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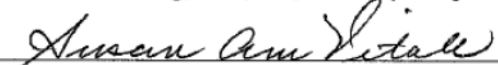
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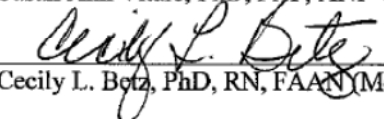
A DESCRIPTIVE MIXED-METHODS STUDY EXAMINING RESILIENCE AND
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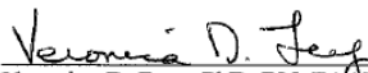
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy

in the Division of Nursing has been read and approved by the Committee:


Veronica D. Feeg, PhD, RN, FAAN (Chairperson)


Susan Ann Vitale, PhD, PNP, ANP-C (Member)


Cecily L. Betz, PhD, RN, FAAN (Member)


Veronica D. Feeg, PhD, RN, FAAN
Associate Dean and Director
PhD Program in Nursing

Date: December 5, 2014

Abstract

A DESCRIPTIVE MIXED-METHODS STUDY EXAMINING RESILIENCE AND TRANSITIONING TO ADULTHOOD AMONG EMERGING ADULTS WITH DISABILITIES

Principal Investigator: Jennifer Emilie Mannino

Molloy College

Rockville Centre, NY

Dissertation Director: Dr. Veronica D. Feeg

Transitioning to adulthood is not without challenges. The move away from family influence towards independence and self-determination is filled with uncertainty. As emerging adults (18-29) transition to adulthood they will encounter various challenges related to their new adult roles (Arnett & Tanner, 2005; Jensen & Arnett, 2012). Increased challenges and vulnerabilities in transitioning are evident among emerging adults with disabilities because they face additional challenges related to their disability over and above what all others of this developmental stage experience (Betz & Redcay, 2002; Blomquist, 2007; Faux & Nehring, 2010; King, Baldwin, Currie, & Evans, 2005; Murray, 2003; National Research Council & Institute of Medicine, 2009; Urbano, 2010).

The purpose of this mixed methods convergent parallel study was to understand resilience in a select group of emerging adults with disabilities as they are transitioning to

adulthood by combining both quantitative and qualitative data. In this approach, quantitative instruments were used to measure the relationship between the independent variable of resilience and the dependent variables of physical health, mental health, satisfaction with life, and future orientation. At the same time, the central phenomenon of resilience was explored using qualitative methods of a focus group and interview with a subset of the participants.

The aims of this study were twofold: (1) To gain a better understanding of resilience from the emerging adults' perspective as it relates to managing adversities while transitioning to adulthood; and (2) To characterize the relationship of resilience with indicators of healthy transitioning. This study describes a select group of transitioning emerging adults with disabilities who have been recognized by others for their accomplishments. It explored their level of resilience and resilience attributes; and identified key attributes of resilience, transitioning goals and values, and challenges encountered while transitioning.

Given the complexity of the topic and uniqueness of the population, this study has combined quantitative and qualitative methods for data gathering purposes. Variables were measured using survey questionnaires to quantify resilience, physical and mental health, life satisfaction, future orientation and social support resources. In addition to the survey questionnaires, a subset of the sample was invited to participate in a focus group or individual interview to supplement the quantitative data. A purposeful sample of 31 participants was recruited and completed the quantitative phase of the study. Ten of the 31 participants also participated in the qualitative phase; five participated in a focus group and five participated in individual interviews. Following a mixed method convergent parallel design, quantitative and

qualitative data were collected simultaneously and analyzed independently. The data were then merged to create a matrix reflecting quantitative variables and qualitative themes.

Quantitative analyses of instrument measures conclude that participants in this select group of emerging adults with disabilities ($n = 31$) have a moderate resilience level ($M = 79.1$), experience average disease burden on physical health ($M = 49.7$), experience less than average disease burden on mental health ($M = 54.1$), feel things are going well in their lives ($M = 24.9$), are future orientated ($M = 3.43$), and have social support resources ($M = 3.9$); independently the participants in the qualitative sample ($n = 10$) have a moderately high resilience level ($M = 82.3$), experience more than average disease burden on physical health ($M = 43.9$), experience an average disease burden on mental health ($M = 50.1$), are generally satisfied with their lives ($M = 23.6$), are future orientated ($M = 3.7$), and have social support resources ($M = 2.9$). No correlation was noted between the variables resilience and physical health ($r = -.277, n = 31, p = \text{n.s. two tailed}$). Regression analysis indicated that resilience is not a good predictor of physical health ($\beta = -.277; t = -1.555; p = \text{n.s.}$). A moderate positive correlation was noted between the variables of resilience and mental health ($r = .502, n = 31, p < .01$ two tailed). Regression analysis indicated that resilience is a good predictor of mental health ($\beta = .502; t = 3.125; p < .01$). A high positive correlation was noted between the variables of resilience and satisfaction with life ($r = .771, n = 31, p < .001$ two tailed). Regression analysis indicated that resilience is a good predictor of satisfaction with life ($\beta = .771; t = 6.519; p < .001$). A moderate positive correlation was noted between the variables resilience and future orientation ($r = .515, n = 31, p < .01$ two tailed). Regression analysis indicated that resilience is a good predictor of future orientation ($\beta = .515; t = 3.234; p < .01$). No correlation was noted between the variables

quantity of social support resources and resilience. Regression analysis indicated that quantity of social support resources is not a good predictor of resilience ($\beta = .189$; $t = -1.034$; $p = \text{n.s.}$).

Qualitative analyses of focus group and interview data revealed the following themes: *standing on my own, longing to create own meaning, altruistic sense of duty towards others with disabilities, challenges specific to me vs. challenges we all face, I am a person with abilities, butterfly's story...our struggles make us stronger, life is a journey, traits that keep me going, patience is a virtue, and it takes a village.* These themes demonstrate transitioning goals and values, challenges encountered while transitioning, and attributes of resilience that have aided in mitigating adversity for these emerging adults with disabilities as they are transitioning to adulthood. Collectively, the themes represent resilience. Purposeful life, self-reliance, perseverance, equanimity and existential aloneness represent individual attributes; and social support resources represent environmental attributes.

The mixed method analysis was comprised of combining the data for meaningful interpretation. Findings from the quantitative analyses were concurrent with the findings from the qualitative analyses. Overall the instrument measures for quantitative variables uphold the prominent themes discovered in the qualitative data. A frequency analysis identified the number of times a particular resilient attribute emerged from the qualitative data. The attribute purposeful life emerged most frequently ($f = 16$), followed by equanimity ($f = 14$), self-reliance ($f = 11$), perseverance ($f = 9$), and existential aloneness ($f = 6$). A cross-tabulation analysis of instrument measures and themes contributed to an enhanced interpretation and understanding of the relationships among the data. Analyses showed that those who contributed to the qualitative theme *I am a person with abilities* ($n = 5$) scored the highest on mental health ($M = 54.6$)

indicating they are emotionally bothered less than most and experiencing a less than average disease burden on mental health. Although these participants reported a physical impairment and a more than average disease burden on physical health (M = 44.2), other measures indicate a moderately high resilience level (M = 86.8), a high level of satisfaction with life (M = 28.4), that they are future orientated (M = 3.8), and have social support resources (M = 3.2). Participants who contributed to the qualitative theme *altruistic sense of duty towards others with disabilities* (n = 4) scored the lowest physical health score (M = 37.2) indicating that they are physically impaired and experiencing much more than average disease burden on physical health. These participants also reported having more than average disease burden on mental health (M = 43), and a slightly below average satisfaction with life (M = 18). However, other measures for these qualitative participants indicate a moderate resilience level (M = 80), that they are future orientated (M = 3.5), and have social support resources (M = 3). A hierarchical categorization of resilience attributes was created to achieve a deeper understanding of the resilient attributes expressed by the participants. This hierarchical categorization demonstrates that resilience for these individuals comes from both within themselves and from their environment.

Nurses care for individuals, particularly those with disabilities. They are uniquely present to intervene throughout all stages of the transitioning process. Identifying resilient attributes can play a vital role in facilitating transitions. Nurses can work as moderators, fostering resilient growth and nurturing the process by incorporating intervention strategies that focus on developing resilient attributes both within individuals and in their environment. Knowing which resilient attributes are most effective in facilitating transitioning would be especially useful in the development of preventative holistic patient-centered nursing

interventions. The research and practice implications of this study may suggest that resilience is a viable concept for the development of strength-based, patient-centered nursing interventions that facilitate transitioning.

This study employed a positive psychological approach aimed at identifying resilient attributes in individuals with disabilities who have been identified for their accomplishments and are transitioning to adulthood. Rather than focusing on problems, this study focused on answers. The findings of this study provide a basis for recommending intervention programs on building resilience among emerging adults with disabilities. This exploratory study may lead to suggestions as to how education, policy, practice, and research can be used to fit the needs of emerging adults with disabilities so that they achieve a successful transition to adulthood.

Dedication

To my wonderful husband and children who have been there to provide unending support and encouragement throughout this journey.

Acknowledgement

I would like to acknowledge those who supported my success. First, I would like to thank my committee chair Dr. Veronica Feeg, and committee members Dr. Susan Vitale and Dr. Cecily Betz for providing me with the guidance that was necessary for my research. Their expertise was invaluable, comments always constructive. My committee compelled me to question and grow as an independent thinker. Next, I would like to thank Dr. Larry DiFiore for his statistical expertise and Theresa Rienzo for her library expertise. I would also like to acknowledge all those at the HSC Foundation and the partnering disability advocacy organizations for supporting my research. Lastly, I would like to thank every participant for taking part in this study, with a special thank you extended to those who participated in the focus group and individual interviews. It was both an honor and a privilege to hear firsthand their heartfelt stories and experiences of transitioning.

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CHAPTER ONE: INTRODUCTION to the STUDY

Statement of Problem

Transitioning to adulthood is not without challenges. The move away from family influence towards independence and self-determination is filled with uncertainty. As emerging adults (18-29) transition to adulthood they will encounter various challenges related to their new adult roles (Arnett & Tanner, 2005; Jensen & Arnett, 2012). Increased challenges and vulnerabilities in transitioning are evident among emerging adults with disabilities because they face additional challenges related to their disability over and above what all others of this developmental stage experience (Betz & Redcay, 2002; Blomquist, 2007; Faux & Nehring, 2010; King et al., 2005; Murray, 2003; National Research Council & Institute of Medicine, 2009; Urbano, 2010).

How well emerging adults transition to adulthood has much to do with the way they handle challenges along the way (Arnett & Tanner, 2005; Arnett, 2001; Froese, 1975). Individuals who are not prepared for these challenges are vulnerable to developing maladaptive behaviors. Challenges associated with transitioning to adulthood are compounded if emerging adults are still struggling with difficulties from adolescence. Like all emerging adults, those with disabilities must be adequately prepared to handle new responsibilities and freedoms associated with adulthood.

Purpose of Study

The purpose of this mixed methods convergent parallel study was to understand resilience in a select group of emerging adults with disabilities as they are transitioning to

adulthood by combining both quantitative and qualitative data. In this approach, quantitative instruments were used to measure the relationship among resilience, physical and mental health, satisfaction with life, future orientation, and social support resources. At the same time, the central phenomenon of resilience was explored using qualitative methods of a focus group and individual interviews with a subset of the participants.

Transitions Theory (Meleis, 2010) guided and informed this study. This study will describe resilience as it relates to managing adversities faced by a select group of transitioning emerging adults with disabilities. It is based on the premise that increased resilience facilitates transitioning and builds upon numerous published studies that have identified resilience as a process of overcoming adversity through the use of attributes known as protective factors (Dyer & McGuinness, 1996; Garmezy, 1991; Luthar, Cicchetti, & Becker, 2000; Masten, 1994; Masten & Coatsworth, 1998; Wagnild, Young, Lau, Morse, & MacFarlane, 2010; Werner & Smith, 1982). Data derived from survey questionnaires, a focus group, and interviews were analyzed to identify key individual and environmental attributes that have had mitigating effects on adversity as reported by a select group of emerging adults with disabilities.

Using a positive psychological approach, this study examined the concept of resilience in emerging adults with disabilities as they are transitioning to adulthood. Positive psychology is a contemporary branch of psychology that subscribes to a strength-based approach to analyzing human function (Kobau et al., 2011; Mannes, Roehlkepartain, & Benson, 2005; Peterson, 2009; Seligman, 2008) This study adhered to the method of positive psychology in identifying individual and environmental attributes that have helped these select individuals in their process of transitioning. It is unlike, but complementary to, previous studies that have identified poorer adult outcomes for persons with disabilities (Kessler Foundation & National Organization on

Disability, 2010b; National Longitudinal Transition Study 2, 2005; National Research Council & Institute of Medicine, 2009), increased needs of parents whose children have disabilities (Feeg, 2006; Kratz, Uding, Trahms, Villareale, & Kieckhefer, 2009) and the shortcomings of public and private programs for persons with disabilities (Duke & Scal, 2011; Luther, 2001; National Council on Disability, 2009). Research reveals that increased personal strength contributes more to positive outcomes than does external support (Litner & Mann-Feder, 2009; Smokowski, 1998). This study provides a basis for the discussion and development of interventions that strengthen the person through the nurturing of both individual and environmental attributes that facilitate transitions.

Significance of the Study

According to the Institute of Medicine's report, *The Future of Disability in America*, there were more than 40 million Americans living with a disability in 2005 (IOM, 2007). That was an increase of 8% as compared to their earlier report in 1991. More recent statistics from the 2010 Household Economic Studies estimate that there are over 56.7 million Americans living with a disability (Brault, 2012). Based upon U.S. population estimates of about 308.4 million, this calculates to 1 out of every 5 Americans as having a disability in 2010 (US Census Bureau, 2010). Among them were 2.8 million school-aged children with reported disabilities (Brault, 2011). The Americans with Disabilities Act, 2009, § 12102 defines a person as disabled if he/she "has a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or is regarded as having such an impairment." The rising number of reported disabilities in the U.S. is due partly to this broad definition, but also to advances in medicine. Today's medical technology has improved the odds

of people surviving complex medical conditions that would have in the past been considered fatal. It is expected that approximately 90% of all children living with disability will survive well into adulthood (White & Gallay, 2005).

Disability does not discriminate. Regardless of race, color, or creed, whether rich or poor, one can be born with a disability or acquire a disability at any point during a lifetime. A disability can result from any number of conditions related to lack of prenatal care, congenital defect, poor nutrition, illness, infection, accident, or injury (Faux & Nehring, 2010). Evidence indicates, despite gains in federal, state and privately funded programs that advocate for persons with disabilities and offer assistance with employment, health care, income and related support services, problems still exist (Kessler Foundation & National Organization on Disability, 2010a; Perrin, 2012; Zirkel, 2012). As more children with disabilities survive into adulthood it is important that they are prepared to manage challenges associated with developmental transitioning.

Conceptual Framework: Resilience

The concept of resilience was used as an overarching framework for this study. This study utilized the central concept of resilience, integrated into the framework of transition to conceptualize the characteristics of emerging adults with disabilities as they are transitioning to adulthood.

Resilience emphasizes human strength and is defined collectively as an individual's tendency to cope with adversity better than expected; the process of becoming proactive rather than reactive in dealing with adversity; and having a positive outcome through the use of

attributes known as individual and environmental protective factors (Dyer & McGuinness, 1996; Garnezy, 1991; Luthar et al., 2000; Masten, 1994; Wagnild & Young, 1993a).

Nurses provide care to individuals, families and communities. Identifying protective factors can play a vital role in planning the care and carrying out the multifaceted activities of the nurse. Knowing one's capacity for resilient behavior would be especially useful in the development of interventions that aid emerging adults with disabilities while they are transitioning to adulthood. In order to prepare emerging adults for transitioning to adulthood, it is obligatory that nurse researchers, policy makers, practitioners, and educators generate and use evidence based upon the comprehensive needs of the patient. Using a holistic nursing approach, such as Meleis' (2010) Transitions Theory to explore resilience lends itself to the potential future development of patient-centered care interventions.

Theoretical Framework: Transitions Theory

Transitions Theory by Meleis was chosen to guide and inform this study (Meleis, 2010). This theory is an evolving theory. Originally developed by Chick and Meleis (1986) out of a concept analysis, the model later emerged as a middle-range theory by Schumacher and Meleis (1994) based on research (Meleis, 2010) (Figures 1 and 2). The two models are similar. While the original model explored universal properties of transitions, types/patterns of transition, transition conditions, indicators of healthy transitions and nursing therapeutics; the more recent model in recognizing the dynamic nature of transition, replaces indicators of healthy transitions with process and outcome indicators (Meleis, 2010; Schumacher & Meleis, 1994). Researchers are urged to consider the uniqueness of each transition experience so that the concepts presented in the model can be further developed (Meleis, 2010). This study examined those concepts in the

model that can be considered resilient attributes i.e. meaning and expectations, level of knowledge and skill, level of planning and preparation, emotional and physical well-being societal norms, cultural beliefs and attitudes, and community resources.

Like other middle range nursing theories, Transitions Theory, is a collection of related concepts that explain a phenomenon related to nursing. A model is generally used to depict the concepts as they are related to other concepts. Middle range theories offer guidance to nursing practice and research (M. Smith, 2008). Nursing, being both a professional and practice discipline, uses knowledge based on theory to organize and guide its practice.

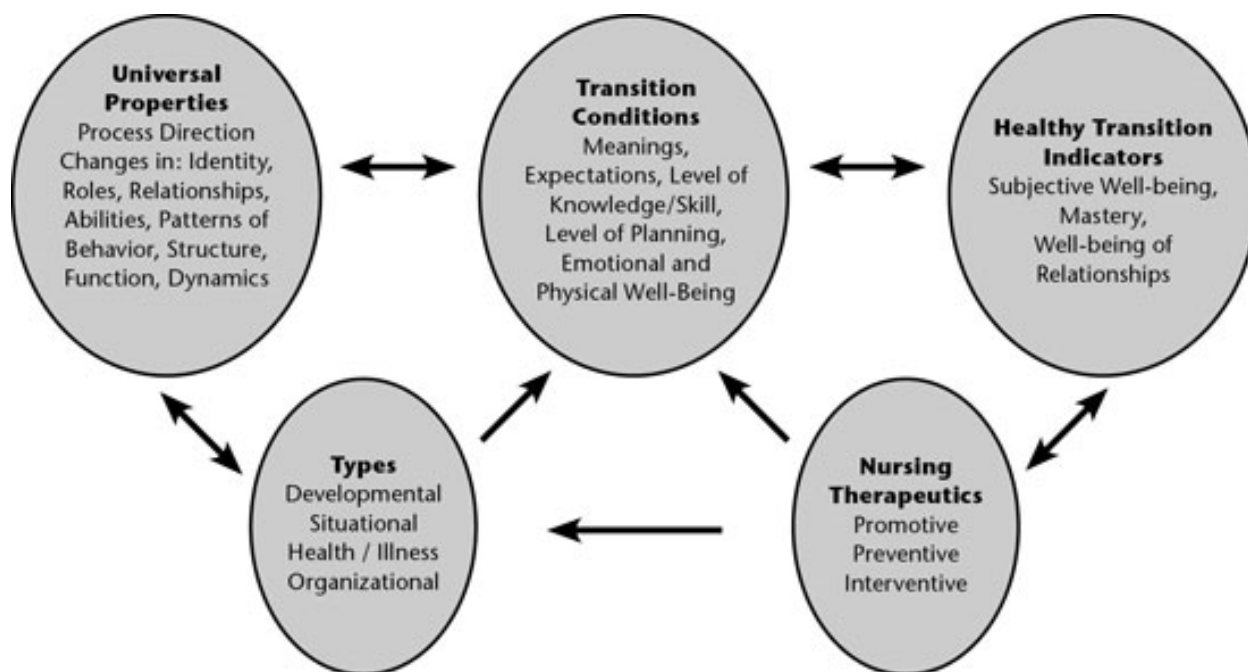


Figure 1: Original Model of Transitions

Chick and Meleis, 1986. Adopted from Meleis, A. I. (Ed.). (2010). *Transitions theory: Middle range and situation-specific theories in nursing research and practice*. New York: Springer Publishing.

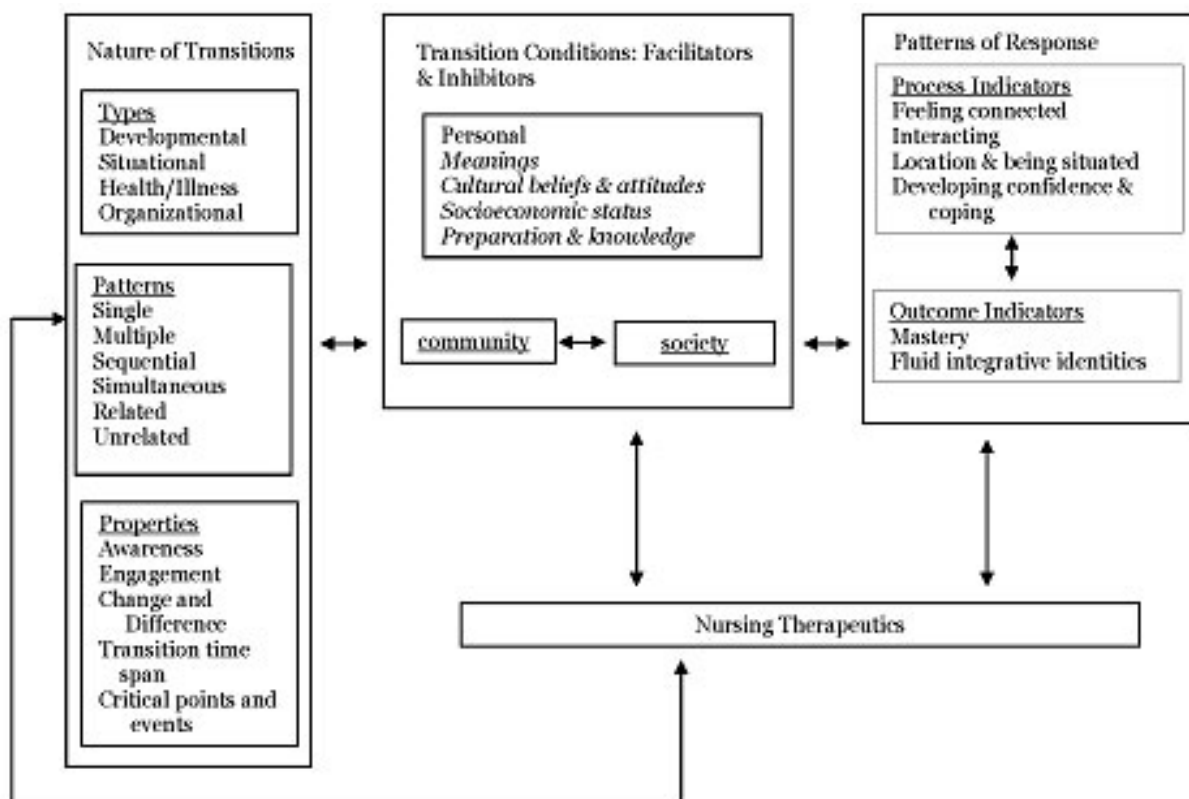


Figure 2: *Transitions: A Middle-Range Theory*

Adopted from Meleis, A. I. (Ed.). (2010). *Transitions theory: Middle range and situation-specific theories in nursing research and practice*. New York: Springer Publishing.

Transition as conceptualized by Meleis (2010) is a change in fundamental life patterns experienced as a “passage from one life phase, condition, or status to another...embracing the elements of process, time span, and perception” (p. 25). Transition is different from change in that change happens as a moment in time, while transition is a process that begins with the anticipation of change, takes place in the events leading up to change, and ends when a new normal is achieved (Meleis, 2010). Transitions are a result of change and “result in changes in lives, health, relationships, and environments” (Meleis, Sawyer, Im, Messias, & Schumacher, 2000).

Transition is dynamic. It is not bound by time or marked by discrete stages, but rather transition itself is a development over time (Meleis & Trangenstein, 1994; Meleis, 2010; Schumacher & Meleis, 1994). New transitions do not always mark the end of previous transitions and individuals can experience overlapping transitions. For example, the developmental transition of the emerging adult transitioning to adulthood is a life cycle transition, however within that developmental transition there are often other transitions occurring simultaneously. Those transitions may be situational, whereas an individual graduates from high school or changes employment. Transitions may also be related to changes in health. Particularly for the target population of this study, health-illness transitions occur when changes in health negatively impact one's regular routine (Arnett & Galambos, 2003; Meleis et al., 2000; Meleis, 2010).

Going through transitions are often difficult, but given adequate transition conditions the end result is essentially positive. This does not imply that all transitions will automatically end in a greater stability. In fact, vulnerabilities are often uncovered as they are "related to transition experiences, interactions, and environmental conditions that expose individuals to potential damage, problematic or extended recovery, or delayed or unhealthy coping" (Meleis et al., 2000, p.12). The state of being after transition has much to do with transition conditions; just as the state of being after adversity has much to do with resilience (Garmezy, 1991; Luther, 2001; Masten, 1994; Wagnild, 2010; Werner & Smith, 1982). Similar to individual and environmental attributes of resilience, transition facilitators include personal, community, and societal conditions that aid transitioning. Among those conditions are personal meanings and expectations, level of knowledge and skill, level of planning and preparation, socioeconomic status, emotional and physical well-being, societal norms, cultural beliefs and attitudes, and

community resources (Meleis, 2010; Schumacher & Meleis, 1994). This study will examine these transition conditions according to Transitions Theory as it focuses on resilience.

