties in emotional regulation and higher risk of psychiatric illness, and impairments in reward-related decision-making, and decreased motivation to pursue rewards" as an older adult (p. 81) causing this population to be less productive. They found in the data that most of the adults did grow up to display some type of difficulty in "decreased intellectual and academic performance,

poorer language abilities, and impairments in executive functioning such as planning and inhibitory control" which suggests a direct connection to the childhood experiences (Fahy et al., 2017, p. 81). This study reinforces the idea that more scientific research is needed in order to uncover coping abilities in the ever-growing populations of adults and how their childhood experiences may affect their coping skills as they age. Liu, Reed, and Girard (2017) reinforced the idea that resilience was historically developed from at-risk children who had experienced some type of adversity and how these adversities were assumed to end in negative results. The researchers found that some of the youth were able to manage the situation and move forward after the exposure and return to their normal lives and demonstrate positives not only in functioning but in their overall lives.

Defining the Concept of Resiliency

Several historical studies were located which explored the meaning of resiliency, either by reviewing previous studies in this area or based on primary research. In the former category, Whitson et al., (2016) conducted a systematic review of 1,078 abstracts to understand how resilience is defined, and of those they found 49 previous published articles relating to resiliency that also confirmed that resilience was explained to be a construct (or idea) that involves the ability to maintain positive thoughts and continue living while overcoming a negative circumstance. They also reported that in the past, the term resilience was used to explain how materials could be flexible and return to their normal position configuration, but currently, the term has gained popularity and has been used to describe systems in the same way that Holling (1973) used it when discussing the environment along with the abilities of communities and people.

More recently, Whitson et al., (2016) reported that literature discussed resilience as a “psychological construct”, adding that, in order to be resilient, one would have had to have experienced a stressful event that tests the ability of that individual to recover from that event. These events could be from any category or situation, for example, an unplanned surgery, a fall, losing a loved one, moving to a new location or surviving a natural disaster. This research also reminded us that resilience is measurable and could be used for specific interventions, especially for older adults, and to ensure individuals can function in their environment and that they have quality of life. Hermann et al., (2011) also agreed that defining resilience is important along with what may trigger the need to implement those skills when needed. Hermann et al., (2011) conducted a literature review on the term resilience and found that positive adaptation despite adversity is a popular definition when discussing resilience. This definition was also suggested that it could be applied to children, adults, and older adults. Hermann et al., (2011) also agreed that resilience studies began with studying children who have been maltreated and concern for what happens to them later in life when they have not dealt with the effects of their adversities. The researchers stated that everyone is responsible from family members to professionals to ensure those who have suffered adversities can grow up having the support they need to be able to grow and age so that they can function the best that they can. This includes the opportunity to remain living independently if this is what the older adult chooses. Hermann et al., (2011) informed us that we are still learning how adverse experiences affect individuals behavior and cognition and without support from family and friends, these individuals may suffer from diseases as they age. Resilience was

mostly reported to be a "personal trait operating after a single short-lived trauma" (Hermann et al., 2011, p. 259). Over time the list of possible adversities began to grow and include negative life events over the entire life span and not just childhood. Some of the possible events were "deficient parenting, poverty, homelessness, traumatic events, natural disasters, violence, war, and physical illness" (p. 259). Support was found to be an important element and can come from many systems to include family, community, friends, and professionals. Resilience was found to come from many sources; personal (personality traits), biological (changes in brain size due to continuous exposure to adversities), environmental (relationships with family and peers), and or a combination of all three. Hermann et al., (2011) reported that they found studies on children usually focused on behavior, emotions and education but reminded us that a child's competency in one area did not automatically mean competency in any of the other areas. They also stated that researchers should be clear about the measures that they use with children and the intensity or duration of the adverse event. Lastly, the literature review highlighted four related concepts; "hardiness" or a sense of control over one's life; "benefit finding" is the ability to make sense of the adversity by focusing on the positives, "thriving" is the return to the original level of functioning or to a higher level after an adverse event and "posttraumatic growth" which was defined as a stage beyond thriving and resilience (p. 262). Hermann et al., (2011) suggested more attention should be focused on reducing adversities at a younger age in order to avoid or reduce health-related issues before they lead into lifetime ailments.

Baskin (2013) questioned how environments (as humans) are able to adapt even during severe changes and why some things manage to survive while other do not. Baskin like Holling wondered how resilience in an environment is built and how this phenomenon connects to humans. When humans suffer a disaster, many have the ability to bounce back, but others may not, and this is very true of both older adults and the environment. Some older adults have learned to accommodate to their lifestyle as unforeseen changes take place just the same as the environment learns to accommodate for its changes. According to Baskin (2013), Holling stated we should "develop and encourage systems that are able to absorb and accommodate future events in whatever unexpected form they may take" which results in the phenomenon of resilience (p. B10). Maltby et al., (2016) conducted a study using the Engineering, Ecological, and Adaptive Capacity (EEA) trait resilience scale that Holling developed with his colleagues to explain resilience in an ecological and social system. Maltby et al., collected data in three samples; first, 295 United States participants (168 men and 127 women) aged 19 to 66, who were recruited using the Amazon Mechanical Turk survey software on 2 occasions. All participants confirmed they spoke English and lived in the United States. Second, 179 undergraduate university students (87 men, 90 women and 2 that did not indicate their sex), aged 18 to 27, recruited from courses at two Japan Universities, to include a second group from the United States of 175 participants (102 men, 73 women with a mean age of 34) who completed the Ten-Item Personality Inventory and the Hospital Anxiety and Depression Scale and the third sample, was 251 undergraduate university students (62 men, 186 women and 3 participants that did not indicate their sex), aged 18 to 27,

recruited from 2 Poland universities. (No other demographics available). All participants completed the 12 item EEA measure of trait resilience. The Ten-Item Personality Inventory has 10 items that are scored on a 7-point scale of 1= disagree strongly to 7=agree strongly used to assess neuroticism, extraversion, conscientiousness, agreeableness, and openness to experience. The Hospital Anxiety and Depression Scale comprised of two 7-item scales measuring anxiety and depression. The United States and the Japanese participants completed the scales online while the Polish completed the scales by pen and paper. Results were that the resilience scores and the psychological meanings were not compatible across all three countries and that the resilience scores and the causes for those scores also were found to not be comparable across the three countries. In the United States subsample, the adaptive expressions of personality category resulted in a variance in the resilience scores that was more similar to the UK findings, with the exception that extraversion does not predict any unique differences in ecological resilience according to Maltby et al., (p. 99). Also, that engineering resilience was connected to neuroticism, ecological resilience is connected to conscientiousness, and adaptive capacity is most connected to openness to experience (p. 99). Maltby et al., also discussed that there are three systems within resilience; engineering, ecological, and adaptive capacity (EEA). This system was expected to predict clinical ‘caseness’ (the degree to which the accepted standardized diagnostic criteria for a given condition are applicable to a given patient or symptoms) but actually resulted in a variance from previous findings in predicting clinical symptoms of depression and anxiety which was consistent with academic literature according to Maltby et al., (2016). The differences

were not considered a negative according to Maltby et al. but encouraging and expected across different cultures. This explained that the Holling model is strong and that it can be applied across not only biological but social systems and that the resilience scale was also strong. Limitations were that this study only assessed personality in the U.S. sub-sample and with missing variables the researchers recommended further research.

Rutter (2012) informed us that resilience is learned over time and not an automatic characteristic we are born with and that we should never assume individuals are resilient to every situation. Yet, according to Clark, Burbank, Greene, Owens, and Riebe (2011), using resilience appears to be a more "preferable concept to the more well-established one of successful aging, because it represents a more reasonable and attainable goal for most older adults" (p. 51). Hayman et al., (2016) and Maschi, Baer, Morrisey, and Moreno (2016) also reported that research on older adults continues to be very limited and they also believed that this population has been mostly ignored.

Davydov, Stewart, Ritchie, and Chaudieu (2010) researched stressful events and the development of resilience or "mental immunity" (p. 4). They reviewed and compared literature about "mental resilience, mental health protection and resilience, and resilience as integrating biopsychosocial constructs-comparing to constructs of somatic multilevel protection an immunity models" (Davydov, Stewart, Ritchie, and Chaudieu, 2010, p. 39). Windle, Bennett, and Noyes (2011) reported that the field of resiliency has grown in interest within the last few years, especially in foreign countries, as they suffer similar or the same issues older adults in this country suffer regarding "health, well-being, quality of life challenges and the aging process" (p. 1). The researchers reported there are "major

international funders" (Windle, Bennett, and Noyes, 2011, p. 1) that are promoting resilience research due to the realization that resiliency research may provide answers to avoiding risk or harm and what it takes for older adults to get back to their normal lifestyle after an event or a health incident.

McMurtrie (2013) reported that she found in one study on resilience that individuals who have had some type of adverse experience were able to say they came back stronger and were better off than those who had none or had never suffered any type of adversity. She points out that this is the ability to bounce back following different types of events whether the event be a traumatic as "war or childhood maltreatment" (McMurtrie, 2013, p. B13).

Influences on Resiliency Among Adult Populations

Much of the published research that was reviewed on resiliency focused on investigating the factors affecting levels of resiliency and the ways in which these vary between individuals. For example, Helmreich et al., (2017) reported that resilience is followed by an exposure to some type of "risk or adversity" (p. 1) and trying to label that individual as resilient could only happen if they were truly exposed and were able to get back to some type of normalcy and move forward putting that event in the past. Hayman et al., (2016) reported it is important to understand the factors that make us resilient during aging and how these factors may promote healing and the ability to move forward. This section focuses on resiliency and some of the reasons for loss of resiliency, how past events may affect resiliency skills, along with the idea that resiliency may include how older adults think about themselves which could interfere with their skills.

Exploring the reasons why levels of resiliency vary between individuals still remains unanswered; could it be experiences from childhood that may cause these levels to vary or could there be something else we are not aware of? Patten et al., (2015) reported that they found that adverse childhood experiences can cause a negative impact on mental health in older adults. They reported that depression was a consistent factor especially for those growing up with adverse childhood experiences. Patten et al., (2015) was also interested if there were outcomes from adverse childhood experiences that resulted in adult health issues by using the data sets from a 1994 called the National Longitudinal Study of Children and Youth (NLSCY). The researchers then compared their findings to the National Population Health Survey (NPHS) which was also linked to the National Longitudinal Study of Children and Youth and was also used to uncover childhood adversities. This study used data that was reported by the person who was the most knowledgeable about the child involved such as the mother who answered questions about the child. The goal was to compare the two assessments and the responses to find a link between childhood adversities and adult mental health issues. Participants totalled 1977; 51.7 % males, 48.3% females, 16.3 % raised by single mother, 83.7% by both parents, 3% reported depressive symptoms with 97% reported no depressive symptoms. Fifteen percent reported living in rural areas and 84.3 reported living in Urban areas. Five percent were married, 84.7 not married, 37.4 reported they had a high school education only, 62.6% reported some secondary education including 67.7% currently working and 32.3 not working. Complete follow up was achieved for 66.0 % of the participants over the 16 years with only 0.7% leaving the study due to death or having been

institutionalized. The National Longitudinal Study of Children and Youth (NLSCY) targeted children from the ages of 0 to 12 and some continued to be followed in the National Population Health Survey (NPHS) when they reached age 12 with some being followed until age 27. The NPHS targeted adults (household dwelling) for 16 years (every 2 years until 2010). The NLSCY included a series of 14 questions that were asked of each child; "death of parent, death of family member, parents separated, number of moves, a stay in foster care, other separated from parents, change in household membership, alcohol/mental health issues, injury/illness of family member, abuse, hospital stay injury/illness of child, conflict between parents and other trauma" (p. 160). The NPHS included retrospective questions directly to the study participants to include; "spending 2 weeks in the hospital, parental divorce, long term parental unemployment, something that scared you so much you thought about it for years after, being sent away from home for doing something wrong, parental drinking or drug use that 'caused problems for the family, physical abuse by someone close to you" (p. 160). Measures used were the Composite International Diagnostic Interview Short Form for Major Depression (CIDI-SF) which of the five symptom-based requirements the participant had to report a depressed mood or loss of interest. The NPHS also included self-report questions on alcohol usage to include a 7-day diary to report frequency of drinking. Patten et al., (2015) reported that Canada considered low risk drinking frequency 14 times for men and 9 for women. Painful chronic conditions were reported by asking about "long-term medical conditions lasting at least 6 months. Three conditions were reported to be painful conditions; migraines, back pain and arthritis and rheumatism.

Patten et al., (2105) reported that they found support for the idea that childhood adversities are associated with major depression but not with alcohol consumption or excessive drinking and less with painful conditions even though they found this to be reported in past literature. Also noted was that the participants might have occurred some type of adversity after the study timeframe which was not captured. They also reported they believes retrospective assessments are more useful that prospective but that they would be more vulnerable to error due to how participants remember facts.

Reuben et al., (2016) agreed with Patten et al., (2015) that people may not always remember what happened in an event and especially older adults who may even remember the event slightly different than what actually occurred. Another consideration is the fact that some participants may not want to share personal events and may be embarrassed about an event and not want to disclose. Reuben reported that childhood adversity has been referred to as "a hidden health crisis "with "far reaching consequences" (p. 1103). With that being said, the researchers then considered if past comparisons of retrospective and prospective reports prove child maltreatment as a risk factor for older adults' poor mental health (based on reports of actual events) then what could be put in place to try to reduce these incidences? Reuben et al., (2016) conducted a study using archival data from the Dunedin Study of New Zealand from seven assessments that were collected from participants that were aged three to fifteen years old and then conducted new face-to-face interviews with 1,037 of the original study participants that were born between April 1972 and March 1973, in Dunedin, New Zealand. Participants were considered eligible because they lived in the providence and

that they were an original participant. Participants were considered to cover the full range of socioeconomic status and met health indicators where there may be issues; body mass index, smoking, visits to the doctor, primarily white, and less than 7% reporting they were non-Caucasian. All participants resigned an informed consent. Measures used in the face-to-face interviews were equal to the CDC Childhood Adversity Experience Study from 1998 using five types of child harm categories; "physical abuse, emotional abuse, physical neglect, emotional neglect, and sexual abuse and five types of household dysfunction; incarceration of a family member, household substance abuse household mental illness, loss of a parent, and household partner violence" (p. 1104). Participants completed a self-report using the Childhood Trauma Questionnaire which asks about physical, sexual, and emotional abuse, physical neglect, and emotional neglect. Participants were also interview about memories of being exposed to family substance abuse, mental illness, and incarceration during childhood using the Family History Screen. Participants were then asked about partner violence using the question "Did you ever see or hear about your mother/father being hit or hurt by your father/mother/stepfather/stepmother?". Parental loss was also asked about; have you had any exposure to either parents separating, divorcing, death or removal form the home?" (p. 1105). The prospective adverse childhood experiences were taken from the data collected from the archival study which included social service contacts, structured notes from assessment staff who interviewed the study children and their parents, notes from pediatricians and psychometricians who observed the interactions between the mothers and their children. Also included were notes from nurses who recorded conditions in the

home and information from the children's teachers who were also surveyed about the children's behaviors and performance. Parents were surveyed about any criminal charges or past criminal history via a survey that was mailed out to the home. The archival data was then reviewed by four trained raters on the Childhood Trauma Questionnaire definition of adverse childhood experiences. The raters agreed on adverse childhood experiences by three of the four raters by 80% with the exception of emotional neglect in which only two agreed that there was emotional neglect on behalf of the participants. The researchers noted that childhood sexual abuse was most likely underrated because in the early 1970's it was considered to be rare. It was found overall that the participants experience more adverse childhood experiences than they reported in the prospective records as the retrospective was higher overall but not in all categories. Adult health and social outcomes were assessed using four domains; physical, cognitive, mental and social. Reuben et al., (2016) reported overall results that when comparing this current study to the previous study there was very little difference; participants that reported 4 or more adverse childhood experiences reported an increased risk for poor health, in the observation category there were slight differences in reports, but this was explained as the parent or teacher may have had different sources and opportunities to observe a child, and that when self-report is used outcomes are more strongly predicted. Finally, the researchers reported that the influence of childhood adversity is underestimated, and that adult psychopathology is strongly associated with retrospective self-reports of childhood sexual abuse over official reports. This is explained as those who have more problems may be able to look back on their childhood and report that they had more problems then,

so these problems carry over into adulthood. This was also stated to be true of the opposite; those who do not have as many problems as adults do not recall many problems as a child. Those participants in this study that had documented adversities but did not recall those adversities had poorer health and cognition but were not likely to document that they had these issues. Also, the researchers reported that those they considered more neurotic would report more childhood adversities than their prospective records indicate with the opposite being true of those who are more agreeable who reported less. Professionals who work with older adults should be cautious about how they self-rate themselves and use all tools to get as accurate of an assessment as possible prior to making decisions about a treatment plan.

Older adults seeing themselves as more capable than they actually are is not considered a negative but can become a serious issue if they are not strong or healthy enough to live independently. Sargent-Cox and Anstey (2014) conducted a study on locus of control and relationships between age-stereotypes and health locus of control. The researchers randomly selected 3,000 participants from the Australian Capital Territory between July and September 2011. The names and addresses were collected from an Australian residential database company and an invitation to the study was mailed out followed by a questionnaire resulting in 739 participants. Of the 739; 42.2 % were females aged 20 to 92 years old. 65.8% reported they were married, had obtained an undergraduate degree or higher and were employed full time. The data was collected using the18 item Multidimensional Health Locus of Control (MHLC-Form A) to measure how the participants believed their own behavior (internal), luck (chance), or other

outside forces (people; friends or professionals) impact their level of health. Examples of questions were “I am in control of my health”, “Luck plays a big part in determining how soon I will recover from an illness” and “Having regular contact with my physician is the best way for me to avoid illness” (Sargent-Cox and Anstey, 2014, p.11). The outcomes showed that participants reported their attitude of negativity towards older adults coincided with believing health is more of chance and that other people (friends or professionals) influence their attitude. Also, the researchers recommended that future studies continue to focus on health or interventions starting with those that are close to an older adult and addressing any negative age issues or stereotypes towards older adults (Sargent-Cox and Anstey, 2014). Connecting this theory to social learning theory, as adult females age and mature, they observe how other older adult females live independently and will report if they believe that they have these abilities and see themselves as successful. Or they may realize that they need to try to put more effort into their living skills to remain independent, and not just rely on luck or hope. Many influences on resiliency among adults in general can be identified from the literature and are discussed in turn below. These add considerably to understanding of the concept and its relevance to older females and provide additional background for the present study.

Psychobiological Factors

Psychobiological factors refer to the thoughts, feelings or other characteristics that may interrupt the thinking process which influences how an individual reacts, thinks or makes decisions. According to the American Psychological Association College Dictionary of psychology (2016), the definition is listed as “a school of thought in the

mental health profession in which the individual is viewed as a holistic unit and both normal and abnormal behavior is explained in terms of interaction of biological, sociological, and psychological determinants" (p. 365). In other words, all aspects of the older adults' life; their overall health, where and how they socialize, and how they manage their stressors, play a part in how they live day-to-day and function. According to Stellefson, Yannessa, and Martel (2012) as the older adults ages and their body begins to weaken, they may suffer falls. Depending on the seriousness of the fall, there may be an injury or pain. Muscles become weaker and muscle strength declines with aging. Stellefson et al., (2012) wanted to look at what also happens with an older adults' cognition after they suffer a fall and does this affect resiliency in the form of thinking that they are not strong enough to function on their own and that they now may need more help. They reported that over one third of people over the age of 65 in the United States had at least one fall and that these same older adults were more likely than not to have another fall (Stellefson et al., 2012). Not all older adults fall but it is more likely that an older adult between the ages of 65 to 85 (and older) have a reported higher number of falls than their younger counterparts. The researchers wanted to research psychological variables and physical strength against falls to understand who would be more considered more of a fall risk prior to a fall occurring. They reviewed data from a past study. A convenience sample of older adults participated in a study examining the psychobiological influences on unintended falls among older adults. The study participants were recruited through an advertisement in the local newspaper, flyers posted at local hospitals and health/fitness centers in the southeastern United States. Participants

had to be living at home and be at least 50 years of age. Participants were required to complete various psychological and physical performance tests, as well as complete a health questionnaire for musculoskeletal, metabolic, and pulmonary disorders. The health questionnaire also included questions on physical activity, any medications and fall history. Individuals reporting or exhibiting signs or symptoms of unstable angina, orthostatic hypotension, systemic illness or fever, or poor coronary artery blood flow were excluded from participation. Measures used were the Berg Balance Test and the one-repetition maximum leg press. The Berg Balance Test is a commonly used tool assessing balance ability in older adults. This test uses 14 brief tasks on balance that are timed. The second measure used was the Tinetti Falls Efficacy Scale which is used to assess an older adult's confidence to avoid falls while completing their activities of daily living. The third measure was the Activities-Specific Balance Confidence Scale which consists of 16 questions rated on a scale of zero to 100 which were averaged for a total score. The higher the score the better the participants balance was while performing activities of daily living and also higher confidence that they can perform these daily living activities. The study also noted that age was also considered when scoring. The researchers also reported that the Tinetti Falls Efficacy Scale and Activities-Specific Balance Confidence Scale are based on Bandura's (1997) theory of self-efficacy, which refers to individuals having confidence in their ability to complete a task which will result in a desired outcome. This study highlighted the importance of knowing the older adults' ability to function independently and still have the ability to complete activities of daily living without unintended falls.

Maschi et al., (2012) also researched resiliency by conducting a literature review on articles pertaining to stress and trauma in childhood and how this trauma may have caused difficulties or reduced resiliency in later life. Searches were conducted using key words; childhood trauma, cumulative trauma, and older adults limited to the past 25 years only. They found only 23 articles that met their criteria; these were peer reviewed empirical studies sample of adults aged 50 and older, who had experienced trauma that occurred in childhood and how this may have changed or affected their physical and mental health as they aged. According to the National Comorbidity Study (Maschi, Baer, Morrisey, & Moreno, 2012), more than half of Americans age 18 to 25 have had at least one type of event in their life that involved trauma. Some factors found in the literature that enabled resiliency were self-esteem, safety, and spirituality (Burnett, Cully, Archenbaum, Dyer, and Naik, 2011), forgiveness, thinking positive, performing positive activities and using socialization for a support system. The findings also provided more understanding about the lifestyles of older adults who have experienced some type of childhood trauma; they found that those traumatic events cause these older adults to have a higher risk for vulnerability, mental and physical health.

Rodin and Stewart (2012) conducted a study of childhood maltreatment using nine older adults who were categorized by their doctor as having resilient characteristics. Participants' ages varied from 67 to 90; 5 females, 4 males, education was divided by; 2 had post graduate degrees, 2 had bachelor's degrees, 2 had some university, 1 had a college degree, and 2 had a high school diploma; 7 reported they were married, and 2 were widowed. The researchers wanted to explore how they became resilient and what

keeps them resilient in older age after experiencing maltreatment. Rodin and Stewart (2012) were interested in their lived experiences and how they managed to remain resilient. Participants were recruited with the help of healthcare providers who contacted them in advance asking if they were interested in sharing their stories as part of a study on resilience. The participants were interviewed for 60 to 90 minutes about their life using an interview guide to get the most information they could and then this information was coded and organized the categories into themes. The researchers stated the participants showed emotion when talking about their life and but were able also to share how they survived. Rodin and Stewart (2012) reported even though some of the participants showed some difficulty in discussing these events even after all this time characteristics of not giving up and dealing with problems were demonstrated. They also reported that it is not unusual for children that suffered some type of maltreatment to grow up having psychological disturbances later in life. The older adults in this study recommended areas to implement to increase satisfaction in life; "being involved in activities, having your own identity, maintain competence, learn to adapt, invest in your own life, and have a desire to learn" (Rodin and Stewart, 2012, pp. 5-7). Rodin & Stewart (2012) also reported that it is important that older adults to have a strong inner strength, social system and motivation to keep living independently. They also must change to a more positive way of thinking in order to promote moving forward in their life which also may increase ideas that they are not so vulnerable. Bercht and Wehrhahn (2010) reported that negative thinking and vulnerability can also be connected to situations such as not having enough money for daily needs, or to pay bills, feeling limited to education

or even lacking healthcare. Polson, Gillespie and Myers (2018) speculated that older adults living in poverty and the impact of cutbacks in health and human services can increase the vulnerability of older adults who may be considered to be isolated and at risk. A vulnerable individual could be defined as one who does not have the ability to take care of themselves on a day-to-day basis or to protect themselves from situations that may adversely affect their safety or overall health. Rodin & Stewart (2012) stated that vulnerability of an older person can also be viewed as an inability to be prepared to handle situations and may end up in a more weakened state. Understanding what factors reduce vulnerability or attitude to aging can make a difference in the quality of life for an older adult.

Positive Attitude and Emotions

When discussing quality of life, one might want to consider how attitude and emotions might have some effect on an older adult living independently. Wiles et al., (2012) reported that the older adults shared that they had specific traits of their own such as "having the right attitude toward aging, being positive, accept aging for what it is, having humor, the need for friends, exercise as often as you can, and live in reality that they were not young anymore" (p. 417). Wiles et al., (2012) conducted a study on resilience with two communities in Aotearoa, Australia which has a history of cultural diversity and high numbers of people living there for a long time. The participants were 121 older adults, aged 56 to 92, to include 44 men and 77 women. The participants attended 17 focus groups and 17 one-on-one interviews. The groups were also facilitated by an older adult with a researcher sitting in for observation. Resilience was first defined

as the ability to bounce back from some type of adversity, the idea that people with a disability or an illness could still function in society independently and that having a good support system in place will enable an older adult to work through problems as they arise and having someone who understands the aging process is even more of a plus. Responses were categorized into seven themes: Clarifying what resilience is, attitude, counting blessings, having a purpose in life, social resources or support and a place to grow old. In these interviews, the term resilience had more meaning to older adults in this study than was recorded in earlier literature. Also, Wiles et al., (2012) found that resilience does not just reside in just one area of functioning. An older adult may be weak in one area but strong in another and that maybe what allows them to continue independently. Alex (2010) conducted a study revisiting the participants from a past Umea 85+ project in Sweden who were able and willing to participate. The requirements were that the participants were born before 1906, in 1910, or in 1915; were able to answer a questionnaire and willing to be interviewed about how they feel about aging. Also, Alex (2010) only asked those participants from the original study who scored highest on the Resilience Scale. Participants were both males and females; 1 female and 1 male aged 95 or older, 6 females and 3 males aged 90, 10 females and 3 males aged 85 years. Seventeen females and six males reported they owned their own home, 15 females and 6 males reported they lived alone, 15 females and 6 males reported they had family to talk to while six females and 3 males that reported they could complete their own activities of daily living. Participants were recruited by telephone and by receiving a letter discussing the past study and how it connects to the current study. An informed

consent was signed and the appointment for the interview was scheduled. Interviews were conducted in the participant's homes. Three research nurses conducted the interviews and then administered the Resilience Scale. The interviews were recorded and then transcribed. Alex (2010) reported that the focus of this study was learning how the oldest old men and women recognize their resilience and what they have in their lives that gives them resilience. Findings included themes of feeling connected, feeling independent, and creating meaning in their lives. Feeling connected was defined in this study as positive feelings of being able to grow old, positive relationships with their parents as a child, and spirituality. Feeling independent was described in this study as being able to rely on themselves and having physical strength to do what they needed to do. Finally, creating meaning in their lives was explained in this study as having good memories, being able to just live, being a part of society, and being connected. This study highlighted the fact that those oldest old men and women in this study felt they did not have to serve others; that at this stage in their life they could be lazy and do what they wanted. Alex (2010) reminded us that the aging process is not only impacted by a persons' health but also includes their past and their living conditions which combined may impact resilience skills and attitude later in life. No limitations were discussed.

Aslan, Kartal, Cinar, and Kostu (2016) conducted a study on the relationship between attitudes toward aging and health-promoting behaviors of older adults in Turkey. The researchers stated that people all over the world are living longer and that older adults are healthier than ever. The age of older adults in Turkey is rising from 66 years old in 1990 to 76 years old in 2016 so it is more important than ever to try to continue

studies on older adults and learning what they can do to live healthier lives. The requirements for this study were that participants were 65 years of age or older, had no communication or cognitive impairment, agreed to participate in the study and could read and write in Turkish. Each participant completed an Attitude to Aging Questionnaire (AAQ) and a Health-Promoting Lifestyle Profile II, demographic information survey and a health-related characteristics form. Aslan et al., (2016) used a convenience sample of 488 community-dwelling older adults who were 65 to 75 and older who were recruited from six family centers in the city of Denizli, Turkey. Two hundred nine were aged 65 to 69, 124 were 70 to 74 years old, and 112 were 75 and older. Two hundred twelve were male and 236 were females with 319 reported married and 129 were single. Education ranged from 297 reporting elementary school or less, 44 reached middle school, 41 went to high school and graduated followed by 66 reported they attended college. Four hundred nine reported no household income and 39 reported no regular income. Chronic diseases were reported by 348 participants with 100 reporting none. Participants reported their perception of good health as 236 (good), 164 (moderate) and 48 (poor). Other results reported were a positive link between attitude towards aging and health-promoting behaviors. The researchers also reported that they noticed overall that as the data for positive attitude towards aging increased so did the reporting of health-promoting behaviors. Health-promoting behaviors were reported higher by the women in the study while those with high school education or higher also reported that they perceived their health status as good and had more access to education on health. Aslan, Kartal, Cinar & Kostu (2016) also pointed out that this study is just one study that provided proof that

having a positive attitude towards aging (also see Fortinsky, 2013) promotes an older adult to want to use health-promoting behaviors and that this way of thinking will add to their quality of life and enhance independent living. It is also noted that those that serve as caregivers should encourage and promote a healthier lifestyle. Limitations included the sample which may not be representative of the entire population, findings that should not be generalized to older adults in Denizli, Turkey. The sample was recruited from a health center, meaning they more than likely had health promoting behaviors and no causal relationship was confirmed.

Armstrong, Galligan and Critchley (2011) also researched resilience connected to emotional intelligence (EI), which is the ability to use emotions in a useful way to regulate and direct their lifestyle, and that without strong emotions the ability to bounce back is reduced. The study included older adults from 56 life event focused online discussion forums (HealingWell.com; widownet.org; joblayoffsupport.com). One thousand one hundred fifty-six individuals responded to the first survey question, 414 completed the survey and were able to provide adult consent. Participants were mostly women (76%) between ages 24 and 58 who had a college degree, working (42% full time, 17% part time), 19% full time students, or worked at home (10%). United States citizens were the largest group (45%), followed by Australia (24%), the United Kingdom (15%), and Canada (9%). The remainder of the participants were from European, Asian, or African countries. The measure of emotional intelligence was collected using a revised 44 item version of the Swinburne University Emotional Intelligence Test (SUEIT). Questions were on emotional self-awareness, emotional awareness of others, emotional

expression, emotional self-control, emotional management of self, and emotional management of others. The researchers reported that one traumatic event can cause a deficit in the ability to manage other events and reduce resiliency skills resulting in possible depression or other symptoms. Also, that if an event is traumatic enough it can impact the individual for up to two years or longer. The researchers found that there was less impact from negative events for those participants that reported they had greater emotional self-awareness, expression, self-control and emotional self-management. Armstrong et al., (2011) reported that it was normal for an event to impact an older adult for even up to two years. Most participants with high emotional intelligence reported having less stressful events in their lives. The researchers explained that awareness of our emotions will be less affected by stressors (also see Gaffey, et al., 2016) or events and can function normally unless the stressor takes over leaving us unable to manage our life. Tovel and Carmel (2014) pointed out that negative events become more frequent during aging and can include reduction of needed resources and health issues. Therefore, a good support system in place can encourage an older adult to continue living independently with the right supports in place.

Support Systems

Family support is an important element for older adults to living independently, maintaining their dignity and the belief they can continue living alone. The review specifically looked at family belief systems, organizational patterns, communication and problems solving. Support systems should consist of individuals from various backgrounds to work together to provide assistance to the older adult while the older

adult builds resilience skills for day-to-day functioning and to manage future events (Fortinsky, Tennen, and Steffens, 2013). Fortinsky et al., also reported that there are more than 45 million Americans providing on average 20 hours per week of unpaid care to older family members living that still live in their home that have some type of physical and or mental health impairment. These caregivers suffer from symptoms of stress, depression, and the feeling that they have no control over their time or their lives due to the caregiving responsibilities. Some reported feeling trapped by their responsibilities of caring for an older adult and at times helpless yet continued to provide services (Fortinsky, Tennen, & Steffens, 2013). Caregivers should be aware of the ability that the older adult has to manage their lifestyle while putting effort into helping them build resilience to future events, so they can feel more able and confident to remain in the lifestyle they choose.

Wedgewood, LaRocca, Chaplin and Scoggin (2017) also studied support systems for older adults and found that the support system does impact the quality of life. Most important was the involvement from family members, social activities outside the home, and positive interactions with caregivers. They suggested observing interactions to work through problems while encouraging communication to strengthen relationships, which will provide a more positive environment and quality of life. Qualls (2016) studied families that provide long term caregiving services and support for their older adult members. These caregivers are usually unpaid and reliant on their own funds to care for a family member; they provided over 75% of long-term care or support. Qualls (2016) reported that in the last year “34.2 million adults provided some type of care for adults

over 50 years old" were mostly female, and were a close relative, spouse or child of the older adult (p. 284). During her research, Qualls (2016) also discovered that systems that oversee or assist families who care for an older adult in her area did not do a good job of ensuring that they are connected to available services which may help them manage the care they provide. The average age of those older adults receiving support or care was "69.4 years old" with "47% being over age 74" (p. 284). It is important to note that 'caregivers' provide a wide range of services from medical needs, monitoring, advocating, cleaning, provide hope, motivation, assist with daily living skills, pets and are the same people who are there during holidays. These services allowed the older adults to remain in their home where they were comfortable; having a family member provide needed support was an added positive.

