OVERCOMING AND OFFERING:

NARRATIVES OF RESILIENCE FROM DIVERSE OLDER ADULTS

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DEDICATION

To all my Balcony People, fictional and factual, who brought me to a higher place – a place where I could flourish, live freely, pursue my passion, and become a better human.

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I would like to acknowledge all those who helped me through the graduate school process. First, thank you to my program director and dissertation chair, Dr. Sally Stabb, who always, always gave me just what I needed to succeed in creating something that I can feel proud of. Her belief in me never wavered, and for that I am eternally grateful. I would also like to thank my committee members, Dr. Lisa Rosen who faithfully stuck with me through a very long process and Dr. Marlene Williams who graciously came on board when I was in need. I am grateful for my husband, Gary, whose love and patience helped me get through even the toughest bouts of procrastination. And to my five amazing children who somehow never doubted that I would finish and finish well.

ABSTRACT

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Advancements in science, technology, and medicine are extending the average human lifespan while the largest cohort in the US is moving into older adulthood. These older adults are diverse regarding gender, race/ethnicity, economic status, and living patterns, resulting in intersecting and multiple advantages and disadvantages that will likely impact the need and availability of care in different ways due to a differential distribution of health risks and behavior, economic status, and family/living structure. Recent theoretical models of aging have found the attributes and processes of resilience to be a key factor in aging well. There is much that has been published on the characteristics and enhancement of resilience, while assessing resilience continues to fall behind in research. Exploring resilience in the lives of diverse older adults from the perspectives of their culture, life history, and individual circumstances is a way to understand unique health outcomes in later years. The purpose of this study was to add to the discussion on the phenomenon of resilience as experienced by diverse older adults in the US through the exploration of the qualities and processes of resilience or resilient adaptation as communicated in personal narratives.

For this study, a phenomenological approach was used to gain a deep understanding of the nature and meaning of resilience described by older adults as positive outcomes after adverse life events. The diverse identities of the storytellers include ages ranging from 65 to 96 years old, and racial/ethnic backgrounds including Black, Asian, White, American Indian, and Hispanic individuals. Six storytellers self-identified as cisgender women, one as a transgender woman, and eight as cisgender men. Twelve storytellers self-identified as heterosexual and three as gay.

The data for this study came from stories previously communicated by older adults, which were found in the public domain. The Google Chrome search engine was utilized to find electronically submitted stories communicated in written and/or oral format by diverse older adults, in which resilience was thematically evident. Stories communicated in written form were copied exactly and stories recorded in oral format were transcribed. Three main themes were identified from the 15 stories collected and analyzed — Theme 1/Personal Attributes, Theme 2/Social Resources, and Theme 3/Actions and Behaviors. Findings were generally consistent with recent aging research suggesting the importance of personal, social, and environmental resources in facilitating successful aging through resilient adaptation (Holstein & Minkler, 2003). Recommendations for training and policymaking are also offered.

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CHAPTER I

INTRODUCTION

"The world breaks everyone and afterward many are strong at the broken places."

E. Hemingway

The United States (US) is aging, and the percentage of older adults is projected to increase from 46 million in 2015 to more than 90 million in 2050 (Mather, Jacobson, & Pollard, 2015). Advancements in science, technology, and medicine are extending the average human lifespan while the largest cohort in the US is moving into older adulthood. The current growth of the population 65 years and older is one of the most significant demographic trends in the history of the United States. Baby boomers—those born between 1946 and 1964—have brought both challenges and opportunities to the economy, infrastructure, and institutions as they have passed through each major stage of life. The number of older adults in the United States, aged 65 years and older, has increased steadily since the 1960s and is projected to more than double by 2060 (Mather et al., 2015). While the youngest members of the baby boom generation will not turn 65 for another 13 years, recent declines in fertility rates as well as immigration to the US have accelerated growth in the percentage of population that is aged 65 years and older, with recent projections showing the number and share of the older adults surpassing that of children by 2035 (Mather et al., 2015).

income, education level, and racial and ethnic background. Accumulating evidence points to health disparities among LGBT older adults, making this cohort an at-risk population. Emlet (2016) has provided an overview of the social, economic, and health disparities, which includes higher rates of poor physical health and disability, HIV, and psychological distress in the aging LGBT population.

Recent comprehensive reports on LGBT older adults found that over 25% of LGBT boomers continue to report concern about discrimination as they age (Espinoza, 2016; Meyer, 2003; Wallace, Cochran, Durazo, & Ford, 2011). While the LGBT older adult population has been integral in increasing attention from the government through the formation of task forces and coalitions, regulations that govern and fund services for U.S. older adults (i.e., long-term housing and care) lack the necessary nondiscrimination protections nationwide to support LGBT elders (Espinoza, 2016).

Social engagement and support play important roles in aging well, with robust links between marriage status and health in older adulthood. Multiple studies found a correlation between marriage in older adulthood and lower rates of chronic illness, disability, and mortality (Goldman, Koreman, & Weinstein, 1995; Holt-Lundstad, Smith, & Layton, 2010; Pienta, Hayward, & Jenkins, 2000). Gender differences exist in married older adults, with women 50% less likely than men to be married and more likely to live alone (Mather et al., 2015). Obstacles facing older adults who live alone include facing the burden of housing costs alone, increased risk of isolation, and lack of daily help with routine life activities. Affordable housing options is a growing need due to the

importance of access to resources that offer health-promoting activities and social connections, and this option is disproportionately insufficient for LGBT elders who face discriminatory practices found in senior housing (Cornwell, 2014).

Frey (2010) examined how individuals are challenged by socioeconomic disparity, such as living with persistent educational or economic disadvantage, and found that well-being, a heightened sense of purpose, and autonomy were positively related to educational attainment, which is associated with longer life expectancy and better health at older ages. Although baby boomers as a whole have higher levels of education and more years of work experience, fewer children and high divorce rates among baby boomers mean that more may live alone in old age without either the financial and social support or informal caregiving provided by a spouse or child (Mather et al., 2015).

Older adults are living longer, disability is less prevalent at the oldest ages, and old age is less likely to mean death or loss of physical or mental functions, but there are signs that baby boomers who are approaching retirement age are in worse health compared with previous generations (Mather et al., 2015). According to U.S. aging reports on health, increase in life expectancy will likely be accompanied by an increase in older adults living with chronic conditions. While older adults are less likely to smoke, have emphysema, or have heart attacks, they are more likely to be obese, have diabetes, or high blood pressure than the previous generation at similar ages (Mather et al., 2015). This likelihood of increased aging with chronic conditions will place

substantial pressure on publicly funded health care and long-term income support programs at the same time when the shrinking number of younger workers may not be able to generate enough tax revenue to continue paying out benefits, making planning for future needs more complicated (Weiner & Tilly, 2002).

Older Americans are in better health and living longer, making it possible to work into older ages. Rising labor force participation rates among older adults have been linked to a combination of factors. Employer pensions and medical benefits for retirees have been largely replaced by employee-funded defined contribution plans, such as 401(k)s, and mandatory retirement ages have been abolished for older adults in many industries—clearing the way for employees to work after age 60 or 65 years (Szinovacz, Martin, & Davey, 2014). Additionally, the age at which workers can receive full Social Security benefits has increased from 65 to 66 or 67 years for those born after 1942, and the tax penalty for earning income while receiving Social Security benefits has been reduced (Mather et al., 2015). However, despite federal laws banning age discrimination in the workplace, these practices continue in terms of hiring and opportunities for advancement for older adults (Szinovacz et al., 2014).

Many current characteristics of older adults suggest that they will experience more economic security in old age than previous generations, yet many other traits will pose challenges for policymakers and service providers. Older racial/ethnic minorities are especially dependent on income from Social Security as they are less likely to have income from pensions, earnings, savings, or assets (Emlet, 2016). According to Emlet

(2016), the needs and perspectives of LGBT elders, as well as elders of color, have been largely absent from national policy discussions on aging. Also, differences between the racial and ethnic composition of the baby boom population and the total U.S. population appears to be heading towards a greater divide as foreign-born mothers have higher fertility levels than native U.S. women, and the foreign-born share of births is disproportionately higher than their share in the total population (Livingston & Cohn, 2012). This gap between generations suggests a potential future conflict over public resources for a mostly White older adult population looking for Social Security and Medicare benefits and a younger, more diverse population entering into the workforce who have historically lagged behind on most measure of economic conditions and may be less able to provide the needed financial support (Mather et al., 2015).

A common stereotype is that older adults are less open or perhaps even averse to adopting new technologies for everyday tasks. However, extensive research makes clear that this is a misperception and/or overstatement (Zickuhr, 2014). Focus groups consisting of older adults and conducted by Pew Internet and American Life Project (2007) reported their use of and attitudes about technology in the context of their home, work, and healthcare. Participants reported using a wide variety of technology items in a wide variety of contexts (i.e., their homes, for work, for engaging socially, and for health). A growing number of older adults with disabilities rely on assistive devices and technologies (e.g., walkers and scooters) to maintain their independence. These results indicate that older adults appeared to view the benefits of technology (i.e.,

communication, research, and health monitoring and maintenance) as outweighing their prior concerns (i.e., perceptions such as inconvenience, security, reliability, and cost).

Of adults who reported using the internet and have chronic conditions, 53% reported that information found on the internet had informed their decision-making about their own health or someone they care for, had affected treatment decisions and strategies for coping with the condition and associated pain, had helped them formulate new questions for their provider, and had influenced a decision to seek a second opinion, which is likely to prove increasingly valuable as older adults age (Pew Internet and American Life Project 2007; Taha, Sharit, & Czaja 2009).

Researchers have defined a number of criteria related to the concept of successful aging, which usually include the absence of disease and disability, maintaining a high level of physical and cognitive functioning, and having meaningful engagement in life (Rowe & Kahn, 1997). In research on the different components of successful aging, the most frequent common elements are preservation of physical functioning and freedom from disability. Of particular interest is how definitions of successful aging might differ across racial or ethnic groups, and for individuals with physical disabilities that would not meet these objective criteria for successful aging (Romo et al., 2012). Additionally, concerns for defining aging well in terms of avoiding disease and disability, maintaining physical and cognitive function, and promoting healthy behaviors have been voiced by gerontologists because they often did not include the ways that social

systems and cultural contexts within which people live vary widely and often restrict individuals' freedom of choice in health-related behaviors and health assistance (Riley, 1998).

A core tenet of developmental psychology is that adaptability happens across the entire lifespan (Ouwehand, de Ridder, & Bensing, 2010). A review of the paradigms of human aging and development highlights the myriad theories that have been proposed to describe and explain a complex process, which is influenced by a wide range of dynamic biological and social conditions. Medical models view aging as a process that extends over the lifespan with a focus on the biological components of aging as measured from a gain and loss perspective (Weinhold, 2006). Researchers continue to debate the fundamental causes, processes, determinants, and mechanisms that control aging as well as to define and maximize healthy aging.

Stage- and age-related models—whether of cognitive, moral, personality, or psychosocial development—describe universal periods in human development that are characterized by certain types of behaviors that last for differing lengths of time and are mostly seen as invariant (Berk, 2014). These models posit that older ages are shaped by a lifetime of experiences that reflect myriad influences during previous life stages such as Erickson's model, which ties subjective well-being to looking back with a sense that life choices made a difference that is valued by successive generations (Ehlman & Ligon, 2012). Biopsychosocial developmental models broadly describe the human experience as both influencing and being influenced by multiple intersecting domains—biological,

psychological, social/cultural, relational, spiritual, and so forth (Moody & Sasser, 2015). These multiple domain models provide a basis for describing gains and losses associated with aging by emphasizing how factors and contexts within varied life domains influence outcomes in later life.

Current lifespan perspectives of human development have focused on the adaptive processes and coping strategies that are optimal for aging well throughout the lifespan. In older adulthood, achieving a positive balance between gains and losses are found to be more difficult to attain (Freund & Baltes, 2002). Control strategies developed by Heckhausen and Schulz (1995) serve to maintain and expand the ability for individuals to change surroundings to fit their needs and desires, and when that is not possible, to focus resources in response to the opportunities and constraints encountered.

Strategies used by older adults for goal attainment and goal distancing impact well-being, such that goal seeking efforts that are not congruent with attainment opportunities may lead to emotional distress, which reduces future motivational resources (Heckhausen, Wrosch, & Schultz, 2010). Baltes and Baltes (1990) posit that the processes of setting, pursuing, and maintaining personal goals and the evaluative processes used to maximize gains and minimize losses throughout development promotes successful aging as goals focus the limited resources of attention and behavior in older adulthood. Commitment to these goals contributes to feeling that one's life has a purpose and promotes well-being.

Age-related changes are found to be influenced by multiple factors including life experiences, social interactions, beliefs, and emotions. Elder Jr. (1998) theorized that a useful way to understand this relationship between time and human behavior is the life course theory (LCT), which looks at how chronological age, relationships, common life transitions, and social change shape people's lives from birth to death. Principles that characterize the LCT include the concept that learning and development are lifelong processes and are impacted by the constraints and opportunities available during the specific historical and developmental time in which individuals live and share relationships (Elder Jr., Johnson, & Crosnoe, 2003).

Multiple studies that have reviewed aging well have considered the complexity of risk and protective factors with the goal of understanding coping processes as they unfold in the lives of diverse older adults (Metzler, Merrick, Klevens, Ports, & Ford, 2017). Metzler et al. (2017) found that vulnerability in at-risk older adults is influenced by ethnicity and other cultural factors, previous trauma exposure such as adverse childhood experiences (ACEs), available resources, and preexisting child and family problems. Turner and Butler (2003) suggested that early life adversities serve as primary stressors that interact with subsequent stressors, creating chains of risk and interrelated hardships throughout the life span. Other researchers have found that ACEs undermine learning and academic achievement, compromising future educational, employment, and socioeconomic success in adulthood, which then increase vulnerability to future stress by limiting social and personal resources (Larkin & Park, 2012; Turner, 2013).

ACEs can heighten the risk of future health problems both directly (e.g., through physiological mechanisms) and indirectly (e.g., through exposure to adverse environments), producing chains of additional stressors that can overwhelm coping abilities and undermine recovery (Nurius, Green, Logan-Green, & Borja, 2015; Schafer & Ferraro, 2012). Subsequent research has found that early childhood adversities increase later risk of age-related diseases (Danese et al., 2009), adult chronic diseases (Gilbert et al., 2010), adult morbidity and mortality (Brown et al., 2009), health-risk behaviors (Dube et al., 2003), persistent, challenging psychological illnesses (Chapman et al., 2004), adult underemployment (Tyler & Lofstrom, 2009), disability (Schussler-Fiporenza Rose, Xie, & Stineman, 2014), poverty (Evans & Kim, 2010), and involvement with the criminal justice system (Langsford et al., 2007).

Differences in how individuals respond to adversities led to research on the concept of resilience and its role in development, and recent theoretical models of aging have sought to establish and define the determinants of resilience through the study of older adults who continue to function well (Levretsky, 2010). While traumas experienced during childhood can alter the stress response, older adults with adverse childhood experiences, regardless of social and cultural backgrounds, physical and cognitive impairments, have shown the capacity to develop, enhance, and demonstrate resilience (Smith & Hayslip Jr., 2012).

Caution is needed when conceptualizing resilience in a generalizable way because people are a mixture of strengths and weaknesses that influence outcomes

across particular populations, times, and circumstances (Ong, Bergeman, Bisconti, & Wallace, 2006; Szanton, Gill, & Thorpe, 2010). Predictors of resilience, according to the APA (2017c), include having supportive relationships, a positive self-view, problem-solving skills, and the ability to regulate impulses and strong emotions. These processes start early in life and are likely to increase as a result of successfully coping with adversity in the past (Wagnild & Collins, 2009). Research on psychological growth and development has revealed the capacity for positive change, and this process results in new opportunities to gain access to and activate untapped strengths as well as new and creative sides in older adulthood (Fisher & Specht, 2012).

In light of the growing numbers of older adults in the US, it is important to identify resources that increase the capacity of older adults to find well-being in a difficult and sometimes hostile world, make use of psychological strengths in times of adversity, and develop the ability to live purposeful lives. Fisher and Specht (2012) suggested that individuals who age well are those who continue to grow and learn by using past experiences to cope with and adapt to present circumstances. Adaptability and coping are also inherent in the creative process, as individuals seek solutions to new problems or challenges. Storytelling as a creative activity offers individuals the opportunity to reflect on past events as a way to make sense of them, find some meaning in them, and integrate them into their identity, which can be validating and affirming (Kenyon, 1996). Exploring the impact of the arts in the lives of older adults has shown a strong relationship between the benefits reported when participating in

creative activities and aging well (Fisher & Specht, 2012). Thus, this investigation used storytelling as a vehicle to examine resiliency in diverse older adults.

Key Terms

Several key terms were used throughout this work; their definitions are noted below.

- Adverse Childhood Experiences (ACEs): Stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse (Centers for Disease Control and Prevention [CDC], 2016).
- Adverse Life Event: A traumatic event that threatens injury, death, or the physical integrity of self or others and also causes horror, terror, or helplessness at the time it occurs—examples include sexual abuse, physical abuse, domestic violence, community and school violence, medical trauma, motor vehicle accidents, acts of terrorism, war experiences, natural and human-made disasters, suicides, and other traumatic losses (APA, 2008).
- Aging Well: For the purposes of this study, the term aging well is used rather than successful aging, a biomedical model which emphasizes the absence of disease and the maintenance of physical and mental functioning. Aging well

emphasizes life satisfaction, social participation and functioning, and psychological resources, including personal growth (Vaillant, 2002).

- Older Adults: Persons 65 years and older (Mather et al., 2015).
- Oldest Adults: Persons 85 years and older (Mather et al., 2015).
- Positive Outcome: Positive subjective experiences, positive individual traits, and positive institutions that aim to improve quality of life; the degree to which an individual is healthy, comfortable, and able to participate in or enjoy life events (World Health Organization [WHO], 2012).
- *Race*/Ethnicity: Race is defined as a socially constructed category based on physical characteristics such as skin color or hair type, and ethnicity is defined broadly as the identification with population groups characterized by common ancestry, language, and custom (U.S. Census Bureau, 2015). For the purposes of this study, the terms used to describe racial/ethnic demographic information will be taken from the U.S. Census Bureau (2015) questionnaire, which is guided by the Office of Management and Budget (OMB) standards. The following race/ethnicity demographic terms will be used:
    - **American Indian or Alaska Native**: A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
    - **Asian**: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example,

Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

    - **Black**: A person having origins in any of the Black racial groups of Africa.
    - Hispanic: A person having Hispanic origin can be viewed as the heritage, nationality, lineage, or country of birth of the person or the person's parents or ancestors before arriving in the United States.
    - **Native Hawaiian or Other Pacific Islander**: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
    - **White**: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

- Resilience: The process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands (Resilience, n.d.).
- Social Location: The groups people belong to because of their place or position in history and society. All people have a social location that is defined by their gender, race, social class, age, ability, religion, sexual orientation, and geographic location (Bishop, 2002).

CHAPTER II

REVIEW OF LITERATURE

The purpose of this chapter is to present a review of the existing academic literature that provides a foundation for the relevance of the study's topic. It begins with an overview of relevant statistics regarding aging worldwide and the challenges global policymakers are facing with this rise in an aging population combined with a decline in overall birth rates. The direction then shifts from global patterns to trends found in the US, including an examination of how the U.S. older adult population both affects and is affected by current and emerging economic, healthcare, and technological trends. The chapter continues with a review the existing theories of aging and adult development (Rowe & Kahn, 1997). Additionally, this chapter examines how adverse experiences in early childhood are impacting older adults as well as how protective factors, such as resilience, influence aging. The goals for the chapter are twofold: (1) provide an overview of the aging literature, what is missing, and how this study might contribute to aging research; and (2) provide insight into the relevance and importance of the phenomenon of older adults' resilience through descriptions of resilient qualities and the exploration of the process of resilient adaptation.

The chapter is organized into four sections, organized by key themes related to the study of aging in the US. The first section explores statistics related to longevity

worldwide and in the US and describes the composition of U.S. older adult population by age, size, and diversity. This section then examines the economic impact of this cohort on the economy. Research includes the perspective of older adults on whether, when, and how to treat retirement; the efficacy and affordability of publicly funded pensions and healthcare programs; and the impact of technological advancements on an aging workforce. The second section contains a review of the existing paradigms that have provided a framework for thinking about human aging and development. Traditional theoretical models of aging will include medical models that view aging in terms of genetic inheritance, expression, and fitness; stage and structural models that describe the ways in which cognitive, physical, and psychological development proceeds through discrete processes; and biopsychosocial models that include the role of socialization and the environment in development. Lastly, current theories of human aging and development, based on life span models, are examined.

The third section examines existing research on the nature of resilience—what it is and why it matters. Included in the understanding of resilience is the examination of risk and protective factors, such as the impact of adverse experiences in early childhood on age-related physiological capacities and individual differences in circumstance as well as how diversity factors impact the nature and intensity of psychological and physiological reactions to stress. The chapter continues with a fourth section that examines the research on the intersection of creativity and aging (i.e., how purposeful engagement in creative expression is experienced by older adults). Research directions

and opportunities in the area of creativity and aging has offered important findings related to the capacity for positive change and/or adaptation in older adults who participate in storytelling as a creative activity. The chapter concludes with a rationale for existing study, how it will contribute to the existing corpus regarding the impact of adversity and resilience on aging in the US and by exploring what diverse older adults are writing and speaking about regarding their subjective experience of aging in the US.

Adults 65 Years and Older: Current Status and Emerging Trends

Globally, populations are benefitting from advancements in science, technology, and medicine. These advancements are affecting the development of societies worldwide in many areas including human health and aging. According to one world aging report (He, Goodkind, & Kowal, 2016), global life expectancy at birth increased from 48 years in 1950 to 71 years in 2012, extending the average human lifespan by over 2 decades. Many factors contribute to this process, but it is generally agreed that improvements in public health, including basic sanitation and advancements in medicine, have led to this increase in average age of death. According to research on the burden of diseases (Global Burden of Disease Study Collaborators, 2015), between 1990 and 2013, the number of deaths from non-communicable diseases (e.g., cardiovascular disease, lung disease, cancer, stroke) increased by 42%, with the largest increases among the population aged 80 years and over. However, He et al. (2016) found a global decline in most of these diseases among adults aged 60 years and older.

In 2015, the proportion of global population 65 years and older reached 8.5%, and this percentage is expected to more than double by the year 2050 (He et al., 2016). Although this may be seen as a human success story, the worldwide phenomenon of increased life-expectancy also presents challenges due to a long-term trend in declining birthrates around the world (Mather et al., 2015). Thus, the main demographic force behind overall population aging, according to world aging data, is declining fertility rates (He et al., 2016). Populations with high fertility tend to have a young age distribution with a high proportion of children and a low proportion of older people, while those with low fertility have the opposite, resulting in an older society.

Estimates of the projected rise in the older adult population globally, from 530.5 million in 2010 to 1.5 billion in 2050, combined with a projected continuation in the decline of birthrates, present a future world in which approximately one out of every six people is 65 years of age and older (Mather et al., 2015). Like the rest of the world, the US is aging; the percentage of older adults is projected to increase from 46 million in 2015 to more than 90 million in 2050 (Mather et al., 2015). While policymakers worldwide must address issues involving the advancement of health and well-being for a growing global population of older adults, this research focuses on the challenges and opportunities facing those 65 years and older as they are situated in the U.S. economy, infrastructures, and institutions.

Demographics

Size and age composition. Americans born between 1946 and 1964, known as the baby boom generation, represent a massive spike in U.S. birthrates following the end of World War II and have been driving the change structure of the U.S. population since their birth (Mather et al., 2015). Frey (2010) suggested that while policymakers, government officials, and marketers have been tracking this cohort, which appears to have shattered precedents in prior generations' aspirations and lifestyles, this baby boom "'pig' is progressing toward the tail end of the python" (p. 28) with little understanding as to how to meet its growing needs. This cohort is not only marked by a substantial rise in birthrates, it also is differentiated from other cohorts, both prior and subsequent, by the length of time for which these higher levels of fertility were sustained (Colby & Ortman, 2015). The National Center for Health Statistics (NCHS) recorded 2.9 million births in 1945, which increased by almost 20% to 3.4 million births in 1946, and births continued to increase reaching a peak of 4.3 million in 1957 (Hoyert, Heron, Murphy, & Kung, 2006). Officially, the baby boom generation ended with the declining birthrate of 1964, when annual births fell below 4 million (Mather et al., 2015).

