Resilience in women older than age 85 is defined as the response of rebound and improvement in function after devastating illness. Using a snowball recruitment method, 7 women from a midwestern U.S. city participated (mean age = 88.625 years), representing various ethnic, racial, and socioeconomic backgrounds. Responses from these women related to resilience after illness late in life included their experiences with frailty, determination to overcome adversity, previous experience with hardship, ability to access care, cultural influences, family support, caring for self, caring for others, and descriptions of functioning similar to an efficient machine. Further research is needed to explore resilience in older women; however, specific nursing interventions are suggested related to these themes.

Resilience in a Multicultural Sample of Community-Dwelling Women Older Than Age 85

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As a group, women older than age 85 are more impoverished, more vulnerable due to fewer resources, and are characterized by uniquely different experiences when compared to younger age groups (65-85 years) and to men in the same age group (Pohl & Boyd, 1993). After age 85, frailty, widowhood, and the sequella of functional impairment due to chronic disease often begin to alter lifestyle, resulting in decline. Consequently, these factors combine to increase the need for supportive services (Siegel, 1996). Understanding the experiences of resilience in women who have been able to remain in the community late in life after devastating illness will help to maximize their

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independence, improve outcomes, and foster effective community support of this cohort.

Advanced nursing practice provides a fertile ground for development of scientific clinical inquiry of this sort (DeGroot, 1988). The clinical nurse specialist (CNS), an advanced practice role with a strong research background, is in an optimum position to make practice-based observations that can lead to new knowledge, theory development, improved interventions, and, ultimately, better patient outcomes.

The researcher is a gerontological CNS, with prescriptive authority, in full-time independent community-based private practice. As an experienced gerontological nurse, the researcher observed that life experiences, disease processes, and health responses of women clients older than age 85 were markedly different from those of both younger women and male clients in her practice.

In response to those clinical practice observations, a qualitative research study was conducted to explore this clinical phenomenon. The purpose of this study was to explore characteristics of resilience in community-dwelling women older than age 85. The research questions were the following: How do older community-dwelling women describe their experience of resilience, and what similarities exist in these experiences? The long-term goal of this research is to generate a middle-range theory leading to improved understanding and clinical practice interventions used to support resilience in women late in life.

BACKGROUND AND SIGNIFICANCE

The conventional definition of the elderly population refers to those between the ages of 65 and 74 as young-old, those 75 to 84 as old, and persons older than 85 as oldest-old (Wray, 1992). In addition, population projections into the next century suggest the cohort of women older than age 85 will include greater numbers of women of color (Siegel, 1996). Considering, however, factors of undercounting and failure to collect subpopulation data, it seems likely that current official statistics underestimate this cohort. Into the 21st century, the oldest-old cohort, those most likely to need health care and physical support, are projected to be the fastest-growing segment of the elderly population. Furthermore, by the year 2050, ethnic minor-

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ity groups are projected to make up one third of the elderly cohort (Leigh & Lindquist, 1998).

Women of color in all age groups represent about 27% of the U.S. female population. In 1995, however, this group comprised approximately half of the 19 million American uninsured (Leigh & Lindquist, 1998). Lack of health insurance and barriers to access, including culturally insensitive delivery, often mean that health care is not obtained in a timely manner, allowing disease processes to progress.

Feminism and the women's movement have increased awareness of the diversities among women's experiences (Afshar & Maynard, 1994). Women diverge, however, on how the meanings of race, ethnicity, age, disability, and geographical location influence their specific experiences.

Standardized conventional empirical instruments developed from universalized criteria have limited value in specialized populations (Hall & Stevens, 1991), especially in regard to this cohort of very old women older than age 85. Instruments developed for the elderly, with sample mean ages less than age 85, have questionable validity (Kerlinger, 1986) when generalized to the very old, who are often many years older than the instrument development population. For this reason, theory leading to the generation of new knowledge is needed to better understand and more effectively meet the health care needs of this population.