When discussing family support, Smith, Banting, Eime, O'Sullivan, and van Uffelen (2017) wondered if older adults would be more prone to physical activity if they had more people to talk to. Understanding that older adults are living longer, they found that in 2010 over "524 million people were aged 65 and older" and it is estimated that "by 2050 this number is expected to triple" (p. 2). Smith et al., (2017) were interested in ways the older adults could age well and conducted a literature review using specific guidelines; studies that reported any association with social support and physical activity in older adults, any connection to specific types or sources of "support (task specific or general support whether from family, friends or exercise groups (if involved) or if there are any types of connections between physical activity in the community, at home, or occupational (if involved)" (p. 2). Smith, Banting, Eime, O'Sullivan, and van Uffelen

(2017) collected studies that included older adults at least 60 years of age and no less than 50, a valid measure of social support with two items, or a measure for loneliness and the studies were acceptable in English, German, French or Dutch language (p. 3). Smith et al., collected 4265 research articles, duplicates were removed leaving 3349 and after screening to remove those that did not fully fit criteria, 211 remained for review of which 27 met full criteria. Smith et al., (2017) pointed out that the way physical activity was defined was very different in the studies as was the definition for older adults and reminded us that there are great differences between young, middle and oldest old. Smith et el also pointed out that as we age, how we need and use social support can also change; older adults retire, there may be one or more illnesses and death. The outcomes were that older adults that have good social and overall support systems are more likely to engage in some type of physical activity. Four studies suggested women more so than men engage in physical activity while enjoying a general support system and that more women than men self-rated their health as an outcome of their support system. Friend support was found to be important for leisure and uncovered a connection to physical activity whereas there was no connection found in the general support systems. Finally, it is recommended from the findings in the literature that having a social support system for older adults can be beneficial and should be implemented into the interventions and assessment of needs.

Roth (2018) focused her resiliency research on the community as a whole as a support system rather than looking at individuals in order to understand whether dependency is a community need or an individual one. Roth (2018) made us aware that

many communities are believed to be resilient and are able to take care of their citizens, but the truth is that those with a mental illness or other disability are not protected, which has the potential to leave them devastated should there be an emergency or a disaster. Roth (2018) also contended that lower income individuals may also suffer reduced resiliency while trying to adapt to unexpected events or changes in their lives. Negative situations that impact the community overall may also impact those who have lower income levels and limited resources to adjust and cause some type of personal distress. Limited or loss of income, lack of a support system, and a reduction in the ability to socialize are examples of situations that may promote vulnerability in this population. Roth (2018) explained that plans that include the whole community leave out those who need more help leaving them in situations which may result in greater vulnerability and reduced resiliency depending on the individual.

Vulnerability

Vulnerability of older adults can come from many life situations such as living in rural areas far away from resources, not having family members for support, limited incomes or low incomes or not being adequately prepared for changes in a community especially for those who live in disaster areas. Ashida, Robinson, Gay and Ramirez (2016) agreed with this statement and reported that the usual concerns about older adults expands into even more concerns over the older population should something happen, and they have no electricity, food, or normal daily care. With approximately 20% of people living in rural areas of the United States, there is a valid concern for these individuals should there be a disaster (p. 2119). During a literature research Ashida

(2016) found that there are disaster plans available through government agencies giving guidelines to get organized and what older adults should have on hand for emergency preparedness but also found out that most older adults in these areas are not that organized which can leave them vulnerable. They were interested in the psychological aspect of being prepared for a disaster or if the older adults' perception is that they will never be exposed to a disaster, are they still prepared or not. This study followed the guidelines of a previously used preparedness training program for those with disabilities in Oregon which was tested in a controlled trial and found to be effective. "PrepWise" (the adapted program for this study) was presented to older network service providers and older adults in Iowa City, Iowa. Five staff members participated from service agencies to include the executive director, case manager, meals coordinator, nutrition specialist and volunteer coordinator to get feedback from those who provide services (p. 2123). This study was set up as five small group trainings, the interviews and focus groups. Trainings were presented first followed by focus groups and discussion on preparedness. Researchers requested feedback from participants on their perceptions of being prepared, reactions after the training and any suggestions or recommendations to change the training to benefit older adults. Service providers were 4 females and 1 male; 2 married, 3 lived alone, all 5 Caucasian, 2 reported some college and 3 had a college degree or more with three reporting they are currently employed and 2 are volunteers. The community residents were 4 females and 1 male; 1 married, 4 lived alone, 4 Caucasian and 1 African American, 2 had high school diplomas, and 3 had some college. The focus groups totalled 30 participants; 23 female, 7 males, 7 married, 24 live alone, 28 Caucasian and 2

African American, 9 had high school diplomas, 5 reported some college and 16 had a college degree. Five service providers and five older adults participated in the interviews with a total of 30 older adults that participated in the five group trainings; the first two groups had 10 participants at a local senior center, the second was at a local church that had one group and 8 participants, and the third was presented at a government-subsidised apartment building for older adults that had two groups with 12 participants. Participants also completed 2 surveys; 1 before the training and 1 after one month to compare if the older adults made any changes to their supplies or perceived vulnerability in a disaster. The interviews were open ended questions; past experience with disasters and emergency situations; current and planned preparedness behaviors; perceptions about their own elderly clients' susceptibility to disasters and emergency situations and how severe the consequences would be. Results were that many of the older adults had had experience with "winter/ice/storms (80%), floods (73%), severe thunder/storm/hail (68%), and tornadoes (63%)" (p. 2125). The Iowa flood of 2008 was the most remembered disaster and many participants reported loss of possessions and that service providers reinforced many had no skill to cope with disasters. The perception among the older adults was that a disaster would be likely to occur and that they may be vulnerable. Service providers reported concern for the older adults being at risk especially if they cannot easily get to them and they have no power especially those who rely on oxygen. Providers reported they felt older adults would have difficulties even if they have family support just because they are rural and those that work to make have a preparedness plan will thrive better if there was a disaster. Participants perceived themselves differently; they reported

what was suggested was not that difficult and they would organize a preparedness kit, but others reported difficulty especially with the cost of the materials they are expected to have and showed concern for having to add to items in their home that would cause clutter. That being said, many of the focus group participants discussed and then agreed that it was a smart idea to be prepared and that this study motivated them to begin the process just in case something happens. The surveys showed that many of the participants had some supplies but would complete their kits to include a flashlight, three days of medications, extra batteries and a fire extinguisher. Social relationships were one of the most important areas and were explained as a resource (children and siblings), a barrier (support system) to disasters and as a motivator. Awareness and preplanning by support systems and care givers will ensure safety and reduce vulnerability of older adults who live in disaster prone areas.

The importance of vulnerability has also been studied in connection with independent living and the ability for self-care in older adults. Burnett et al., (2011) recruited 100 older adults who lived in a community and were reported as self-neglectful of "physical, medical, or mental health" and who were clients of the Texas Adult Protective Services (APS) office (p. 392). They also recruited 100 older adult participants from a geriatric outpatient clinic with the same basic demographic data (age, race, gender, socioeconomic status), yet had no previous referral to APS. The assessment included the Mini-Mental State Exam (MMSE) and the 15-item Geriatric Depression Scale. The Kohlman Evaluation of Living Skills (or KELS) was also included to assess activities of daily living such as cooking, cleaning, personal hygiene, safety, and other

daily functions. The researchers used a scoring system of 0 to 16 (one point for every activity requiring some type of assistance). Those participants who scored less than five were considered able to live independently in the community. Any score over five was considered to be in need of more assistance in order to live independently. Outcomes for both groups, which were basically the same in demographics, showed the APS group were more likely to live independently, yet had more depressive symptoms, were more likely to deny participation in spirituality (Burnett, Cully, Archenbaum, Dyer, & Naik, 2011), took fewer medications, and had higher scores on the KELS (ADL measurement). Overall, they also reported better daily functioning than the community group. There was a significant difference in the self-efficacy scores for the ADL group resulting in the finding that those who had higher independent ADL scores also had 13% higher self-efficacy.

Vaingankar, Subramaniam, Abdin, He, and Chong (2012) also researched vulnerability of older adults who may need for help in their daily living and how this impacted their family members. They reported that older family members who are suffering a mental illness was a reason many families reported that they had to make an adjustment in their work schedules to ensure proper care was provided to that family member. The researchers explained that not only does the care giver go through experiences while in this role but also emotions that may range from “feelings of guilt, embarrassment, stress and anxiety” of having a mentally ill loved one and feeling somehow, they could have done something different or provided better care for the loved one (p. 213). The researchers organized how they saw the burden of care into two areas;

objective and subjective. Objective was defined as the physical effort it takes day-to-day to provide care to include shopping, bathing, feeding, and keeping living areas clean. Subjective was the managing of any acting out behaviors, relationship issues, loss of employment and loss of social life and leisure activities due to the care giving role. The Singapore Mental Health Study (SMHS) began with a list of residents from an administrative database. The survey was conducted over a 1-year period between December 2009 and December 2010 using the World Mental Health Composite International Diagnostic Interview (CIDI version 3.0). Thirteen thousand five hundred possible participants were sent a letter inviting them to be in the study with 6,616 responding. This resulted in 2,458 actual participants that met criteria of having at least 1 family member with any chronic physical and/or mental illness. The study included diagnosis of "asthma, neurological, cardiovascular disorders, etc) and mental disorders (major depressive, bipolar, generalised anxiety and obsessive compulsive, dysthymia and alcohol abuse and dependency" (p. 214). Participants included Singapore residents, aged 18 years and above, who were Chinese, Malay, Indian and any other ethnic groups. Demographics included; 1,207 males, 1,251 females, 568 never married, 173, currently married, with 15 reporting they are divorced/separated. Education was reported as 101 completed pre-primary, 366 primary, 765 secondary, 472 Pre-u/Junior College/ Diploma, 241 vocational and 513 had university degrees. One thousand twenty reported they currently were employed, 548 were economically inactive (includes homemakers, students and retirees/pensioners), and 117 were unemployed**.** Participant incomes were reported as 1,207 (below $20,000), 730 ($20,000 to 49,999), with 41 (50,000 and above).

Caregivers reported mental illnesses of those they cared for as 183 (Major Depressive Disorder), 13 (Dysthymia), 44 (Bipolar Disorder), 45 (Generalised Anxiety), 101 (Anxiety Disorder), 101 (Obsessive Compulsive Disorder), 94 (Alcohol Abuse), 21 (Alcohol Dependence), 605 (any mental disorder), and 1198 (any chronic physical condition). Participants were asked two open-ended questions about the burden of being a care giver. The first was; "taking into consideration your time, energy, emotions, finances and daily activities, would you say that [his/her/ their] health problems effect your life a lot, some, a little or not at all?" along with the level of (1) embarrassment and (2) to be worried, anxious or depressed using 4-point scale where from 1 being (A lot) to 4 (not at all). Also, 4 questions were also asked about financial impact that caregiving had on the family member (money spent out of pocket or lost). Vaingankar et al., (2012) reported outcomes of the study as Malay men were the highest to report a burden in care giving especially with diagnosis of anxiety and depression. Burden was reportedly connected to caregivers' fear of the unknown and worry about what the future holds for those that they provide care for. Yet, these thoughts and emotions were greatly reduced when the care giver could report they had good social support in place for themselves. No limitations were reported.

When discussing caregiving roles, Larkin and MacFarland (2012), also pointed out that women on average earned less than men so they would be the more likely choice to have to leave their jobs to care for an older adult. Decisions whether to continue working or quit a job to provide family care was approached by exploring the availability of services that could be accessed before making a rash decision to quit a job that

provides needed income. Overall, it was also discussed that the vulnerability of the older adult should be discussed not only with the individual but also those who may consider the caregiver role along with an assessment to determine needs in order to make decisions about who the caregiver could be and what burdens this individual would have to manage. This section provided studies that show that it is not just in the United States that older adults are in need of support, but it continues to be a worldwide issue.

Population Aging

The previous sections have discussed literature on the nature of resiliency in general and the factors that researchers have identified as influences on it in the general population. Since the focus of the current study is on resiliency among older females with mental health issues, the remainder of the literature review examines the research that has been conducted on resiliency among older adults in general and on the links between resiliency and mental health. First, an overview of relevant literature on the aging of the population is presented.

Older adults are living longer, and this population continues to grow (U.S. Census Bureau, 2011). According to the 2010 U. S. Census, between the year 2000 and 2010, the population of persons 65 and older grew by 15.1%. In contrast, the total U.S. population only grew 9.7% (U.S. Census Bureau, 2011, p. 1). The grouping of 65 to 69-year olds grew the fastest. These numbers rose from “93.5 million to 124 million from the year 2000 to 2003” (p. 3). This population was expected to grow more rapidly as baby boomers started turning 65 in 2011. The U.S. Census Bureau (2017) reported that in 2017

there were 325,719,178 total people living in the United States with 276,861,301 (15.2 %) older adults 65, suggesting that this population is growing.

As older adults age, they may experience a number of increased stressors combined with new health issues, according to Krause & Hayward (2015) and Van Wormer et al., (2011). The population of persons who suffer with a severe mental illness, for example, is growing at such a rapid rate that it will double by 2030, resulting in at least one in four older adults having a mental illness as reported by Larkin and MacFarland (2012). Lowe and McBride-Henry (2012) stated that older people who live longer could expect at least one chronic illness during the latter part of their lives (p. 18). This is one reason to research resiliency and uncover ways for older adults to optimize their quality of life. According to Shastri (2013), a discussion of resilience should include an understanding of what is involved in an individual's life. Everyone has a different life story and different factors that may determine resiliency. For older adult women, for example, numerous factors resulting from their age and length of life experience contribute to their resiliency as opposed to the personal factors influencing that of a twelve-year-old boy. Clark et al., (2012) also added that older adult population increases are the result of reduction in one's health, mental health, overall well-being, and ability to function on a day-to-day basis.

Tkatch et al., (2017) studied older adults' perception of health and found that there is a need for social and psychological resources which can aid in maintaining a healthy lifestyle while aging. A marketing firm was hired to complete the interviews. Participants were recruited from the insurance plan American Association of Retired

Persons (AARP) from Phoenix, Arizona and Chicago, Illinois. Four thousand older adults aged 65-86 who were enrolled in the AARP Medicare supplement plan were contacted and selected according to their Hierarchal Condition Category (HCC), meaning how often claims were processed for that individual by 3 categories; healthy and active, at risk and very sick. Researchers then categorized the at-risk group into high and very low resulting in a total of 32 participants aged 66 to 80 (mean age 72) of which 17 were females, 15 males, 27 reported being married, 4 widowed and 1 had a significant other. Participants had to agree to be available for a scheduled phone interview and not be employed by a marketing or advertising agency or United Health Care. Participants were asked to discuss their overall health, health needs and what they felt they needed to maintain their lifestyle. The first theme that emerged was that there was a difference in true health issues (according to insurance claims) and how the older adults saw their health. Most participants with chronic health issues downplayed those issues and rated themselves as healthier than they truly were. Healthy lifestyles include psychological and social well-being. Strong resilience was considered a part of aging successfully along with coping mechanisms and a good support system was revealed to be important not only for current health but for future health and abilities to remain independent along with the ability to maintain day-to-day functioning. Results also found that the older adult cherished good health days, being with family, and having a purpose in life, yet admitted fears of future health issues that may disrupt their lifestyle.

Wild and Wiles (2011) stated that the term resilience is considered a concept that attempts to explain how people cope with disadvantageous life events or sudden changes

in one's lifestyle. They explained that they found that earlier research was referred to resilience as a "personality characteristic or trait" but more recently the focus has shifted towards how people actually learn to be resilient (p. 3). Wild and Wiles (2011) also stated that there continues to be a debate over how resilience actually aids in assisting an individual to manage unexpected events while maintaining their day-to-day functioning without increasing vulnerability. More recent concentration has moved to the older adult's environment and how environmental factors may play a role in developing good coping skills to use during unexpected events and was labeled 'person–environment interaction" that empowers the person to adapt to changes (p. 3).

Hayman et al., (2016) also investigated past and current literature articles and reported they found that the challenges reported were not only mostly the same but also were discussed in the same manner as what was reported in the past. They stated that factors such as decline in physical and mental health, finances, availability of resources, aging, reduced dependence, feelings of loss of personal control, and a decline in needed services may be contributing factors to reduced resiliency. They pointed out that older adults have the capability to adjust what they need with what they can get and have the ability to adjust their lifestyles to accommodate for these changes. They also stated they found that older adults were aware they were aging and that some activities they used to be involved in may have had to be exchanged for other activities they enjoy and can participate in. It was found that even in later life, older adults, when they were able to integrate good coping skills or problems solving, the result was a more positive view of aging. Finally, Hayman et al., (2016) reported that studies on health declines stated that

the reduction in socializing was a cause for other issues to surface that included becoming more reclusive. They suggested that a good support system combined with knowing the older adults' abilities and history, can enable them to manage their lifestyle and increase feelings of self-worth.

Levels and Perceptions of Resilience Among Older Adults

Older adults may not always agree on their perception of resilience. According to Fortinsky et al., (2013) who conducted a literature review questioning where older adults collect their resiliency skills while aging and managing health issues. The researchers stated that resilience is the result of learning to cope under stressful situations. Three specific features were examined to understand the process of building resilience; individual control, how older adults learn to accommodate, and how a positive attitude can help build resilience. Under individual control; Fortinsky et al., (2013) reported that they found in the research that as older adults age they may find themselves unable to do many things they have in the past forcing them to rely on secondary help (adult children) to step in and assist. This assistance then allows the older adult to not only to maintain their current lifestyle but also instils a feeling of confidence that increases resilience to maintain their lifestyle while also reducing thoughts of helplessness. Under the category of how older adults learn to accommodate; the researchers found that those older adults who are able to learn to accommodate by seeing themselves in a more positive manner and able to handle the situation versus thinking they are unable to manage a situation are more able to manage a situation and move forward. This is especially common when the older adult has no other support system and in circumstances that involve illnesses, pain

or loss. Lastly, how a positive attitude can build resilience; efforts to maintain a positive attitude regardless of situations is believed to build resilient resources along with engaging in enjoyable events is a good strategy to improving attitude.

Shastri (2013) conducted a review of literature on resilience and identified that "resilience is considered to be essential as a component of successful psychosocial adjustment" (p. 2). Shastri furthermore stated that "mental health is a fundamental element of the resilience, health assets, capabilities, and positive adaption that enables people both to cope with adversity and to reach their full potential and humanity" (p. 2). He reported that resilience is connected to mental health and relies on many factors that allow an individual to manage adverse experiences. Interest in resilience has spread to the education and the business world. Shastri (2013) found that there are 3 main aspects of resilience; 1). "the ability to achieve positive results in high risk situation, 2). The ability to function competently in situations of acute or chronic stress and 3). The ability to recover from trauma" (p. 3). Shastri also reported that he found factors of resilience: 1) "identifying resilient factors and qualities, 2). Processes for building resilience, and 3). Developing measuring instruments" (p.3). Finally, Shastri (2013) reported that there are many characteristics of resilience that show ability to manage events or situations. Some of the characteristics were "control over the process of remembering traumatic experiences, integration of memory and emotions, regulation of emotions related to trauma, control of symptoms, self-esteem, internal cohesion (thoughts, emotions and actions), establishment of secure links, understanding the impact of the trauma, and developing a positive meaning" (p. 3). Overall, Shastri (2013) found that even children

that have protective or resilient factors are able to manage events even though they are young. This of course has to do with the age of the child, his or her development, the environmental situation they are trying to manage, and that resilience can be different in different stages of life. Older adults focus should be on their environment, their resources, vulnerability, and available services. So those older adults that suffer from illnesses of hardships can be still considered aging well.

Domajnko and Pahor (2015) also wanted to better understand resilience in older adults and how their resilience and health were connected. The researchers set up a 12 week fall prevention training course for older adults at the University of Ljubljana, Faculty of Health Sciences and recruited participants from the Pensioners Association of Slovenia, senior clubs and day care centers within Ljubljana. The participants were 22 females and 3 men (no age breakdown). The researchers conducted semi-structured interviews at the beginning and ending of training as the researchers also wanted to include an evaluation of the training program while interviewing. Topics discussed were aging, health and illnesses, healthcare and the training program. The researchers found that the participants felt they had healthy well-being despite being diagnosed with having serious medical conditions (high blood pressure, vertigo, Alzheimer's, musculoskeletal disorders, etc.), had strong attitudes toward socializing and the important effects of socializing (feeling more like working out with friends than at home, strong attitudes toward working out (being arounds friends and their children make me want to move and play), keeping a positive attitude while aging (I stay in contact with young people even though I am old), and socializing can be life changing (being with friends makes me

forget my problems, I would not be here had it not been for my friends making me get out of the house). Socializing in the community and having friends was found to be an important preventative measure against negative aging and health, whether it was within a public program or family and friends. The researchers also pointed out that this study was conducted with older adults who were considered healthy and proactive in how they dealt with aging and health issues.

Zeng and Shen (2011) also studied resiliency on centurions in 2008-2009 using a data set from the Chinese Longitudinal Healthy Longevity Survey. Data from 16,566 people who were over the age 65, including 3413 aged 94 to 98, were reviewed. The results showed that the oldest individuals, compared to younger elders, had a 43% higher resiliency in their day-to-day living abilities than those who were younger. The higher resilience in older Chinese correlated with good physical and psychological health that seemingly enhanced the probability of their longer survival. Zeng and Shen reported also that they found that policies and programs specifically geared toward creating activities to encourage older adults to stay productive were worthwhile as they build and maintain resiliency levels.

Response to Stressors

Along with creating activities should also be education on managing stressors and implementing coping skills. Coping with stressors is a common theme among studies of resiliency in older adults and according to Kuo (2011) stress and coping are universal experiences for everyone regardless of culture but that different cultures might respond differently depending on goals, strategies to set goals and how they view outcomes (p.

1084). For example, Hardy, Concato, and Gill (2012) studied 754 older adults who live in the community in order to explore the relationship between the stress that they experienced and their resiliency. The goal of this study was to pinpoint specific stressors (Davydov et al., 2010) older adults have to deal with and learn which stressors are most stressful. The respondents reported stressful events such as "personal illness (18%), death of a family member or friend (42%), illness or injury of a family member (23%), and a non-medical event (17%) with a small number reporting physical illness as a stressor" (p. 842). Resilience levels were found to vary depending upon how the participants categorized their perception of their stressors. The results indicated: "18% identified a personal illness or injury, 42% the death of a family member or friend, and 17% identified a nonmedical event such as a home break in or being cheated" (p. 842). The outcomes also included "18% identified a personal illness or injury, 42% the death of a family member or friend, and 17% identified a nonmedical event such as a home break in or being cheated" (p. 842). The respondents reported stressful events specifically as "personal illness, death of a family member or friend, illness or injury of a family member, and a non-medical event, with a small number reporting physical illness as a stressor" (p. 842). Most of the participants reported that they would like to have the opportunity to discuss these events with their primary doctor in order to not cause a distraction in their lives, but many stated they did not do so. Davydov et al., (2010) suggested that more research was needed in order to understand the role of stressors such as family problems or other possible issues within the individuals living environment. They also suggested that it was also important to understand what learned coping

behaviors individuals had at their disposal to manage these stressors (Krause & Hayward, 2015; Van Wormer, Sudduth, & Jackson, 2011) or other challenges that may arise in daily life.

Smith and Hollinger-Smith (2015) reviewed the literature that was available on resilience and stressors and reported they found that those older adults who have learned over time to enjoy life experiences also had higher resilience resulting in a happier life. Stressors were also reported to come in many different forms and depending on an individual's lifestyle and resilience, some stressors may be more difficult to manage. Since stressors can come in different forms or situations, those individuals with higher resilience also have a higher quality of life along with an opportunity to grow and learn according to Smith and Hollinger-Smith (2015). Wild, Wiles and Allen (2013) researched what it means to age successfully and agreed that older adults that were able to learn how to adapt to changes in their lives whether controlled or uncontrolled and also had a positive attitude could report a higher quality of life.

According to Itzhar-Nabarro and Smosi (2012) promoting and building these skills builds confidence making the next stressor or problem less difficult to solve. For example, older adults who lose a person with whom they had a close relationship may suffer bereavement issues, especially if the loss is a spouse or their main caregiver resulting in a new stressor. Such a bereavement can also cause an increase in already existing depressive symptoms and possible deficits in resiliency.

Lim et al., (2015) agreed that adjusting to life after the death of a spouse can be difficult and also may increase stress on an older adult especially for those who the

spouse was the main person who provided the family income. Resilience skills should be used during this time if older adults' have learned those skills and have them available to incorporate into their lifestyle to avoid more depressive symptoms. Lim et al., conducted a study starting with 500 older adults who were a sub sample of the Singapore Longitudinal Ageing Studies that was an ongoing study of aging and health of community-dwelling older adults. This study resulting in 385 older Chinese adults participating and that were recruited from a housing development for older adults through door-to-door visits by trained research nurses. The participants were aged 60 to 72; 66.9 were between 60-69 years of age with 58.6 being female and 75 were aged 70 and older with 57.9 being female with over sixty-two reported they were married (no other demographics available). The nurses had the participants fill out questionnaires on health, lifestyle, and recent adverse events, resilience and their current well-being. The nurses were fluent in Chinese and English and for convenience, met with the participants in the senior center closest to their unit. Stressful life events were measured by using an 11-item life events inventory, depressive symptoms were measured by using the Geriatric Depression Scale (GDS) responding yes or no to 15 items about how they felt over the last week. Resilience was measured using the Connor-Davidson Resilience Scale (CD-RISC) of 25 items on a Likert scale ranging from "not true at all" to "true nearly all the time". Stressful life events that scored the highest was a family member/close friend died/had serious illness, major problems with money, a family member/close friend lost job/retired, hospitalization or an emergency room visit or at least one stressful life event. Other reported outcomes that were reported as less disruptive was a divorce, spouse or

partner died, family member had a divorce or a breakup, major conflict with children or grandchildren major accidents/disasters/muggings/unwanted sexual experiences/robberies, physically abused or threatened, verbally abused, or pet died (p. 1008). Lim et al., (2015) reported the outcomes were not surprising for this age group and that the older adults used resilience as a barrier to avoid increased depressive symptoms after a stressful life event was not new. The participants also reported personal competence and optimism in daily living which along with hope underlies resilience skills to manage when they are faced with a stressful life event. This study reminds mental health practitioners to assess resilience in older adults prior to starting treatment to understand how stressors may disrupt the day-to-day functioning of the older adult with a mental illness.

Lima et al., (2015) conducted a study on older adult Chinese resilience and late life resilience as a possible buffer against depressive symptoms after a stressful life event. The researchers reported non-health stressors such as a death of a partner, conflict with another individual, loss of a pet, a partner having a serious illness, death of spouse, or financial troubles as major contributors to depressive symptoms (Lima et al., 2015). It was noted that late life depression can also be a contributing factor for ill health, so it is important that protective factors against late-life depression remain at the forefront of research. Lima et al., (2015) began with 500 participants aged 60 from the original Singapore Longitudinal Ageing Studies (SLAS-2), an on-going population-based study of aging and health of community-dwelling older adults aged 55 and above living in local geographically defined areas in the Central and South Western regions of Singapore. The

participants for this study were 385 Chinese participants for whom complete data on health, lifestyle and psychosocial variables including occurrence of recent adverse life events, resilience and their subjective wellbeing were available for analyses. Participants were advised that the study was to investigate the factors relating to well-being in older adults then asked for informed consent to participate. Trained research nurses administered all scales and questionnaires used in the study via face-to-face interviews using a language the participant spoke and understood, either English or Chinese, and in a location closest to the participant's residence. The mean age of the participants in this study was 72.1 years, 58.2% were female and 56.1% were married. Participants had an average of 4.1 years of education with the younger participants aged 60-69, having more years of education than those 70. Stressful life events that were reported overall was death or serious illness of a family member or a close friend (17.1%), followed by major financial problems (14.0%) and hospitalization or visit to the emergency room for medical illness (9.9%). Resilient factors reported were personal competence, optimism, commitment, perseverance, independence and self-esteem (Lima et al., (2015). The researchers found that stressful life events cause an individual to have higher depression and that less stressful life events were associated with less depressive symptoms. The researchers reported their outcomes were not surprizing due to the fact that it has been shown in other literature that higher resilience allows an individual to manage life stressors easier (Schure, Odden, and Goins, 2013).

Edo, Torrents-Rodas, Rovira and Fernandez-Castro (2012), explained that coping skills and resilience play a role in the ability to accept and manage stressors, events or

news that may disrupt an individual's lifestyle. This may include diagnosis of a mental illness and the impact on the individual and those who may provide support. This diagnosis may first lead to adverse reactions (Edo, et al., 2012) such as depression, anxiety, negative thinking or a combination of these symptoms. Itzhar-Nabarro and Smoski (2012) found that older adults are happier if they have relationships that make them feel good about themselves. These authors conducted a literature review about data from relationships focusing on marital satisfaction and bereavement for lost spouses. The authors looked at how the death affected their respondents psychologically and their stress level. They concluded that most of the research reviewed supported the idea that participants had resiliency skills and were able to move forward with their lives without their partner. The authors also reported that following marriages that were more stressful and had conflict, the spouses had more difficulty accepting and moving on after the spousal death.

Problems with cognition and memory can disrupt the day-to-day functioning of an older adult and also add in an element of stress. Powers, Bisconti, and Bergman (2014) conducted a study using 57 widows from northern Indiana and southwest Michigan. The widows ranged in age from 57 to 83 and were married from 14 to 63 years. The researchers reported that managing after the loss of a spouse might mean changes in current living conditions and might require extra support to manage life after a death. The researchers revealed that with a support system in place, older widows were able to maintain as much of a normal lifestyle as possible without a lot of variation in resilient abilities, emotions, depression or life satisfaction for many months following the loss of a

spouse. Depressive symptoms that did develop were also found to be reduced over time. Changes that were reported where evident to surface during or around the upcoming date the anniversary of the death of the spouse. It was then noted that the participant could return to her normal lifestyle after the date had passed. According to Alex, (2010), many older adult females may have lower than desirable incomes especially after the death of a spouse which may cause lower resilience. This combined with having to adjust how they lived, most likely will involve more emotions. Ghesquiere et al., (2016) also conducted a study about the bereavement of homebound older adults to uncover if there was an increase in poor mental and physical health, any type of abuse, neglect, or financial stressors after a death. They used a sample size of 5,561 from the New York City Department for the Aging by accessing data entered by case managers about the loss of a partner or child in the last year. Participants were 60 to 108 years of age with a mean age of 81.4. A total of 3,884 were female, 1,677 males, 1,280 were African American, 3,430 White, 160 Asian and 691 reported they were Hispanic. Eight hundred eight reported mental health issues, 141 experienced death of a partner or child in the last year with 42% of those participants being males. Those that reported bereavement also reported that they had a depressed mood and more financial problems than those who did not suffer a death (or did not report). This was reported due to the older adult having to take on other daily tasks such as financials and care of the home plus those with lower incomes reported life became harder to manage by themselves. Overall, this study showed that while managing bereavement along with lifestyle changes, depressive and financial issues increased causing the older adult to try to find more support and assistance to include some case

management for financials, bill paying, housework, meals, laundry, and medications (Ghesquiere et al., 2016). Ghesquiere et al., (2016) did state that one limitation of the study was that dates of the deaths were not confirmed so causality could not be reported, and the researchers were unsure if the symptoms of bereavement were prestudy symptoms.

Montpetit, Bergemen, Deboeck, Tiberio, and Boker (2010) conducted a study on stressors (Krause & Hayward, 2015; Van Wormer et al., 2011) using participants from a subsample from the Notre Dame Longitudinal Study of Aging which was designed to measure stressors as aspects of aging using two methods. The 42 participants were 65 to 92 aged, 90% White, 5% African American, and 5% Hispanic. Eighty three percent were female, 54% living alone, with 37% reported they were married. Ninety eight percent reported education through high school, 64% had some post high school education with 24% reporting yearly incomes of less than $15,000 and 34% between $15,000 and $25,000; 24% between $25,000 and $40,000; and 17% reported over $40,000. Participants were initially surveyed asking about daily negative affect using the Negative Affect subscale (10 items) of the Positive and Negative Affect Schedule. A 5-point scale was used ranging from 1=slightly to 5= not at all. Daily stress was measured by using 10 modified items from the Perceived Stress Scale reporting daily life stressors; “Today, how often have you been upset because of something that happened unexpectedly?” and “Today, how often have you felt difficulties were piling up so high that you could not overcome them?” using a 5-point scale from 0=never to 4=very often (p.634). The Dispositional Resilience Scale also was used to measure perceived protective factors;

control, commitment and challenge; 1- not true at all to 4=completely true. Examples of questions were; “Planning ahead can help me avoid most future problems”, “Trying your best at everything you do really pays off in the end” and “I like it when things are uncertain and unpredictable”. (p. 634). Finally, social support was measured using The Interview Schedule for Social Interaction looking at frequency and supportive behaviors of family members and friends asking questions; “How many people (family or friends) can you share your innermost feelings with and confident?”, “How many people in your neighbourhood do you know well enough that you can ask them for things?” and “How many people do you know who can share your joy or who will be happy for you because you feel happy?” (p. 634). Answers were scaled as 1=(nobody), 2= (1-2), 3= (3-5), 4= (6-10) and 5= (11 or more). Participants were also required to keep records (their personal daily diary) for an additional 56 days. The researchers were interested in what older adults currently stated was linked to their stressors and what the overall effect these stressors were on their functioning. The researchers found a connection between stress, daily functioning, and negative emotions. In this study the participants who reported that they were able to handle their day-to-day stressors also reported that they suffered fewer negative emotions and that friendship was a significant predictor for resilience. The same participants also reported their recovery time from stressors lessened as they developed better coping skills, built a stronger support system of friends and family, and strengthened their resistance to detrimental effects of ongoing stress. The researchers suggest that more research is needed on mental illness symptoms and support systems to

include how people are able to bounce back after an adverse event or not having a good support system in place to talk about events.