Baby boomers began turning 65 in 2011 and are now driving growth at the older ages of the population. Although the number of baby boomers will decline through mortality, this shift toward an increasingly older population is expected to endure (Mather et al., 2015). Between 2020 and 2030 alone, the number of older persons is projected to increase by almost 18 million as the last of the large baby boom cohort

reaches age 65 years. Although much smaller in total size, the number of people aged 85 years and older is projected to more than triple from current estimates of 6 million to nearly 20 million by 2060 (Mather et al., 2015). Increasing longevity rates account for the growing number of U.S. centenarians, which has already risen from 32,000 in 1980 to over 53,000 by 2010. This cohort of people aged 100 years and older is expected to rise to 600,000, just under 1% of the population by the year 2060, adding to the impact that the baby boom cohort has had, and will continue to have, on the age composition of the population. (Mather et al., 2015).

Although the younger members of the baby boom cohort will not reach 65 until 2029, the decline in post-boom birthrates is estimated to accelerate the growth of the older adult population. In 2014, children under 18 years made up less than one-fourth the population, while those over 65 years of age accounted for 15%, but recent projections suggest that the number and share of the older adult population may surpass that of children by the year 2035 (Mather et al., 2015). Slow growth in working age population, combined with increased numbers of older adults, translates to fewer individuals paying taxes necessary to support public programs for the older, dependent population and fewer workers in fields that provide needed services to older adults. These projections of higher numbers of older adults than children are likely to impact the U.S. economy, work patterns, family and living structure, as well as public programs (Colby & Ortman, 2015; U.S. Department of Labor, 2009).

Diversity composition. Older adults are diverse regarding gender, race/ethnicity, economic status, immigration status, and living patterns, resulting in intersecting and multiple advantages and disadvantages (Emlet, 2016). This important feature of older adults will likely impact the need and availability of care in different ways due to a differential distribution of health risks and behavior, economic status, and family/living structure (Du & Xu, 2016; Kim, Acey, Guess, Jen, & Frederickson-Goldsen, 2016). In reviewing the current research on aging, differences were found by this investigator in the type and number of contributions exploring diversity factors that affect aging well. The majority of research found examined race/ethnicity and LGBT identities. Fewer contributions focused on other diversity factors or social contextual variables, such as family composition, safe housing, employment opportunities, education, affordable/available healthcare, and their intersectionality, which also have strong implications for the U.S. older adult population.

According to the AoA (2016), census data from 2010 showed that 75% of U.S. older adults were members of a White majority and 21% were members of a non-White racial minority. These estimates mirror the race and ethnic composition of the U.S. population during the years when these cohorts were born, and they account for previous trends in childbirth rates, mortality rates, and immigration rates, which have since changed. The AoA estimates that between 2012 and 2030, the older adult White population is expected to increase by 54% compared to a 126 % rise in older racial and ethnic minority populations, including Latinos (155%), Black people (104%), American

Indian and Native Alaskans (116%), and Asians (119%). Racial and ethnic diversity is an important feature of this aging population due to a differential distribution of health risks that impact successful aging (Du & Xu, 2016; Levine & Crimmins, 2014; Mather et al., 2015).

Census reports put the current estimated total of White older adults around 75% of the population compared with only half of children under 18 years of age (Mather et al., 2015). Through increases in immigration and minority births, differences between the racial and ethnic composition of the baby boom population and the total U.S. population appears to be heading towards a great divide. Livingston and Cohn (2012) found that foreign-born mothers have higher fertility levels than native U.S. women, and the foreign-born share of births is disproportionately higher than their share in the total population (Livingston & Cohn, 2012). This trend has been called a *diversity gap* between generations, and it is suggested that this gap could bring about conflict over public resources for a mostly White older adult population looking for Social Security and Medicare benefits and a younger, more diverse population entering the workforce (Mather et al., 2015).

As America's older population is growing, so is the number of LGBT adults who are moving into older adulthood. And, like LGBT people in general, LGBT older adults are diverse regarding such characteristics as gender, race/ethnicity, socioeconomic status, disability, and so forth. Of the more than 39 million U.S. adults 65 years and older, 1.5 million identify as LGBT (Choi & Meyer, 2016), and according to an APA (2016) report,

this number is expected to double by the year 2030, reaching more than 3 million. Among the LGBT population, baby boomers have been integral in the increasing visibility they have received in the US, which began with the contemporary gay rights movement. However, recent comprehensive reports on LGBT older adults found that over 25% of LGBT boomers continue to report concern about discrimination as they age, citing experiences of past and present stigmatization and prejudice related to their sexual orientation or gender identity (Espinoza, 2016; Meyer, 2003; Wallace, Cochran, Durazo, & Ford, 2011).

Family composition and living arrangements. Marital status and family living arrangements play an important role in both social and financial support as well as available caregivers for adults in their later years. There are robust links between marriage and health in older ages; married people, particularly married men, have been found to enjoy longer, healthier lives than their unmarried counterparts with lower rates of chronic illness (Pienta, Hayward, & Jenkins, 2000), disability (Goldman, Koreman, & Weinstein, 1995), and mortality (Holt-Lundstad, Smith, & Layton, 2010). Hank and Wagner (2013) found that divorce and widowhood are related to depressive symptoms in older adults due to the positive relationship between marital status and well-being. However, relationship quality does matter. The mere presence of a spouse is not what protects against late-life depression but characteristics of reciprocity in relationships is found to positively impact psychological well-being in both men and women (Hank & Wagner, 2013; Rauer, Sabey, & Jensen, 2014).

Mather et al. (2015) found that the proportion of older women who are married has increased steadily as the baby boomers have aged, but these researchers also found that a gap continues to widen between the percentage of men (75%) and women (50%) aged 65 years and older who are married. These gender differences in marital status of current older adults are influenced by multiple factors including increased longevity for women compared with men (Mather et al., 2015), the pattern of women choosing to marry men who are older than themselves (Kinsella & Phillips, 2005), and the greater likelihood that older widowed men will remarry in comparison to women who are widowers (Mather et al., 2015). Differences in marital status among older men and women who live independently are also reflected in the number of persons living in households. Older adults who live alone are less likely to have regular access to another person to help with activities of daily living and less likely to have regular care if they become ill or injured. Even after a decades-long increase in the proportion of older adult women who are married and declines in widowhood due to rising longevity rates for men, more than one-fourth of women ages 65 to 74 years live alone—with the percentage increasing with age—and more likely to have lower levels of income and higher levels of poverty (Mather et al., 2015).

Whether married or unmarried, older adults who live alone are faced with the burden of housing costs, leaving many without adequate resources for food, transportation, and medical expenses (Mather et al., 2015). Cornwell (2014) explored communities with concentrations of economic and social disadvantage, finding that

these communities share characteristics such as unfavorable zoning laws, insufficient transportation networks, and harmful land-use policies that limit access to resources conducive to health-promoting activities and social connections. Affordable, accessible, and well-located housing has been described as the “linchpin of well-being” for older adults by the Joint Center for Housing Studies at Harvard University (JCHS, 2014). The 2010 census found the clear majority of older adults in the US living in homes and apartments, with over three-fourths owning their homes (Mather et al., 2015). However, JCHS (2014) found that much of the current housing inventory in the US does not provide needed housing for older adults to lead quality, independent lives while maintaining financial stability (JCHS, 2014). For older adults, attention is being devoted to meeting these housing needs by providing options with the understanding that most older adults prefer to remain in their homes if possible (Cornwell, 2014).

One obstacle facing all adults as they age is the risk of social isolation due to changing and/or decreasing communities within which they find support. Social isolation risk compounds the effects of long-term discrimination and victimization (Emlet, 2016). Individuals with intersecting age and LGBT identities face risk factors that are unique and disproportionate (Espinoza, 2016). Recent populations studies have reported a higher prevalence of lesbian, gay, and bisexual older adults are living alone compared with their heterosexual counterparts, impacting financial resources and social support (Kim & Fredriksen-Goldsen, 2014; Wallace et al., 2011). According to Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders (SAGE, 2014), LGBT older

adults are “twice as likely to live alone, twice as likely to be single, and 3 to 4 times less likely to have children – and many are estranged from their biological families” (para. 4), primary risk factors for social isolation. Older same-sex couples applying for senior housing were found to experience high rates of discrimination (Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders [SAGE], 2014), placing them at a significant disadvantage at a vulnerable time in their lives. When living arrangements and loneliness was studied, households having a spouse or partner appeared to provide more secure feelings of belonging and lower levels of loneliness, emphasizing the importance of reducing barriers to partnered living arrangements (Kim & Fredriksen-Goldsen, 2014).

Regardless of racial/ethnic or other diverse identities, for older adults with chronic conditions and disabilities, the availability of housing with supports and services will be a large determinant of health and well-being. While the number of adults 65 years and older who live in group housing such as nursing or skilled-nursing facilities is estimated at a low 4%, the proportion increases considerably as adults reach 80 years and beyond—7% for ages 80–89 years; 19% for ages 90–99 years; and jumping to 35% for those 100 years and older (Mather et al., 2015). Larger numbers of adults aging in the US will increase the need for this type of living facility by an estimated 1 million in the next decade (Mather et al., 2015). The quality and cost of long-term care, particularly the portion paid with public funds, may force low-income older adults to sacrifice living safely and comfortably in their own homes, increasing the likelihood of

isolation from friends and family (JCHS, 2014).

Educational attainment and economic security. Some current analyses of baby boomers suggest that they will experience more economic security in old age compared to previous generations (Frey, 2010), yet wide disparities exist in the economic and physical well-being of older adults by gender and across different ethnic groups (Mather et al., 2015). Compared with earlier cohorts, baby boomers have higher levels of education and more years of work experience, which should increase their lifetime earnings and economic security as they reach age 65 years and beyond. Steadily rising education levels in the past 50 years has resulted in a higher rate of older adults who have completed high school and some college, and evidence indicates an association between higher education and longer life expectancy (Mather et al., 2015). However, these same researchers note relevant gender differences such that only 20% of women completed a bachelor's degree compared to 31% of men, noting that lower educational levels are tied to lower income levels and higher poverty rates (Mather et al., 2015).

The Great Recession in 2007–2009 had wide-ranging effects on the older adult population. For those older adults already retired, reports indicate an increased likelihood of outright home ownership and decreased likelihood of home foreclosure (West, Cole, Goodkind, & He, 2014). Poverty rates increased among children and working-age adults and remained unchanged overall for those aged 65 years and above (Pfeffer, Danziger, & Schoeni, 2013). Yet, while households headed by older adults experienced smaller percentage declines in wealth relative to those run by working-age

adults, 25% versus 61% respectively (Pfeffer et al., 2013), data from a series of surveys found that financial help flowed from older parents to their adult children during this time, effectively reducing spending on themselves and their own healthcare needs (Hurd & Rohwedder, 2013).

Overall, poverty rates for many American older adults have decreased substantially in the past 50 years, from 30% down to 10%, due in large part to an expansion in Social Security benefits (Mather et al., 2015). Although Social Security has been keeping most older adults out of poverty, wide economic disparities exist across population subgroups. Inequalities among working-age adults by gender, race/ethnicity and other minority statuses, and education tend to persist into old age. Gendered disparities in U.S. poverty rates place older women at a disadvantage, which increases as they age. Poverty rates among men and women aged 75 years and older show that women are twice as likely to be poor (U.S. Census Bureau, 2015). This disparity reflects longer life expectancy and increased likelihood of living alone among women, but it is also linked to the gender gap in earnings at younger ages, which translates into lower retirement benefits (Mather et al., 2015).

In 2014, poverty research estimates for White people were at 8%, while comparable figures were 18% among Latinos and 19% among Black people (Mather et al., 2015). Reports indicate that older racial/ethnic minorities are less likely to have income from savings, pensions, or other assets; 20% of Black and Latino older adults rely solely on Social Security for their family income compared with 13% of White older

adults (Mather et al., 2015). Growing evidence is revealing overall disparities among LGBT older adult poverty rates and those of their heterosexual peers (Emlet, 2016), noting sub-group differences that may put many individuals at an additional risk. People who live in poverty are less healthy than those who are financially well off across all measures such as mortality rate, prevalence of disease, and mental health and place substantial pressure on policymakers to minimize negative economic impacts of older adults.

Health and well-being. By many standards, the U.S. older adult population is healthier and more well off than previous cohorts. Older adults are living longer, disability rates have decreased, and old age is less likely to mean automatic decline in mental and physical functioning. The number of years a person is likely to live without disabilities has been increasing; between 1992 and 2008 overall life expectancy disability-free at age 65 years increased by 1.8 years. This increase in life expectancy free of disability is linked to improvements in the prevention and treatment of certain diseases such as heart disease (Chernew, 2015). Compared to other high-income nations, the US ranks 27th out of 34 countries in overall life expectancy (CDC, 2016). However, estimates of future disability levels among older adults appear to be heading up because of the relatively high disability rates among boomers who are now reaching retirement age due to higher rates of obesity, diabetes, and high blood pressure than prior same-age cohorts (Scommegna, 2015).

Studies using various health indicators, including disease and mortality patterns

(Levine & Crimmins, 2014), chronic conditions (Du & Xu, 2016), and health behaviors (Mather et al., 2015), suggest that race is linked to striking health disparities in the United States. While White women can expect to live longer than White men, older Black men and Black women may not expect to live as long as either White men or White women (Case & Deaton, 2015). Levine and Crimmins (2014) found support for the association of significantly higher biological ages at any given chronological age in Black people relative to White people as measured by levels of disease and disability. These researchers suggest that the various social, economic, mental, and physical factors encountered by racial/ethnic minorities can accelerate the aging process (Levine & Crimmins, 2014). This racial gap has persisted over time, but there may be signs that it is narrowing due to both higher rates of drug and alcohol abuse, suicide, chronic liver disease, and cirrhosis among White men and women and the continued falling mortality rates among Latino and Black populations (Mather et al., 2015).

There are wide gaps in the health of older adults based on the intersection of racial/ethnic affiliation, sexual orientation, and gender identity. Literature documenting health disparities among older populations has found members of various minority groups, including Black people, American Indians/Alaska Natives, Asians, and Latinos/Latinas, are less likely to rate their health status as excellent or very good when compared with older White people (Min, Rhee, Lee, Rhee, & Tran, 2014). Available literature on the health of older adult minority populations reveals a greater likelihood that racial/ethnic minorities suffer from chronic health conditions and disabilities.

Examples include higher rates of obesity among Black individuals and Latinos (Fakhouri, Ogden, Carroll, Kit, & Flegal, 2012) and a higher prevalence of diabetes and hypertension among Latinos, Black individuals, and Asians (U.S. Census Bureau, 2014). While White individuals have higher rates of heart disease than all minority groups, the mortality rate from heart disease is higher among Black individuals (CDC, 2016). According to the HHS (2014), health disparities among racial/ethnic minorities is believed to be the result of many factors including biological characteristics, health services, social factors, government policies, and various interactions of these factors.

Research by SAGE (2014) describes LGBT older adults as aging with higher rates of disability and chronic illness than their heterosexual counterparts. Data suggest health disparities, such as higher rates of poor mental and physical health, may be directly or indirectly related to the deleterious effects of long-term discrimination and victimization (Emlet, 2016). Fredriksen-Goldsen et al. (2013) found an association between lifetime victimization and poorer general health, more depressive symptoms, and greater disability among LGBT older adults. Important health-related sub-group differences among the LGBT older adult population do exist as exemplified by the increased risk for poverty, financial barriers to healthcare access, higher rates of disability, and lower overall social support that exists among transgender older adults when compared to their lesbian, gay, and bisexual peers (Fredriksen-Goldsen et al., 2013).

In a recent study, Kim et al. (2016) found that approximately 20% of LGBT older

adults identified as people of color. Research focused on older LGBT adults of color has remained “largely invisible within the frameworks of most aging services, research, and public policy initiatives” (p. 49). An emerging concern for LGBT older adults, regardless of racial/ethnic identity, stems from fear of discrimination in long-term-care facilities (Stein, Beckerman & Sherman, 2010).

Workforce infrastructure. Although population aging will create fiscal challenges, many argue that these challenges can be managed through structural changes to existing entitlement programs, an increase in retirement savings among workers, and by shifting retirement to later ages. Improved health and longer life expectancy among older adults are paving the way for employment well beyond the traditional retirement age of 65 years, generating many challenges in the labor force. According to reports on labor participation in 2014, 23% of men and 15% of women ages 65 years and older were in the labor force, and these numbers are projected to rise further as baby boomers continue to age (Mather et al., 2015). Since the 1990s, the rise in workforce participation among older adults may be linked to a number of factors—some related to the economic fallout of the recession, some to changing retirement benefits by employers, and some by the repeal of a mandatory retirement age in many industries (Mather et al., 2015; Szinovacz et al., 2014). Additionally, the increase in life expectancy may be incentivizing many older adults to remain in the workforce in order to finance the added years after retirement (Mather et al., 2015).

Recent labor force participation among older adult men ages 65 to 69 years rose from 24 to 36% in the past 2 decades, with participation by similar aged women increasing from 18 to 27% (Mather et al., 2015). However, data from 2014 report men aged 70 years and older participate at lower rates than 50 years ago, while the rate among similarly aged women is the highest it has been in the same 5 decades (U.S. Census Bureau, 2014). On the organizational level, workforce infrastructure is typically comprised of decades-old policies that have focused on phasing out older employees in favor of younger replacements who have less impact on companies' bottom lines in terms of salary and healthcare insurance costs (Sanders, 2013).

For many older adults, staying on the job is not an option; physical and health-related limitations make it impractical for people in some professions (e.g., those more physically demanding) to expect an extended career. According to Bosworth and Burke (2012), individuals who are less educated, less healthy, and working in blue-collar jobs are more likely to take early benefits even though they are not confident that they will have enough financial resources in retirement without extending their working years to age 70 years. Opportunities for job security, despite federal anti-discrimination laws, are more likely to be felt by older adults who are more dependent on government programs for their source of income (Szinovacz et al., 2014).

Sources of income for older adults in the US are a combination of Social Security benefits, pensions, retirement savings including Individual Retirement Accounts (IRAs) and employer participating programs such as 401(k)s. These income sources are

increasingly being supplemented by full-time and part-time work in the same or a different field (Bosworth & Burke, 2012). While the average age of retirement in the 1970s–1980s fell from 67 to 62 years, these trends have now reversed (Mather et al., 2015). Transitioning into some part-time, self-employment, or temporary work after full-time employment ends and permanent retirement begins, known as bridge employment, is already being practiced by older adults (von Bonsdorff, Shultz, Leskinen, & Tansky, 2009). While some older adult workers continued their employment, others left and then re-entered the workforce due to economic downturn. Data from a 2014 Bureau of Labor Statistics report indicate that approximately 15% of older adult employees left and re-entered the labor force after retirement (Cahill, Giandrea, & Quinn, 2015). Cahill et al. report that 40% of employed older adults usually worked fewer than 35 hours per week in 2014. To adapt to an aging workforce, employers are beginning to offer greater flexibility in roles and schedules for older adult employees (Bloom, Boersch-Supan, McGee, & Seike, 2011).

The rising trend of older adult labor participation is not only due to the size of this cohort, but also declining participation by working-age adults ages 16 to 64 years (Mather et al., 2015). Concerns exist that there will be fewer workers who will be supporting a growing retired population. The elderly support ratio—the number of working-age adults aged 18–64 years for every person 65 years and older—is a way that social and financial need is evaluated. According to reports (Mather et al., 2015), the elderly support ratio in the US at the turn of the 21st century was approximately five

working-age adults per adult 65 years and older dropping to four by 2014. Projections by the U.S. Census Bureau (2014) put this ratio, which is driven in large part by the size of the baby boom cohort, closer to two working-age adults for every older adult by the year 2060. Projections are stated as an approximation because they do not include statistics on how many persons are actually participating in the labor force, as an increasing number of older adults are continuing to work past age 65 years. However, they do give a picture of the fiscal challenges that are likely to exist as the baby boomers continue to age (Mather et al., 2015).

Policies affecting older adults. Increasing longevity, as well as the rapid increase in the population of older adults, poses a challenge to the health-care professionals and policymakers tasked with meeting the needs of this cohort such as government-supported healthcare and long-term care (Mather et al., 2015). The older adult population is currently estimated at about 14% of the U.S. population but accounts for over 35% of government health-care spending (Centers for Medicare and Medicaid Services, 2014; U.S. Census Bureau, 2015). The two major entitlement programs in the US, Social Security and Medicare, play an important role in the health and well-being of the older adult population through the reduction of poverty and access to healthcare (Mather et al., 2015). However, the cost of these programs is expected to rise as the numbers of people receiving benefits increases. Over the next decade the number of older adults benefitting from Medicare alone is projected to increase by one-third, and expenditures for the combined programs are projected to double from 6.7 percent in

2010 to almost 15% in 2050 (Social Security Administration, 2014). These rising numbers are being driven by both the older adult population size and by the cost of inflation (Mather et al., 2015).

The rising number of older Americans will put pressure on entitlement programs and create challenges for the labor market and health care systems—as well as family members who provide the majority of care to older adults with disabilities. Some elements of societal infrastructure may include a defined federal retirement age; ages for enrollment in Social Security, Medicare, other pensions or entitlements; and entitlement-based earning restrictions in later life (Tishman, Van Looy, & Bruyère, 2012). Medicare, a publicly financed social insurance program covers a broad range of services but does not cover out-patient prescription medicine (Weiner & Tilly, 2002). According to current estimates, the cost of this government-sponsored health insurance could double in the next ten years as average life expectancy is extended, and many policymakers see that these programs are unsustainable as they are currently being implemented (Mather et al., 2015; Williamson, 2013).

In response to the growing concern over current and future access to healthcare, the Patient Protection and Affordable Care Act (ACA, 2010) was signed into law with the purpose of improving the quality, access, and affordability of healthcare and health insurance. The impact of this legislation on older adults has been debated without a consensus being reached, but according to ObamaCare Facts (2017), many of the most vulnerable populations in the US were to benefit. Under the ACA, expansions made to

programs such as Medicaid and Children's Health Insurance Program (CHIP) would reach the nation's poorest, cover millions uninsured older adults and low-income individuals, and provide new home- and community-based options for elderly and disabled Americans who require long-term care services. Additionally, disadvantaged populations were addressed by ACA policies, including insurance coverage for older adults with incomes under federal poverty rates; expanding the Medicaid assistance program to include more people who do not have it in their budgets to pay for health care; funding to build, expand, and operate community health-care facilities in underserved communities; funding to provide incentives for primary care providers to practice in these underserved communities; and temporary reinsurance program to sustain group coverage for early retirees prior to 2014 reforms (ObamaCare Facts, 2017). With the administrative changes that occurred with the most recent elections, the debate surrounding the best policies that will focus on helping those most in need continues (American Action Forum, 2017).

While it is an important goal that these additional years be as free from major disease as possible, it is also relevant to ensure the maintenance of mental and physical functioning. Otherwise, society will be faced with larger numbers of dependent older persons with tremendous needs for costly long-term care (Siegler, Bosworth, Davey, & Elias, 2013). As the population ages, a steady increase in the number of older adults with functional and cognitive disabilities is projected. In the past, older adults have relied heavily on their adult children for support and caregiving (Mather et al., 2015).

According to estimates, nearly half of female baby boomers will have been divorced by age 65 years and although many have remarried, older women are more likely to be living alone and in need of care than older men (Fingerman et al., 2010). Trends in marriage and family patterns over the past half century have resulted in single-parent homes and blended families, leading to weaker family ties and less support for aging parents (Fingerman et al., 2010).