Research indicates that youth with disabilities experience poorer adult outcomes than do youth without disabilities (Betz & Redcay, 2002; Blomquist, 2007; Faux & Nehring, 2010; King et al., 2005; Murray, 2003; National Research Council & Institute of Medicine, 2009; Urbano, 2010); however knowledge of those factors influencing these differences are not well understood. Transitions Theory suggests there are transition conditions or factors that either facilitate or inhibit transition (Meleis & Trangenstein, 1994; Meleis et al., 2000; Schumacher & Meleis, 1994). This study utilized Transitions Theory (Meleis, 2010) to inform and guide the exploration of the central phenomenon of resilience as it relates to the transitioning to adulthood among emerging adults with disabilities. It examined the transition conditions of these individuals paying particular attention to those conditions that are facilitators of transitioning. Resilience emphasizes human strength and is defined collectively as an individual's tendency to cope with adversity better than expected; the process of becoming proactive rather than reactive in dealing with adversity; and having a positive outcome through the use of attributes known as individual and environmental protective factors (Dyer & McGuinness, 1996; Garnezy, 1991; Luthar et al., 2000; Luther, 2001; Masten, 1994; Masten & Coatsworth, 1998; Wagnild & Young, 1993a). Congruent with what is known about resilience, it can be hypothesized that attributes of resilience will aid in facilitating the process of transitioning to adulthood for emerging adults with disabilities.

Transitions Theory to Guide Nursing Practice

Nursing practice is a human practice discipline with a distinct scientific body of knowledge derived from its own profession (Carper, 1978; Chinn & Kramer, 2008). Nursing knowledge is an integration of the nurse's clinical and personal experiences combined with theory, principles and standards. This knowledge is used specifically to enhance the understanding of the human phenomena and for the betterment of human health (Carper, 1978; Chinn & Kramer, 2008).

Nurses are active members in the patient's transition process. Nurses are concerned with health and wellness, as well as how people interact socially and with their environments. Understanding transition allows for a more comprehensive appreciation of how interactions between persons and environment bring about health and wellness (Meleis, 2010). Nursing care and the therapies performed by the nurse facilitate transitioning.

Nurses work with patients throughout the transition process; they are present in the time leading up to an event, during an event, and after an event occurred. In doing so, nurses have the ability to intervene most anywhere along the process and work towards mitigating transition inhibitors. Nursing interventions are categorized as interventions that utilize cognitive, interpersonal, and technical skills (Craven, Hirnle, & Jensen, 2011). Cognitive skill interventions include actions such as patient teaching, creating strategies, and altering an environment; interpersonal skill interventions include actions such as coordination of patient activities, patient advocacy, and serving as a role model; technical skill interventions include actions such as providing care and performing patient assessments (Craven et al., 2011). Whether provided individually or in combination, nursing interventions are distinct actions performed by nurses that serve to improve patient transitions. Freedom from illness, disease, or

disability may not always be possible; however improving the process of transitioning is achievable. Through the integration of Meleis' Transitions Theory and nursing practice, nurses have a framework for providing interventions that identify and incorporate transition facilitators to reduce vulnerability and facilitate the process transitioning.

Aims of the Study

This study explored resilience in emerging adults with disabilities as they are transitioning to adulthood. The aims were twofold: (1) To gain a better understanding of resilience from the emerging adults' perspective as it relates to managing adversities while transitioning to adulthood; and (2) To characterize the relationship of resilience with indicators of healthy transitioning. This study describes a select group of emerging adults who have been recognized by others for their accomplishments. It explored their level of resilience and resilience attributes; and identified key attributes of resilience, transitioning goals and values, and challenges encountered while transitioning. The research and practice implications of this study may suggest that resilience is a viable concept for the development of strength-based, patient-centered nursing interventions that facilitate transitioning.

This study employed a positive psychological approach aimed at identifying resilient attributes in individuals with disabilities who have been identified for their accomplishments and are transitioning to adulthood. Rather than focusing on problems, this study focused on answers. The findings of this study provide a basis for recommending intervention programs on building resilience among emerging adults with disabilities. This exploratory study may lead to suggestions as to how education, policy, practice, and research can be used to fit the needs of emerging adults with disabilities so that they achieve a successful transition to adulthood.

Research Questions

Given the complexity of the topic and uniqueness of the population, this study was developed using a mixed methods approach. The following quantitative, qualitative and mixed-methods research questions were created for this study to examine resilience, resilience attributes, transitioning goals and values, and challenges encountered while transitioning.

Resilience research identified numerous protective factors, also called attributes of resilience, that allow certain individuals to handle adversity better than others (Benard, 1991; Haase, 2004; Luthar et al., 2000; Luthar, 1991; Masten, 1994; Rhodewalt & Zone, 1989; Wagnild, 2010; Werner & Smith, 1992). In the same way, Transitions Theory suggests that certain transition conditions will facilitate the process of transitioning to bring about positive transitioning among subjective, behavioral and interpersonal domains (Meleis & Trangenstein, 1994; Meleis et al., 2000; Meleis, 2010; Schumacher & Meleis, 1994). Among those protective factors and facilitators of transitioning are physical health, mental health, life satisfaction, future orientation and social support. These, along with additional attributes of resilience, transitioning goals and values, and challenges encountered while transitioning will be examined to answer the following research questions.

Quantitative Research Questions

The quantitative descriptive strand was guided by the following research questions and hypotheses.

1. What is the level of resilience, physical health, mental health, life satisfaction and future orientation among this select group of emerging adults with disabilities?

2. What is the relationship among resilience, physical health, mental health, life satisfaction and future orientation among this select group of emerging adults with disabilities?
3. How many areas of social support are reported by this select group of emerging adults with disabilities?
4. What is the relationship between the quantity of self-reported social support and resilience among this select group of emerging adults with disabilities?

Hypotheses

The hypotheses for the quantitative portion of this study are:

H₁: Resilience will be associated with the transition facilitators of self-reported physical health, mental health, satisfaction with life and future orientation.

H₁: The quantity of self-reported social support will be associated with the level of resilience.

Qualitative Research Questions

The qualitative descriptive strand was guided by the following research questions and objectives.

1. To what extent are the self-reported values and goals of developmental transitioning consistent across this select group of emerging adults with disabilities?
2. To what extent are the self-reported challenges of transitioning consistent across this select group of emerging adults with disabilities?
3. To what extent are the self-reported attributes of resilience consistent across this select group of emerging adults with disabilities? Those found within the person? Those found in their environment?

Objectives

The objectives for the qualitative portion of this study are:

1. To identify the goals of healthy transitioning that are reported by this select group of participants.
2. To identify the adversities related to transitioning that have challenged this select group of participants.
3. To identify the attributes of resilience that are reported by this select group of participants and to further identify which attributes are key characteristics of the individual and which attributes come from sources in the environment.

Mixed Research Question

Using a mixed methods convergent parallel design, quantitative and qualitative data were merged to create a matrix reflecting quantitative variables and qualitative themes. The following research question and sub-question guided this study.

Do the quantitative measures uphold the prominent themes discovered in the qualitative data? To what extent does the qualitative data contribute to an enhanced interpretation and understanding of the relationships discovered among the quantitative variables?

Definitions

Disability: “A physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or is regarded as having such an impairment” (Americans with Disabilities Act, 2009, § 12102).

Emerging Adult: An in-between stage when individuals are neither adolescents nor adults; it is a stage when individuals begin to explore their own ideas about life and their future, approximate age 18-29 years old, follows adolescence and comes before young adulthood (Arnett, 2007; Jensen & Arnett, 2012).

Resilience: Collectively defined as an individual's tendency to cope with adversity better than expected; the process of becoming proactive rather than reactive in dealing with adversity; and having a positive outcome through the use of attributes known as individual and environmental protective factors (Dyer & McGuinness, 1996; Garmezy, 1991; Luthar et al., 2000; Luther, 2001; Masten, 1994; Masten & Coatsworth, 1998a; Wagnild, 2010).

Transition: A change in fundamental life patterns experienced as a “passage from one life phase, condition, or status to another...embracing the elements of process, time span, and perception” (p. 25); process that begins with the anticipation of change, takes place in the events leading up to change, and ends when a new “normal” is achieved (Meleis, 2010); dynamic process that is not bound by time or marked by discrete stages (Meleis & Trangenstein, 1994; Meleis, 2010; Schumacher & Meleis, 1994).

Developmental Transitioning: The process of movement from one stage in the life cycle to another (Meleis, 2010). This study will focus on the movement from emerging adulthood to adulthood.

Physical Health: An overall disease burden on one's physical health through a combined subjective evaluation of one's own physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional and mental health (Ware et al., 2010).

Mental Health: An overall disease burden on one's mental health through a combined subjective evaluation of one's own physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional and mental health (Ware et al., 2010).

Satisfaction with Life: Global cognitive judgment of satisfaction with one's own life as a whole (Diener, Emmons, Larsen, & Griffin, 1985); an overall perception of well-being of one's life using their own criteria (Pavot & Diener, 1993).

Future Orientation: An individual's perception of their future (Nurmi, Poole, & Seginer, 1995); signifies one's life has meaning, motivation, and purpose (Wagnild, 2010). This is a particularly important concept for the emerging adult because their adulthood plans are now being explored (Arnett, 2000a; Arnett, 2000b).

Social Support Resources: Support that comes from family, friends, school, work, community, places of worship and healthcare providers (Norbeck, Lindsey, & Carrieri, 1981). These resources help the individual through challenging times and foster the individual's ability to reach full potential (Bolla et al., 1996; Hobfoll & Lerman, 1989; Hyman et al., 2003; Norbeck et al., 1981)

CHAPTER TWO: LITERATURE REVIEW

Introduction

The purpose of this chapter is to provide a review of the literature that was used to inform this study. The literature that has informed this study covered the three general areas of disability, transitioning and resilience. Disability is presented in terms of the general impact of disability on individuals, their families and society as a whole. Transitioning is presented from the developmental perspective of an individual moving from an emerging adult to an adult, dependence to independence; barriers to transitioning will be presented. Resilience is presented first, from a historical perspective; then, in terms of the individual and environmental attributes of resilience; and then, in terms of resilience as a balance. Next, resilience is presented as a facilitator of transitioning. An evaluation of transitioning is presented according to Transitions Theory. Lastly, an integration of transition and resilience research is presented as a guide to nursing practice.

Impact of Disability on Individual, Family and Society

Having a disability affects the individual, their family and society as a whole. Research shows that youth with disabilities have fewer opportunities and poorer adult social and medical outcomes compared to those without disabilities (Betz & Redcay, 2002; Blomquist, 2007; Faux & Nehring, 2010; King et al., 2005; Murray, 2003; National Research Council & Institute of Medicine, 2009; Urbano, 2010). Adults with disabilities tend to be of a lower socioeconomic status and suffering from poverty at a rate twice that of adults without disabilities (Kessler Foundation & National Organization on Disability, 2010a). Adults with disabilities are more

likely to be isolated and engage in fewer social and leisure activities as compared to adults without disabilities (Kessler Foundation & National Organization on Disability, 2010b). Fewer adults with disabilities (17.8%) are employed as compared to 63.9% of adults without disabilities (Bureau of Labor Statistics, 2013). Individuals with disabilities are less likely than individuals without disabilities to complete high school (National Longitudinal Transition Study 2, 2005), or graduate from college (Kessler Foundation & National Organization on Disability, 2010a). Individuals with disabilities are susceptible to the same medical ailments that affect everyone else i.e., common cold, obesity, hypertension etc., but they are also more vulnerable to a number of secondary health conditions specifically associated with their disability i.e., pain, depression, contractures, and infections (Faux & Nehring, 2010; Hough, 1999; Kinne, Patrick, & Lochner Doyle, 2004). Secondary health conditions are not only physical; but rather they can incorporate a number of cognitive, emotional, and social conditions that adversely affect quality of life (Hough, 1999). Several studies have found that youth with disabilities experience a poorer quality of life as compared to youth without disabilities (Bastiaansen, Koot, & Ferdinand, 2005a; Bastiaansen, Koot, & Ferdinand, 2005b). As the data reveal, adult outcomes for individuals with disabilities are not comparable for adults without disabilities.

Living with a disability not only affects the individual, but is a major concern for families as well. When providing care for a child with a disability, often the increasing needs of parents are overlooked. Unmet parental needs can lead to stress, anxiety, and depression (Feeg, Huang, Kuan, Miller, & Williamson, 2009). The parental role changes when a child has a disability. Not only do they have the typical responsibilities of being a parent, but they often have to assume the responsibility of care coordinator, medical expert, and systems advocate as well (Kratz et al., 2009). In extreme situations, parents suffer the loss of their parenting roles as they

change their life routines to accommodate the child's needs, such as living in the hospital or assuming total care of the sick child at home. Parents are often required to master the knowledge needed to participate in complex medical decisions (Feeg, 2006). The stress on families is further complicated as parents age and experience declining changes in their own health. A longitudinal study of parents of individuals with intellectual and developmental disabilities revealed that parents experienced poorer health and functional abilities that increased over time (Seltzer, Floyd, Song, Greenberg, & Hong, 2011). Planning ahead is essential for parents when managing their own changing needs, those of their children and other family members.

In addition to individual and family implications, having a disability has public policy implications as well. Accommodations through government intervention are often considered necessary for people with disabilities so they can participate fully in the community (Brault, 2012). Beginning with the Rehabilitation Act of 1973, U.S. major legislation enacted has provided protection and rights to ensure equal opportunity to and prohibit discrimination of all individuals with disabilities (Smith & Savage, 2010). The Rehabilitation Act prohibits federally funded entities from discriminating solely on the bases of disability. This Act has been amended in 1993 and 1998 to meet the changing needs of persons with disabilities and address specific population concerns (Smith & Savage, 2010). The Individuals with Disability Education Act (IDEA) resigned into law as the Individuals with Disability Education Improvement Act (IDEIA) focuses primarily on special education. This law guarantees that every person with a disability from birth to age 21 receives federally funded early intervention, special education and related services (U.S. Department of Education, 2004). Although the percentage of children enrolled in an IDEA funded education has gone up from 8.3% in the 1976-77 academic year to 13.1% for the 2009-10 academic year (U.S. Department of Education, National Center for Education

Statistics, 2012), students with disabilities, especially those requiring special education services, are still less likely to finish high school as compared to students without disabilities (National Longitudinal Transition Study 2, 2005).

The Americans with Disabilities Act (ADA) is primarily concerned with making the U.S. more accessible to people with disabilities (U.S. Department of Justice, Civil Rights Division, 2013). A primary focus of the ADA is removing barriers to education, employment, transportation, public accommodations and communications (Smith & Savage, 2010). Although ADA was signed in 1990, multiple barriers still exist (Kessler Foundation & National Organization on Disability, 2010a). Not only have these barriers inhibited socialization and participation in the community, but they have resulted in overwhelming economic and social expenditures (Americans with Disabilities Act: Questions and Answers, 2009).

Multiple barriers also exist in healthcare. While there are persons and procedures in place to facilitate the educational plans for youth with disabilities under Section 504 of the Rehabilitation Act and IDEIA (Smith & Savage, 2010), Federal legislation in the U.S. has limited regulatory supervision as to how health care is delivered to persons with disabilities (National Council on Disability, 2009). Many individuals with disabilities and their families do not receive necessary services because complexities in our current healthcare system leave some struggling to navigate fragmented services, while others have no healthcare coverage at all (Duke & Scal, 2011; Luther, 2001; National Council on Disability, 2009). Twice as many people with disabilities reported that they have gone without necessary healthcare as compared to those without disabilities (Kessler Foundation & National Organization on Disability, 2010a). Disability has been labeled the nation's largest public health problem in America because it not only affects those who are disabled and their families, but it also affects all of society (IOM,

1991). While much improvement has been made over the last forty years, problems are still present. U.S. legislation has made a remarkable difference in the lives of some with disabilities, but not everyone experiences the same benefits equally (Kessler Foundation & National Organization on Disability, 2010a). Appendix B presents the goals of major legislation in the U.S. that applies to persons with disabilities.

Developmental Trajectory of Transitioning to Adulthood

Transitioning to adulthood, the movement from dependence to independence is no longer a well-defined process. The traditional timeline of finishing school, leaving home, starting a career, getting married and having children has been blurred due to contemporary economic and social changes (Settersten, Furstenberg, & Rumbaut, 2008). Individuals today are more financially and psychologically dependent on their adult counterparts. They are putting off their traditional adult roles to stay home longer, further their education and, in a sense, find themselves through exploration of their worldview (Arnett, 2000a; Settersten et al., 2008).

As a result of this shift, a new stage of development has materialized. Emerging adulthood, as it is termed, is an in-between stage when individuals are neither considered to be adolescents nor adults. This stage is typically characterized as late teens through mid-late twenties (Arnett, 2007; Jensen & Arnett, 2012). Emerging adulthood is a stage when individuals begin to explore their identity and their own ideas about life and about their future. Although emerging adults begin to rely less on their adult counterparts for support and direction, they are not yet totally independent (Arnett & Tanner, 2005; Arnett, Ramos, & Jensen, 2001).

Meeting the responsibilities of adulthood is more challenging than it was in the past. Settersten et al., (2008) implies that “it is not possible for most young people to achieve

economic and psychological autonomy as early [in life] as it was a half century ago” (p. 5). These challenges are further compounded for individuals with disabilities. Emerging adults with disabilities not only face the same economic and social challenges as emerging adults without disabilities, but they face additional challenges inherent to their disability.

Challenges Related to Transitioning to Adulthood for Individuals with Disabilities

The transition to adulthood, a move from dependence to independence, poses increased challenges for the emerging adult with disabilities (Banta, 2004; Betz, 1998; Betz & Redcay, 2002; Blomquist, 2006; Davis & Ann Vander Stoep, 1997). Not only do transitioning emerging adults face the same challenges as do emerging adults without disabilities, but they face additional challenges related to their disability. Betz and Redcay (2002) offer many challenges that impede transitioning for emerging adults with disabilities that are related to healthcare, employment, education, independent living, social and recreational skills and the service system. These challenges, or obstacles as referred to by Betz and Redcay (2002), include absenteeism from school, lack of access to and utilization of adult healthcare, inability to find and secure employment, lacking skills necessary for independent living, and delays in social maturity. While absenteeism from school is related to the nature and pathology of the individual’s disability, and a lack of adequate adult healthcare is related to healthcare providers not being adequately trained to take care of adults with what may be a lifelong disability. The other challenges of employment, independent living, and social maturity may be related to the societal limitations placed on persons with disabilities (Imrie, 1997).

Societal labels and stereotypes lead to public misconceptions that negatively impact persons with disabilities (Green, Davis, Karshmer, Marsh, & Straight, 2005; Link, Phelan,

Bresnahan, Stueve, & Pescosolido, 1999). The misconception that individuals with disabilities are less capable than their counterparts without disabilities results in them having less opportunity in the future (Blomquist, 2007). A study of college seniors and recent college graduates with disabilities revealed that they were not offered the same variety of college courses and did not experience that same quality of career counseling services as compared to the students and graduates without disabilities of the same institutions (Silver, Strehorn, & Bourke, 1997). Individuals with disabilities face the challenge of being seen as persons with abilities.

In addition to public misconceptions, the stigma associated with labeling and stereotyping may influence how a parent cares for a child with a disability. The literature suggests that parents of children with disability tend to be overprotective, such that they limit activities in which the child may engage (Betz & Redcay, 2002; LeMoyne & Buchanan, 2011). While it is expected that parents protect their child from inherent danger, resilience researchers posit that exposure to moderate adversity is beneficial. Theoretically similar to the way a vaccine builds immunity, exposure to moderate adversity will prepare individuals better deal with adversity in the future (Rutter, 2013; Seery, Holman, & Silver, 2010). Research shows that overprotective parenting contributes to a lack of preparation for adulthood. It inhibits psychological maturity (Ungar, 2009) and results in a poorer sense of well-being (LeMoyne & Buchanan, 2011). Preventing a child with disabilities from experiencing adversity also prevents them from learning how to negotiate decisions and problem-solve.

Resilience

Resilience studies first emerged in psychological research primarily to investigate the maladaptive behaviors of schizophrenic patients (Luthar et al., 2000). These studies continued

with the exploration of resilience as it is related to “protective factors” (Masten, 1994). According to Garmezy (1991), protective factors are attributes that “enable individuals to circumvent life stressors” (p. 416). Protective factors have also been defined as “specific competencies that are necessary for the process of resilience to occur” (Dyer & McGuinness, 1996, p. 276).

Initially, protective factors were thought to be personality traits found only within those having extraordinary abilities. However, a landmark study conducted by Werner and Smith (1992) sparked resilience research to not only consider personality traits as resilient attributes, but to also consider the individual’s environment as a source of resilient attributes. Their three-decade longitudinal study of children born in 1955 (n = 505) on the island of Kauai, Hawaii revealed that despite having biological, psychological, and sociological risk, those who were able to obtain positive environmental attributes were more resilient and better able to adapt as adults (Werner & Smith, 1992). This study challenged earlier notions that resilience was purely psychological. Masten’s comprehensive review of resilience research involving disadvantaged children and adolescents revealed that resilience was associated with “ordinary rather than extraordinary human development” (p. 227), thus challenging the earlier notion that children needed to be “superheroes” (p. 228) to survive disadvantaged lifestyles and adversity (Masten, 2001). From this it can be posited that resilience emerges from basic human adaptation facilitated by physical and psychological function, positive relationships, education, and opportunities (Masten, 2001).

Resilience attributes, or protective factors, help to “moderate the effects of adversity” (Masten, 1994, p.7). Having these attributes creates a “powerful adaptive system” (p. 205) that leads to successful coping in both favorable and unfavorable environments (Masten &

Coatsworth, 1998), thus bringing about positive outcomes. Protective factors can be broadly grouped into two main categories: those found within the individual and those found within the individual's environment.

The attributes presented in Table 1 represents a collection of individual and environmental attributes of resilience that work as protective factors to mitigate adversity. The attributes presented here are those that have been most commonly identified in the resilience research literature (Benard, 1991; Dyer & McGuinness, 1996; Haase, Britt, Coward, Leidy, & Penn, 1992; Haase, 2004; Luthar et al., 2000; Luthar, 1991; Masten, 1994; Masten & Coatsworth, 1998; Olsson, Bond, Burns, Vella-Brodrick, & Sawyer, 2003; Rhodewalt & Zone, 1989; Wagnild & Young, 1993a; Wagnild, 2010; Werner & Smith, 1992; Zulkosky, 2009). The individual attributes are grouped according to larger categories defined by Wagnild (2010) as the five essential characteristics of resilience: purposeful life, perseverance, self-reliance, equanimity, and existential aloneness. The environmental attributes of resilience are grouped according to Kim's (2010) Theoretical Domain of Environment; physical, social, and symbolic forces that impact one's existence. Table 1 serves to demonstrate that resilience comes from a combination of protective factors that exist both within the individual and their environment.

Table 1: Attributes of Resilience with Expanded Characteristics

Attributes of Resilience with Expanded Characteristics	
Individual Attributes	Environmental Attributes
<p>Purposeful Life Self-Worth Value Self-Determination Future Oriented Desire to Succeed Meaningful Life Hope Religious Beliefs</p> <p>Perseverance Flexibility Readiness Tolerance Fortitude Self-Efficacy Hardiness Invulnerability</p> <p>Self-Reliance Problem-Solving Skills Self-Sufficiency Competence</p> <p>Equanimity Emotional Control Physical Control Emotional Intelligence Sense of Humor Optimistic Good Interpersonal Skills</p> <p>Existential Aloneness Sense of Self "Comfortable in Own Skin" Acceptance</p>	<p>Physical: Living Health Absence of Disease</p> <p>Physical: Non-Living Shelter Transportation Sunlight Water Climate</p> <p>Social: Support Resources Family Peers Community Workplace Educational Spiritual Healthcare Providers</p> <p>Symbolic Cultural Values Role Expectations Social Norms Spiritual Beliefs</p>

Individual Attributes

Through the inductive approach of grounded theory research, Wagnild and Young (1990) identified characteristics that were common among well-adjusted older women after suffering a major loss, such as the death of a spouse. Those characteristics were later coined the five essential characteristics of resilience and used to measure resilience in a variety of populations of varying ages including, but not limited to adolescents (Hunter & Chandler, 1999), adolescent mothers (Black & Ford-Gilboe, 2004) and homeless adolescents (Rew, Taylor-Seehafer, Thomas, & Yockey, 2001), college students with ineffective coping (Li, 2008), adults with cancer (Armando, 2010; Brix et al., 2008), and high and low income older adults (Wagnild, 2003).

The five essential characteristics of resilience are a purposeful life (formally meaningful life), perseverance, self-reliance, equanimity, and existential aloneness (Wagnild & Young, 1990; Wagnild, 2011). A purposeful life encompasses the attributes meaningful life, self-worth/value, self-determination, motivation, future oriented and desire to succeed. Wagnild (2011) asserts that meaningful life may be the most important attribute of resilience because it is the foundation for all other resilient attributes and “provides the driving force in life” (Wagnild, 2010, p. 2). It is what motivates us to move forward beyond difficulties. Haase (2004) similarly uses the term “derived meaning” as an individual protective component (p. 293). Haase (2004) claims that derived meaning for the adolescent with cancer is a “factor composed of hope and spiritual perspective” obtained from “friends, family, health care providers and religious belief” (p. 293); thus concurring with the symbiotic relationship among the individual and environmental attributes noted in this review. Perseverance is the “determination that keeps us going despite difficulties, discouragement, and disappointment” (Wagnild, 2010, p. 2).