Research into the impact of daily stressors on older adults was also conducted by Diehl and Hay (2010) who were interested in the differences between the ability of young, middle-aged, and older adults to handle stressors (Krause & Hayward, 2015; Van Wormer et al., 2011; Montpetit et al., 2010). They stated that they believed how individuals perceive their personal control over stressors was also important in the management of daily living skills. Their study participants were 239 adults: 120 men and 119 women who were recruited from the North Florida Tri-State area. The researchers required that the participants would have no history of or current major sensory impairments, no symptoms of depression or history of a mental illness. Participants also had to have the ability to physically come to the research site and have adequate cognition to answer questions. The outcomes reported were significantly different in the younger adult's self-coherence (inner awareness of strengths) compared to confidence levels as reported by the older adults. The younger adults reported less control of their daily lives including work and school compared to the older participants who reported they felt they had control; the younger adults reported higher negativity on a daily basis than the older adults with the older adults reporting greater daily management over control of daily stressors combined with having greater health stressors than the younger to middle-aged adults. The researchers reported that control over stressors may depend on the stressor itself (Krause & Hayward, 2015; Van Wormer et al., 2011; Montpetit et al., 2010; Diehl and Hay, 2010) and the individual's attitude. Also, that if an individual has a

mostly negative attitude, then they also may not be able to manage the stressor as well as an individual who has a more positive attitude and believed that they can handle their life and stressors they face. Collazzoni et al., (2016) explored resiliency following the experience of violence as a stressor during childhood and whether resilience was able to help that child to deal with the situation in order to move on. Participants were 608 university students, mean aged 28-29 years, 323 males and 285 females. The participants filled out Risky Family Questionnaire (RFQ) which asks questions about family environment and conflict between family members, the Brief Symptoms Inventory which assess psychiatric symptoms, the Global Severity Index (GSI), and the Positive Symptoms Total (PST). The Resilience Scale for Adults (RSA) was used to measure resilience and has 33 items measuring six resiliency dimensions. They also looked at situations where there had been no violence, but evidence of extreme family stressors may have initiated their resiliency skills to activate and allowed better management of the situation. The researchers found that it was the individual's perception of the event that either allowed resilience to take over or not. The researchers found as results that having negative experiences while growing up challenged the growth of a child's resilience, and that resilience, if present, protected them from having symptoms; likewise, a lack of resilience made it difficult to cope with negative experiences. Resilience was found to carry into adulthood and the researchers stated that they found past events or situations could interfere with the ability to manage life in older adult years. Larkin and MacFarland (2012) also reported that Kaiser Permanente and the Centers for Disease Controls reported that there is a strong connection between adverse child experiences and

older adults' health risk behaviors to include substance abuse, overall health issues and mental health.

Kwag, Martin, Russell, Franke, and Kohut (2011) were also interested in how older adults could manage living independently, what symptoms they reported, and what stressors they had to deal with while living independently. They stated they felt that it was important, not to only evaluate depression, but also loneliness and fatigue, conditions that could also promote symptoms. They explored studies that discussed how poor mental health could be linked to current life stressors, past life stressors, limited social relationships, and low levels of exercise. Since little is also known about the effects of fatigue on older adults, the researchers decided to conduct a study looking at perceived stress, social support, and home-based physical activity to see if these had any direct connection with fatigue, loneliness, and depression in older adults age 65 and over. The study began with only two specific requirements; that the participant was age 65 and older and that they lived in a rural or urban county. The researchers reported this study was part of a larger study on risk and resilience in rural counties. Participants were invited to participate by an advertisement in the local newspaper, by a referral by local agencies and extension specialist, advertising in senior centers, nutritious meal sites and senior expositions. 212 participants were contacted by telephone, with 163 agreeing to participate. The researchers agreed that there is still little research on the population of over 65, but also little research on other stressors they may have to manage. Kwag et al., (2011) reported that the older adults perceived higher stress levels when they felt more fatigued, lonely, and more depressed, but when the older adult perceived more social

support, they reported that they felt capable of managing life independently. Also, they reported that when older adults are involved in physical activity that they can implement in their own home, they also felt less stressed and fatigued. The researchers also found that there was an indirect reduction of stress which was attributed to reducing fatigue through physical activity and that the stress of feeling lonely was also reduced knowing they had a social support system in place. The researchers stated that an understanding of an older adult's lifestyle can help with prevention and intervention programs while guiding the older adult to learn better ways to manage stressors by building friendships, having a good support system, learning and implementing new activities and changing how they perceived their life. Lowe and McBride-Henry (2012), reported that those older individuals who have lived with the stress of chronic illnesses have learned to adapt their lifestyles by using their abilities. This life adaption while also putting in effort to meet their own expectations have a different quality of life than those who do not. These individuals then realized that they have the ability to reroute their focus on other activities that they enjoy.

Influences on Resiliency Among Older Adults

Resiliency for older adults is affected by many variables such as learned coping skills, the process of aging, their experiences related to the stigma of mental illness, family support inside or outside the home, and the dignity of living independently. Four main factors emerged from the literature review that appear to have an influence on levels on resiliency among older adults: cognition or memory; state of mind and coping abilities; support of family and the community, and dignity and independence. However,

several studies have reported that it is a combination of several factors that is important in promoting resiliency. These are discussed below, followed by consideration of the three main themes arising from the literature.

Multifactor Influences on Resiliency

Resiliency skills may not be so easy to implement for some older adults; more education, support, or assistance may be the answer. Learning and understanding what issues they deal with may help the professional, family members, and the older adult decide what type of help is available and specifically what is needed. It is suggested that this information may also result in less long-term problems. There are many factors that may interrupt or cause some type of suspension in this process. The following research will discuss these possible combinations of influences, outcomes and more.

Relationships and Networks

Relationships can be a combination of many influences depending on who is involved in the relationship and how these individuals communicate and change over time. Fuller-Iglasius, Webster, and Antonucci (2015) additionally researched older adults and their well-being in conjunction with family size, strength of their relationships to include negativity and problems relating by revisiting the longitudinal Social Relations, Age, and Health Study of 1992 with the intent of learning if over time family networks changed and if these same individuals have progressed psychologically over the years. The researchers reported that randomly selecting participants that lived in the Detroit, Michigan area were part of the first wave of this study and these same participants were re-contacted for Wave 2 twelve years later. Wave 1 participants totalled 1,703 aged 8 to

93 and were surveyed. The 8 to 12-year-old participants were given modified surveys but then were dismissed due to age. Both waves had the participants sign consents to participate and were interviewed face-to-face in Wave 1 and by telephone for Wave 2. Participants were then aged 18 and older in Wave 1 and aged 30 to 100 in Wave 2; mean age 55.5, 60% were women, 72% reported White, 26% Black, and 2% as Hispanic, Native American, Asian and Other or did not provide a response. Participants had an average of 13% reporting some college, 68% reported married or living with a partner. Participants then were split into 3 groups; young (aged 18 to 34), middle (aged 35 to 49) and older (aged 50 to 80 and older). Researchers stated they categorized participants this way to distinguish any changes related to transition of stages when aging. Close family support network was examined by participants identifying their close relationships on a diagram showing three concentric circles. Perceived family negativity was examined by the relationships reported from spouse/partner, mother, father, and child. The family negativity scale included 2 items; “My family member gets on my nerves” and “My family member makes too many demands on me”. Participants scored on a Likert scale of 1) agree to 5) disagree. Depressive symptoms were reported using a 20-item Center for Epidemiological Studies Depression (CESD) scale. Participants reported their level of depression as 0 (rarely) to 3 (most of the time). Participants also completed a demographic questionnaire for gender, highest grade of school completed, race, and marital status. Change in close family support was no indicative of changes in well-being in the younger participants was with the older age group. The older group that reported a close support network also reported fewer depressive symptoms. The researchers stated

that older adults were more impacted by family relationships and that a healthy balance of support and socializing was found to improve psychological well-being over time. They found, in this study, that family closeness and size also seemed to allow an older adult to have more resources to pull from in times of need, with the result of reducing mental health symptoms and enhancing their life. The positives of not only the size of the family but also the willingness to be available to help promotes a more positive lifestyle for the older adult. It is also noted that a diverse system allows the older adult to count on other family members rather than the same ones over and over resulting in a possible risk to the wellbeing of the older adult when those members are not available. When discussing vulnerability, personal distress and coping, there also needs to be an awareness of how the older person feels needed as a part of the family, their usefulness to others, and supported in overcoming life's difficulties Those older adults who maintain low interaction with others may suffer a higher level of symptoms such as feeling more anxiety-ridden and depressed compared to those who put more effort into positives such as having friends and socializing (Fuller-Iglasius et al., 2015; Bowling and Iliffe, 2011).

Johansson et al., (2011) also researched the literature about older adults and relationships involving family support in Sweden. Four areas were identified as main caregiving entities: "the household and informal care, the state or public sector, the voluntary and nongovernmental sector and the care market or private sector" (p. 336). Next of kin and those involved in the family's social network were considered to be a support system, the main source of assistance and a guarantee that the older adult with have some type of continuous support. Also, consideration should be taken of the

demographics of family members. The closer a family member is the easier to provide support. Johansson, Long & Parker (2011) reported that, in Sweden, older adults that are involved with their family members was their main source of support, survival and an important element of aging. When looking at ways to help older adults, they suggested that the support system should be the first element reviewed for its strengths and positives and that those family members should want to be involved and have good a relationship. According to McMurtrie (2013, p. B13), a good support system allowed an individual to be able to function better when there are life changes, and this is connected to the closeness of our relationships with each other. The closer the relationships are and the wider the network social support is, the better people are able to manage life events and be resilience.

Hahn, Cichy, Almeida, and Haley (2011) conducted a study on widowed older women compared to married women and if they differ in daily time use and resilience. Two thousand twenty-two participants which included 75 widows and 125 married women aged 60 and older from the National Study of Daily Experiences II who completed daily diaries for over 8 days. Widows who remarried were not included. Demographic included age, education (percent with a high school degree), number of children, race (White or non-White), employment, and how many years since widowhood. Participants had 8 consecutive days of telephone interviewing asking about daily time spent; time spent with their children, doing housework, relaxing, watching television and then asking about daily well-being to include negative emotions (worthless, hopeless, and restless) and positive emotions (good spirits, calm, cheerful,

and calm). This questionnaire was a 5-point scale from 0 (none) to 4 (all the time). Participants also completed self-report questionnaires. Results were that widows reported relationships were both giving and receiving more emotional support from friends and neighbors than did the married women and they also received more daily emotional support from religious groups. Married women received the highest amount of daily emotional support from spouses, whereas widows received daily support from children, friends and neighbors. It was determined that the widows learned to find more support from outside the home than the married women. Widows also showed more resilience than married older women and that the act of engaging more with neighbors and friends resulting in less stress while also accepting support from outside sources.

According to Czaja (2016), family members provide the majority of support for an older adult. Approximately two-thirds of older adults over age 65 relied on their family members for relationships and to supply some type of support. The fact that a good support system enhances life satisfaction for the older adult with less stress. They found support in the home or home visits was a main contributor for older adults having a more positive outlook on life satisfaction. The researchers recommended the use of preventative home visits by family and professionals to provide needed support for the older adult and to intervene when an issue arises. This kind of intervention may provide a more positive atmosphere resulting in the older adults increased resiliency and an opportunity to maintain their current lifestyle. Factors to consider if an older female is resilient includes whether she has multiple resources at her disposal such as the ability to find social support by being around other older adults, being active in the community, as

well as having the ability and means to be involved in organized groups such as in the church (Manning, 2011).

Bowling and Iliffe (2011) completed a postal follow-up survey of older adults (65 and older) who participated in face-to-face interviews about their quality of life through the Office of National Statistics Omnibus Surveys. Fifty-four percent were females, 49% married or reported they lived with someone, 49% lived alone with 85% reporting they were owner-occupiers (No other demographics were available). Five hundred fifty-three surveys were mailed out asking about quality of life with 287 actually completing the Older Peoples Quality of Life Questionnaire (OPQOL). Thirty-two items with a 5-point Likert scale of "Strongly Agree to Strongly Disagree" "asking about life overall; health, social relationships and independence, control over life, freedom, home and neighbourhood, psychological and emotional wellbeing, and financial circumstances" (p.3). Bowling & Iliffe reported that they were interested in the participants' perceived self-efficacy and optimism while reviewing how they see their quality of life. The researchers' findings indicated that healthy aging outcomes are not just about physical or mental abilities but a combination of healthy living habits, strong self-efficacy, and resiliency in maintaining a healthier independent lifestyle.

Smith and Bryant (2016), also conducted a study on life satisfaction of older adults including physical and mental health and how they savor positive experiences while aging. Participants were 266 adults aged 55 to 94 years (mean age 73.4), 81% female, 45% married or reported having a domestic partner, 27% widowed, 15% single and 14% divorced. Seventy-four percent reported they were White or European America,

22% Black or African American, three fourths reported they had education beyond high school to include 9% who had an associate degree, 32% had a bachelor's degree and 36% graduate or professional degree. Thirty-six percent of participants reported household incomes as $50,000 or less, 33% reported $50,001 to 100,000 with 31% reporting they had greater than $100,000 incomes. Participants were recruited from a senior living community and local community centers. Participants completed the 24-item Savoring Beliefs Inventory (SBI) to record their beliefs about their ability to enjoy reminiscing about past events, current events, and have a positive outlook on future events; "I enjoy looking back on happy times from my past", "I know how to make the most of a good time", "Before a good thing happens, I look forward to it in ways that give me pleasure in the present" (p. 7). Participants also completed the RAND 36-item Health Survey to self-report how they see their general health; "My health is excellent", physical functioning; "Lifting or carrying groceries and climbing stairs", social functioning; "During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal activities with family, friends, neighbors, or groups?" The survey also included 2 items to assess for pain; "How much bodily pain have you had during the past 4 weeks?" and 4 items that assessed limitations due to physical health; "Cut down the amount of time you spend on work or other activities?", "Accomplished less that you would like?" (p. 8). Lastly, the participants completed a 1 item taken from the Personal Wellbeing Index (PWI) measuring overall satisfaction with their life; "Thinking about your own life, and personal circumstances, how satisfied are you with your life as a whole?" using a 7-point scale 1=completely dissatisfied to 7=completely satisfied (p. 9).

The researchers found when older adults are able to positively reminisce and savor positive life experiences their overall life is reported to be positively satisfactory with the opposite being true that when older adults suffer health issues their satisfaction with life tends to decrease. The researchers concluded that they found a positive relationship between older adults' health and life satisfaction when the participants had more positive life events to discuss and reminisce about. This was then compared to those who had less positive life events reporting a lower life satisfaction. It was also found that the lack of social support was one element that caused an increase in depression and can add to a lower life satisfaction. Limitations were that life satisfaction was not compared to heath and psychological well-being, but this study showed savoring has a positive impact during good and bad health but that the real benefit was reported for those who had poor health. Self-report can be a poor indicator of real health issues and it is recommended for the future to use an objective measure as older adults may not want to report health issues honestly.

St. John, Mackenzie, and Menec (2015) reported that there is still a need to know more about older adults, how they define life satisfaction and if life satisfaction has any effect on how long they may live. Their continued interest in life satisfaction resulted in a study using data from the Manitoba Study of Health and Aging (MSHA). The researchers reviewed data from 1,751 randomly selected older adults aged 65 and older. Demographics were collected by self-report and included; the mean age was 77.5, females were 58.5%, mean average for education was 9.3 years. Ethnicity included 12.8% Canadian, 38.5% British, 38.5 % Scottish, 6.5% German, 12.1% Ukrainian, 5.7%

French, and 24.4% were listed as other. Measures used were the Self-rated health asking general health questions; for example: “How is your health these days?”. Response choices were very good, good, not good, poor, and very poor. The Older Americans Resource Survey (OARS) was used to measure functional status asking about activities of daily living. Trained interviewer asked other questions relating to overall general health, daily living and any other problems that older adults must deal with. The scale was from 0 to 36 and responses averaged 16 for an individual. The Terrible-Delightful Scale was also used to measure life satisfaction. Twelve questions about health, finances, family relationships, paid employment, housing, a living partner, recreational activities, religion, self-esteem and transportation were asked and were rated on a 0 to 7 scale. The final question that was asked was “how do you feel about your life as a whole right now?” “Is your life generally dissatisfying or satisfying?” (p. 363). Results were that over the five year study period; 417 participant died, and it was noted that these older adults self-reported that they were somewhat older, had lower education, were males, and self-reported poor health, comorbid conditions, and functioning impairments. The researchers found that the overall data showed that most of the participants had high life satisfaction with scores being slightly lower in those that suffered health issues. They also reported that even though there is limited data connecting life satisfaction with how long people will live, they report that there is evidence that happy people live longer.

Bene et al., (2016) was also interested in where resiliency comes from, and what elements could make resilience either stronger or weaker. The researchers conducted a study on resilience, involving 480 older fishermen (no age specifications provided)

asking what was important to their wellbeing, quality of life and how their resilience to unexpected events allows them to bounce back after an event that could possibly cause a loss in income or a delay in getting back to work. Results indicated that at least half of the events or stressors were predictable and known in advance which gave an opportunity to make plans to lessen impact. Also reported was the use of coping skills such as reducing food intake and general expenses, having support in place, and seeking out new support systems. The issue of household wealth was found to have little difference between households in the different cities. Bene et al., (2016) also reported they found that these fishermen must recover from events quickly in order to move forward and that they used their coping strategies to get back to their daily schedule. Learned resiliency skills were the key to being successful fishermen regardless of wealth, level of education, or assets and that the perception of the event was critical in responding. Also, these learned resilient skills were tools that should be on hand and ready to implement if needed to manage unexpected events and directly impacted the swiftness of getting back to work to avoid possible the loss of income. Bene et al., (2016) also reported that participants believed having resilience can promote management of stressors and life events.

The role of resilience is an important aspect of aging and may reduce symptoms of depression while enhancing independent living as found by Jeste et al., (2013). The researchers attempted to assess how resilience skills may enhance independent living skills by conducting the Successful Aging Evaluation (SAGE) study, randomly recruiting 1,300 adults who lived in San Diego County, age 50 to 99, who had a land line telephone,

could participate in a telephone interview, sign consent to participate, and complete a survey. Older age was found to be significantly connected to the worst physical health, but age was not found to be related to levels of depression, optimism or resilience. Yet, older age was associated with higher Self-Rated Successful Aging (SRSA) and after adjusting for age, SRSA was connected to "higher education, better objective and subjective cognitive functioning, better perceived physical and mental health, less depression and higher optimism and resilience" (p. 5). The researchers also reported they found that older adults still had limited information available. Overall, they reported that perfect health is not a requirement for successful aging but if older adults wanted to build resilience, they must be optimistic and take good care of themselves**.** This includes proper eating, exercise, taking care of their minds, being involved in the community and having social and personal support system. In their study of older Chinese people, Zeng and Shen (2011) found higher resiliency in those individuals having to perform daily responsibilities with minimum or no assistance. These individuals reported a mostly positive mental and physical health, positive emotions, and high self-rating of older persons living independently.

Hope and Well-Being

Hope is another variable that may affect resilience and general well-being of an older adult. Polson et al., (2018) reported that before they started their study, they conducted a literature review and found that more studies are reporting that positive psychological factors such as hope, self-esteem and optimism may contribute to understanding resilience among older persons. The researchers then conducted a study to

find answers to 2 research questions: 1). To what extent does hope contribute to resilience among at-risk community-dwelling older persons and 2). How is this contribution affected by social support, spiritual experience, health, (ADL's) and ethnicity? Polson et al., (2018) began by recruiting 255 participants from the Meals on Wheels program resulting in 120 participants: 61 females and 59 males. Requirements were that participants be aged 60 and older, be receiving services from an agency, have income below the poverty level, live in standard urban housing and live alone. Recruitment was conducted by the Meals on Wheels staff and participation was voluntary and would not affect their meal service. Polson, Gillespie & Myers (2018) reported that hope was found in their research as a significant resource for coping and resilience and especially important for older adults. In their study hope was also found to be a significant resource especially when having to manage challenges of living in poverty. The researchers reported that also all of the participants had been exposed to challenges due to age, living in poverty, social isolation, living environmental hazards, and health deficits and reported that these alone are not considered sufficient predictors of diminished resilience in this population. Yet, these participants reported a higher level of hope and resilience by reporting they continue to "looking forward to the future and have a sense of optimism and anticipation" (p. 74).

Satici (2016) also believed hope influenced the lifestyle of individuals and their overall wellbeing. She conducted a study to understand how vulnerability, resilience, and well-being are affected during aging. Three hundred thirty-two university students participated in this study; 195 females, 137 males, mean age 20.96 years old who

attended classes in the northwest and middle part of Turkey and were all enrolled from 1st year (freshman) through 4th year (seniors). Individual participants could not be identified. No other demographics were available. Participants completed Positive and Negative Affect Schedule (PANAS) and Satisfaction with Life Scale (SWLS). The PANAS consisted of Two 10-point items; positive affect and negative affect which was scored on a 5-point Likert scale; 1=very slightly or not at all to 5=extremely. The SWLS was used to measure cognition dimension of subjective well-being, using 5 items asking questions such as; "If I could live my life over, I would change almost nothing" using a 7-point Likert scale; 1=strongly disagree to 6= strongly agree. (p. 69). General levels of hope were measured using the Dispositional Hope Scale (DHS) using 12 items and asking questions such as; "My past experiences have prepared me well for my future", "I can think of many ways to get the things in life that important to me". (p. 70). Resilience was measured using the Brief Resilience Scale (BRS) that assessed the participants' ability to bounce back and recover from adversities or stress. The BRS is a 6-item scale using a 5-point Likert scale of 1= strongly disagree to 5=strongly agree. The higher the score the better resilience. Lastly, psychological vulnerability was measure using the Psychological Vulnerability Scale (PVS) which has 6-items using a 5-point Likert scale; 1=unsuitable to me to 5=suitable to me asking questions for example "I tend to set my goals too high and become frustrated trying to reach them" (p. 70). Overall, it was found in this study that having hope promotes individuals to feel they can reach goals was associated with positive outcomes. Satici reported that there is "a direct link from resilience to hope, and an indirect link from resilience, to hope, to subjective wellbeing" (p. 72). This link was

found by hope being directly associated with positive outcomes by participants including their reported ability to adjust to events and have a positive overall well-being. Satici included that she found that hope also positively promoted resiliency during aging and that people who have hope reported feeling happier, more satisfied with their life, are able to handle situations more positively, and overall just felt better about themselves. One limitation was that the data was collected through self-report measures and the next study is recommended to use peer review or other measures especially when studying resilience.

Overall well-being and aging was also studied by Alex and Lundman (2011), who examined the experiences of 19 older adults. Participants were aged 85 to 95, 14 women (2 were aged 95 and older, 5 were aged 90, and 7 were aged 85). The 5 males were (1 was aged 95, 5 were aged 90, and 7 were aged 85), 10 women and 4 males reporting they owned a home, 13 women and 3 males reported they lived alone, 13 women and 4 males reported they had family to talk to, and 1 woman and 3 males reported they were completely independent in activities of daily living. All participants were a subsample of a larger Umea 85 study and were contacted by a letter and then a follow-up phone call. Appointments were set up; the interviews were conducted in the participants' home by three research nurses along with signing an informed consent. The Resilience Scale was then administered by the same nurse to ensure the participant was comfortable and free to speak. Interviews lasted 30 to 90 minutes. The researchers wanted to understand the experiences of becoming old. They categorized themes garnered from the interviews into four categories; the first was "being out of it", the second was "emphasizing life

experiences from the past", the third was "religious doubting", and the fourth was "accepting of age" (p. 306). Overall, more resilience was found in the older adults who accepted their age, where they were in life, still had hope, and social responsibility. They also could find a positive balance between what has been gained and what has been lost over time. Another finding, according to the researchers was that the older adults in this study stated that they felt good when comparing themselves to their counterparts and the negative stereotype of the old age person. Women were found to be more vulnerable and reported more negativity when telling their stories and the researchers reported that they may need to strengthen their social relationships to increase their resilience and positive thinking. No limitations of this study were reported.

Francis (2012) conducted a literature review on support systems and building in those who suffer a mental illness and by studying the tools available. Recovery in general should suggest someone is working on getting better and perceives themselves as someone who can get better. Negative thinking causes increased stigma and discrimination of those living with a mental illness and can be reinforced through professionals that serve this population (Francis, 2012). Using a collaboration or a team approach with The Principles of Recovery as a guide to assist the relationship with professionals, family and the older adult which he believed would result in the mentally ill individual believing they can be stronger and can feel and function better. Francis discussed the principles of recovery as a way to explain how mental illness should be approached. In general, the principles state; "Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not they are ongoing

or recurring symptoms or problems, recovery represents a movement away from pathology, illness, and symptoms to health, strength, and wellness, hope is central to recovery, self-management is encouraged and facilitated, the helping relationship between clinicians and patients moves away from being the expert/patient to being coaches and partners, people do not recover in isolation, recovery is about discovery or re-discovering a sense of personal identity separate from illness or disability, language used and the stories and meanings are constructed have great significance as mediators of the recovery process, the development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications and family and other supporters are often crucial to recovery and they should be included as partners whenever possible" (p. 22). Francis also reported that "personal recovery" is based on the internal process an individual goes thru and the effort they put forth to master the illness and symptoms and should be revelled as a journey (p. 23). Francis also stated that individuals should be able to function on their own but with a support system in place to assist and guide as needed. According to Francis (2012) older adults need to know that they have strengths and capabilities, and that this information would be useful for care givers to focus on making adjustments for the weaknesses to promote independent living.

Spirituality

Spirituality was also found in the literature to be an important element for the existence of resilience in independent living for older adults (Polson et al., 2018). Chatters et al., (2015) researched spirituality and questioned if socializing within the church may reduce depressive and serious psychological symptoms in the African

American population. Specific focusing on emotional support from church members and the frequency of negative interactions with church members may affect symptoms. The researchers used data from the National Survey of American Life; Coping with Stress in the 21st Century (NSAL). A total of 6,082 older adult in an age range of 55 to 93 volunteered to be interviewed to include 837 African Americans. This number was reduced 686 (229 males and 457 females) when the question was asked who attended church at least a few times a year. Demographics included an average household income of $32, 695 with 1 out of 6 having less than 9 years of formal education. It was noted that 40% were married or living with a partner and reported having 2.61 physical problems. Depressive symptoms were assessed using the 12-item Center for Epidemiological Studies-Depression Scale (CEDS) and serious psychological distress was measured using the Kessler 6 (K6). The CEDS item responses range from a 1 (hardly ever) to a 3 (most of the time) and focuses on the last 30 days. The 12 items measure if the individual is having trouble keeping mind on tasks, enjoying life, crying spells, getting started on the day, feeling depressed, hopeful, restlessness, feeling as good as you believe others feel, that every moment is an effort, that people are unfriendly, and the belief that people dislike you. The K6 is designed to measure non-specific psychological distress to include depression and anxiety. The K6 is also designed on a 5-point Likert scale; from 0 (none of the time) to 4 (all of the time) (Chatters, Taylor, Woodward, & Nicklett 2015). Outcomes reported were that the older adults attended church once a week, received emotional support from church members and that they felt they rarely had a negative interaction with any church members. They also reported that they received some

emotional support from family and little negative interaction with family members. This study showed that older African Americans that attended church at least a few times a year found emotional support that indicated their symptoms of depression and severe psychological distress were reduced. Limitations discussed were that this study did not include a sample of those older adults that may be institutionalized or homeless and that the data suggests but does not confirm the findings that either depressive symptoms or serious psychological distress is reduced by the involvement in a church or by positive family interactions. The researchers reported that this area has little research and suggest that more investigation is needed into how the church and the family system may or may not be a supportive network for older adults.

Manning (2011) also considered spirituality important for older adults and conducted a research study based on the how spirituality may affect advanced aging. Participants were interviewed five times each in order to understand and clarify their spiritual journeys and determine how spirituality was used by them in everyday life to strengthen resiliency. Spirituality was found to be a valid coping skill used by older adult females and, according to Manning, spirituality increased their sense of independence and ability to manage their lives. Also found was the fact that the older adults believed spirituality was in fact a coping skill that they used to get past a tough situation, maintain emotional balance and increase their resiliency skills. Resilience was noted to have been a lifelong journey with all the participants using spirituality as a "framework" for facing challenges in conjunction with a support system and independent living skills (p. 574). Having access to church along with having feelings of spirituality was considered to be a

coping skill by older adults (Manning, 2012). The researcher stated that higher levels of spirituality enhanced coping strategies in older adults and resulted in greater resiliency. Manning (2011), along with Clark et al., (2011), found that the need for spirituality had a strong connection to resiliency, especially in older adults. No limitations were discussed. Polson et al., (2018) agreed that religion and spirituality have been identified as a significant correlate of resilience along with positive psychological factors such as hope, ability to manage independently, how one feels about themselves and positive thinking all contribute to understanding resilience among older persons. A study was conducted using 255 Meals on Wheels clients that were aged 60 years and older, income below the federal poverty level, lived in standard suburban housing and had to be living alone. The Meals on Wheels staff provided basic information about the study and invited clients to participate. Meals on Wheels staff and other volunteers administered the survey during face-to-face home visits.

Independence and Dignity

Successful aging depends on the ability of the individual to maintain a preferred lifestyle and their dignity whether it be independently or with family. When discussing the dignity of older adults, Black and Dobbs (2014) stated that dignity should be a basic human right regardless of age and a part of successful aging and health. Dignity was also reported to be connected to "successful aging, healthy aging, spiritual aging, quality of life, and positive aging" (p. 1293). Black and Dobbs conducted a study with individuals residing in the South-eastern United States and used purposeful sampling to target older adult living in residential and recreational communities including a high-end retirement

community. This community was specifically targeted due to the high percent of adults over aged 65 and for the fact that they have high-income as well as high school diplomas (91%) as compared to the overall United States where older adults with high school diplomas were reported to be around 9%. According to the researchers, participants were aged 65 to 98 years old with 70% female, 98% white, 42% Protestant, 90% attended or graduated college. Also, 52% reported that they lived with others and 89% reported that they had children. Before the study began, the researchers completed a literature review on dignity and community-based living situation and older adults. Black and Dobbs stated they found one article that fit their criteria, and this reinforced their idea that this topic needs more attention and new research could be helpful to those caring for older adults. The participants began the study by completing a consent form and then joining a focus group which was offered at several locations: a continuing care retirement center, a senior residence, a senior center, a community center, and a local library. These were chosen due to the fact that older adults congregate and socialize in these facilities in the community. Local radio stations, newspapers and electronic media advertised the study to recruit participants. The focus groups were held in private rooms at each site and lasted approximately 1.5 hours and were audio taped. Surveys were also completed by each participant and could be filled out by a hard copy or online. The surveys were specifically developed with questions that pertained to dignity and reflection of experiences that the older adults have had in the past. The data was collected and analysed by two gerontology and methodological researchers, and two graduate students currently involved in aging studies. Themes that emerged from the study were dignity as

autonomy; having individual choices and making their own decisions, having someone ask what I would like to do instead of telling me what I will do, being self-sufficient, being respectful to others and receiving respect, and having self-pride. Some challenges to dignity reported were conditions that limit self-care and self-esteem; "illnesses such as dementia, cancer, hearing loss, macular degeneration, incontinence, falls, hip fractures, diabetes, stroke and impotence" (p. 1303). Friends and neighbors were listed as a part a positive support system that helps maintain ones' dignity while aging. Thinking positive, having a positive attitude and using action oriented behaviors was also reported by the participants as reinforcing dignity. Black and Dobbs (2014) pointed out that the themes reported are connected to how older adults perceive dignity in a mostly social situation with a focus on not only giving respect but also receiving respect while socializing with other older adults and family members. No limitations were discussed.

Mallers, Claver and Lares (2013) agreed with Black and Dobbs' findings that older adults given an opportunity to make decisions live a more positive lifestyle than older adults who have no control over their lives. They conducted a literature review on healthy aging and decision making with older adults. They explained they found that those older adults who have no control of their life result in more negative outcomes while aging versus those that are encouraged and asked to give input about what they want. They also found that the literature stated those who have some type of illness or physical problem still have the opportunity to be active by selecting activities they know they can be a part of. This decision making promotes dignity, socialization, and good feelings to make the most of aging. No limitations were discussed. Preferences in living

arrangements and decision making continues to be addressed especially when the older adult requests to age in place.

Aging in Place

Even though some older adults may not have the ability to remain living independently, the numbers of older adults who wish to remain living independently continues to rise, according to Czaja (2016). Social isolation continues to be a problem along with support systems and needed services. Social isolation has been connected to poor quality of life, life satisfaction, poorer mental and physical health and deterioration of cognition. Older adults that can secure long term support will benefit from medical, social, personal, supportive and specialized housing and transportation according to Czaja (2016). Family members provide most of the support to allow an older adult to live at home and meet their needs and a large number relies on a mix of family and community services. Czaja who researched technology and how it can be helpful to keep older adults in their home found that it is beneficial as a way to provide more support to not only the older adult but those that provide services. Computers, cell phones, telemedicine, home based monitoring, sensing and monitoring systems, and tablets. Technology already plays a vital role in health care with computerized medical records and the ability to talk to your doctor on the phone and these innovations will continue to grow and add to the needs of the older adults and the caregivers allowing the older adult to age where they prefer. Many older adults lack the access or skills to use technology and Czaja recommended that psychologists working with the older adult population can suggest

technology as an avenue to keeping up with their health care, appointments and overall skills with computers and socialization. No limitations were discussed.

According to findings from the White House Conference on Aging (2015), aging in place was still highly preferred by older adults over finding a different housing situation. Staying in the home was reported to make the aging process more comfortable without adding the stress of moving and adjusting to a new situation. Another option presented was that families might need to re-engineer their current homes to accommodate the needs of aging parents. As the older population grows, providing optimal housing that meets their needs is increasingly important. Tanner, De Jonge, and Aplin (2012) conducted a review about what the term 'home' means to older adults. The researchers reviewed literature from environmental psychologists and gerontologists and found that having a place to call home was considered an important element and that most of the older adults in the literature stated they prefer to remain in their own home as they age. With many older adults spending the majority of their time at home, it becomes a major issue in their resiliency and ability to thrive in the community. Wiles, Leibing, Guberan, Reeve, and Allen (2011) shared their research about older adults "aging in place" (p. 1). This idea of aging in place is defined as "remaining living in the community, with some level of independence rather than in a residential care" (p. 358). Participants were 121 older adults aged 56 to 92; 44 men and 77 women who participated in 17 focus groups and 17 interviews in Aotearoa, New Zealand. (No other demographics were listed). The participants were recruited by health and social service providers, churches, community development organizations. Older adults' clubs, and societies. The

focus groups attended to one main question “what is the ideal place to grow?” and discussed how they felt about aging, where they lived and family relationships (p. 1). The researchers found that older adults want to have a say in where they live and have a voice in their life. Older adults felt they had the right to live life and not just be in the community trying to survive. Options for housing can also ensure the older adults stays connected to family and friends. Aging in place also gave them a sense of connection to the community, security, independence and continued familiarity in the lifestyle they already know. While aging in place support systems for older adults could monitor progress and/or the likelihood of problems as they occur. This will also help the older person not only become aware of what issues they may have, but also when they occur and what are the possible triggers (Wiles et al., 2012). No limitations were discussed. Matthews (2012), who researched the experiences of aging people in home care, also found that older persons prefer to live in their private homes as long as possible when given the option to move or remain independent. He conducted a review on literature connected to assessing older adults and their ability to continue living independently. He suggested other placement should occur only if the older person is no longer able to function safely at home alone, if there is a lack of support or if the individual can no longer care for themselves without support (Matthews, 2012).