A growing number of older adults with disabilities relay on assistive devices and technologies such as walkers, wheelchairs, and scooters to maintain their independence, a key goal of the 1990 Americans with Disabilities Act (Mather et al., 2015). Disparities exist as to who does and does not benefit from these technologies based on majority status such that White people and people with higher income and education are more likely to use these devices compared with racial/ethnic minority and lower socioeconomic status individuals (Freedman, Martin, Schoeni, & Cornman, 2008). These technologies have been found to increase the length of time an older adult can age in place, reducing the number of older adults needing to be placed in long-term care facilities and reducing the cost to both the individuals and to the public health-care system (Mather et al., 2015).

Recently, a decennial conference on aging (CCD, 2016) outlined a variety of recommendations and actions from both the public and private sectors; these recommendations addressed areas impacting older adults in the US—retirement security, healthy aging, long-term services and supports, and elder justice—albeit with

little reference to the increasing numbers of older adults who identify as LGBT and their unique concerns. In the United States, about 80% of long-term care for older people is provided by family members, such as and spouses, children, and other relatives. But LGBT elders are only half as likely as their heterosexual counterparts to have close family to lean on for help. This means that they rely heavily on the services of professional health care providers—doctors, pharmacists, or hospital and nursing home staff—who might be uncomfortable with or even hostile toward LGBT elders and who are not trained to work with them. State and area agencies on aging have not been required to measure the extent to which they are actually serving LGBT individuals, and according to Espinoza (2016), "regulations governing Medicaid managed care and long-term facilities contain no requirements to track and measure LGBT people as consumers, beneficiaries, and residents" (p. 92). Thus, it remains unclear as to how public policies and entitlement programs are supporting LGBT older adults.

Current and emerging trends in technology use among older adults. America's older adults have been late adopters to the world of technology compared to its younger population, but according to recent reports from the Pew Research Center, internet use among adults ages 65 years and older have been the fastest growing demographic group in the past 5 years to adopt this type of technology (Smith, 2014). Current data suggest usage rates as high as 86% of older adults online, with 47% having high-speed connection at home, and 7% using cell phones (Smith, 2014). The majority of older adult internet users reported daily online activity (Anderson & Perrin, 2016).

Anderson and Perrin (2016) reported that demographic variations do exist among U.S. older adults in internet usage, including those related to age, educational attainment, household income, and community type (i.e., urban, suburban, and rural communities). Household income and education indicators suggest that one-third of older adults with less than a high school education do not use the internet, with the share falling as the educational attainment increases (Anderson & Perrin, 2016). Also, older adult members of households earning less than $30,000 annually are approximately eight times less likely to be online than those with higher earnings (Anderson & Perrin, 2016). Rural Americans are about twice as likely as those who live in urban or suburban settings to never use the internet. Gender differences indicate that older adult women are about 10% more likely to be online than their male peers, and consistent racial/ethnic internet use data reveal little difference in use among White people, Black people, and Latinos, while data found regarding Asian respondents was insufficient to offer a separate analysis (Smith, 2014). Overall, research into technology usage describes two very different groups of older adults; younger, more highly educated and affluent seniors who own technology hardware (i.e., smartphones, tablets, and home computers) and older, less affluent seniors who are more likely to be facing health or disability challenges and are "largely disconnected from the world of digital tools and services, both physically and psychologically" (Smith, 2014, para. 2).

According to Mitzner et al. (2010), the low-adoption rates of technology by older adults were associated with low self-efficacy and high anxiety due in part to limited

exposure. Research indicated that prior to adoption, older adults were found to have negative attitudes toward technology, such as inconvenience, unreliability, and security uncertainty (Mitzner et al., 2010). Once older adults were exposed to these technologies, and they received instruction, outcomes indicated positive attitudes, including perceived usefulness, convenience, and enjoyment (Mitzner et al., 2010; Smith, 2014). Educational opportunities offered by multiple publicly and privately funded agencies, such as the AoA and SeniorNet, provide older adults information on the many types of technology available, how these may be beneficial to them, and how to these platforms can be used with greater safety (AoA, 2016). The types of internet use among older adults are as varied as the population itself. Studies that have looked at the ways online technology is being used by older adults have found three common types of use. The first of these types of use revolve around communication. Wilson and Nicholas (2008) found that older adults are using various internet-based support sites to broaden their communication efforts such as email, newsgroups, forums or message boards, chat-groups, and weblogs or blogs. Communication online provides opportunities for older adults to both give and receive information, allowing them to stay connected with family and friends, regardless of distance and/or lack of mobility (Rainie, 2015). For many older adults—88% of 65 years and older and 86% of 85 years and older—email is being used to correspond with family and friends, while other platforms of communication are also being utilized such as texting (41%), video sharing (34%), and going on social networking sites such as Facebook (78%). Smith (2014) found

that older adults who use social networking sites are more likely to regularly socialize with friends, whether online, in person, or over the telephone, compared with seniors who are not social networking site users. Additionally, after controlling for demographic factors such as age, income, geographic location, fully 81% of older adults who use social networking sites say they socialize with others on a daily or near daily basis compared with 71% of peers who go online but do not visit social networking sites and 63 % of peers who are not online at all (Smith, 2014).

Another way the internet is used by older adults for communication is through online communities and blogs; these are sites where people communicate with others from a similar cohort and/or others who are confronting similar problems (Wilson & Nicholas, 2008). Online communities are groups of people who exchange information and messages on websites that offer forums or bulletin boards, and older adults are connecting with others who have a shared membership or interest, such as a hobby or a health condition (Health in Aging Foundation, 2016). Many online communities for older adults are sponsored by senior organizations such as American Association of Retired Persons (AARP) and Health in Aging, and they offer chat rooms where participants can have online conversation in real time (Health in Aging Foundation, 2016). In a study on the use of blogging conducted by Pew Research in 2005, over half of bloggers were under the age of 30 years (Lenhart & Fox, 2006), while recent studies indicate a sharp decline in blogging by younger adults and a corresponding increase in blogging among older adults (Lenhart, Purcell, Smith & Zickuhr, 2010). The blogosphere, the collective

social universe created online using web log publishing platforms, has been found to be dominated by individuals who use this format as a type of personal journal, covering a myriad of topics such as life experiences, politics, and other issues related to public life (Lenhart & Fox, 2006).

According to research, older adults are becoming increasingly active in the blogosphere by reading blogs as a way of keeping up with the current U.S. political and social climate, seeking information about healthcare and medical concerns that are personally relevant, and following blogs of ordinary people who report on their own lives or a particular topic. Lenhart et al. (2010) found that the blogging population is evenly split between men and women and that they are racially diverse. Additionally, studies indicate that older adults are creating their own blogs and posting comments on the blogs of companies, individuals, news outlets, and political groups with over half of bloggers reporting that they blog mainly for themselves rather than an audience (Lenhart et al., 2010).

Studies that have focused on older adults' use of the internet indicate that almost half of these users have searched for information regarding medication prescriptions, with approximately 16% have compared prices and made purchases, and 14% have sought information regarding healthcare providers online due to ease of access (Kaiser Family Foundation, 2007). The Pew project studied older adults with chronic health conditions and found that 53% of these adults reported that online sources had informed their decision-making about their own health concerns and the

health concerns of their friends and family (Pew Internet and American Life Project, 2007). Taha, Sharit, and Czaja (2009) found that older adults reported online health information had affected treatment decisions and strategies for coping with conditions and associated pain, helping them formulate new questions for their providers, and/or influencing a decision to seek a second opinion. Other types of information searched by older adults include community news, maps and directions, hobbies and interests, and weather reports (Smith, 2014). Managing finances and shopping are other ways older adults are using the internet. Zickuhr (2014) reports that a study on internet use by older adults found over half of older adult internet users listed shopping and managing finances as very important or important. While older adults may be late adopters of online technology, once they are online, 56 percent admit that it would be very difficult to give up this convenience (Zickuhr, 2014).

The above snapshot has provided an overview of some aspects of the older adult population in the US. The influence of distinctive experiences, during critical developmental periods, distinguish this cohort from other generations. Additionally, various forms of inequalities often coexist and exacerbate disparities in the factors that impact successful aging (Williams & Mohammed, 2009). Understanding the unique elements of any specific generation requires input from multiple theories of human development. How theorists understand the process of aging for the baby boomer generation is important in light of their many intra-cohort variations.

Existing Paradigms of Aging

The focus on how older adults have been conceptualized and represented is not new. In 44 BCE, the Roman statesman Cicero, himself advanced in years, wrote an essay on aging in which he offered a defense of then-current views on aging as decline and disease. According to Cicero (as cited in Jarcho, 1971), “the most important deeds are done not by physical strength but by intellectual qualities – precisely those qualities of character and judgment in which the old exceed the young” (p. 1441). In this statement, Cicero suggests two differing frameworks for how we might view aging and the aged. First, in his defense of prioritizing intellectual qualities over physical attributes, it appears that he is expecting physiological changes of aging (i.e., the deterioration of the human body, even as he suggests its value as less than the value of a sound intellect). In this view, aging is the inevitable and progressive deterioration of the body over time, which occurs in all living organisms (Kelly, 2011).

Secondly, Cicero appears to presume that the qualities of character and judgment are inherent in the aged. In this view, time offers humans the opportunity to gain such qualities as morality and wisdom through an accretion of life experiences that culminate in the highest form of human development (Baltes & Baltes, 1990). These two frameworks for conceptualizing aging—the first that examines what leads to the decline and deterioration of our organs throughout the lifespan until they cease to function at all (Jin, 2010), and the second that conceptualizes aging as the continued process of intellectual, social, emotional, and moral development gained throughout the life span

(Baltes, 1997)—are echoed in time-honored models of human aging and development across the lifespan.

Traditional Lifespan Models of Human Aging and Development

Many theories have been proposed as models to explain the processes, determinants, and mechanisms that influence human aging and development. Aging theories and models of human development also have served as frameworks for organizing research findings and general observations regarding aging into meaningful patterns and predictable changes (Baltes, 1997). The substantial increases in life expectancy at birth achieved over the previous century, combined with medical advances, escalating health and social care costs, and higher expectations for older age, have led to an interest in how to promote a healthier old age.

Three traditional models of human aging and development are discussed. The first of these models are medical models, which view aging as a process that extends over the lifespan and is influenced by genetic differences, external and environmental stressors, and health-related behaviors (Weinhold, 2006). Secondly, stage- or age-related developmental models, describing how cognitive, physical, psychological, and moral advancements proceed from simple to more complex understandings of the self and the world over the lifespan, are reviewed (Berk, 2014). Thirdly, biopsychosocial and other multiple-domain models of aging and development are discussed; these models broadly describe the human experience as influenced by multiple domains—biological,

psychological, social/cultural—and presumes the interrelationship and multidirectional influence of these domains (Moody & Sasser, 2015).

Medical models. Medical sciences have long proposed that human aging is a complex and gradual process of physiological changes. These changes were posited as determined and one-directional—having a beginning in utero, moving through birth and periods of growth, and ending with death. According to Mitteldorf (2010), early theorists described aging as the irreversible breakdown of living systems, such as the reduction in metabolic rate, the loss of muscle and bone mass, and the functional decline in all organs. Despite advances in biology and genetics, researchers continue to debate the fundamental causes of aging (Goldsmith, 2014). A review of currently prominent modern biological theories of aging have been divided into two main categories—damage/error theories and programmed/predetermined theories—as a way to describe research into the process of aging. Also, there is a review of the cumulative effects of allostatic load, a dysregulation state that results from the body's response to stress over the lifespan (Read & Grundy, 2012).

Damage theories. Damage theories propose that while individuals age, a significant amount of biological damage is accumulated over time as a by-product of normal living (Kolling & Knopf, 2014). These theories suggest that aging is simply the result of the accumulation of deteriorative processes (i.e oxidation through the build-up of free radicals [Gomez-Cabrera et al., 2012], telomere shortening [Simon et al., 2006], mitochondrial DNA damage [Freitas & de Magalhães, 2011], and disease-specific

processes such as the cancer-causing accumulation of cell mutations) that cannot be offset by maintenance and repair mechanisms responsible for slowing this cumulative effect. Thus, aging is an unalterable fact of life resulting from fundamental limitations that have not been overcome throughout human evolution.

Programmed theories. Many traditional aging theories posit that aging is programmed into human DNA and follows a biological timetable from womb to tomb (Berk, 2014). Research into human aging has uncovered examples of hormones that control the pace of aging. Burzynski (2004) found that approximately 90% of the human genome codes were inactive in adult life, suggesting the silencing of gene function at a time of increasing senescence and age-associated deficits. Underlying many of these theories is an evolutionary perspective, suggesting aging as an adaptive process; aging genes are part of evolved mechanisms that purposely limit lifespan due to lack of biological utility in post-reproductive individuals (Kolling & Knopf, 2014). Notable age-related gene expression changes include the silencing of tumor suppressors (Esteller, Com, Baylin, & Herman, 2001) and other genes involved in the control of the cell cycle, apoptosis, and detoxification (Campisi, 2003; Widschwender & Jones, 2002), with an increase in genes associated with typical diseases of old age (Bernards, 2003). The immune system is programmed to decline over time, which leads to increased vulnerability to infectious disease and is believed to be a major factor leading to progressive aging, cancer, and ultimately death (Rozemuller, van Gool, & Eikelenboom, 2005).

Allostatic load. While biological approaches to aging have been characterized by programmed and non-programmed factors that impact change in human physiology and function, additional threats from exposure to social, psychological, or environmental stressors also appear to be associated with risk to major regulatory systems, such as the cardiovascular, immune, hypothalamic-pituitary-adrenal (HPA), and sympathetic nervous system (SNS). In their study of how the body reacts to stress, Read and Grundy (2012) describe allostatic adaption as the process by which the body responds to psychosocial stressors in order to regain homeostasis. These researchers express the concept of allostatic load as the cost to these regulatory systems in terms of accumulated physiological deterioration, which occurs with repeated adaptive responses to environmental stressors (Read & Grundy, 2012). While the stress response in itself does not lead to adverse health conditions, each time this response is activated, the physiological adjustments that are made lead to wear and tear (McEwen, 1998).

According to Nielsen, Seeman, and Hahn (2007), excessive cycles of response, due to frequent and enduring challenges, tax the body's response systems such that they become dysregulated and/or damaged. The cumulative effects of dysregulation are associated with greater risks for subsequent disease, declines in physical and cognitive function, and overall mortality (Seeman, Singer, Rowe, & McEwen, 2001). Research has found psychosocial conditions previously associated with greater risk of disease and mortality (e.g., lower socio-economic status and poor social engagement) are also

associated with cumulative burdens of physiological dysregulation that occurs with increased allostatic load (Seeman et al., 2001).

Medical models appear to define aging well largely in terms of the optimization of life expectancy and minimization of physical and mental deterioration and disability. Focus has been on the absence of chronic disease, minimization of risk factors for disease, and the maximization of behaviors that promote good health. Finch and Kirkwood (2000) discuss traditional aging from a gerontological perspective indicating that it is a “time-dependent process characterized by irreversible changes that lead to progressive loss of functional capacity” (p. 6).

The overall goal of aging research from a medical model viewpoint is to understand genetic, neurologic, and hormonal mechanisms that control the process of aging and to find ways to modify these processes to gain the most successful outcome possible (Kolling & Knopf, 2010). Understanding the biological pathways through which stressors impact health and aging has led to the hypothesis that inequalities in risk of disease and mortality exist due to differences in exposure to various types of stressors (Seeman et al., 2001). Studies on aging and social inequality have found a correlation between behavioral choices and aging, with advantage yielding advantage and disadvantage yielding disadvantage (Dannefer, 2003). The significance of differentials in life experiences, such as gender differences in exposure to social resources (Prus & Gee, 2003), educational attainment (Ross & Wu, 1996), social support and social integration

(Jasso, 2001) result in differences in the accumulation of biological wear and tear and health in older ages.

Stage- and age-related models. Old age, the stage at the end of life, has been shaped by a lifetime of experiences that reflect the myriad combinations of influences throughout previous life stages (Dannefer, 2003). Berk (2014) provides an overview of lifespan models of human development, indicating that progress is gradual and ongoing, with momentum almost always forward toward greater, more complex understandings and abilities. Common attributes of stage models of human development suggest that people pass through stages in a specific order, with each stage building on capacities that are established in the prior stage (Berk, 2014). Four notable theories of development appear to have proven influential over time—Freud's (1905/2000) psychosexual stage theory, Erikson's (1950) psychosocial theory of development, Piaget's (1970) cognitive stage theory, Kohlberg's (1973, 1976) moral development stage theory. A brief review of these notable theories follows.

Psychosexual stage theory. Freud's (1905/2000) theory of psychosexual development began with the supposition that mental activity existed on both conscious and unconscious levels, and human personality is determined by childhood experiences that are processed both consciously and unconsciously during important stages in the individual's childhood (Person, 2005). Reisner (2001) describes Freud's theoretical approach regarding the development of the human personality. Freud conceived that the human psyche consisted of three interworking parts, the *id*, which is the

unconscious drives to satisfy bodily needs and impulses such as sexual and aggressive drives; the *ego*, which is the conscious, rational part of the personality; and the *superego*, which restricts the desires of the id and applies the principals of the ego in order to conform to social norms and values (Reisner, 2001). Five stages, oral (birth to 1 year), anal (1–3 years), phallic (3–6 years), latency (6–12 years), and genital (12 years and above), involve satisfying the sexual or libidinal desires that come in to play during these different stages of development. Successfully resolving the conflicting physical drives and social expectations, through correct parental guidance, determines future coping and functioning ability in adulthood (Reisner, 2001). Freud suggested that working with older adults would not be effective due to the lack of elasticity in mental processes necessary for psychoanalysis, a viewpoint that he changed as he aged (Stern & Lovestone, 2000). While criticized for lack of empirical evidence, Freud's theory is stated as being influential in the work of others, such as Erickson, who focused on social interaction and conflicts that arise during different stages of development (Hunt, 2007).

Psychosocial stage theory. Like Freud, Erikson (1950) believed in the importance of early childhood, but he proposed a theory of personality development that occurs over the entire course of a person's life. According to Erikson, eight stages occurred over the lifespan, each having a centralized conflict. In each stage, people face new challenges, with outcomes dependent upon how each stage is negotiated. The stages begin in infancy (birth to 18 months) during which trust is established, moving through early childhood (2–3 years) when independence is sought while learning new skills,

preschool (3–5 years), when impulse control is developed, and school age (6–11 years), when a sense of competency is sought in preparation for adulthood (Erickson, 1950). These stages continue throughout the lifespan, all the way to maturity, which lasts from age 65 years to death. Erickson (1950) suggested that in the eighth and final stage of development older adults reflect on their lives to determine whether their cumulative experiences and choices have resulted in satisfaction. Success at this stage leads to a sense of wisdom and integrity, while failure results in regret, bitterness, and despair (Erickson, 1950). Ehlman and Ligon (2012) posited that Erikson expanded on this eighth stage while in his later life, suggesting that older adults need to be able to feel as if their life accomplishments are valued by successive generations, tying subjective well-being to future outcomes rather than present experience.

Cognitive development stage theory. Piaget (1970) theorized that people progress through a series of critical stages of cognitive development during childhood, which are marked by shifts in understanding. Piaget emphasized that there is a fundamental change in how individuals think as they gradually progress through these stages rather than just a process of accumulating additional information (Berk, 2014). The goal of Piaget's theory is to explain the mechanisms and processes by which the child develops into an individual who can reason and think using the development of cognitive processes (Inhelder & Piaget, 1958).

The cognitive development theory places primary emphasis on the acquisition of cognitive thought processes and describes both the mental and physical actions

involved in gaining knowledge and then categorizing it in a way that best fits or interprets this knowledge. These categories, called schemas, include both the knowledge itself and the process of obtaining it (Berk, 2014). Piaget (1970) theorized that ongoing experiences throughout childhood led to modification or change in schemas through *assimilation*, the process of taking in new information into existing schemas or *accommodation*, adapting or altering existing schemas in light of new information and experience.

In this view, intelligence is something that grows and develops through a series of stages, maintaining a balance by applying previous knowledge and changing behavior to account for new knowledge (Piaget, 1970). The four stages of cognitive development are the sensorimotor stage (birth to 2 years), which is characterized by learning about the world through basic actions such as sucking, grasping, looking, and listening; the preoperational stage (2–7 years), which is characterized by symbolic thinking and the use of words and pictures to represent objects; the concrete operations stage (7–11 years), which is characterized by thinking logically about concrete events; and the formal operations stage (12 years and above), which is characterized by use deductive logic or reasoning from a general principle to specific information.

Piaget's theory suggests that highly sophisticated intellectual capabilities were developed by age 15 (Piaget, 1970). During the period from adolescence through adulthood, individuals were posited to use symbols related to abstract concepts to systematically think about multiple variables, formulate hypotheses, and conceptualize

abstract relationships and ideas. Piaget (1970) believed that intellectual development was a lifelong process, but that when formal operational thought was attained, no new structures were needed. Intellectual development in adults involves developing more complex schema through the addition of knowledge (Wood, Smith, & Grossniklaus, 2001).

Moral understanding stage theory. According to Kohlberg (1973), morality starts from early childhood and can be affected either positively or negatively, depending on how an individual accomplishes the tasks that each stage requires. The basis of ethical behavior in humans is developed in these stages, with each new stage replacing the fundamentals of reasoning found in the former stage (Kohlberg, 1973). Kohlberg followed Piaget's requirements for a stage model, as described in the cognitive stage model theory, as well as expanding on Piaget's earlier work on the development of logic and morality through constructive stages. Kohlberg (1973) determined that the process of moral development was primarily concerned with justice, and that understanding gained in each stage was retained in later stages, continuing throughout the lifespan. Three distinct levels of moral reasoning were identified, with each stage having two sub-stages, and each stage is passed through in a fixed order. The pre-conventional morality stage follows unvarying rules and is based on rewards and punishments. In the conventional morality stage, problems are approached in terms of one's own position as a good, responsible member of society. The post-conventional

morality stage uses logical application of universal, abstract, moral principles (Kohlberg, 1976).

There have been critiques of Kohlberg's theory suggesting that the emphasis on justice excludes other moral values. Gilligan (1982) posited that Kohlberg's method of evaluating the reasoning behind individual moral choices neglects traits that have traditionally been associated with the socialization of women and that emphasize compassion as a moral approach to ethical behavior. Additionally, where Kohlberg's research is centered on hypothetical situations, the moral thinking and behavior of women is contextualized in real, ongoing relationships with ethical decision-making arising from personal insights (Gilligan, 1982).

Another aspect of this theory that has come under question has to do with the difference between moral thinking and moral behavior, in other words not only thinking rightly but also acting on the right thinking. Bee (1998) stated that Kohlberg never claimed that there would be a one-to-one correspondence between thinking and acting but does suggest that the two are linked. However, it is suggested that behavior develops over time, and there are costs and benefits to behavior choices that are influenced by competing motives such as peer pressure or self-interest (Bee, 1998). Thus, moral behavior is only partly grounded in moral thinking or reasoning, it is also influenced by other factors, such as the extent to which individuals feel constrained to match their moral thinking to their moral behavior (Bee, 1998).

Understanding the maintenance or continued growth of cognitive expertise in older adults, as well as the characteristics of wisdom and emotional maturity, is useful in providing a balanced and accurate account of aging. It is important to note that these stage models describe general or normative characteristics proposed to be common among people. The theories reviewed human development from somewhat different points of view; however, it has been noted that each model tends to be more descriptive than explanatory—describing what happens during the typical process of development rather than explaining why or how it happens (Bee, 1998).

Biopsychosocial/multiple domain models. The biopsychosocial models of human aging and development are founded on the premise that interactions among multiple domains of life, biological, psychological, and social/cultural, are mutually influential. Accordingly, changes in one area of life will have change effects in other areas (Whitbourne & Whitbourne, 2011). Nelson and Dannefer (1992) found that with increasing age, adults become a more diverse segment of population in terms of physical functioning, psychological performance, and conditions of living, underscoring the significance of these multiple influences throughout the lifespan in shaping human development (Whitbourne & Whitbourne, 2011). Three theories of human aging and development that incorporate multiple domains are discussed—Vygotsky's sociocultural model of development, Bronfenbrenner's bioecological model of development, and Havighurst's biopsychosocial model of development.