Flexibility, readiness, tolerance, fortitude, self-efficacy (Zulkosky, 2009), hardiness and invulnerability (Rhodewalt & Zone, 1989) are the attributes that make perseverance possible. Self-sufficiency, competence, and problem-solving skills lead to self-reliance. Self-reliance, according to Wagnild (2010), means believing in your own abilities while at the same time knowing your limitations. Equanimity refers to being level headed even while under stress, it is being able to “sit loose in the saddle” (Wagnild 2010, p. 3). The attributes of emotional and physical control, emotional intelligence, sense of humor, optimistic, and having good interpersonal skills are demonstrations of equanimity. The attribute of sense-of-self falls within the category of existential aloneness. Wagnild (2011) describes existential aloneness as an acceptance of self, i.e. “becoming your own best friend” or being “comfortable in own skin” (p. 16). In other words, resilient persons learn to accept and live with themselves despite the difficulties they face. Through concept analysis, Haase, Britt, Coward, Leidy, and Penn (1992) also describe this phenomenon of acceptance as a resolution of fear. They offer:

Central to acceptance is the resolution of the fear and resistance to the part of oneself that is rejecting an unwanted experience. Based upon these critical attributes, acceptance is defined as a present-oriented activity requiring energy and characterized by receptivity toward and satisfaction with someone or something, including past circumstance, present situations, others and, ultimately, the self (p. 144).

Individual attributes of resilience are personality traits that enhance adaptation. In addition to individual attributes of resilience, are protective factors found within the individual’s environment.

Environmental Attributes

Kim's (2010) theoretical Domain of Environment suggests that one's environment contains physical, social and symbolic forces that place a great influence on the existence of that person. Interactions with each other and with the environment are central to human development. The domain of environment explores the notion that one's surroundings are a powerful force influencing existence; one's environment is present externally and is the source of physical, social and symbolic forces that place influence on the existence of that person (Kim, 2010). Studying Kim's (2010) theoretical domain of environment is an examination of the relationship between external forces and the individual in regards to human wellness. Appendix A presents a further explanation of Kim's Domain of Environment. When applying this as a framework, the attributes of resilience present in the individual's environment can be grouped into physical, social and symbolic categories. These environmental categories are also identified as important factors of resilience in families (Lee et al., 2004).

Environmental attributes within the physical category may be further divided into living and non-living categories. The category of living includes such attributes as health and absence of disease, while the non-living category includes shelter, transportation, sunlight, water, and climate. The social environment refers to available support resources found in the family, among peers, within the community, at work or school, spiritual support, and/or support from healthcare providers. Resilience research identifies a positive correlation among social relationships, such as those occurring in the family, at school or in the community, and resilience for both adolescents with cancer (Haase, 2004) and high-risk adults (Alim et al., 2008). The symbolic component of environment is the ideology or the principles that guide our being. Cultural values, role expectations, social norms, and spiritual beliefs are very powerful and according to

Kim (2010) may be the very foundation of resilient behavior. Religious beliefs and spirituality have been found to be extrinsic factors that enable resilience in high-risk adults (Alim et al., 2008).

Resilience research supports evidence of both individual and environmental attributes of resilience as having mitigating effects on adversity; however findings suggest that individual attributes of resilience may have a greater influence than environmental attributes as to how well one handles adversity (Litner & Mann-Feder, 2009; Rutter, 2013; Smokowski, 1998; Wagnild, 2010).

Resilience as Balance

The simple notion of balance is central to the concept of resilience. It is suggested that individuals “succeed to the extent that they balance different needs” (Ungar et al., 2008, p. 178). Resilient persons encounter the same difficulties as everyone else. They are not immune to challenges, but rather they have learned to manage the inevitable difficulties in life (Wagnild, 2009). Resilient persons are emotionally mature and are in control of their physical and psychological being. Emotional stability, functional adequacy and/or social competence may be considered outcome measures of resilient persons (Olsson et al., 2003). Life and all life’s experiences are transformative. It is important to teach emerging adults with disabilities not to let adversity control their future, but rather to seize adversity and learn from it so that they transition well.

Resilience is demonstrated in Figure 3 as a balance of the opposing forces of adversity and positive attributes. Simplifying these elements can be useful to exemplify the essential components of the phenomena of resilience. Such that, the Teeter-Totter Resilience Model was

created by the researcher to illustrate that resilient persons experience adversity, but are able to balance that adversity with positive attributes. A model similar to this one is used in health care to illustrate “health as a continuum with optimal health (broadly defined) at one end and poor health at the other” (Gurung, 2010, p. 5). The model “serves as a medium to convey a phenomenon to others” (Rodgers & Knafel, 2000, p. 199). The simple concept of a teeter-totter can be used to describe and illustrate the concept of resilience.

The individual, being central to this model, is illustrated with arms and legs outstretched, as if trying to maintain balance. Either end of the teeter-totter is weighted with adversity and attributes. The teeter-totter board represents the individual’s life, while the fulcrum, with its delicate point, symbolizes vulnerability. The dynamic nature of life allows for movement in either direction. This movement symbolizes the instability in a vulnerable individual’s state of being. The dashed circle represents the individual’s environment. The individual is not encapsulated in a protective shell, but rather pervious to outside influences, as such they are vulnerable to their environment (Kim, 2010). Influences, both good and bad can enter into the individual’s environment or flow from it. The words exposure, duration, frequency, and intensity, attempt to add the dimension of time to the model. Time does not behave like other spatial dimensions. Time cannot be reversed, stopped, or sped up. Studies of sympathetic nervous system arousal suggest that exposure to “intermittent stressors” results in a physiological toughness that correlates with “coping, positive performance, and emotional stability” (Dienstbier, 1989, p. 84). Seery, Homan and Silver (2010) in their longitudinal study of a U.S. national population of 18-101 year-olds (n = 2,398) demonstrate how exposure to adversity in moderation has adventitious benefits. They discovered that those exposed to moderate amounts of adversity in the past were better able to deal with newly encountered distressing situations.

This concept is referred to as “inoculation and coping” (Rutter, 2013, p. 445). Different from exposure to a major adversity for an extended period of time or no exposure to adversity at all, exposure to a moderate adversity with subsequent coping for short episodes will have a positive impact and prepare persons to deal with future adversities (Rutter, 2013; Seery et al., 2010).

This phenomenon is true for most, but particularly true for the vulnerable individual (Seery et al., 2010; Werner & Smith, 1992).

Finally, the double sided arrow extending across the bottom of the model represents the relationship of adversity and attributes to emotional stability, functional adequacy, and social competence on a continuum. Exposure to adversity and human function has a positive relationship (Seery et al., 2010; Werner & Smith, 1992). As adversity in one’s life increases it leads to harmful effects on human function, particularly in the area of mental health if not mitigated by resilient attributes. If an individual is faced with major adversity for an extended duration the teeter-totter tilts to the left and the individual is more likely to experience poor emotional stability, functional adequacy, and social competence. However, if the individual is only faced with minimal to moderate amounts of adversity for short periods of time and possesses many positive attributes the teeter-totter tilts to the right, more likely resulting in positive emotional stability, functional adequacy, and social competence. Similarly, if the individual chooses to navigate towards positive environmental attributes, such as community resources and social support, they will be better equipped to handle adversity and maintain balance. Whereas, if the individual intrinsically possesses positive individual attributes, such as self-reliance and perseverance, they start off with the teeter-totter weighted in the right direction, as a result they are better positioned on the board to balance adversity (Ungar, Liebenberg,

Boothroyd, Kwong, Lee, Leblanc, Duque, and Makhnach (2008). Resilience is demonstrated by the concept of balance as illustrated by the Teeter-Totter Resilience Model.

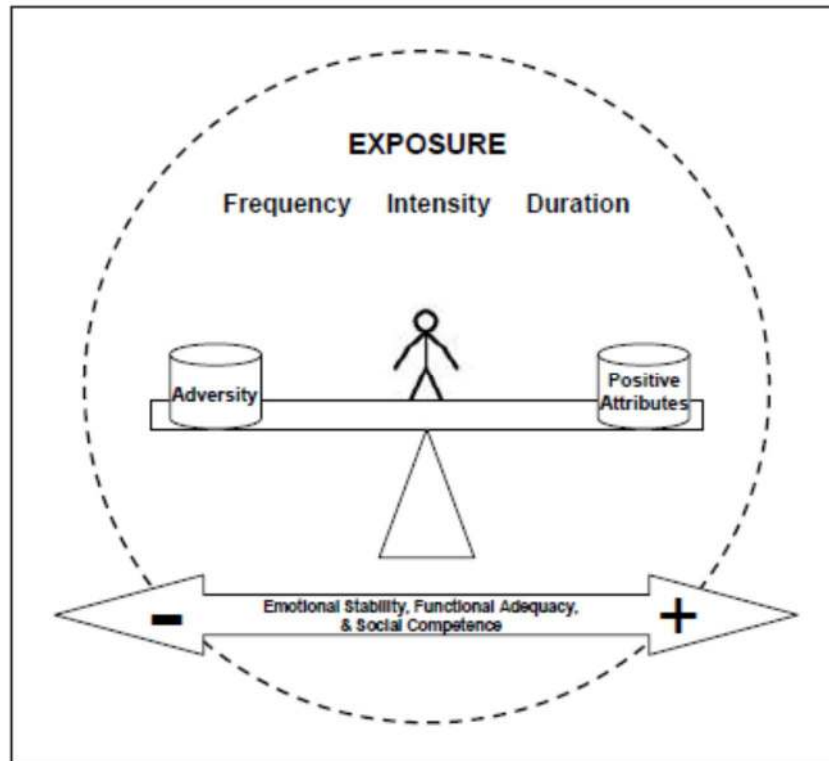


Figure 3: Teeter-Totter Resilience Model

Resilience as Facilitator of Transitioning

Much of the earlier resilience research has been problem focused, as such exploring resilience as a response to adversity (Rutter, 1987; Rutter, 2007). However, later research suggests exploring resilience using a more comprehensive framework. This more recent framework that includes protective processes found within the individual and those protective

processes that come from the environment, including family, peers, school or work, the community, healthcare, and faith community (Olsson et al., 2003). Individual and environmental attributes of resilience or protective factors, are elements that facilitate the process of effective adaptation (Masten & Coatsworth, 1998; Rutter, 1987).

There is a lack of resilience literature specific to emerging adults with disabilities transitioning to adulthood; however, the studies presented here identify resilience and resilient attributes that have been effective in bringing about positive outcomes for individuals with disabilities undergoing various types of transitioning. Based on the following literature it can be hypothesized that increasing resilience in emerging adults with disabilities will also facilitate their transitioning to adulthood.

In a review of literature, overall resilience and resilience attributes were associated with more favorable outcomes for adolescents and emerging adults with disabilities and chronic illnesses. Increased social competence and engagement with family and peers were associated with improved quality of life for individuals with physical disabilities (Alriksson-Schmidt, Wallander, & Biasini, 2007). Social support was associated with improved adaptation for individuals with a combination of physical and intellectual disabilities (Migerode, Maes, Buysse, & Brondeel, 2012). Internal and external protective factors facilitated adjustment for individuals with learning disability (Morrison & Cosden, 1997). Increased resilience was associated with decreased vulnerability and improved post-school outcomes for individuals with learning, emotional, behavioral, developmental and/or cognitive disabilities (Murray, 2003). Resilience was associated with improved adjustment, satisfaction with life, spirituality and fewer depressive symptoms for individuals with spinal cord injury (White, Driver, & Warren, 2010). Personal protective factors were associated with positive self-concept, future orientation, assertiveness,

enthusiasm, positive attitude, drive, good interpersonal relationships and internal locus of control for students with learning disabilities (Theron, 2004). Increased protective factors were associated with decreased risk and positive health for individuals with chronic illness (Haase, 2004).

Although there is a lack of research specific to resilience in emerging adults with disabilities while transitioning to adulthood, the literature above supports the notion that higher levels of resilience will theoretically facilitate the process of transitioning to adulthood, just as it has been shown to do in other types of transitioning. Combined, the attributes of resilience are referred to as transition facilitators in Transitions Theory (Meleis & Trangenstein, 1994; Schumacher & Meleis, 1994). In accordance with Transitions Theory, transition facilitators are those factors that bring about successful transitioning (Meleis & Trangenstein, 1994; Meleis et al., 2000; Schumacher & Meleis, 1994). Like resilience, successful transitioning can also be conceptualized as a balance of transition conditions, facilitators and inhibitors (Meleis, 2010).

Evaluating Transitioning to Adulthood

There is no widely held definition as to what constitutes successful transitioning, by whose standards, and by what measures the transition goals should be evaluated (King et al., 2005; Luther, 2001). Success of transitioning is often specific to the individual and to the nature of the transition. According to Meleis (2010), “a successful transition is one where feelings of distress are replaced with a sense of well-being” (p. 73). As such, some propose a subjective global measure as opposed to measuring specific life domains objectively, i.e. domains of health, financial, social function, or role function. This way an individual considers all that is occurring and evaluates their life according to their perception of well-being using their criteria (Diener,

1984; Pavot & Diener, 2004; Pavot & Diener, 1993). Similarly, Transitions Theory refers to this subjective and situational evaluation of one's self as "fluid integrative identities" (Meleis, 2010, p. 63) and suggests that transitions be evaluated through a mix of subjective, behavioral and interpersonal domains. Furthermore, given the dynamic nature of transitioning, Transitions Theory suggests that transitions be evaluated both during the process of transitioning and the end of the transitioning period (Meleis, 2010).

While a complete evaluation of transition calls for indicators to be assessed throughout the process of transitioning, as well as, at the end of a transitioning period, this study only examined the process of transitioning to adulthood for emerging adults with disabilities. It explored the transition facilitators of individual and environmental attributes or resilience, physical health, mental health, satisfaction with life and future orientation. Further studies are suggested to examine the outcome at the end of their transition to adulthood.

Transitions and Resilience Research to Guide Nursing Research

In the recent decade, the popularity of transition research has steadily increased (Masten et al., 2004). Although studies of transitioning are growing in popularity, very few focus specifically on resilience (Masten et al., 2004) and even fewer on resilience in populations with disabilities (Murray, 2003). A large portion of the transition literature is problem focused i.e. concerned with identifying specific barriers that impede transition (Betz & Redcay, 2002; Betz, 2004), while others focus on vocational training and the acquisition of technical skills (King et al., 2005). Healthcare, education, employment, independent living, social skills and recreational skills are predominant areas for concern (Betz & Redcay, 2002). While identifying and eliminating specific barriers and technical skill development are viable methods in aiding

transition, another method may be to examine strengths within the person and their environment and building resilience so that they may be better equipped to deal with varied challenges along the way (Benard, 1991; Masten & Coatsworth, 1998; Wagnild, 2010). Although not explicitly stated, the Transition Support Model by Hughes (2001) suggests building resilience to facilitate positive transitions to adulthood for emerging adults. The strategies in this model look to improve post-school outcomes by developing support in the individuals' environment and to increase competence within the individual (Hughes, 2001). The approach taken in this study is not meant to replace problem focused research but rather to complement it.

Nurses care for individuals, particularly those with disabilities. They are uniquely present to intervene throughout all stages of an individual's transitioning process; in the time leading up to an event, during an event, and after an event has occurred. Identifying resilient attributes can play a vital role in facilitating transitions. Nurses can work as moderators, fostering resilient growth and nurturing the process by incorporating intervention strategies that focus on developing resilient attributes both within individuals and in their environment. Knowing which resilient attributes are most effective in facilitating transitioning would be especially useful in the development of preventative holistic patient-centered nursing interventions. This study explored the central phenomenon of resilience. The research and practice implications of this study may suggest that resilience is a viable concept for the development of strength-based, patient-centered nursing interventions that facilitate transitioning.

CHAPTER THREE: RESEARCH METHODOLOGY

Introduction

The purpose of this chapter is to provide a narrative of the methodology employed in this study. The methodology will begin with a description of the mixed-methods design. Here, the philosophical underpinnings of mixed-methodology research will be presented along with the rationale for using a convergent parallel design. A procedural diagram will illustrate the study's sequence. Next, the overall sampling plan and strategy for use in the targeted population will be discussed. The quantitative and qualitative strands will be presented. Specific design descriptions, data collection procedures, instrumentation and method of analysis for each strand are presented, followed by the combined mixed methods plan for data analysis. This chapter will conclude with ethical considerations. Findings of the analyses will be presented in Chapter Four.

Methodology

This study utilized a mixed methods convergent parallel design. In convergent parallel designs, quantitative and qualitative data are collected simultaneously, analyzed independently and then combined for meaningful interpretation (Creswell & Plano Clark, 2011). In doing so, the researcher looks for mutually supported findings from those traditionally found separately in quantitative and qualitative methods. Both quantitative and qualitative strands have equal importance in informing the study and the results are converged for interpretation (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 1998).

The philosophical underpinning of this methodological triangulation is pragmatism (Tashakkori & Teddlie, 1998; Creswell & Plano Clark, 2011). Unlike positivism of a quantitative methodology and constructivism of a qualitative methodology, pragmatism rejects

the “either-or” (Tashakkori & Teddlie, 1998) and offers the logical solution of “what works” (Creswell & Plano Clark, 2011) by using both deductive and inductive logic. The primary focus was on answering the research questions. As a result, mixed-method research offered a more complete analysis and greater validity (Bryman, 2006; Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 1998).

Resilience in emerging adults with disabilities, in transition, was too complex for a single research method. Like other complex human phenomenon, this phenomenon was best explained through the use of combined data (Sandelowski, 2000). In this study, quantitative analyses measured variables using survey questionnaires to quantify resilience, physical health, mental health, satisfaction with life, future orientation and social support resources as they are facilitators associated with and indicators of healthy transition (Meleis, 2010). A qualitative focus group and individual interviews added depth and meaning to this study. Self-reported attributes of resilience were shared and goals of transitioning were revealed through prolonged engagement with participants. Personal stories provided insight into the complexity of transitioning from the emic perspective of the emerging adults with disabilities.

Due to the intricacy of this mixed methods study, a notation system is used to describe the methodology and a procedural diagram was created to illustrate and describe the design methods, procedures and products (Creswell & Plano Clark, 2011). The notation for this methodology *QUAN + QUAL = converged findings* means that equal emphasis was given to each strand and that both strands were conducted simultaneously to yield findings that were converged for meaningful interpretation.

As illustrated in Figure 4, a quantitative descriptive-correlational and a qualitative descriptive study was conducted at the same time. There was equal emphasis placed on these

two strands. Numeric data from survey questionnaires and text data from the focus group and individual interviews were analyzed independently. After independent analysis was completed, the findings were merged, cross tabulated and interpreted to assess relationships meaningfully. Methodological triangulation of qualitative and quantitative data produced a better understanding of resilience and identified key individual and environmental attributes that facilitate transitioning as reported by this select group of transitioning emerging adults with disabilities.

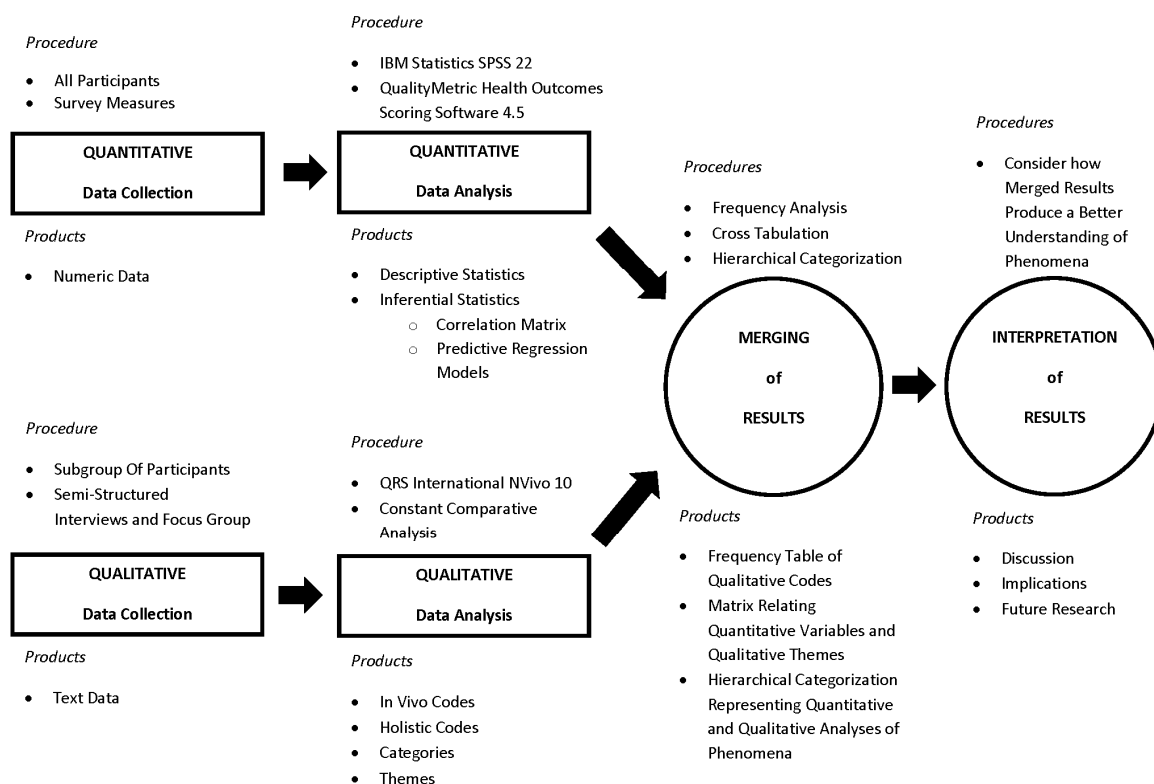


Figure 4: Procedural Diagram

Note. Diagram is to illustrate and describe the design methods, procedures and products of convergent mixed-methodology (Adapted from: Figure 4.3 Diagram for a Study That Used the Convergent Design as it appears in Creswell, J. & Plano Clark, V. (2011). *Designing and conducting mixed methods research*. (2nd Edition). Sage Publications)

Sampling Plan

The primary purpose of this study was to explore the central phenomenon of resilience among emerging adults with disabilities as they are transitioning to adulthood so as to identify key attributes that facilitate transitioning for these individuals. With that in mind the researcher chose an intensity sampling strategy to include “information-rich cases that manifest the phenomenon of interest” (Patton, 1990, p.169) guided by the theory of positive deviance (Pascale, Sternin, & Sternin, 2010). This purposeful sampling strategy (Patton, 1990) sought to

enroll participants who have been identified by disability advocacy organizations and given awards for their successes. The aim was to enroll participants who are willing and able to provide insights into the central phenomenon of resilience.

Positive deviance is of the contemporary branch of positive psychology. It is an approach to studying human behavior that focuses on what one is doing right (Pascale et al., 2010). It is based on the notion that there are certain people whose behaviors enable them to be more successful than others given the same circumstances (Pascale et al., 2010). The positive deviant is one who has already solved the problem that continues to confound others (Pascale et al., 2010). Positive deviance offers a strength-based focus that is different, but complementary to problem-focused studies (Mannes et al., 2005; Masten & Coatsworth, 1998; Peterson, 2009). This approach was chosen to maximize utility in eliciting meaningful data from participants.

Participants for this study are all recipients of a LEAP award. LEAP or Life Enrichment Awards Program is a grant program cosponsored by the Health Services for Children (HSC) Foundation in Washington, DC and partnering disability advocacy organizations that recognize the transitioning needs of adolescents and emerging adults with disabilities. Consistent with HSC Foundation's Youth Transitions Initiatives, LEAP is designed to assist adolescents and emerging adults with disabilities in transition. Multiple awards are given annually to individuals in the expanded Washington, DC area who demonstrate promise in achieving their transitioning goal. There have been an estimated two-hundred LEAP awardees since the program's inception in 2007 to 2013.

LEAP awards vary in nature. While many awards have consisted of technological assistive devices such as computers equipped with specialized programs, other awards have included enrollment in therapeutic exercise programs, piano and/or voice lessons, academic

enrichment programs and proper attire for school or job interview (HSC Foundation, 2009). In all, the LEAP awards are designed to assist youth with disabilities to meet the challenges related to transitioning to adulthood.

This study purposely sampled participants who were LEAP awardees from 2007 to 2013. It was decided by the researcher to include a cross-disability sample of participants. Cross-disability is an approach that does not distinguish among types of disability. This non-categorical sampling strategy has been used in a number of studies of persons with disabilities and concludes, “despite differences related to diagnoses [individuals with disabilities] share more similarities than differences when measured by psychosocial constructs” (Betz, 2004, p. 224). Although illness varies, the psychosocial constructs of disease impact and disability are common (Stein & Jessop, 1982). No one was excluded on the basis of their disability. It was equally important to learn about resilience and transitioning experiences from individuals with physical and mental disabilities, intellectual and developmental disabilities, and emotional disorders (Rubin & Rubin, 2012). All who met the eligibility criteria for this study were included regardless of their diagnostic category.

In addition to being a LEAP award recipient, additional enrollment criteria for this study included:

- age 13-26 years at the time of receiving the LEAP award
- age 18-26 years at the time of data collection
- able to communicate in English
- able to read and comprehend English at a 6th grade level
- able to understand study instructions
- able to complete the survey questionnaires independently or with surrogate assistance
- able to participate in a focus group or an individual interview
- able to provide own consent to participate

Failure to meet all enrollment criteria would constitute exclusion from this study.

Following IRB approval from Molloy College (Appendix R) and written support from HSC Foundation (Appendix S) data collection began.

Quantitative Strand

Quantitative Research Questions

The quantitative descriptive strand was guided by the following research questions and hypotheses.