Nursing homes are considered to be home by many older adults, especially when their health or abilities do not allow them the option of returning to their old home. Bartels (2011) conducted research using older adults who reside in a nursing home in order to learn if they believed they should remain in the nursing home, live in a

community setting or could manage in their own home. (no demographics were listed). The researcher surveyed the nursing staff along with the older adults who have a severe mental illness (no identifying information or total numbers of participants were supplied) and found that 40% of the nursing home residents believed that they could live on their own in the community with the appropriate care system and support in place. The nursing staff identified 51% of the residents who they felt may be able to live independently yet disagreed among themselves about which specific older adults they felt would actually be able to live in the community and also what would be the most appropriate setting. The older adults stated they felt they could manage living independently in their own homes or apartments, but nursing staff suggested some type of assisted living would be more appropriate. Bartels reminded us that growing older and having a severe mental illness does not necessarily decrease an individual's ability to function in the community but would require the ability to adapt and be flexible to changes in their lives. The researcher explained there is still a lack of mental health services available to an older adult wanting to live in the community but that this same older adult would benefit from being involved in some type of psychosocial program to increase home and community skills to remain independent. No limitations were discussed. Bandura (1991) informed us that the individual must monitor their own current behaviors, the circumstances when these behaviors occur, and the effects of those behaviors in order to make adjustments. This monitoring is an ongoing exercise in being cognizant in the present day and practicing positive behaviors to enable who does or does not have the ability to live independently. According to Mutchler, Lyu, Xu & Burr (2017) older adult's households have decreased

in size not only in the United States but in other countries due to the affordability of living alone. This independence is based on family being able to help the older adult financially in combination with their incomes from social security and or retirement. It is noted that older adults prefer to live independent and will (if they can) “purchase their privacy” while opting for “intimacy at a distance” (Mutchler, Lyu, Xu and Burr, 2017, p. 2496). The researchers were interested in the cost of living and the likelihood of living alone versus living with others. A literature review was first conducted followed by a study using microdata downloaded from the Integrated Public Use Microdata Series website. The literature review revealed that older adults who are financially comfortable refer to live alone and usually in a one-person household if unmarried or two-person if married. Living independently shows others that the older adult is financially sound and can manage on their own. Yet, those older adults that have a large family network will choose to live with family versus living alone. The data set included community-residing adults aged 65 and older not married resulting in 428,257 adults, using only those who reside in the metropolitan statistical area reduced the participant number to 285 who were considered the “householder of a one-person house-hold”, all others were coded as living with family (p. 2499). Demographics on participants were; 72.6% females, 73.7 white, 13.2 Black, 4.1 Asian/Pacific Islander, 0.4 other, and 8.6 Hispanic. 62.7 % lived alone, 9.6% have personal income, 43.3 % have a disability, 27.4 rent, 21.7 have less than a high school education, 43.6% graduated from high school, 34.7% have some college or a college degree. The results showed there is a relationship between personal income and likelihood of living alone. Cost of living in a metropolitan area is costlier for older adults

and more difficult to make ends meet with a lower income ($15,000) but more comfortable for those with a higher income of at least 3 times ($46,500) reported less difficulties according to the Elder Index which has federally generated date and calculates the cost of living for counties. Participants also reported that it depended on what area they wanted to live in was calculated with their income to determine how much they could afford to have their privacy. The Elder Index takes into account daily expenses; "housing costs, food expenses, transportation expenses, cost of health care, and a small additional amount for miscellaneous expenses" to determine the best area to live in according to income levels (p. 2500). The researchers also included the fact of whether an older adult had rental costs or owner costs (mortgage or no mortgage). Results also showed a significant difference when the Elder Index was used instead of only comparing what is believed to be the cost of living in an area using only income as a measure. Females were found to be more likely to live alone but overall gender was not reported as a significant predictor for who chooses to live alone or with family. Overall, this study showed that an older adult needed higher incomes in order to live alone in a high cost metropolitan area or most likely would end up living with family which would be more affordable and also would include a support system. Expenses were also taken into consideration and it is recommended that by using Elder Index for cost of living analysis, those choices are easier to make, and the older adult would not move where they know they could not afford to live. Also, those older adults that still want to live in a higher income metropolitan area may opt for family to live with them which would offset expenses to live where they prefer. Mutchler et al., (2017) recommends more research in

this area to continue understanding how to make the best decision for older adults living arrangements. One limitation addressed was the fact that cost of living where an older adult chooses to live may differ from the metropolitan area in this study and that the options available should be discussed with the older adult prior to any decision making.

Older adults that suffer a mental illness should also be involved in discussions about where they may or may not live. They also may have their own ideas about what they can afford, and families and support system can provide information to guide and suggest alternatives that may be unknown to the older adult. Mental illnesses may play a factor in how well an older adult can function independently and what options they have for housing and ability to care for themselves.

Mental Illness and Resiliency

When discussing resiliency, it is important to also focus on the awareness that mental illness can affect not only resiliency skills but also how the older adult is able to manage health care while living independently. Larkin and MacFarland (2012) pointed out that it is expected that 1 in 4 older adults will suffer some type of mental illness or disorder in their lifetime and by 2030 this number will be doubled.

According to Whiteford et al., (2016) the Wisconsin government reported that a clearer definition of mental illness was required and that those who suffer a mental illness may not have the same degree of severity prompting the State of Wisconsin to release Chapter 51 legislation defining severe and persistent mental illness as one which causes an individual to have a decreased level of functioning in daily living and in their ability to manage their demands of life. The government noted that this need may result in the need

for lifelong treatment combined with some type of support (Government of Wisconsin, 2014). Whiteford et al., (2016) also agreed that mental illnesses can vary depending on severity and if the individual has periods of remission. They also reported that the severity of the mental illness may require accommodations to live with family or in private care facilities while some may have withdrawn from their families and require more services.

Manderscheid, Ryff, Freeman, and McKnight-Eily (2010) provided an easily understood definition of mental illness as "conditions that affect cognition, emotion, and behavior (schizophrenia, depression, autism)" (p. 2). They also stated that they discovered through the literature review that mental illness is frequently connected to a physical illness and the individual's social situation. So, those older adults with a mental illness could benefit from increased understanding of their specific illness and then how it may affect their day-to-day functioning and resiliency (Hsiao and Van Riper, 2010). Windle (2010) also conducted a literature review researching resilience in everyday life with older adults and found that it was suggested that older adults need the right resources and that exposure to risks and adversity were not found to cause reduced resilience. Awareness of assets, resources, having access to the right treatments, and a support system were found to enhance day-to-day living and wellness. Also, those older adults suffering a mental illness, that has access to resources, to include family, were found to be able to manage their health and wellness better.

Aschbrenner et al., (2014) agreed that family involvement with not only mental illness care, but also medical issues is important to not only to understand but to support

and guide in better decision making and healthier daily living for an older adult. Those individuals who suffer with a severe mental illness have a shorted life expectancy than the rest of the general population and this illness combined with other unhealthy behaviors can lead to other severe health issues. This study was designed to improve patient-centered care by interviewing family members and their perception of their relatives' medical care. Participants were 28 adults aged 50 and older, with cardiovascular problems who were recruited from a state mental health center and 13 family members who agreed to participate. Family members were 53% siblings, 23% adult children, 14% were parents, 1 reported as a significant other and 76% reported as females. Informed consent was signed by all participants. Medical charts were reviewed to confirm participant criteria; age 50 and older, living in the local community, have a DSM-IV diagnosis of schizophrenia spectrum disorder, bipolar disorder or major depression with a functional impairment of at least 12 months or longer, at least one cardiovascular risk factor (heart disease, diabetes, impaired fasting glucose, hypertension, hyperlipidaemia, currently a smoker, or overweight/obese (BMI more than 25) (p. 123). Family members were recruited by the participant which resulted in over half (57%) recommending at least 1 family member. Demographics were collected including how often there is family contact and family involvement in medical care lasting around 90 minutes. Participants completed a Family and Social Contact Questionnaire asking whether they had any family members or close friends considered to be "like" family whom they saw on a regular basis. If the participants answered yes, then they answered more questions in detail about frequency, who they were and what they did. Participants

then filled out a Medical Care Questionnaire (MCQ) asking about family attending medical appointments regularly, going with you to doctor appointments, pick up prescriptions, help you to remember to take medications and participate in making decisions about medical care. Positive responses were collected and used to calculate percentage of frequency of family involvement. Family members were interviewed and asked about their involvement of the participants medical care and any other support provided; medication management, promoting healthy behavior changes. Also, for more in depth information, family members were also asked 2 other questions: "1). Are family members satisfied with their level of involvement in their relative's medical care; and 2). What, if any, other types of health-related support (beyond involvement in medical care) do family members provide to a relative with a severe mental illness and cardiovascular health risk?" (p. 125). All interviews were 60 - 90 minutes, audiotaped and then transcribed. Aschbrenner et al., (2014) reported results of 57% of the participants stating that they have face-to-face contact with a family member, 89% reported family was involved in at least one area of their medical care; 39% scheduled medical appointments; 68% go with them to the appointments; 46% pick up prescriptions; 43% give reminders to take medications; and 57% participate in making decisions about medical care. Eleven percent of participants reported that they have no family that is involved in medical appointments or any type of care, one reported they see a family member a couple of times each week and two participants reported contact with a family member one time a week. Family members clarified if they reported they went to medical appointments they were mostly only providing transportation and rarely went into the doctor office or if they

did, they waited in the waiting room and only went into the appointment if there was a crisis. The family members recognized a need to be more compliant especially since the participant was suffering not only a severe mental illness but also a severe health condition. The most common concern was the obesity of the participants by the family member and many reported that they did not know what to say or do to provide more support. It was also reported that those participants that had family members involved with medical appointments understood the appointment and the doctor orders better than trying to manage the appointment alone. This study provided information that confirmed that family members involvement in an older adults' life provides not only a better overall living experience, but aids in the understanding of medical appointments and suggestions by the doctor, while building resilience to manage future issues by themselves if there are no family member to accompany them. No limitations were discussed.

Gooding, Hurst, Johnson, and Tarrier (2012) conducted a study to see if there were any differences in older and younger adults' resilience. Participants were sixty, older adults 65 years and older, living in the community and sixty younger adults, between ages 18 and 25, who were psychology students at the University of Manchester. The participants began by giving demographic information, age, sex, marital status and education. The participants then completed the Geriatric Depression Scale, Beck Hopelessness Scale, Resilience Appraisal Scale and the Medical Outcomes Study 36-Item Short-Form Health Survey. The outcomes showed that the older adults were more resilient when they had emotional support and problem-solving skills. The younger adults

reported more resilience related to social support. Older adults perceived their quality of life higher even though they reported more stressors than the younger adults and the category of ill health was perceived equally over all participants to not be a predictor of reduced resilience. Overall, the researchers stated that older adults had higher resilience and reported they were able to manage their stressors without reducing their resilience. Collazzoni et al., (2016) also reported that they found that older adults who have and live with family members and have a mental illness may find families may contribute to their challenges of maintaining a healthy lifestyle due to stress.

Schure et al., (2013), noted that resilience literature still remains limited but is even more limited when discussing American Indians aging. The researchers found in the resilience literature that higher resilience was found to be positively correlated with greater social opportunities, seeing life optimistically, body strength and ability to function on one's own. Opposite of this is considered negative resilience or the difficulty that an older adult has to function on their own was found to be the result of decreased mental and physical health, depression, post-traumatic stress disorder, and physical disability. Schure, Odden & Goins (2013) conducted a study about depression in American Indians and mental health involving the biological, psychological, and social causes of depression in older adults. The American Indians consider 55 and older to be elders, therefore participants were all aged 55 and older, and the research suggests that health declines more rapidly with age. Data was collected from July 2006 to August 2008 as a part of the Native Elder Care Study, who were members of a tribe in the rural Southeast. Face-to-face interviews were used to gather information on ability to function,

mental and physical health, functional ability, any persona assistance, socializing, and health care needs. Participants had to be an enrolled member of the tribe, aged ≥ 55 years, lived in the tribal service area, not be institutionalized at the time of the study, and were able to demonstrate adequate cognitive ability. One thousand four hundred and thirty persons were potentially eligible for this study resulting in 680 tribal members from three age groups: 55-64, 65-74, and ≥ 75 years. Randomly selected persons were recruited by an interviewer via telephone call or home visit to participate in the study. Of the 680 potentially eligible persons in the sample, 505 actually participated. Demographics were collected by self-report for age, sex, and marital status. The 10-item abbreviated version of the Conner-Davidson Resilience Scale (CD-RISC) was used and the 10 items were scored on a 5-point response scale (0 = not true at all to 4 = true most of the time). Respondents noted the frequency with which they experienced each item during the past month, with the following response options: Not true at all, Rarely true, Sometimes true, Often true, or True most of the time "1. Able to adapt to change, 2. Can deal with whatever comes, 3. See the humorous side of things, 4. Coping with stress strengthens 5. Tend to bounce back after illness or hardship 6. You can achieve your goals, 7. Under pressure, focus and think clearly, 8. Not easily discouraged by failure, 9. Think of self as strong person, 10. Can handle unpleasant feelings." (Schure et al., 2013, p. 30). Also used were two measures of mental health, including the Center for Epidemiologic Studies Depression Scale (CES-D), the mental health component of the SF-8 Health Survey and the Chronic Pain Grade scale which has six items that capture the severity of chronic pain and its impact on daily physical and social functioning. Results showed that 25% of

respondents reported low resilience, 41% reported medium resilience, and 34% reported high resilience. The mean age of the respondents was 68.7 with the majority of the sample being female (69%) and unmarried (54%) (Schure et al., 2013). According to the researchers, this study demonstrated that there were significant resilience levels associated with good mental and physical health and high levels of resilience were associated with lower depressive symptoms. (Schure et al., 2013) also reported that they found little evidence of the relationship of resilience either higher or lower associated with the symptoms of chronic pain. The researchers suggested that more resilience studies are needed, and that the biopsychosocial perspective would help us understand if resilience is still important in the development of mental health issues and management of chronic pain. Several limitations were discussed; due to the data being cross sectional (observation of many subjects comparing their differences) there was no way to shows causality, no assessment for social support was administered, prescriptions were not considered, and the fact that this study used only one tribe which limits generalizing to other older American Indians.

German researchers Warner, Schüz, Wurm, Ziegelmann, and Clemens (2010) also looked at individuals who has at least 2 chronic conditions and required some support. They reviewed data from the German Aging Survey of community-dwelling adults, with 1,414 participants, aged 40 to 85 years old, (both males and females) with a mean age of 64.9 (no other age or demographics breakdown provided). The results showed that anticipating receiving support was positively associated with the participant's self-esteem and quality of life. The researchers concluded that a good support system can enable an

individual to “profit in terms of health and wellbeing” (Warner et al., 2010, p. 661) and by “providing support to enhance mental quality of life, coping and purpose-in-life while it reduces depressive symptoms, anxiety and levels of mortality in the support provider” (Warner et al., 2010, p. 661).

The question of exactly how many older adults live with severe mental illnesses and what the needs of these individuals still remains unknown. Whiteford et al., (2016) was interested in exploring these issues using multiple data sources. They studied the number of people in Australia with severe mental illness who have multi agency needs while also exploring what service needs they had. Results from the data showed that approximately 3.1% of the total population of Australia had a severe disorder and that number was higher within the older adult population (3.3%). Whiteford et al., (2016) estimated that approximately “496,000 Australia adults had a severe mental illness in 2015” (p. 5) and that 165,000 or “(1%)” were estimated to be affected by a severe and persistent mental illness that requires ongoing services” (p. 5). Service needs were listed as “clinical mental health, substance abuse, employment, housing, financial assistance, social support, assistance with personal care, Criminal Justice services and other psychosocial support (p. 7). Recommendations from this study were more mental health reforms, clarifying and matching needs to support available, and clarification of criteria of the different mental illness symptoms to ensure the right services are being offered to the right older adult and that these are available. Limitations were that this study only focused on emotional support and it is suggested that further research may want to focus

on receiving, anticipating, and providing other types of social support against quality of life.

Stigma against those with a mental illness continues to be an issue not only on the United states but also in other countries according to Hsiao and Van Riper (2010). They reported finding stigma against families that support an older adult with a mental illness, living in China, adds difficulty to providing care. The researchers conducted a literature review on mental illness and families that provide care. Some of the searches included words such as caregiver, caregiver role, mental illness, cultural and ethical differences which resulted in 37 studies. Hsiao & Van Riper (2010) found in the literature that there is still much unknown about mental illnesses and that little support was extended to families as mental illness continues to remain a limited topic that is discussed or dealt with in public. Societal attitudes played a large role in the type and degree of support families either sought out or received. Because of this continued attitude, it was found that families received minimal assistance from the community and usually preferred to not share about a mental illness to also avoid high degrees of shame or stigma. They found also in the literature review that if a family member was understood to have a mental illness because of a biological cause, then there is a greater reduction of negativity towards the family and that individual is more often than not enrolled in a community program. If the mental illness is believed to be from more supernatural causes, then the family would be less likely to support psychiatric care or public programs. When researching the family role in caregiving, the researchers found that it was important to take on some or all of the responsibilities involved with a mentally ill family member.

When this does not happen, it was found that the family and the individual both may suffer. Hsiao and Van Riper (2010) indicated that reported that they found that much of the literature on caregiving still focused on negatives but that some of the more recent literature did discuss positives. Some of the positives listed were feelings of "fulfilment and satisfaction, personal growth, more compassion for others, and improved relationships" (p. 1). It was also found that families should educate themselves on mental illnesses and provide interventions and support as needed. The literature also stated that all family systems are not the same, so whatever solutions that are agreed upon should be discussed with the older adult and the professionals that treat them (Hsiao & Van Riper, 2010).

Furlotte and Schwartz (2017) agreed that mental health issues and stigma are prevalent and may interrupt resilience in the older population. They also confirmed through literature that older adults are living longer, report resilience in day-to-day abilities while managing HIV symptoms. The researchers also reported they found little literature supporting older adult's resilience with HIV and opted to expand their search to literature from the United States and found that older adults living with HIV also suffer symptoms of mood disturbances, suicidal thoughts and behavioral problems. Furlotte and Schwartz (2017) were interested in the mental health experiences of older adults in Ottawa, Canada and what resilience skills they used to manage these experiences by conducting face-to-face recorded interviews with 11 older adults, two female and nine males aged 52 to 67. Participants also completed a consent form, demographics and a health and social services survey about the services they currently use. Participants

reported demographics as; European ancestry, all 11reported they were White, spoke English, high school education or higher with varying incomes. Participants self-identified as gay, bisexual, straight, or two-spirited (masculine and feminine), with 10 identifying as retired. Six participants reported they were HIV positive but were suffering no symptoms at the time of the study, one reported symptoms advanced to AIDS, 2 reported they did not know their progression of their HIV, 8 had known they were HIV positive for 10 years or more and had known this information for less than 5 years and 7 participants learned they were HIV positive after age 45. Eight participants reported they lived alone, 2 lived with family members, 2 reported they were homeless, 4 reported they had a mortgage, and 2 rented. Five participants reported they were receiving benefits from the Ontario Disability Support Program, 6 reported they received benefits from the Canada Pension Plan, and 3 reported they were receiving private pensions. Furlotte and Schwartz (2017) reported common themes as; uncertainty, stigma, and resilience. The uncertainty for many was daily survival, severity of symptoms, and medical outcomes over time. Stigma included discrimination in the health care system, feeling misinformed, physical appearance, and future stigma. Coping skills were reported as; awareness of how HIV takes over life, making lifestyle changes to live healthy as possible to include having a good social support system in place. This study provided insight into older adults and mental illness while managing HIV symptoms plus an understanding that HIV can cause stigma and mental health issues to increase and that learned resilience skills allows older adults to maintain their lifestyle choice while managing symptoms. Limitations reported were that those older adults that are isolated could not have been included in this study,

the data was collected over 9 years ago, and that there was no complete mental health history conducted and it was unknown if participants had any mental health concerns before or after the study.

Penkunas, Friedman, and Hahn-Smith, (2015) were also interested in mental illness symptoms and the impact on older adults. They conducted research using treatment records of 148 older adults' who had a severe mental illness and who were in home publicly funded mental health treatment. The researchers found; a high prevalence of mood disorders (75%) and psychotic disorders (23.6%). The presence of suicidal thinking was a common symptom (1 in 3). Major depression was consistent with the existence of suicidal thinking. They also found co-morbid substance use, that the majority lived with a family member, and that the majority were involved in mental health treatment (71.6 %). The researchers agree that this population is one of the fastest growing populations and it is important to know that they will also be the largest group with a diagnosable mental illness by 2030. Without treatment, these older adults more than likely will also suffer from other lifestyle performance issues such as less socializing, less time in the community, and a reduction in their quality of life. Unfortunately, there continues to be a large amount of numbers of older adults who need mental health treatment yet do not receive it according to Penkunas et al., (2015). The researchers reported this population is overall at risk of continued deterioration, stigma, and will need continuous treatment and care under the ICM program. The researchers recommended that future studies should continue to focus on outcomes of treatment in mental illness programs for overall health of the older adult population and for better

quality of life. This includes relationships the individual has with family or a caregiver. Older adults' relationships can be vital as not only a support system but as a tool for day-to-day care and communications. No limitations were discussed.

Oelke et al., (2016) conducted a study on older adults and their mental health needs and integrated community services. The researchers reported that older adults in Canada with a mental illness has risen to over "20%" to include chronic diseases that also present more challenges to functioning independently and vulnerability (p. 1). Mental health was found to be one of the last issues that is addressed with this population which if continues to be ignored could result in increased costs of overall care for not only the healthcare system but also the individual and their caregivers (p. 1). Oelke et al., (2016) conducted a research study involving 3 rural/semi-rural communities in southern British Columbia, Canada. The researchers were interested in identifying problems experiences by older adults living in these three areas: First, to identify the needs of adults 50 and older who have a mental illness and have concerns for their continued care; to identify what services and supports are currently available and if there are any gaps; and lastly, to identify any opportunities to integrate services and supports for those involved with the older adults' life whether it be in caregiving or providing services. Participants were aged 50 and older, lower socioeconomic, lower education level, had limited access to health care and due to living in a rural area were considered somewhat isolated. No mention of how participants were recruited, no breakdown of males and females, or the total number of participants were provided. Two face-to-face interviews were conducted within the three different communities: one with the older adults asking about their concerns about

their mental health and one with health care representatives. Participants signed an Informed consent form and the interviews were audio-recorded. Problems that the older adults felt needed addressing were: inability to be seen in a reasonable amount of time due to long waiting lists, finding available services and supports in rural areas, inability to find transportation to get to these services, inability to afford any private services, lack of help in completing confusing and detailed paperwork, meeting the eligibility for services by having a professional diagnosis, living in poverty, balancing needs and finances, choosing between medications or food, plus stigma of aging and having a mental illness (p. 2). Participants also discussed that they felt they lost purpose and meaning in life which they believed was caused by several life changing circumstances: no longer working, family moving away, not being challenged to think or having socialization regularly, the feeling of not being valued, any memories of past trauma, feeling isolated, stressors (new or old), and self-medicating due to being isolated and no transportation to access services due to the lack of local services and supports. This study brought awareness of older adults needs and concerns, importance of community-based services being integrated for easier access, the lack of ability to attend appointments due to lack of transportation, difficulties faced while aging with a mental illness and the stigma of aging with a mental illness. No limitations were discussed.

Stigma of mental illness was also addressed in a study conducted by Young, Ng, Pan, and Chen (2017). They uncovered a definition of stigma as a "mark of disgrace or discredit that separates people with a mental illness from others" (p. 103). The researchers wondered if those with a mental illness experience self-stigma against

themselves. Stigma of any type was reported to have a negative impact on those who live with a mental illness and this impact can also affect the ability to function. The researchers conducted a study with 295 Chinese individuals recruited from five non-government Chinese mental health centers. Results indicated that most participants had suffered with a mental illness more than five years, with the highest percent being schizophrenia. Eighty-Two percent admitted to being in a psychiatric hospital at least one time. It was noted that because the Chinese culture believes in fate, those with a mental illness also believe they are stigmatized as well as their families. They also reported this includes feelings of "shame, disgrace, loss of reputation, and devaluation in the family" (Young, Ng, Pan, and Chen, 2017, p. 108). It was recommended by the researchers to reduce these stigmas by ensuring that the individual is involved in treatment and interventions that directly address these stigmas. The researchers suggested the need for more research in the area of stigma and self-stigma to promote more independent living situations with those who suffer a mental illness. Similar to this study, was a study conducted by Ye et al., (2016) on stigma and discrimination of adults with a mental illness. Participants were 50 men and women who had a primary diagnosis of schizophrenia or schizoaffective disorder and have the ability to give consent. Interviews were conducted, and the researchers found that discrimination was reported to be experienced often and the most common in both men and women was being "shunned or ignored" by family and neighbors (p. 534). This discrimination was also displayed by health care professionals and included some of the mental health workers who provide case management to these participants. Positive outcomes reported were; first, that 31%

of the participants stated that they have managed to live with the stigma and do not feel affected by it, second; that making friends with people not involved with mental health was easier resulting in less stigma, less problems and a happier quality of life, and third; that 50% of the participants reported family treated them well, and that was considered a positive. The researchers reported that interviewing this population allowed them an opportunity to share their lived experiences and educate professionals on how they manage stigma and discrimination while also managing their mental illness symptoms. Limitations presented were that the results were limited to this population only and should not be generalized to other Chinese older adults, the sample does not represent the whole Chinese population who have a mental illness, to include those that live outside of Hong Kong and Macau and cannot understand Cantonese, and lastly, this sample does not represent those older adults who have a mental illness combined with a neurocognitive disorder, comorbid diagnosis of intellectual disability, impatient hospitalizations, and those under 18 years of age.

Researchers have uncovered the fact that regardless of the country, older adults aging, and mental illness remain an issue that requires more research. It was also discovered in the research that regardless of where in the world older adults live, they still must attend to many of the same issues as American older adults (i.e. stigma, discrimination, aging, low self-esteem, and mental illness) to name a few. The outcome of first trying to understand the mental illness and then discussing it with the older adults was considered overall a first step in the older adult having a part in the decisions about

their life. Also, the fact that living a lifestyle with a mental illness does not have to hold an older adult back from enjoying life's pleasures.

It is estimated that 85% of older persons with severe mental illness reside in the community and that one-half to one-third live with family members. Family members, in many cases, have limited understanding about older relative's illnesses and the need for symptom management. This limited understanding, or lack of interest, could be a driving force for increased poor overall physical and mental health for the older adult, according to Lawrence and Kisely (2010). These researchers also stated that even nonlife-threatening appointments to see a primary care physician may become problematic for the older person if the physician's personal belief (stigma) or attitude toward mental illness (severe mental illness) is an initial problem. These older adults may fall into the category of "disruptive" patients or the physician may overall just not be comfortable treating them regardless of the illness.

According to Lawrence and Kisely (2010), a strong support system that is aware of the overall health and mental illness of the individual can provide guidance and support to ensure the older person receives the proper treatment by qualified medical staff. Lawrence and Kisely (2010) also have indicated that the presence of social support is important in helping older persons with difficulties to remain positive in independent living situations. Family support has been found to decrease the level of depressive symptoms, according to researchers Fuller-Iglesias, Webster and Antonucci (2015). The researchers looked at the complexity of families providing needed support to an older parent and conducted a study using participants that were drawn from the Social

Relations, Age, and Health Study longitudinal study originated in 1992. The researchers revisited the earlier study in order to measure the depressive symptoms of participants in relationship to family size and support after 12 years using the same participants. Participants were interviewed in their homes and responded to questions about the level of relationships they have with family members and their depressive symptoms. They were also shown a diagram of three circles that intertwined relationships and were asked to explain these relationships. Of these relationships, the participants explained which was most important and why. The results indicated that the older adults felt that it was important to have a large support system to draw from when needed. They also reported having fewer depressive symptoms due to the availability of a stronger support system. The older adults felt that they understood that they always had a family member available to handle issues that might arise. Fuller-Iglesias, Webster and Antonucci (2015) reported that family support can be complex, yet the older adult believing they have a safety net of support feels a sense of comfort. Along with the feeling of comfort is a more positive attitude, fewer depressive symptoms, and stronger resiliency. The reduction of symptoms is a positive for the older adult and the family members who provide support and it is vital for an older adult who is trying to put effort into wanting to live healthier and be an active part of their life (Aschbrenner et al., 2014). The researchers also reported that there is still a limited amount of research discussing support systems and specifically, family support. They also remind us that many older adults who suffer a mental illness also suffer from other health issues. These other issues may cause family members to feel overwhelmed or that they should not be involved in support or care whether the adults are

living in the family members home or independently. These researchers were interested also in family support and care for older adults with a severe mental illness and conducted a mixed methods study addressing family support and care for older adults with severe mental illness (SMI) and cardiovascular issues. The researchers recruited 28 study participants through a community mental health center, a Federally Qualified Health Center, and two primary care practices in Manchester, New Hampshire. Researchers reviewed the participants' medical charts at the clinics and the community mental health center in order to identify patients who met the following criteria: older than 50 years of age, living in the local community, currently having a DSM-IV diagnosis of schizophrenia spectrum disorder, bipolar disorder, or major depression associated with a functional impairment of at least 12 months or longer; and having at least one major cardiovascular risk factor (heart disease, diabetes, impaired fasting glucose, hypertension, hyperlipidaemia, current smoker, or overweight/obesity. Participants were informed they could invite one family member (biological or non-biological) to participate in an interview to explain what role they specifically play in support or care of either the participant's medical care, physical health, and promoting health behavior changes or all of these. More than half of the participants (57%) referred at least one family member. The researchers then conducted ten semi-structured interviews with 13 family members who provided informed consent for their involvement in the qualitative interviews. The outcomes resulted in 57% of the participants reporting that they saw a family member one time a month. Of these family interviews, 53% were siblings, 23% were adult children, 14% were parents, and one was a significant other. Over three-quarters (76%) of

family members were female. Approximately 89% of older adults with severe mental illness reported that they has some type of family involvement in at least one aspect of personal medical care: 39% stated they needed more assistance scheduling medical appointments; 68% stated a family member going with them to medical appointments; 46% stated assistance picking up prescription medication; 43% stated they needed a reminder to take medications along with 57% stating they needed assistance in making decisions about medical care. Among the 11% (n = 3) of participants who reported no family involvement in any aspect of personal medical care, one participant reported contact with a relative a couple times per week, while two participants reported contact with a relative once per week. The reported lack of family involvement in this study is opposite of the reported 40% of older adults with severe mental illness who do have a family member or other individual that accompanies them to medical appointments, communicates with the provider, and are actively involved in care and treatment decisions. Overall, it was found that older adults who have some type of support for appointments may enable them to understand the appointment better and possibly follow treatment options easier. Limitations presented were that this study was over 12 years which was considered a limitation in itself but also the researchers could not examine short term effects of family support but were able to so over long term, family structures were only 10 and were the closest and not the entire support network.

Chronic mentally ill older persons who suffer a severe mental illness are faced with other problems in addition to daily living issues. They must deal not only with mental illness, but also interpersonal relationships and anxiety management. Cummings

and Kropf (2011) conducted a literature review on older adults with severe mental illness and reported that they experience a higher level of "physical illness, functional impairment, cognitive deficits, and social disability" compared to those older adults without a mental disorder (p. 175). They found that the oldest adults had a need for more care in several areas: managing psychological pain, physical illness, social contacts, and looking after the home and daily activities. Overall, the researchers stated that they found in the literature that less than 30% of older adults said they that they felt that they received the appropriate type of help where they had a need. The highest percentages reported were in areas that the participants felt they were not receiving the most help which was in "benefits, sight/hearing, incontinence, and social contacts" (p. 622). Cummings and Kropf reported that these older adults must also over time learn and accept that because of their symptoms they may not have social and economic resources in place that they need to provide supports later in life. Older adults with severe mental illness also struggle with finding and keeping employment, which may also lead to reduced income and a deficit in social support according to the researchers. Additionally, they must also learn to deal with other situations such as aging, loneliness, isolation, treatment, and support issues according to Mueser, Bartels, Santos, and Pratt (2012) who also studied severe mental illnesses such as schizophrenia, bipolar disorder and major depression, combined with medical issues of hypertension, hyperlipidaemia, COPD, osteoarthritis, and diabetes. The researchers looked at self-care habits and if the older adults could learn better care and implement it in their lives. They conducted a study with the Illness Management and Recovery program located in New Hanover, New

Hampshire. All participants had some type of severe mental illness and a comorbid medical condition. The older adults were able to learn psychiatric and physical illness self-management, understand how to set up target goals for themselves, cognitive behavioral approaches for medication compliance, relapse prevention coping skills and social skills to enhance resiliency. Mueser et al., (2012) also reported these older adults could accept that they have the ability to apply some self-care techniques to themselves. The researchers also reported that it is important to have good communication between the older person, their support system (which included the caregiver), and the treatment planner in addressing all needs before difficulties arise. No limitations were discussed. Jimenez, Alegría, Chen, and Laderman (2010) also studied mentally ill older adults living independently and the possible impact of the language barrier of older immigrants combined with aging. They conducted the study using data from the National Latino and Asian American Study, National Study of American Life and the National Comorbidity Study Replication (p. 257). Participants who provided data for this study were 2,375 aged 60 and older; 831 non-Latino Whites, 420 Latinos, 260 Asians, 671 African Americans, and 193 Afro-Caribbean's. Professional interviewers form the University of Michigan Survey Research Center conducted the face-to-face interviews. The researchers conducted this study as part of the National Institute of Mental Health Collaborative Psychiatric Epidemiological Studies. The researchers found that the non-Latino whites were another fast-growing segment of the older adult population and that the older non-Latino whites had a greater prevalence of mental illness over a lifetime. The older Latino immigrants (not born in the United States) reported higher depressive symptoms,

dysthymia, and generalized anxiety disorder while the older Asians also reported high levels of generalized anxiety symptoms. The researchers also reported that they found the participants' age, plus the occurrence of times when they felt they did not belong, contributed to isolating behavior and a higher level of depressive feelings which may result in a need for more treatment. A lack of fluency in the English language causes reports of feeling isolated and that they did not belong and difficulties overcoming social isolation which could assist with reducing anxiety and depression. Future studies should continue to focus on the ethnic minority over 60 age group and difficulties they have living in the United States. No limitations were discussed.