Sociocultural model. According to Vygotsky (1962), individual development cannot be fully understood without reference to the social and cultural context within which it is embedded. Vygotsky asserted that cognitive development in humans begins in childhood and is fostered by social interactions with others who are more knowledgeable. Vygotsky's model posits that higher mental processes have their origin in social processes (i.e., movement from the social world to the individual) rather than the reverse (Vygotsky, 1978). This acknowledgement of the social component emphasizes the importance of interaction with significant adults (i.e., parents and other caregivers, as a crucial factor affecting learning). Vygotsky (1978) posited three ways that knowledgeable others provide help in development—imitative learning, instructed learning, and collaborative learning. Through interaction with adults and more capable peers on the social plane, children learn to proceed through step-by-step changes in thought and behavior, engage in cooperative dialogues, and strive to understand others (Tomasello, Kruger, & Ratner, 1993). Vygotsky himself does not appear to have addressed older adults in his original model, though some Russian scholars have attempted to expand on his ideas (e.g., Belorusets & Frolov, 2011).

Ecological model. The ecological model posits that human development takes place within the context of the social and cultural environments in which individuals are raised, and the relationships within these environments. Bronfenbrenner (1990) advanced the theory of impact through a complex layering of systems, from the most immediate environment of daily home, school, and peer interactions to the broadest

societal landscape with its various attitudes, traditions, and practices. The bioecological theory emphasizes that it is not the setting that predicts behavior but one's interpretation of the setting, in both time and space, as the best way to fully understand their development (Bronfenbrenner, 1994).

According to Bronfenbrenner (1994), it is the relationships that are experienced in each of these environmental layers, the ways by which people treat each other, by what is said, and by what others within that setting do, that are the most impactful. As such, relationships provide context for the developing individual and shapes how appropriate roles, activities, and expectations are conceptualized and internalized (Bronfenbrenner, 1994). While the developmental process is most deeply impacted, for good or ill, by the relationships that are closest to the individual rather than the environmental contexts in which they occur, changes and conflict in any one layer will have a ripple effect throughout all other layers, impacting the individual's development, and this influence is reflected in outcomes later in the individual's life (Bronfenbrenner, 1994). While Bronfenbrenner's model does not speak specifically to aging per se, the framework has been applied to older adults in several ways, including aging in place initiatives benefitting U.S. elders (Greenfield, 2012) and the contribution and importance of personal, familial, community, and religious factors to health behaviors in Swiss elders (Wangmo, 2011).

Environmental model. Havighurst (1972) posited development as being influenced by biological, social, and cultural factors that prompt developmental tasks in

six age-related stages—infancy (birth–6 years), middle childhood (6–13 years), adolescence (13–18 years), early adulthood (19–30 years), middle age (30–60 years), and later maturity (60 years and older). These milestone tasks often arrive at a time when an individual demonstrates maturation at a level that is most conducive to learning, "when the body is ripe, and society requires, and the self is ready to achieve a sensitive task, the teachable moment has come" (Havighurst, 1972, p. 7). Many of these tasks are typically faced by people across cultures, such as walking, talking, and gaining control over bodily functions; while others, such as how to prepare for adulthood and learning what it means to be a responsible citizen, are varied according to the individual cultures. Overall, successful accomplishment or mastery of these tasks results in feelings of pride and satisfaction as well as provides a sound foundation for facing subsequent tasks with minimal experiences of difficulty (Havighurst, 1972).

Research in gerontology led Havighurst (1961) to question how older adults structure their lives after the age of 65 years and under what conditions they achieve satisfaction. According to Havighurst, successful aging could be defined as the process of learning one's way through life and adjusting to changes with three developmental tasks for the older adult to experience success in this stage—new social affiliations, new social roles, and new living arrangements (Havighurst, 1961). These developmental theories provide a basis for describing both gains and losses associated with aging as well as limits of intra-individual changes across the lifespan. Due to the combinations of influences—biological, environmental, psychological, relational—many developmental

outcomes are possible for each person, some outcomes are more likely than others, some outcomes can be effectively made more likely, and some outcomes are not possible. As the developmental process tends to be cumulative, with success at each new stage being influenced by the success of previous stages, developmental delays can result in serious problems in later life (Berk, 2014).

Current Lifespan Models of Human Aging and Development

Over the past several decades, traditional models of human aging and development have been found to be limited in their application to older adults due to the broad indicators of successful accomplishment or performance that are applied to individuals at various ages. Addressing past medical models of aging, Rowe and Kahn (1997) distinguished between normal decline in physical, social, and cognitive functioning with age, which can be heightened by extrinsic factors, and aging well, in which functional loss is minimized with little or no age-related decrement in physiological and cognitive functioning. Rowe and Kahn (1997) described three components of successful aging: absence or avoidance of disease and risk factors for disease; maintenance of physical and cognitive functioning; and active engagement with life, including maintenance of autonomy and social support.

Although such measurable indicators are necessary to assess whether individuals show developmental growth or decline relative to their own previous performance, stark contrasts appear to exist when assessing the determinants of successful aging from older adults' own perspective of what constitutes successful aging. Relative to

studies demonstrating that decreased biological, physiological, and cognitive capacity are negatively correlated with well-being in older adults, Reichstadt, Sengupta, Depp, Palinkas, and Jeste (2010) found that older adults emphasized self-acceptance, self-growth, and engagement with life as contributing to well-being rather than freedom from or avoidance of decline. This seeming paradox in the research literature appears to find common ground with adaptive aging theories from a lifespan perspective. Rather than conceiving of aging as solely a build-up of deficits and diseases, or dependent on cumulative successes as in age- or stage-related models, theories within the lifespan perspective view development as a lifelong adaptive process, which highlights the importance of multidirectionality (including gains and losses), multidimensionality, and multiple determinations of behavior (Baltes, Staudinger, & Lindenberger, 1999).

Of note, the theories of aging and development reviewed next are essentially from Western and individualistic perspectives about what constitutes and adds to aging well, and as such, these may not be applicable across cultures both in the US and globally. For example, since the cultural environment has an influence on the way in which people approach aging, immigrant elders may express different values from those who live in their country of nativity as they face unique issues related to cultural differences between normative practices of elder care in the US versus the traditions from their native homeland (Nguyen & Seal, 2014).

Adaptive lifespan models. Current lifespan models of human development have focused on the adaptive processes and coping strategies that are optimal for aging well

throughout the life span. Four current theories describing the processes that promote adaptation across multiple domains throughout the lifespan are discussed—the life-span theory of control (Heckhausen & Heckhausen, 2008; Heckhausen & Schultz, 1995), the motivational theory of lifespan development (Wrosch, Scheier, Miller, Schultz, & Carver, 2003; Heckhausen, Wrosch, & Schultz, 2010), the selective optimization with compensation theory (Baltes & Baltes, 1990; Freund & Baltes, 2002), and the socioemotional selectivity theory (Charles & Carstensen, 2012). An additional theory known as the life course theory (LCT) of aging and development (Elder Jr., 1998), which served as the theoretical model for this study, is the last theoretical model to be reviewed. Elder Jr.'s (1998) LCT is significant due to its emphasis on the historical and geographical embeddedness in which individuals live as being integral in the larger perspective of life span development.

Life-span theory of control. The life-span theory of control was developed to provide a developmental framework that accounts for major life-course transitions while "remaining sensitive to the biological constraints and opportunities characteristic of human development, as well as the social-structural forces that shape individual lives" (Heckhausen & Schultz, 1995, p. 284). This theory considers individuals as actively taking part in their own development by seeking to control important life outcomes through primary and secondary control strategies to maximize goal attainment (Heckhausen & Schultz, 1995). Both primary and secondary control strategies involve cognition and action, but primary control is more often characterized by action behavior

and secondary control is typically a more cognitive process related to individual need. Primary control enables individuals to shape their environment to fit their particular needs and developmental potential, while secondary control strategies help individuals change the self to fit better with the environment (Heckhausen & Schultz, 1995).

Aging individuals were found to use secondary control when primary control strategies failed or needed reinforcement to reduce losses related to aging (Heckhausen & Heckhausen, 2008). Extensive literature on aging report both primary and secondary control strategies are used throughout the lifespan in response to the opportunities and constraints encountered. However, the use of secondary control strategies in older adulthood addresses normative age-related losses reducing the risk of negative outcomes that are correlated with delayed or ineffective coping (Heckhausen & Schultz, 1995).

Motivational theory of life-span development. Additional process models were developed to explain how maturing individuals choose to optimize their development and then act to attain goals. Combining the control theory and goal attainment model provides a comprehensive theory of life-span development called the motivational theory of lifespan development (MDT), in which individuals take an active part in their own development using motivation and self-regulation strategies that allow them to accomplish major developmental life tasks (Heckhausen et al., 2010). According to this theory, MDT focuses on adaptation across the lifespan through examination of control strategies in relation to the key processes of goal engagement, goal disengagement, and

matching goals to opportunities (Wrosch et al., 2003). MDT suggests there is adaptive congruence between opportunities and goal engagement, which involves the investment of primary and select secondary control strategies. As goal attainment becomes increasingly constrained (e.g., biological deadlines), goal seeking efforts intensify with increasing use of engagement strategies. As goal attainment opportunities decrease or become very costly, the efforts involved in goal seeking are less functional. The continuation of goal seeking efforts that are not congruent with attainment opportunities have been associated with increasing emotional distress and reduced motivation for future goal seeking that may be available (Heckhausen et al., 2010). However, MDT asserts that older adults who adapt to constrained or disappearing opportunities by using secondary control strategies to disengage from unsuccessful goal seeking attempts (e.g., devaluing the goal and/or its importance) protect their motivational resources from the negative consequences of failure or loss (Wrosch et al., 2003). The shift from goal engagement to disengagement can be the most adaptive response to age- or deadline-related decline in opportunities. Other secondary control strategies are self-protective (e.g., avoiding self-blame by attributing failure to external factors rather than personal limitations) and aimed at minimizing distress. Active employment of these strategies by older adults minimizes the long-term damage that goal attainment failure could have on future motivational resources such as self-esteem and hope (Heckhausen et al., 2010).

Selective optimization with compensation theory. The selective optimization with compensation (SOC) model developed by Baltes and Baltes (1990) posits that there are fundamental processes by which individuals react to functional losses that occur throughout the lifespan. The SOC model asserts that as individuals age, they adapt to age-related losses and impairments to maintain their level of functioning by using *selection* to focus on specific goals, *optimization* to take advantage of the best means to ensure success of these goals, and *compensation* by adapting alternate ways of functioning (Baltes et al., 1999). While striving for personal goals, the SOC processes are aimed at maximizing gains and minimizing losses. Despite decline, the SOC processes enable aging individuals to choose realistic goals and act in ways that allow them to achieve these goals (Freund & Baltes, 2002).

Socioemotional selectivity theory. A second related theory, the socioemotional selectivity theory (SST) applies the SOC model to social relationships (Carstensen, Fung, & Charles, 2003; Ouwehand, de Ridder, & Bensing, 2010). Emotional goals embedded in meaningful relationships often demand emotion regulation. According to Carstensen et al. (2003), there are three life span changes, all rooted in motivation, which contribute to improved emotion regulation across adulthood and into old age. The first involves the prioritization of meaningful relationships over acquaintances. As individuals age, and time becomes a greater factor; older adults become more selective in their social relationships and activities, and their increased maturity and improved social skills allow them to manage their social interactions better (Charles & Carstensen, 2012). The

second factor concerns coping with negative events. Carstensen et al. (2003) state that older adults representing diverse groups consistently report better control of negative emotions than their younger counterparts. The third change concerns cognitive processing differences; older adults tend to focus on and remember positive events more than negative ones as compared to their younger counterparts (Reed & Carstensen, 2012). This strategy is known as the age-related positivity effect and has been correlated with increased well-being in attention and memory. While there are gains and losses at every stage of life, evidence suggests that emotion regulation in older adulthood is characterized by selectively constructing a social and cognitive world that maximizes emotional payoff (Reed & Carstensen, 2012).

Life course theory. As a developmental model, the LCT asserts that individual lives are shaped by the ever-changing historical context in which they exist (Elder Jr., 1998). The fundamental assumption underpinning this theory is that relationships among social and historical variables shape the “trajectories of family, education, and work, and they in turn influence behavior and particular lines of development” (Elder Jr., 1998, p. 2). The LCT targets the historical location of birth cohorts, both in time and place, and embeds this factor within the larger perspective of life span development (Elder Jr. & Johnson, 2003).

Elder Jr. (1998) posited that aging and development are characterized by interdependence among individuals living in the same historical context and who are similarly influenced by the institutions and social structures of that time and place. As

the theoretical framework for this current study, the LCT organizes aging and development through a biological, psychological, social, and historical framework that affects the myriad changes impacting individuals over the life span (Alwin, 2012). A clear example of this concept can be seen in Elder Jr.'s (1974) follow-up study with data from earlier longitudinal children's studies (e.g., Berkeley Guidance Study, Oakland Growth Study) relevant to individuals born prior to and during the initial years of the Great Depression. A combined social-historical and developmental approach was used to assess the influence of the economic crisis of the Great Depression on the life course of those two cohorts. Elder found that children born a decade prior to the depression encountered hardships after a relatively secure phase of early development and succeeded in rising above their disadvantages and in achieving a full life into older adulthood (Elder Jr., 1974). However, children born as the depression was just beginning experienced the vulnerable years of childhood during a period of greater stress and instability, which changed the trajectory of their life events and produced an accumulation of disadvantages (Elder Jr., 1974). Contrasting the effects of economic depression on cohorts born a decade apart revealed that the life course of individuals is shaped by historical times and places and have enduring consequences due to cumulative advantages and disadvantages (Alwin, 2012).

More recently, Elder Jr., Johnson, and Crosnoe (2003) have derived several principles that characterize the LCT: (1) learning and development are lifelong processes, (2) people's experiences are impacted by the choices they have made within

the constraints and opportunities available, (3) people's lives are shaped by historical times, (4) consequences of events and transitions throughout the lifespan are shaped by the developmental timing of their arrival, and (5) people's lives are lived interdependently with both social and historical influences being expressed through shared relationships. Along with these core principles, Hitlin and Elder Jr. (2007) note that the exercise of personal agency to achieve one's goals may be one of the most important contributions to an LCT perspective. The attempt to "exert influence to shape one's life trajectory" involves acting intentionally as individuals seek out "possible selves" (Hitlin & Elder Jr., 2007, p. 183). Elder Jr.'s LCT provides key conceptual elements for analyzing cohort experiences through age-related, social-structural, and institutional processes, laying a necessary foundation for the exploration of resilience that accounts for the disparity in aging outcomes found in the U.S. older adult population.

Resilience in Older Adulthood: Risk Factors, Protective Factors, and Outcomes

Over the past decades, the focus on successful aging used in many models of human aging and development has been critiqued by gerontologists due to the emphasis on avoiding disease and disability, maintaining physical and cognitive function, and promoting healthy behaviors (Harris, 2008). Concerns for this focus include the ways that social systems and cultural contexts within which people live vary widely and often restrict an individual's freedom of choice in health-related behaviors and health assistance (Riley, 1998). Holstein and Minkler (2003) suggest that the underlying values

and assumptions implicit in the term *successful aging* often exclude many older adults, particularly those with disabilities and impairments. By emphasizing the processes and determinants of adaptation, the focus shifts away from health paradigms grounded in preventing or limiting loss and targets the risk and protective factors that impact resilience despite experiences of adversity including loss.

Conceptualizations of Resilience

The concept of resilience began to be explored decades ago when researchers found varying experiences and outcomes among children exposed to significant and severe life adversities (Garmezy, Masten, & Tellegen, 1984). Individual differences in sensitivity to the environment, or susceptibility to environmental influences, have long been recognized in the research on risk and resilience in childhood (see Condly, 2006 for a review of literature). These differences may be influenced by “developmental level, ethnicity/cultural factors, previous trauma exposure, available resources, and preexisting child and family problems” (APA, 2008, para. 6). Cumulative studies have revealed that nearly all children and adolescents manifest some physiological and/or emotional distress in the immediate aftermath of traumatic events, yet the majority, particularly in the case of single-incident exposure, return to their previous level of functioning (Kumar, Steer, & Gulab, 2010). Through the studies on resiliency, vulnerable populations have been identified as at-risk for developing psychopathology later in life due to early-life adverse experiences.

Vulnerability is described as the “failure of resilience,” referring to the lack of personal and social resources available to individuals in response to adversity (Smith & Hayslip Jr., 2012, p. 7). Further, vulnerability is conceptualized as a continuum that combines individual characteristics (e.g., affective or emotional styles; Lavretsky, 2012) and life experiences (e.g., social location; Giovanelli, Reynolds, Mondi, & Ou, 2016) that threaten one’s ability to successfully cope with stress.

Risk Factors

Risk factors impacting vulnerability in older adults jeopardize the availability of personal and social resources from which to draw, which further increases the probability of distress throughout aging (Szanton et al., 2010). Acknowledged risk factors found to predict negative outcomes among older adults include, but are not limited to, age-graded events (e.g., death of a spouse or friends), declines in physical health, reduction in social support, and financial insecurity (Smith & Hayslip Jr., 2012). However, because risk is used to predict the likelihood of a specific outcome within a group, measurable group characteristics are determined without identifying which individuals within the group will experience that outcome.

Personal risk factors. Improved understanding of the neurobiological response to stress have found that resilient adaptation varies among individuals, resulting in a continuum of vulnerability to the effects of stress. Lavretsky (2010) reviewed existing research on resilience, stress, and neurobiology finding that exposure to trauma, even in resilient individuals, can result in the inability to return to homeostasis. Cumulative

biological research findings agree that each person is born with resilient potential, but this potential can change over time depending on the nature and chronicity of challenges being met and the individual response to these challenges (Albert et al., 2015).

Consistent evidence suggests that the role of genetics largely determines how sensitive or resilient an individual is to stressful stimuli, and these differences influence a person's resistance or adaptation to stress. Response to stressful events framed in terms of individual physiologic reactions show temporary upregulation in the hypothalamic-pituitary-adrenal axis, activating the release of neurochemicals to maintain stability that may be adaptive in the short run but damaging if not shut off when no longer needed (Lavretsky & Irwin, 2007). Decades of research indicate that the body's overactive or inefficiently managed stress response processes impair its ability to return to pre-stressed functioning and over time may lead to increased vulnerability (Gallo, Fortmann, & Mattei, 2014). Additionally, Gallo et al. (2014) found that exposure to stress influences the epigenetic modification of genes regulating the stress response, placing individuals at greater risk of being unable to resist or recover from stressors.

Researchers have voiced ongoing difficulty in identifying specific persons more likely to be vulnerable to stress, thus at greater risk of long-term negative outcomes, due to the heterogeneity in stress response; individuals' reactions to the same stressor appear idiosyncratic and dependent on personal as well as contextual variables (Diehl, Hay, & Chui, 2012). Stressful events have an immediate effect on a person's emotional

and physical functioning and additionally the potential to carry over with longer term effects on physical and mental health. When examining factors that impact reactivity to stress, researchers found person-specific characteristics, such as personality traits (e.g., neuroticism, pessimism) and self-concept (e.g., self-acceptance, self-efficacy), along with perceptions of control, to play an important role in reactivity to stress (Diehl et al., 2012). Theory and research suggest these person-specific characteristics to be relatively stable and trait-like but not invariant.

Age-related risk factors. Several studies have considered the role of age in reactivity to stress with mixed results. Birditt, Fingerman, and Almeida (2005) found older age to be associated with increased reactivity to stress in the domain of interpersonal stressors, and Neupert, Almeida, and Charles (2007) found no such relationship between increased reactivity when stressors were in the domains of home or work. Therefore, certain risk factors appear to be common among older adults in the context of specific domains and life events. Common risk factors among older adults include normative and age-related events such as the death of a spouse, death of friends, declines in physical health and functioning, financial insecurity, and the effects of ageism, many of which continue to increase throughout aging (Smith & Hayslip Jr., 2012). Older adults, by virtue of having lived many decades, have accrued experiences of functional, social, and role-related losses. Thus, in addition to age-graded risk factors, many older adults have accumulated experiences associated with alterations in the stress response such that increased sensitivity to stress results in a decreased capacity

to respond to future stress and an increased risk of later life health concerns, which add to stress load in older adulthood (Lavretsky & Irwin, 2007).

Diehl et al. (2012) stated that there are no universal generalizations that can be made regarding age-related factors, and they suggest that the number and chronicity of risk factors may be of greater significance than the variable type. Risk factors do not exist in isolation, thus multiple risk factors across the lifespan are significant in older adults when simultaneous losses and challenges are found in conjunction with age-related depletion of resources and age-associated diseases (Smith & Hayslip Jr., 2012). Interaction among personal and environmental differences appear to coalesce in an additive manner and contribute to the overall probability of a poorer response to resilient adaptation.

ACEs as risk factors. Childhood experiences, both positive and negative, have a tremendous impact on lifelong health and opportunities, and as such are an important issue. ACEs have been defined by the CDC (2011) as "childhood events, varying in severity and often chronic, occurring in a child's family or social environment that cause harm or distress, thereby disrupting the child's physical or psychological health and development" (para. 1). Prevalence rates of ACEs among randomly selected U.S. adults were analyzed by the CDC in 2009, and results indicated well over half of respondents reported having at least one ACE, and over 10% reported five or more ACEs (Bynum et al., 2010). Additionally, the CDC (2016), stated that most children with exposure to adverse childhood experiences are not identified and consequently do not receive any

help. Even those who are identified as in need of help frequently do not obtain any services, which increases poorer health outcomes in older adulthood.

The increased risk of physical and psychological diseases in older adulthood as a result of adverse childhood experiences has been recognized as important by researchers in multiple fields including medicine, epidemiology, psychiatry, psychology, and sociology because of the magnitude and effects in outcomes across multiple domains (Merrick et al., 2017). Foundational research has overwhelmingly demonstrated that ACEs are associated with subsequent psychological and physical health problems throughout the lifespan, including emotional problems, chronic diseases, risky health behaviors, and low life potential (Felitti et al., 1998). Subsequent research has found that early childhood adversities increase later risk of age-related diseases, adult morbidity and mortality, increased health-risk behaviors, and challenging psychological illnesses (Lavretsky, 2010). Thus, the impact of early adversity can be felt not only across individuals' lives, but also can have the potential to limit upward mobility and increase potential for intergenerational risk (Schofield, Lee, & Merrick, 2013).

Social location as a risk factor. Vulnerability in old age has been approached by identifying high-risk groups, including those for whom life course opportunities have not been equitable because of race, gender, socioeconomic status, area of residence, and education, to name a very few. Studies exploring the required sustenance for developmental opportunities in human ecosystems have found vastly different

outcomes for populations without access to proper support just as forests without support will likely have different outcomes than forests with support when their plant ecosystems are faced with adversities such as global warming, deforestation, and pollution (Cadenasso & Pickett, 2008).

The term social location, as used in this study, refers to the groups to which people belong based on their place or position in history or society (Okamoto & Rude, 2007). In particular, a person's social location is defined by, but not limited to, their gender identification, race/ethnicity, social class, educational attainment, age, ability, religion, sexual orientation, immigrant status, and geographic location. Group membership confers a certain set of social roles and rules, power, and privilege (or lack of), which heavily influence identity, not only by those who identify as members but also by those outside the group (Atkinson, 2013). The long history of systemic discrimination has led to inequities that intersect with one another, such as racism, sexism, poverty, and lack of opportunities, with the impact felt across generations (Lee & Chen, 2017). Since vulnerability is the outcome of complex interactions among exposure to threat and the lack of resources to effectively deal with the threat, historic and contemporary processes of discrimination that have increased the odds of exposure to social and economic disadvantage place an additional burden on marginalized populations (Lee & Chen, 2017).