1. What is the level of resilience, physical health, mental health, life satisfaction and future orientation among this select group of emerging adults with disabilities?
2. What is the relationship among resilience, physical health, mental health, life satisfaction and future orientation among this select group of emerging adults with disabilities?

3. How many areas of social support are reported by this select group of emerging adults with disabilities?
4. What is the relationship between the quantity of self-reported social support and resilience among this select group of emerging adults with disabilities?

Hypotheses

The hypotheses for the quantitative portion of this study are:

H₁: Resilience will be associated with the transition facilitators of self-reported physical health, mental health, satisfaction with life and future orientation.

H₁: The quantity of self-reported social support will be associated with level of resilience

Design

The quantitative strand of this study utilized a descriptive-correlational one-group design with a bivariate analysis of the relationship between predictor and criterion variables. It will describe the current status of the participants' level of resilience, physical and mental health, satisfaction with life, future orientation, and quantity of social support; and determines the relationship among those variables for this select group of emerging adults with disabilities as they are transitioning to adulthood.

Data Collection

Data collection for the quantitative strand took place over a seven month period, October 2013-May 2014. In order to maximize the sample size, the researcher followed a tailored design method using multiple ways to contact participants (Dillman, Smyth, & Christian, 2009).

First a representative from the HSC Foundation contacted the LEAP cosponsoring organizations to introduce the researcher and garner support for the study. Then, the researcher emailed the study proposal abstract and answered any questions the LEAP cosponsoring organization had regarding the study. Contact information of LEAP awardees was requested by the researcher. The LEAP cosponsoring organization contacted their LEAP awardee(s) first, and then sent contact information to the researcher. From an estimated 200 LEAP awardees a total of 150 names with contact information was received; 107 names with U.S. postal addresses and 43 names with email addresses.

The researcher then made a second contact via U.S. mail or email, depending on the contact information that was received. One hundred fifty recruitment packets were sent. Each contained the Invitation to Participate, Informed Consent, Informed Consent Signature Page, Instructions and instruments (Appendices D - F, K, L- O) along with a prepaid self-addressed return envelope. A follow-up post card or email was sent approximately one month later as a reminder. Using the names provided by LEAP partners and contacting awardees via their preferred method reduced coverage error (Dillman et al., 2009). Of the 150 recruitment packets, nine were returned unopened due to incorrect addresses and one parent contacted the researcher to say that the child was deceased. Of the remaining 140 recruitment packets, 32 completed packets were received representing a response rate of 23%. A thank you note with a token incentive of \$15 was distributed to all participants. One packet was later excluded during the qualitative phase due to the participant's inability to answer the interview questions independently without parenteral involvement, resulting in a final sample size $N = 31$.

Instruments

Three instruments and one demographic questionnaire were used in the quantitative strand of this study. The estimated time for completion of all survey questionnaires was forty-five to sixty minutes. All survey questionnaires were written in English at a 4th-6th grade reading level. Participants were permitted to use assistive technology for reading, such as an Intel Reader or similar, or have the survey questionnaires read to them and answers recorded by a parent/guardian or assistant. Although a participant may have received assistance in completing the survey questionnaires, it was explicitly stated in the instructions (Appendix K) that the responses must be their own. It was important that data in this study remained true to the participant's point of view and not that of their parent/guardian or assistant.

14- Item Resilience Scale (RS-14)

The Resilience Scale (RS), developed by Wagnild and Young in 1993 is a widely used tool designed to measure five underlying characteristics of resilience: meaningful life, perseverance, equanimity, self-reliance and existential aloneness. These characteristics of resilience are known as the Resilience Core and are those personality characteristics that enhance adaptation (Wagnild, 2010).

Although the RS was developed from grounded theory research studies of older populations, it has been widely used on adolescents and young adults (Wagnild & Young, 1993b). One methodological review of instruments that measure resilience determined that the RS was the "best instrument to study resilience in the adolescents" (Ahern, Kiehl, Sole, & Byers, 2006); while another review, determined the RS had "the widest application out of those

[instruments] identified, and has been used with adolescents, younger and older adults” (Windle, Bennett, & Noyes, 2011).

The 14-item Resilience Scale (RS-14) used in this study is a 7 point Likert-type scale that ranges from strongly disagree to strongly agree. It was adapted from the original 25-item RS by Wagnild and Young (1993). Like the original, the RS-14 has well documented reliability and validity. Support for internal consistency is demonstrated by Cronbach’s’s alpha coefficients ranging 0.91-0.94. Evidence to support content and construct validity is documented in the user’s guide (Wagnild, 2010). The 14-item RS was chosen over the original 25-item RS for this study in an effort to reduce response burden.

Satisfaction with Life Scale (SWLS)

Diener’s SWLS is a 5-item, 7 point Likert-type scale that ranges from strongly disagree to strongly agree. It was designed to measure global cognitive judgments of satisfaction with one's life as a whole (Diener et al., 1985). This tool does not measure satisfaction within specific life domains, i.e. health, financial, social function or role function, but rather it allows the participant to determine their own overall perception of well-being using their own criteria (Pavot & Diener, 1993).

The SWLS has demonstrated validity and reliability in studies of adolescents and young adults (Gadernann, Schonert-Reichl, & Zumbo, 2010) . Support for internal consistency is demonstrated by Cronbach’s alpha coefficients ranging 0.79-0.89 (Neto, 1993; Pavot & Diener, 1993) and evidence to support convergent validity is documented with moderate to large correlations (Neto, 1993; Pavot, Diener, Colvin, & Sandvik, 1991; Pavot & Diener, 1993).

Medical Outcomes Study 12-Item Short Form Version 2 (SF-12v2)

The 12-Item Short Form Health Survey (SF-12v2) was developed from the SF-36v2 and used for the Medical Outcomes Study (MOS), a multi-year study of patients with chronic conditions (Ware, Kosinski, & Keller, 1995; Ware et al., 2010). The instrument is a five-choice response scale that provides a generic measure of disease burden that is applicable to those aged 14 years and older by quantifying eight health domains affected by disease. The domains are physical functioning, role-physical, bodily pain, general health, vitality, social functioning, role-emotional and mental health. Together the measures yield a score for overall physical and mental health: the Physical Components Summary (PCS) and the Mental Components Summary (Ware et al., 1995; Ware et al., 2010). All SF instruments are scored using QualityMetric Health Outcomes Scoring Software 4.5. Scoring is norm-based with standardization of mean scores and standard deviations for the U.S. general population (Ware et al., 2010). The population norms were determined in 1998 using a total sample of 6,742 non-institutionalized 18-75+ year-olds in the U.S. (Quality Metric, n.d.).

The SF-12v2 has well documented reliability and validity in measuring disease burden. Support for internal consistency is demonstrated by Cronbach's alpha coefficients ranging .86-.91 for the PCS and .76-.87 for the MCS in numerous studies. Evidence to support construct, convergent and discriminant validity, known-groups comparisons and criterion validity is documented in the SF-12v2 user's manual. The SF-12v2 was chosen over the SF-36v2 in an effort to reduce response burden.

Demographic Questionnaire

The demographic questionnaire was purposely created for this study. The first ten items were adapted from items found on two national surveys: 2009-2010 National Survey of Children with Special Health Care Needs Frequently Asked Questions (CDC/National Center for Health Statistics, 2013) and the 2009 National Longitudinal Transition Study (NLTS2) parent and youth interview and questionnaire (Newman, Wagner, Cameto, & Knokey, 2009). Questions addressed areas of gender, age, education, living arrangements, community dwelling, employment, diagnosis, illness severity, nature of disability, current services, functional limitations, transportation and select resilient attributes.

The final two items on the demographic questionnaire were developed to assess select resilient attributes, social support resources and future orientation. The item pertaining to social support asks the participant to select all the areas from which they receive social support. The theoretical construct of social support as a factor in improving outcomes is well documented in the literature (Bolla, De Joseph, Norbeck, & Smith, 1996; Hobfoll & Lerman, 1989; Hyman, Gold, & Cott, 2003; Norbeck et al., 1981). Social support may come from family, friends, school, work, community, places of worship and healthcare providers. These resources help the individual through challenging times and foster the individual's ability to reach full potential and are among those environmental attributes of resilience identified in research that act to moderate an individual's social risk (Earvolino-Ramirez, 2007; Kim, 2010a; Masten, 1994; Masten & Coatsworth, 1998; Olsson et al., 2003; Rhodewalt & Zone, 1989; Rutter, 1987; Wagnild, 2010; Wallston, 2010; Werner & Smith, 1982). The item pertaining to future orientation asks participants to select their level of agreement to the statement, "I am very sure that one day I will get to where I want to be in life." This item was taken from the New American Dream poll

(Hornblower, 1997). Future orientation is an individual's perception of their future (Nurmi et al., 1995). Future orientation, although not directly observable signifies one's life has meaning, motivation, and purpose (Wagnild, 2010). This is a particularly important concept for the emerging adult because their adulthood plans are now being explored (Arnett, 2000a; Arnett, 2000b). (Appendix L)

Quantitative Data Analysis

Descriptive and inferential statistics were applied to analyze all data using Statistical Package for Social Sciences (SPSS) statistical software version 22. The SF-12v2 scores were first analyzed using QualityMetric Health Outcomes Scoring Software 4.5 that was provided to the researcher by QualityMetric Incorporated; the individual mean scores were then further analyzed along with all other study measurements using SPSS statistical software version 22.

Research questions that were addressed are:

1. What is the level of resilience, physical health, mental health, life satisfaction and future orientation among this select group of emerging adults with disabilities?
2. What is the relationship among resilience, physical health, mental health, life satisfaction and future orientation among this select group of emerging adults with disabilities?
3. How many areas of social support are reported by this select group of emerging adults with disabilities?
4. What is the relationship between the quantity of self-reported social support and resilience among this select group of emerging adults with disabilities?

Table 2 below summarizes the nature of the research variables and the corresponding measurement instruments used to explore each research question.

Table 2: Research Variables and Measurement Instruments

Research Question	Variable	Variable Type	Measurement Instrument
1	Resilience		RS-14
	Physical Health		SF-12v2: SFPCS
	Mental Health		SF-12v2: SFMCS
	Life Satisfaction		SWLS
	Future Orientation		D13*
2	Level of Resilience	Independent	RS-14
2a	Level of Physical Health	Dependent	SF-12v2: SFPCS
2b	Level of Mental Health	Dependent	SF-12v2: SFMCS
2c	Level of Satisfaction with Life	Dependent	SWLS
2d	Level of Future Orientation	Dependent	D13*
3	Quantity of Social Support Resources	Independent	D12*
4	Quantity of Social Support Resources	Independent	RS-14
	Level of resilience	Dependent	D12*

**Note. D12 and D13 are Demographic Questionnaire questions #12 and #13*

Descriptive statistics: Frequencies and percentages were calculated for participant socio-demographic characteristics. The means, medians, modes and standard deviations were calculated from the participants' level of resilience, physical health, mental health, life satisfaction, future orientation and quantity of social support.

Inferential statistics: Pearson product-moment correlations were computed to examine the relationship among transition facilitators: resilience, physical health, mental health, life satisfaction, future orientation and quantity of social support resources. A regression analysis was computed to examine the linearity and define the relationships identified in the correlation analysis. Bivariate linear regressions were computed to determine whether resilience is a

predictor of self-reported physical health, mental health, life satisfaction and future orientation; and whether the quantity of self-reported social support was a predictor of resilience.

Scientific Adequacy

A descriptive-correlational one-group design is not as effective in controlling threats as would be a controlled experimental design. However to maintain rigor, the investigator adhered to the epistemological standards of power and reliability, and meeting assumptions for statistical analysis. Every effort was made to control potential bias or error.

There are a number of ways to determine sample size in research. This study explored a method based on the number of variables. This method calculated a sample size that that would provide at least five observations for each category of each variable (Wood & Ross-Kerr, 2011). That method yielded a sample size of 10 for two variables, one predictor and one criterion per analysis. This study sampled 31 participants, thus assuring adequate power.

Reliability was assessed using Cronbach's alpha test for internal consistency and inter-item correlations. Support for reliability is considered acceptable when Cronbach's alpha is greater than or equal to 0.7 and inter-item correlation coefficients are 0.3 or higher (LoBiondo Wood & Haber, 2010).

The Cronbach's alpha reliability coefficient of the RS-14 was 0.925 as compared to coefficients ranging 0.91-0.94 obtained in previously published studies (Wagnild, 2011). Cronbach's alpha reliability coefficient of 0.925 indicates a high level of internal consistency and overall reliability of the instrument with this sample.

Table 3 shows Item correlations for the RS-14. It demonstrates what the Cronbach's alpha would have been if a particular item were deleted from the RS-14. The column titled

Cronbach's Alpha if Item Deleted indicates that if any items, with the exception of item 4, were deleted the Cronbach's alpha would be lower. The corrected item-total correlation value of item 4 is 0.279 indicating that this item is not correlating well with the rest of the items on the scale. However, the removal of item 4 would only result in a small improvement in Cronbach's alpha and the item-total correlation is close to acceptable standards, therefore item 4 was not excluded. Additionally, the RS-14 is an acceptable instrument with demonstrated reliability and internal consistency and therefore was not altered.

Table 3: Item Correlations RS-14

<i>Item Correlations RS-14</i>		
Item #	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
1	.801	.915
2	.733	.918
3	.659	.920
4	.279	.933
5	.519	.925
6	.744	.917
7	.704	.918
8	.557	.923
9	.643	.920
10	.680	.919
11	.865	.914
12	.709	.918
13	.656	.920
14	.822	.913

The Cronbach's alpha reliability of the SWLS is 0.858 which compares well to coefficients ranging 0.79-0.89 obtained in previously published studies (Pavot & Diener, 1993). Cronbach's alpha reliability of 0.858 indicates a high level of internal consistency and overall reliability of the instrument with this sample.

Table 4 shows Item correlations for the SWLS. It demonstrates what the Cronbach's alpha would have been if a particular item were deleted from the SWLS. The column titled Cronbach's Alpha if Item Deleted indicates that if any items, with the exception of item 5, were deleted the Cronbach's alpha would be lower. The corrected item-total correlation value of item 5 is 0.410 indicating that this item may not be correlating as well as the rest of the items on the scale. The removal of item 5 would only result in a small improvement in Cronbach's alpha and the item-total correlation exceeded acceptable standards, therefore item 5 was not excluded. Additionally, the SWLS is an acceptable instrument with demonstrated reliability and internal consistency and therefore was not altered.

Table 4: Item Correlations SWLS

<i>Item Correlation SWLS</i>		
Item #	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
1	.768	.804
2	.628	.839
3	.810	.791
4	.773	.800
5	.410	.889

Graphical displays of data in the form of scatterplots, normality histograms, normal probability plots and residual plots demonstrate that the assumptions necessary for bivariate linear regression have been met. Scatterplots demonstrated linearity between the dependent and independent variables. Histograms demonstrated a normal distribution. Probability plots also demonstrated normality of data. The normal probability plot of the residuals showed the points are close to the diagonal line; therefore, the residuals appear to be approximately normally distributed. Residual plots demonstrated homoscedasticity. The residual plots showed the points

are randomly scattered around zero. This implied that the variance is relatively constant and the assumption of homoscedasticity has not been violated.

Qualitative Strand

Qualitative Research Questions

The qualitative descriptive strand was guided by the following research questions and objectives.

1. To what extent are the self-reported values and goals of developmental transitioning consistent across this select group of emerging adults with disabilities?
2. To what extent are the self-reported challenges of transitioning consistent across this select group of emerging adults with disabilities?
3. To what extent are the self-reported attributes of resilience consistent across this select group of emerging adults with disabilities? Those found within the person? Those found in their environment?

Objectives

The objectives for the qualitative portion of this study are:

1. To identify the goals of healthy transitioning that are reported by this select group of participants.
2. To identify the adversities related to transitioning that have challenged this select group of participants.
3. To identify the attributes of resilience that are reported by this select group of participants and to further identify which attributes are key characteristics of the individual and which attributes come from sources in the environment.

Design

The qualitative strand utilized a descriptive design. A qualitative descriptive methodology was chosen for its clear potential for mixed method triangulation with quantitative data. Pure description was obtained to answer the research questions as to how this sample of emerging adults with disabilities manages adversities related to their transitioning to adulthood.

A qualitative descriptive methodology is best when seeking to provide only accurate description and interpretation (Speziale & Carpenter, 2007). This methodology is pragmatic in nature by which it “stays very close to the data and to the informants’ points of view” (Neergaard, Olesen, Andersen, & Sondergaard, 2009). The strength of this methodology is that it leads to “interpretation that is low-inference” and is “likely to result in easier consensus among researchers” (Sandelowski, 2000, p. 335). While it is not grounded in one particular theory or philosophy, qualitative descriptive research embodies a number of “hues, tones, and textures” from phenomenology, grounded theory, ethnography, and narrative methodologies

(Sandelowski, 2000, p.33). While some may feel qualitative descriptive research is too simplistic and lacks rigor (Milne & Oberle, 2005), it is this researcher's opinion that the purely factual and uncomplicated nature of this methodology is its strength. The method had utility in the population of interest for this study and readily triangulated with quantitative data.

Congruent with the purpose of qualitative descriptive studies, this study sought to identify "what" and "how" in managing adversities related to transitioning (Knupfer & Lellan, 2001). Understanding adversity related to transitioning is important because today more children with disabilities are surviving into adulthood (Okumura et al., 2010). Although causal relationships are beyond the scope of descriptive studies (Knupfer & Lellan, 2001), this exploratory study can contribute to studies for future recommendations and interventions offered to emerging adults with disabilities as they are transitioning to adulthood.

Data Collection

Data collection for the qualitative strand took place over a five month period, January 2014-May 2014. The qualitative sample (n = 10) drew from the larger quantitative sample (N = 31). All who participated in the quantitative strand were invited to participate in a focus group or an individual interview. Upon completion of the survey questionnaires, interested participants checked a box indicating they would be willing to be contacted to take part in an interview. The researcher contacted each interested participant by telephone and provided information about the focus group and individual interview. A total of 12 participants expressed interest in taking part in the qualitative strand; six expressed interest in taking part in a focus group and six expressed interest in taking part in an individual interview. One participant who originally expressed interest in the focus group changed his mind. A final five participants took part in the focus

group. Six individual interviews were conducted; one was excluded due to the participant's inability to answer questions independently without parenteral involvement. A final five participant interviews were included for analysis. In total, the qualitative strand of this study included ten participants; focus group (n = 5) and individual interview (n = 5). Questions for both the focus group and individual interviews were drawn from the same semistructured, open-ended interview guide.

Consistent with qualitative research, the researcher was the instrument for data collection in this study. A focus group and individual interviews were the two major data sources. Data collection ceased when the researcher determined that repetition of ideas was occurring and that additional data collection and analysis would not add to the findings; saturation was reached as no new ideas emerged (Glaser & Strauss, 1967). Other data sources included researcher memos and field notes. Combined, these sources were triangulated to provide mutually supported findings. Triangulation facilitated the researcher's ability to examine the experiences, motives, opinions of the participants (Rubin & Rubin, 2012) and achieve a deeper understanding of the central phenomena of resilience through the lens of this select group of emerging adults with disabilities as they are transitioning to adulthood.

Focus Group

The focus group sought to encourage group discussion and identify a range of perspectives that can be useful in exploring the complex subjects (Ivey, 2011; Morgan, 1996; Powell & Single, 1996), such as the central phenomena of resilience. The focus group adhered to the method of positive psychology. The goal of the focus group was to achieve consensus in key individual and environmental attributes that have worked in helping these select individuals

manage adversities during their process of transitioning. Participants spoke openly and interacted comfortably with each other and the moderator. Responses were drawn from their personal experience and spontaneous interaction from the group. The sharing of personal experiences and spontaneous interaction is a particular advantage of the focus group method (Ivey, 2011; Morgan, 1996; Powell & Single, 1996).

The focus group was conducted at Health Services for Children (HSC) Center for National Youth Transitions in Washington, DC. Although all participants were LEAP awardees, they met for the first time during the focus group and for the purpose of this study. The participants were cordial and appeared comfortable with each other. The room was private with sufficient space and lighting and was handicap accessible. Chairs were arranged in a circular fashion around a conference table to invite discussion. The focus group consisted of five participants ($n = 5$) and was convened for approximately 2 hours. This number of participants and length of time allowed each participant ample time to speak and exchange information. Participants presented their points of view and respectfully observed other points of view. Supporting comments were made and consensus of information was reached. The group followed a somewhat structured format in that the researcher guided the discussion of resilience using a set of prepared questions (Morgan, 1996) which fostered meaningful interaction and in-depth discussion among the participants. The interview questions were asked from a rehearsed semistructured, open-ended interview guide. In order to fully capture the experience of the participant accurately, it was sometimes necessary for the researcher to repeat the participants own words as a form of follow-up and to gain clarification (Rubin & Rubin, 2012). Probes were used as needed during times of no response and/or prolonged silence of greater than five seconds

(Appendix M). The focus group allowed for a wide range of ideas to be discussed that ultimately lead to group consensus of ideas.

The session was audiotaped with permission of the participants, transcribed and prepared for analysis. The researcher recorded notes by hand before, during and after the focus group. All data were de-identified and stored in a password protected file. Participants received an incentive of \$25 plus traveling expenses upon completion of the focus group.

Focus group participants and their families participated in a pre- and post-focus group gathering hosted by HSC. The pre-focus group gathering afforded the researcher, participants and participants' families the opportunity to get to know each other. This informal gathering was valuable and facilitated the more formal discussion to follow (Powell & Single, 1996). Light refreshments were served. Upon completion of the focus group, participants stayed for a post-focus group "pizza party" reception. During that time the researcher, participants and participants' families along with a representative from HSC shared openly about the LEAP program.

Individual Interviews

Individual interviews were conducted to elicit rich and detailed information from the participants (Rubin & Rubin, 2012). The greater depth of information is an advantage of individual interviews (Morgan, 1996). During the interview, participants were encouraged to answer questions in a manner that they felt was most appropriate. Participants spoke openly and shared information drawn from personal experiences, knowledge and attitudes. Participants were in control of their responses and revealed opinions that were not influenced by others. Like the focus group, the individual interviews adhered to the methods of positive psychology. The goal

of the interview was to elicit key individual and environmental attributes that have helped these select individuals in managing adversities during their process of transitioning.

The individual interviews were conducted via telephone by the researcher during a previously agreed upon time, in the privacy of the researcher's office. To assure privacy, the office door was locked and a sign stating "interview in progress" was posted outside the office to avoid any interruption. Each interview took approximately forty-five minutes to complete. The interview questions were asked from the same rehearsed open-ended interview guide as was the focus group. In order to fully capture the experience of the participant accurately, it was sometimes necessary for the researcher to repeat the participants own words as a form of follow-up and to gain clarification (Rubin & Rubin, 2012). Probes were used as needed during times of no response and/or prolonged silence of greater than five seconds (Appendix M). The individual interviews allowed for a deeper examination of personal experiences.

Interviews were audiotaped with permission of the participant, transcribed and prepared for analysis. The researcher recorded notes by hand before, during and after each interview. All data were de-identified and stored in a password protected file. Participants were mailed an incentive of \$25 upon completion of the interview.

Interview Guide

A semistructured, open-ended interview guide with probes was developed specifically for this study (Rubin & Rubin, 2012). The same interview guide was used for both the focus group and individual interviews. The questions were designed to explore personal experiences of overcoming adversity and to identify attributes of resilience that have aided these individuals

during their process of transitioning. In the focus group, this guide stimulated group discussion on that same topic. The guide follows an Appreciative Inquiry (AI) approach.

AI is a method of inquiry that focuses on learning strengths (Cooperrider, Whitney, & Stavros, 2003; Cooperrider & Whitney, 2005). Although AI was originally developed by Cooperrider as a means of organizational development, an AI approach has been used in a number of situations and in a variety of ways including recent studies of at-risk youth (Bonham, 2011; Jones, Lyrantzis, & Kastens, 2010; McAdam & Mirza, 2009) and building a framework for family-centered services (Madsen, 2009). An AI approach is particularly useful in research when the researcher is looking to focus on what one does well (Cooperrider et al., 2003; Cooperrider & Whitney, 2005). Appreciative inquiry follows a 4-D cycle of inquiry. Each stage: discovery, dream, design and destiny, guides the researcher in effectively asking questions that will evoke positive responses (Cooperrider et al., 2003; Cooperrider & Whitney, 2005). Consistent with the contemporary branch of positive psychology, rather than focusing on what one is doing wrong (Kobau et al., 2011; Peterson, 2009), an AI approach focuses on what one is doing right (Cooperrider et al., 2003; Cooperrider & Whitney, 2005). Figure 5 provides a visual display of the cycle and each of the four stages which is described as follows.