Finally, Clark et al., (2011) recommend that older adults should continuously be building up a collection of skills and healthy habits to build a "repertoire" for maintaining healthy aging, happiness and to reinforce living as they choose (p. 53). They conducted a literature review on the concept of resilience and wondered if once resilience skills are learned does it change or stay the same. Clark et al., (2011) first researched what factors older adults need to offset the aging process. The researchers referred to "buffers of old age or external factors" such as social supports (someone living within 50 miles) or "internal factors" such as having a reason for living (p. 52). Five components of health are highlighted in connection to resilience which are health status, health promotion, physical activity, nutrition, and medication compliance" according to Clark, Burbank, Greene, Owens and Riebe (2016, p. 56). Poor health can be an entryway into limitations and these limitations can change the status of an older adult from independent living to assisted living or even the need for full care accommodations. Health promotion is the

ability to be aware of how important good health is and showing effort to try to be as healthy as possible during aging and not waiting until becoming ill to try to make changes. Physical activity is essential on a daily basis to build up health and ability to be as physical as possible. Nutrition would seem to be most important, but many older adults have limited incomes and may not eat as healthy as they would like which could cause them to suffer other health issues. Medication compliance and personal medicine promotes personal well-being, but many older adults may be in the position that they cannot afford their medication or medications may be confusing and may need assistance in understanding what medications they are taking and in daily medicine compliance. Personal medicine includes some medications that have side effects and cause the older adults not to want to take this particular medication. This is where social support can play a role. A family friend or a neighbor that can come by to talk or assist with medications can not only reduce isolation and loneliness but also ease concerns of medications by discussing them with the older adult. It is important to have personal relationships during the aging process and this can also be considered a support system. Activities also promote socialization and exercise while reducing symptoms of depression and loneliness. The researchers reported that those older adults that were involved in leisure or social activities self-reported they felt they were aging successfully and were happy. Finally, finances in the literature on older adults was reported to not affect the quality of life in many older adults as much as a lack or loss of social support. In conclusion, Clark et al., (2016) suggest that individuals should be health aware starting at a younger age and that it is a lifetime of health efforts and awareness that reinforces resilience which

can reduce risks for an older adult along with good nutrition and physical activity. No limitations were discussed.

The approach selected will allow the researcher to gain understanding of the lived experiences of the older adult female who has a mental illness and lives independent in the community. The research questions were designed to focus specifically on the participants lived experiences having a family support system in place; including what this support means, what this support does, and what are some of the experiences that the older adult females get to participate in because they have this support. Also, the hope is that the participants will share details of how they managed their life independently when an event occurs.

Summary and Conclusions

This chapter has discussed the findings of the literature review relating to the issues of resiliency among older adults and the factors influencing this. Relevant key literature about resilience on children and among adults in general has also been presented in order to provide additional context for the current study. The review revealed that relatively little primary research has been conducted about resiliency in older adults in the past, especially in older adult females diagnosed with a mental illness. Older adults were found to be increasingly influenced by negative stressors and even more by those stressors that remain unresolved. These stressors, over time, were found to promote increased vulnerability, negative attitudes, and adaptability to overall living independently. Some stressors uncovered that were found to affect older adults' resilience capabilities and their quality of life were the loss of a spouse or family member, past

events, limited resources, stigma and childhood maltreatment. Resilience skills were discovered to affect many areas of functioning including the ability to accept life as it is and the aging process, finding positives, incorporating humor, putting forth an effort to be healthier, and increasing socialization. Family and community support was also found to be important to inspire older adults to become involved in activities they may be interested in to include church and volunteering. These activities were also found to promote an opportunity to socialize which also increased thoughts of belonging, having something to offer, and self-esteem. Also, since this population continues to grow, there may be new stressors to manage alongside a mental illness and other health issues which may also cause a disruption in resiliency skills.

Research suggested that those involved with any older adults' care should take the time to investigate and offer any assistance to the resolution of any life stressors. This includes integrating hope, promoting a more positive lifestyle to reinforce independent living, finding appropriate services, and being available as much as possible to assist as services are needed. A good support system was found to promote a better quality of life and to retain ones' dignity. However, it appears to be the combination of these factors that is most important in promoting resiliency. Among those older adults with mental illness, researchers found a relationship between willingness to seek treatment and resiliency that enhanced their ability to manage other areas of their life. Support inside or outside the home is shown to be very important for this population, and the review has revealed research gaps in this area that the current study is intended to help address. The proposed study was designed with the hope of uncovering areas where older females may

need assistance with independent living while managing their mental illness symptoms through the assistance of family support and resiliency.

The two theories were selected as they provide support to answer the research questions, the problem statement, the nature of the study and the assumptions by providing a base for the study. The first theory, Social Learning Theory (Bandura, 1991) conveys the idea that individuals may change their behaviors by observing how others use their skills to promote independent living. The second theory, Resilience Theory (Holling, 1973), suggests that the environment flourishes by using what it has to replenish and maintain itself during problems/irritations on a day-to-day basis. The two theories were selected to support and answer the research questions while educating about what different coping strategies older adult females use, how do they cope with their mental illness on a daily basis, do they believe that they have resiliency, and if so, what skills do they specifically have that they use, and what might be some services that they may need that are not already in place? These questions, combined with what support is given by family and what it does to promote independent living, is the base for this research. Chapter 3 will discuss the research design, research questions, participant recruiting and qualifications, data collection, plus the procedure that will be used to establish rapport and trust of the researcher.

Chapter 3: Research Method

The purpose of this qualitative study was to explore the individual stories of older women living independently who suffer from a mental illness and have a support system. According to Lowe and McBride-Henry (2012), little information is known about older adults living with chronic illnesses and how mental illnesses impact their lives. The present study addressed at least one gap of providing research on lived experiences of older adult females who have a mental illness and choose to live independently with some type of family support. I found little information in the literature on this topic. I also proposed that the lack of a support system for older females may cause reduced resiliency skills and an increase in mental illness symptoms while managing independent living. Areas of the study addressed in this chapter include participant selection, ethical procedures, permission from the mental health center to conduct the study (Appendices H, I, J), Table 2 connecting research questions to the interview questions, and the role of the researcher.

Research Design and Rationale

I approached the problem using qualitative methodology. Taylor et al., (2016) explained that "in qualitative methodology, the researcher looks at settings and people holistically; people, settings or groups are not reduced to variables but are viewed as a whole" (p. 19). I examined the experiences of women in the age range of 65 to 80 who live independently, have a mental illness, have family support either inside or outside the home, and wish to remain living in the community. To accomplish this, I used interviews

with the intent of opening dialogue with the participants to collect and compare participants' stories and identify common themes resiliency skills.

This research began with acknowledging problems older adult females struggle with and how they cope with living in the community with a mental illness. I have firsthand experience with older females, including the struggles they have experienced living in the community and their need for more situational family support. I have observed that older females often look for support systems when struggling to function in the community. Some of these support systems include neighbors or friends, even if they are not in a close relationship.

The phenomenological research design was selected because my intent was to look for meaning, patterns, and relationships with the views of the researcher intertwined. According to Manen (2014), this design is focused directly on the "wonder" (p. 37) of an individual's life story through questions that allow experiences to be shared and an opportunity to understand lived experiences. I examined family support through the lived experiences of 8 females ages 65-80 years who are in treatment at a mental health center in South Carolina. In addition, commonalities of the participants described as they report their experiences with the phenomenon. This study benefited from the process of qualitative analysis as the information came directly from the participants regarding their lived experiences. I kept the focus on how older adult females manage to live independently, what support systems they have, and what their support systems do for them.

The intent of this study was to understand the day to day lived experiences and if family support is an important part of managing day to day as they are described by the older adult female age 65 to 80 through face-to-face interviews using the research questions as a guide. The research questions in this study were built upon the two existing theories by participants answering the specific questions from their lived experiences and by allowing a look into their private world. This research focused on the lived experiences of older adult females who live independently with a mental illness and participate in treatment at a local mental health center. This research has one main question and 2 subordinate questions. The overarching question this study explored is exactly what family support does for the participant and whether that support comes from someone living inside or outside the home? The subordinate questions that will be explored are:

1. What does "family support" mean to older female adults who have chronic mental health issues and receive outpatient care in their local communities?
2. What resilience skills are used by older adult females to be able to remain in independent living?

The research methods to be used are phenomenological in nature; this mode was chosen to allow the older adult females an opportunity to tell their stories as they see it from their lived experiences. Taylor, Bogdan, and DeVault (2016) explained that phenomenology allows reflection to occur from the start of the interviews through to the end, allowing the researcher to understand the experience only through the individual that experienced it. This opportunity also allowed the participant freedom to share what she

felt was important for other older adult females to learn while aging and what has helped her stay independent. Also, I was able to obtain a firsthand account of life as an older adult female and the struggles she faces every day. There are many other research methodologies to choose but the researcher wanting lived experiences making the Realistic Phenomenology the best choice for this study. The combination of the interview protocol, the research questions, the demographic survey, the St. Louis University Mental Status Exam (SLUMS) and the consent forms were all used in an effort to collect lived experiences and address the research questions.

Role of the Researcher

Qualitative researchers should be searching for answers to questions that have not been answered in previous studies. Focus should be on the "how and what" and the "meaning of what people do" versus the cause of what happens as explained by the participant in their personal point of view (Taylor et al., 2016, p. 46). In order to collect these views from older adult females in treatment at a local mental health center, this researcher used the SLUMS versus the MMSE as recommended by the South Carolina Department of Mental Health Institutional Review Board (SCDMH IRB) and for the fact that the scoring is being based on the participants education level (high school education or less than high school) versus just their age. Also, that the participants can understand that they are participating in a research study, are able to sign the informed consent form, and that they are able to answer the basic interview questions. This researcher used the SLUMS only for the purpose of providing cognition of the participant and to show that they understood that they are participating in a research study and to provide informed

consent. The phenomenological researcher's role is to provide a study that is free of personal biases and any preconceived ideas of the results that may skew the data.

I focused on being objective and tried not to interpret what is being said. Taylor, Bogdan, and DeVault (2016) suggested that the researcher set up the interview more like a conversation, so the individual will be comfortable and feel they are able to talk more freely. Researchers also should never voice their personal opinion. The interview is about the individual, not the researcher. They also suggested a guideline to follow so researchers get the most out of an interview:

1. "Be nonjudgmental". When a researcher sets up a comfortable interview situation, they may find that the participant become comfortable and discloses more information than the researcher planned. Be aware of reactions and by avoiding judgement the result will be a better interview. (p. 116)
2. "Let people talk". Patience is required during qualitative interviews. Participants may take longer to share a point or even get off track. If this occurs, the researcher should gently reroute the discussion back to the research question (p. 116).
3. "Pay attention". Show interest in what the participant is saying and if needed ask more questions. Take notes to avoid missing important points even if tape recording the interview. This will show your interest and allow the researcher to remain focused and interested (p. 117).
4. "Be sensitive". Researchers should never be patronizing but it is acceptable to be empathetic or sympathetic. Researchers should be mindful that the

> participant agreed to be a part of the study and respect should be shown throughout the process (p. 117).

I was also able to learn what participants have in common (if anything) when they experienced the phenomenon. To recognize and control any biases or favoritism, I remained objective and purposefully focused on the participant's story during the interview. I was aware of my body language, attitude, breathing, behaviors, thoughts, and responses and how I paid attention to the participant to avoid bias or specialized treatment. This was also be achieved by making notes to highlight specific information and asking questions for clarification enabling me to stay focused on the story not the individual. I also did not discuss the fact that I was a supervisor at this center in the past and I did not act in any manner other than professional while in the role of the researcher. I also reminded myself that each participant has a different story and that my opinion of that story is irrelevant. I have a vast history of working with older females and this has taught me to remain objective, listen and focus on what's important to the older adult female, not myself.

Bias was also reduced by aligning the research questions and the method with the proposed problem statement, purpose and nature of the study. Meaning that the study was created to answer the specific research questions by the older adult females and those responses propose to answer the problem statement by use of phenomenological methods. Another method to reduce bias was by asking the research questions in a manner that is not beyond the participants' understood education level (obtained through the use of the demographic survey, the consent to participate, and by the SLUMS). (Podsakoff,

MacKenzie, and Podsakoff, 2012). The proposed research questions in this study was simplified for basic understanding and provided responses that promoted direct answers without confusion.

I have worked professionally for 7.5 years at the local mental health center as a licensed clinical counselor and a supervisor in senior adult services. In this role, I provided therapy and group services and support for mentally ill older females and males. I continually noticed during my experience that senior adults struggle living in the community independently, yet older adults' struggles are not always the same in severity or theme. This past work with older adult females reinforced a continuous interest in wanting to learn more about their life management, a need for increased education about how they feel about themselves, and where and how they learn skills provided the spark to pursue this research project. Interest in the lived experiences combined with these interests made the phenomenological method a natural choice. My past experiences gave me insight into the need to make the participants feel comfortable and assert their significance to the community. I also reinforced to participants the importance of their contribution to the study and how the outcomes will help other professionals understand the needs of older females living in the community. Additionally, my background of having over 80 clients at a time allowed my perspective to not be colored by one issue but to embrace the many facets of the struggles of the older population. Working with older men and women has allowed myself to also continuously be aware of any presumptions of how older adults live and maintain different lifestyles. I made notes of comments from participants during the study and continuously checked in with the

participants about their comfort levels to ensure that I did not bring in any personal biases or show any favoritism to any participant.

A staff member from the local mental health center quality control and the patient advocate's office was also available if needed. The research assistant that was assigned to the study was also a therapist at the local mental health center and works with the senior adult population and not only selected participants that met criteria but also was instrumental in ensuring that they were comfortable before and after the interview. Each participant was introduced to the researcher and then at the end when they completed their interviews, the research assistant confirmed that they were comfortable, and they had no problems at any time during the interview. This assistant was also available to handle any problems that may have occurred. This staff member was put in place by Dr. Al Edwards who was the Director of the local mental health center through a suggestion by the Walden University Institutional Review Board. This staff member was also available to address any immediate needs or problems that may have but did not arise psychologically for the participants during the study (Appendix H) as they share lived experiences.

Methodology

The qualitative method for exploring the perceptions of how older women, age 65 to 80 view and explain their life abilities is outlined in this chapter. The qualitative design for this study was chosen because this allowed participants to have an opportunity to express how they feel about their personal lived experiences and share a combination of emotion and experiences and how they utilize learned coping skills that allow them to

maintain independent living. The qualitative design allowed only those selected participants that are involved in the study to talk about their specific experiences and give meaning to their lives rather than a format where there may be a large number of older adults wanting to present their stories and much information may be lost or ignored. Agreeing with Taylor et al., (2016), I was interested in the participants stories and that these stories are a gate way to learning and education of older adult females. Their stories are lived experiences and these stories will help other researchers and those involved in treatment to better understand their world not through numbers or analysis but through these special stories. Phenomenology is based on the idea that the researcher makes no judgements or suggestions of what will happen but rather "naively" forms questions that focus on the problem or phenomenology to discover findings that may direct the researcher to future studies (Taylor et al., 2016). Realistic Phenomenology (Linsenmayer, 2011) is the chosen type for this study. The realism of their experiences, the wonder if experiences are more universal and similar, the willingness to open their world, and to discuss their real life and how they have managed their mental illness while aging. Specifically, Realistic Phenomenology fits for this type of research because "human action" (Linsenmayer, 2011) is always of interest to understand lives other than our own (p.1). Also, the research questions were written with this type of phenomenology in mind asking about the participants specific challenges and learned skills to live independently with a support system. This study answered the research questions using the interview questions which were specifically written for this population. Taylor et al., (2016) agreed that interview questions should be specific in order to obtain the information the

researcher is needing and that has not been provided by past studies. They also shared that it is appropriate at the start of the interview to begin with simple questions such as "how's it going" to take some of the uneasiness out of participants.

Bias touches every research study according to Smith and Noble (2014); the researchers explained that it is hard to avoid because researchers are human beings with their own thoughts and feelings. To minimize my personal bias, I first focused on selecting those participants that fit the study requirements and what it is I am researching. Then I followed the methodology steps adding in the changes proposed by both Walden University and by the South Carolina Department of Mental Health Institutional Review boards for each participant. All consent forms were completed and collected at the time of first meeting the participant and prior to starting the interview. The dates for all interviews were set up by the research assistant. The research assistant, the researcher and the department supervisor emailed to plan a date to meet and discuss the study and a date to set up the first interviews. It was agreed that this meeting would occur on a non-treatment day to avoid the me coming in contact with any potential participants. The date of the meeting, the flyer and the consent for potential participants was delivered to the research assistant and the study basics were discussed. All questions were answered. The same procedure for each participant was planned with no intentional influence or treatment. I also clarified that the assistant would be the individual who finds the participants and they would be drawn from her group therapy pool. It was also clarified that I will not use any participant that I either provided therapy for in the past or had any type of relationship with as a supervisor in the facility. I personally also worked to

minimize my bias by being aware how I feel about each participant and the stories they share and by also accepting their lived experiences as how they lived it, not how I assumed they lived it. Also, I was continuously aware of my training, having worked in the past with this population while maintaining my professionalism and how I feel talking to the older adult females. While making notes during the interviews I was aware that I did not have any attitudinal changes towards any of the participants to include thoughts, feelings, or changes in how I am responding or reacting to the participants answers, and then also evaluated if I felt I was reacting differently that I normally would around older adults. I minimized bias in this study also by having a design method that justifies using a qualitative methodology and following each step as written to curb any biases that may surface.

I began the process by setting a date to meet face-to-face at the mental health center with the senior adult therapist who served as the research assistant and the department supervisor to review the information about possible participants, asking for at least 8 to 10 participants (or more if available to allow for any that may drop out of the study). The research assistant who works with these older adult females was the one assigned to recruit participants and followed the criteria explained by the researcher. The research assistant knows the clients personally and was more able to screen for those that fit the criteria and would be willing to participate. Once an acceptable number of 8 participants were invited and agreed to participate, the researcher then went to the local mental health center on the agreed start date and met with the research assistant. The assistant helped carry the researchers supplies and the snacks to the assigned room and I

then began setting up my computer and digital recorder. All forms were laid out along with the interview protocol, snacks and pens. At the start of this process, the researcher was texted by the research assistant to confirmed she was ready to begin. The research assistant brought the first participant and introduced her to the researcher. I greeted the participant, thanked her for participating, confirmed she had never met the participant and the participant has never met the researcher and that the participant had no affiliation with the researcher. I then took time to look over the participant for any visible signed of abuse and then were confirmed they did not have a power of attorney. Then I reviewed the research study, confidentiality of personal information, had the participant read and sign the letter to potential participant, consent to participate which included the three questions that were added to the consent also for cognition; Question 1. Can you explain what you believe the study is about? Question 2. How will the researcher protect your private information? Question 3. Can you tell me how you met the requirements for this study? These questions were added by the South Carolina Department of Mental Health Institutional Review Board (SCDMH IRB) to confirm cognition and the ability to participate. The remainder of the forms were also completed to include the St. Louis Mental Status Examination (SLUMS), and both the researcher and the participant cosigned all forms and the signed forms with the participant name on them were put in 1 locked box and the other forms with only the participant code (P1, P2…P8) were put into the other locked box. The locked boxes were in the room until the interviews were completed for the day and then the locked box with the name of the participant was locked and given to the research assistant to lock in a locked file cabinet until the next

interview day. The methodology was written that after all interviews are completed the locked box that had all signed consents with names of participants on them indicated that "to be retained until (date), destroy after this date". At that point, the center will destroy them. No signed consents were taken outside the mental health center. Once all the forms are completed the researcher administered the SLUMS instead of the MMSE. Once the SLUMS was completed and the participants met or exceeded the required score, they had an opportunity to ask questions about the study. Once all questions were answered, the researcher confirmed the participant were ready and started the interview. The interview took approximately 60 minutes to complete for each participant. Once the interview was complete, the researcher turned off recorder, collected the participant's completed consents, demographics, and the SLUMS, and put them in the appropriate locked boxes and then prepared for the next participant. Once each scheduled interview was completed I gave a heartfelt thank you to the participant, ensured there were no questions, asked if the participant felt comfortable and again thanked them for their participation. Each participant then chose a snack and a drink to take with them and said thank you to the researcher. I then texted "done" to the research assistant and she came and brought the next participant then returned the completed participant back to the group therapy room. Prior to starting the next interview, I confirmed the forms were in the right lock box prior to the boxes being locked with a key and the box with the names being given to the research assistant to lock up. Once all scheduled interviews for that day were completed, I locked both boxes; one was stored in my rolling briefcase and then the briefcase was locked. The other box was locked and then given to the research assistant to store in a

locked file cabinet. This procedure was set up to protect all participants' information and confidentiality.

Establishing rapport between the researcher and research subject began at the initial meeting at the mental health center and followed through until the study was completed. My experience working as a supervisor in the Senior Adult Services department at the local mental health center has allowed me the ability to easily build rapport with participants in this age group. I am comfortable with older females and I have much experience on issues they live with on a day-to-day basis by having worked with clients on initial assessments, individual therapy, and group services involving older females and males.

The purpose was to have the participants freely discuss their life experiences regardless of whether they live inside a family member's home or independently in their own home or apartment. Their views about family support and how it helps or hinders the ability to live in the community was also be discussed. My goal was to identify any reoccurring themes, common perceptions of older adults' lives, and similarities in coping abilities that enhance resiliency. The interview protocol was designed to sufficiently answer the research questions by allowing the participant to describe her "lived experiences".

Participant Recruitment

Participants were invited by a flyer that was delivered to the local mental health center and presented during the meeting with the research assistant and her supervisor. The researcher contacted the Walden Institutional Review Board (IRB) and was sent a

Research Ethics Planning Worksheet to complete and attach to her IRB form for permission to use this population. The IRB stated the form will cover any questions that must be addressed along with the suggestion of obtaining another letter from the local mental health center director stating the participants will be protected during the study by a staff member who will oversee the study and be available if a need should arise. This letter is found in Appendix H. The staff was directed to use purposeful sampling when selecting participants specifically based on their experience with resiliency, the phenomenon being studied (Suri, 2011). The logic and power of purposeful sampling lies in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry, thus the term purposeful sampling. I assumed that participants have an education level that falls somewhere between the categories of some high school to a college degree. Participants were between the ages specified of 65 to 80, live in the community either with or without family, have a diagnosed mental illness, and be in treatment at the local mental health center. The research assistant who works with this population of older females was asked to identify possible participants who meet the research criteria in advance of the study, compile a list of those interested older females, including contact information, and the possible qualifying criteria. The research assistant also verified the candidate's interest in participating. I was then contacted by the research assistant by email informing me that she had eight participants who reviewed the flyer and were interested and willing to participate. Specifics are documented on the demographics form found in Appendix D. Several start dates were discussed and then

two dates set up. The research room used was not confirmed until the day of the first interviews as it was a room that was separated not only from the participants but also from all other clients who were in treatment on those days. No participants contact information was shared with the researcher prior to the start of the interviews. This methodology change was made due to the fact that in order to protect participants and their confidentiality the only option offered was that they all had to be interviewed at the mental health center. All participants are on the same group schedule, so this was agreed on for convenience of the researcher and the participant. This change also reduced worry and stress on the participants due to the convenience of them already being in group at the center.

Suri (2011) explained that when using qualitative research, the researcher should purposefully select participants who are familiar, live with, or can help the researcher understand the problem and the research questions by learning new knowledge. Therefore, random sampling does not work in qualitative research or specifically this study. Lowe and McBride-Henry (2012), explained that using a smaller number of participants in a qualitative study allows for more depth in answering the specific questions and increases the richness of the data. Smaller numbers also allow for more depth in the analysis as well. Mason (2010) stated it is a norm that samples for qualitative studies are smaller than those used in quantitative studies. For this study, the sample number was to be between 8 to 10 participants with P=8 being the final number who agreed to participate. This number also provided enough data to initiate saturation, but saturation was not achieved because hygiene was not repeated 5 times in a row but

scattered throughout the different participants responses. Qualitative research looks for saturation, which is the moment when information begins to repeat (Mason, 2010). Once saturation is reached, interviewing stops because more data collection does not necessarily provide the researcher with more information (Mason, 2010). I only had 8 participants available who would participate and of those 8, 5 participants stated that hygiene was very important to living independently, referring to showering and clean clothing. Saturation was not reached but hygiene was a very distinct and popular answer for the question that asked what family support does for the older female. It was my intent that the participant sample will include a combination of ethnic and racial backgrounds and the sample confirmed this intent. Participants constituted a purposeful sample that would be available to one working at a mental health facility where there is a large population of older adult females in different types of treatment. The interview protocol that was designed for this study was used for the interviews. A complete copy of the interview protocol is located in Appendix A.

Cognition

Participation in this study required that the individual be able to understand what the study is about, why she was selected as a possible participant, and why she agreed to participate. Originally, I proposed to use the Folstein Mini-Mental State Exam (MMSE) to assess cognition in participants prior to acceptance into the study. The MMSE was changed to the St. Louis Mental Status Examination (SLUMS) by direction of the South Carolina Department of Mental Health Institutional Review Board for its ability to score using either a high school education or higher or less than a high school education versus

scoring all older adults on the same level regardless of education. Folstein Mini-Mental State Exam was originally considered as it has a history of a high level of internal consistency and validity. The tool was originally selected as it is expected to provide evidence that the participants will able to understand the study, have the ability to participate in the study, and be able to provide consent that they want to be a part of the study. The Folstein Mini-Mental State Exam (MMSE) "is an eleven item screening tool which assesses cognitive domains of orientation to time, orientation to place, registration, attention/calculation, recall, naming, repetition, comprehension, reading, writing, and drawing. The maximum possible score is 30, with a score of 23 or lower noted to be suggestive of cognitive impairment". The instrument is highly recommended due to the ease of administering which takes only about 10 minutes, has "strong psychometric properties and is considered the "gold standard" of cognitive screening tools" (Brown, Joliffe, and Fielding, 2014, p. 231). The researchers also added that they found "surveys of psychogeriatricians in the USA, Canada, and the UK have-consistently found the Mini Mental State Examination (MMSE) to be the most commonly used cognitive screening tool by some distance.

Folstein et al., (1975) developed a short version of the MMSE, referring to it as the "Mini-Mental State" (p. 189) and used it to teach residency students how to assess for severity in cognition in 200 older patients. Tombaugh and McIntyre (1992) historically reported that the validity of the MMSE can be compared and considered valid against a variety of other measures and also stated that the tool was considered a to be a "gold standard along with the DSM-III-R and the NINCDS-ADRDA (National Institute of

Neurological and Communicative Disorders and Stroke and the Alzheimer's Disease and Related Disorders Association used for Alzheimer's criteria), clinical diagnosis, Activities of Daily Living measures, and other tests that putatively identify and measure cognitive impairment" (p. 922). The researchers also reported "the reliability and construct validity were judged to be satisfactory. Measures of criterion validity showed high levels of sensitivity for moderate-to-severe cognitive impairment and lower levels for mild degrees of impairment" (p. 931). Cronbach's alpha is an example of a measure of reliability and was developed by Lee Cronbach in 1951 (Tavakol and Dennick, 2011) for a test or scale's internal consistency, meaning all items on a test measure the same thing. Cronbach's alpha is expressed in a number between 0 to 1 and involves whether the items on a test are correlated or associated and is connected to how many items or questions there are. Test items that are correlated would cause an increase in alpha as explained by Tavakol and Dennick (2011). Wedgeworth, Larocca, Chaplin, and Scogin (2017) also confirmed the use of Cronbach's alpha studying older adults correlating their quality of life in connection with demographics, interpersonal sensitivity, and their support system. The outcomes showed that social support positively impacted an older adults' quality of life. In this study, the MMSE which has correlating items involving cognition and memory, will only be used to confirm that the participant has the ability to understand that they agree to participate in a study and have the ability to provide consent to participate.

The technical features of reliability and validity for the MMSE-2 were explained by Folstein, Folstein, White and Messer (2010) as first conducting a study with a sample

of over 1,500 individuals from 26 states to establish reliability and then studied a sample of individuals who reported having either Alzheimer's disease or subcortical dementia which were used to establish validity. Convergent validity, meaning that two constructs that should be related show that there is a relationship, was then verified by questions pertaining to recall and orientation to the time and place questions. The MMSE was also compared to other tests that were designed to measure cognitive abilities to include the "WMS®-III Digit Span Forward and Digit Span Backward subtests, the Category Naming Test, the Boston Naming Test, and the Trail Making Test" (Folstein et al., 2010, p. 2). The MMSE was developed for ages 18 and older and has 10 sections; registration and recall, orientation to time, orientation to place, attention and calculation, naming, repetition, comprehension, reading, writing and drawing with no reverse scoring (Folstein et al., 2010). Raw scores are based on correct answers ranging from 0 to 30 with a suggested cut off score of 22 to 23 (Folstein et al., 2010). The MMSE was also developed using a bias panel to assess for potential bias or offensiveness in the questions and an expert review panel consisting of 2 neuropsychologists, 1 geriatric psychologist, 1 geriatric psychiatrist. This panel also gave feedback on test items, how it is the test should be administered, to include a pilot test, and standardization (Folstein, Folstein, White & Messer, 2010).

Nieuwenhuis-Mark (2010) agreed that the MMSE also has high inter-rater reliability; meaning those who use the tool mostly agree it does measure for dementia symptoms or a deficit in cognition. It was reported that "internal consistency and test-retest reliability (0.80 to 0.95) are also generally good" (p. 23). Reliability can also be

considered high when the test is administered the first time and then waiting about a year to retest. This author also remarked that using a cutoff score of 24 versus 23 has an 87% sensitivity rating and 82% for "specificity" (p. 23). Baek, Kim, Park, and Kim (2016) also reported that they found the MMSE to have the same "good test-retest reliability (0.80-0.95) and acceptable sensitivity and specificity to detect mile to moderate stages of dementia" (p. 19). In conclusion, the MMSE provides a brief screening tool which can be used to assess cognitive impairment and also can be used as a reassessment tool to document possible changes over time.

Regarding use of the MMSE and the cut off scores, opinions differ about what the cut off score should be used compared to what was originally set up (23 out of 30) by Folstein et al., (1975). In a study conducted by Matallana et al., (2011), the authors studied 2861 Mexican Americans, aged 65 and older from the Hispanic Established Populations Epidemiological Studies of the Elderly (EPESE) from 1990 to 1994 until 2004 to 2005. The study showed that those participants who had more education had higher memory scores and that the MMSE scores were affected by the level of education that the participant had. They found that those individuals who spoke Spanish and had higher levels of education scored 5 points or higher on the MMSE concluding that the MMSE cut off score should be adjusted to allow for education levels. Monroe and Carter (2012) also had similar concerns with how the MMSE is scored and what may affect the outcome. They conducted a literature review of 50 studies where the MMSE was used to assess cognition and found that at least fourteen of the studies reported concerns with education level, sensory, and language which would affect the validity. They also found

that education and demographics may also affect the outcome of the test and that this should be taken into consideration when scoring the MMSE. The authors also reported that they found in the studies that people with an 8th grade education or less may be considered to have dementia under the original scoring but in fact, did not do well on the exam due to problems understanding some of the questions. The researchers proposed the scoring being adjusted to 24 to 30 as no impairment; 18 to 23 as mild cognitive impairment; and 0-17 as severe cognitive impairment (Monroe and Carter, 2012). They also reported that the MMSE should always be administered by someone who is qualified and is trained to understand the scoring system. Lacy, Kaemmerer, and Czipri (2015) also conducted a study of the MMSE scoring system by reviewing data from clinical charts of 304 older adults, aged 64 to 96, who were referred for a neuropsychological evaluation. The patients were separated into two groups; those that had less than 25 as a cutoff score and those that had less than 28. The researchers reported that they found that 169 of the participants that scored above the less than 25 cut off (which was noted to be used in many clinics versus the 23) were still considered to be moderately to severely impaired in memory functioning. Raising the cut off score to less than 28 was then documented as a suggestion only to find that the 109 participants that scored in this range were also considered to be moderately to severely impaired. The balance of 26 participants completed the MMSE with a perfect score yet were also documented in medical charts as having between mild, moderate and severe impairment.

Lacy et al., (2015) agreed with Matallana et al., (2011) and Monroe & Carter (2012), that the individual who administers the MMSE should be trained, and that

administer should have all demographics on the individual being tested. The authors also agreed that other assessment tools should be used in conjunction with the MMSE in situations where decisions about treatment will be made. After review of these studies and the recommendation of the SCDMH IRB, the original SLUMS designed scores were used (Table 1).

Table 1

SLUMS Scoring

Education level	Normal	MCI	Dementia
High school	27-30	20-27	14-19
Less than high school	20-30	1-19	1-14

This researcher is also trained in the use of the SLUMS with no adjustment to the original design being used.

Overall, the SLUMS provided a quick and fun assessment of cognition by the combination of questions to include general knowledge, math, drawing a clock, selecting squares from triangles, and comprehension about a short story and the details of that story. The participants showed no stress from the questions with many commenting that they enjoyed the questions. Only a few participants asked for a minute to think through a question before responding. The scoring also was instrumental because not all participants had high school or college education. The researcher recognized that this gave others the opportunity to participate and this was recognized as an accomplishment by the participants in their statements that “they have never been asked to do anything

like this before". The combination of all the tools confirmed the understanding that the participants did in fact get to participate in a research study, were able to sign the informed consent form, and that they were able to answer the basic interview questions. This researcher is also trained in the use of the SLUMS with no adjustment to the original design being used.

Procedures for Recruitment, Participation, and Data Collection

Data collection took place at the local mental health center. A location such as a private home or in the community was changed in the methodology and was not offered as an option. If participants were interviewed in their home and a situation or upset arose from telling their story, then there would be no staff available to assist. Plus, using the mental health center for all interviews kept uniformity in the methodology. The local mental health center was chosen by the researcher due to her familiarity with the center, and as a resource that has agreed to provide participants. The local mental health center has rooms available to be used for confidential interviews, and the researcher had no conflicts with staff members who assisted with the study.

Permission to conduct the study was requested and approved in advance by a letter from the local mental health center director (Appendix H) which included a statement that allows the researcher access to the facility. The director also shared a copy of this permission in email to staff who assisted with the study to reinforce the protection of personal information and validity of the results.