One of the reasons standardized empirical instruments may not reflect the experience of older women is that operational definitions of resilience may not be the same at different developmental stages (Kinard, 1998). Although resilience in children has been studied (Anthony & Cohler, 1987; Cowen & Work, 1988; Garmezy, 1985, 1991; Masten & O'Connor, 1989) and connections between resilience in childhood and adulthood have been suggested (Liem, James, O'Toole, & Boudewyn, 1997), longitudinal studies have not been done to measure construct stability of resilience across the life span (Kinard, 1998). Questions must be considered related to the meaning of resilience: in whose eyes, by whose standards, and compared to what (Kinard, 1998)?

Resilience has been given multiple definitions from differing perspectives. Jacelon (1997) defined resilience as the ability to spring back after adversity, comparing notions of resilience as

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a trait to that of resilience as a process. Similarly, Dyer and McGuinness (1996) described resilience as a process, the ability to bounce back from adversity and go forward. Polk (1997) defined resilience as the ability to transform disaster into a growth experience and move forward, a response to tremendous stress.

In a grounded theory study of older women (mean age = 78 years), Wagnild and Young (1990) suggested two definitions for resilience in older women. They defined resilience in older women as a unique human phenomenon distinguished by the lived experience of rebound in health after loss late in life, as well as the ability to adjust successfully to major life losses. Five themes thought to contribute to resilience in older women were identified: equanimity, perseverance, self-reliance, meaningfulness, and existential aloneness.

Equanimity is a balanced perspective, involving the ability to consider a broader range of experiences, modulating the extreme response to adversity. An older woman demonstrating equanimity could find something positive, despite the loss experience, seeing the ordeal as an opportunity to learn more about her own strengths. *Perseverance*, a survival instinct, is active persistence in overcoming adversity or discouragement. *Self-reliance* involves a new sense of confidence developing after experiencing loss. Some of the women, who never had the opportunity to test their strengths and resources, were surprised by their self-reliance after adversity. *Meaningfulness* refers to the ability to derive meaning from events and benchmarks in life individually. Finally, *existential aloneness* provides an opportunity for creativity, solitude, and self-acceptance. Existential aloneness provides the opportunity for physical and/or mental space to bounce back. This theme particularly describes older women designing unique methods for resilience, according to their own rules. The Wagnild and Young (1990) study is limited in that selection of racially homogeneous participants, all frequenting a senior center, may not yield culturally relevant and diverse data (Baker, 1997).

The term *resilience* is from the linguistic root of the French word to *resile*, to recoil (Woolf, 1973). Resilience in women older than age 85 is defined as the ability to achieve, retain, and/or regain a level of physical and/or emotional health after devastating illness or loss (Felten & Hall, 2000). It is conceptually dif-

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ferentiated from hardiness (Kobasa, 1979), a resistance to illness, and adaptation (Selye, 1956), an alteration in function after response to stress (Felten & Hall, 2000). Resilience has been obscured conceptually through the interchangeable use of these similar but distinctively different terms, which convey very different responses, especially with an aging population. Resilience is the response of not only rebound but even of improvement in function after devastating illness, a critical characteristic needed if older adults are to live independently.

METHOD

SAMPLE

Using a snowball recruitment technique, the researcher studied 7 community-dwelling women representing various socioeconomic, religious, ethnic, and cultural backgrounds. Inclusion criteria were that the women had to be 85 or older, legally competent, have a working knowledge of the English language, live outside a skilled nursing facility, and agree to participate. Participants were considered to be in relatively good health because of their ability to live in the community. None of the participants were previously known to the researcher.

When recruiting participants, the researcher explained the purpose of the study to community gatekeepers, requesting names of potential participants who fit the age and community-dwelling criteria. After receiving telephone numbers, the researcher called the potential participants, briefly explained the purpose of the study, and then set up an appointment. Written informed consent was obtained at the beginning of the appointment, including permission to audiotape. Participants were informed they could withdraw at any time, although none asked to stop the interview. The interviews required approximately 1 hour to complete, and they were recorded on audiotape. Names and telephone numbers obtained to make appointments and gain access to the participants were destroyed after the interviews to maintain confidentiality. The researcher personally interviewed all participants. Procedures were approved by the Institutional Review Board of the University of Wisconsin-Milwaukee.