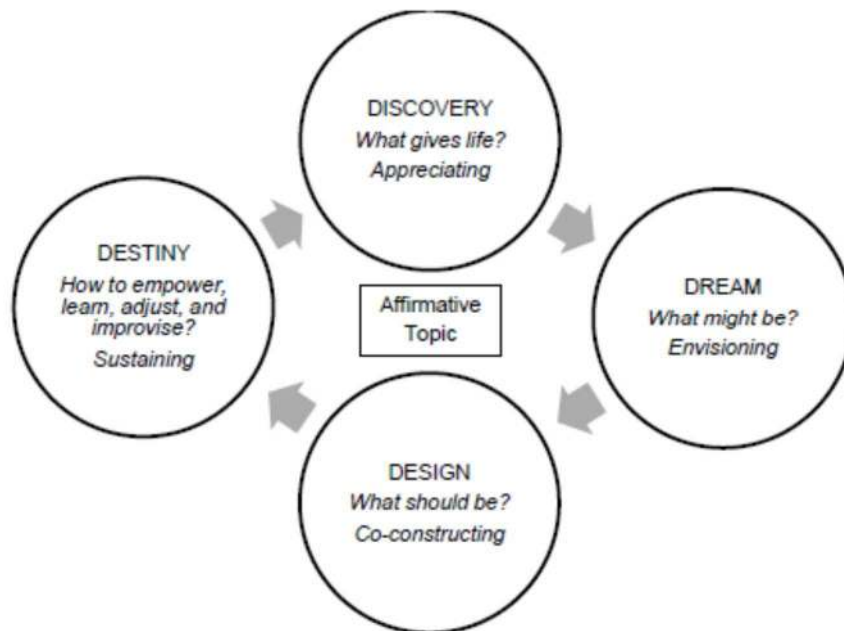


Figure 5: 4-D Cycle of Appreciative Inquiry

Note. (Adopted from Cooperrider, D., & Whitney, D. (Eds.). (2005). *Appreciative inquiry: A positive revolution in change*. San Francisco: Berrett-Koehler Publishers. pp. 16.)

The Discovery stage of the 4-D cycle is described as “the articulation of strengths [and reveals] the best of what has been and what is” (Cooperrider & Whitney, 2005, p. 16). The discovery stage of the interview guide consisted of seven questions with probes. Participants were asked affirmative questions designed to elicit positive responses about their values on becoming an adult and goals they hope to achieve; the challenges they face and how they are managing those challenges as they prepare for adulthood; their most proud moments; what they value most in themselves; who in their life offers the most support; and lastly, what is valued in that person who offers the most support.

The Dream stage of the 4-D cycle of is an affirmative exploration of what could be. This stage is described as “a clear results-oriented vision in relation to discovered potential and

in relation to questions of higher purpose” (Cooperrider & Whitney, 2005, p. 16). The dream stage of the interview guide consisted of three questions with probes. Prior to answering, participants were asked to first imagine themselves as a leader in an advocacy movement for persons with disabilities. The affirmative questions for this stage were designed to elicit positive responses about what inspired them to lead; what they hoped to contribute; and how others can learn from their accomplishments.

The Design stage of the 4-D cycle reveals the ideal of how something should be done. This stage encourages individuals to embrace and draw upon their own strengths while expanding their view of self (Cooperrider & Whitney, 2005). The design stage of the interview guide consisted of one question with probes. Participants were asked to first reflect on some of the ways they, or others they know with disabilities, are managing challenges related to transitioning to adulthood. The affirmative question for this stage was designed to elicit positive responses about what in themselves stands out as being exceptionally promising in managing challenges related to transitioning to adulthood and if that can be passed on to others.

The Destiny stage of the 4-D cycle affirmatively explores what the future may bring. This stage is described as strengthening the whole and building hope (Cooperrider & Whitney, 2005). In this stage, participants were asked to identify three wishes, followed by what small changes can be made now and how they would like to be personally involved.

AI questions are positive questions developed to solicit key behaviors or characteristics that are working, rather than highlighting what is not. AI empowers individuals by helping them to identify and build upon what is working well in their lives, i.e. work and relationships (Selcer, Goodman, & Decker, 2012). The emerging adults in this study were asked affirmative questions pertaining to managing adversities during their transition to adulthood. The interview guide was

designed using an AI approach specifically to investigate life values and goals, inner strength and support systems; and to elicit positive behaviors that have aided in mitigating adversity in the lives of this select group of emerging adults with disabilities (Appendix M).

Qualitative Data Analysis

Saldaña's (2009), Codes-to -Theory Model served as the primary method of analysis for the qualitative data. Other analysis methods by Glaser (1965), Lincoln and Guba (1985) and Rubin and Rubin (2012), were also employed to enhance the analysis. Transcripts were first manually coded. NVivo 10 ® was then used as a platform to further organize, link and analyze data across interviews. The following research questions were addressed.

1. To what extent are the self-reported values and goals of developmental transitioning consistent across this select group of emerging adults with disabilities?
2. To what extent are the self-reported challenges of transitioning consistent across this select group of emerging adults with disabilities?
3. To what extent are the self-reported attributes of resilience consistent across this select group of emerging adults with disabilities? Those found within the person? Those found in their environment?

Qualitative findings for this study were revealed through data triangulation. Data from focus group and individual interviews provided mutually supported findings. Blending data sources is an added advantage to this study. While the focus group data offered breadth, individual interview data offered depth (Morgan, 1996). The focus group allowed for a wide range of ideas to be discussed that ultimately lead to group consensus; and the individual

interviews allowed for a deeper examination of personal experiences. The combined focus group and individual interview data converged to create a triangulation of findings.

Focus group and individual interview data were analyzed sequentially throughout the data collection period. Two telephone interviews were conducted and analyzed prior to the focus group then the final three telephone interviews were conducted and analyzed after the focus group. Data collection ceased at the point of saturation when no new relevant information was discovered (Glaser & Straus, 1967). All data were combined for interpretation. The researcher concluded that further data collection would not add to the findings.

Word-for-word transcripts were prepared by a professional transcription service. Accuracy of each transcribed interview was verified by the researcher through the use of audiotaped playback. Data reduction began with reading, rereading and summarizing the transcripts. Summarizing transcripts is beneficial when analyzing across interviews (Rubin & Rubin, 2012). After summation, the transcript data were sorted according to each stage in the appreciative inquiry 4-D Cycle of Appreciative Inquiry; discovery, dream, design and destiny and examined. Transcript data were then sorted again according to the research questions and further examined (Rubin & Rubin, 2012). After further examination and consultation with qualitative expert, the latter technique was chosen because it proved to be more meaningful in addressing the purpose of this study. The qualitative expert read the transcripts and summaries, and reviewed the researcher's preliminary analyses.

Next, the researcher examined the transcripts line-by-line in search of relevant data; excerpts and notable quotes were highlighted. Excerpts were initially coded in vivo and a separate file was created for notable quotes. Congruent to qualitative-descriptive studies, coding in vivo or using the participants own words serves to keep data in its naturalistic form (Lincoln

& Guba, 1985). Notable quotes are words in which the participant uses to recap and convey a message; such quotes were further examined for they often suggested themes directly related to the research question (Rubin & Rubin, 2012). Careful attention was taken to compare transcript data to the researcher's memos. The researcher's memos identified significant experiences and expressions reported by the participants during the data collection process, as well as body language and group interaction witnessed by the researcher during the focus group.

Holistic codes were then created from the in vivo codes to “capture and represent the essence” (p. 19) of an entire excerpt (Saldaña, 2009). Utilizing the inductive process of constant comparative method of analysis, new codes were compared to earlier codes and all other data (Glaser, 1965). Similarities and differences were sorted and codes were grouped and regrouped into categories that represent the phenomena. Each category was then further analyzed for emerging themes (Saldaña, 2009). Searching for, recognizing and linking relevant concepts is essential in early analysis (Rubin & Rubin, 2012; Saldaña, 2009).

As relationships among codes appeared the patterns were identified. Categories and subcategories were developed and themes emerged. Caution was taken so as not to make hasty generalizations during the analyses. A qualitative expert was again consulted to confirm that each code, category and theme conceptually represented what the data signified. The goal of this analysis was to capture the themes from the emic perspective of the participants and to interpret their perspective truthfully in a meaningful context that is significant (Milne & Oberle, 2005). Figure 6 serves as a visual representation of the process of this qualitative analysis (Saldaña, 2009). Table 5 is an abridged example of how the researcher utilized Saldaña's Codes-to-Theory process for the development of the theme *Life is a Journey*. Themes were not further developed into theory, because theory development was beyond the scope of this descriptive study.

THE CODING MANUAL FOR QUALITATIVE RESEARCHERS

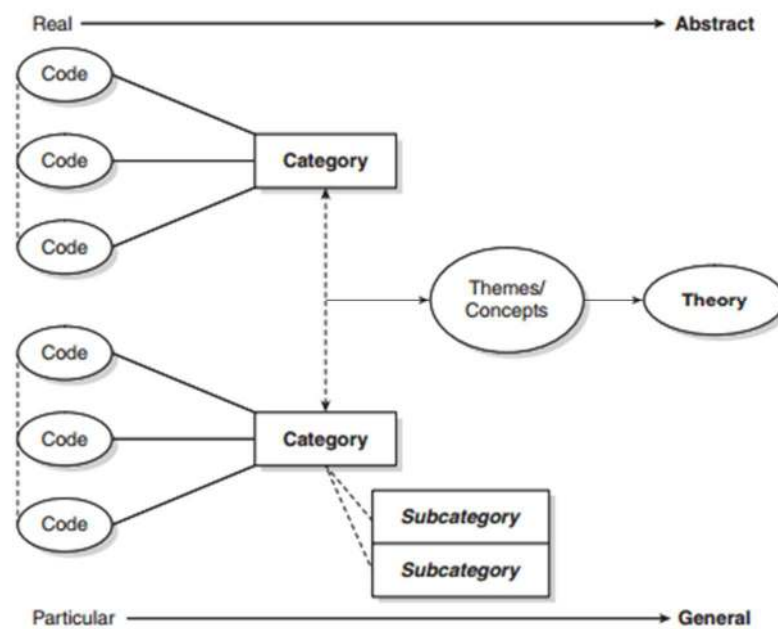


FIGURE 1.1 A streamlined codes-to-theory model for qualitative inquiry

Figure 6: Codes-to-Theory Model

Note. (Adopted from Saldaña, J. (2009). *The coding manual for qualitative researchers*. Thousand Oaks, CA: Sage Publications Ltd.)

Table 5: Researcher's Application of Codes-to-Theory Model

Theme: <i>Life is a Journey</i>		
In Vivo Code	Holistic Code	Category/Subcategory
<i>I was not in good health but I was able to maintain, I guess, a certain level of focus despite the chronic medical issues that were going on at the time and still complete the course to the level of my ability that I was, given the circumstance.</i>	maintained focus despite the chronic medical issues	Perseverance
<i>I guess no matter how many times you fail and fall, you always have the choice to get back up.</i>	have the choice to get back up	Perseverance
<i>Because things happen in life where you can't do everything, you know, all the time.</i>	you can't do everything	Existential Aloneness/ Acceptance
<i>So just taking that and moving forward. Like you can't dwell on the things you can't do, you just got to focus on what you can do and know that everybody's different.</i>	you can't dwell on the things you can't do	Existential Aloneness/ Acceptance
<i>Everything happens for a reason. And I think if [my life] was different, I wouldn't know now what I know. So I wouldn't change.</i>	Everything happens for a reason	Existential Aloneness/ Acceptance
<i>Everything doesn't come overnight, but if you keep pushing and not giving up and moving forward, then you'll eventually make it if you have the motivation to keep going.</i>	Everything doesn't come overnight keep pushing and not give up	Perseverance Existential Aloneness/ Acceptance
<i>Be inspired about the things around you and keep going forward.</i>	Be inspired keep going forward	Perseverance Existential Aloneness/ Acceptance
<i>I learned to never give up and keep going and stuff and people always make mistakes and you should learn by your mistakes.</i>	never give up people always make mistakes	Perseverance Existential Aloneness/ Acceptance

Scientific Adequacy

To maintain and ensure trustworthiness, the investigator adhered to the epistemological standards of credibility, transferability, confirmability and dependability (Creswell & Miller, 2000; Lincoln & Guba, 1985).

Credibility (truth value) was achieved through prolonged engagement; thick description; peer debriefing; negative case analysis; and triangulation. The investigator built trust with

participants prior to conducting the study. Thick description is provided through narrative summaries of each participant and rich excerpts from transcripts. The search for and identification of negative cases also assured truth value. Triangulation was achieved through the verification of findings through multiple sources of data: a focus group, individual interview, quantitative survey questionnaires, as well as comparing the findings of this study to what is known in the literature (Creswell & Miller, 2000; Lincoln & Guba, 1985).

Transferability (applicability) was achieved through an intensity sampling strategy. Participants were purposely selected based on their ability to provide insight into the phenomena of resilience and were enrolled until saturation was reached, such that no new information was discovered. Ensuring participants had freedom to speak provided for accurate and factual accounts from the participants.

Confirmability (neutrality) was ensured through bracketing, checking ongoing personal reaction and triangulation so that the findings represent the emic perspective of the participants and not that of the investigator (Lincoln & Guba, 1985).

Dependability (consistency) was ascertained through data auditing (Hiroaki & Ichiro, 2009). An audit trail consisting of audio “recordings, transcripts, interview guides, data reduction, and analysis products” (Hiroaki & Ichiro, 2009 p. 70) supports all findings of this study.

A member of the dissertation committee who is an expert in qualitative methods served as a qualitative consultant. This member read all transcripts and summaries and reviewed data reduction procedures and analysis products. The researcher met with the committee member multiple times throughout data collection and analyses.

Mixed Methods Data Analysis

The mixed method analysis was comprised of combining the data for meaningful interpretation (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 1998). The researcher looked for mutually supported findings to address the following research question and sub-question:

Do the quantitative measures uphold the prominent themes discovered in the qualitative data? To what extent does the qualitative data contribute to an enhanced interpretation and understanding of the relationships discovered among the quantitative variables?

Given the complexity of the topic and uniqueness of the population, this study has combined quantitative and qualitative data in a convergent parallel design. The method of analyses followed Creswell, Plano and Clark (2011) *Steps and Decisions in Mixed Methods Data Analysis* for convergent designs. Quantitative and qualitative data were collected simultaneously then analyzed independently using the approach most suited to answer the quantitative and qualitative research questions. After independent analysis was completed, the findings were further examined to determine how they will be compared. Refined quantitative and qualitative analyses were performed to analyze the extent of which the quantitative and qualitative data converged for joint interpretation in answering the mixed-methods research question.

Quantitative and qualitative data was compared by quantifying the qualitative data. This procedure is referred to as quantizing (Creswell & Plano Clark, 2011). First, a frequency analysis was performed so as to identify the number of times a particular resilient attribute emerged from a qualitative theme or excerpt. Next, a cross-tabulation analysis was performed to compare quantitative variables and qualitative themes. A matrix of quantitative categorical and

continuous variables and qualitative themes was developed. This method of analyses is considered to be the most direct form of displaying both sources of data (Creswell & Plano Clark, 2011). Lastly, a hierarchical categorization of resilience attributes was created to achieve a deeper understanding of the resilient attributes expressed by the participants. This hierarchical categorization represents a collection of resilient attributes identified through an analysis of the survey questionnaires, focus group and interview data. Merged findings were then used to answer the research question meaningfully (Creswell & Plano Clark, 2011).

Scientific Adequacy

Methodological triangulation or validation of findings verified through combining qualitative and quantitative methods, aides in providing a complete picture of the participants and is vital in telling the participants' whole story (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 1998). The merging and interpreting of quantitative and qualitative findings afford the researcher a more robust analysis of the phenomena.

Protection of Human Subjects

This study was submitted to the Molloy College Institutional Review Board (IRB) and was approved as expedited (Appendix R); and was supported by the HSC Foundation (Appendix S). The process of consent/assent involved the following procedures: all participants provided informed consent to participate by signature or verbal agreement (Appendices E – J). The original consents are securely maintained by the investigator. Participants were encouraged to maintain their own copies of the consent form. Participants/parents/guardians were informed of their rights to withdraw from the study at any time. Participants/parents/guardians were informed that the findings of this study and their direct quotes may be presented and/or published;

however, no information that could identify participants or their families would be included in presentations and/or publications of the study findings. The investigator and their professional readers, advisors, and assistants complied with regulations to maintain confidentiality and anonymity of subjects. Other than sharing their own experiences, participants were informed there are no direct benefits to the participant for taking part in this study. Those who completed survey questionnaires received an incentive of \$15. All those who participated in the focus group or individual interview also received an incentive of \$25. Additionally, focus group participants received a “pizza party” reception and travel expenses. Indirect benefits may have included the valuable information gathered about better understanding the emerging adults’ sources of resilience as it aids in transitioning. No risks were anticipated and no emotional discomfort from taking part in this study was expressed.

Summary of Chapter Three

Chapter Three discussed the mixed methods convergent parallel design employed in this study. Quantitative and qualitative data were collected, analyzed and combined for meaningful interpretation specific to the research questions. Drawn from mutually supported data, the triangulated findings offer a complete and valid analysis of central phenomena of resilience for this select group of emerging adults with disabilities as they are transitioning to adulthood. In accordance with a positive deviance sampling plan, the participants for this study were purposely selected as they have been identified by disability advocacy organizations and given awards or received recognition for their successes. Data were collected via survey questionnaires, a focus group and individual interviews. Survey questionnaires were carefully chosen to measure the level of and relationship among resilience, physical health, mental health, life satisfaction, future

orientation and social support resources. The interview guide was designed using an AI approach to investigate life values and goals, inner strength and support systems; and to elicit positive behaviors that have aided these individuals in mitigating adversity as they are transitioning to adulthood. Quantitative data were deductively analyzed using descriptive and inferential statistics, while qualitative data were inductively analyzed using a constant comparative method of analysis to code data, identify themes and emerging patterns and categorize findings. After independent analysis was completed, the findings were merged for joint interpretation in answering the mixed-methods research question. Refined quantitative and qualitative analyses were performed to analyze the extent of which the quantitative and qualitative data converged for joint interpretation in answering the mixed-methods research question. Quantitative and qualitative data was compared by quantifying the qualitative data; frequency analysis, cross-tabulation analysis, and hierarchical categorization of resilience attributes were performed to achieve a more robust understanding of resilient in emerging adults with disabilities as they are transitioning to adulthood. Merged findings were then used to answer the research question meaningfully (Creswell & Plano Clark, 2011). Findings are presented in Chapter Four.

CHAPTER FOUR: FINDINGS

Introduction

The purpose of this chapter is to present the study findings. The sources of data and findings from each strand of this study are reported. Sources of data and participant socio-demographics are presented first followed by three sections: quantitative, qualitative and combined mixed-methods. The quantitative section begins with a review of the research questions, hypotheses, research variables, instruments used to test the variables and the methods employed for data analysis. Each research question is then analyzed in chronological order. Pertinent findings are reported. The qualitative section begins with a review of the participants' data as it is compared to the entire sample. A biographical sketch is provided to serve as an overview of each qualitative participant. Research questions are presented next, following by prominent themes and supporting quotes. The mixed-methods section begins with a review of the research questions, data sources and methods of analyses. Two matrices reflecting the triangulation of quantitative variables and qualitative themes are presented. Findings from the quantitative, qualitative and mixed-methods research are presented in this chapter. A complete discussion of the findings will be presented in Chapter Five.

Sources of data

Quantitative and qualitative data for this study were drawn from multiple sources: survey questionnaires, a focus group and individual interviews (Table 6). Triangulation of findings were drawn from mutually supported data and offer a complete and valid analysis of the central phenomena of resilience for this select group of emerging adults with disabilities as they are transitioning to adulthood.

Table 6: Data Sources and Sample

<i>Data Sources and Sample</i>	
<i>Data Sources</i>	<i>N = 31</i>
Survey	N = 31
Focus Group	n = 5
Individual Interview	n = 5

Quantitative Participants' Socio-Demographics

Participants' socio-demographic characteristics are presented in narrative and table format. Socio-demographic information is necessary for the determination of whether these participants may be representative of the population (LoBiondo Wood & Haber, 2010). This information will later be combined with quantitative and qualitative data for meaningful interpretation. Select items from the 2009-2010 National Survey of Children with Special Health Care Needs (CDC/National Center for Health Statistics, 2013) and the 2009 National Longitudinal Transition Study (NLTS2) (Newman et al., 2009) were used to gather the socio-demographic information. The socio-demographics to follow consist of four parts: participant characteristics (Table 7), diagnoses and therapeutic services (Table 8), reported functional difficulty and independence (Table 9), and mode of transportation (Table 10).

All participants were emerging adults aged 18-26 years old (100%), just over half were male (55%). Educational levels varied among the participants. While most reported that they were still students (58%), the highest levels of education achieved at the time of the study was some high school (16%), high school graduate or GED (48%), some college (32%), college graduate (7%), trade/technical/vocational training (7%). The majority of participants lived with their immediate family (81%), in a suburban community (81%). Just under half of the

participants were employed for wages (42%). Descriptive statistics, frequencies and percentages for the personal characteristics of age, gender, education level, living arrangements and employment are presented in Table 7.

Table 7: Characteristics Frequency and Percent

<i>Participant Characteristics Frequency and Percent</i>		
<i>Characteristics (N = 31)</i>	<i>f</i>	<i>%</i>
Age:		
Range 18-26 years	31	100
Gender:		
Male	17	55
Female	14	45
Highest Level of Education*:		
Some High School	5	16
High School Graduate or GED	15	48
Some College	10	32
College Graduate	2	7
Trade/Technical/Vocational Training	2	7
Lives With:		
Immediate Family	25	81
Extended family	4	13
Group Home/Assisted Living	1	3
Independently	1	3
Type of Community:		
Urban	6	19
Suburban	25	81
Employment Status*:		
Employed for wages	13	42
Self-employed	1	3
Out of work and looking for work	2	7
Student	18	58
<i>*Note. Frequencies may not equal 31 and percentages may not equal 100%, due to multiple responses and statistical rounding</i>		

To assess medical diagnosis, participants were asked to respond to the question, “Have you ever been told you have the following?” A checklist of 21 health conditions or the option of selecting “other” was provided. The two most common reported diagnoses among the participants were Intellectual Disability (42%) followed by Cerebral Palsy (39%). Other reported medical diagnoses included: any Developmental Delay that affects ability to learn (32%), Autism, Asperger's Disorder, Pervasive Developmental Disorder, or other Autism Spectrum Disorder (29%), Anxiety Problems (26%), Attention Deficit Disorder (23%), Attention Deficit Hyperactivity Disorder (23%), Depression (19%), Allergies (13%), Asthma (10%), Epilepsy or Seizure Disorder (10%), a Head Injury, Concussion, or Traumatic Brain Injury (10%), Behavioral or Conduct Problems, such as Oppositional Defiant Disorder or Conduct Disorder (6%), Heart Problem, including Congenital Heart Disease (3%), and/or Arthritis or other Joint Problems (3%).

To assess therapeutic services, participants were asked to respond to the statement, “Select the services that you currently receive.” A checklist of three therapeutic services or option of selecting “other” was provided. Participants in this study reported receiving the following therapeutic services: speech (16%), physical (13%), occupational (3%), and other (13%); two reported services in the category of other included a scribe in school and behavioral therapy. Descriptive statistics, frequencies and percentages for the participants’ diagnoses and current therapeutic services are presented in Table 8.

Table 8: Diagnoses and Therapeutic Services Frequency and Percent

<i>Participant Diagnoses and Therapeutic Services Frequency and Percent</i>		
Diagnoses and Therapeutic Services (N = 31)	<i>f</i>	<i>%</i>
Diagnoses*:		
Attention Deficit Disorder (ADD)	7	23
Attention Deficit Hyperactivity Disorder (ADHD)	7	23
Depression	6	19
Anxiety Problems	8	26
Behavioral or Conduct Problems, such as Oppositional Defiant Disorder or Conduct Disorder	2	6
Autism, Asperger's Disorder, Pervasive Developmental Disorder, or other Autism Spectrum Disorder	9	29
Any Developmental Delay that affects your ability to learn	10	32
An Intellectual Disability	13	42
Asthma	3	10
Epilepsy or Seizure Disorder	3	10
A Head Injury, Concussion, or Traumatic Brain Injury	3	10
Heart Problem, including Congenital Heart Disease	1	3
Cerebral Palsy	12	39
Arthritis or other Joint Problems	1	3
Allergies	4	13
Other	3	10
Current Therapies:		
Speech	5	16
Physical	4	13
Occupational	1	3
Other	4	13
<i>*Note. Frequencies may not equal 31 and percentages may not equal 100%, due to multiple responses and statistical rounding</i>		

In addition to diagnosis and current therapeutic services, this study surveyed participants as to the areas in which they report functional difficulty and independence. To assess reported functional difficulties, participants were asked to respond to the question, “Do you have difficulty with any of the following?” A checklist of six functional areas or the option of

selecting “I do not have any difficulties in these areas” was provided. Participants most commonly reported functional difficulties in the physical tasks of walking (39%), carrying or lifting 10 lbs. (36%) and walking up a flight of stairs (36%). The following reported functional difficulties in descending order were having their speech understood (23%), seeing (13%) and hearing (3%). To assess reported independence, participants were asked to respond to the statement, “I am able to do the following all by myself.” A checklist of 11 functional areas was provided. The majority of participants reported independence in using a computer (94%) and telephone (90%). Despite reported physical difficulties, the majority of participants also reported independence in getting around inside the home (87%), getting into or out of a bed/chair (87%), taking a bath (84%), getting dressed (84%), eating (84%), going outside the home (77%), and doing light housework (68%). Keeping track of money/bills and preparing meals had the lowest reported independence (61%). Descriptive statistics, frequencies and percentages for the areas in which the participants report difficulties and independence are presented in Table 9.