The SLUMS and the consent forms were administered and were exactly the same for all participants. This was to ensure all participants followed the same methodology.

The participant were made fully aware of all the forms, their purpose and the overall purpose of the study. The consent form followed the guidelines of the South Carolina Department of Mental Health Institutional Review Board and was written at a sixth grade level for participants comprehension. Confidentiality of the study and the paperwork along with how the researcher would protect their confidentiality was discussed prior to the start of each interview. The local mental health center also had the assigned staff research assistant, Courtney Hudson, who assisted in finding participants and scheduling the interviews. Any participant interested in being a part of this study would have to score a minimum on the SLUMS depending on whether they have a high school or less than high school education. Any participant that did not meet the minimum score or higher would be disqualified from consideration for this study. The MMSE was originally proposed for cognition but was changed to the SLUMS for the scoring which included those who do not have a high school education but fell within either the Normal or MCI (Mild Neurocognitive Disorder) range. The SLUMS like the MMSE may have questions the participant does not or cannot answer and those would have not been counted in the final score. No participant refused or could not answer any question. However, a few did ask for a moment to think then responded but no one refused any question. No alternative days were set up either by no shows or by refusal to cooperate. All face to face interviews were completed on the scheduled days; 3 on the first Tuesday and 5 on the second Tuesday. The research assistant scheduled the interviews on the same days that the participants have group therapy for convenience and due to many no longer able to drive. The participants were assigned a unique identification number (P1, P2 …P8) by the

research assistant. The idea of writing appointment sips with the participants assigned code on it was also deleted from the methodology due to the participants being in group therapy and not having to come at a different time. This participation number (P1, P2…P8) was entered in a confidential spreadsheet with the participants name which was set up by the research assistant to protect the participant's identification. Participants were only referred to as P1, P2…P8. The researcher did remind the participants that there is a phone number they can call if they felt they had any other questions about the study. All participants refused this phone number. The SLUMS is located in Appendix E and the MMSE is located in Appendix F.

Data collection took approximately 60 minutes per participant, and the researcher scheduled two days in order to accommodate all participants and collect all data. Prior to the interview, the researcher ensured each participant was comfortable by offering a drink and a snack (these were provided by myself), sharing the location of the restroom, asking if a restroom visit is needed, or if they have any questions prior to starting the interview. Also, by explaining that this interview is a one-time event. I also explained the benefits of participating in a study and any risks; for example, discussing personal issues, situations that the participant has had to deal with which may have caused discomfort, along with a confirmation that the participant will be offered a copy of the translated interview. The center provided an assigned staff member (research assistant) of the mental health center to monitor the study and to ensure proper research procedures are used. This is a requirement of the center as part of the center's monitoring procedure. I administered and secured all assessments and documents. I also confirmed that no participants had any type

of contact with the researcher prior to beginning and if so, they would not be allowed to participate. No participants were found to have any prior relationship with the researcher and no participants were excused from the study.

I then set up all materials in a room assigned by the mental health center prior to meeting with possible participants that met the specific criteria. All participants who took part in the study were given a copy of the Letter to Potential Participant (Appendix B), Informed Consent (Appendix C), Consent to Audio Record (Appendix K) and will completed the demographic survey (Appendix D). Once all forms were completed participants were given the SLUMS which was administered by me who also answered any questions.

For accuracy and authenticity, all face to face interviews were conducted using the interview protocol while being recorded and then typed verbatim, and then were printed for review for accuracy and to ensure authenticity. Two systems were used for the recordings; the first was the Dragon® dictate professional computer dictation recording system that was already on the researcher's computer. The second system used to record the interview using a digital recorder in order to compare it to the Dragon® recording for accuracy. The explanation of the recording and the participant's approval for the recordings is included on the consent form and all the participants did consent in advance to the set up to avoid any delays during the actual interview. Prior to the interview, I verbally clarified the participant number who is speaking and again after the interview to ensure participant's stories are kept separate and to aid in the transcription process. The participant also had an opportunity to have any other questions answered by the

researcher. I also reconfirmed confidentiality of their document, the reason for the locked boxes, and that the participant's rights and identity will be protected during data collection. Clarification and a reminder to the participant that the interview is being recorded was also explained during the procedure portion of each interview. This format allowed the participant to openly share her perceived skills and her needs in a confidential location of her choice. I used other questions to clarify participants' statements if needed, added in any detail if needed, or asked for more information to enhance the interview. Notes were taken as the interview was being conducted for review after the face-to-face interviews for completed for the day. These notes were reviewed only by myself and then filed in the locked file box with all coded documentation. An appropriate number of possible participants (8) were scheduled. If the participants resulted in less than 8 participants, then the researcher would have met with the staff from mental health who are assisting with the study and discuss an alternate recruiting plan. This plan was discussed prior to the study. This may have involved requesting from IRB a modification in research form to adjust methodology. Eight out of 10 participants completed the study and there was evidence of saturation.

The interview questions were designed to direct the individuals to share experiences; their responses were categorized into themes and then compared. The questions are presented here and also are included in Appendix A.

1. Can you tell me what it is like living with a mental illness?
2. Does your support system come from inside or outside the home and who is in your support system?

3. Can you tell me how your support system helps you live independently?
4. Can you tell me what skills you believe you have that help you live independently?

The connection between the research questions and the interview questions is shown in Table 2.

Table 2

Interview Questions' Connection to Research Questions

Research question	Interview question
RQ1: What does family support mean to older female adults who have chronic mental health issues and receive outpatient care in their local communities?	Can you tell me what it is like living with a mental illness?
RQ2: What resilience skills are used by older adult females to be able to remain in independent living?	Does your support system come from inside or outside the home and who is in your support system?
RQ1: What does family support mean to older female adults who have chronic mental health issues and receive outpatient care in their local communities?	Can you tell me how your support system helps you live independently?
RQ2: What resilience skills are used by older adult females to be able to remain in independent living?	Can you tell me what skills you believe you have that help you live independently?

At the end of each interview, I summarized the interview and clarified if there were any questions from the participant. The interview was then concluded including a heartfelt thank you to the participant and her willingness to be a part of the study. A snack and drink were offered, and then I texted the research assistant the word "done" to confirm completion and that she was ready for the next participant. After the participant left the room, I reviewed the interview using the Dragon® dictate professional computer dictation recording system to confirm categories that surfaced, noted any additional

comments, thoughts, or ideas prior to leaving the site. I then completed all scheduled interviews for that day and then showed respect for the site by having cleaned all debris, food, and trash and returned the room to its original set up.

My personal computer was used to store all research transcripts from interviews and to document themes. A separate document was started to compile all categories of possible themes in an effort to make decisions about coding of the data and the themes participants shared; they then were compared for multivocality. This document was then also locked in researcher's personal computer and can only be accessed through a secret pass code known only to the researcher.

All data, consents and paperwork were stored on my personal computer's hard drive in a folder that can only be unlocked by a personal password. A coding system was put in place by me and explained to the research assistant and then explained to the participants to clarify confidentiality of the study and the participants names and identity. The codes were known only to the researcher and the research assistant and were accessed only by the researcher. This information will be stored in my personal computer for a period of five years and when deemed no longer needed it will be deleted completely from the computer and hard drive. Any other paperwork will be shredded to ensure all information is destroyed. The coding, storing and destroying of paperwork is in accordance with the American Psychological Association (2010) Publication Manual of the American Psychological Association section 1.08 'Ensuring the Accuracy of Scientific Knowledge'. The interview protocol, informed consent, research questions, demographic survey, and letter to potential participants were all designed by the

researcher. The consent to audio record was initially drafted by the mental health center with changes added by the South Carolina Department of Mental Health Institutional Review Board. All forms were confirmed for use by the South Carolina Department of Mental Health Institutional Review Board. All forms also were initially designed to ensure only participants who met the criteria for this study were invited to participate. All protocols are located in the appendix section of this proposal. All statistical analysis came from the SLUMS and the demographic survey.

Content validity was verified by using the interview protocol that was developed specifically for this study to answer the specific research questions developed for this study with the age group and research questions in mind. The interview protocol developed was used for this study only, with the participants aged 65 to 80, and promoted the older adult female to share her lived experiences with the phenomena of life independently with a mental illness and family support.

Ethical Protection of Participants and Issues of Trustworthiness

Protection of human research participants is the most important aspect when planning any type of study and was the first step when planning the interviews. The researcher is responsible for not putting participants at risk at any time during the study, showing respect and ensuring participants do not feel forced into any type of situation. Also, I took into consideration the vulnerability of the population being researched and addressed any known special needs in advance (Wendler, 2012). At this point, I addressed the need for a translator but found that all participants spoke English and a translator was not needed. If it was needed, the mental health center would have provided

a staff member who would have been available to translate. Also important is where the interview can take place depending on the participant's choice. All participants were informed prior to the study that all interviews would take place at the Greenville Mental Health Center. This change ensured participants did not have to schedule their own time, the center could protect them during the center and the research assistant would be close by if any participant became upset or needed to stop the interview. This was also clarified through the research assistant during the process of finding participants. Participants were confirmed that they agreed to be in the study and were not persuaded in any way to participate. Participants understood that they were not paid any stipend to participate; this was also clarified in the Informed Consent Form and was verified when signed by participants. (This can be found in Appendix C). The participants were also notified that their private information will remain confidential. It was also explained to the participants that they may withdraw at any time from the study without consequences. By categorizing each participant by number (P1, P2…P8 as referenced), the personal identifying information is protected. The numbers were assigned prior to each participant meeting with the researcher to compete the SLUMS. The mental health center director assigned a staff member from the senior adult's department, Courtney Hudson, to assign the numbers from a pre- numbered spreadsheet which is located on the researcher's laptop under the protected study file. In the event a participant experiences some type of psychological issue during the interviews or at any time in this process, the protocol is that the researcher will stop the interview, address the issue or how she is feeling and then have the option to continue, stop and speak to the mental health staff member. If the

issue can be worked out and the participant wishes to continue, then the interview will begin again. If not, then the researcher will contact the mental health staff member and the interview will be stopped. The protocol is if a participant decided at any time not to complete the interview, the researcher will thank them for their time and express appreciation for their willingness to participate. As discussed earlier, a new study conducted using this specific criterion, except changing participants to males, would result in not only generalizing but would allow for transferability. No staff or participants were contacted by the researcher until appropriate approvals were received from the IRB to begin the study.

Data Organization and Analysis

During the interviews data was collected by the researcher, and notes were taken. These notes are referred to as "analytic memos" and were used to write down findings from the interviews, how the researcher thought about the study progress, and that the participants appeared comfortable and willing to participate (Taylor, Bogdan, and DeVault, 2016, p.180). These memos also provided a place to make notes to review later of the responses in order for me to begin finding codes, themes, and similarities in the participants experiences. All memos were collected and once reviewed were stored in the locked box with the coded documents during the interviews for confidentiality. A master list of categories was developed, and the main ideas were organized into these categories until all the information was collected.

Data collection was first organized by the information provided by the participants on the demographic. This information includes gender, age, race, and highest

educational level or grade completed. This information was provided by each participant at the start of their interview. The demographic survey and all consent forms were written in English. Unless requested, no other language was to be offered and all participants spoke English. Optional language accommodations if needed would have been made through the use of an interpreter appointed by the mental health center because the researcher does not speak any language other than English.

Data Analysis and Coding Process

The participants' identifying information was the first coding used in this study to protect their privacy and to stay within the research guidelines set by South Carolina Department of Mental Health and Walden University. The researcher started by opening up a spreadsheet on the researcher's secure laptop and allowing only the study assistant access to this spreadsheet. Coding was assigned by the research assistant, (a staff member from mental health assigned to provide assistance to the researcher) for each participant on this spreadsheet prior to the start of the interview. These assigned codes were also written on all paperwork connected to each individual participant from the start to the end of the interviews in an attempt to keep paperwork organized and provide confidentiality. The staff assisting the researcher completed the coding using preset codes of P1, P2, P3…P8 and these codes protected the participants personal information and also allowed the researcher to conduct the interview using the code versus the participants name allowing for more confidentiality and also in an attempt to reduce bias. This step was completed before the interviews for ease of the interviews and so the participants

understood I did not know their names but only the code assigned to them. The next step in coding was that I

Coding was also conducted by the researcher after the interviews were completed in an attempt to list possible categories from the responses which ultimately lead to specific themes (Taylor, Bogdan & DeVault, 2016). The Dragon® recordings were printed out and the responses were clarified and ensured that they matched the digital recorder transcript. The responses were then organized in a chart listing all possible categories. The researcher then studied the results of the categories and began analyzing the responses looking for similarities and frequency of specific statements from the participants. According to Saldana (2013) the process of coding is a way to organize or group together similar responses. These responses were collected from the four interview questions and typed into categories for clarification and review. After several reviews of these categories using the responses from the interview questions, I was able to begin separating the categories which resulted overall in a total of 19 categories. The data was reviewed numerous times, and the recordings were comparing to the transcripts to ensure themes were accurate and correctly represented. I then went back and reviewed the interview questions repeatedly to ensure I captured all possible categories. Taking my time to review each category several times, I then began to find themes and similarities in the participants stories. The total of three themes were found; managing my mental illness, the need and importance of family support, and skills I have to live independently. For example, if the majority of the participants stated that they only need family members to provide assistance with their medications, this would be coded as a

category not a theme. All themes were processed in the same manner until all repeated themes were accounted for. This coding allowed the researcher to quickly identify major themes and aided in the review process to answer the research questions. The data collected was analyzed and was used by strategies outlined previously in the study. All techniques outlined in this section were utilized to guarantee the best outcome as evidence of trustworthiness in this study.

Verification of Findings

The validation of findings in a phenomenological study comes from describing what the participants said and then comparing these statements to uncover similar themes (Taylor, Bogdan, and DeVault, 2016). Some examples of possible strategies included: triangulation of different data sources to confirm data outcomes, member-checking to determine the accuracy of the findings, peer review, extensive transcriptions and notes, prolonged time in the field, and an external auditor. Triangulation of different data sets could be accomplished if this researcher elected to use two different types of interviews: conversational interviewing and structured-question interviewing. By using two different methods, or approaches, to collect data, the researcher may obtain different information that provides data sets that complement one another. For this study, only face-to-face structured interviews were used. The questions were written in basic English language and were easy to understand. Extensive transcriptions were produced by recording during the interviews then typing out for verification and to validate accuracy of findings. Handwritten notes (memos) were also collected and used for review to confirm ideas or themes. Finally, external auditors will be represented by this study's chair and the

committee member (who both have consistently audited this study) and who will confirm themes.

Notes also were taken and verified with the participant at the end of the interview. The researcher then used member checking with the participant to confirm major concepts and themes found and verify. The second strategy used was verifying the notes through the transcription notes taken during the interviews and then comparing them with the audio recordings and typed verbatim. These recordings were reviewed prior to processing and compared to the Dragon® transcripts. This process verified that the participants wording is correct and ensures validation of their specific story. Dependability was also verified through this process. The methodology for why a population was chosen, the research questions, the protocols, any instruments used, and the steps in the interviewing process should be clear and this researcher was diligent in ensuring each interview were conducted in the same manner with the same protocol. According to Qualitative Inquiry in Daily Life (2016), "the more consistent the researcher has been in this research process, the more dependable are the results" (p.1). Confirmability was also verified, meaning the researcher ensured all steps were taken and the data outcomes or themes represent what was said by the participants not what the researcher prefers the outcome to be. By being clear in the methodology another researcher could walk through the steps and confirm the researcher did what they said they were going to do, and the outcomes were those of the participants.

Summary

This study's main question: does support outside the home affect the mentally ill older person's resiliency and the ability to cope, was explored through face-to-face interviews. Consent forms were signed, and questions were clarified prior to starting the interviews. Abilities and characteristics of the participant living in the community were revealed with open-ended questions and audio recordings. Rapport was established to ensure comfort of the participant before beginning the interviews. The interviews occurred in a comfortable setting to allow the participant to open up and disclose to the best of her abilities.

The initial step was to receive appropriate approvals to conduct research from the South Carolina Department of Mental Health and Walden University Institutional Review Board (IRB). The researcher then set up a meeting with Greenville Mental Health Center director first to explain the study and request the use of the center and participants. The researcher met with the center director many times to discuss methodology and make all changes requested by the South Carolina Department of Mental Health Institutional Review Board. Once approval was given to start the study, the researcher arranged an appointment to meet again with the director of the local mental health center, Dr. Edwards, to confirm consent to start the study and the participant's requirements. Once that approval was given the researcher requested face-to-face meeting with the staff who work with the older adult females to deliver the flyer (Appendix L), introduce the study, share criteria, and answer questions. Dr. Edwards emailed the staff and they responded with dates to consider for a meeting to discuss the study. Dates were reviewed and it was

agreed that this meeting would occur on a non-treatment day to avoid the researcher coming in contact with any potential participants. On the date of the meeting, the flyer and the consent for potential participants was delivered to the research assistant and the study basics were discussed. All questions were answered. Methodology was discussed and that the same procedure for each participant was planned with no intentional influence or treatment. It was discussed that the original plan was that the researcher would call each participant who was interested to set up an appointment, but this was changed due to all participants being in group therapy and that the research assistant suggested she arrange all participants to be available on two dates. The two dates were treatment days so they would be in group and then the research assistant just brought each one to the researcher. This was simpler and caused less stress on the researcher and all the participants.

The researcher then was assigned an interview room at the mental health center and a schedule was set to begin interviews. During the initial meeting with the participant all paperwork was completed to include the SLUMS and together the researcher and the participant signed all consents. Each participant was assigned a code for all paperwork (by the staff assisting the researcher (P1, P2...P8) to protect confidentiality. Once all paperwork was completed, any questions that the participant had was answered, and the interview began. Only one problem occurred during this process and that was two of the participants forgot their glasses, so the researcher read all the forms to them. There were only two days used for interviews. This researcher requested between 8 to 10 participants (or more) that met the study criteria to complete the interviews and resulted in 8

interviews. The researcher used the preassigned codes for all documents to reinforce confidentiality of the participants. This coding system is known only to the researcher and the research assistant. Participants were not persuaded in any way to participate in this study. Table 4 shows the connections of the research questions to the interview questions.

Once interviews were complete, the researcher informed the center director that the study is complete and thank him for allowing this study to be conducted. Once completed the researcher stored all recorded interviews in her computer under a confidential password, the coded forms in the designated locked box, and stored the actual signed paperwork (all consents) in the second locked box and given to the research assistant to store in a locked file cabinet until the study is complete. A locked file bag was originally planned but no locked file was located locally so the researcher chose to use the locked file boxes. Also changed was the plan that the researcher kept all paperwork, but the South Carolina Department of Mental Health Institutional Review Board stated that no paperwork that the participant signs their name to can be removed from the mental health center due to confidentiality, so the locked file box was added. With the study being completed this locked box is stored in the mental health center medical records department with the note " the contents were used in a research study and must remain confidential and stored for 5-7 years and then may be destroyed by the mental health center".

The intent of this study was to understand the day to day lived experiences and if family support is an important part of managing day to day as they are described by the

older adult female age 65 to 80 through face-to-face interviews using the research questions as a guide while in treatment at a local mental health center. This study used a qualitative methodology approach of conducting face-to-face interviews using the research questions as a guide. The research questions in this study are built upon the two existing theories by participants answering the specific questions from their lived experiences.

This research has one main question and 2 subordinate questions. The overarching question this study wishes to explore is exactly what family support does for the participant and whether that support comes from someone living inside or outside the home? The subordinate questions that will be explored are:

RQ1: What does "family support" mean to older female adults who have chronic mental health issues and receive outpatient care in their local communities?

RQ2: What resilience skills are used by older adult females to be able to remain in independent living?

The interviews were used to promote open dialogue in order to collect and compare participant's stories to establish common themes, resiliency skills, and any commonalities. Also included was the procedure for administering the Letter for Potential Participants; Informed Consent; Consent to Audio Record; Department of Mental Health Letter consenting to the Study at Mental Health; Department of Mental Health Letter consenting to the changes in procedures; Department of Mental Health Letter confirming the study will be completed at the Greenville Mental Health Center; Demographic survey; and the St. Louis Mental Status Examination (SLUMS), to include a systematic

explanation on the procedure that was followed; a copy of the SLUMS; the permission letter to conduct the study; as well as forms used with the participants. The participants were recruited from Greenville, South Carolina only. These interviews were conducted verbally and recorded for accuracy. Protection of participants is of the utmost importance and was taken into account during this entire process. There also was no stipend paid for participating; however, snacks and water was available. Dependability and confirmability have been addressed and all modifications were approved and addressed

Chapter 4: Results

This qualitative study addressed resilience factors in older adult females with a mental illness who live independently and have family support. I also explored whether the support system enables them to be more independent and what skills they have that allow them to maintain independent living. The goal of this research was to understand through phenomenological interviews how older adult females with chronic mental illnesses manage living independently with a support system. The support system location clarified whether the support comes from inside or outside the home, who is the support system, and what they do for the older female. If there had been no support system reported during the interview, I would have inquired about the older adult female's resiliency skills; their ability to handle situations, stressors, and problems in their life; and where their resilience comes from. All participants reported that they have some type of support system and were able to explain where their support comes from.

I looked at support systems inside and outside of the home of older adult females in South Carolina who are in outpatient treatment at a mental health center and how they

manage their day-to-day lives. The qualitative research design included a demographic survey and a face-to-face interview using a group of questions to explore reported resiliency skills that older adult females use in their day-to-day life. The purpose of the interviews was to understand how older females manage to live independently. The Folstein Mini-Mental State Examination (Folstein et al., 1975) was changed to the St. Louis University Mental Status Examination (SLUMS, 2006) by the South Carolina Department of Mental Health Institutional Review Board due to the scoring evaluated on the participants' education level (high school education or less than high school) rather than their age.

The study focused on the lived experiences of older adult females, how they describe their abilities to manage day-to-day living with a support system in place, how the support system helped them, and what they may not be able to accomplish without a support system. These interviews allowed the older females to share a better understanding of what it takes for them to live their life each day and what support they may need to do this. There was no variation to the plan that would cause any participants any trauma or uncomfort.

Chapter Organization

This chapter is organized by starting with the introduction, which includes the purpose and research questions. The next section addresses the setting, demographics, whether there were any influences on the participants, and whether any influence was caused by the setting or me. This is followed by demographics (Table 3); data collection SLUMS scoring; data analysis; the interview questions, responses, and emerging

categories and themes (Table 4); and evidence of trustworthiness (credibility, transferability, dependability, and confirmability). A discussion of the answers to the research questions is included along with a summary of the research questions followed by the outcomes along with a transition to chapter 5.

Research Questions

The intent of this study was to understand the day to day lived experiences and if family support is an important part of managing day to day as they are described by the older adult female age 65 to 80 through face-to-face interviews using the research questions as a guide while in treatment at a local mental health center. The research questions in this study were built upon the two existing theories; Social Learning, Self-Efficacy (Bandura, 1991), and Resilience (Holling, 1973) by participants answering the specific questions from their lived experiences and by allowing a look into their private world exploring their skills and resilience that allow them to live independently. This research focused on the lived experiences of older adult females who live independently with a mental illness and participate in treatment at the local mental health center. This research has one main question and two subordinate questions. The overarching question this study wishes to explore is what family support does for the participant and whether that support comes from someone living inside or outside the home? The subordinate questions that will be explored are:

1. What does “family support” mean to older female adults who have chronic mental health issues and receive outpatient care in their local communities?

2. What resilience skills are used by older adult females to be able to remain in independent living?

Settings

Only one setting was used to complete the face to face interviews which was the local mental health center in Greenville, South Carolina. This setting was made available by the director of the mental health center Dr. Al Edwards. All interviews were directed to be completed at this mental health center by the South Carolina Department of Mental Health Institutional Review Board to provide safety and protection of participants and their confidentiality as a participant

There were minimum personal conditions set up by the researcher, such as needing participants to meet criteria of age, that they have a diagnosed mental illness, live independently, and have some type of family support. The Department of Mental Health Institutional Review Board, who was clarified to be the lead office for this study changed several methodologies set up by the researcher to ensure protection of the participants safety and confidentiality: (1) that all of the interviews are to be completed at the mental health center and none in the participant's home because the mental health center would not be able to protect the participant if the interview is in the home, (2) that no participant may have a power of attorney, (3) that a locked file/box be used to store all signed documents that have the participants name and this box will remain locked during the interviews and then given to the assistant to lock up when the researcher leaves the mental health center. This locked box will then be stored in a locked file cabinet until the study is completed and then stored at the mental health center with a note on the top of

the box stating “the contents were used in a research study and must remain confidential and stored for 5-7 years and then may be destroyed by the mental health center”. The other lockbox remains with the researcher and contains the paperwork that only has the participant codes P1…P8 (no signatures) and then will be stored with the rest of the research paperwork. While traveling, this box will stay in the researcher’s trunk, (4) that the researcher conduct an overview of how the older female presents to confirm that there is no indication of possible abuse or neglect and if there was some indication or a question of abuse that the assistant to the researcher be notified immediately, (5) that a few questions be added to the consent form to ensure the participant is able to understand what the study is about, how their personal information will be protected during and after the study, how she met the criteria for the study, and that the consent form be simplified to a 6th grade level for easy comprehension, (6) that there be a procedure to handle those participants that do not score within the acceptable scores on the SLUMs and are unable to participate and how they will be excused from the study, (7) that Dr. Patricia Handley’s contact information at the South Carolina Department of Mental Health Institutional Review Board office be added to the audio consent form in case a participant would like to contact her, (8) that the researchers personal address be removed from all paperwork and replaced with the local mental health centers address, (9) that Dr. Edwards writes another letter stating he is still sponsoring the study, that all interviews will be conducted at the mental health center, that the consent and audio forms be written using the South Carolina Department of Mental Health Institutional Review Board guidelines (sixth grade level), that all of the paperwork used in the study be considered

protected under the mental health centers quality assurance guidelines, and that the researcher will follow all ethical issues/policies of the center during the study. The South Carolina Department of Mental Health Institutional Review Board (SC DMH) also agreed having an assistant would minimize the researcher contact with other clients and would help the study participants remain confidential, and (10) change the name of my new chair, add in the new committee member, and that Dr. Metoyer's (past chair) name be removed.

Participants were told during the presentation of the study that the researcher had previously worked at this mental health center as a staff member but that she has no affiliation with the center currently or with any of the clients. Also, the participants had no relationship with the researcher before they were approved to participate. This clarification was confirmed by Courtney Hudson, who is the mental health therapist over the Senior Adult Program and who was assigned to assist this researcher by Dr. Al Edwards, who was the director of the mental health center during the time the study was being approved and planned out. The research also confirmed that she did not know the participants when they arrived for their interview. There is no budget associated with this study due to there not being any cost for the study. The researcher also confirmed with each participant that they did not experience any trauma while participating in the interviews and were allowed to ask any questions and give feedback on how they felt afterward. It was also confirmed that the participants volunteered to participate, and if any participant decided not to participate at any time during the interview that this decision would have no effect on their treatment while at the mental health center. The

study was conducted in a room that was separated from all other client and staff activities for that day for confidentiality and privacy.

Demographics

A demographics questionnaire was completed at the start of each interview after all consents were signed, along with the SLUMS was completed verifying the participant had the cognition to consent to participate in the study. The demographics are explained below in Table 3.

Table 3

Participant Demographics

Participant	Age	Ethnicity	Education (years)	Prior occupation	Support inside or outside home
P1	72	White	13	None	Outside
P2	78	African American	9	Newspaper	Outside
P3	68	White	9	None	Outside
P4	70	Asian	16	Nurse	Outside
P5	72	White	9	None	Outside
P6	78	White	13	Dental assistant	Outside
P7	65	White	19	Nurse practitioner	Outside
P8	65	African American	16	Teacher	Inside and outside

Data Collection

The procedure for data collection began initially by the researcher setting up a meeting with the staff that works with older female adults at a local mental health center during a morning where there was no scheduled group therapy. This meeting allowed the

researcher to meet with the staff without the possibility of having any interaction with possible participants before the start of the study. Specific criteria was presented, along with an overview of the construct of resilience. The researcher then discussed a timeframe for each face to face interview, followed by answering questions from the staff. The mental health staff decided that the assistant, Courtney Hudson, would select all participants from her client list since she is the therapist and group leader over Senior Adult Services and knows the clients. It was also discussed that the South Carolina Department of Mental Health Institutional Review Board requested that all interviews be conducted at the mental health center to not only provide confidentiality but also to provide safety for the participant. The South Carolina Department of Mental Health Institutional Review Board suggested that the location be one where the participants were familiar with their surroundings. Also, in case the participant shared information and then became upset, the research assistant would be nearby to come to talk to the participant. The assistant was instrumental in setting the date to begin the study and kept communication open with the researcher on what dates worked best for the participants. At the onset of the study, the assistant brought the first client to the room where the researcher was going to do the interviews. It was agreed between the researcher and the assistant that once the initial interview was completed, then the researcher would text the assistant the word “done,” meaning that the interview was completed, and the researcher was ready for the next participant. The assistant would bring the next participant and walk the participant that completed her interview back to her group. This process was agreed on by the researcher and the assistant to maintain calmness and ease of switching

out the next participant since the researcher and the assistant were set up in different areas of the mental health center. No real names of any participants were used at any time, and the only code used was the "P" for the participant (P1, P2…P8) to ensure confidentiality. The assistant made the study go smoother by arranging to have the participants at the center the day of their interview sitting in group therapy and by using the text system to reduce disruption while the group was in session. This process also kept the study more confidential and protected the other clients who were in treatment at the time the study was being conducted at this mental health center.

The participants were scheduled for the interviews during their group time for convenience and to accommodate the fact that many participants no longer drive. The participant would then have had to rely on other transportation either by a family member or schedule on another day with the Medicaid van that brings them to the group several times during the week. Each participant was greeted, offered a snack and a drink, and then explained the process of the interview, beginning with the completion of all forms, which explained what the study was about. Each participant was able to ask any questions they had and given a few minutes to become comfortable before the researcher began with the review of forms and asking the first question. The researcher also was mindful of speaking slowly and clearly when starting the process to ensure the participant never felt rushed, which may have caused stress and the inability to complete her interview. All participants were assumed to be able to pass the St. Louis University Mental Status Examination (SLUMS) by the research assistant. This tool was

recommended by the IRB at South Carolina Mental Health in place of the Mini-Mental State Exam (MMSE) because scoring is based on education level.

Data collection began with a total of 8 (P=8) older females that participated in group therapy in the Senior Adult Services program. The program only had eight that met the age requirement of being sixty-five and older and that were willing to participate. All 8 participants completed the required releases and consents to participate. It was also confirmed in advance by the assistant that no participant had a power of attorney, that they all spoke English (no translation was needed by another staff member), and that all 8 would be able to participate and could sign for their participation in the study. The study was conducted over two days at the mental health center on Tuesdays as this is 1 of 2 days Senior Adult Services conducts group therapy. On the first Tuesday, three of the participants completed the study, and the remaining five were interviewed the following Tuesday. The procedure was that each participant would be brought by the assistant to the interview room that was preset up by the mental health center. When the interview was completed, the researcher would text the word "done" to the assistant, and she would then return to the interview room with the next participant. Then the participant that completed the study was taken back to her group room.

The researcher started the process by opening up a spreadsheet on the researcher's secure laptop and allowing only the research assistant access to this spreadsheet. Coding was assigned by the research assistant using the participants' first name and last initial for each participant on this spreadsheet before the start of the interview. These assigned codes were written on all paperwork on each participant's paperwork on the day of the

interview. The codes not only kept the paperwork organized but confidential. The staff assisting the researcher completed the coding using preset codes of P1, P2, …P8 and these codes were set up to protect the participants' personal information and allowed the researcher to conduct the interview using the code versus the participants' name allowing for more confidentiality and also in an attempt to reduce bias. The research assistant followed the sequence of her assigned codes, and when delivering the participant introduced the participant by just stating, "here is the next participant," keeping the sequence of assigned codes. At the onset of each interview, the participant was greeted and thanked for participating and then addressed by their coded participant number (Participant number 1, Participant number 2 … ending with Participant number 8). Two locked metal file boxes and one lockable file cabinet was available to store the signed consents and to store this box at the mental health center between the research dates. A locked file bag was initially set up to protect the paperwork but was not available locally, so two locked file boxes were purchased and used.

After the first research Tuesday was completed (4 participants interviewed), the file box was locked, then given to the research assistant (Courtney) and stored in a locked file cabinet by the research assistant. This box contained all signed forms that had the participants' names on them. The 2nd lockbox that contained the coded paperwork stayed with the researcher. This box was locked while the researcher cleaned up her research area and secured all trash. This box was then put in a rolling briefcase with all other research materials, and when the researcher left, the building was secured in the trunk of the researcher's car for confidentiality and transportation back to her home. The locked

box and all materials remained in her trunk until she reached her home and then were taken into the home to begin analyzing the questions and responses. On the next research day (the 2nd Tuesday) that was scheduled, all materials were then returned to the trunk of the researcher's car and then taken back into the mental health center while locked to keep all documents confidential. The 2nd box that was locked up in a locked file cabinet by research assistant was brought back to the researcher on the 2nd Tuesday to secure the balance of the paperwork for those participants that completed interviews on this date. After all 8 participants completed their interviews the last of the paperwork was put into the locked box for mental health to store with a sign on it stating "This box contains consent forms used in a research study and are to be retained until August 2024 (5 years) or longer, paperwork may be destroyed after this date". This was a requirement made by the South Carolina Department of Mental Health Institutional Review Board. The file box was given to the research assistant to take to medical records for permanent storing until the destroy date.

At the onset of each participant interview, the researcher looked over the participant for visible signs of elder abuse as also required by the South Carolina Department of Mental Health Institutional Review Board. All participants presented clean, mostly neat, able to greet the researcher with a happy mood, and showed no visible signs of suspicion of elder abuse. Also, no participant reported any problems of this magnitude during their interview.

The data was collected in 3 ways; first, by the participant completing all consents, including the SLUMS, and the demographics, second; the use of the Dragon® recording

system that typed out the researcher's explanation of the study and the interviews on to a blank document on her personal computer that was coded in advance with Participant 1, Participant 2…Participant 8 to ensure the researcher was talking to the correct participant and that the researcher did not use the participants name. Third, a digital recorder was used and was placed next to the microphone to allow the convenience of recording along with the Dragon® system for comparisons of responses. The Dragon® and the recorder were accepted easily by the participants, and all eight confirmed verbally that they were comfortable with using these tools and shared that they understood that the researcher wanted their responses to be "in their words from their lived experiences."