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The 7 participants, with a mean age of 88 years, represented ethnic/racial backgrounds of Russian Jewish, African American, Native American (First Nation), Chinese, and German heritage. Several were immigrants or were born to immigrants. Their socioeconomic status ranged from very high to very low income. Only one of the participants had graduated from high school. One participant was currently enrolled as a student in a technical school.

DATA COLLECTION

An interview guide designed to gather descriptive qualitative data specifically related to resilience in women older than age 85 was developed and previously tested for feasibility. Questions were loosely based on the theoretical themes described by Wagnild and Young (1990) as well as on the researcher's clinical practice. The following are examples of some of the interview questions: "You have lived a very long time, and have experienced so much in your life, what do you think has allowed you to live this long?" "In your opinion, what has influenced you the most in being able to be so relatively healthy at this age?" "Have you had any major illness or injury since you retired?" "How has that influenced your life since that time?" "Try to remember back to when you were experiencing that illness; how did you make it back this far?" "You were able to get better after you were so sick; how was it to regain your health after that experience?" "What does it mean to you to regain your health?"

Participants were interviewed in private, except for very brief interruptions from others in their environments. Locations for the interviews included a church office at a senior meal site, private residences, and private suites in a congregate living campus. Although the majority of participants responded directly, one woman spoke mostly through a Chinese interpreter to express herself better.

DATA ANALYSIS

The completed interviews were transcribed, verbatim, onto computer disks by a professional transcriptionist. To ensure accuracy, the written transcripts, as well as the taped interviews, were reviewed by the researcher. To preserve the context

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of the women's stories, the researcher included several lines of response to convey the richness of the data and to respect the primacy of the experiences (Hall & Stevens, 1991).

Using the constant comparison method, the written transcripts were categorized using a commercial computerized qualitative software program. Content from the interviews was analyzed from emerging themes, via grounded theory method, and was condensed by similarity of content. The participants expressed so many comments regarding hardship that the file was initially too large to print.

RESULTS

Brief descriptive participant introductions have been provided to supply the reader with a contextual background.

FRAILTY

All of the participants described serious physical impairments. More than one had some difficulty with memory. Although living outside skilled nursing facilities, most of them described previous experiences with illness that, at one time in their later adult years, impaired functional ability and could have resulted in a nursing home stay. The difference seemed to be that these women were able to experience resilience from those impairments.

Each of the participants is introduced briefly as their responses are initially presented. The following are some excerpts of the interviews illustrating frailty in the participants.

Betty is a Russian Jewish immigrant who came to the United States as an infant. She lives in an upscale elderly assisted living setting, where the interview took place. Her husband, a retired podiatrist, died several years ago, and her only son lives far away. Betty suffered from extreme chronic pain due to sciatica, which was evident to the researcher as we spoke:

> Betty: My health now is not as good. It is comparable, but what I used to have it's not as good. . . . That's the way it goes as you get older. You know, now people are living longer, but I'm still gonna be 89 in 4 months. And as you get older the pain doesn't get better, the pain gets worse.

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Researcher: How do you handle it at this age?
Betty: Well, I don't. Really!

Frailty was presented as a different clinical picture with Evelyn. Evelyn is Native American, and she is divorced. She lives with her extended family in a one-story home in a crime-infested neighborhood, where the interview took place:

Evelyn: I had a major stroke. I didn't have a minor. This was a major one.
[Comment by son]: She was in a coma for over a month.
Researcher: You were in a coma for a month?
Evelyn: Yes, I was in a coma for a while. I had several surgeries. I had two craniotomies and one craniectomy, that's bone cut away.
Researcher: For what reason? What happened?
Evelyn: Well, I first got two clots out of my brain and then the third one was a shunt. Because there was infection in the bone. So they put something in there.
Researcher: When did this happen?
Evelyn: In 1975, 1976.