Table 9: Reported Functional Difficulty and Independence Frequency and Percent

<i>Participant Reported Functional Difficulty and Independence Frequency and Percent</i>		
<i>Reported Functional Difficulty and Independence (N = 31)</i>	<i>f</i>	<i>%</i>
<i>Reported Difficulties:</i>		
Seeing	4	13
Hearing	1	2
Having my speech understood	7	23
Walking	12	39
Carrying or lifting 10 lbs.	11	36
Walking up a flight of stairs	11	36
<i>Reported Independence:</i>		
Getting around inside the home	27	87
Getting into or out of a bed/chair	27	87
Taking a bath	26	84
Getting dressed	26	84
Eating	26	84
Going outside the home	24	77
Keeping track of money or bills	19	61
Preparing meals	19	61
Doing light housework	21	68
Using the telephone	28	90
Using a computer	29	94
<i>Note. Frequencies may not equal 31 and percentages may not equal 100%, due to multiple responses and statistical rounding</i>		

The demographic questionnaire was used to also assess modes of transportation used by participants. To assess mode of transportation, participants were asked to respond to the statement, “When you need to go somewhere you most often.” A checklist of nine modes of transportation or option of selecting “other” was provided. The two most common reported modes of transportation among the participants were to get a ride from a family member (42%) and to take transportation provided by service agency (36%). Other reported modes of transportation included: drive myself (16%), use wheelchair or other assistive device

(walker/braces/crutches) (16%), take public transportation (10%), walk, ride bike, roller blade, use scooter (3%), and use a dial-a-van service (3%). Descriptive statistics, frequencies and percentages for the participants' mode of transportation are presented in Table 10.

Table 10: Mode of Transportation Frequency and Percent

<i>Participant Mode of Transportation Frequency and Percent</i>		
<i>Mode of Transportation (N = 31)</i>	<i>f</i>	<i>%</i>
Walk, ride bike, roller blade, use scooter	1	3.2
Use wheelchair or other assistive device (walker/braces/crutches)	5	16.1
Drive myself	5	16.1
Get a ride from a family member	13	41.9
Take public transportation	3	9.7
Take transportation provided by service agency	11	35.5
Use a dial-a-van service	1	3.2

Note. Frequencies may not equal 31 and percentages may not equal 100%, due to multiple responses and statistical rounding

Quantitative Findings

Findings of the quantitative strand of this study are reported in a question and answer format. The research question is presented followed by the method of analysis and findings of that analysis. The first research question is exploratory in nature: *What is the level of resilience, physical health, mental health, life satisfaction and future orientation among this select group of emerging adults with disabilities?* Descriptive statistics will be presented and discussed. The second research question seeks to identify relationships: *What is the relationship among resilience, physical health, mental health, life satisfaction and future orientation among this select group of emerging adults with disabilities?* The findings of the data analyses using Pearson's product-moment correlation and bivariate linear regression will be presented and discussed. The third question is exploratory in nature: *How many areas of social support are*

reported by this select group of emerging adults with disabilities? Descriptive statistics will be presented and discussed. The fourth and final quantitative question seeks identify a relationship:

What is the relationship between the quantity of self-reported social support and resilience among this select group of emerging adults with disabilities? The findings of the data analyses using Pearson's correlation and bivariate linear regression will be presented and discussed.

Table 11 presents each quantitative research question with hypothesis, variables, measurement instruments and methods of analyses employed in this study.

Table 11: Quantitative Research Hypotheses, Variables, Measurements and Analyses

<i>Quantitative Research Hypotheses, Variables, Measurements and Analyses</i>				
#	Hypothesis	Variable Type	Measurement(s)	Analysis
1	Not applicable	Not applicable	RS-14, SF-12v2: SFPCS, SF-12v2: SFMCS, SWLS Demographic Questionnaire #13	Descriptive Statistics
	Resilience will be associated with positive transition facilitators: physical health, mental health, satisfaction with life and future orientation.	Independent: level of resilience	RS-14	
	H ₀ : Resilience is not a useful predictor of physical health H ₁ : Resilience is a useful predictor of physical health	Dependent: level of physical health	SF-12v2: SFPCS	Pearson's Correlation
2	H ₀ : Resilience is not a useful predictor of mental health H ₁ : Resilience is a useful predictor of mental health	Dependent: level of mental health	SF-12v2: SFMCS	Bivariate Linear Regression
	H ₀ : Resilience is not a useful predictor of satisfaction with life H ₁ : Resilience is a useful predictor of satisfaction with life	Dependent: level of satisfaction with life	SWLS	
	H ₀ : Resilience is not a useful predictor of future orientation H ₁ : Resilience is a useful predictor of future orientation	Dependent: level of future orientation	Demographic Questionnaire #13	
3	Not applicable	Not applicable	Demographic Questionnaire #12	Descriptive Statistics
	Quantity of social support will be associated with level of resilience	Independent: quantity of social support resources	Demographic Questionnaire #12	Pearson's Correlation
4	H ₀ : The quantity of social support will not be associated with level of resilience H ₁ : The quantity of self-reported social support will be associated with level of resilience	Dependent: level of resilience	RS-14	Bivariate Linear Regression

Quantitative Research Question 1

RQ: What is the level of resilience, physical health, mental health, life satisfaction and future orientation among this select group of emerging adults with disabilities?

Descriptive Statistics

Descriptive statistics of quantitative measures were computed to provide summaries about this sample in relation to the purpose of this study. The descriptive statistics to follow will be the basis of the quantitative data analysis and later combined with the qualitative data for methodological triangulation. Six measures were computed for mean (M), median (Mdn), mode (Mo), standard deviation (SD) and range (Ra). Table 12 aids in presenting and interpreting the data in a meaningful way.

Table 12: Instrument Measures of Central Tendency

<i>Instrument Measures of Central Tendency</i>					
Research Variable	Mean	Median	Mode	SD	Range
Resilience	79.1	82	82	15	28-95
Physical Health	49.7	53.8	57.4	11.1	24.6-65.6
Mental Health	54.2	57.3	59.7	9.9	33.7-69.6
Satisfaction with Life	24.9	27	29	7	6-35
Future Orientation	3.42	4	4	0.72	2-4
Quantity of Social Support Resources	3.90	4	4	1.578	1-7

Note. SD = standard deviation

Resilience

The participant's level of resilience was determined using the 14-Item Resilience Scale (RS-14). Resilience levels ranged between 28 and 95 ($n = 31$; $M = 79.1$; $SD = 15$). The mean resilience score for this study sample ($M = 79.1$) falls within the range of 74-81. A score within the range of 74-81 is interpreted as moderate, neither high nor low level of resilience. Those who score in the moderate range have many resilient traits and have the ability to reach higher levels of resilience (Wagnild, 2011). This variable was computed as continuous. Appendix O provides a complete interpretation of this score as well as other resilience levels.

Earlier research by Wagnild (2011) examined resilience in individuals of a similar age category. Resilience levels for 18-29 year-olds without disabilities ($N = 427$) ranged between 14 and 98 ($M = 72.9$; $Mdn = 76$; $SD = 14.2$). The mean resilience level for the current study sample of 18-26 year-olds with disabilities ($M = 79.1$) is higher than the mean resilience level for that sample of 18-29 year-olds without disabilities ($M = 72.9$).

Physical and Mental Health

The participants' level of physical and mental health was determined using the SF-12v2. This instrument measures disease burden by quantifying eight health domains that are believed to be affected by disease. Together the domain measurements yield a score for overall physical and mental health (Ware et al., 1995; Ware et al., 2010). The scores for this sample are compared to the 2009 U.S. general population of non-institutionalized adults aged 18-75+ (Ware et al., 2010) and then to the 1998 U.S. population of non-institutionalized emerging adults aged 18-24 ($N = 207$) and aged 25-30 ($N = 1038$) (Quality Metric, n.d.). Figure 7 provides a graphical representation of the physical and mental health scores for this study sample as compared to the

2009 U.S. general population norm of 18-75+ year-olds. Appendix Q provides a detailed data on two 1998 U.S. emerging adult populations aged 18-24 and 25-30.

Physical Health

The participant's level of physical health was determined using the SF12v2 Physical Component Summary (PCS). PCS for participants in this study ranged between 24.6 and 65.6. ($N = 31$; $M = 49.7$; $SD = 11.1$). The mean PCS score for this study sample is 49.7. This is about average (Figure 7). Mean scores below 47 indicate impairment in physical health and more than average disease burden (Ware et al., 2010). The mean PCS score of this study sample is average as compared to the 2009 U.S. general population norm indicating that this samples is experiencing about the same amount of disease burden on physical health as does the 2009 U.S. general population (Ware et al., 2010). Although the mean PCS score for the participants in this study ($M = 49.7$) is about average as compared to the 2009 U.S. general population, it is lower than the 1998 U.S. norms for non-institutionalized emerging adults aged 18-24 ($M = 53.46$) and 25-30 ($M = 53.81$) (Quality Metric, n.d.) indicating that these participants are more physically impaired than those of like ages.

Physical Function (PF) was the only construct in the PCS that fell below the normed benchmark ($M < 47$). The mean PF ($M = 44.87$) for this study sample indicated impairment in physical function. All other constructs in the domain of physical health exceeded the benchmark, role-physical ($M = 48.86$), bodily pain (53.37), general health ($M = 56.79$). When considering that all other physical health constructs were above the benchmark, it can be concluded that although PF was below the benchmark, this samples' physical impairments contributed negligibly to their overall disease burden on their physical health (Figure 7).

Findings were similar as compared to the two 1998 emerging adult populations. While this study sample ($M = 44.87$) scored below the benchmark for PF, the 1998 sample of 18-24 year-olds ($M = 53.46$) and 25-30 year-olds ($M = 53.81$) scored above the benchmark for PF. Although this study sample ($M = 48.6$) did not score below the benchmark for RP, the 1998 sample of 18-24 year-olds ($M = 52.65$) and 25-30 year olds ($M = 52.75$) scored considerably higher in RP. Interestingly, this samples' level of bodily pain ($M = 53.37$) indicates they are experiencing less bodily pain that did the 1998 U.S. samples of 18-24 year-olds ($M = 51.83$) and 25-30 year-olds ($M = 52.36$), as well as the 2009 U.S. general population ($M = 50$).

In the physical health domain, almost half (45%) of this study sample scored above the norm, 16% of sample scored at the norm and 39% scored below the norm. Figure 8 displays a graphical representation of the participants' physical and mental health scores by percent as compared to the 2009 U.S. general population norm.

Mental Health

The participant's level of overall mental health was determined using the SF12v2 Mental Component Summary (MCS). MCS for participants in this study ranged between 33.7 and 69.6 ($N = 31$; $M = 54.2$; $SD = 9.9$). The mean MCS score for this study sample is 54.2. This is just above average (Figure 7). Mean scores below 47 indicate impairment in overall mental health and more than average disease burden (Ware et al., 2010). The mean MCS score of this study sample is above average as compared to the 2009 U.S. general population norm indicating that this sample is experiencing less disease burden on mental health than does the 2009 U.S. general population (Ware et al., 2010). The mean score for the participants in this study ($M = 54.2$) is also above average as compared to the 1998 U.S. norms for non-institutionalized

emerging adults aged 18-24 ($M = 46.19$) and 25-30 ($M = 49.20$) (Quality Metric, n.d.) indicating that these participants are less emotionally bothered than those of like ages.

All constructs in the MCS, vitality ($M = 57.63$), social functioning ($M = 50.01$), role-emotional ($M = 49.91$) and mental health ($M = 53.29$) were above the normed benchmark ($M = 47$) (Figure 7). In addition to being above the benchmark, these scores were also above the 1998 mean scores for the 18-24 year-olds, vitality ($M = 47.11$), social functioning ($M = 49.16$), role-emotional ($M = 49.80$) and mental health ($M = 46.87$); as well as for the 25-30 year-olds, vitality ($M = 49.93$), social functioning ($M = 50.04$), and mental health ($M = 49.87$). Role-emotional was the only construct in the MCS where the 1998 sample of 25-30 year-olds scored just above ($M = 51.34$) the mean for the participants in this study.

In the mental health domain, just over half (52%) of this study sample scored above the 2009 U.S. general population norm, 26% of sample scored at the population norm and 23% of sample scored below population norm. Figure 8 displays a graphical representation of the participants' physical and mental health scores by percent as compared to the 2009 U.S. general population norm.

A first stage depression screening was automatically generated by the QualityMetric Health Outcomes scoring software. Findings from the screening indicated that a smaller percent (16%) of this sample is at risk for depression as compared to 20% of the 2009 U.S. general population. Figure 9 provides a graphical representation of the participants' first stage positive depression screening as compared to the 2009 U.S. general population norm.

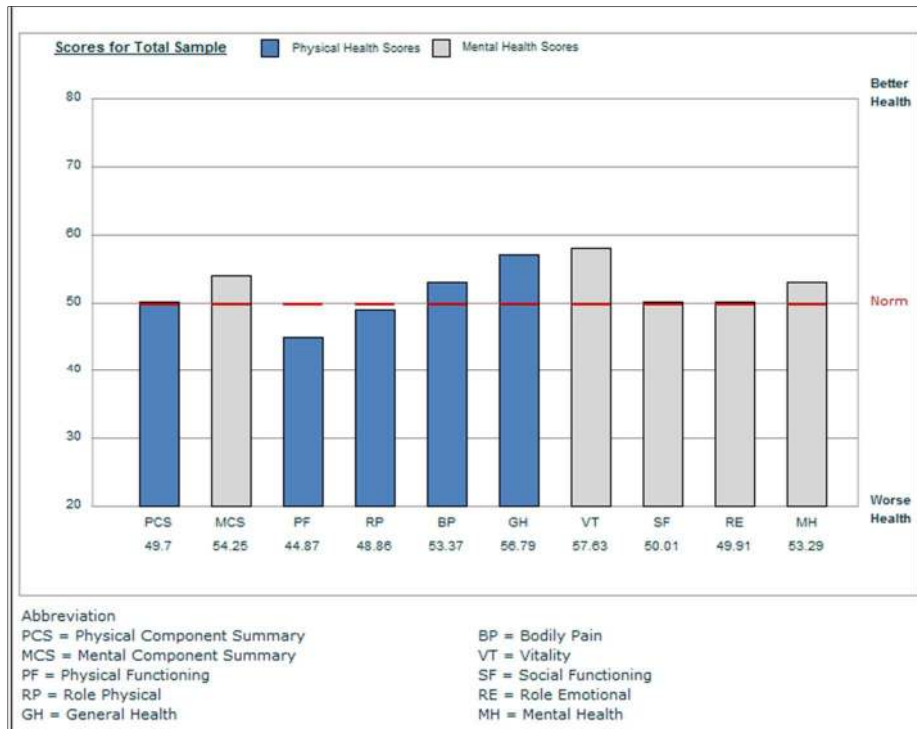


Figure 7: Physical and Mental Health Scores with expanded Domains

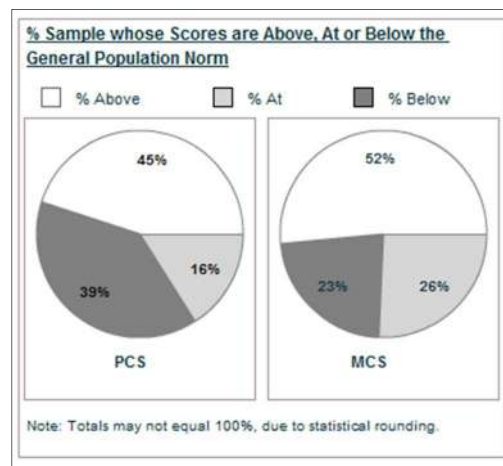


Figure 8: Physical and Mental Health Scores by Percent

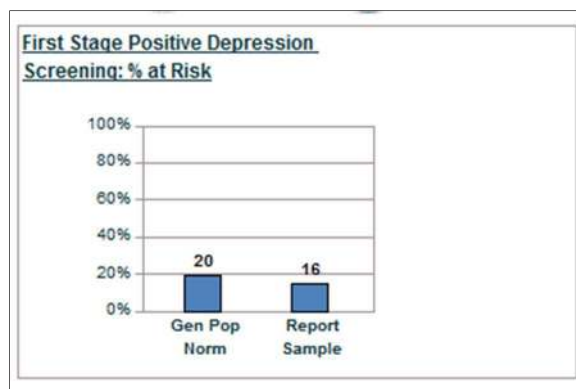


Figure 9: First Stage Positive Depression Screening

Satisfaction with Life

The participant's level of satisfaction with life was determined using the Satisfaction with Life (SWLS). Satisfaction with life ranged between 6 and 35 ($N = 31$; $M = 24.9$; $SD = 7$). The mean satisfaction with life score ($M = 24.9$) for this study sample falls within the high score range. Those who score in the high score range are satisfied with their lives and report things in their life are going well (Diener, 2006). This variable was computed as continuous, thus making class boundaries for a high score 24.5-29.5. Appendix P provides a complete interpretation of this score as well as other life satisfaction scores.

Normative data for the SWLS is available for diverse populations (Pavot & Diener, 1993). The normative data for samples that best fit the characteristics of this study sample are American College Students ($M=23-25.2$, $SD=6.3-5.8$) and Students with Disabilities ($M = 20.8-24.3$, $SD=7.4-8.4$). The satisfaction with life mean and standard deviation ($M=24.9$, $SD=7$) for the current study sample of students (58%), either enrolled in college (37%) or completed college (2%), all with at least one diagnosed disability (100%) is comparable to that of the normative data presented in Table 13.

Table 13: Normative Data for the SWLS

<i>Normative Data for the SWLS</i>			
Sample characteristics	N	M	SD
American College Students	176	23.5	6.4
	130	24.5	6.3
	271	25.2	5.8
	358	23.0	6.4
	244	23.7	6.4
Students with Disabilities	32	20.8	8.4
	29	24.3	7.4

Note. Adapted from: Pavot, W. & Diener, E. (1993). Review of the satisfaction with life scale. Psychological Assessment, 5, 164-172.

Future Orientation

Item #13 on the demographic questionnaire assesses future orientation by asking the participant to respond to the statement, “*I am very sure that someday day I will get to where I want to be in life.*” Future orientation measures range between 2 and 4 (N = 31; M = 3.42; SD = .72). The mean future orientation score for this study sample is 3.42. This variable was computed as categorical; 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree.

Table 14 presents data meaningfully as frequency and percent. In this study, the majority of participants (87%), either strongly agreed (55%) or agreed (32%) with that statement.

This item was used in the New American Dream poll, where an overwhelming 96% of the 18-24 year olds agreed with the statement (Arnett, 2000a; Arnett, 2000b; Hornblower, 1997). Although anecdotal, the response in this study as did in the poll presents a very compelling finding that speaks to the hopeful and enthusiastic nature of emerging adults.

Table 14: Future Orientation Frequency and Percent

<i>Future Orientation Frequency and Percent</i>		
	<i>f</i>	<i>%</i>
Strongly Agree	17	54.8
Agree	10	32.3
Disagree	4	12.9
Strongly Disagree	0	0

Quantitative Research Question 2

RQ: What is the relationship among resilience, physical health, mental health, life satisfaction and future orientation among this select group of emerging adults with disabilities?

Inferential Statistics

Quantitative research question two was examined using Pearson product-moment correlation and bivariate linear regression analysis. Assumptions for correlation and regression analysis were met.

Pearson Product-Moment Correlation Analysis

Pearson product-moment correlation coefficients were computed among six measurements used to assess resilience, physical health, mental health, satisfaction with life, future orientation and quantity of social support among the 31 emerging adults with disabilities selected for the current study. Table 15 aids in presenting and interpreting the data in a meaningful way.

Table 15: Correlations Among Measures

<i>Correlations Among Measures</i>						
Measure	1	2	3	4	5	6
1. Resilience	1					
2. Physical Health	-.277	1				
3. Mental Health	.502**	-.164	1			
4. Satisfaction with Life	.771**	.091	.538**	1		
5. Future Orientation	.515**	-.273	.389*	.423*	1	
6. Quantity of Social Support Resources	.189	.141	.337	.311	-.139	1

Note. * $p < .05$; ** $p < .01$

A Pearson product-moment correlation coefficient was computed to assess the relationship between resilience and physical health. No correlation was noted between the variables resilience and physical health ($r = -.277$, $n = 31$, $p = .131$ two tailed). This suggests there is no association or relationship between resilience and physical health. The scatterplot suggests no linearity (Figure 10).

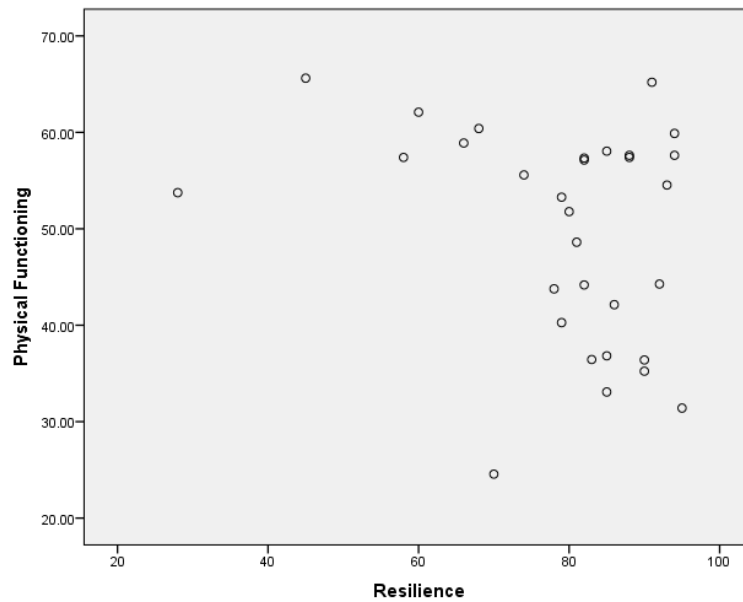


Figure 10: Scatterplot of Resilience and Physical Health

A second Pearson product-moment correlation coefficient was computed to assess the relationship among resilience and mental health. A positive correlation was noted between the variables resilience and mental health at the 0.01 level ($r = .502$, $n = 31$, $p = .004$ two tailed). There is a moderate, positive correlation between the level of resilience and mental health. Increases in resilience levels were correlated with increases in mental health. This suggests that individuals with a higher level of resilience also have a higher level of mental health. A scatterplot summarizes the findings (Figure 11).

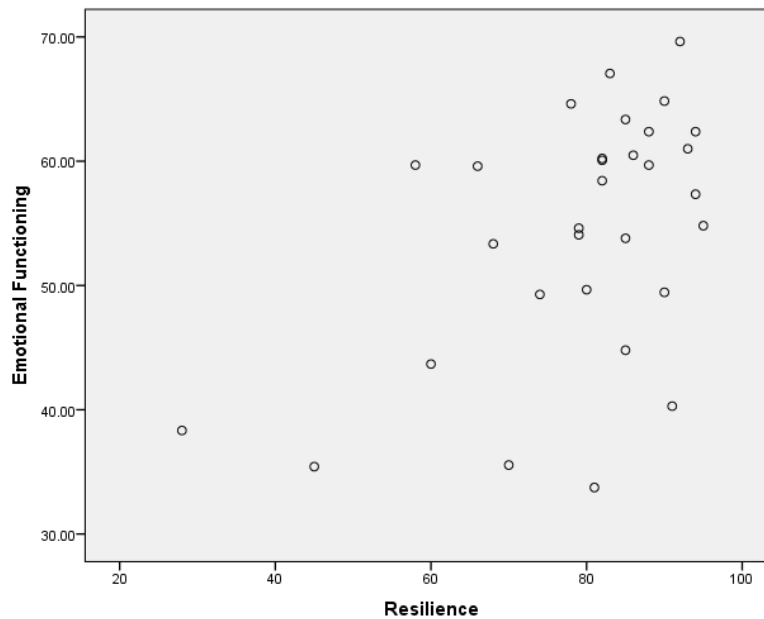


Figure 11: Scatterplot of Resilience and Mental Health

A third Pearson product-moment correlation coefficient was computed to assess the relationship among resilience and satisfaction with life. A positive correlation was noted between the variables resilience and satisfaction with life at the 0.01 level ($r = .771$, $n = 31$, $p = .000$ two tailed). There is a high, positive correlation between the level of resilience and satisfaction with life. Increases in resilience levels were correlated with increases in satisfaction with life. This suggests that individuals with a higher level of resilience also have a higher level of satisfaction with life. A scatterplot summarizes the findings (Figure 12).

predictor of physical health (Table 16). Model two examined resilience as a useful predictor of mental health (Table 17). Model three examined resilience as a useful predictor of satisfaction with life (Table 18). Model four examined resilience as a useful predictor of future orientation (Table 19). Of the four bivariate linear regression models computed, three indicated significance: model two, three and four. Tables 16-19 aid in presenting and interpreting the data in a meaningful way. All assumptions for regression analysis were met; details are available in Chapter Three.

Model One: Resilience as a predictor of Physical Health.

Resilience levels ranged between 28 and 95 ($n = 31$; $M = 79.1$; $SD = 15$). Physical health ranged between 24.6 and 65.6. ($n = 31$; $M = 49.7$; $SD = 11.1$). The bivariate regression analysis showed that resilience level does not significantly affect physical health, in that resilience is not a useful predictor of physical health ($\beta = -.277$; $t = -1.555$; $p = .131$). The R value indicated that there is no correlation between independent and dependent variables ($R = .277$) The F-test also delivered a non-significant finding ($F = 2.41$). Based on this, the model cannot predict the outcome variable with any statistical significance; the null hypothesis will be accepted. There is enough evidence to accept the null hypothesis:

H_0 : Resilience is not a useful predictor of physical health.