The SLUMS scoring is broken down by education level and into 3 categories of what is considered "Normal", "MCI" (Mild Neurocognitive Disorder), or "Dementia". Most participants scored ranged in the normal range depending on their education level (see Table 2).

The outcomes of the SLUMS were that 3 participants scored in the "Normal " range having some college with one participant reporting she has a Master's Degree; 3 participants scored in the "Normal" range having less than a high school education and 2 participants scored in the "MCI" range reporting that they have a high school education. No participant scored into the Dementia range. There was only 1 unusual circumstance that occurred while conducting the interviews and that was that 2 participants forgot their glasses and the researcher had to take the time to read each consent for them, confirm that they understood the consent and what they are participating in, and then had them sign each form while confirming they understood what they were signing. There were no

discrepant cases or problems that occurred or that were reported to the researcher during any of the interview days by either the participants or the research assistant.

Data Analysis

Data analysis was initiated by first printing out all the Dragon® interviews from the researcher's personal computer designating them that they were from the Dragon®. Second, typing out all of the interviews from the digital recorder, designating those interviews that they came from the digital recorder then comparing for accuracy looking for themes. Phenomenological interviews are designed for the individual to share their personal experiences and for this experience to be explained as close as possible to the original experience by the researcher. The process to move from recorded interviews to categories and themes was initiated with the researcher making a chart to break down each specific question and then this chart was followed up with the quoted responses. The printed out responses from the interview questions were reviewed looking for common categories. The researcher then made a list of these specific categories which resulted in the three themes; managing my mental illness, the need and importance of family support, and skills to live independently. For this study, only face-to-face structured interviews and the recordings were used.

Interview Question 1

Can you tell me what it is like living with a mental illness? Participant responses included the following:

1. "It's a little scary can get used to things, mental illness and not being able to think straight."

2. “It is very difficult to understand. I cry a lot.”
3. “It’s very hard, very hard, but if you have the right medication you can feel almost normal.”
4. “Living is suffering. Sometimes I have to deal by myself when sickness comes up you have problems with friendships, and you don’t know it and then I feel sorry for things I say, and I can’t take it back and people get upset. Also, when I got the sickness come up - I don’t like watching tv. The tv makes me hear noises and I don’t go anywhere; I cry a lot.”
5. “It’s very hard, because you don’t understand what’s it all about, because you don’t how your brain is working, and your brain is one way and your mind is another way. I struggle with it every day, it doesn’t go away, - it’s always there, it might rest for a while, but it pops back up. I get relief from going to therapy, psychiatrist and the medications.”
6. “I hear voices, hallucinations, anxiety, scared, depression, fear of who you are, worried about my home, money, who will take my finances, I worry about who will take my finances and will they be abusive or understanding.”
7. “Living with a mental illness before I was diagnosed it was hell. Life sucked, didn’t know what was going on. When I got diagnosed it helped me understand, I love myself, I love retirement, I pray to the Lord everything is fine, I get lonely but living by myself, but those depressive moments are short and few between. When I am manic, I try to manage, I

talk to myself and try to reduce mania. I know I will be on my meds forever, but meds are not the only thing."

8. "Sometimes it's very hard. Because you get very anxious very unhappy and lonely, but I take my medication as I'm supposed to, stay clean, and try to do the things that I've learned in my group study to be a healthy person."

Categories included the following: (a) fear/worry, (b) difficulty living with a mental illness/suffering, (c) not always knowing what's going on/confusion, (d) going to treatment/socializing/learning, (e) loneliness, (f) medication compliance, and (g) hygiene

Interview Question 2

Does your support system come from inside or outside the home and who is in your support system? Participant responses included the following:

1. "Support system comes from outside the home. My mom, my brother and sisters and my son".
2. "Support system comes from outside the home. Virginia yelled me, she yells a lot, but I know it is my sister and she shops for me to make sure I have everything I need and that's all very nice".
3. "Support system comes from inside the home. My children, my medication my counselor Emily".
4. "Support system comes from outside the home. I enjoy going to group and being with other people in the group. I have been here many years and mental health center has helped me a lot".

5. “Support system comes from outside the home. My son mainly. My favorite son. The rest just talk not helping me. He cares more about me than the rest of my family.
6. “Support system comes from outside the home. Friends and my aid; She understands my illness, my age and understands me…She is keen about things I am not alert about now”.
7. “Support system comes from outside the home. Son and ex-husband. Son climbs cell towers for a living. On 10 days and off 4. He takes me to the store and my ex also supports me by taking me to get groceries. I am lucky that I have them but if I didn’t, I don’t know what I would do. I used Cathy for a long time, but they help me right now and I do well. I appreciate the mental health center”.
8. “Support system comes from inside and outside. My daughter is in my support system, she makes sure that I take my medication correctly helps with my dressing, hygiene, and make sure that I do daily showers. I still could still pay myself she just make sure to keep what I’m supposed to do”

Categories included the following: (a) going to treatment/socializing/learning, (b) feeling no one cares, (c) positive attitude, (d) hygiene, (e) trust, (f) family takes me places, and (g) provide socialization.

Interview Question 3

Can you tell me how your support system helps you live independently? Participant responses included the following:

1. “They’ll take me to my doctors’ appointments because I don’t have a car and they help me out at Christmas with Allie’s give me a check at Christmas. Yes, it’s very nice”.
2. “I would like to own my own time, I get really tired, I can cook and clean; I have asthma and I have to go slow since I can’t breathe. A good house cleaning would help me live better and make me happy”.
3. “They take me places. I remind them of my checkups. If you have a checkup or something coming up going doing good you never know I have to I’m supposed to keep my checkups going every six months because of my illness”.
4. “My son is my support, but he is busy and no time to talk to me – children support me. Come talk to me. 3 children; they help me a lot. They give me suggestions on how to manage living my lifestyle. My family out of the country messages me and we keep in touch”
5. “He takes me around places, explains things I don’t understand. He is my beneficiary He is my baby child and he will always be my baby child”.
6. “My son helps if its early and I have an appt he will take me. I just need my brain to straighten out”.
7. “The aid has been with me a long time and has seen different phases of me and my behaviors. She will point out- she makes me count it back to me so I can know what I have at all times. I have everything I need and the meds from

mental health. I have the aid and some friends, and I do get out every now and then; the movies, the park or dinner".

8. "My daughter is in my support system make sure that I take my medication correctly make up the problem I have with my dressing, hygiene and make sure that I do daily showers I still could still pay myself she just make sure to keep what I'm supposed

Categories included the following: (a) going to treatment/socializing/learning, (b) housekeeping/cook, (c) positive attitude, (d) hygiene, (e) trust, (f) family takes me places/appointments/events, (g) medication compliance, and (h) empowerment.

Interview Question 4

Can you tell me what skills you believe you have that help you live independently? Participant responses included the following:

1. "I have to keep really diligent on my money and I can cook and clean, so much I got the inside under control. I just take my medicine and follow that strictly. My family gives me a hard time if I ask for anything but after that they still do what I need. I hate asking for anything because I can't do everything by myself, so I need their help and I appreciate it."
2. "I can do some cleaning, and some small things but a good house cleaning would help me live better and make me happy".
3. "Vacuum, mop the floors – change sheets on the bed, painting outside of the house before we had to put siding on, I painted it front and back one time but now we have siding, so I don't have to do that".

4. “Waitress right now. I enjoy it at the Mexican restaurant. Getting out into the community and meeting other people.
5. “Good hygiene, good behaviors, keep house clean, go to my job pt. time.
6. I can do everything but drive. I like I can shop, show respect for people, save money, buy food without going over, I just go if I can, stay clean, and I wash clothes too. I can catch a bus too”.
7. “I am very independent. My heath is good I am mobile, my thoughts process is good, I don’t have Alzheimer’s and dementia. I have a lot of energy and want to maintain my standards. I keep a positive attitude. I can cook a little bit, not abusive about burning things and leaving things on and I can straighten up a little bit, but the aid does the rest of it.
8. “I am very independent. I can drive, I can pay bills, keep myself clean, clean my apartment go shopping, do hair I assist taking care of myself now”.

Categories included the following: (a) housekeeping/cook, (b) behave in public, (c) mobility/driving, (d) family takes me places, (e) ability to work, (f) positive attitude, (g) hygiene, and (h) trust.

Themes

Themes that emerged from the data totaled 3 repeated themes that provided the most information from the interviews. The participants were able to show comfort with the researcher in their posture as they opened up about their experiences living with a mental illness on a daily basis. Themes emerged from the data are explained next.

Theme 1: Managing mental illness

This theme was brought up and explained many times during the interviews and found to be not only important to the participants but also was discussed many times as part of managing day-to-day living independence. The treatment at the mental health center was considered extremely important by many of the participants and the socialization and learning allowed them to have friends, enhance their independent abilities to be on their own, and an opportunity to learn about their illnesses. Quotes from the interviews that represent how important managing mental illness are presented; “It’s a little scary can get used to things, mental illness and not being able to think straight”. “It is very difficult to understand. I cry a lot”. Living is suffering. Sometimes I have to deal by myself when sickness comes up you have problems with friendships, and you don’t know it and then I feel sorry for things I say, and I can’t take it back and people get upset. The tv makes me hear noises and I don’t go anywhere; I cry a lot”. “It’s very hard, because you don’t understand what’s it all about, because you don’t how your brain is working, and your brain is one way and your mind is another way. I struggle with it every day, it doesn’t go away, - it’s always there, it might rest for a while, but it pops back up**.** “I hear voices, hallucinations, anxiety, scared, depression, fear of who you are, worried about my home, money, who will take my finances, I worry about who will take my finances and will they be abusive or understanding”. “Living with a mental illness before I was diagnosed it was hell. Life sucked, didn’t know what was going on. When I got diagnosed it helped me understand. I get lonely but living by myself, but those depressive moments are short and few between. When I am manic, I try to manage, I talk to myself and try to reduce mania”**.**

“Sometimes it’s very hard. Because you get very anxious very unhappy and lonely”. I’m supposed to keep my checkups going every six months because of my illness”. “I’m supposed to keep my checkups going every six months because of my illness”. I just take my medicine and follow that strictly”.

Theme 2: The Need and Importance of Family Support

The importance of family support was another main theme that emerged from the data. It was revealed during the face-to-face interviews that the families and aids provided different types of services and that the aids that they didn’t want to deal with the backlash from those who didn’t want to help. Many participants commented that regardless they would ask for help. All services were deemed very important, needed, and appreciated. Responses for this theme are listed; “My children my medication my counselor Emily said my children my medication and my counselor”. my daughter is in my support system, she makes sure that I take my medication correctly, she helps with my dressing, hygiene, and makes sure that I do daily showers”. “They’ll take me to my doctors’ appointments because I don’t have a car and they help me out at Christmas with Allie who gives me a check at Christmas”. “They take me places. I remind them of my checkups”. “He takes me around places, explains things I don’t understand”. “My son helps if its early and I have an appt he will take me”. “The aid has been with me a long time and has seen different phases of me and my behaviors. She will point out- she makes me count it back to me so I can know what I have at all times”. “My daughter is in my support system make sure that I take my medication correctly make up the problem I have with my dressing, hygiene and make sure that I do daily showers”. “My family

gives me a hard time if I ask for anything but after that they still do what I need". "I need their help and appreciate it". "the aid does the rest of it".

Theme 3: Skills to Live Independently

Skills was another reoccurring theme and a very important one as shared by the participants. These independent living skills allowed the participant to feel good about herself, adding to her positive attitude and strength that she can continue living on her own and working on her living skills and her mental illness. Responses for this theme are listed; "It's very hard very hard but if you have the right medication you can feel almost normal". "I get relief from going to therapy, psychiatrist and the medications". I know I will be on my meds forever, but meds are not the only thing". I take my medication as I'm supposed to, stay clean, and try to do the things that I've learned in my group study to be a healthy person". I have everything I need and the meds from mental health. I have the aid and some friends, and I do get out every now and then- movies, the park or dinner". "I have to keep really diligent on my money and I can cook and clean, so much I got the inside under control". "I can do some cleaning, and some small things". "Vacuum, mop the floors – change sheets on the bed, painting outside of the house before we had to put siding on, I painted it front and back one time but now we have siding, so I don't have to do that". "Waitress right now. I enjoy it at the Mexican restaurant. Getting out into the community and meeting other people". "Good hygiene, good behaviors, keep house clean, go to my job pt. time". I can do everything but drive. I like I can shop, show respect for people, save money, buy food without going over, I just go if I can, stay clean, and I wash clothes too. I can catch a bus too". "I am very independent. My heath

is good I am mobile, my thoughts process is good, I don't have Alzheimer's and dementia. I have a lot of energy and want to maintain my standards. I keep a positive attitude. I can cook a little bit, not abusive about burning things and leaving things on and I can straighten up a little bit". "I am very independent. I can drive, I can pay bills, keep myself clean, clean my apartment go shopping, do hair and I assist taking care of myself now".

Evidence of Trustworthiness

Credibility was shown by the researcher using the structured questions that were built for these interviews and for this specific population of older female adults who have a mental illness and live independently. The questions were asked verbatim as written and then recorded with the Dragon® system and the digital recorder. The participants responses were recorded for accuracy and as their personal lived experience not the researcher's assumption of how they live independently. The researcher used member checking to confirm each participant's response by reviewing their answers with them and allowing the participants to clarify or to add to their answers. This process was used to not only ensure understanding but also to increase trustworthiness. According to Kornbluh (2015) when a researcher takes the time to follow their planned methodology, they reinforce their obligation to tell the participants story as they reported it while building trust between the participant and the researcher.

Transferability was confirmed by the process of using the same questions that were specifically structured for this particular research group of older female adults who have a mental illness and live independently to an older male population. Along with the

structure of the research plan the questions focused on their actual lived experiences and gave the participants an opportunity to open up and share their positives and negatives of having family as a support system and what skills they possess. In this study, older adult females, who live independently, were found to rely on their support system as a part of everyday living. Many relied on the support more often and for more reasons than were originally thought. Hygiene was considered the most important support need of these participants and this also could be transferred to males in this same population. According to Cope (2014) if other populations can connect the stories of one population to themselves then transferability is possible. Therefore, it is possible that a new study, structured by using the specific criteria from this study, with only changing the population to older adult males, would allow the potential for transferability. Results showed that the questions would be appropriate for either older males or females.

Dependability was also verified throughout the process of this research study by following the original planned methodology. First, by using the planned older adult females who have a mental illness, are involved in treatment at Greenville Mental Health Center and live independently in Greenville, South Carolina and have some type of family support. Second, by using the specific population that was originally planned to be used, the research questions, the protocols, the instruments, and following the methodology as it was written. There were minimum changes to original process or forms that were directed by the South Carolina Department of Mental Health Institutional Review Board; (1) that all of the interviews are to be completed at the mental health center and none in the participants home because the mental health center would not be

able to protect if the interview is in the home, (2) that no participant may have a power of attorney, (3) that 2 locked files/boxes be used to store all signed documents; the first will have paperwork with the participants signature on them and this box will remained locked during the interviews and then given to the assistant to lock up when the researcher leaves the mental health center. This first locked box will also be stored in a locked file cabinet until the study is completed and then permanently stored at the mental health center with a note on the top of the box stating "the contents were used in a research study and must remain confidential and stored for 5-7 years and then may be destroyed by the mental health center". The 2nd lock box remains with the researcher and contains the paperwork that only has the participant codes P1…P8 (no signatures). This locked box will remain with the research at all times until the study is completed and then stored with the rest of the research paperwork. While traveling, this box will remain in the researcher's trunk, (4) that the research do an overview of how the older female presents and there is no indication of possible abuse or neglect and if there was some indication or a question of abuse that the assistant to the researcher be notified immediately, (5) that a few questions be added to the consent form to ensure the participant is able to understand what the study is about, how will their personal information be protected, and how she met the criteria for the study, and that the consent form be simplified to a 6th grade level for easy comprehension, (6) that there be a procedure to handle those participants that do not score with in the acceptable scores on the SLUMs and are unable to participate and how they will be excused from the study, (7) that Dr. Patricia Handley's contact information at the South Carolina Department of

Mental Health Institutional Review Board office be added to the audio consent form in case a participant would like to contact her, (8) that the researchers personal address be removed from all paperwork and replaced with Greenville Mental Health Centers address, (9) that Dr. Edwards write another letter stating he is still sponsoring the study, that all interviews will be conducted at the mental health center, that the consent and audio forms be written using the South Carolina Department of Mental Health Institutional Review Board guidelines, that all of the paperwork used in the study be considered protected under the mental health centers quality assurance guidelines, and that the researcher will follow all ethical issues/policies of the center during the study. The South Carolina Department of Mental Health also agreed having an assistant would minimize the researcher contact with other clients and would help the study participants remain confidential, (10) Update the name of the researcher's new chair and new committee member on the be added to the South Carolina Department of Mental Health Institutional Review Board application to conduct research and that Dr. Metoyer's (past chair) name be removed.

Confirmability was also verified by the researcher who ensured all steps through the methodology were taken, all changes recommended by the South Carolina Department of Mental Health Institutional Review Board were implemented, and the data outcomes or themes represent what was said by the participants not what the researcher prefers the outcome to be. By being consistent and following planned methodology another researcher could walk through the steps and confirm the researcher did what they said they were going to do and that the outcomes (themes) came from the participants and

not from the researcher (Cope, 2014). Also, consistently building rapport, validating the participants feelings, and observing them throughout the interviews adds depth to the study according to Cope (2014).

Study Results

This qualitative study looked specifically at resilience factors in older adult females with a mental illness who live independently. Also explored was whether the support system enables them to be more independent and what skills the participant could identify that allow them to maintain life independently. I examined the phenomenon of the individual experiences and perceptions of living independently as an older female with a mental illness and what, if any family support does for them. It was found through the interviews that family support was not only considered to be immediate family members but also outside friends and aids that provide services to the older female.

RQ1: What does "family support" mean to older female adults who have chronic mental health issues and receive outpatient care in their local communities?

RQ2: What resilience skills are used by older adult females to be able to remain in independent living?

Table 4 explains the interview questions and the emerging categories.

Table 4 *Interview Question Responses and Emerging Categories*Interview question	Emerging Categories
RQ1: What does "family support" mean to older female adults who have chronic mental health issues and receive outpatient care in their local communities?	Going to treatment/socializing/learning Housekeeping/cook Positive attitude Hygiene Trust Family takes me places; appts, events Medication compliance Empowerment
RQ2: What resilience skills are used by older adult females to be able to remain in independent living?	Housekeeping/cook Behave in public Mobility/driving Family takes me places Ability to work Positive attitude Hygiene Trust

Summary

This qualitative study looked specifically at resilience factors in older adult females with a mental illness who live independently and have family support. The researcher also explored whether the support system enables them to be more independent and what skills the participant is able to identify that allows them to maintain life independently. The goal of this research was to understand through phenomenological interviews how older adult females with a chronic mental illness manage living independently with a support system and what this support system does for them. Chapter 4 provided the results of the research, including relevant themes that emerged, the setting, demographics, and if there were any influences on the participants whether it was caused

by the setting or the researcher. This was followed by the demographics (Table 1), data collection (SLUMS scoring, Table 2) data analysis (Table 3), interview questions responses and emerging categories (Table 4), evidence of trustworthiness, credibility, transferability, dependability and confirmability. A discussion of the outcomes to the research questions was explained along with a summary of the research questions followed by the outcomes along with a transition to chapter 5. Chapter 5 will conclude this study with interpretations of the findings, limitations to the study, recommendations for future research, researcher's reflections, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

This section presents the conclusions of a qualitative phenomenological study that addressed resiliency in older females ages 65-80 living independently with a mental illness. The older females described their experiences in in-depth interviews, including how they are able to live on their own, whom they consider family members who provided support, and what help these family members provide to assist them in independent living. The purpose of this study was to explore what resiliency factors older females have learned. I also explored whether their support system enables them to be more independent and whether this support system encourages their innate skills that allow them to maintain life independently.

This chapter also addresses the history of resilience research and provides an in-depth discussion of the term resilience and the researchers who conduct studies on this phenomenon. Resilience research began around 1970 (Masten, 2018). Researchers studied for years the effects of prior events that caused trauma and stress on not only children but also their families. Concern for how these events affected the ability to function became an important area of study. The realization emerged that some people were able to adapt and move forward while others became paralyzed or were more vulnerable. Researchers attempted to understand whether the difference was innate traits or characteristics (positive attitude, good problem-solving skills) or learned negative thinking or negative life circumstances (poverty, lack of support system, high stress). Resilience was originally referred to as “invulnerability or stress resistance” (Masten, 2018, p. 13) until researchers settled on the definition of adapting to adversities.

The definition for resilience or resiliency can be different depending on the researcher, but in general it focuses on the characteristic or the learned ability someone has to manage events or changes in life situations. These situations include but are not limited to physical health, mental health, grief, previous or present trauma, or the day-to-day problems faced while aging. Resilience can include strength, optimism, flexibility, awareness of true life circumstances, having a positive attitude to not give up when times become tough, and the ability to return to normal day-to-day operations after an event. Situations in which older adults have family support that may enhance their living situation allow ease of monitoring for changes in mood, attitude, and abilities to function or make decisions. Whiteman, Ruggiano, and Thomlinson (2016) agreed that older adult females in a mental health system should have their treatment plan built for them as women and personalized by their specific problems rather than being grouped together with older men. Whiteman et al., reviewed articles on life stressors and traumatic life events in older women. Whiteman et al., reported that older women have a higher risk for depression from life stressors and these stressors lead to decreased socializing and overall functioning. Whiteman et al., also agreed that the limited research they reviewed indicated a need for more research focusing on this population and how to plan and provide treatment more focused on their individual issues.

Interpretation of the Findings

This section described themes that emerged from participant responses to the interview questionnaire. The older females responded to open-ended interview questions about their abilities and needs living independently. Bandura's (1991) theory of social

learning, self-efficacy, and Holling's (1973) resilience theory are connected to this research because they have the potential to explain what is involved in having resiliency. Information extracted from the theories was also shown to help support older adult females returning to some normalcy after some type of event and living one's life independently while instituting learned motivation to want to return to life as it was prior to the event. Motivation and self-regulation also are an important part of the theories supporting this study and also play a role in older adults' decision to remain as independent as possible in the place of their choosing. Several excerpts from the interviews revealed that without the positive support and influence of those family members, living independently may not be an option for those who wish to remain independent as long as possible.

While discussing theories it is important to know that there are also several models of resilience. One model of resiliency was created by Ataoui and Ermini (2015) and was found to be similar to Hollings environmental resiliency. Environmental concerns by these researchers connected to the risk reduction of water systems to flow without suffering stress and or a failure which would result in increased costs to manage. The less resilient the less water flow, pressure and water quality. The researchers developed a resiliency model that would measure the ability to manage costs of processing water and ensuring customers receive what they need and that the water is clean and drinkable. Hollings served as the backdrop to this model and continues to be applicable to not only environmental resilience and survival but also connects to humans.

Liu, Reed, and Girard (2017) researched models of resilience and reported that they agree that the basic understanding of resilience is the ability to bounce back after an event and that resilient individuals have certain traits, assuming the individual has resilience of any type. Plus, the researchers questioned how we know who has these traits, how did they get them, and what is the difference between resilient people and those who are not. Also, the researchers reported they found there is not one specific standard to follow and that there is no way currently to measure whether people even have resilience. The researchers suggested using a Multi-System Model of Resilience (MSMR), which encompasses resilience measured by using an individual's traits, experiences, and events over time, skills, resources, and adversities they have had to manage. The researchers report this model categorizes resilience as an "outcome, a coping strategy, and a trait" (p. 117), and using other models is no longer needed.

According to Mohseni, Iranpour, Naghibzadeh-Tahami, Kazazi, and Borhaninejad (2019), resilience continues to be an important factor in having the ability to adapt to life circumstances as we age. They agreed that older adults are living longer, and more research is needed to continue learning how resilience makes a difference in the aging process. The researchers agreed that having resilience allows older adults to keep a positive attitude while they adapt to situations that may be out of their control and enhances opportunities to learn from these situations, which in turn reinforces their skill to live independently. They found that older adults with resilience reported that they felt they had a more positive meaning of life and believed they were healthy enough to manage situations that arose to reinforce independent living. Stronger support systems

and higher education also were found to be positive for resilience skills. Another research study looking at models of resilience was conducted by Gulbrandsen (2016), who was interested in the resilience and aging of older adult females. Gulbrandsen reviewed past research to evaluate whether the Conner-Davidson Resilience Scale and the Resilience Scale were found to be reliable to measure resilience in older adults. Both scales are used often and created to measure resilience. Gulbrandsen stated the research she reviewed reported focused more on the reliability of the scales themselves and not on outcomes of older adult females and their actual resilience levels. Gulbrandsen stated that even though these scales were developed to measure resilience, are well known, and popular, there is still a need for more research on older adult females and how they gain their ability to manage the problems that come with this population as they age.

This research noted that few studies have focused explicitly on the resilience of older females and what skills they have to live independent living. Many studies focused more on overall adult issues to include attitude, vulnerability, aging, and stressors. According to the literature, older adults' resilience was affected by many other areas to include relationships, networking, diminished hope, health issues, spirituality, dignity, aging in place, and resilience. Therefore, the results from this study added to a vast knowledge base and body of research about the duration of older adult females living independently, with a support system and their resiliency skills.

I analyzed the data in multiple ways; first, by printing out the Dragon® recording system transcripts and then by typing out the transcripts from the digital recorder. I compared both sets of transcripts for emerging categories and how often those categories

were repeated. Several categories emerged during the interview process that allowed some insight into resilience of the older adult female and how older adult females view their world and their abilities. The themes that emerged from the data included an understanding of the importance of managing their mental illness, the need and importance of family support, and the skills they have to live independently. Participants showed comfort in sharing their experiences about the importance of their support system. When asked specifically "What does 'family support' mean to older female adults who have chronic mental health issues and receive outpatient care in their local communities?" most participants responded by sharing stories about their family or someone in their support system and the positives of that support. One participant (P8) summed up the impact of having a good support system by saying; "My daughter is in my support system and makes sure that I take my medication correctly, make up the problem I have with my dressing, my hygiene, and make sure that I do daily showers. I still could pay myself; she makes sure I keep what I'm supposed to". This comment made it evident that family support provides not only the ability to have someone nearby to reduce loneliness but also to encourage independent living skills and resilience. Participant number 9 (P9) described her experiences with her support system and also that she now can use her learned resilience skills, "I am thankful for my daughter and the local mental health center; keeps me out of the hospital. I can get one to one help if needed. I have my medicine; I am not scared to ask for extra help".

The literature reviewed in Chapter 2 provided the evidence to support Banduras' theory of self-efficacy by presenting areas where older adults need to be aware of their

relationship with where they live and also with their life and how they manage day-to-day in their surroundings. The theoretical basis for this study is *the Social Learning Theory proposed* by Bandura (2001). Bandura's theory states that individuals need to self-regulate their own behaviors in order to survive and deal with the demands of life**.** Social Learning Theory (Bandura, 2001) was also used to show that older persons have the capability to be "self-reactors with a capacity for self-direction" (Bandura, 2001, p. 3). It is assumed, according to Bandura (2001), that people have the ability to self-regulate consistently, not just when an event prompts this regulation. Bandura's theory states that individuals must self-regulate their behaviors in order to survive and deal with life's demands. Bandura (2001) explained that motivation is the use of setting personal goals followed by the use of "available resources, skills, and effort to fulfill them" (p. 3). The older person then uses self-regulation to monitor the progress of the set goals. This was shown in the participants' responses to having skills to manage their struggles (resilience), using available resources (family support), and how they must regulate change to remain independent (increase in symptoms and using the mental health center). Self-regulation requires the individual to be motivated, and this motivation must come from within the self. This was also proven in the positive stories shared by most of the participants and how their support system motivates them to be as independent as possible and do as much for themselves as they can while providing the support as needed. The literature in Chapter 2 also provided the evidence to support Holling (1973) theory which stated that having resilience means that the environment (in this case the study participants) flourish by using what they have available to replenish and maintain

during problems/irritations on a day-to-day basis (family support). Holling (1973) used the environment and compared it to humans to explain that the abilities or skills of a system can be interrupted when there are changes (or life stressors), and the system has to fight to maintains its original structure and function by not allowing the stressors to cause a collapse or an increase in symptoms. Holling (1973) reminded us that we all live in this world, and those that have learned resilience skills in place when they are needed allow individuals to live as best as they can; in that way, they can accept and deal with stressors without losing control of their situation. Also, those who can use these learned skills (older adult females) are understood to be more capable of managing and anticipating life changes and accommodating those changes without increasing problems. These two theories provided a base for the study: Social learning theory as proposed by Bandura (1991) provided the idea that observing others promotes individuals to adjust their behaviors and may promote interest in changing their lives to live more independently. The second theory of Resilience by Holling (1973) connects to the research questions by helping us understand that, when the environment changes for older adult females, what learned skills are available to use to get back on track and not allow these situations to disrupt life for long term. The recounting of experiences by the older adult females included some humorous stories, difficulties, and the sad situation they have tried to work through but also their efforts to manage their lives with what they have available without giving up. The older adult females' in this study and their responses to the questions highlighted the importance of social change to focus treatment and support towards what they need versus what would be considered a cookie-cutter approach or a one plan fits all.

As previously stated, self-regulation and resilience were significant in encouraging older adult females to adjust and regulate their life using support and learned skills.

Chapter 2 literature stated that older adults prefer to age in their homes versus other arrangements. This idea was confirmed in the interviews that the older adult females felt more comfortable living on their own but did state many times that they need that support from family but did prefer to live independently. Also, several participants stated that they would like to see more research on older adult females and how they age, tools that they need to be successful. These tools include technology, where they prefer to live, and being involved (communities, churches, families) and what this involvement does for how they see and feel about themselves. According to Bielderman, Schout, Greef, and van der Schans (2015), they conducted face to face interviews with older Dutch adults who live independently in a lower socioeconomic neighborhood. Participants were interviewed face to face, and they shared several areas that helped them manage their day-to-day functioning; awareness of health and possible future, accepting aging, accepting their current situation, being content with what they have and where they live, and finally, having a positive attitude. This research study confirmed some of the findings that matched this current study. First, that older adults are living longer and that their numbers are rising at a rapid rate. Second, that there is concern for how these adults are able to maintain a reasonable level of health while living independently. Third, that the researchers reported that the older adults were resourceful when faced with adversities and fourth; that their perspective on aging shows they are resilient and are more positive when they must manage situations to include their personal health care.

Chapter 2 research uncovered positive attitudes and emotions, having a support system in place, vulnerability, aging, perception of resilience, and response to stressors.

Limitations of the Study

This study had several limitations that could have affected the design. One limitation was that I resulted in a small, purposive sampling of participants (P=8) rather than a randomly selected group of participants. Greenville Mental Health Center only had a limited number of older adult females that fit the criteria (aged 65-80, have a mental illness, have family support and live independently), yet all were interested in participating and showed up for their interviews. The study only focused on older females who live in Greenville, South Carolina, specifically, and did not include males or any other older adults inside or outside this city. Conducting a new study, including males, may change some of the themes due to a male's perception or experience with a support system, and what they report that they need may differ from females. Also noted is the fact that a different group of participants might change outcomes if expanded to include other populations or ages. If expanded to include males, this might change the results to shift in yet another direction as a male's perception or experience with a support system may be different than females. An equally important limitation is the fact that all participants had to have some type of support and be able to specify if it comes from inside or outside the home. Similarly, participants were limited to discussing their current lifestyle rather than discussing past events or experiences and stories. Another limitation was that there was limited prior research on older females with a mental illness and even less discussing support systems. This gap in the literature was identified at the start of this

study, and this research study will fill at least one gap of older adult females and resiliency. Not only was access to participants closely monitored but also limited to the population and criteria set at the start of this study. Yet, Greenville Mental Health Center ensured those that did meet the criteria were invited to participate and then confirmed through the research assistant that these participants were at the center the day of their interview. Conducting a longitudinal study was also a limitation. Since this is a graduate course, and this researcher plans on completing this project soon, a longitudinal study would not be appropriate. But a future study, changing participants may be an opportunity for a longitudinal study looking at resilience and independent living.

Recommendations

This chapter addresses the fact that this qualitative study used a small participant sample. This was addressed but was not considered a negative because small numbers of participants are normal for this type of study. The recommendation for additional research and participant recommendations are included in this section. Eight to ten was the initially suggested sample, which resulted in only eight matching the criteria and agreeing to participate. This number was an explicit limitation, and it is recommended to readdress this study using the same criteria of older adult females, aged 65-80, living independently, with a mental illness, and having family support but changing to males. Changing the study using only males with the same criteria may also produce different themes, and again depending on how men perceive their life situation and their support system, a new study may result in a completely different set of what's important. Comparing the male study to the female study may yield different outcomes. Also,

lowering the age criteria may result in different outcomes as aging may change what's important to the older female compared to a male. Another suggestion is that this study be conducted on a larger scale and using quantitative using older adult females who are in a much larger mental health center that may yield a larger number of participants. In regard to the interview questions; one suggestion for future research is to frame interview questions as open questions to more accurately the researcher is trying to find out. Though they were closed, they elicited rich responses. One other limitation of the study was that all participants were interviewed at the mental health center and not in any of their homes as originally planned if needed. The South Carolina Department of Mental Health changed the locations due to the mental health center not being able to protect the participant or be responsible for them if they are in their homes.

One of the strengths of this study was the cooperation between the South Carolina Department of Mental Health, the local mental health center, the South Carolina State Mental Health Department Institutional Review Board, Dr. Edwards, and the staff working with the participants. One major concern was that only a few older females would be interested or that they would not want to share their stories. The study was conducted with little problems, and all participants were available on the day assigned. These interviews also allowed the older persons to share a better understanding of what it takes for them to live their life each day and what specifics they may need in order to do this. Additionally, another strength was the fact that lockboxes were used to protect confidential information from each participant as they took turns in their interviews. One lockbox stayed with the researcher, and the other stayed with the research assistant and

then was permanently stored in the medical records department and remains there for 5-7 years, which after this time frame can be destroyed. Each interview was treated just as important as the one prior, and each participant was able to only focus on their paperwork and story. Equally important was that Dr. Patricia Handley's contact information at the South Carolina Department of Mental Health Institutional Review Board office was required to be added to the audio consent form in case a participant would like to contact her. This change in the form also confirmed that the study was under the direction of the South Carolina Department of Mental Health, and the participants were invited to ask any question they had or contact the South Carolina Department of Health Institutional Review Board. The last strength of the study was that the South Carolina Department of Mental Health Institutional Review Board (SC DMH IRB) also agreed that having an assistant would minimize the researcher's contact with other clients and would help the study participants remain confidential. The final recommendation for this study is to provide social research on older adult females who live with a mental illness while trying to maintain independent living.