Although Minnie is very independent, frailty is a constant reality for her. Minnie was born of Russian Jewish immigrant parents. The widow of a retired dentist, she lives in an upscale, independent elderly apartment, where she was interviewed. Her son, living in a distant city, called during the interview:

Minnie: I fell and broke this ankle. I had two screws and a plate in there. So, I tell them, I'm screwy.
Researcher: When did you break the ankle?
Minnie: It must be about 5 years ago. It was a funny experience. I was standing and watching a program, a TV program in my son's house. And I was standing there a long time. I must have been in a trance. All of a sudden my leg went dead on me and I collapsed. It just gave way and I fell.
Researcher: And you were 88 years at the time?

DETERMINATION

The women all expressed a strong will to survive, a refusal to be defeated. The women demonstrated that the key components for their survival were not by chance or coincidence, but by sheer will, attitude, and determination not to let illness take over their lives.

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Rebecca is African American. She is single and has raised several foster children. Pictures of the foster children, and their children, filled her apartment, and she has frequent contact with them. She was interviewed in her apartment in a low-income elderly public housing building. She is a current student at a local technical school:

> Researcher: Try to remember back when you were experiencing the illness, how did you make it back this far? How are you able to be as independent as you are now since the problems with your knees?
>
> Rebecca: I just wasn't going to let it defeat me. I had the will to continue on anyway. To do, and so, by the help from the Lord and the exercise that I took and everything, it helped me and brought me this far. Well, trusting that I will always have that feeling that I will come back. And the help of the Lord. That you can come back if it's willed for you to come. You have to have that determination in yourself that you want to come back. . . . Never give up. Always have that you can do as long as physically able. Always be looking for better. Always have the self-esteem to do better, courage to go on to do the things you want to do. You never leave out where your life and well-being and everything comes from. You never forget that. You have to have that determination in yourself that you want to come back.

Evelyn responded to questions related to her regaining function after a devastating stroke:

> I just made up my mind I am not going to be totally helpless. I didn't want to be totally helpless. I knew some people that were. See, I am paralyzed on the one side. But I made myself help myself with the one side. See I can sew, I use a sewing machine. I don't give up. I made up my mind I wasn't going to give up. I wasn't going to give in to my stroke. I know a lot of women give up right away. I have seen them give up. I seen the ones that paralyzed on both sides and they just give up. I just made up my mind to keep going, I guess. I wasn't going to succumb to anything then. Just 3 years ago I was in the hospital for 3 weeks.

Minnie shared how her experiences helped her regain function after the broken ankle: "Well, by willpower. In the beginning, I had to walk with a cane. I had pain but I kept at it and kept at it. Of course I had exercises. I still do the exercises to this day."

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PREVIOUS EXPERIENCE WITH HARDSHIP

Earlier experiences with difficulty gave these women insight to manage their health problems. All the women described hardship earlier in their lives, including challenges associated with racism, religious or ethnic discrimination, divorce, the Great Depression, death of a husband, domestic violence, and the effects of war. Often, they said these experiences made them stronger. They were able to recall emotions related to these hardships even though the events may have occurred 50 years before.

Minnie experienced anti-Semitic discrimination:

> I worked there for 14 years. I came right out of high school. All of a sudden he says to me, "What's your religion?" I says I'm Jewish, does that make any difference? He hired me and from that time I ended up before I left, I was his private secretary. I went all the way up. But after 2 years, one day we were talking he says you know, we never hired a Jew before. We had nobody in the firm, lot of girls were stenographers and different things. No one was Jewish. Nobody in the firm was Jewish.