Table 16: Regression Analysis for Physical Health

<i>Summary of Bivariate Regression Analysis for Physical Health</i>						
Variable	B	SE(B)	β	t	F	Sig. (p)
Resilience	-.204	.131	-.277	-1.555	2.41	.131
<i>Note. $R = .277$; $R^2 = .077$</i>						

Model Two: Resilience as a predictor of Mental Health

Resilience levels ranged between 28 and 95 ($n = 31$; $M = 79.1$; $SD = 15$). Mental health ranged between 33.7 and 69.6 ($N = 31$; $M = 54.2$; $SD = 9.9$). The bivariate regression analysis showed that resilience level significantly affects mental health, in that resilience level is a useful predictor of mental health ($\beta = .502$; $t = 3.125$; $p < .01$).

The R value represented a moderate degree of correlation ($R = .502$). The R^2 value represented how much of the dependent variable, mental health can be explained by the independent variable, resilience ($R^2 = .252$). In this case, 25% of the variability (or variation) in mental health can be explained by resilience. The F-test also delivered a statistically significant finding ($F = 9.765$), thus supporting the contribution of resilience to mental health. T-tests indicate that the predictor variable resilience contributes significantly to the model ($t = 3.125$; $p < .01$). Resilience has a significant influence on mental health; each unit increase of resilience results in a 0.331 increase in mental health. Level of mental health could be predicted from level of resilience by the following regression equation:

$$\textit{Emotional Function} = 28.075 + 0.331 \textit{ times the level of Resilience}$$

One can be 95% confident that the slope of the true regression line is positive and lies between 0.114 and 0.548. That means, at a 95% CI the population mean mental health increases between 0.114 and 0.548 for each unit increase in resilience.

The statistical significance of the regression model that was applied is $p < .01$. Based on this level, the model can significantly predict the outcome variable; the null hypothesis will be rejected in favor of the alternative:

H₁: Resilience is a useful predictor of mental health.

Table 17: Regression Analysis for Mental Health

<i>Summary of Bivariate Regression Analysis for Mental Health</i>						
Variable	B	SE(B)	β	<i>t</i>	F	Sig. (<i>p</i>)
Resilience	.331	.106	.502	3.125	9.765	.004
<i>Note. R = .502; R² = .252</i>						

Model Three: Resilience as a predictor of Satisfaction with Life

Resilience levels ranged between 28 and 95 ($n = 31$; $M = 79.1$; $SD = 15$). Satisfaction with Life ranged between 6 and 35 ($N = 31$; $M = 24.9$; $SD = 7$). The bivariate regression analysis showed that resilience level significantly affects satisfaction with life scores, in that resilience level is a useful predictor of life satisfaction ($\beta = .771$; $t = 6.519$; $p < .001$).

The R value represented a high degree of correlation ($R = .771$). The R^2 value represented how much of the dependent variable, satisfaction with life can be explained by the independent variable, resilience ($R^2 = .594$). In this case, 59% of the variability (or variation) in satisfaction with life can be explained by resilience. The F-test also delivered a statistically significant finding ($F = 42.493$), thus supporting the contribution of resilience to satisfaction with life. T-tests indicate that the predictor variable resilience contributes significantly to the model ($t = 6.519$; $p < .001$). Resilience has a significant influence on satisfaction with life; each unit increase of resilience results in a 0.358 increase in satisfaction with life. Satisfaction with life could be predicted from level of resilience by the following regression equation:

$$\text{Satisfaction with Life} = -3.369 + 0.358 \text{ times level of Resilience}$$

One can be 95% confident that the slope of the true regression line is positive and lies between 0.246 and 0.470. That means, at a 95% CI the population mean mental health increases between 0.246 and 0.470 for each unit increase in resilience.

The statistical significance of the regression model that was applied is $p < .001$. Based on this level, the model can significantly predict the outcome variable; the null hypothesis will be rejected in favor of the alternative:

H₁: Resilience is a useful predictor of satisfaction with life.

Table 18: Regression Analysis for Satisfaction with Life

<i>Summary of Bivariate Regression Analysis for Satisfaction with Life</i>						
Variable	B	SE(B)	β	<i>t</i>	F	Sig. (<i>p</i>)
Resilience	.358	.055	.771	6.519	42.493	.000
<i>Note. R = .771; R² = .594</i>						

Model Four: Resilience as a predictor of Future Orientation

Resilience levels ranged between 28 and 95 ($n = 31$; $M = 79.1$; $SD = 15$). Future orientation measures ranged between 2 and 4 ($N = 31$; $M = 3.42$; $SD = .72$). The bivariate regression analysis showed that resilience level significantly affects future orientation, in that resilience level is a useful predictor of future orientation ($\beta = .515$; $t = 3.234$; $p < .01$).

The R value represented a moderate degree of correlation ($R = .515$). The R² value represented how much of the dependent variable, future orientation, can be explained by the independent variable, resilience ($R^2 = .265$). In this case, 27% of the variability (or variation) in future orientation can be explained by resilience. The F-test also delivered a statistically significant finding ($F = 10.460$), thus supporting the contribution of resilience to future orientation. T-tests indicate that the predictor variable resilience contributes significantly to the

model ($t = 3.234$). Resilience has a significant influence on satisfaction with life; each unit increase of resilience results in a 0.025 increase in future orientation. Future orientation could be predicted from level of resilience by the following regression equation:

$$\text{Future Orientation} = 1.470 + 0.025 \text{ times level of Resilience}$$

One can be 95% confident that the slope of the true regression line is positive and lies between 0.009 and 0.040. That means, at a 95% CI the population mean future orientation increases between 0.009 and 0.040 for each unit increase in resilience.

The statistical significance of the regression model that was applied is $p < .01$. Based on this level, the model can significantly predict the outcome variable; the null hypothesis will be rejected in favor of the alternative:

H₁: Resilience is a useful predictor of future orientation.

Table 19: Regression Analysis for Future Orientation

<i>Summary of Bivariate Regression Analysis for Future Orientation</i>						
Variable	B	SE(B)	β	t	F	Sig. (p)
Resilience	.025	.008	.515	3.234	10.46	.003
<i>Note. $R = 0.515$; $R^2 = 0.265$</i>						

Quantitative Research Question 3

RQ: How many areas of social support are reported by this select group of emerging adults with disabilities?

Descriptive Statistics

Descriptive statistics were computed to provide a summary about this sample's social support resources in relation to the purpose of this study. The descriptive statistics to follow will

be the basis of the quantitative data analysis and later combined with the qualitative data for methodological triangulation. Quantity of social support resources was computed for mean (M), median (Mdn), mode (Mo), standard deviation (SD), range (Ra), frequency (*f*) and percent (%). Measures of central tendency were presented earlier in Table 12. Frequency and percent are presented in Table 20.

Table 20: Quantity of Social Support Resources Frequency and Percent

<i>Quantity of Social Support Resources Frequency and Percent</i>		
	<i>f</i>	<i>%</i>
Family	31	100
Friends	23	74.2
School	16	51.6
Healthcare Provider	16	51.6
Place of Worship	15	48.4
Community	12	38.7
Work	9	29

*Note. Frequencies do not equal 31
and percentages do not equal 100%,
due to multiple responses*

The participant's social support resources were assessed by asking participants to respond to the following statement, "When I am in need the following are there to support me." A checklist of the seven areas of social support as documented in the literature (Bolla et al., 1996; Hobfoll & Lerman, 1989; Hyman et al., 2003; Norbeck et al., 1981) was provided. Quantity of social support measures ranged between 1 and 7 (N = 31; M = 3.9; Mdn = 4; SD = 1.578). This sample reported having between one and seven social support resources; on average between three or four areas of social support were reported. All participants reported family (100%) as a social support resource. Following family, other sources of social support in

ascending order were friends (71%), school (52%), health care provider (52%), place of worship (48%), community (39%) and work (29%).

Quantitative Research Question 4

RQ: What is the relationship between self-reported social support and resilience among this select group of emerging adults with disabilities?

Inferential Statistics

Quantitative research question four was examined using Pearson product-moment correlation and bivariate linear regression analysis. Assumptions for correlation and regression analysis were met.

Pearson Product-Moment Correlation Analysis

A Pearson product-moment correlation coefficient was computed to assess the relationship between self-reported quantity of social support and resilience among this select group of 31 emerging adults with disabilities. No correlation was noted between the variables quantity of social support and resilience ($r = .189$, $N = 31$, $p = .310$ two tailed). This suggests that there is no linearity between quantity of social support and resilience. A scatterplot summarizes the findings (Figure 13). The following graph aids in presenting and interpreting the data in a meaningful way.

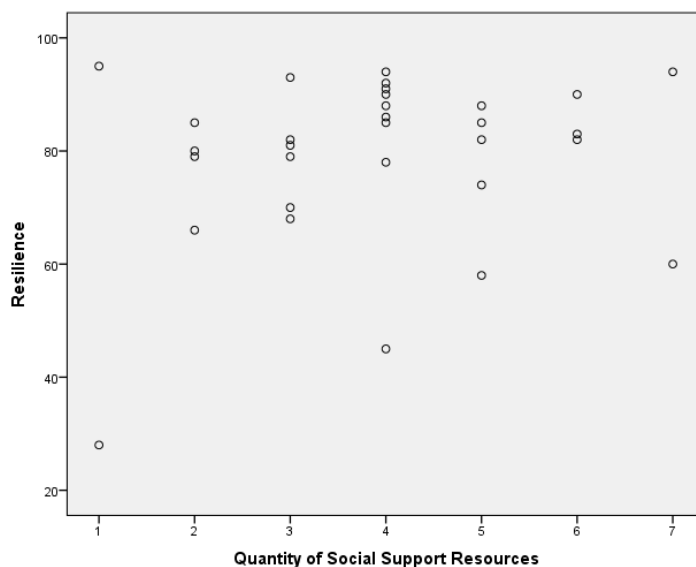


Figure 13: Scatterplot of Quantity of Social Support and Resilience

Bivariate Linear Regression Analysis

Regression analysis was computed to further examine the linearity and define the relationship identified in the correlation analysis. The model examined quantity of social support resources as a useful predictor resilience. No significance was noted. Table 21 aids in presenting and interpreting this data in a meaningful way.

Model: Quantity of Social Support Resources as a useful predictor Resilience.

Quantity of social support measures ranged between 1 and 7 ($N = 31$; $M = 3.9$; $Mdn = 4$; $SD = 1.578$). Resilience levels ranged between 28 and 95 ($N = 31$; $M = 79.1$; $SD = 15$). The bivariate regression analysis showed that quantity of social support does not significantly affect resilience level, in that quantity of social support is not a useful predictor of resilience ($\beta = .189$;

$t = -1.034$; $p = .310$). The R value indicated that there is no correlation between independent and dependent variables ($R = .189$) The F-test also delivered a non-significant findings ($F = 1.060$). Based on this, the model cannot predict the outcome variable with any statistical significance; the null hypothesis will be accepted. There is enough evidence to accept the null hypothesis:

H_0 : Quantity of social support is not a useful predictor of resilience.

Table 21: Regression Analysis for Resilience

<i>Summary of Bivariate Regression Analysis for Resilience</i>						
Variable	B	SE(B)	β	t	F	Sig. (p)
Quantity of Social Support	1.796	1.737	.189	1.034	1.069	.310
<i>Note. $R = .189$ $R^2 = .036$</i>						

Summary of Quantitative Findings

The following is a list of major findings discovered through quantitative analyses of the variables resilience, physical health, mental health, satisfaction with life, future orientation and quantity of social support resources.

1. The participants' level of resilience ranged between 28 and 95 with a mean resilience score of 79.1. This is interpreted as a moderate range of resilience; and is greater than that of a similarly aged group of emerging adults without disabilities.
2. The participants' level of physical health ranged between 24.6 and 51.6 with a mean physical health score of 49.7 indicating that this samples' physical health is about average as compared to the 2009 U.S. general population, but is lower than the two 1998 U.S. emerging adult samples.
3. The participants' mean physical function score ($M = 44.87$) indicates functional impairment. These participants reported a greater level of disease burden on physical function as compared to the 2009 U.S. general population and to the two 1998 U.S. emerging adult samples.
4. The participants' level of mental health ranged between 33.7 and 69.6 with a mean mental health score of 54.2 indicating that this sample's mental health is above average as compared to the 2009 U.S. general population and even higher as compared to the two 1998 U.S. emerging adult samples.
5. The participants' level of satisfaction with life ranged between six and 35 with a mean satisfaction with life score of 24.9. This score is in the high range indicating that this

sample reports they are satisfied with their life and that things are going well. This score is similar to the normative data for American college students and slightly higher than that of students with disabilities.

6. The majority of the participants in this sample either strongly agreed or agreed with the statement “I am very sure that someday I will get to where I want to be in life.” This finding is consistent with the findings of 18-24 year-olds who were surveyed in the New American Dream Poll.
7. The participants’ quantity of social support resources ranged between one and seven with a mean of 3.9. All participants reported having family as a social support resource.
8. No correlation was noted between the variables resilience and physical health. Regression analysis indicated that resilience is not a good predictor of physical health.
9. A moderate positive correlation was noted between the variables of resilience and mental health. Regression analysis indicated that resilience is a good predictor of mental health.
10. A high positive correlation was noted between the variables of resilience and satisfaction with life. Regression analysis indicated that resilience is a good predictor of satisfaction with life.
11. A moderate positive correlation was noted between the variables resilience and future orientation. Regression analysis indicated that resilience is a good predictor of future orientation.

12. No correlation was noted between the variables quantity of social support resources and resilience. Regression analysis indicated that quantity of social support resources is not a good predictor of resilience.

Quantitative data were used to measure resilience, physical health, mental health, satisfaction with life, future orientation and quantity of social support resources for a select group of emerging adults with disabilities. The findings discovered through quantitative analyses will be combined with the findings of qualitative analysis for methodological triangulation; and further discussed in detail in Chapter Five.

Qualitative Participant Socio-Demographics

This section introduces the qualitative findings from this sample of participants. The socio-demographic characteristics and variable measurements of the participants in the qualitative strand of the study ($n = 10$) with a comparison to the entire study sample ($N = 31$) are presented in narrative summary and table format. First the socio-demographic areas are presented; participant characteristics (Table 22), diagnoses and therapeutic services (Table 23), reported difficulties and independence (Table 24), and modes of transportation (Table 25); followed by the variable measurements (Table 26); resilience, physical health, mental health, satisfaction with life, future orientation and social support resources. The information in this section will later be combined with quantitative and qualitative data for meaningful interpretation.

A subsample ($n = 10$) of the participants participated in the qualitative strand of this study. Like the quantitative participants, all qualitative participants were emerging adults aged 18-26 years old (100%). Both samples had a similar dispersion of gender, education, living arrangements and geographical area. A greater percentage of qualitative participants were students (70%) and fewer were employed (20%). The most commonly reported diagnosis for the qualitative participants was Cerebral Palsy (50%); for the quantitative participants it was Intellectual Disability (47%). Both samples had a similar dispersion of reported functional difficulty and independence. Participants most commonly reported a functional difficulty with walking, but independence with using a computer. Getting a ride from a family member was the most commonly reported mode of transportation for both samples.

Table 22: Comparing Quantitative and Qualitative: Characteristics

<i>Characteristics Data Comparing Quantitative and Qualitative Participants</i>		
Characteristics	<i>f (%)</i> all (N = 31)	<i>f (%)</i> qualitative (n = 10)
Gender:		
Male	17 (55)	5 (50)
Female	14 (45)	5 (50)
Age:		
Range 18-26 years	31 (100)	10 (100)
Highest Level of Education		
Some High School	5 (16)	2 (20)
High School Graduate or GED	15 (48)	4 (40)
Some College	10 (32)	3 (30)
College Graduate	2 (7)	1 (10)
Trade/Technical/Vocational Training	2 (7)	0
Lives With:		
Immediate Family	25 (81)	9 (90)
Extended family	4 (13)	0
Group Home/Assisted Living	1 (3)	0
Independently	1 (3)	1 (10)
Type of Community:		
Urban	6 (19)	1 (10)
Suburban	25 (81)	9 (90)
Employment Status:		
Employed for wages	13 (42)	2 (20)
Self-employed	1 (3)	0
Out of work and looking for work	2 (7)	1 (10)
Student	18 (58)	7 (70)
<i>Note. Percentages may not equal 100% and frequencies may not equal 31 or 10 due to multiple responses and statistical rounding</i>		

Table 23: Comparing Quantitative and Qualitative: Diagnoses and Therapeutic Services

<i>Diagnoses and Therapeutic Services Data comparing Quantitative and Qualitative Participants</i>		
	<i>f (%) all (N = 31)</i>	<i>f (%) qualitative (n = 10)</i>
<i>Diagnoses:</i>		
Attention Deficit Disorder (ADD)	7 (23)	2 (20)
Attention Deficit Hyperactivity Disorder (ADHD)	7 (23)	1 (10)
Depression	6 (19)	3 (30)
Anxiety Problems	8 (26)	5 (50)
Behavioral or Conduct Problems, such as Oppositional Defiant Disorder or Conduct Disorder	2 (6)	0
Autism, Asperger's Disorder, Pervasive Developmental Disorder, or other Autism Spectrum Disorder	9 (29)	1 (10)
Any Developmental Delay that affects your ability to learn	10 (32)	2 (20)
An Intellectual Disability	13 (42)	1 (10)
Asthma	3 (10)	0
Epilepsy or Seizure Disorder	3 (10)	1 (10)
A Head Injury, Concussion, or Traumatic Brain Injury	3 (10)	1 (10)
Heart Problem, including Congenital Heart Disease	1 (3)	1 (10)
Cerebral Palsy	12 (39)	5 (50)
Arthritis or other Joint Problems	1 (3)	1 (10)
Allergies	4 (13)	3 (30)
Other	3 (10)	2 (20)
<i>Current Therapies:</i>		
Speech Therapy	5 (16)	2 (20)
Physical Therapy	4 (13)	2 (20)
Occupational Therapy	1 (3)	1 (10)
Other	4 (13)	2 (20)

Note. Percentages may not equal 100% and frequencies may not equal 31 or 10 due to multiple responses and statistical rounding

Table 24: Comparing Quantitative and Qualitative: Reported Functional Difficulty and Independence

<i>Reported Functionally Difficulty and Independence Data Comparing Quantitative and Qualitative Participants</i>		
	<i>f (%) all (N = 31)</i>	<i>f (%) qualitative (n=10)</i>
<i>Reported Difficulty:</i>		
Seeing	4 (13)	3 (30)
Hearing	1 (3)	1 (10)
Having my speech understood	7 (23)	3 (30)
Walking	12 (39)	5 (50)
Carrying or lifting 10 lbs.	11 (36)	4 (40)
Walking up a flight of stairs	11 (36)	4 (40)
<i>Reported Independence:</i>		
Getting around inside the home	27 (87)	8 (80)
Getting into or out of a bed/chair	27 (87)	8 (80)
Taking a bath	26 (84)	8 (80)
Getting dressed	26 (84)	8 (80)
Eating	26 (84)	7 (70)
Going outside the home	24 (77)	7 (70)
Keeping track of money or bills	19 (61)	6 (60)
Preparing meals	19 (61)	6 (60)
Doing light housework	21 (68)	6 (60)
Using the telephone	28 (90)	9 (90)
Using a computer	29 (94)	9 (90)

Note. Percentages may not equal 100% and frequencies may not equal 31 or 10 due to multiple responses and statistical rounding.

Table 25: Comparing Quantitative and Qualitative: Reported Mode of Transportation

<i>Reported Mode of Transportation Data Comparing Quantitative and Qualitative Participants</i>		
	<i>f (%)</i> all (N = 31)	<i>f (%)</i> qualitative (n = 10)
Mode of Transportation:		
Walk, ride bike, roller blade, use scooter	1 (3)	0
Use wheelchair or other assistive device, i.e. walker/braces/crutches	5 (16)	3 (30)
Drive myself	5 (16)	3 (30)
Get a ride from a family member	13 (42)	4 (40)
Take public transportation	3 (10)	2 (20)
Take transportation provided by service agency	11 (36)	2 (20)
Use a dial-a-van service	1 (3)	0

Note. Percentages may not equal 100% and frequencies may not equal 31 or 10 due to multiple responses and statistical rounding.

Table 26 compares instrument means for the qualitative participants (n = 10) as compared to instrument means for the entire study sample (N = 31). The mean level of resilience for the qualitative participants (M = 82.3) is slightly higher than the mean for the entire study sample (M = 79.1). The mean level of physical health for the qualitative participants (M = 43.9) is slightly lower than the mean for the entire study sample (M = 49.7). The mean level of mental health for the qualitative participants (M = 50.1) is slightly lower than the mean for the entire study sample (M = 54.2). The mean level of satisfaction with life for the qualitative participants (M = 23.6) is slightly lower than the mean for the entire study sample (M = 24.9). The mean level of future orientation for the qualitative participants (M = 3.7) is slightly higher than the mean for the entire study sample (M = 3.4). The mean quantity of social support resources for the qualitative participants (M = 2.9) is slightly lower than the mean for the entire sample (M = 3.9).

Table 26: Comparing Quantitative and Qualitative: Instrument Means

<i>Instrument Means comparing Quantitative and Qualitative Participants</i>		
Research Variable	Mean all (N = 31)	Mean qualitative (n = 10)
Resilience	79.1	82.3
Physical Health	49.7	43.9
Mental Health	54.2	50.1
Satisfaction with Life	24.9	23.6
Future Orientation	3.4	3.7
Quantity of Social Support Resources	3.9	2.9

Qualitative Participants

The following biographical sketches are provided to present an overview of each qualitative participant. Each sketch provides the participants' age, gender, medical diagnosis, current therapeutic services, self-care independence/dependence, living arrangements, employment and educational status, support systems, the degree to which they optimistically view their future, and a notable quote taken from the focus group or individual interview transcript that serves to highlight their personal conviction. The participants' actual names have been replaced with pseudonyms to maintain anonymity.

Barbara

Barbara participated in the focus group. She is a 21 year-old female emerging adult with Cerebral Palsy (CP). Barbara has difficulty walking and lifting or carrying objects. She uses a walker to ambulate. Barbara is independent in all self-care activities, but reports needing assistance to go outside the home. Barbara lives at home with her immediate family in a suburban community. Barbara is not working at the moment, but is looking for work. She reports her family, friends and peers at school are there to support her. Barbara strongly agrees

with the statement, *“I am very sure that someday I will get to where I want to be in life.”*

Barbara’s notable quote, “Everything happens for a reason...I think if [my life] was different, I wouldn’t know now what I know. So I wouldn’t change. I wouldn’t ask for anything.”

Carl

Carl participated in the focus group. He is a 21 year-old male emerging adult with Autism Spectrum Disorder (ASD) and receives speech therapy. Carl is independent in all self-care activities. Carl lives at home with his immediate family in a suburban community, attends college and is employed. He reports his family, friends and peers at school are there to support him. Carl strongly agrees with the statement, *“I am very sure that someday I will get to where I want to be in life.”* Carl’s notable quote, “Life is not easy, but you can always push yourself to be the best that you can be.”

Frank

Frank participated in the focus group. He is an 18 year-old male emerging adult with Cerebral Palsy (CP), Developmental Delay, and Epilepsy. Frank has quadriplegia with limited self-mobility through use of a motorized wheelchair, visual problems and difficulty having his speech understood. He receives physical and occupational therapy, and requires complete self-care assistance. Frank lives at home with his immediate family in a suburban community and attends high school. He reports his family is there to support him. Frank strongly agrees with the statement, *“I am very sure that someday I will get to where I want to be in life.”* Frank’s notable quote, “I’m just a naturally smart person...Good at school subjects.”

Laura

Laura participated in the focus group. She is a 20 year-old female emerging adult who suffered an Anoxic Brain Injury as a teenager. Laura has quadriplegia with limited self-mobility through use of a motorized wheelchair, depression and anxiety. Laura requires complete self-care assistance and has home health services. Laura lives at home with her immediate family in a suburban community and attends high school. She reports her family, friends, her spiritual community and healthcare providers are there to support her. Laura strongly agrees with the statement, *“I am very sure that someday I will get to where I want to be in life.”* Laura’s notable quote, *“I’ve become very spiritual since my whole incident... I found, you know, what I was missing before. I found more of the meaning of life. And I just found, I found myself in like God.”*

Rachelle

Rachelle participated in the focus group. She is an 18 year-old female emerging adult with low frequency hearing loss, anxiety and a speech and language disorder for which she is receiving speech therapy. Rachelle is independent in all self-care activities. Rachelle lives at home with her immediate family, is a high school student, but also attends a pre-college program to study art. Rachelle reports family, friends, peers at school, her spiritual community and healthcare providers are there to support her. She agrees with the statement, *“I am very sure that someday I will get to where I want to be in life.”* Rochelle’s notable quote, *“I try my best and never give up.”*

Eunice

Eunice participated in a telephone interview. She is an 18 year-old female emerging adult with Cerebral Palsy (CP), Attention Deficit Hyperactivity Disorder (ADHD) and Asthma. She has difficulty walking and navigating stairs; she uses forearm crutches to ambulate and a transportation service for persons with disabilities when she needs to go somewhere. Eunice is not receiving any therapeutic services, i.e. physical, occupational or speech therapies and can manage most of her own self-care activities, except for cooking. Eunice lives at home with her immediate family in a suburban community and attends high school. She reports her family and friends are there to support her. Eunice strongly agrees with the statement, *“I am very sure that someday I will get to where I want to be in life.”* Eunice’s notable quote, “Stay positive...breathe out each challenge and just like calming down and thinking about what to do instead of just reacting.”