Implications

The impact of this study on social change had many positives. This study showed that having a support system in place allows the older adult female to continue living independent while having someone to reach out to in situations or illnesses preventing using the emergency room unnecessarily. The support system provided more opportunities for involvement in the community and church, resulting in using knowledge and skills to educate others, more positive feelings of their believed abilities and

accomplishments, which will also provide a better lifestyle. Further, this study supports the idea that those with family support have the increased feeling of a loved one caring for them, and the hope is this will add to the older adult females' interest in maintaining an independent lifestyle. This study's outcomes show that having a family member providing support in or outside the home gives the older female a more positive outlook, something in which to believe in and someone to look forward to seeing on a regular schedule. This study also impacts social change by filling one gap in the body of limited knowledge regarding not only older adult females but also how they see themselves managing independent life on a day-to-day basis with or without a support system combined with a mental illness and other medical comorbidities. Experience working with older persons in the past has shown this researcher that, as this population ages, their physical and mental issues can become more difficult to handle. The result could be the older person is no longer able to see a purpose to his life. She may begin to feel alone, and the decisions made are not always positive to her existence. Mohd, Yunus, Hairi, Hairi, and Choo (2019) conducted a study of older Asian adults living independently with symptoms of depression and having a support system. Their review included 16,356 records, 66 full-text articles, twenty-four observational studies, and 19 cross-sectional studies. The age range was adults 60 years old and older who are living in the community. The researchers wanted to understand what the support system did for the participants and was it actual support or only perceived. They found that a good support system was indicative of providing overall support for any situation and at times being able to actually live with family or a spouse. This support system was reported to be

instrumental in reducing depressive symptoms and enhancing the quality of living for older Asian adults that live independently. Again, locating, educating, and using solutions/coping skills to improve specific issues can enable older persons to deal with their problems and not turn day-to-day problems into disabling situations. This study's findings present an opportunity for education and social change while being a catalyst for future research. This study also fills a gap in the research by participants sharing how valuable support systems are and what they actually provide for the older adult female.

The study also showed that older adult females have had to learn how to self-regulate if their support system is not available. This was especially noticeable in a statement made by Participant 4 "Sometimes I have to deal by myself when sickness comes up you have problems with friendships, and you don't know it and then I feel sorry for things I say, and I can't take it back and people get upset". This study also pointed out the importance of a support system for social change in a society that can be critical of those who must manage their mental illnesses and the aging process. Understanding what is needed may promote more interest in mental illnesses plus reduce stigma while promoting more interest in volunteers or other family members who may be able or willing to donate time to assist those in need. Lastly, I did find that the social implications of using the real-life experiences of older adult females were substantial and valuable to explore.

Purpose of the Study

The purpose of this qualitative study was specifically to look at resilience factors in older adult females with a mental illness who live independently. Likewise, the

researcher explored whether their support system enables them to be more independent and if this support enables their innate skills that allow them to maintain life independently. The goal of this research was to understand through phenomenological interviews how older adult females with a chronic mental illness manage living independently with a support system.

Methodology

The methodology using face to face confidential interviews at the local mental health center allowed each participant to share in her own words how she manages her life as an older adult female with a mental illness, living independently, and what her support system actually does for her. The researcher set up a meeting with the local menta health center staff that works with the older adult females to review criteria and deliver the study flyer. The therapist agreed to pass out the flyers, and then during the following week, each group member was given a flyer to initiate an interest in participating. Those interested were scheduled to complete their face-to-face interviews on a day they were at the center for treatment for convenience. It was directed that all interviews be completed at the mental health center so the participants can be protected while in the study. A date was set, and the research assistant arranged each participant to the room assigned and then, when completed, brought the next participant. The total study took place over 2 days. The participants signed a Letter to Potential Participants, a Consent to Participate, a demographic survey, a Consent to Audio Record, and completed the Saint Louis Mental Status Examination (SLUMS). All 8 of the participants answered the interview questions without difficulty, and the study was completed without problems

or rescheduling. This methodology yielded 8 out of 10 participants and three main themes. Also, it was shown that this methodology was not stressful, and participants showed they enjoyed themselves by open discussions and appearing relaxed. The Mini-Mental State Exam was replaced by the SLUMS due to the South Carolina Department of Mental Health Institutional Review Board believing that the educational guidelines will result in enough participants who are cognitive and can answer the questions. Howland, Tatsuoka, Smyth, and Sajatovic (2016) confirmed that the population of older adults over aged 60 is growing at a fast rate, and there is a concern for those who may have mild cognitive impairment (MCI) and not be aware. They suggest the use of the SLUMS as an alternative to the MMSE for this very reason and also that the SLUMS is available for use in the public domain and not subject to copyright laws like the MMSE (p.1). The use of this tool in this study resulted in 2 participants with high school education falling into the MCI category, yet they were able to participate without difficulties. There was only one unusual circumstance, and that was 2 participants forgot their glasses. The researcher took the time to read each consent for them, confirm that they understood the consent and what they are participating in, and then had them sign each form while confirming they understood what they were signing. There were no discrepant cases or problems that occurred or that were reported to the researcher during any of the interview days by either the participants or the research assistant.

Theoretical

This research study and the research questions were built using two theories; Social Learning Theory (Bandura, 1991) and Resilience (Holling, 1973) to explore how

older adult females, manage life with a mental illness when using resiliency skills and family support. Bandura taught us that individuals might not be aware that they caught between their behaviors and how the environment may promote self-regulation. The older adult females in this study with a mental illness had to decide if they would let the mental illness completely debilitate them or try to use what skills they have to continue to live independently. Also, being involved in treatment at Greenville Mental Health Center automatically involves watching others and learning what they do, and then taking what was observed and integrating these behaviors into daily life may promote changes. These older adult females shared that their treatment at Greenville Mental Health Center is the backbone of their daily lives. The education and support they receive promotes changes to have a healthier and happier life and encourages them to make some decisions on their own. Bandura's (1991) theory also supports this study by hearing the personal stories of how these participants believe that they are capable of living independently and how they adjust behaviors to remain independent.

Resilience Theory (Holling, 1973) was created with the idea of the environment being able to adapt to changes, regardless of how severe they may be, and return to some state of normality. Holling included humans in the idea of adaptive cycles and the capacity to adjust when an unexpected event occurs. Resilience theory also reminded us that many times, changes to the environment are unplanned or unexpected. The older adult females in this study have recognized this fact and made adjustments to their life to ensure they can live independently with the assistance of a good support system in place. These older adult females also have shared during this study that they have had to endure

these unplanned or unexpected situations but showed the ability to survive, adjust and maintain their level of a steady-state with the use of learned resiliency skills and their support system.

Empirical

Empirical evidence in this study is the information collected from the participants and the observation of them while being involved in this study. Specifically, their enthusiasm, yet calmness, and ability to be able to be involved in a study was observed and documented as they responded to the interview questions. The participants were able to share their life situations and how they manage their mental illness while having a support system in place for support. The participants presented somewhat guarded at first but easily became comfortable and relaxed. Participants were observed becoming enthusiastic about being involved in a study and commented that they appreciated interest in their problems and how they manage life and aging with a mental illness. The findings provided a better understanding of what each participant believes they need to manage independently with the assistance of their support system. The outcomes of being able to have good hygiene and clothing added to participants overall physical and mental health. This theme was the most repeated and therefore was found to be the most important by a majority of the participants. Other outcomes uncovered were the opportunity to go to treatment which included socializing and making friends while being educated on how to manage their mental illness and symptoms. Going to treatment also connected to trust in their support system and also trusting the mental health center and the staff that provide medications and education about mental illness, aging, and their support. These themes

were reinforced by participants comments; Participant 1 reported: "*It's a little scary can get used to things, mental illness and not being able to think straight" and* Participant 5 who reported: *"I get relief from going to therapy, psychiatrist and the medications." " I take my medication as I'm supposed to and try to do the things that I've learned in my group study to be a healthy person"*. Participant 7 also reported*: "I am thankful for my daughter and Greenville Mental Health; keeps me out of the hospital. I can get one to one help if needed. I have my medicine I am not scared to ask for extra help." Having a positive attitude was also found to be important.* The participants were open and honest about how their mental illness affects their mind and can be scary not knowing if it will get worse or ever go away. ng the right attitude was an important theme that enabled participants to try harder and want to feel better which also enhanced their independent living situation. Participant 1 said; *"It's a little scary",* Participant 2 reported; *"It is very difficult.* Participant 3 said; *"It's very hard very hard",* Participant 4 stated; "Living is suffering" and Participant 5 reminded us that" *It's very hard, because you don't understand what's it all about, because you don't how your brain is working, and your brain is one way and your mind is another way. I struggle with it every day, it doesn't go away, - it's always there, it might rest for a while, but it pops back up*". Family taking me places was another theme that the many participants felt strongly about which affected their health and wellbeing. By being able to get out of their home the participants talked about opportunity to have a meal out, visit with other family members, and change their day-to-day routine which made them feel better and that someone cared about them.

Recommendations for Practice

The recommendation for additional research and participant recommendations are included in this section. One suggestion is that older adult female research be continued using males only and then comparing themes looking for similarities or extreme differences. This study also could be reproduced as quantitative using a larger scale of participants involving more than one mental health center. For example, a full South Carolina mental health study using all males from each mental health center. One issue discussed is the need for educating the support system so those who care for these older adult females have more knowledge about their diagnosis and symptoms, which would reduce stigma and poor attitudes when support is much needed.

In Chapter 2, I discussed the two theories of Social Learning Theory (Bandura, 1991) and Resilience (Holling, 1973). The two theories supported the fact that the participants learned from others at the mental health center and used their support system as needed. Hollings' theory also connected to the study by the participants discussing how they managed to overcome situations and problems in their support system similar to the environment.

Conclusion

This study was conducted to learn what resilience skills older adult females with a mental illness have that enables them to live independently with a support system. This study's outcomes show that managing a mental illness can be achieved but it is a constant battle that requires much effort. Being involved with a mental health center along with the care and socialization was an important finding. Having a family member or someone

considered to be family providing support in or outside the home gives the older female a more positive outlook, enables them to have good hygiene, clean clothing, something in which to believe in and someone to look forward to seeing on a regular schedule. Finally, the older adult female participants were able to discuss many skills that they believe enables them to feel good about themselves and enhances their ability to live independently.

This study also impacts social change by filling one gap in the body of limited knowledge regarding not only older adult females but also how they see themselves managing independent life on a day-to-day basis with or without a support system combined with a mental illness and other medical comorbidities. Several excerpts from the interviews revealed that without the positive support and influence of those family members, living independently may not be an option for those who wish to remain independent as long as possible.

Aging is a fact of life, and many older adults operate the best they can with not only physical issues but in many cases, a mental illness that can cause difficulties being able to manage life on their own. According to the CDC (2016) "9.42% to 11.18% of older adults over fifty years of age reported that they never received the support they needed and that approximately 20% of people aged 55 and older have had some type of experience with a mental illness to include anxiety, severe cognitive impairment, and mood disorders such as depression or bipolar" (p. 2).

This study gave older adult females at a local mental health center an opportunity to share their personal stories and experiences with what resilience skills they use and

how they perceive their lifestyle living on their own with a mental illness. This study's outcomes show that it is important to try to manage their mental illness, the need for family support, and the skills they believe they have to live independently. Having a family member providing support or having support outside the home gives the older female a more positive outlook, something in which to believe in, and someone to look forward to seeing on a regular schedule.

This research contributed to the existing literature and addressed one gap of not knowing about support systems for older adult females with a mental illness and more about what it is they need and want from family members. This study also validated the chosen theoretical frameworks of Social Learning Theory (Bandura, 1991) and Resilience (Holling, 1973) by providing insight into the fact that these older females learn skills from other group members to handle difficulties while being independent. They also have an extra support system at the mental health center. They also shared how their current difficulties cause a deficit in their day-to-day functioning and how they use their learned resilience skills to keep their dignity by being able to live as they choose versus being forced into another family home or a facility. The three themes were intertwined in the interviews and all were deemed important to the participants. Also, it was reinforced by in the interviews that the category of hygiene was an important part of living as healthy as possible. The idea of having good hygiene (including a clean home and clean laundry) enhanced the independent living opportunity and allowed the participant to feel good about herself, adding to her positive attitude and strength that she can continue living on her own and working on her living skills and her mental illness. All of these

themes were reinforced that they could not be obtained without the support system. In conclusion, resilience was displayed by the older adult female's abilities to live the healthiest they can within their abilities, and their support system enhances those abilities.

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Appendix A: Interview Protocol

Participant ID # _____

Interview Protocol

Thank you for agreeing to meet with me today and to be part of this study. Your information will help us better understand how older females with a mental illness are able to live independently and what exactly family support does for your resiliency skills.

REVIEW INFORMED CONSENT, CONFIDENTIALITY (PROTECTION OF INFORMATION), RISKS AND BENEFITS OF BEING IN A STUDY AND EXPLAIN BRIEFLY THE NATURE OF THE STUDY

Do you have any questions before we begin?

1. The first interview question asks: Can you tell me what it is like living with a mental illness?
2. The second interview question asks: Does your support system come from inside or outside the home and who is in your support system?
3. The third interview question asks: Can you tell me how your support system helps you live independently?
4. The fourth interview question asks: Can you tell me what skills you believe you have that help you live independently?

We have covered a lot of information during this interview. Is there any other information that you think would be important for me to know that may help understand your specific resiliency skills and what family support does for you? I want to thank you again for participating in this study. Your participation will help to understand not only resiliency better but also what family support does for older females living independently with a mental illness.

Appendix B: Letter to Potential Participants

Dear participant.

My name is Dawn Harbin. I am a doctoral candidate at Walden University. I am conducting a dissertation research study about the help that older adult females receive to help them continue to live as they have previously lived. This means that I will ask you for information about your coping strategies, your approach to aging and the levels of help that you receive from your family.

To take part, you must be female, be between the ages of 65-80, living independently, with or without family support and be a current client in treatment at this mental health center.

If you are interested in participating, you will be asked to complete the following:

- a confidential consent form in order to participate,
- a consent for audio recording of your interview
- answer questions about your ability to understand instructions,
- provide information about yourself
- participate in a face-to-face interview.

This entire process will take approximately 60 to 90 minutes in a private room specified by this mental health center or at a location of your choosing. The interview will be audio recorded and a copy of the transcript will be available for participants to review and confirm content. No names or personal identifying information will be used in this research. This number will be coded on each participant's document and the face-to-face interview transcripts. You may withdraw from this project at any time and you will not be

penalized in any way for not participating. Refreshments of coffee, water and cookies will be offered as a thank you for your time and willingness to add to the research community. If you are interested in being a participant, please complete the information below and return the form to your case manager or your psychiatrist. I will meet with the case managers and psychiatrists to collect the potential participant names. You will then be contacted to set up an appointment for your assessment at Greenville Mental Health Center on one of the specific days scheduled, or, if more convenient, I can meet you at a location of your choosing. Only specific days will be available for this appointment. Any concerns or questions can be addressed prior to the appointment or at the appointment.

I want to thank you in advance for your willingness to participate in this research and look forward to meeting you.

Name: _____

Phone number: _____

Alternative number: _____

Appendix C: Participants' Demographics

Identifying information: Please mark the answer that describes you.

Age: Please mark the one age group that applies to you.
- 65-70
- 70-75
- 75-80

Ethnicity: How do you identify yourself?
- African-American
- Caucasian
- Asian
- Hispanic
- Native American
- Other _____

Education: Please indicate what level of education you have completed.
- Less than a high school degree.
- High School Graduate/GED
- Some College
- Bachelor's Degree
- Master's Degree
- Ph.D. Degree
- Other _____

Occupation: _____
Family Help: Please indicate if you have such help or not**.**
- inside the home
- outside the home
- No family help
- Other help _____

Would you like a copy of this transcript? Circle one: Yes No

Appendix D: St. Louis Mental Status Examination

Saint Louis University

Mental Status (SLUMS) Examination

Name _____ **Age** _____
Is patient alert? _____ **Level of Education** _____

(1) **1. What day of the week is it?**

(1) **2. What is the year?**

(1) **3. What state are we in?**

4. Please remember these five objects. I will ask you what they are later.

Apple Pen Tie House Car

5. You have $100 and you go to the store and buy a dozen apples for $3 and a tricycle for $20.

(1) **How much did you spend?**

(2) **How much do you have left?**

6. Please name as many animals as you can in one minute.

0-5 animals 5-10 animals 10-15 animals 15+ animals

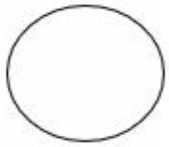
(5) **7. What were the 5 objects I asked you to remember?** 1 point for each one correct.

(3) **8. I am going to give you a series of numbers and I would like you to give them to me backwards.**

For example, if I say 42, you would say 24.

87 649 8537

9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.



(2) Hour markers okay

(2) Time correct

(1) **10. Please place an X in the triangle.**

Which of the above figures is largest?

11. **I am going to tell you a story. Please listen carefully because afterwards, I'm going to ask you some questions about it.**

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

2 **What was the female's name?**
2 **What work did she do?**
2 **When did she go back to work?**
2 **What state did she live in?**

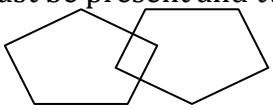
Scoring		
High School Education		**Less than High School Education**
27-30	**Normal**	**20-30**
20-27	**MCI**	**14-19**
1-19	**Dementia**	**1-14**

Appendix E: Folstein Mini-Mental State Exam

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)

1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.) 
30		TOTAL

Instructions: ***Ask the questions in the order listed. Score one point for each correct response within each question or activity.***

Appendix F: PAR Letter to Use Folstein Mini-Mental State Exam

PAR
Creating Connections. Changing Lives.

16204 N. FLORIDA AVENUE • LUTZ, FLORIDA 33549
Telephone: 813.968.3003 • Fax: 813.968.2598 • Web: www.parinc.com

July 22, 2014

Dear Ms. Harbin,

Thank you so much for taking the time to contact me today regarding the use of the ***Mini-Mental State Examination (MMSE)*** in your research project.

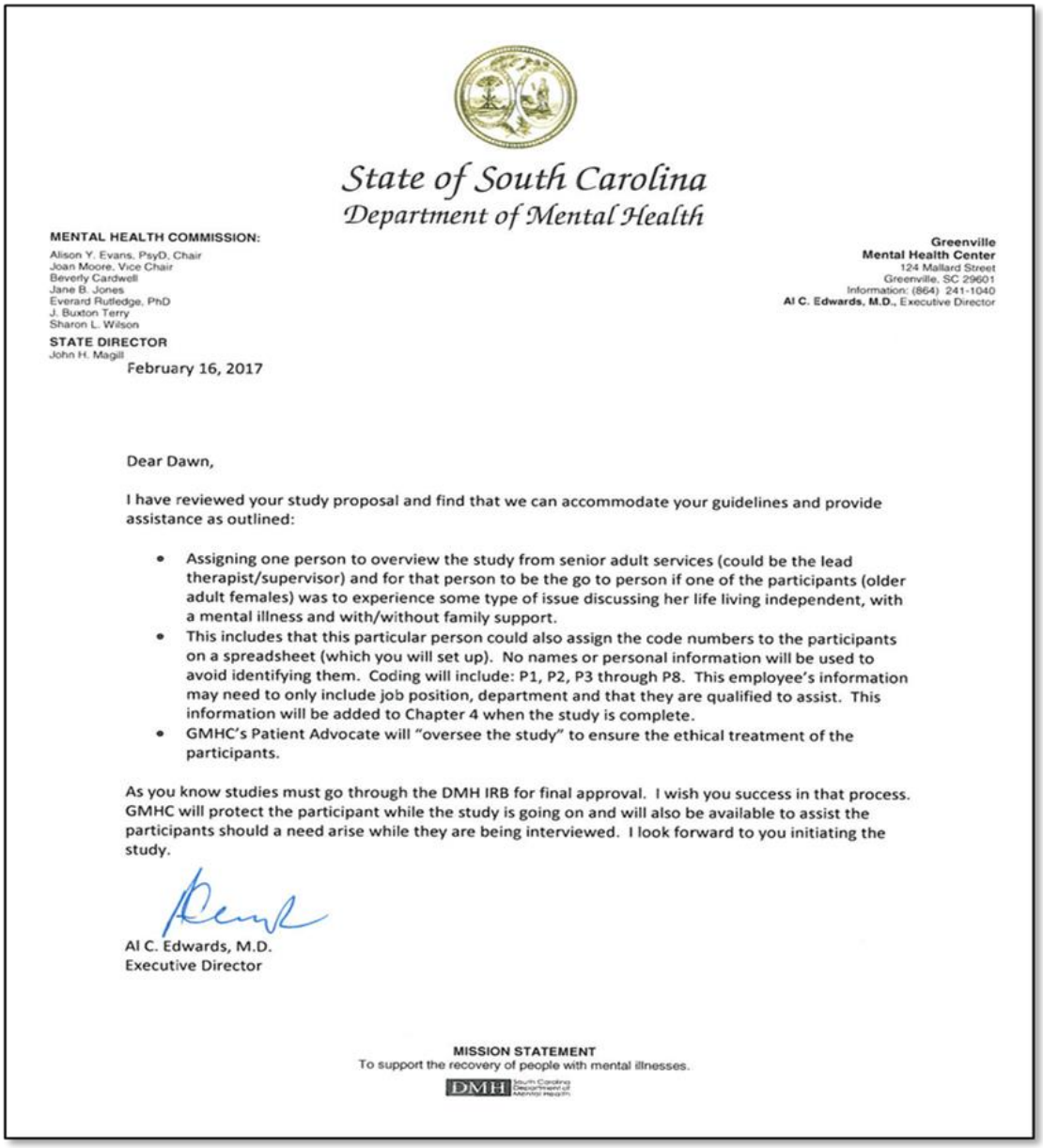
As you requested, the purpose of this letter is to verify that you have our permission to use the published form of the MMSE for your project once you have purchased the published forms from us.

We very much appreciate your business and the opportunity to be of service to you. If you have any further questions or concerns, please do not hesitate to contact us at 1-800-331-8378.

Sincerely,

Kirsten Lark
Customer Support Specialist II

Appendix G: Site Approval From Local Mental Health Center



State of South Carolina
Department of Mental Health

MENTAL HEALTH COMMISSION:
Alison Y. Evans, PsyD, Chair
Joan Moore, Vice Chair
Beverly Cardwell
Jane B. Jones
Everard Rutledge, PhD
J. Buxton Terry
Sharon L. Wilson

STATE DIRECTOR
John H. Magill

Greenville
Mental Health Center
124 Mallard Street
Greenville, SC 29601
Information: (864) 241-1040
Al C. Edwards, M.D., Executive Director

February 16, 2017

Dear Dawn,

I have reviewed your study proposal and find that we can accommodate your guidelines and provide assistance as outlined:

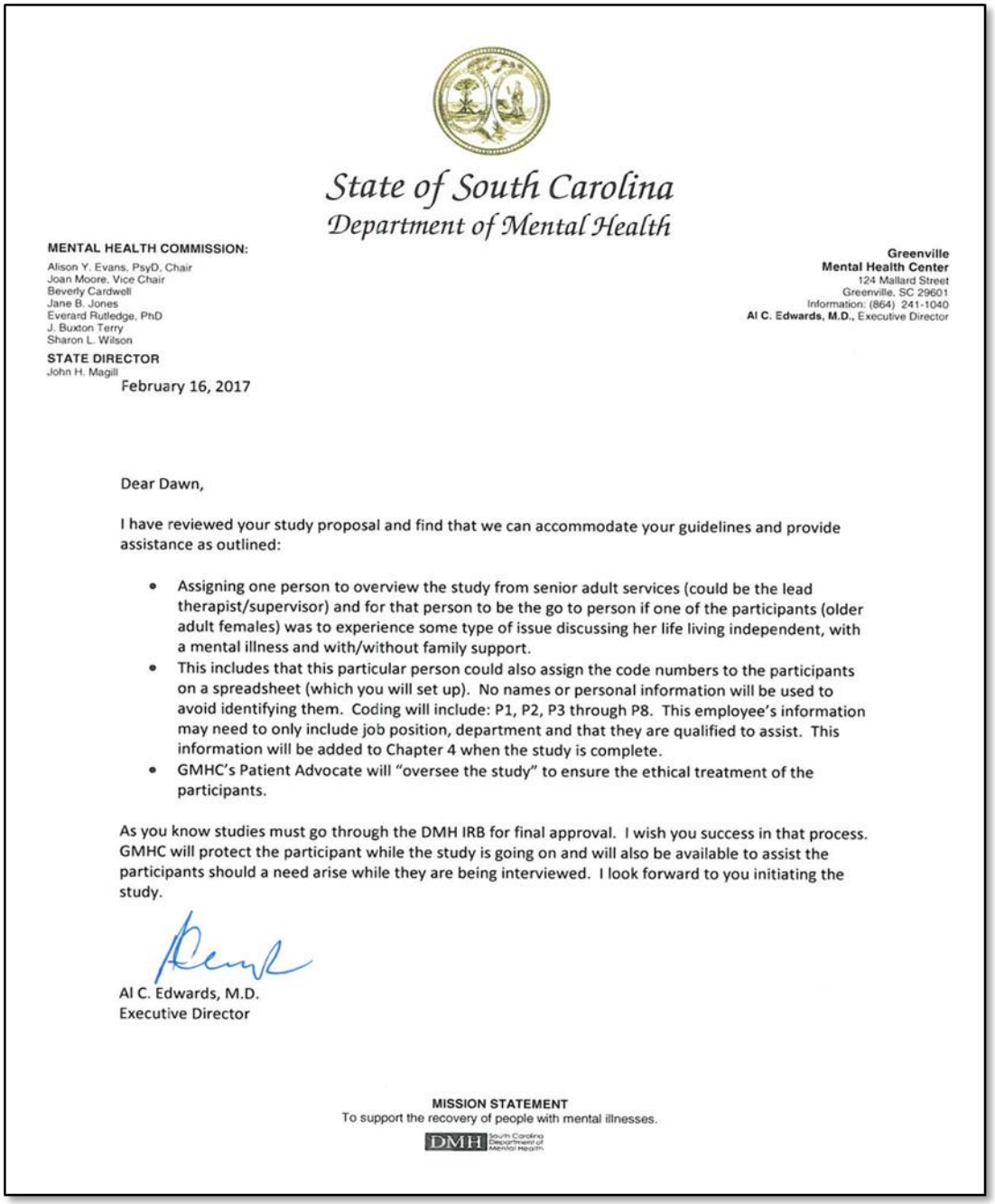
- Assigning one person to overview the study from senior adult services (could be the lead therapist/supervisor) and for that person to be the go to person if one of the participants (older adult females) was to experience some type of issue discussing her life living independent, with a mental illness and with/without family support.
- This includes that this particular person could also assign the code numbers to the participants on a spreadsheet (which you will set up). No names or personal information will be used to avoid identifying them. Coding will include: P1, P2, P3 through P8. This employee's information may need to only include job position, department and that they are qualified to assist. This information will be added to Chapter 4 when the study is complete.
- GMHC's Patient Advocate will "oversee the study" to ensure the ethical treatment of the participants.

As you know studies must go through the DMH IRB for final approval. I wish you success in that process. GMHC will protect the participant while the study is going on and will also be available to assist the participants should a need arise while they are being interviewed. I look forward to you initiating the study.

Al C. Edwards, M.D.
Executive Director

MISSION STATEMENT
To support the recovery of people with mental illnesses.
DMH South Carolina Department of Mental Health

Appendix H: Participant Support From Local Mental Health Center



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Al C. Edwards, M.D.
Executive Director

MISSION STATEMENT
To support the recovery of people with mental illnesses.
DMH South Carolina Department of Mental Health

Appendix I: Mental Health Letter Confirming Support for Study

State of South Carolina
Department of Mental Health

Greenville
Mental Health Center
124 Mallard Street
Greenville, SC 29601
Information: (864) 241-1040
Al C. Edwards, M.D., Executive Director

March 14, 2019

This letter is to serve as letter of sponsorship for the doctorial level study concerning senior adult female patients proposed by Dawn Harbin. Ms. Harbin was an employee of Greenville Mental Health Center for several years and as such is familiar with the ethical issues/policies as well as center operations. It is my understanding that the entirety of the study will be done within the Greenville Mental Health Center and does not include work within the community. The consents/paperwork relative to the study will be kept within the quality assurance division of the center which is under the direction of Susan Marshburn. Since the study involves Greenville Mental Health Center/Department of Mental Health patients, and is taking place within our facility I suggest the use of our Department of Mental Health consent form which I believe covers the extent of this project. If other questions arise please feel free to contact me.

Sincerely,

Al C. Edwards, MD

Medical Director

Greenville Mental Health Center. Please copy Pete Camelo, Susan Marshburn, and Courtney Hudson.

Appendix J: Consent to Audio Record

AUTHORIZATION FOR EDUCATIONAL USE OF PROTECTED HEALTH INFORMATION

Mental Health Center (name removed for confidentiality)
864-241-1040
I,_____,_____,
(Name of Participant) Address (Street, City, State Zip (Code)

And _____.
(DOB)

authorize the following regarding my participation in this study: (Check all that apply):

☐ Audio recording of my interview as a participant in the study about older females living independently with a mental illness and their family support. The recordings will only be used for educational purposes to find themes in the interviews and will not be shared with any staff member or anyone other than the researcher.

☐ Participate in interviews with the researcher who is in charge of the study at Greenville Mental Health Center.

I authorize the release of this information for the time period from _____ to _____.

I understand that the above information is protected by applicable law and if this form is not complete, SCDMH may not be able to release the information. I understand that the information may include accounts of personal and real life situations and that no information will ever be disclosed or reviewed by anyone except the researcher.

This Authorization is valid for one year from my signing unless an earlier date, condition, or event is specified here:

_____
_____

I understand that the information disclosed may be subject to re-disclosure by the entity named above. I may cancel this Authorization by contacting the researcher and informing the mental health center. I understand that if I cancel this Authorization, I will not be penalized. I also understand that I can withdraw from the study at any time, and that my participation in this study has no effect on my treatment at Greenville Mental Health Center. SCDMH cannot take back any information used or released made with my Authorization, and SCDMH will house these signed forms at the mental health center until the appropriate retention rate is reached. I understand this form will be locked up in a locked file folder inside a locked cabinet during the entire study and then once the study is complete, the researcher will notify the study sponsor Dr. Al Edwards and the senior adult service staff assistant that the signed forms be then moved to a permanent locked file for storage at the mental health center until the appropriate retention rate is reached. At that point, the center can destroy them. The consents will be left locked up with a note on it indicating "to be retained until (date), destroy after this date". No signed consents will be taken outside the mental health center. At that point, the center can destroy them. The rest of the study's materials will remain in a locked file and taken by the researcher to write up results (themes). This process will ensure privacy and confidentiality. I understand that I may refuse to sign this Authorization and that my refusal will eliminate me from participating in the study as interviews must be recorder for verification with the typed version of the interview with the use of the Dragon® system. No information about you or your interview will ever be released. You will be given a participant code that will be written on all your paperwork (P1, P2…P10) and no identifying information will be able to connect you to the study. Only general outcomes will be shared, and the participant codes will be used to categorized themes.
I have been given a copy of this Authorization.

_____ _____ _____
Signature of Individual Participant Printed Name Date

_____
Witness

Appendix K: Flyer for Study

WOULD YOU LIKE TO BE PART OF A RESEARCH STUDY ON OLDER ADULT FEMALE'S RESILIENCY?

THIS STUDY INCLUDES OBTAINING INFORMATION ABOUT YOUR COPING STRATEGIES, YOUR APPROACH TO AGING AND YOUR LEVELS OF FAMILY SUPPORT.

PARTICIPANT REQUIREMENTS WILL BE 8-10 FEMALES ONLY, AGE 65-80, LIVING INDEPENDENTLY, WITH OR WITHOUT FAMILY SUPPORT, AND A CURRENT CLIENT IN TREATMENT AT THE LOCAL MENTAL HEALTH CENTER.

DATE: TO BE SCHEDULED
WHERE: LOCAL MENTAL HEALTH CENTER
124 MALLARD ST, GREENVILLE, SC 29601

Appendix L: SC DMH IRB Approval to Conduct the Study

State of South Carolina
Department of Mental Health

2414 Bull Street• P.O. Box 485
Columbia, SC 29202
Information: (803) 898-8581

John H. Magill
State Director of Mental Healt

MEMORANDUM

TO: Dawn Harbin

FROM: Monica McConnell, Ph.D., SCDMH IRB Chair

SUBJECT: Approval of Proposed Project

DATE: 6/22/19

The proposed project "Older Adult Females Resiliency: A Qualitative Study of Mental Illness and Family Support" has been reviewed and approved by the SC Department of Mental Health Institutional Review Board.

SCDMH IRB Study Assigned Number: 2019-6-21

Stamp for Informed Consents:

DMH South Carolina Department of Mental Health

IRB Number# IRB 2019-6-21
Date Approved 6/21/19
Expiration Date 6/22/20

Thank you for submitting your application. We wish you success in your project. If you make any changes to the project or decide to publish the data produced by this project, please contact the IRB immediately.

cc: Patricia Handley, Administrator SCDMH IRB
Deborah Blalock Deputy Director SCDMH
Albert Patrick, Agency Privacy Officer

Appendix M: Walden University Approval to Start Study

IRB <irb@mail.waldenu.edu>
Thu 7/11/2019 9:46 AM
Dawn Harbin; Patricia A. Heisser

Dear Ms. Harbin,

This email confirms receipt of the approvalletter for the community research partner and also serves as your notification that Walden University has approved BOTH your doctoral study proposal and your application to the Institutional Review Board. As such, you are approved by Walden University to conduct research.

Congratulations!

Libby Munson
Research Ethics Support Specialist, Office of Research Ethics and Compliance

Leilani Gjellstad
IRB Chair, Walden University

Information about the Walden University Institutional Review Board, including instructions for application, may be found at this link:http://academicguides.waldenu.edu/researchcenter/orec