Several studies have identified a disparity in prevalence rates among adult victims of ACEs associated with other factors related to social location. According to the

HHS (2014), the highest prevalence rates for ACEs as reported by race/ethnicity were among American Indian/Alaska Natives at over 40%, followed in order by Black individuals and Bi-/Multi-racial individuals, White individuals, Hispanic, Pacific Islanders, and Asian individuals. Austin, Herrick, and Proescholdbell (2016) found that LGB adults were one and a half to three times more likely to have reported ACEs than heterosexual adults. In similar studies, sexual minority adults have reported higher rates of exposure to multiple ACEs compared to heterosexual adults (Anderson & Blosnich, 2013; Brown, Masho, Perera, Mezuk, & Cohen, 2015). Research focused on prevalence rates of ACEs among adults who identify as having a disability indicates they were almost six times more likely to have experienced multiple ACEs when compared to participants without disability status (Schussler-Fiorenza Rose, Xie, & Stineman, 2014). The strong relationship between childhood exposure to adversity and later life physical and mental health problems, compounded by disparity in prevalence rates among vulnerable populations, paints a fuller picture of the increased risk in these older adults.

As a composite, prevalence rates of ACEs have implications for many social equality related measures. Racial health disparities in the US found in the continuation of racial segregation have been found to be associated with increased risk of illness and death (Williams & Mohammed, 2009). Wade, Shea, Rubin, and Wood (2014) investigated experiences of participants in an urban, low-income, and racially segregated setting who reported a disproportionate distribution of extreme levels of stress. These participants maintained that their disadvantaged community was relevant

in contributing to their own persistently poor health outcomes (Wade et al., 2014). Szanton et al. (2010) described the disparity in opportunities as differentially impacting individuals and groups, a critical part of conceptualizing factors impacting health disparities among older adults. Some identified challenges linked to health outcomes for at-risk groups include living in a safe environment free of fear (Thorpe et al., 2006); access to quality educational opportunities (Krovetz, 2008); geographic access to healthy food (Moore & Diez Roux, 2006); and social support, which are necessary resources throughout the aging process (Barnes, Mendes de Leon, Wilson, Bienias, & Evans, 2004).

Protective Factors

Protective factors have been defined as the specific attributes of individuals or situations that are necessary for the process of resilience to occur, linking exposure to hardship with the personal, environmental, and social resources that develop or maintain healthy adaptation (Dyer & McGuinness, 1996; Kocalevent et al., 2015). According to Cosco, Kaushal, Richards, Kuh, and Stafford (2016), the most salient protective factor affecting adaptation is an individual's resilient response to physiological, psychological, and social challenges in their environment. The APA (2017c) guidelines suggests that resilience is not trait-specific and focuses on strategies that enable or enhance resilience, including "behaviors, thoughts and actions that can be learned and developed in anyone" (para. 4). However, intra-individual differences have been found to exist in how people react to similar traumatic and stressful life events,

emphasizing the importance of examining individual attributes affecting the process and outcome of resilience in individuals and groups (APA, 2017c).

Resilient attributes as protective factors. According to Smith and Hayslip Jr. (2012), a conceptualization of resilience includes an "adaptive dispositional *attribute*" possessed individually in varying strengths, a "dynamic *process*" of adapting to and coping with change, and an "*outcome* derived from" the exposure to stress and adversity (Smith & Hayslip Jr., 2012, p. 5). Levetsky and Irwin (2007) identified personal characteristics that, while not considered wholly innate, are impacted by innate affective or emotional styles, which are a part of the personality structure. These characteristics have been identified as playing a crucial role in the physiological and psychological response to stress by utilizing personal and social resources to facilitate recovery from the negative effects of stress and maintain or increase positive adaptation in the wake of exposure to stress. Levretsky (2010) posited that one of the most prominent characteristics is temperament, which impacts sociability, intelligence, internal locus of control, and active engagement of emotional support within the familial network. Additional characteristics that are predictors of resilience, according to the APA (2017c), include the ability to tolerate negative affect and to regulate impulses and strong emotions.

Resilient processes as protective factors. Resilience, as a process of adapting well in the face of adversity, involves actions and behaviors that promote resilience. Conceptual frameworks that have been applied to gerontological research do not accept

a single definition for adaptation, but they reflect a diverse set of processes that interact with adverse life conditions to “reduce negative effects” (Wyman, 2003, p. 308). The heterogeneity of resilient response in multiple studies have offered researchers an opportunity to “shift from the ‘what’ questions of description to the ‘how’ questions of underlying processes that influence adaptation” (Masten, Best, & Garmezy, 1990, p. 439).

Examination of how individuals become more resilient as they cope with adversity suggests that some amount of stressors, which are not unrelenting or overwhelming, may offer adults the opportunity to develop and exercise coping skills; thus, under certain circumstances, facing adversity may play an important role in gaining resilience (Diehl et al., 2012). A study exploring the presence of resilience in older adults infected with the HIV/AIDS virus found the following themes to be important in their road to resilience: (1) self-acceptance, which is described as recognizing and utilizing one’s own strengths, and allowed participants to move forward with their lives; (2) optimism, which fostered their ability to look forward and set goals; (3) commitment to themselves and their own health, which reminded them of their own value and that their current lives have meaning; (4) altruism, which when expressed as concern for the well-being of future generations, gave them a sense of their own part in history that they could share; (5) relational living, which emphasized the value of social support; and (6) self-reliance, which underscored the way that some experiences, when faced alone, uncover hidden strengths (Emlet, Tozay, & Raveis, 2011). This study highlights how, by

employing resilience strategies, these older adults found strengths within themselves and their support systems to overcome adversity and optimize well-being.

Resilience and older adulthood. Aging can be stressful for many individuals as accumulated losses in health, independence, finances, and social support are faced. Some resilience constructs found in studies of oldest adults indicate three aspects of resilience linked to longevity, quality of life, and well-being: "robust personality," cognitive reserve, and perceived social and economic resources (Levretsky, 2012, p.50). Additionally, Diehl and Hay (2010) posit that the ways in which older adults think about themselves influence their reactivity to daily stressors and may be particularly important when facing age-related events such as disease, disability, and decline. According to Szanton et al. (2010), an individual's self-perception shapes their resilience potential and has been positively associated with psychiatric recovery and myocardial infarction recovery.

Resilience in older adults is associated with greater physiological and psychological adjustment when facing stressors (Levretsky, 2012), expanded cognitive functioning for problem-solving (Barnes et al., 2004), and enhanced emotional capacity to adapt to stressful events (Fontes & Neri, 2015). The outcome of psychological distress, physiological distress, illness, and disability that develop as a result of exposure to age-related stressors hinges on these resilient attributes.

Resilience and social inequality. The negative impact of discrimination on human development has long been recognized and examined in terms of resiliency

findings among individuals in marginalized groups. The APA (2017c) describes the development of resilience as a personal journey, but Unger (2015) suggests that resilience can only be understood in the broader context of support that relies on individuals' ability to access, navigate, and negotiate these supports and resources, which are not equally distributed. This approach to resilience includes not only overcoming adversity but also recognizing the disadvantages and inequalities that inhibit the development of resilience in vulnerable populations. These inequalities can overlap and intersect with one another, creating compounding experiences of adversity.

Racial health disparities in the US found in the continuation of racial segregation are associated with increased risk of illness and death (Williams & Mohammed, 2009). Sanders, Lim, and Sohn (2008) examined health resiliency among poverty-level Black families through the framework of environment (e.g., housing quality), community (e.g., social support), family influences (e.g., religiosity), and individual mental and physical health behaviors. These researchers found that when poverty could not be eliminated, improving personal and social environments fostered resilience that decreased harmful health effects (Sanders et al., 2008). Additionally, Sanders found that supportive social networks and church attendance buffered the negative effects of institutional discrimination and bolstered mental health. Of note, minority group status was found to be a positive predictor of well-being compared to majority group status and may reflect the possibility that psychological strengths are engendered in the face of race-related adversity (Ryff, Keyes, & Hughes, 2003).

Dentato et al. (2014) identified intra-cohort differences among LGBT older adults who experienced similar historical events (e.g., being labeled sick by health professionals, immoral by clergy, and unfit for service by the military) due to individual perceptions of support, expectations for acceptance or rejection, and perceived or actual experiences of discrimination. Past studies on resiliency within the LGBT older adult community found that many gay men and lesbian women who faced early life struggles have approached aging with unique resiliency and particular strengths (Butler & Hope, 1999). Furthering this finding, Butler (2004) asserted that coping skills developed through the coming out process such as managing social perceptions of “difference” throughout life and creating “families of choice” after rejections by families of origin (p. 32) may engender greater flexibility and adaptation in the aging process.

Outcomes

The meaning of positive outcomes within the context of resilience is complex because of the variance in personal and environmental risk factors and their interaction across multiple domains throughout the life course. Resilience plays an important role in outcome by influencing an individual’s success in recovering from adversity and sustaining healthy functioning in later life, yet the very process of coping with adversity appears to be a relevant factor in creating resources for resilience (Aldwin & Igarashi, 2012; Manning, Carr, & Kail, 2016). Emerging evidence exploring how older adults cope with age-related stressors reveals that adjustments in social and emotional functioning, despite previous experiences of adversity, counterbalance the effects of age-related

losses (Charles & Carstensen, 2012). Researchers in the area of resilience have suggested that there are multiple factors leading to healthy outcomes while acknowledging that variability in the value or importance of a factor is often contextual, situational, and individual (Earvolino-Ramirez, 2007). Many of the studies reviewed acknowledge that factors present or beneficial for one person and lead to healthy outcomes may not be present or beneficial for a similar individual (Johnson & Wiechelt, 2004). Additionally, resilience researchers acknowledge a range of outcomes in recovery from the negative consequences of adversity, suggesting that resilience is not an "all-or-nothing" phenomenon (Smith & Hayslip Jr., 2012, p. 12).

Considering the complexity of individual factors, several determinants have been acknowledged as important for positive outcomes, including a recognition of internal personal strengths (e.g., positive self-view, commitment, openness to change) and external resources (e.g., friends, vocation, family, and faith), which enable individuals to identify and work toward meaningful goals (Levretsky, 2010). Many of these determinants, such as self-determination, flexibility, and a sense of purpose have also been found in studies on the intersection of aging and creative expression (Cohen, 2006). Exploring the impact of the arts in the lives of older adults has shown a strong relationship between the benefits reported when participating in creative activities and aging well (Fisher & Specht, 2012). Specifically, stories and storytelling, as a creative activity, is linked to positive outcomes following adverse events, offering potential cathartic and therapeutic benefits (East, Jackson, O'Brien, & Peters, 2010).

Creativity, Aging, and Storytelling

Cohen (2006) described how he was stirred by research that focused on avoiding the negative changes related to aging, which was conceptualized as the inevitable. In response, Cohen et al. (2006) conducted research over a 2-year period that measured the impact of participation in professionally conducted and community-based arts programs on the physical health, mental health, and social activity involvement of individuals aged 65 years and older. Results revealed significant positive intervention effects in overall physical health as measured by a decrease in number of doctor visits, a decrease in medication usage, and a decrease in reports of depression (Cohen et al., 2006).

Fisher and Specht (2012) described creative activity as a process where individuals seek novel solutions to challenges and are open to new ideas, which promote problem-solving skills and increase adaptive abilities. Engaging in the creative process appears to facilitate practical creativity in other areas of life such as coping with the difficulties by trying different techniques (Fisher & Specht, 2012). Self-expression and communication, which promote healthy growth and development, are benefits of creative activities and contribute to successful aging when carried into later life (Cohen, 2006).

The Aging Narrative Self

Carr (1991) stated that “in the complex actions and experiences of everyday life we are subjects or agents, narrators, and even spectators to the events we live through

and the actions we undertake" (p. 7). What people find meaningful about themselves and their world is given expression through stories, narratives, and autobiographies (Kenyon, 1996). Narratives become especially important in understanding how older adults interpret their most difficult life experiences and how they integrate them into their identity.

As exposure to age-related changes and losses increase throughout the life course, individuals may become more invested in finding meaning rather than information about themselves and their world, which constitutes a shift from knowledge attainment to emotional gratification (Robertson & Hopko, 2013). The emotional aftermath of stressors can seriously threaten their interpretation and meaning, and studies have shown that an inability to move past a difficult experience is associated with negative affect and poor emotional health (Bauer, McAdams, & Pals, 2008; King & Raspin, 2004). Personal focus on the biographical sense of aging rather than the biological, and older adults who participate in storying their experiences report the positive potential of "getting old rather than growing old" (Kenyon, 1996, p. 24). One important identity process in older adulthood is the construction of a well-integrated and complete story of a difficult life experience that concludes with a positive ending and emphasizes how emotional well-being was restored (Pals, 2006).

Social Construction of Personal Past

The process of constructing one's life story is an everyday phenomenon, as people participate in activities, think about their own perspective on these activities,

and consider how others might perceive these same activities (Fisher & Specht, 2012). According to Rodin and Salovey (1989), old age is best understood in broadly construed relational terms: relating to one's own cultural attitudes and practices, which acts as a context for current expectations and experiences of the aging process and relating to upcoming generations with their own cultural priorities, which points to elders' attitudes regarding the importance and value of the aging process.

Pasupathi (2001) described how the mechanisms by which older adults socially construct their world are influenced by conversational reconstructions of past events. Because the life story is constructed from significant memories, "conversations about our pasts are a way that the social world can migrate from an abstract social context toward a destination in the center of our identity and at the core of our relationships with others" (p. 670). Narratives and stories reflect the way the world is experienced by individuals, and personal storytelling is from a particular point of view that was created by historical, economic, family, emotional, and cultural contexts (Kenyon, 1996).

The Impact of Storytelling

As a creative activity, storytelling uniquely connects the teller and the listener by providing insight into how individuals have overcome adversity through offering their personal experiences and insight (East et al., 2010). Stories represent a vital form of communication through which people share and give insight by relaying messages, experiences, and knowledge, and this often reveals differences and similarities between people's experiences (East et al., 2010). In fact, personal accounts, through stories or

narratives, are the focus of phenomenological research, and the basis for research aimed at greater understanding of the human experience.

According to Frank (1995), personal stories carry individual meaning and perceptions, because individuals emphasize or diminish parts of the story to prevent themselves from being seen in a negative light. Research in resilience literature indicates that personal stories have the potential to generate adverse effects through the recall of distressing events, yet other findings suggest that sharing these stories can help develop personal resilience by gaining new perspectives, increasing understanding, or making sense of stressful events (Cowling, 2005; Dean, 1995). Storytelling is not limited to gaining knowledge and understanding of life events, its impact is felt in the affirmation and validation of both lives and experiences, with the ability to connect people with themselves, with others, and with society (Atkinson, 2002). Stories represent or contain the key to human emotions, relationships, beliefs, and identity—who we are and how we live and have lived. Kenyon (1996) described personal storytelling as a “present phenomenon that involves a past and a future; an interpretation in the present which may reflect a reinterpretation of the past in light of present circumstances and future projections” (p. 32), which links memories and aging with the potential to re-story and prepare for the future.

Summary and Rationale for the Current Investigation

Summary

A review of the literature on aging in the US shows that the growth in population of older adults is one of the most significant demographic trends in U.S. history both in size and status (Colby & Ortman, 2014). The aging of the baby boomer cohort is also noteworthy because its membership reflects wide disparities in economic and physical welfare both by gender and across racial/ethnic divides, as well as in other determinants of social location, which has important social, economic, and health implications as these factors have been shown to affect individuals' capacity to resist or recover from life stressors (Mather et al., 2015).

Varied theories of human aging and development such as biomedical approaches, which emphasize the absence of disease and maintenance of physical and mental functioning, and psychosocial approaches, which focus on social functioning and participation, life satisfaction, and adaptive ability, link future outcomes with earlier experiences (Bowling & Dieppe, 2005). However, individual and differing trajectories in adaptive responding to stressors have led to interest in the characteristics of resilience, both traits and processes, and its association with aging well (Szanton et al., 2010). Multiple studies have reviewed risk and resilience, considering the complexity of factors with the goal of understanding stress and coping processes as they unfold in the lives of diverse older adults (Merrick et al., 2017). There is much that has been published on the

characteristics of resilience, and the APA (2017c) has published guidelines to help develop and enhance resilience.

Studies that explored creativity and aging have found that older adults who participated in creative activities reported an increase in several factors associated with resilience and aging well, such as sense of purpose, meaningful social interactions, self-acceptance, autonomy, and personal growth (Cohen, 2006; Fisher & Specht, 2012). Storytelling as a creative expression has the potential for making sense of past distressing or traumatic life events and integrating them into the present—finding the significance of negative events in the development of resilience (Kenyon, 1996). Stories, when shared, have the potential to bring about strength and healing to the tellers through increased personal insight, acknowledgement of positive outcomes in the face of adversity, and recognition of the complexity and uniqueness of their individual lives (Fisher & Specht, 2012).

Rationale

Assessing resilience continues to lag in the aging research compared to research into the determinants and role of resilience in older adulthood (Wagnild & Collins, 2009). Additionally, differences in societal attitudes on the aging process itself suggest the importance of exploring resilience in the lives of diverse older adults from the perspectives of their culture, life history, and individual circumstances as a way to understand unique health outcomes in later years. Furthermore, fewer than 10 prior researchers were found to have examined the process of narrative storytelling as it

relates specifically to older adults. Studies in narrative gerontology have explored the impact of storytelling by older adults as a therapeutic intervention and have found potential healing benefits such as enhanced resilience (e.g., East et al., 2010; Kenyon, 1996). However, East et al. (2010) indicated that there is a link between the storyteller and the listener in the cases of narratives shared in support groups or with caregivers, which likely impacts the nature of what is shared and the effects of the sharing. This study explored original stories of personal experience previously communicated by older adults and offered publicly online to determine if resilience was thematically evident in the narrative. It adds to the discussion on the phenomenon of resilience as experienced by diverse older adults in the US through the exploration of the qualities and processes of resilience or resilient adaptation as communicated in these personal narratives.

Research Question

One principal research question was used to guide this study: What are the essential experiences of older adults who choose to publicly write or talk about their experiences of resilience after adverse life events?

CHAPTER III

METHODOLOGY

Rationale for Qualitative Method

Poet M. Rukeyser (1968) imagined that “the universe is made of stories, not of atoms” (lines 56–57). Patton (2015) reminds us that imbedded within storytelling lies the “in-depth, individualized, contextually sensitive understanding” of human attitudes and experiences (p. 7). Qualitative research seeks to explore and describe experiences, both explicitly and implicitly, communicated by individuals in order to find their essence or essences (Patton, 2015). The value in using a qualitative research method is in its ability to gain a first-hand experience of individuals through “truthful reporting of actual conversation” (Husserl, 1962/1977, p. 252). Additionally, Morse (1994) described qualitative research as involving “an interpretive naturalistic approach to the world” (p. 3), which does not place prior constraints on the outcomes of the research data. The value in using a qualitative research method is in its ability to gain a first-hand experience of individuals through “truthful reporting of actual conversation” (Husserl, 1962/1977, p. 252).

According to Patton (2015), phenomenology is an approach to the qualitative research method that allows the researcher to focus on the direct investigation of the meaning, structure, and essence of the phenomenon of interest, such as the lived

experience of a person or group of people. The single research question of this study—What is the essence of resilience in older adults as a positive outcome after adverse life events—was innately phenomenological because it assumed the presence of essence or essences to the experience of resilience as well as a systematic way in which to understand this essence (Moustakas, 1994). Thus, phenomenology provided the opportunity to come as close as possible to the meaning and experiences of resilience in older adults, both intellectually and emotionally.

Researcher Qualifications and Biases

Researcher qualifications. Miles, Huberman, and Saldaña (2014) note the importance of addressing the researcher's qualifications when conducting qualitative research. The purpose of this study was to examine resilience in older adults who convey stories containing positive outcomes after adverse experiences. Throughout my coursework and training in graduate level counseling psychology programs, I developed a deeper understanding and sensitivity to the concerns of diverse populations within their social and cultural contexts. This knowledge and sensitivity has been beneficial as I completed multiple semesters of practicum placement—first at a community health care facility where I worked with older adults referred for therapeutic and practical living support by the Texas Department of Assistive and Rehabilitative Services (DARS); second at a family advocacy center, where I formed trusting relationships with low income individuals and families and provided therapy aimed at moving through adversities with adaptation and personal adjustment; and third at a university

counseling center where I worked with a diverse population including individuals from historically targeted/marginalized populations. Working with these clients has given me the opportunity to develop skills in identifying themes in psychotherapeutic interviews that will be of benefit during the analysis phase of the study.

My graduate work also included the completion of a series of research design and statistics courses covering quantitative methods, a research-based thesis equivalency, a graduate class in qualitative research methods, which included a class project, cross-coding experience on two peer research projects in addition to my own qualitative research, and additional research team experience. In research projects, I examined topics and populations related to my dissertation. My qualitative class project explored experiences of older adults in an acting group as a pilot project for my thesis equivalency. My thesis equivalency expanded on the original research using a phenomenological framework to explore the lived experiences of five older adults who participate in an amateur theatre group as a leisure activity (Nevin & Harris, 2017). The experience of completing these research projects provided me with experiential knowledge about qualitative philosophy, methods, and analysis. Also, I gained familiarity with current aging literature and how this study might contribute by providing insight into the prevalence and importance of resilience in older adults through descriptions of positive outcomes after adverse experiences.

Researcher biases. Patton (2015) recommends that qualitative researchers engage in reflexivity, so that the researcher can work to maintain credibility by

intentionally disclosing biases, expectations, and knowledge of this field of study. Giorgi (2009) refers to this step as "assuming the correct attitude" (p. 127) through the bracketing of the researcher's own assumptions regarding the phenomenon of interest. Throughout my doctoral program, I have been encouraged to identify biases and clarify my personal world view through concentrated self-exploration. I am a 64-year-old White woman and a doctoral candidate in an APA accredited counseling psychology program. Self-determination is a personal value that led me to begin my post-high school education after 25 years as a stay-at-home mother and home-educator of my five children. As a clinician, my theoretical orientation includes aspects of relational-cultural theory, which explores the complexity of intersecting cultural and social identities, privileges each client's perspective, and sees each client as capable of moving toward strength-based change by fostering personal and interpersonal empowerment (Jordan, 2010).

As a doctoral candidate and emerging psychologist as well as a member of the baby boom generation I am personally and professionally interested in exploring the experiences of resilience in older adults due to the correlation between resilience and aging well (Levretsky & Irwin, 2007). I value the roles that agentic autonomy, self-determination, and self-motivation play in how individuals make life choices while acknowledging the ways individuals are affected by the relationships and experiences they have encountered. I have found that the concepts of agentic autonomy and self-determination are derived from a predominantly U.S. mindset that values movement

away from dependence so that individuals might enjoy greater personal freedoms and take greater pride in individual accomplishments (Kitayama, Park, Sevincer, Karasawa, & Uskul, 2009). This is evident in my own life choices, particularly the choice to enter a doctoral program in my late 50s.

The personal relevance of this topic had the potential to limit or skew my interpretation of results due to my own biases. For example, I expected to find that stories told by diverse older adults would likely have attributes positively associated with human resilience, such as the recognition and acceptance of negative past experiences, awareness and acknowledgement of personal and social resources that contributed to overcoming these adverse experiences, and the desire to share their stories to make peace with the past and prepare for the future. Thus, it was necessary for me to address these possible limitations in order to minimize the impact of my biases and personal experience on the data, which I describe with the data analysis.

Overview of Method

The data for this study came from stories conveyed by older adults that were recorded and archived as well as stories written and found online. Before I could concretize my study and determine a method of analyzing stories conveyed by older adults, I needed to confirm that there were available recorded and online sources for stories communicated by older adults. One of the potential challenges I anticipated involved the accessibility of the internet by older adults as a means of expressing thoughts and opinions. Additionally, Lenhart and Fox (2006) suggested that the open

platform of online platforms could potentially generate unreliable or manipulative content. However, there was also evidence for rich personal descriptions of people's lived experiences through online sources (Wilson & Nicholas, 2008).