Evelyn's husband abused her. She fled with her children to a new city. Although she had not seen her husband in years, he divorced her while she was recovering from a stroke:

> Evelyn: Well he liked to drink and liked to beat me up if he could, which he did many times. But I made it out of there and I brought the kids down here. . . . He divorced me while I was in the hospital, in rehab. I didn't even know I was getting divorced. We had made contact with him before that. We didn't know where he was. He was out east or west of here for awhile. We didn't know where he was. Finally I got a letter from a lawyer up north in Thallward saying that my divorce would be final in March. Well, April.
>
> Researcher: You didn't know you were being divorced?
>
> Evelyn: No.

Mary is Native American (First Nation). She is divorced. She lives in a poorly maintained, walk-up second-floor apartment that she shares with several other nonrelated people. She also spoke of hardship related to domestic violence with her first husband:

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Mary: I had him arrested, he beat me up. Well, I was raised on a farm and you know you are stronger on the farm.

Betty spoke of hardship from the death of a beloved pet bird:

Betty: Well, of course, I was very sad. When you lose a loved one, it is not easy and that was the first point. Then I lost a little bird we had for 11 years. And I loved that little bird so much.
Researcher: When did the bird die?
Betty: It died after 11 years. It was 11 years old when it died. So that was another experience that was depressing to me.

Alice was born of German immigrant parents. Just recovering from an episode of congestive heart failure, she compensated for slight memory impairment during the interview by suddenly jumping out of her recliner chair and retrieving a small notebook from her drawer. She then began to read a laundry list of illnesses she had experienced during her life, dating back to the 1930s. She described hardship associated with her traumatic divorce more than 50 years before:

Researcher: It must have been very traumatic for you when you found out he was cheating on you?
Alice: And how, I lost 40 pounds in a short time. It was terrible. That's all that goes on now is cheating. I listen to those talk shows every once in a while. Terrible . . . She was a single girl too who broke up our home.
Researcher: How did you feel during all that, how did you cope with all that?
Alice: I don't know. It was terrible, a terrible feeling you know. I couldn't eat or sleep and I used to cry a lot.
Researcher: Those feelings don't generally go away just because you divorced the man?
Alice: No, of course now he's been dead since 1987 already, you know.
Researcher: How did you learn to cope with those feelings?
Alice: I guess by going back to work and liking my job.

Betty spoke of her experiences living with the hardship of chronic pain:

Betty: The pain is what's very noticeable and it was very painful, very painful the first 2 years. But after that, it became where I could cope and I could do all my things. I never had help. And I could do all my own things. All my washing and do a lot of things. The pain was there and it wasn't as bad and I could cope with it.

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> If somebody would be telling something very interesting I'd forget a little bit about the pain, but it's there.

ACCESS TO CARE

Knowledge of timely, accessible, assistive services was crucial to participants when they experienced declines in function. As a result, when their health needs required assistance, participants knew where to find services. They all mentioned specific community-based service agencies they would contact if they needed help.

Minnie spoke of her need for assistive services with the broken ankle:

> Well, the episode when I was sick was when I had this fractured ankle and I was in bed and in the hospital for awhile. I think about a week. Then I had to come home and an aide had to come with me because I couldn't walk in the beginning. She had to teach me how to exercise and how to walk with the walker. So that was a hard experience but I learned how and I think she was with me for maybe 4 or 5 weeks. And then I got on my own.

Rebecca spoke of her knowledge of agencies with available services: "If I need help, I know about the different agencies for people to come in and help me. Cook your meals, do your laundry, things like that."

CULTURE

Several women mentioned health practices, ways of life, or healing techniques based on cultural beliefs. Additionally, they reported spirituality and religious values. Spiritual and religious values were sources of strength aiding them in the process of resilience.

Chan was the oldest participant, age 96. She was born in China and speaks limited English. She has been a widow for more than 50 years, and she lives with her daughter and son-in-law. She was interviewed in a church office, whose basement serves as a senior meal site. She responded to questions related to how she recovered from surgery a few years ago, by sharing beliefs distinctly related to culturally based healing beliefs:

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Researcher: Try to remember when you were experiencing illness, perhaps related to your surgery, how did you make it back this far and stay so independent?
Chan [through an interpreter]: By Chinese medicine. When she was in surgery, after surgery then she went to Hong Kong and ate deer meat and the Chinese herbs.