Online search engines are research tools that provide Internet users with access to important information by directing them to links to available sources of interest (Wilson & Nicholas, 2008). Among the top three most-used search engines, Google Chrome was chosen because it accounts for 70% of the search engine market, offering the most online sources for rich personal descriptions of people's lived experiences (Dwyer, 2016; Wilson & Nicholas, 2008). Using the Google Chrome search engine, I searched with key words *older*, *adult*, *blogs*, and *stories*. This search led me to websites reviewing blogs written by and for older adults. Also, while listening to NPR, I became aware of the StoryCorps, a national project inspiring people to record stories in sound (StoryCorps, 2017). StoryCorps narratives are digitally archived and available online. Scanning the content of both blogs and recorded stories, I found several data sources available that would provide examples of resilience. The activity of writing a blog or narrating personal stories and first-person events generates a platform for personal information that in the past would likely have been unattainable for research (Lenhart & Fox, 2006). This initial exploration allowed me to envision the project as well as to ensure that data sources would be available.

Sampling

I employed a purposeful sampling strategy, which entailed the selection of information-rich cases for analysis so that the deepest layers of meaning emerged, as well as criterion sampling, which set specific selection criteria (Patton, 2015). Cases were selected from internet blogs and recorded narrations based on two criteria, age of author and content of story. Stories selected were first-person accounts conveyed by adults over the age of 65 years, which is the age accepted as the beginning of older adulthood by much of aging research (Mather et al., 2015) and by the APA Office of Aging (2017b). Stories that did not identify the age of the author or were communicated as a second-hand account were not included. Also, all stories described or illustrated the phenomenon of resilience after adverse experiences. For the purpose of sampling, I used the APA ("Resilience," n.d.) definition of resilience, which is "the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands" (para. 1). An additional consideration for sampling selection was for stories to have been conveyed by a diverse selection of older adults. As highlighted throughout the review of literature, the U.S. older adult cohort is a very diverse group, with disparities in health risks and behavior, economic status, and family/living structure (Mather et al., 2015). Because of these inequalities, it was important to include as varied a sample of cases as possible in terms of social location. This kind of maximum diversity

sampling is also considered a good strategy for strengthening conclusions in qualitative work (Patton, 2015).

In seeking stories that expressed resilience and were communicated by older adults, I focused on forms of social media found online and currently used widely throughout the world and here in the US including weblogs (blogs) and recorded personal narratives (Lenhart & Fox, 2006). After receiving Institutional Review Board approval, I used the Google Chrome search engine to find electronically submitted stories communicated in written and/or oral format by older adults that met the criteria for analysis. All stories were by definition in the public domain, making informed consent a non-issue. I selected cases from internet blogs and recorded narrations based on two criteria, age of author and content of story.

Procedure

I began my search using the key words *older*, *adult*, *blogs*, *narratives*, and *storycorps*, which directed me to website links with content about and/or by diverse older adults. The first site I accessed was NPR's *StoryCorps* website, which organized their recorded stories in the following specific collections: Griot–Interviews about African American Life, Stonewall Outloud–Preserving and Celebrating the Stories of LGBTQ, Historias–Life Experiences about Latina/Latino People in the United States, Justice Project–Stories of People Impacted by Mass Incarceration, Crossing Over–Immigration Stories, and Military Voices Initiative–Platform for Veterans, Service Members, and Military Families. In addition to NPR's *StoryCorps* website, I found written

stories communicated by diverse older adults through the following sites: *The Living History Project*, *Freedom for All Americans*, and *Diverse Elders*. I read or listened to all stories found on these three sites to determine if they met study criteria for age, firsthand accounts, and whether resilience was thematically evident in the narrative. When relevant cases were identified, I printed out stories communicated in written form and transcribed stories recorded in oral format. I found a total of 18 possible stories, which I noted on a document summary form (see Appendix A). After reviewing each of the 18 stories, I found three stories that did not meet the age and/or thematic criteria, thus a final total of 15 stories were collected and analyzed before saturation was reached. Saturation is defined as the point in data collection when new data is no longer bringing additional insights to the phenomenon being studied (Patton, 2015), which occurred when both my cross-coder and I found that data were not leading to any new emergent themes.

Cases/Stories

Storyteller information. The final analysis includes data from the stories of 15 older adults expressing resilience after adverse experiences. Table 1 presents storyteller demographics from the 15 total stories included in the current study. To summarize, six storytellers are cisgender females, one is transgender female, and eight are cisgender males. Ages range between 65 and 96 years old. Racial/ethnicity variables include five White, four Black, four Asian, one American Indian, and one Hispanic. Twelve storytellers identify as heterosexual and three as gay.

Table 1

Storyteller Demographics

Pseudonym	Age	Race/ ethnicity	Sexual orientation	Gender identity	Additional diversity factors
Ray	96	White	Heterosexual	Cis/M	Childhood poverty/WWII POW
Klara	90	White	Heterosexual	Cis/F	Jewish/ holocaust survivor/immigrant
Harold	66	White	Gay	Cis/M	HIV/AIDS survivor
Jed	95	Black	Heterosexual	Cis/M	Blind/severe hearing loss
Sahar	80	Asian	Heterosexual	Cis/F	MD in refugee camp, immigrant to US (Pakistan/Bangladesh)
Stella	65	Black	Heterosexual	Cis/F	Parent of child with fragile bone disease
Dale	76	Black	Heterosexual	Cis/M	Teen social justice activist
Walter	69	Black	Heterosexual	Cis/M	Forced integration in all-White HS
Elspeth	66	White	Heterosexual	Trans/F	Young adult gender reassignment
Kumari	82	Asian	Heterosexual	Cis/F	Childhood poverty, immigrant to US (India)
Mathew	78	Asian	Gay	Cis/M	Japanese internment Camp Survivor
Bill	73	White	Gay	Cis/M	Victim of anti-gay harassment
Letti	72	Native American	Heterosexual	Cis/F	Childhood sexual abuse, military veteran, alcoholism
Calla	78	Asian	Heterosexual	Cis/F	Single mother, immigrant to US (Philippines)
Diego	84	Hispanic	Heterosexual	Cis/M	Childhood poverty, limited education

Data Analysis

For this study, I used a phenomenological approach to gain a deep understanding of the nature and meaning of resilience described by older adults as positive outcomes after adverse life events. Phenomenology stems from the work of philosophers such as Husserl (1962/1977), who sought to study how people describe and make meaning of what they experience through their senses. The guiding theme of phenomenology is to go “back to the things themselves,” which provides the opportunity to come as close as possible to participants’ experiences (Husserl, 1962/1977, p. 252).

Philosophical basis. I used Giorgi’s (1997) descriptive phenomenological approach to guide my procedural strategies and to extract meaning from the data. Giorgi closely follows Husserl, observing the description and interpretation that coexist in Husserlian phenomenology. In Giorgi’s (2009) descriptive phenomenological method, there are both descriptive moments and interpretive moments. In the descriptive moments, the full lived meaning of the experience is described, while interpretive moments include only that which “relates to implications of the results” (p. 127). Giorgi (2009) cautioned the researcher to use great care when attending to these different acts.

One concept that is unique to phenomenological research methods is epoché. Giorgi (2009) refers to this step as “assuming the correct attitude” through the bracketing of the researcher’s own assumptions regarding the phenomenon of interest

(p. 172). In this way, the researcher attends to the descriptions as expressed without forcing meaning into pre-defined concepts or categories. Although individuals such as Creswell (2009) and Patton (2015) have noted that this state is difficult to achieve fully, I took steps to initially bracket, or set aside, my biases as discussed earlier.

Steps in analysis. To bring phenomenological descriptive analysis to life in a concrete manner, Giorgi (1997) suggested five steps: (1) gathering narrative data, (2) reading the data, (3) breaking the data down into parts, (4) organizing the data to a unified perspective, and (5) summarizing the data for the scientific community. In keeping with Giorgi's (1997) steps of qualitative inquiry, I began the research process by personally collecting data as described earlier. I utilized my established criteria, definitions of criteria terms, and previous knowledge from the literature to understand what participants were trying to convey as a means of determining whether each story met the content criterion for analysis.

Next, I transcribed the data conveyed orally and read through all transcriptions. Each transcribed story and each written blog was read through in its entirety to get a better sense of the whole situation in which the experiences occurred. Moustakas (1994) described how the researcher enacts this step by reading the data and initially considering each statement with respect to the topic of study. Throughout this initial reading of the data, I remained open and kept a curious stance in relation to the data. I wrote margin notes and reflected on what was emerging from the initial reading, a

process that is consistent with assuming the correct attitude and revisiting bracketed biases.

The third step in data analysis is breaking down data into parts by reading the data carefully and marking places in the data in which shifts in meaning are detected. Giorgi (1997) suggests the use of "meaning units" (p. 251), units of information that capture a relevant theme in the narrative. In this step I examined the data for patterns and themes without preconceived analytical categories, while remaining open to ideas as they emerge from the data (Patton, 2015). I kept track of meaning units through a code book, in which I organized all meaning units and their supporting verbatim material. I consulted with my dissertation chair regarding ideas I had about themes, patterns, and other analytic hunches as they arose and detailed them in analytic memos. Analytic memos are write-ups or mini-analyses about what the researcher is thinking about or learning during data collection and evaluation and help flesh out concepts and patterns that may be emerging in the data (Saldaña, 2015). According to Patton (2002), recording and tracking insights as they occur during data collection is the beginning of qualitative analysis and vitally important because there is no guarantee these insights will be remembered if not recorded as they occur.

The fourth step taken was to organize the units of meaning into language that is consistent with psychology. After a single description was broken down into separate units, each unit was reduced to the essential or universal essence of the phenomenon to get a sense of the lived meaning of each description. Giorgi (1997) noted that the

number of themes and essences can vary depending on the phenomenon and the amount of data collected; the data do not need to be constricted, as there is freedom for essences to emerge as they arise from the data. I considered each meaning unit and what was being expressed, relating each to what is known about resilience in general. This step was systematically documented as the process unfolded.

Finally, I summarized the data into a depiction of resilience that included seeing the data from a psychological perspective (Giorgi, 1997). This final structure is meant to serve as an ideal representation of older adults' expressions of resilience (Giorgi, 1997), which I communicated in language suitable for the discipline. I employed NVivo, a computer software program designed to support qualitative research, to organize, manage, analyze, and display the data obtained (QSR Int'l, 2012). I consulted with the Center for Research Design and Analysis (CRDA) at Texas Woman's University and my dissertation chair throughout the process of using NVivo for structuring the data and interpreting output.

Credibility and Trustworthiness

In qualitative research, evidence for asserting the credibility of the data is viewed from the perspective of phenomenological epistemology. In quantitative inquiry, both reliability and validity suppose that there is a truth to be known and that results should be consistent and generalizable (Lincoln & Guba, 1981). However, qualitative methodology in general, and phenomenology more specifically, allow for multiple meanings in various contexts. Instead of reliability and validity, qualitative methods

examine whether the data analysis is credible and trustworthy (Lincoln & Guba, 1986). In order to maintain credibility and trustworthiness of the data, two triangulation methods were used: analyst triangulation and data source triangulation (Patton, 2002).

Triangulation. From a phenomenological perspective, triangulation allows for the data to be viewed from different perspectives in order to discover the essences of the phenomenon (Husserl, 1977). Analyst triangulation is the use of multiple analysts to examine the data (Patton, 2015). By using multiple analysts, potential biases are reduced, and more consistent themes can emerge from the data. I obtained the help of another analyst, a counseling psychology graduate student who also had taken the qualitative research and methods course. After we both independently enacted Giogori's Steps 2–4 with the data, I considered this analyst's investigation of the data's meaning units with my own to reduce potential biases in my own analysis. This triangulation method resulted in intercoder agreement on the coding of resilience, allowing for more credible and consistent results (Patton, 2015).

Data source triangulation refers to the use of multiple methods or data sources in qualitative research to develop a comprehensive understanding of phenomena (Patton, 2015). I examined data from multiple cases collected from online sources. These sources featured written or spoken first-person accounts of resilience after adversity. I also considered the unique and valid world view of each storyteller to find similar themes and patterns within very different circumstances.

As noted earlier, throughout the project, I kept track of analytic memos, documenting my reflections and thoughts about the research process. These steps assisted me in keeping the essences and meanings that emerged from the data as close as possible to the descriptions of resilience, consistent with the goals of phenomenology. As dominant themes emerged, I reviewed stories for disconfirming evidence and unanticipated outcomes as they emerged and made note of unique or conflicting experiences as they related to overall themes that were being developed (Miles et al., 2014).

CHAPTER IV

RESULTS

Analysis of Results

The narratives provided by storytellers express adverse experiences of trauma, violence, abuse, neglect, harassment, and discrimination either personally witnessed or experienced first-hand. Events described by storytellers occurred in multiple settings—temporal, geographical, societal, and personal. Examples of settings include wartime periods, the civil rights movement, medical events, and home-life environments. Storyteller expressions depict attributes, resources and behaviors of resilience or resilient adaptation that occurred prior to, during, and in the wake of their adverse experiences.

Using Giorgi's (1997, 2009) phenomenological approach to analyze the data, a total of 128 meaning units were identified after a careful reading of transcriptions. These meaning units were grouped into 24 codes that presented a broader concept of the phenomenon. Finally, each code was further grouped into one of three main themes. Each code was endorsed by at least two of the storytellers. Table 2 provides a delineation of themes with their contributing subthemes and codes.

Table 2

List of Themes

Theme 1: Personal Attributes
1.1 Emotional/Affective Styles
1.1.1 Gratitude
1.1.2 Hopefulness
1.1.3 Compassion
1.1.4 Pride
1.2 Thought/Cognitive Styles
1.2.1 Self-Esteem
1.2.2 Resourcefulness
1.2.3 Inner Strength
1.2.4 Positive Outlook
1.3 Personal Abilities/Skills
1.3.1 Self-Determination
1.3.2 Perseverance
Theme 2: Social Resources
2.1 Family/Friends
2.1.1 Positive Childhood Experiences
2.1.2 Positive Role Model
2.1.3 Validation
2.1.4 Support by Others
2.2 Group Identity
2.2.1 Belonging
2.2.2 Shared History
2.2.3 Camaraderie
2.2.4 Mutuality
2.3 Faith/Spirituality
2.3.1 Connection with Higher Power
2.3.2 Aspirational Values
Theme 3: Actions/Behaviors
3.1 Pro-Social
3.1.1 Giving Back
3.1.2 Altruism
3.2 Agency
3.2.1 Goal Seeking
3.2.2 Adaptation

According to Miles et al. (2014), credible and trustworthy analysis requires the investigator to organize data in such a way as to be able to “focus on multiple variables at the same time for readily analyzable information at a glance” (p. 111). A conceptual map offers a visual representation of data to see and interpret comparisons, differences, patterns, and themes. After reviewing themes, subthemes, and codes, I visualized the relationship between expressions of resilience and the time in which they occurred in the life of the storyteller by mapping them out in a display. Figure 1 provides a conceptual map in which each of the codes in Table 2 is positioned in relationship to the time in which adversity was experienced.

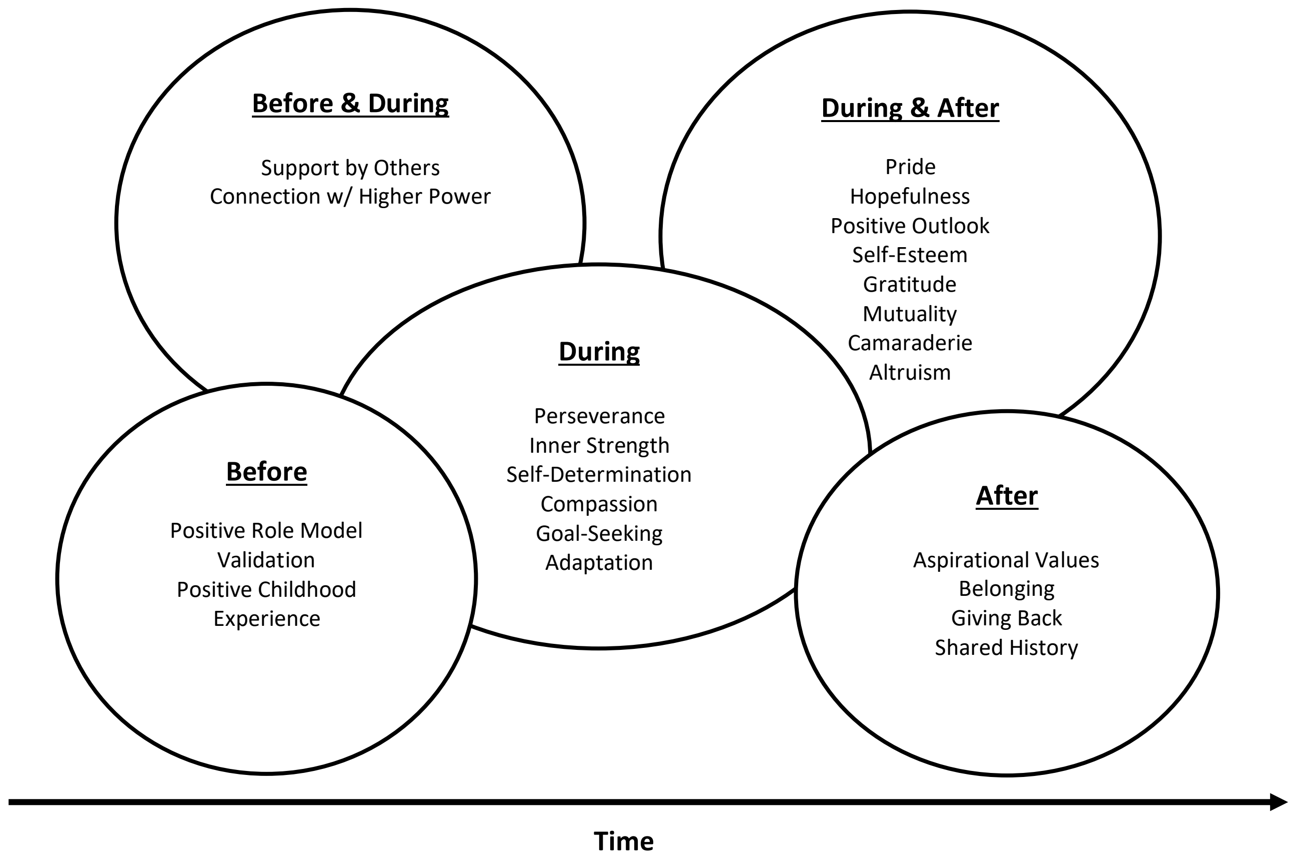

Figure 1. Visual representation of attributes, resources, and behaviors of resilience or resilient adaptation that occurred prior to, during, and/or in the wake of adversity.

Theme 1: Personal Attributes

1.1 Emotional/Affective Styles

Theme 1 reflects personal styles and abilities revealed by storytellers that expressed a range of emotional, mental, and behavioral flexibility in response to the internal and external demands of adversity. Emotional or affective styles expressed by storytellers include gratitude, hopefulness, compassion, and pride, which occurred both during and after adverse experiences.

1.1.1 gratitude. Storytellers expressed various experiences of gratitude that described an appreciation of what was valuable and meaningful to them as well as an emotional response to receiving something good that feels undeserved. For Harold, gratitude was expressed after years of witnessing the invasion of acquired immunodeficiency due to HIV/AIDS upon his community and ultimately his own body, confining him to a wheelchair. Harold stated:

> One of the things I've always loved about San Francisco is the abundance of naturally blooming flowers during every season, even the dead of winter. Flowers that I might have overlooked—literally, looked over—from a standing viewpoint now grab my nose's grateful attention. I can reach out and brush my hand through the flowers, enjoying their fragrance from much closer than when I walked.

Jed, who was born blind and with severe hearing loss, had limited educational opportunities yet learned to read books in braille to "learn to ways of life." Recording with his eldest daughter, Jed described his experience of parenting his sighted and hearing children, "I was so glad you were born. I cannot express the way I felt when I held your sweet little body." Although Diego grew up in a migrant labor family and with little education, he expressed feelings of thankfulness:

> I think I've had a wonderful life; to me I think I'm blessed. And all my kids are doing good, one's a painter, one works for the sheriff department … I have a pretty good house size here … one of the reasons that I built it is all the

> neighbors used to come around when my kids were young. We used to have the whole neighborhood come over here on stay overnight or on the weekends.

1.1.2 hopefulness. Several storytellers shared experiences of hope as the expectation of a positive outcome from a negative situation, often to cope with significant stresses. Dale, a Black man who participated in civil rights demonstrations as a youth, shared his hope for the future as he reflects on experiences of discrimination:

> Word spread throughout the neighborhood. And that's when they started gathering around. This child … took his finger and pointed to me, like, 'get out, you know you are not wanted here.' I could only hope as he got older, some of his attitudes regarding equality and equal rights would change.

As a child, Mathew suffered forced incarceration in a concentration camp with his Japanese American parents. Speaking after decades of fighting for social justice, Mathew shared, "… as I add on a few years, I hope the wisdom I continue to gain by supporting different communities and different movements will remain an important tool in the work I do." Harold described a hopeful future gained from his and other long-term HIV/AIDS survivors, "We have harnessed our experience and our knowledge to combat the virus's damage today and to prevent it's spread tomorrow."

1.1.3 compassion. Several storytellers expressed strong feelings of sympathy with another person's feelings of sorrow or distress, which often prompted a desire to help or comfort that person often at some personal cost to themselves. Kumari expressed her response to her own childhood experiences of extreme poverty,

restrictions for women, and political instability in her small village as India struggled through its independence stating, “Every day was a crisis without enough money … I would cook for poor kids who didn’t have anything to eat. I’d feel sad for them.” With her grown daughter present in the interview, Stella recalled an earlier time with her daughter in the hospital, sharing that she was told by the doctors to go home because “… you would probably die during the night … your skull was fractured, your arms, your ribs, your legs … but there was no way that I was going to leave you there.” Despite finding out that her father had died “within the first half hour at Auschwitz,” Klara chose not to share her grief with her mother and sister until after they were released stating, “… why would I tell you? To make your life more miserable? I kept that secret all that time; I didn’t tell anybody.”

1.1.4 pride. Several storytellers described a positive self-conscious emotion that occurred during or as the result of their accomplishments. Dale reminisced:

> Today when people read my name, they may not know who I am, and most likely won’t. I have three grandkids; they aren’t the least bit interested. But any time I pick up a historical publication, I feel as if a period or a comma in that book is my contribution.

Despite experiencing hardship, Kumari declared:

> I became a teacher and taught primary school from first to seventh grade. I liked teaching the small children in the first grade. The kids loved me, and everyone

> gave me a lot of respect. Some parents would come to the school and insist that they wanted their child to be in my class.

Because her grandfather advocated for her to be educated, Sahar was admitted to a medical school set up by the WHO in Bangladesh. She disclosed, "We were 100 students in the medical school. Out of 90 students from home country, I was one of 10 female students."

1.2 Thought/Cognitive Styles

Storytellers expressed different cognitive or thinking styles as they looked back on times of adversity. Expressions offered by storytellers highlight their capacity to envision and expect favorable results regardless of their circumstances. The thinking styles include constructs around self-esteem, resourcefulness, inner strength, and a positive outlook.

1.2.1 self-esteem. Some storytellers shared personal appraisals that offered a positive view of and confidence in strengths and abilities. Sahar shared her experience during her country's war for independence:

> He [my cousin] brought a letter from my uncle asking me to go with him to the refugee camp in Assam, India … there were a lot of women refugees with gynecological problems … but there were no female doctors … so, I worked there and the camp officials were very happy to see me.

Mathew asserted:

> I have always drawn on my experiences to help me understand those of others, making me an effective leader for my constituents. I have always been a fighter for equality, civil rights, social justice, and improving our transportation and education systems. I've seen what's possible in bringing different constituencies together to unleash our collective power in common cause.

Klara asserted, "They [her mother and sister] survived because I made sure they were going to survive."

1.2.2 resourcefulness. Storytellers expressed many incidents in which they met the needs of situations where needed resources were not immediately visible. Klara described getting help from a German army soldier when her sister became very ill. She stated:

> They [guards] could talk to us, but we couldn't talk to them. Anyway, he came by every day … just to say hello. So, one day my sister got very, very sick … and there was nothing we could do. So, one day this soldier came around and I said, 'I'll ask you for a very, very big favor.' And he said, 'What would you like?'