Mary spoke of healing ways of her Native American (First Nation) grandmother, but she seemed hesitant to disclose too much information:

Researcher: Tell me how your culture has influenced you.
Mary: My culture. My grandma taught a lot of things to do. I just . . .
Researcher: So your grandmother taught you some of the Indian ways? Some of the ways of healing?
Mary: Healing, she was, my family was all old. My dad was 85, a very hard-working man.

FAMILY SUPPORT

Although few of the participants lived near or with traditionally defined family, familylike support was evident among all the participants. At times, this support ranged from bringing in fresh fruit to in-home caregiving during illness. One woman described an adoptive, nonblood-related family who helped her a great deal.

Evelyn lived with her extended family. Her son is her primary caregiver and was present during the interview:

> I don't know. I just said I didn't want to go to a nursing home and they didn't want me to go to a nursing home. I have five children. And he's the youngest. I have three of them living here. There's two older daughters. He has two older sisters and two younger sisters here. They didn't want me in a nursing home either.

When asked about "family," Alice did not think she had any because she had no children of her own. The researcher then asked about her family of origin:

Researcher: How about those nine brothers and sisters you've talked about?
Alice: Yes, oh sure! My sisters come to see me. They come over to see me and bring me things to eat.

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SELF-CARE ACTIVITIES

Participants described classic self-care activities such as getting plenty of exercise, eating the right foods, and not smoking or drinking as being useful in helping them experience resilience. They spoke of dedication to do things for themselves that enhanced everyday function and helped them avoid disease.

Minnie spoke about her daily exercise routine:

> Another thing I do is, that helps me, is I walk. I walk every day. I put on boots and I walk. I also when I get out of bed in the morning, I have my exercise for 15 minutes. Hand exercise, back exercise, squatting, getting on the floor, arching my back and bending my knees. I do that religiously every single day.

Rebecca spoke of following a prescribed exercise program and following a nutritious diet, consciously aimed at maintaining physical and mental health:

> Rebecca: How did I regain my health?
> Researcher: Yes.
> Rebecca: By exercising. Doing the exercises that the therapist told me to do.
> Researcher: In your opinion, what has influenced you the most in being so relatively healthy at this age?
> Rebecca: I try to eat the food that is required for your body and your mind to keep you going.

Alice had other advice:

> Researcher: If you were going to tell other women, if you are going to give them advice as how to be able to reach the age of 91 or maybe above that even, what kind of advice would you give them to be able to be healthy late in your life?
> Alice: All I can think of is work hard and enjoy life and don't smoke or drink or anything like that.

CARE FOR OTHERS

In addition to doing activities related to self-care conscientiously, the participants also provided care for others, which they felt enhanced their own well-being. They felt doing for oth-

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ers gave them even more benefits than it did for the people they helped. According to participants, their active sharing lifestyles, despite the discomfort from aches and pains in everyday life, kept them more functional. Working with others allowed participants to focus their attention away from daily aches and pains and kept them from dwelling on their own chronic illnesses.

Minnie is an active community fund-raiser, and volunteers at a nursing home: “I think the fact that I am being busy all the time. And my thanks to God is to keep busy and helping everybody. I feel that it does more for me then I do for them.”

EFFICIENT WORKING MACHINES

Participants referred to themselves as stronger and tougher, like machines. And like machines, they work better by being used.

Minnie: I feel it’s like a machine. If you don’t use the machine it gets rusty. Well I use my machine. My machine isn’t rusty.
Researcher: What do you think is meant by the term to bounce back after being sick?
Chan: Just like a machine.

DISCUSSION

These results offer an initial attempt at exploring the phenomenon of resilience in a diverse sample of women over age 85. Participants all lived in urban settings with access to support services. Other older women’s experiences, however, could be very different.

Although the interview guide was loosely based on the themes identified by Wagnild and Young (1990), participant responses in this study did not reflect the themes of equanimity, self-reliance, existential aloneness, perseverance, and meaningfulness. Rather, participants spoke of issues related to frailty, determination, previous experience with hardship in learning how to cope, access to care, culturally based health beliefs, family support, and self-care activities. They also spoke of caring for others and functioning like efficient working

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machines that enabled them to experience resilience after devastating illness.

Unlike the abstract themes of Wagnild and Young (1990), participants identified very practical strategies resulting in resilience after devastating illness late in life. Resilience, for these women, occurred as a result of a plan, a strategy, not by chance or coincidence.

NURSING PRACTICE IMPLICATIONS

Frailty. Gerontological nurses need to teach older women the importance of constant vigilance regarding their safety. Even though broken bones can occur without any trauma, strategies aimed at reduction of risk can be effective. Home care nurses must teach older women about fall risks in their homes, such as avoiding throw rugs and stretched electrical cords across floors. In the community, safety includes walking outside with secure footwear and realistically assessing the risks of crime in a neighborhood, planning assisted group activities during daylight hours if crime is an unavoidable threat.

After a lifetime of independence, women may find it difficult to admit their own limitations. Delaying or ignoring early intervention preventive services can mean the difference between a problem staying minor and debilitating illness or accident resulting in decreased function. Regular self breast exams, screening mammograms, Pap smears, and flu shots are examples of methods that address frailty in older women. With determination, participants in this study experienced resilience after illness to levels beyond the expected "normative" standards.

Determination. The will to survive is powerful. Nurses must use the power of determination to help older women overcome impairment. Interventions to help foster resilience include helping older women to be informed consumers, encouraging them to choose options, and giving them control.

"Gag rules" imposed by some managed care organizations as methods to cut health care costs create serious barriers to determination in older women and should be outlawed. With determination, participants in this study experienced resilience after ill-

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ness to levels beyond predetermined normative standards based on their age and health status. Generically determined standards—allocating resources based on progress or lack of it according to artificially set time periods—deny needed support services to older women who have different health/illness/life experiences, and they limit the potential for resilience.

Previous experience with hardship. Hardship was a strong commonality in the experience of participants. As a result of facing hardship earlier in their lives, they grew stronger and were able to cope better with devastation later in life. Nurses can be of great value in counseling women who may be experiencing hardship through the life span. Clinic visits, well-baby checks, and other opportunities exist for the nurse to provide an avenue for venting and strategizing problems with women through the life span. Timely referrals to community support agencies or even a listening ear may help a woman gain strength from an adverse situation. A clinic visit for hypertension should not just focus on blood pressure.

The experience of previous hardship earlier in these women's lives taught them how to cope. A nursing intervention focused on exploring how an older woman coped with hardship earlier in her life is an opportunity to help her regain coping skills perhaps thought long-forgotten. Nurses in the hospital, the rehabilitation setting, the home, and the parish have wonderful opportunities to intervene in helping older women gain strength and skills in coping with current hardship, based on the earlier experiences of these elderly women.

Access to care. Minority women with low incomes, and those with limited education have poor health outcomes and less access to health care services (Collins & Bussell, 1997). Similarly, Native Americans (First Nation) obtaining health care through the U.S. Indian Health Services are affected by changes in annual appropriation of funds by the U.S. Congress (Cunningham, 1993). Despite these challenges, the participants in this study said they were successful in accessing health care services.

Providing older women with information regarding resources before they may need them helps increase awareness of services and increases access and provision of services in a timely fash-

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ion. Nursing interventions here must focus on community education and marketing of services to the older women, families, acute care providers, and other community outreach workers. Access to health care depends on services being readily available, affordable, and acceptable to those who use them.

Culture. Acceptability of care services has definite implications regarding cultural sensitivity. For older women to use services, they must be provided in a respectable manner. Additionally, integration of culturally specific cultural beliefs into an older woman's overall plan for care adds another therapeutic dimension, working with, not against, culturally based belief systems.