Ray, a WWII prisoner of war (POW), described his process of avoiding the amputation of limbs due to severe frostbite, which occurred when POWs were packed so tightly on boxcars that they could not move: "Once being in a boxcar, I was sitting next to another soldier. I told him, now don't sleep. Just rub your legs or we're not going to have legs. So, we just kept rubbing our legs, rubbing our legs." Calla, a single mother, described

meeting her goal of raising her son well, "I got jobs that were easy … so when I got home, I could take care of him."

1.2.3 inner strength. Storytellers shared expressions of mental resistance to doubt or discouragement in response to adverse experiences. For Stella, her belief that "children come as a gift to their parent" occurred as she experienced the stress of raising her daughter, "Well, I remember giving you a bath. And you turned your arm and I heard it [the bone snap]. And you were crying, I'm crying … but I knew I made the right decision." Elspeth, a trans woman, described being "endlessly hassled" by her classmates and teachers for not conforming to their ideas about gender roles. She described how her "armor was that I was a really good student, a book nerd." Bill "came out [as gay] in the Air Force in the 1960s," without experiencing direct discrimination until decades later. In response to experiences of discrimination as gay older adult Bill stated that he and his husband "have no intention of going back in the closet as seniors."

1.2.4 positive outlook. Many storytellers expressed experiences of thinking positively, such as choosing to see the good both during and after their adverse situations. Klara shared that she "was always a positive thinker, even as a child …. even in the camp, I was always thinking positively." Harold described his response to the impact of suffering from HIV/AIDS:

> I know I'm not the only long-term HIV survivor who has considered it [suicide]. I suspect all of us have. I choose to stick with the meds for now … I'm a writer. A

> writer writes. My brain and my fingers still work fine, so I'm sticking around a while to see where this goes.

Ray shared:

> Everything worked out well for me … I was so blessed … to still have my leg … after so many months and the maggots … they did the job of getting the infection out … and the reason the maggots left my leg was the 12-day march because of the cold.

1.3 Personal Abilities/Skills

Storytellers recounted experiences in which they were able to withstand and/or adapt to adversity. Many storytellers shared certain behavior styles and/or actions they took when meeting specific challenges. Some described experiences of self-determination, in which they made their own choices based in their own will. Others described their ability to persevere or stick with an undertaking despite the obstacles, such as opposition or discouragement, or the effort involved.

1.3.1 Self-Determination. Despite being arrested on multiple occasions, Dale offered his reason to continue with "private sit-ins" stating, "I guess I got tired of looking at signs that said, 'Whites only.'" As a young adult, Elspeth elected to be one of the "original Johns Hopkins kids" who underwent gender reassignment surgery. She described the type of participants that the program was interested in as "Stepford wives," but she chose to "meet the doctors and researchers dressed in my usual tank top and a blue mini-skirt, with chopsticks in my hair," which they found "inappropriate."

Calla related, “I had to make a big choice—either to further my career or to raise my son.”

1.3.2 perseverance. Walter, the only Black student integrated into an all-White high school, shared that there “wasn’t a single day when they did not tell me that I didn’t belong.” He stated that “learning became almost a spiteful activity to prove the teachers at the high school wrong.” Ray described his experience with some of the POW guards after his leg was injured:

> I thought maybe they’d shoot me, but they didn’t … my leg is just wide open. And so, then he [a guard] throws me on the horse-drawn supply wagon to go back to the stalag. And, uh, it was so cold this was in the end of December. It was so cold I knew I’d freeze to death [if I stayed on the wagon]. I had only a jacket and pants, and so I crawled off that wagon and started marching … I just kept marching, marching, marching. Four days I marched, and then we finally reached the prison camp.

Sahar immigrated to the US after years of medical practice in Africa and Europe. She described her experience of becoming qualified to practice in America as “hard … I had foreign student status. I was older, my children were in school. It was very difficult to get residency.”

Summary of Theme 1

The personal attributes outlined in Theme 1 reflect a range of emotional, mental, and behavioral flexibility in response to the internal and external demands of adversity.

Emotional attributes such as compassion and hopefulness appear to prompt the behavior choices of some of the storytellers. For other storytellers, gratitude and pride seem to be how they made meaning of the adversities they endured. Cognitive styles such as self-esteem and positive outlook seem to have enabled storytellers to envision and expect favorable results regardless of their circumstances. Resourcefulness and inner strength appear to influence storytellers' capacity to make realistic plans and take steps to carry them out. Additionally, there were personal abilities that likely impacted how storytellers were able to successfully cope with adverse experiences. Storytellers expressed the ability to determine their behavior choices and goals, as well as the role of perseverance in their ability to continue pursuing outcomes despite obstacles.

Theme 2: Social Resources

2.1 Family/Friends

Theme 2 represents social resources identified by storytellers as positively impacting their physical, emotional, and psychological well-being before and during adversity. Expressions of tangible and intangible resources provided by family and friends include positive childhood experiences, positive role models, validation, and support given by others.

2.1.1 positive childhood experiences. Storytellers recalled positive experiences in childhood such as closeness, support, protection, love, and responsiveness to needs.

Klara shared:

> Before I was in the camp, I had a really beautiful childhood really. My dad had a very nice business. He was in grocery wholesale and retail, and we were doing really, really well. And I had a lot of girlfriends … I had everything a child would want.

Describing his family experience before being drafted, Ray shared, "I lived on that farm until I went into the service in 1943. I had 11 sisters and brothers and we all were the most happy family, all wonderful people …and then my life changed after I got drafted." Kumari shared experiences playing "a game with cowrie shells …" as well as how she celebrated when her country won its independence by running "out into the street cheering … we went around the city in a big parade."

2.1.2 positive role models. Many storytellers described how they were influenced by the ideas or values found in a person they admired and wanted to emulate. Walter shared:

> My father was everything to me. And it's actually kind of difficult talking about him without becoming very emotional. Up until, you know, he died, every decision I made, I'd always call him. And he would never tell me what to do, but he would always listen and say, 'Well, what do you want to do?' And he made me feel that I could do anything that I wanted to do.

Diego expressed the value he placed on his mother's life choices:

> My dad died when I was 13 years old. I'm real proud of the job my mother did, raising us without a father … we did not bother Uncle Sam to help us. We all work on the farm, and everybody came out real good, no one got in trouble.

Kumari shared:

> My father-in-law was a gem. There were so many restrictions for women in those days. They were to be veiled, they couldn't laugh or talk in front of their in-laws or even wear shoes. My father-in-law said, 'wear your shoes.' He was an enlightened person; his attitude was so modern. He always said, 'do something new, leave these outdated ancient rituals.

Letti spoke of how her grandmother, a Dimooyehn or matriarch, and mother were available to give help to community members yet always "held our family together, especially financially. Like Grandma and Mama, I was always busy, yet I found time to help my native community."

2.1.3 validation. Some storytellers expressed having a sense of being seen or that their feelings or opinions were worthwhile to others. Sahar recounted, "We were nine sisters and my grandfather, a retired lawyer, was taking care of us. He said to my father, 'No matter what the sex of the children, they need education." She also described how her grandfather noticed her specific need and "asked my father to put me in the POD Girls School. It was a dorm school [boarding]. He said, 'There'll be a library, she will have companions.'" Diego stated, "I only went to the third grade … I

push for education because I didn't have any." Diego shared that, despite his limited education, he served as commander of the American GI Forum, interpreted for other Mexican American veterans who were being discriminated against, and sought grants available to veterans. Calla described the meaning she placed on her son's response to her struggles when focusing on raising her son rather than a career:

> He said 'Thank you for not being too tight on me, but … not too loose on me either. Thank you for doing that.' I was so happy … after all the sacrifices … it's kind of fulfilling for me because even if my career it's not so great, I have raised a son that is going to have a future.

2.1.4 support by others. Several storytellers shared experiences of being supported through resources such as time, effort, finances, and/or abilities. Walter described the support he received as a high schooler from one of his middle school teachers, some of which he recognized at the time and some he was not aware of until much later:

> I was home one evening wondering what I'm going to do when there's a knock on the door, and it's my seventh-grade science teacher from the Black school, Mr. Hill. He said, 'You know, I understand that you're having some trouble. What I need you to do is to come back to the junior high school after school everyday and Saturday mornings.' And so, every day waiting for me would be Mr. Hill with assorted other teachers—the English teacher, the math teacher—and they tutored me.

Walter disclosed that he was accepted by Howard University with a scholarship even though he never applied. He shared:

> I’m at my older brother’s funeral, talking to Mr. Hill. And I said, ’You know, Mr. Hill, if I had not gotten that scholarship, I don’t know what would have happened.’ And he said, ’I know, because I filled in the application and sent it off for you.’ So, Mr. Hill stepped in and, I believe, saved my life. And, at the time, I didn’t realize how much I was being helped … that’s the ignorance of youth and the wisdom of age when you look back on it you say, ’How did I get here? How did I make it?’ Because people helped you, whether you knew it or not.

Dale recounted help from fellow inmates that likely spared him physical harm:

> The last time I was arrested in Baton Rouge … the White guards told the other inmates ‘We have a troublemaker here, gang. If you give him a hard time you may get time off for good behavior.’ I think that was the time I was most frightened. Except a couple of the guys in there, they knew somehow who I was and told the other guys ‘Don’t mess with him.’ That was my salvation.

2.2 Group Identity

Many storytellers related their experiences through the lens of a social category or group identity. Some storytellers identified their sense of self as defined by group membership, while others expressed social influence, such as emotional or physical support, through interpersonal interactions. The positive social influence described by

storytellers include feeling a sense of belonging as well as connectedness through shared history, camaraderie, and mutual support.

2.2.1 belonging. Several storytellers shared a sense of strength as they felt accepted and approved by a particular group or community. Elspeth found support and creative energy as part of an ensemble of cast and crew members making several films together. She shared, "Instead of being the joke, I got to make the joke. I got to win." Letti expressed:

> Our culture is rich. Our families have always sought guidance from the Dimooyehn. We were the matriarchs of our village, and we still are. We're doing what we can to keep our culture alive and live a good way, what we call Mino Bimaadziwin.

Ray described the value of being recognized and part of something bigger than himself when he shared how one of the soldiers he served with "took it upon him to write about [an] entire battle, the whole thing. He's got everything, men and all, and I'm in four places where I was in combat and all of our pictures … it's such a treasure."

2.2.2 shared history. Some storytellers shared experiences that formed a foundation for how they understood or made meaning of the hardships they endured. Mathew shared:

> As a Japanese American whose family was interned during World War II and later went on to serve in the Peace Corps in El Salvador, moving in and between different communities is not new for me. Expressing my commitment to public

service in environments from San Salvador to San Jose has allowed me to value diversity not just as a buzzword, but to really live my truth in ways that pushed me to walk in other peoples' shoes.

Harold remarked:

> We have history. Both alone and together as a community, we survivors of the virus share a history of widespread stigma; of being shunned and feared like lepers; of being ignored by a government that seemed to want us to die; of being unpaid guinea pigs for pharmaceutical companies; of being duped by charlatans peddling snake-oil "cures" and phony feel-good psycho-babble bromides; of hatred aimed at us—sometimes, sadly, from within our own community. We share a history of innumerable hospital rooms and hospice beds and memorial services; a history of Acting Up, of fighting and marching for research and treatment options; a history of frustrations, disappointments, and defeats. We share a history of oceans of tears, of cracks in our hearts, of hopes dashed and dreams unlived.

2.2.3 camaraderie. Some storytellers described experiences in which a spirit of goodwill was felt both during and after adversity. Ray recounted:

> So, we got to this camp, overloaded [with] too many soldiers, so they put us in the barn again. It happened to be Christmas Eve, and we had very little food, a slice of bread a day if they gave it to us. And we were there lying on the cement floor Christmas Eve, thinking about our days before. We were really desperate

> then, not knowing what tomorrow would bring. And so, all of the sudden, one voice, another voice, the entire barn was singing Silent Night, Holy Night. Every nationality just singing away. So, that fueled us up again.

Harold described his experience with other HIV/AIDS survivors saying, “Every meal shared, every hug given, every tear wiped away, every gathering we attend fills in the cracks of our emotional and spiritual mending.”

2.2.4 mutuality. Storytellers recounted experiences of giving and receiving comfort or support both during and after their adverse experiences. Harold shared his experience of mutual support in the aftermath of the AIDS epidemic. He stated:

> We are mending. And yet, beyond all our expectations, beyond our wildest hopes, we are mending! We come together—in all our diversity, despite our differences, in the face of our individual and shared griefs—we come together to feed one another, to comfort our sick, to offer solace where none was available, to educate our young and elevate our old, to support and cheer and encourage each other.

Klara depicted the role of mutual support in survival after release from the death camps:

> We didn’t know where we were, we had no idea what part of the country we were in. So, there were some women from Poland, and they said you know we want to go back to Poland, too. Let’s get together a few people and let’s start walking. Whatever we found, we shared. And that’s how we got back to Prague.

2.3 Faith/Spirituality

Expressions of belief and trust in a higher power or spiritual force were shared by some storytellers as they sought meaning in their experiences. For some storytellers, it was the feeling of connection with something greater than themselves to guide them and respond to their need. Other storytellers identified faith practices as standards of conduct, a way of being in the world.

2.3.1 connection with higher power. Letti shared a meaningful connection with a spiritual force that responds to prayer, “In our culture, an eagle is the messenger who takes our prayers to the creator. It has very powerful significance for our people.” She recounted creating her Eagle staff, Migizi, to “spread healing among Native Americans.” According to Letti, “Migizi has helped guide my journey in ways that I can’t explain. She leads me to so many places.” Klara related several experiences in which she recognized and acted on a feeling or sense in something greater than herself. She shared feeling a sense of connection with her deceased grandmother as she sought to help her sister who was very ill. While she did not know what would help, she described that “it seemed like my grandmother was with me and telling me what to do.” On another occasion Klara recalled telling her sister that they would be free on her birthday, which was in less than two weeks. “And the 70 women in the room all laughs and say I think you went crazy. And I don’t know why, something came over me. And that day we were liberated was May third. My sister’s birthday was May tenth.” Klara went on to describe her experience of God’s help as she searched for her brother after the war. She shared:

> I walked and walked … I didn't eat. I didn't drink. I was exhausted. Everywhere they [those she asked] said no, no, no. I said, okay, I'll start over again tomorrow morning. And I start walking and I walk maybe two blocks and I thought let me go back. Maybe I'll ask one of those guys if they know him. So, I walk back, and these guys were still talking. And I was standing there listening and listening from in back of one of the guy's head. He looked familiar to me. So, I stood there and while they were talking; I said, Andy? And my brother turned … it was my brother. And that's how I found my brother. God made me turn back because I would have continued next day.

Kumari related experiences of looking to her faith to guide her in life and provide for her and others: "If you have enough to eat, feed others. Every day I pray that God gives me the means to help others. I say, eat, drink, be happy, help others, and don't be selfish with money."

2.3.2 aspirational values. Some storytellers expressed the desire to be better, to make a positive impact on life. Mathew shared, "I like to think that by fighting for issues like equality and justice, I'm helping people live in their truths and be their authentic selves." Diego recounted his experience of working toward the betterment of other immigrants:

> We started getting progress now; we have people who have good positions. My nephew is a lawyer, two nephews, who are lawyers, grandson is a lawyer, and some nephews who are doctors too, and we progressed quite a bit and most of

> the family is doing real good. I wish we could get more people yet to get more education.

Letti described how she shares her own personal journey with alcoholism "in order to help those who are still struggling … it makes my life worthwhile actually, and it's part of the healing process."

Summary of Theme 2

Theme 2 describes a variety of social resources identified by storytellers as positively impacting their physical, emotional, and psychological well-being before and during adverse experiences. Storytellers described both tangible and intangible resources provided by family and friends prior to or during adverse experiences. Positive childhood experiences offered closeness, protection, and love though the responsiveness to the needs of storytellers. Positive role models early in life provided guidance and reassurance of individual worth and value. Storytellers expressed the impact of tangible or instrumental support through resources such as time, effort, and finances given by others. Storytellers identified feelings of acceptance and belonging as they saw themselves through the lens of a social category or group identity. They described the positive impact of interpersonal interactions, such as camaraderie, shared history, and mutuality. Storytellers also described a sense of connection with something greater than themselves, to guide their behavior, respond to their needs, and find meaning in their adverse experiences.

Theme 3: Actions/Behaviors

3.1 Pro-Social

Theme 3 represents actions and behaviors that promote personal and communal well-being and protects from the negative effects of stress and adversity. Storytellers related experiences of pro-social behavior, those intended to help others. These include responding to adversity by giving back in return for what one has received and altruism, acting to help someone else at some cost to oneself.

3.1.1 giving back. Storytellers shared experiences of willingly sharing their personal resources in return for what they received. Jed shared, "Well, I did not graduate from high school. So, I began to read books in braille and then I taught people to read braille. So, if I could help some person, then my living will not be in vain."

Diego recalled:

> I got involved with the union, I always wanted to help the veterans … With the help of some colleagues, we were able to do a renovation; the union helped us out and other organizations as well. I've slowed down quite a bit but I'm still active with the GI forum, the Veterans union, and the American legion as a VFW. I try to help people out … because we still got a lot of people that are coming from south of the border, Guatemala, Salvador that come here to Flint looking for jobs.

Bill shared his story is the way he can fight for others, "The effect this [harassment] has had on us has been devastating. That's how bullying and bigotry work. And that is why

we are speaking out about this and working for equality for all our lives." Mathew shared, "As a grandfather, I am now more invested in fighting for the future … as my granddaughter and her family move through her experience as a transgender person, the work I've done to support the LGBT community becomes more real."

3.1.2 altruism. Some of the storytellers described experiences of acting to help others even though it came with some cost to themselves. After retirement Letti intended to "relax and enjoy the rest of my life." However, she chose to "create the healing Eagle staff" that she carries for women and veterans. She shared, "I will help as many people for as long as I can … The magic of seeing somebody really get recovered or really get that spark of recovery is hard to describe." Sahar shared that it took three days to travel to the refugee camp where she would be treating women. She described hiding at night because "fighter planes were flying overhead … looking to drop bombs." She went on to share how at one point they were told, "'everyone get off the boat slowly and crawl into the forest' so, my cousin and me got off the boat. It was a terrible feeling. But on the other hand, I did it for my country." Walter recounted a childhood experience of sacrificial giving and its impact then and now:

> I remember walking up the street Christmas Eve, and I see this kid riding down the street on a bicycle. And I say, 'Boy, that looks like my brother's bike.' I get to the house and say, 'Wayne, where's your bike?' And he said, 'It was down on the steps.' I said, 'No it's not. It's gone.' It's a small neighborhood so we find out where the kid lives who has the bike and it's a shack in an alley. Now, my brother

and I, we're going to beat this boy, but my father was there, and he said, 'Just shut up and let me talk.' So, we knock on the door and this old black guy comes on a cane. The house was cold; the only light he had was a candle. It was his grandson who had stolen the bike, so he calls him out. He was the same age as my brother, about ten years old. The little boy starts crying and he says, 'I just wanted something for Christmas.' So, we get the bike, and we leave. We go back to my house. My father tells my mother, and she doesn't say anything. She just starts cutting the turkey in half and all the fixings. She started packing it up. My father went to the coal yard and got a big bag of coal. And then he told my brother, he said, 'You've got another bike, don't you?' My brother said, 'Yeah…' So we went back with food, coal—so they'd have some heat—and the bike. The little boy is just crying, but the thing that moved me the most was the old man. My father gave him $20, which was a huge deal back then, and said, 'Merry Christmas.' He said, 'Thank you,' and then just broke down in tears. My father was a chauffeur; my mother was a domestic, so we didn't have a lot of stuff. And that Christmas, I don't even remember what gift I got but I do know that made me feel better than any Christmas I've ever had.

3.2 Agency

Storytellers shared experiences in which they felt a sense of agency or control over their actions and consequences. Some of the behaviors expressed were intentionally goal-seeking, oriented toward attaining a particular goal. Storytellers also

described experiences of adaptation, in which they were able to adjust to new information or experiences or when they encountered obstacles.

3.2.1 goal-seeking. Elspeth described acting with intentionality when she chose to sign up for gender reassignment surgery as a young adult and then performing in film as a trans woman. She stated, “standing up unapologetically as an out trans woman performer and artist over 40 years ago, that was an act of extreme defiance.” Klara described experiences in which she initiated behavior for the purpose of attaining a specific goal, such as when she volunteered to work while in the camp for months, stating “they were giving us a little better food than the rest of the camp cause I guess they had to keep us alive.” Also, Klara volunteered her mother and sister while keeping their familial relationship a secret, “they were not supposed to know we were related.” Calla shared, “I don’t have to hold back for myself anymore. And who knows what the future can bring? That’s why I like to go to seminars. I just want to learn.”

3.2.2 adaptation. Harold expressed how he is adjusting to his new situation:

> If I’ve learned nothing else during the twenty-nine years since I was diagnosed with HIV, I’ve learned that getting from day to day often entails a major effort to get used to the “new normal” and making the best of it—taking meds every day for ever; quarterly blood draws and evaluation; battling opportunistic infections and ailments; etc.

Bill’s adaptation took the form of choosing to move rather than stay in a hostile environment. He recounted:

> Every morning I would go out and look at our garage door to make sure no one had written ‘fag’ again on it. It put us in such a hard situation that we had to withdraw ourselves from that. We just aren’t comfortable here anymore.

Sahar recounted:

> I worked in Libya for 16 years. My children were born there and were going to British schools. Finally, I resigned and followed my husband to Switzerland, then New York. My children were still studying when my husband had a stroke and became bedridden. I started supporting the house … just like my parents took care of me, I took care of my family.

Summary of Theme 3

Theme 3 reflects the actions and behaviors that storytellers described as promoting personal and communal well-being as well as protecting from the negative effects of stress and adversity. Storytellers related altruistic experiences, acting with the intention of helping others, often at personal cost, as well as giving back in return for what has been received. Storytellers also shared engaging in actions and behaviors oriented toward attaining a particular goal, adjusting when encountering obstacles to that goal. Storytellers also described their experience of adopting new behaviors that allow them to cope with change. An overall summary of the findings is presented in Chapter 5.

CHAPTER V

DISCUSSION

Summary of Findings

The purpose of this study was to explore the phenomenon of resilience or resilient adaptation experienced by diverse older adults in the US from the perspectives of their culture, life history, and individual circumstances. I sought to gain a deeper understanding of and sensitivity to the essential experiences of older adults who chose to publicly communicate their personal experiences of resilience after adverse life events. Given that assessing resilience continues to lag in the aging research compared to research into the determinants and role of resilience in older adulthood (Wagnild & Collins, 2009), the present study makes a unique contribution to the literature through the examination of the phenomenon of resilience, its qualities and processes, as experienced by diverse older adults in the US through their narratives.

Overall, findings revealed the presence of three main themes with each theme dividing into multiple subthemes. Theme 1/Personal Attributes was divided into the three subthemes: Emotional/Affective Styles, Thought/Cognitive Styles, and Personal Abilities/Skills. This theme reflected a range of emotional, mental, and behavioral flexibility in response to the internal and external demands of adversity. Some storytellers shared feelings of gratitude as they expressed appreciation for

unanticipated outcomes of their adverse experiences, while others shared appreciation of something valuable and meaningful found in the midst of struggles. Hopefulness in envisioning a positive future was another key process of meaning-making for storytellers. Additional emotional responses expressed include compassion and pride. Compassion appeared to be a motivational factor, which fostered a desire to act in a helpful or comforting way at some personal cost. Pride in oneself or accomplishments suggests positive self-image and attitude as these storytellers looked back on adversities they endured.

The cognitive styles of self-esteem and resourcefulness reflect ways of thinking for some storytellers to envision favorable results through confidence in their ideas and abilities. Self-esteem and a positive outlook reflect storytellers' confidence in personal strengths and abilities, such as the capacity to make realistic plans and problem-solve when facing adverse events. Inner strength are expressions of mental resistance to doubt and despair both during and after adverse events for these storytellers. Personal abilities and skills reflect behavior styles and/or actions taken when meeting the specific challenges faced by storytellers. Self-determination describes the way storytellers viewed their ability to make choices, take actions, and manage their own lives despite opposition or discouragement. Most of the storytellers described experiences in which they persevered or stuck with their undertaking regardless of the effort involved or the obstacles they encountered.