Health care providers need to improve acceptability of care to diverse groups; culturally insensitive generic dominant culture-based care is no longer accepted as the norm. One method of improving access to minorities is to recruit more people of color into health care professions. A more diverse health care team would be more sensitive to cultural issues and act as clinical role models for delivering care.

Because people of diverse backgrounds often live in extended-family situations, family support in the lives of diverse women has an entirely different pattern of nurturing compared to that of dominant-culture Caucasian elderly households. The role of the oldest woman in the household is different across cultures, as are the power and esteem accorded her. By understanding the position and role of the older woman in a given household, health care providers can support the cultural values of a family.

Family support. Often in health care, nurses will speak more directly to family members, perhaps assuming they will take primary responsibility for health care decisions and care provision. The older women in this study made their own decisions. They were in charge. Although family support was an integral part of resilience, families did not take away the sovereignty of participants over their own bodies. Nurses must remember not only the older woman but also her position within her family.

Self-care. Although some of the self-care activities could be related to dealing with frailty, on the whole these activities

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were more wellness-focused. Just as with other aspects of the life cycle, nursing interventions that are focused on teaching the importance of good nutrition and exercise are important components to nurture resilience. Although the participants identified their own versions of self-care activities, many persons with low educational levels and some minority women do not participate in behaviors such as regular exercise, weight control, health screening, and abstinence from smoking (Collins & Bussell, 1997).

Care for others. The experiences of resilience described by participants follow a pattern ranging from dealing with and grappling with the realities of frailty, to accessing services, to focusing on function. The importance of caring for others underscores and facilitates function. The importance of nurses enabling older women to be able to do for themselves and to have confidence to do for others is perhaps an important principle for gerontological care in the future. Allowing and encouraging older woman to take an active role in nurturing and working with others, even during times of impairment, provides a light of encouragement during times of dependence.

Efficient working machines. Going one bold step even beyond the description of caring for others are the words of participants describing their function as that of efficient machines. Although these words have similar meaning to the machinelike action of a coil, this researcher is not yet prepared to formally describe a theoretical model of resilience related to the action of a coil based only on this data. More studies must be done in this area.

The machinelike action does hint to policy and interventions. Society has used the age of 65 arbitrarily as that of traditional retirement, yet most of these women expressed disappointment that purposeful work, even for pay, was not available to them. By denying older women the opportunity for gainful purposeful work late in life, one important source of life satisfaction, and a reason for resilience from devastating illness, is denied.

Using professional sports as a comparison, part of the reason sports stars return early from serious injury is often the sheer love of the game. In employment situations, workers are

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encouraged to return to work, often with adaptations made in the work setting. Older women do not have any of the economic or life satisfaction incentives available to others to facilitate resilience from illness. Although lifelong job discrimination continues to be an important factor in women's lives, opportunities must be created for older women to do voluntary, purposeful work.

Nurses can facilitate an older woman's desire to contribute purposeful work by contacting local aging departments regarding job opportunities and lobbying legislators. Policy makers and visionary employers could redesign senior centers to make it easier for older adults to do purposeful work. People of both genders gain self-esteem from the fruits of hard work and a job well done. Is it any surprise that older people lose motivation to overcome illness late in life when they have outlived their ability to contribute?

SUMMARY

Understanding the different health experiences of women older than age 85 from various cultural groups is important in planning for this growing diverse population. Because women are living longer, prevention of frailty and living with disability (Collins & Bussell, 1997) have become priorities in geriatric care. Still, more data is needed on older women's experience of resilience in other diverse groups, especially Native American (First Nation) women, Asian women (Collins & Bussell, 1997), and women in other environments.

The words of these older women can lead to new knowledge, teaching health care providers what is meaningful and useful to them in facilitating resilience after devastating illness late in life. Appreciating and understanding what is meaningful in the experience of resilience in older women will help to generate important theory and, ultimately, improvement in geriatric clinical practice.

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