Theme 2/Social Resources was also divided into three subthemes: Family/Friends, Group Identity, and Faith/Spirituality. This theme reflects tangible and intangible resources that storytellers shared as having a positive impact on their physical, emotional, and psychological well-being, both before and during adversity. Positive childhood experiences and positive role models were expressed as meaningful for storytellers. Some storytellers described feeling loved and supported through family connectedness, which appears to be an intangible resource of stability and strength for them throughout the struggles they faced. Other storytellers shared how they were influenced by the ideas or values found in others they admired and wanted to emulate. For some, the intangible resource of validation provided the experience of feeling as if they were seen and valued for who they were.

Storytellers described experiences of tangible support given by others during adversity, which was instrumental in their ability to persevere and thrive in hostile environments. Identification with or belonging to a social class or group was also shared as having a positive impact through a sense of acceptance and approval. Similarly, some storytellers described the influence of having a shared history in how they made meaning of the hardships they endured. Camaraderie and mutuality were also expressed as meaningful group experiences that provided physical and emotional strength. Camaraderie expresses a spirit of goodwill storytellers experienced during adversity and mutuality describes giving and receiving assistance or comfort to help cope with hardships. Storytellers shared feelings of connection with others and with a

higher power through faith and/or spirituality. Some described experiencing connectedness with a higher power who guided them and answered their prayers. Others shared experiences in which they recognized and acted a sense that something greater than themselves were leading them. Aspirational values, the desire to be a better person or the person needed to make a positive impact on others, reflects how some storytellers described how their deeply held principles were positively influenced by their adverse experiences.

Theme 3 Actions/Behaviors was divided into the two subthemes: Pro-Social and Agency. This theme reflects the actions and behaviors of storytellers as they responded to adverse events. Some storytellers shared how they responded to their adverse experiences by giving back in return for what they received. These storytellers described their choice as one of giving in like kind to others similarly impacted by the negative effects of stress and adversity. Others expressed the aim of their giving is to protect others from being impacted by adverse events altogether. Altruism was another pro-social behavior expressed by storytellers, acting to promote the well-being of others even though the action came at a cost to themselves.

Behaviors that were expressed as coming from a sense of personal agency include goal-seeking and adaptation. Storytellers described experiences in which they behaved out of a sense of having control over their own choices regardless of the amount of control others were able to exert in the situation. Descriptions include experiences in which storytellers adapted by the changes they made, either in

themselves or in their environment, when facing circumstances shaped by adversity, which they did not choose or want. Each of these themes and subthemes highlight resilience or resilient adaptation that was expressed by diverse older adults and reflect multiple qualities and processes that interact with adverse life events to reduce their negative effects.

Integration with Theory and Research

The LCT of aging and development, which served as this study's theoretical model, embeds both historical and geographical location of birth cohorts within the larger context of life span development (Elder, Jr. & Johnson, 2003). The LCT posits that individuals living within the same historical context are similarly influenced by the institutions and social structures of that time and place. While these storytellers share many historical and geographical context similarities, there are also intra-cohort differences.

Five core principles characterize the LCT of aging and development, providing conceptual elements for analyzing individual and cohort experiences through age-related, social-structural, and institutional processes (Elder Jr. et al, 2003). The first and second of these principles state that learning and development are lifelong processes and people's experiences are impacted by the life-long choices they make or have made that are within the constraints and opportunities available. Several of the storytellers shared ways they were continuing to grow and learn as older adults. These storytellers expressed confidence in themselves and optimism in their future, regardless of previous

adverse experiences. One storyteller shared how he continues to use the wisdom he has gained to improve life for himself and for later generations. Another storyteller shared how she has personal and financial goals for herself and her future. These and other storyteller experiences appear consistent with the process of life-long learning as a factor in aging well.

Several instances were described in which storytellers expressed self-determination and goal-seeking behavior in situations that offered limited opportunities. Two of the storytellers chose to parent in difficult circumstances. One storyteller was told by doctors that her infant daughter, who was born with a rare bone disease, would probably die during the night, and they advised her to leave her baby there in the hospital. This storyteller chose to stay and bond with her infant, who lived, and raise her despite life-long health difficulties. Another storyteller shared how his ability status as blind and hearing impaired had limited his education, and yet he chose to become a father and continue teaching himself to read in braille. These choices allowed him to achieve his own goal of learning and then exert his influence on others as he taught them to read in braille. Yet another storyteller shared several instances of making choices to shape her own life and that of her mother and sister while they were in German prison camps. Hitlin and Elder Jr. (2007) note that the exercise of personal agency to achieve one's goals is one of the most important factors contributing to aging well.

The third, fourth, and fifth principles of LCT appear to be interrelated. These principles posit that people's lives are shaped by historical times in which they live, the developmental time of life in which adverse events occur, and the social and historical influences of shared relationships (Elder Jr. et al., 2003). This cohort of older adults share a history of wars, both foreign and domestic, and civil rights activism that addressed discrimination based on race, gender, and sexual orientation. Several of the storytellers described experiences of adversity within the context of war or civil unrest. For four of the storytellers, experiences of hardship and trauma due to wartime events came after a childhood period of strong, supportive family relationships. Each of these storytellers described resilient attributes and processes in response to adversity, which is consistent with findings that suggest hardships encountered after a secure phase of early development are met with greater success (Alwin, 2012; Elder Jr., 1998).
One question remaining with this researcher is if/how a spirit of unity related to the war effort (e.g., fighting against those who attacked the US or for freedom in Bangladesh) might have contributed to how these storytellers made meaning of their adverse experiences.

Storytellers shared how living through the pre-civil rights era impacted them due to practices and policies that existed at that time. One female storyteller shared the role of gender-based discrimination in her adverse experiences. She described having to make a choice between financial stability through employment advancement opportunities or accepting employment without advancement opportunity so that she

could focus on raising her son as a single mother. Other storytellers described adverse experiences due to race-based discrimination. For one Black storyteller, forced integration after years of segregation, resulted in harassment by the teachers and students of this otherwise all-White high school. This storyteller described how he was supported by others in his Black community through time and effort in helping him succeed academically. Another storyteller shared how he chose to respond to racial discrimination through acts of civil disobedience (i.e., public sit-ins). Both of these storytellers shared positive relationships with family and community that existed prior to their adverse events.

Experiences of sex-based discrimination were expressed by three storytellers. A transgender female storyteller shared the harmful effects of discrimination that began in adolescence. A cisgender gay storyteller shared how discriminatory policies and practices impacted research on HIV/AIDS, resulting in sickness and death for so many of his friends as well as his own illness. These storytellers shared experiences consistent with research indicating that identification with a minority group is a more positive predictor of well-being compared to majority group status (Ryff et al., 2003). These storytellers expressed the importance of a felt sense of belonging and mutual support in how they made meaning of the hardships they experienced and how they adapted to the life changes that resulted.

One storyteller shared his experience of adversity, which appears contrary to LCT core principles regarding the developmental time in an individual’s life in which adverse

events occur. For this storyteller, experiencing sex-based discrimination occurred in his older adulthood, years after living as a fully out gay man. He shared that he came out while in the U.S. Airforce during the 1960s without experiencing direct discriminatory confrontation. Although this event occurred later in life, after years of living with policies discriminating against same-sex relationships, this storyteller described feeling shocked by his experience. He shared that the situation occurred around the same time that the Supreme Court ruling on marriage equality. Thus, there could be a correlation between historical events and this experience. The choice of this storyteller to move away, suggests that he chose to cope by distancing himself from the adversity.

Integration with Scholarship on Diversity Factors

Vulnerability in older adulthood has been approached by identifying high-risk groups, including those for whom life course opportunities have not been equitable because of differences in race, gender, socioeconomic status, area of residence, and education. Since vulnerability is the outcome of complex interactions among threat exposure and the lack of resources, social and economic disadvantages place additional burdens on marginalized populations (Lee & Chen, 2017).

Among the diverse identities represented in the data, race/ethnicity differences appear to be one of the most salient factors reported in childhood adversity research. The highest prevalence rates for ACEs as reported by race/ethnicity were among American Indian/Alaska Natives at over 40% followed closely by Black individuals and Bi-/Multi-racial individuals (HHS, 2014). Current research in health disparities among

diverse racial/ethnic populations in the US shows an increased risk of illness and death among Black individuals with a lived history of racial segregation (Williams & Mohammed, 2009). Results of the present study reflect experiences of adversity in childhood, including experiences of racial segregation and discrimination, among storytellers with American Indian and Black racial/ethnic identities. The intersection of race/ethnicity and discrimination, disability, and poverty suggest greater risk of long-term negative outcomes. However, storyteller data appear consistent with resiliency research, suggesting that improvement in personal environments (e.g., maintaining a positive outlook) and social environments (e.g., developing supportive relationships) fosters resilience and decreases the harmful health effects of adversity among these diverse older adults.

Acknowledging the unique lived experiences of adversity among the LGBT community is necessary to gain a realistic perspective on the complex and intersecting factors impacting this population's health across the lifespan. However, much of the research on LGBT health focuses on factors that contribute to poorer health outcomes among LGBT populations (Anderson & Blosnich, 2013; Brown et al., 2015; Colpitts & Gahagan, 2016; SAGE, 2014), which could hide or overshadow protective factors already being utilized to enhance optimal health outcomes. Viewing the determinants of successful aging in LGBT populations through an intersectionality lens offers a more complete understanding of factors that promote and enhance health across the life-course (Kwong, Du, & Xu, 2015). Thus, exploring resiliency from a strengths-based

approach is one key to deepen understanding of LGBT health concerns. Colpitts and Gahagan (2016) challenge current models of resiliency viewed through “individual-level, mainstream, heteronormative and cis-normative models of resilience” (para. 21). The present study adds to the discussion of how we can think about the determinants of resiliency, such as the attributes and processes necessary for resilience to occur, among LGBT older adults within their sociocultural context.

Studies investigating the impact of adverse experiences in early life have identified vulnerable populations, which have higher prevalence rates of exposure (Atkinson, 2013). In addition to racial/ethnic, gender, and sexual orientation, factors that influence developmental outcomes include educational attainment (Krovetz, 2008), ability status (Schussler-Fiorenza Rose et al., 2014), immigrant status (Kwong et al., 2015), area of residence (Moore & Diez Roux, 2006; Thorpe et al., 2006), social support (Barnes et al., 2004) and the complex interaction among them. Diversity factors among storytellers, both in their personal identities and in the type and amount of adversity experienced, provide a snapshot of resiliency after adversity among older adult members of traditionally vulnerable populations. Prioritizing the study of disparities in health outcomes among diverse older adults is essential for achieving equity in healthy aging.

Integration with Scholarship on Resiliency

Data gathered were generally consistent with research on aging, which emphasizes the attributes and processes that enable or enhance resilience are key

factors in aging well (Diehl et al., 2012; Ouwehand et al., 2010). Protective factors include specific attributes of individuals or situations necessary for the process of resilience to occur and link exposure to hardship with the personal, environmental, and social resources that develop or maintain healthy adaptation (Smith & Hayslip Jr., 2012). Person-specific attributes that promote resilience were represented in the storytellers' experiences. Storytellers described feeling positively about themselves and their accomplishments as they looked back on their adverse experiences. Both gratitude and hopefulness appear to have facilitated resilient adaptation during stressful experiences and promoted recovery from the negative effects of stress (Lavretsky 2010; Wyman, 2003). Cognitive attributes, such as self-esteem, self-determination, resourcefulness, and perseverance, were found to have enabled storytellers to adapt well in the face of adversity, by recognizing their own strengths, looking for opportunities, taking decisive actions, continuing to work toward meaningful goals, and maintaining a hopeful and positive outlook despite adversity (Barnes et al., 2004).

Social resources reflected in storytellers' experiences and consistent with current research suggesting that resilience can only be understood in the broader context of social support networks and resources, such as tangible and intangible resources from family, friends, and group affiliation (Unger, 2015). Storytellers described many examples of tangible resources provided by others, such as time, effort, and/or financial support, were important and necessary for the positive outcomes they experienced. Intangible support through positive childhood experiences, positive role models, and

feeling validated reflect the presence of positive social interactions such as stability, connection, and positive examples of values and/or behaviors worthy of emulating (Levretsky, 2010). Storytellers also expressed positive benefits of supportive social networks through group affiliation, such as a sense of belonging, affirmation, and connection with others. Group identity also offered storytellers a way to understand themselves and their place in the world through a shared set of social roles and expectations (Dentato et al., 2014). Consistent with recent studies identifying religious and spiritual factors as resources for coping with stress (Pargament & Cummings, 2010; Sanders et al., 2008), storytellers described faith and spirituality as sources of comfort, hope, and meaning. Storytellers shared physical, emotional, and spiritual support they felt through communication with God or a higher power that offered guidelines for living well and envisioning a framework for making meaning of the challenges faced.

Vulnerability, conceptualized as a lack of personal and social resources available to individuals in response to adversity (Smith & Hayslip Jr., 2012), threatens the ability to successfully cope with stress and further increases the probability of distress throughout aging. Thus, resilience, as a process of adapting well in the face of adversity, involves actions and behaviors that promote resilience. Dentato et al. (2014) found that under certain circumstances, facing adversity may play an important role in gaining resilience, such that individuals become more resilient as they successfully cope with adversity. By employing resilience strategies during adverse experiences, these

storytellers found strengths within themselves and their support systems to overcome adversity and optimize well-being.

Implications for Practice

In light of the growing number of diverse older adults in the US, it is important to identify attributes and processes that facilitate resilience. According to the APA (2017a), the guidelines for promoting optimal health and independence in older adults include strategies for developing and enhancing resilience through behaviors and actions that can be learned and developed in everyone. However, issues related to differences in social equality play a role in exposure to and management of stressors in the lives of diverse older adults that may not be readily apparent (Hinrichsen, 2006). Existing paradigms of aging well recognize and acknowledge the importance of promoting personal strengths and attributes already being used by older adults in successfully coping with age-related stressors (Holstein & Minkler, 2003). As exposure to age-related changes increase, older adults may become more invested in finding meaning rather than information about themselves and their world (Pals, 2006). Findings from this study add to the body of research suggesting that an important part of the identity process in older adulthood is the construction of a well-integrated and complete story of difficult life experiences can provide insight into how individuals have overcome past adversity and make sense of stressful life events (Pals, 2006).

Implications for Policy

The APA (2017b) recognizes age as a risk factor for discrimination through prejudicial attitudes, practices, and policies that maintain stereotypical beliefs about aging. Diverse older adults face a double jeopardy as age intersects with sex, race, gender, sexual orientation, disability, health and socioeconomic status, social class, and other stigmatized identities that place additional burdens on marginalized populations. A comprehensive understanding of age-related issues facing diverse older adults must consider ageism within all discussions of equity, diversity, and inclusion in order to reduce discrimination and health disparities and health equity (APA, 2017a).

To effectively respond to the needs of older adults, interventions are needed that are tailored to the distinctive health and aging needs of our older adult population. Recommendations by the APA (2017a) include applying what is known from psychological research to promote optimal health through the development of appropriate services and support systems that address the challenges and opportunities of our aging population. Targeting the recruitment of diverse participants in aging studies will likely identify additional practices and policies that support diverse older adults. Additionally, promoting the role of resilience in successful recovery from adverse experiences among vulnerable populations can facilitate optimal aging efforts.

Implications for Training

Rapid population growth among older adults in the US means that there is an increased need for psychologists prepared to provide mental health services to this

population. Individual differences, environmental factors, and socio-cultural contexts are some of the many age-related challenges to consider when adapting psychotherapy for older adults (Knight & Poon, 2008). However, one of the most prevalent difficulties facing our future psychologists is our own attitudes and biases toward older adults. According to the APA (2017a), inaccurate stereotypes of older adults can contribute to personal biases and affect ethical and effective delivery of psychological services. An example of this effect is the misattribution of treatable depression symptoms (e.g., loss of appetite, anhedonia, lethargy) to the normative aging process.

In the coming decade, clinicians will likely encounter diverse older adults in greater numbers. The APA (2017b) has published guidelines for working with older adults, which should be included in all psychology training programs. These guidelines include providing a balanced evaluation of older adults through the identification of personal strengths and social support networks that can be used to address deficits. In addition, support from cultural, ethnic, and religious communities can be helpful in addressing issues of concern (APA, 2017b). The APA (2013) has also compiled a helpful resource guide for working with diverse elders which would serve both the training community and practitioners alike. While there are many barriers to accessing competent and affirming health services, a lack of trained, culturally competent psychologists should not be one of them.

Strengths and Limitations

This researcher reviewed the attributes and processes of resilience communicated by diverse older adults. While much has been published on the characteristics of resilience, including the APA (2017c) guidelines to help develop and enhance resilience, assessing resilience continues to lag in aging research. Current theories of successful aging indicate that differences exist both in personal and societal attitudes on the aging process itself (Wagnild & Collins, 2009). The value of this current study is in the acknowledgement of these differences through the exploration of resilience in the lives of diverse older adults from the perspectives of their culture, life history, and individual circumstances to understand unique health outcomes in later years. Assessing resilience through storytelling also offers a nuanced, qualitative counterpoint to the more common empirical work on older adults' resilience.

Given that the present study employed a qualitative design, no generalizations about the larger population should be made. Nonetheless, current results may provide a view on the extent to which findings from the literature are consistent with the lived experiences of resilience among these diverse older adults. While cohort differences limit the transferability of results, due to differences in historical context, this researcher can readily imagine that the recent worldwide pandemic could result in cohort-specific gains and losses among the U.S. population. Additionally, further research with different age populations, such as high school and college ages, would be useful to determine what, if any, effects the recent worldwide pandemic has had on development.

Conclusion

The purpose of this study was to gain a deeper understanding of resilience or resilient adaptation as experienced by diverse U.S. older adults from the perspectives of their culture, life history, and individual circumstances. It is anticipated that the number of older adults with mental and behavioral health problems will almost quadruple, from 4 million in 1970 to 15 million in 2030 (APA, 2017a). Unprecedented demographic shifts in the U.S. older adult population are pointing to an increasingly diverse older adult population over the next 1 or 2 decades.

Given the increasing diversity of the aging U.S. population, it is imperative to address health and well-being from historically disadvantaged populations. Understanding aging across the life course from the perspective of diverse older adults can provide insights into the risk and protective factors that impact aging well. While there are no universal generalizations that can be made regarding age-related risk factors, exploring health and well-being of older adults from historically disadvantaged populations can shed light on the cumulative nature of risks due to diversity in age, gender, race/ethnicity, education, income, geographic location, and ability status. Results from the present study add to the discussion on personal, social, and environmental resources that enhance resilience in diverse older adults to optimize well-being and achieve maximum potential during later years.

Recent events worldwide have brought to light the need for change in how we view care for our rapidly growing older adult population. Conceptual frameworks that

have been applied to gerontological research do not accept a single definition for adaptation but reflect varied attributes and processes that interact with adverse life conditions to enhance resilience and resilient adaptation. Factors that influence successful recovery from adversity are found across multiple social levels, including community, family, and individual, as well as the interaction among these personal, societal, and environmental factors (Kocalevent et al., 2015). Future strategies of aging well must focus on more than the process of disease and decline, rather they must prioritize and promote equal access to the resources and support systems that build resiliency in our older adult population.

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APPENDIX A

Data Summary Form

Data Summary Form

ID	Date	Source	Demographics	Length	Notes
1/RA	3/25/18	https://docs.wixstatic.com/ugd/cb5b69_13a653d2ef284e98b7656512519f8685.pdf	96, CisM, White, Low SES	4:41 min./ 3340 words	Story of WW2 POW survivor
2/KS	4/2/18	https://www.livinghistoryprojectmi.com/katherine-sattler	90, CisF, Jewish/Hungarian Immigrant to US	5:38 min., 5961 wds	Age 15, she and fam taken to Nazi concentration camps for 2 yrs.
3/HT	3/25/18	https://www.diverseelders.org/author/hanktroutdec/	66, CisM, Gay, Married	2925 wds	Long-term HIV survivor
~~4/ED~~	~~3/25/18~~	~~https://storycorps.org/listen/ellie-dahmer-and-bettie-dahmer-170113/~~	~~92, CisF, Black, Het, Widow~~	~~2:29 min 274 wds~~	~~Husband target of KKK in 1966/Not in first person~~
5/JW	3/25/18	https://storycorps.org/stories/john-washington-and-melva-washington-toomer-160819/	95, CisM, Black, Het, Blind, Hearing Impaired	2:34 min 182 wds	Blind father raising 3 sighted children & teaching braille

6/SM	3/25/18	https://www.diverseelders.org/what-you-can-do/explore-our-stories/shireens-story/	80, CisF, Asian, Het (Pakistan/Bangladesh)	29 para 1330 wds	F med student aids in refugee camp
7/SC	3/25/18	https://www.npr.org/2017/05/12/527939087/a-mother-daughter-bond-we-have-one-heart-you-and-i	65, CisF, Black, Het, Single-mom	2:40 min 189 wds	Mother with disabled daughter
8/DD	3/25/18	https://www.npr.org/2018/01/12/577343980/the-civil-rights-activist-whose-name-youve-probably-never-heard	76, CisM, Black, Het	2:49 min 333 wds	Teen Civil Rights Activist
9/WLW	3/25/18	https://storycorps.org/stories/william-lynn-weaver-171215/ https://storycorps.org/stories/william-lynn-weaver-170825/ https://storycorps.org/stories/william-and-kimberly-weaver/	69, CisM, Black, Het	8:05 min 1119 wds	Integration in White HS
10/ECW	4/2/18	https://www.freedomforallamericans.org/10-lgbt-seniors-who-need-non-discrimination-protections-in-pennsylvania-now/	66, TransF, White	7 para, 339 words	"Original Johns Hopkins gender re-assignment kids"
~~11/JP~~	~~4/2/18~~	~~https://www.freedomforallamericans.org/10-lgbt-seniors-who-need-non-discrimination-protections-in-pennsylvania-now/~~	~~70, CisM, Gay, White~~	~~10 para, 437 words~~	~~Fired from job for sexual orientation /Not is first-person~~

~~12/AF~~	~~4/2/18~~	~~https://www.freedomforallamericans.org/10-lgbt-seniors-who-need-non-discrimination-protections-in-pennsylvania-now/~~	~~69, M to F Trans~~	~~10 para., 392 words~~	~~EMT inspired by 9/11 events, Employment discrimination/No resilience apparent~~
13/KC	4/2/18	https://www.diverseelders.org/what-you-can-do/explore-our-stories/maganbhai-and-kamubens-story/	82, W, Asian (India)	5 para, 603 words	Abject poverty in India, immigrated to US
14/MH	4/2/18	https://www.diverseelders.org/what-you-can-do/explore-our-stories/mikes-story/	78, M, Asian American	17 para, 1088 words	Intered as child during WW2, Trans GD
15/BC	3/25/18	https://www.freedomforallamericans.org/same-sex-couple-faces-housing-discrimination-at-active-adult-community-in-arizona/	73, CisM, Gay (husband JB is 64)	1822 words	Same sex couple faced housing discrimination at active adult community
16/LW	3/25/18	https://www.youtube.com/watch?v=TeEmYEbYICw https://www.record-eagle.com/news/lifestyles/tribal-	72, CisF, Native Am.	1342 words	Vet w/ sex/phys childhood

		member-named-to-women-s-hall-of-fame/article_b0470ce5-eb3f-5e16-83bf-f164ed5e9508.html			abuse history
17/CM	3/25/18	https://www.diverseelders.org/what-you-can-do/explore-our-stories/coras-story/	78, F, Asian (Philippines)	7 para, 561 words	Immigrant, single mom
18/DB	3/25/18	https://www.livinghistoryprojectmi.com/domingo-berlanga	84, CisM, Mex-AM	3:31 min/2510 words	Migrant Labor childhood, Advocate for WW2 Mex-AM Vets