Rodger

Rodger participated in a telephone interview. He is a male emerging adult with Cerebral Palsy (CP) and Intellectual and Developmental Delay (IDD). He is not able to ambulate and has difficulty writing, but can manage most of his own self-care activities, except cooking. He uses a wheelchair and has a scribe in school. When he needs to go out he will most often get a ride from a family member. Rodger lives at home with his immediate family in a suburban community and attends college. He reports family and friends are there to support him. Rodger strongly agrees with the statement, *“I am very sure that someday I will get to where I want to be in life.”* Rodger’s notable quote, “I’m very determined, so if I set my mind to something, I’m doing it.”

Richard

Richard participated in a telephone interview. He is a 24 year-old male emerging adult with Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD), Depression and Anxiety. He currently receives social and behavioral therapies. Richard is independent in all self-care activities. Richard graduated college, is employed and lives on his own in an urban community. He reports his family, friends and work colleagues are there to support him. Richard strongly agrees with the statement, *“I am very sure that someday I will get to where I want to be in life.”* Richard’s notable quote, “I know my resiliency has held me together at times through very rocky points and has helped me keep going...I have a faith in myself and a peace in the world that is higher or more, more set in place than most people I feel...I don’t worry about things I can’t control.”

Tammy

Tammy participated in a telephone interview. She is a 21 year old female emerging adult with Cerebral Palsy (CP) who reports history of a cardiac condition, anxiety, and visual and mobility deficits. Tammy is receiving physical therapy services. She stretches her legs by herself and is independent in all self-care activities. She is currently away at school pursuing a degree in the Fine Arts. When not in school, Tammy lives at home with her immediate family in a suburban community. She reports her family, friends and spiritual community are there to support her. Tammy strongly agrees with the statement, *“I am very sure that someday I will get to where I want to be in life.”* Tammy’s notable quote, “If you have a dream, just to go with that dream and don’t let anyone tell you that you're not able to do the dream.”

Wayne

Wayne participated in a telephone interview. He is a 23 year old male emerging adult with Common Variable Immunodeficiency (CVID). Wayne was diagnosed shortly after birth. As a result of CVID, Wayne suffers many concomitant illnesses and requires continuous oxygen to breathe. He has endured multiple hospitalizations; most recently Wayne had major abdominal surgery due to a chronic gallbladder infection. He also has depression and anxiety, and an oral motor dysfunction causing difficulty in having his speech understood. He currently is taking a medical leave from college, but plans to return Fall 2014. Wayne lives at home with his immediate family. When he needs to travel outside the home, Wayne usually drives or gets a ride from a family member. He reports his family, friends and healthcare providers are there to support him. Although Wayne disagrees with the statement, *“I am very sure that someday I will get to where I want to be in life”* his notable quote is, “No matter how many times you fail you always have the choice to get back up”.

Qualitative Findings

Findings of the qualitative strand of this study are reported in question and answer format. As suggested in Rubin (2012), themes are organized by how they addressed the research questions. The research question is presented first, followed by the findings of the thematic analysis. The thematic analysis revealed patterns that emerged across the focus group and interview data. Exemplar quotes from the focus group and individual interviews are linked together to create narratives depicting the essence of personal sentiments discovered through prolonged engagement with the participants. The narratives are rich with thick description to offer accurate and unadulterated perspectives through the lens of the participant. Prominent

themes are presented. Table 27 summarizes the qualitative research questions, objectives, data source and method of analyses employed by this study.

Table 27: Qualitative Research Questions, Objectives, Data Sources and Analyses

<i>Qualitative Research Questions, Objectives, Data Sources and Analyses</i>			
Question	Objective	Data Source	Analysis Method
1. To what extent are the self-reported values and goals of developmental transitioning consistent across this select group of emerging adults with disabilities?	To identify the values and goals of healthy transitioning that are reported by this select group of participants.		
2. To what extent are the self-reported challenges of transitioning consistent across this select group of emerging adults with disabilities?	To identify the adversities related to transitioning that have challenged this select group of participants.	Focus Group and Individual Interview	Thematic Analysis
3. To what extent are the self-reported attributes of resilience consistent across this select group of emerging adults with disabilities? Those found within the person? Those found in their environment?	To identify the attributes of resilience that are reported by this select group of participants and to further identify which attributes are key characteristics of the individual and which attributes come from sources in the environment.		

Qualitative Research Question 1

To what extent are the self-reported values and goals of developmental transitioning consistent across this select group of emerging adults with disabilities?

The following three themes emerged from the data to address this question: (1) standing on my own; (2) longing to create own meaning; (3) altruistic sense of duty towards others with disabilities.

Standing on My Own

When asked what they valued most about becoming an adult, participants spoke of adulthood as a time for independence and self-reliance. A time when they no longer follow the path created by others, but rather adulthood is a time to create their own path. The following exemplar quotes are from both the focus group and individual interviews. They represent what the participants aspire to do and be as an adult.

My personal freedom and independence to make decisions based on my wants, needs and dreams instead of being told what to do and maybe told to do things that would hold me back. (Richard)

Basically just independence, because living with a disability isn't easy, but basically just overcoming like everyday challenges. (Barbara)

My independence...do things on my own. Like trying to do your own bank accounts and stuff (Rachelle)

Just the independence of it... Just being able to take care of myself... own my own place, become a lawyer, and one day I have my own family (Rodger).

Independence...like can do stuff on my own... handle my stuff...just do like the stuff that my grandma would do for me; I have to do it by myself now. (Eunice)

I value my independence, because I would want to be more independent as an adult and be able to go out and do things on my own...My goals that I wish to achieve are to, one, graduate high school and become employed in my field, which is painting visual arts. And as well as to own my own home and own a car in my name. (Tammy)

Would be that I could be more independent of my parents and family. Even though I said that I feel like they're very valuable. I guess what I meant is that many friends of mine are doing what I have wanted to do. You know, they're all in college; one of my friends just got engaged. They're living their lives, going places, doing things, independently and I'm very restricted in what I can do. (Wayne)

To be that adult that I've always wanted to be...That adult is one where I can go out and be myself, not to be so shy; be able to stand my own ground and pay bills on time; to be an adult, really, and know what not to do and things, and always be respectful and cautious of different situations. And just to be myself. (Tammy)

So just to, like if you have like a dream, just to go with that dream and don't let anyone tell you that you're not able to do the dream. (Tammy)

I would say freedom of choice. (Wayne)

I think I would say just all of the things that the world has to offer for a young disabled person. Just getting out there and like being able to like make my own choices and stuff and being independent from – I mean I love my mom, but being independent from my mom. Doing things like on my own. (Laura)

Longing to Create own Meaning

While most participants articulated specific goals they hoped to achieve as they entered adulthood, one participant reported adulthood as a time to create meaning.

The goals reported by participants in both the focus group and individual interviews are in line with pursuing higher education as a means to employment. They hoped to:

Get better at math (Eunice) further my education. (Rodger) Passing college. (Carl) Get my Associates Degree in Biochemistry. (Wayne) Graduate from high school, go to a good art school, and get my bachelor's degree in the arts, do 3D animation. And might work at Walt Disney Studios or something (Rachelle) Going through college and getting a degree and putting the degree to use (Laura) Get a good job (Rachelle) A good paying job. (Eunice) Being a lawyer. (Rodger) Working at or owning a daycare. (Eunice)

Well, I'd like to, I wish I was able do research, on my own conditions. In a more scientific setting, in the hospital laboratory or a biomedical research lab. I'm hoping to get a dual degree in biochemistry and biomedical engineering... and then take that and use that for going to medical school or more likely research. (Wayne)

This participant did not report a specific goal, but rather he reported the desire to create meaning in his life. Having struggled to find direction, he described his transition to adulthood as a search for meaning.

I struggled to find my direction and kind of destiny to follow, struggled to find what I'm supposed to do with my life and it becomes overwhelming because I can't live a life like a lot of other people... I need a little bit more out of my life, a little more meaning....I

really, really did not want to fall down that path so I made sure to really be real thorough with my choices and decisions to make sure and just kind of started to fall all into place...I think it was really just knowing that I [didn't] want my life to be flushed down the toilet through a bad decision. And, I just feel a lot of people do that and throw their life away....How can I make an impact and not get lost in the shuffle. (Richard)

Altruistic Sense of Duty towards Others with Disabilities

The overarching theme of this collection of exemplar quotes is *altruistic sense of duty towards others with disabilities*. Together the participants' words relay the sentiment of the desire to share one's experience with others similar to themselves. The participants long to teach others what they themselves have learned. In one instance, the participant wants to share her story so that others do not make the same tragic mistake she herself has made. In another instance, the participant wants to share her story so that others understand people with disabilities and persons with disabilities understand themselves.

My first goal would be making life, or trying to make life easier for everyone else, especially the younger kids with disabilities, 'cause I remember what that's like. Going to elementary school and being the one that's like can't go play at recess; you can't have as much fun as you want to at recess with the regular kids. Even though you want to and you kind of feel alone and by yourself. So, that would be my main focus, to make sure that those kids feel happy and comfortable within that is inside, 'cause most kids at that point, they don't feel comfortable. They feel like something's wrong with them. They feel like everybody's gonna treat them completely different 'cause they're that way. But, and get them to understand that this is how things are and there's nothing wrong with it. And you'd have to get them comfortable being in that situation. I think it's that you don't get till you're strong enough or until someone speaks to you about it. I think that would be a good place to start, making sure that people feel comfortable being in that situation. (Rodger)

Having a platform to be able to specifically speak to kids that are disabled or that have the same kind of problems that I do, or fitting in as a kid in elementary school or something, 'cause that's always been a goal of mine. We – when I say we, I mean me and my girlfriend always talked about when we become successful, this is what we want to do.

We want to have a company that is just specifically speaking to kids with disabilities, 'cause we think that it would be better if it were to come from us, instead of someone who doesn't have a disability, but they have the same intention of making that person feel comfortable in that situation. But you're not in a chair. There's nothing wrong with you specifically. And you're come up to a kid in a chair that's, he's gonna listen to you, listen to you, but they're not really gonna connect with you, so that's one of the things that I feel like I should be one of those people who develops that and makes sure the kids' with disabilities understand that there's people out there just like you who went through the same thing and they're successful now. You could do the same thing... for me to be a leader for people with disabilities; I personally see it as a great honor. And I'd be happy that those people chose me to be their voice. (Rodger)

I want to make sure that everyone else in my situation be as comfortable and able to transition the way that I did, I'm gonna do my best to make sure that that happens, whether it's, I have to sit down and talk to that person or talk to their parents, or whatever I have to do, I'll do it. Even if I have to try to help them myself, I'll do that. So that's one of my goals and one of my things that I love to do. (Rodger)

The potential for others helping me and potential that there are others in this movement with similar or the same as or the same disability as myself, the large number of people I could potentially represent and also advocate for and I guess the lasting impact and legacy I could leave for others to follow. (Wayne)

I want to affect people's lives for the better. I think they can be inspired by me. (Frank) Pushing myself to be the best I can be and encouraging others to follow behind so they can push them as I would push myself. Encouraging and supporting them. (Carl) To share my joy and my inner happiness and contentness with who I am and what my life is. And just to help somebody else to find that, other people to find that within themselves. (Laura)

This participant reflects on her life and the unfortunate events that led to her disability.

In doing so she selflessly hopes to teach others not to make the same mistakes she has made.

After I like woke up from my coma and stuff, I knew like, I got to help other 15 year olds out of struggling. Because I know a lot of young kids in high school, they do those drugs and drinking and...Or just young adults in general...And so because this, my wheelchair and disability is a result of that lifestyle...I spoke at a lot of high schools about the dangers of drugs. And it's more like in your face. (Laura)

Similarly, this participant shares his story of a failed adoption. He too, longs to use his unfortunate experiences to help others.

I've been through a lot in my life and I really value making an impact on people in my life and leaving my personal footprint that has a positive impact on a lot of people... and to go a little more specific I'd like to continue to give back to foster care and raise adoption awareness in ways that I struggled. And my adoption failed so I wanted to continue to promote strategies to help adoptive parents and their foster care adoption... I feel I have an obligation and right to give back to something that failed me or give back to a cause that deeply impacted my life and I wanted to not hold others into painful times in the future or not, you know, I want to help others into the future so that they don't feel the things that I felt in my past, long story short. And I know, I kind of, there's part of me that it's not really, it's a little bit of a shame feeling I think that pushes me to do some of these things...A wish of mine would be is that my impact would really touch upon and change the lives of many within the adoption system in a positive way. (Richard)

The objective of research question one was to identify the values and goals of healthy transitioning that are reported by this select group of participants. The themes *standing on my own, longing to create own meaning, and altruistic sense of duty towards others with disabilities* emerged from the exemplar quotes from the focus group and individual interview participants. They represent the common values and goals on becoming an adult expressed by the participants. Together these themes represent a purposeful life, which is an individual attribute of resilience. Research question two will identify the adversities related to transitioning that have challenged this select group of participants.

Qualitative Research Question 2

To what extent are the self-reported challenges of transitioning consistent across this select group of emerging adults with disabilities?

The following three themes emerged from the data to address this question: (1) challenges specific to me vs. challenges we all face; (2) I am a person with abilities; (3) Butterfly's Story...our struggles make us stronger.

Challenges Specific to Me vs. Challenges We All Face

The quotes that convey challenges specific to the individual and challenges common to emerging adults without disabilities are presented next. They begin with describing challenges germane to the disability and are followed by challenges that are relevant to emerging adults without disabilities.

The following exemplar quotes represent the first half of the theme, *challenges specific to me vs. challenges we all face*. Over and above the challenges of meeting the everyday responsibilities of adulthood, these emerging adults with disabilities face additional challenges related to their disability. This participant shares feelings of social isolation because he is the only student at school who has a physical disability. He says, *there's not a lot of disabled kids in high school... And the thing is they all have mental disabilities. (Frank)*

The next quote is by a participant who wanted to participate in the focus group but was unable due to postoperative complications. He was later interviewed.

I have Common Variable Immune Deficiency and basically in laymen's terms, that means that my immune system, from time to time, attacks various organs of my body. In the past, it's attacked my bones, it's attacked my stomach, intestines, it's attacked my kidneys, my blood... another system my immune system has compromised are my lungs and because of that I have to have continuous oxygen constantly so that means that for, basically for my science courses, I'm not able to take anything that is laboratory related so it's been a very difficult challenge trying to find other sources of, I guess, learning...I had a lot of health issues going on, basically. I had to have major abdominal surgery because of a chronic gall bladder infection and that has been a problem for over two years and it wasn't corrected until shortly before New Year's so I was in the hospital a lot, on and off between October and January 2014 and that made it very difficult to get schoolwork done... I'm so chronically ill, so much is participation in the course so I wasn't able to develop my whole attention to this as I normally would have, you know? (Wayne)

This participant shares both the emotional and physical challenges she experiences related to her physical limitations.

I get so frustrated. I mean not with people, but mostly with myself because I can't – my body doesn't allow me to do the things it used to do. And I just get so mad, like, I'll want to, like, I don't know, reach something, or, I don't know, you know? I don't. I can't. Just like my own body. It's like within myself, kind of, and I kind of get angry within myself, and then I take it out on people around me that are taking care of me, like my nurses, and my mom, and my friends...I wasn't always disabled. But I think mostly because people know that I am the age I am and that I – It's mostly – It's like a physical disability more than like – yes, I have a brain injury, but I have recovered so much. Like, my brain has healed a lot. And so pretty much my main thing I struggle with would be physical things, like taking care of myself and my hygiene and stuff. And then just getting around and getting to bed and getting up in my chair and getting to places. That's what I – I mean anybody with a disability can say that they have a difficult time with those things...getting dressed is a pain in the butt and I get very like irritated and irritable with whoever is... I think I made my mom really upset one time, and she's like, L, you get so, you go off on people that are trying to care for you the most. (Laura)

This participant envisioned his future and the challenges that lie ahead related to his physical disability.

Just the mobility problems, like how I'll be able to do stuff that people do. Like for instance, if I had a child or something, how would I take care of the child... I would just be like basically turning stuff around from one place to another if I didn't have anyone else. It's hard to do that, to either push myself or carry something on my lap. And it's hard to do it, 'cause that thing could fall on my foot, causing me further injury. So, you know there are problems. (Rodger)

The right to maybe be more independent, I guess, because there's so much going on now that we feel that some, well, in my case, disability-wise, I think that other people have difficulty maybe getting around, maybe such as like crossing the street, or something like that, that you have to be very cautious of that, by having the disability and everything like that... maybe like walking down a maybe a hill or something like that, because sometimes I trip when I'm walking. I have cerebral palsy, so it causes my muscles to contract and things like that. So sometimes I have trouble walking. And yeah, sometimes I limp when I walk and I trip sometimes when I walk. And some people notice. Well, like today I'm at my mom's job and one of her co-workers noticed that I was limping when I was walking, so that was why I said that... But that's some of the things I face, challenges I face. (Tammy)

This participant is challenged with convincing others she has a disability. Quite possibly because others cannot see her disability, she is blamed for faking it. Additionally she shares the challenge of not being able to communicate clearly as a result of her hearing impairment.

My challenge with becoming an adult is to [have people] understand I have hearing loss and people think I don't, people think I don't have a disability, I'm faking it, but I do have a disability of hearing loss, and my speech problems and stuff. My language problems...I think they try and understand me, but there's some people don't understand me a lot. (Rachelle)

The following exemplar quotes represent the second half of the theme, *challenges specific to me vs. challenges we all face*. In addition to the challenges related to their disability, these emerging adults face the challenge of meeting the everyday responsibilities of adulthood just as any other emerging adult would experience. The first quotes represent the challenge of employment. Two focus group participants concur that finding a job will be difficult. They say, *trying to find myself a job after college (Carl)*, *Nowadays there are not many jobs, especially for us young people. (Barbara)*. In addition to having difficulty finding a job, Carl also expressed he had difficulty speaking publically. He says, *[I want to] improve on my speech skills when I talk to people. One on one is okay, but public speaking, I am not good at. That's my number one fear right now (Carl)*. Another participant, like many his age, shares the challenge of *algebra (Frank)*.

I am a Person with Abilities

The following dialogue taken from the focus group exemplifies the participants' desire to be regarded as a person with abilities not as one with a disability. The negative sentiment expressed in the following quotes is a result of societal labels and stereotypes of persons with disabilities.

All five focus group participants supported each other in that they feel they are misjudged by others as a result of having a disability. The participants engaged in an impassioned discussion describing how others always do for them; and how that can be

demeaning. In one instance a participant implied, rather than others learning to accept him, he has learned to be patient with others who treat him like a baby.

Challenges... just people underestimating the things I can do because I'm physically disabled, but as far as – I don't feel I'm the only one, because I know a lot of people with my disability and I feel like we go through the same things...[People], they like to do everything for me. (Barbara) I feel that, too. (Frank) Me, too. (Carl) Me, Too (Rachelle) A lot of people try to treat me, because they see I walk with a walker, like I'm helpless or I can't do anything for myself, so they do everything for me. (Barbara) They treat me like I'm five. (Frank) It's the same thing over here. (Barbara) Five, four, three, two. (Carl) Me, too, me too. (Rachelle) I understand, don't speak to me like I'm, you know, five. And yeah, I would say that that's what my, what I struggle with and what I'm worried about (Laura) I've learned to be more patient with people [when they are] talking to me like a baby (Frank) .

This participant feels that others do not fully understand what it means to have a disability. She wants to teach people without disabilities that people with disabilities are able and enduring individuals deserving of acceptance and respect.

I want people to know about some people like me who have hearing loss to know, like, we don't give up and stuff. And also try to know that like my disease doesn't – my disease is not the problem. It's just what [they] believe. It's what's inside. Like our – what we come with, what we're born with. And you have to accept the way we are. Like other kids don't accept their abilities and stuff. Like I want them to know, accept the way they are (Rachelle).

Group consensus demonstrated that these individuals collectively feel misjudged and underestimated by others without disabilities. The following theme expands on this notion through one interview participant's sentiments. As a person with disabilities, this participant feels others have always done too much for him, such that he has not had the opportunity to grow as an independent.

“A Butterfly’s Story...Our Struggles make us Stronger”

The Butterfly’s Story (Appendix N) is a story about the transformation of a butterfly. In the story, the butterfly is witnessed as it struggles to break out of its cocoon. Seeing the struggle, a man tries to help by snipping the cocoon off the butterfly. The butterfly appears, however its wings were not fully developed. Because its wings were not fully developed, the butterfly was never able to fly and soon after it dies. What the man did not realize was that the butterfly needed to struggle; for it is as a result of the struggle the butterfly’s wings are made to develop. While there are a few versions of this story, the lesson to be learned is that struggling is an important life experience and through struggles we become stronger and learn to overcome.

While sentiments paralleling those of the Butterfly’s Story were weaved throughout the focus group and individual interviews, one participant explicitly expressed the negative impact of being sheltered and protected. He explained that transitioning to adulthood is more difficult for individuals with disabilities, not because of their disability per say, but because of never having learned to do things on their own. He implies that when you are a child with a disability the adults in your life tend to all your needs, as a result you never learn how to handle situations on your own. Like in the case of the butterfly, struggling is necessary and having too much help does more harm than good. Having always had people do for him has made his transition to adulthood more challenging.

The quote below exemplifies how overprotection and coddling from parents/guardians can impede transitioning to adulthood especially for individuals with disabilities.

I think that honestly, transitioning to adulthood for a normal teenager is easier than it is for a kid in my situation, 'cause most kids in my situation, they are so sheltered and protected. There's always someone there to do this for you [or] to do that for you. When you come out of that place of being sheltered and have someone there to do something for you, when you get out to a point that you have to do it for yourself, it's harder, 'cause

there's no one to like cook for you or wash your clothes. And all things that you're used to, you have to learn to do that for yourself. So I think that that's what makes it hard, 'cause a normal kid, their parents, at a certain point [say], you do stuff for yourself. You wash your own clothes. You cook for yourself. You can come in the house safe and you take care of yourself. But most kids in my situation aren't able to do that. There are a few people that I personally know that can't. So that's just one of the things that I think that makes things harder for kids with disabilities to be able to transfer from being kids to adults. (Rodger)

Undertones of insecurity are also evident. The words, “*a normal kid...You can come in the house safe and you take care of yourself. But most kids in my situation aren't able to do that,*” suggests that this individual is feeling insecure about his own transition to adulthood.

The objective of research question two was to identify the adversities related to transitioning that have challenged this select group of participants. Emerging adults with disabilities face increased challenges as they are transitioning to adulthood. They not only face the challenges as do emerging adults without disabilities, but they face additional challenges related to their disability. This sample of emerging adults with disabilities expressed the challenges in preparing for adulthood as would any emerging adult, such as getting a job, doing well in school and public speaking. However they also expressed facing some very specific challenges germane to their disability, such as social isolation, missing school and events due to multiple hospitalizations, emotion stress, and physical limitations. While these challenges were characteristic of the disability, many others are not. Emerging adults with disabilities are also burdened with challenges brought upon by societal labeling and stereotyping and overprotection and coddling from parents/guardians. The theme, *I am a person with abilities* is specific to the damaging effects of societal labeling and stereotyping, while the theme *A Butterfly's Story...our struggles make us stronger* is specific to the damaging effects of overprotection and coddling by

parent/guardians. Research question three will identify the attributes of resilience that are reported by this select group of participants and will further identify which attributes are key characteristics that come from the individual and which come from sources in the environment.

Qualitative Research Question 3

To what extent are the self-reported attributes of resilience consistent across this select group of emerging adults with disabilities? Those found within the person? Those found in their environment?

The findings from the qualitative analysis reflect that these individuals share many individual and environmental attributes of resilience. The following four themes emerged from the stories shared by the participants: (1) life is a journey; (2) traits that keep me going (3) “patience is a virtue”; and (4) “it takes a village”.

Life is a Journey

The theme, *life is a journey* highlights the resilient attributes of acceptance and perseverance. Participants spoke of accepting and embracing life with all its challenges and persevering through complications and adversity. The following collections of exemplar quotes represent difficulties faced by the participants. They accept that difficulties are a natural part of life and ultimately it is up to them to keep moving forward.

Being on your own...it's not gonna be easy. (Eunice)

I didn't know where I was going, I didn't have a job, I didn't know anybody out here...I still didn't have a job, still didn't have a place to live and had no really access money and I'm screaming and freaking out and blah, blah, blah. Ultimately a few weeks later I found a job and it just all started to unravel and fell into place and I ended up getting my own place a couple months later and just really attacking that problem that really was a

pretty big one. I had nothing going on in my life out here in D.C. and all the pieces came together through just really pushing all my effort towards that goal. (Richard)

I learned that you're not going to be accepted by everybody, so you have to just live your life for you. (Barbara) Live your life to the fullest. (Carl) Don't let life get you down (Frank) I'd have to say that I look for, look for ways to do what [I] want to do despite others becoming obstacles to the test. (Wayne) I think it's like, you know people want to be perfect and stuff. So I want them to know, just be the way you are. Don't act like others around you. Just be yourself. And don't give up. And continue your dreams. And work really hard. (Rachelle) Be very determined and not so much listen to what the negative things that people say or that they are gonna say. (Rodger) I have a faith in myself and a peace in the world that is higher or more, more set in place than most people I feel. Like, I don't worry about things I can't control. I don't talk about the weather 'cause I have more important things in my life. (Richard)

[There is a] community of women that have been in wheelchairs like for years and years and years and how they've had children and like lived their life and they didn't let their disabilities (Laura) Get in the way (Barbara) Exactly. Hold them back from taking care of an infant or like getting married and living their life (Laura) Life is not easy, but you can always push yourself to be the best that you can be. (Carl)

Sometimes I have trouble walking, but not so much, 'cause I get up early enough in the day where I can manage and have time to take my time and walk to where I have to be. (Tammy) I was not in good health but I was able to maintain, I guess, a certain level of focus despite the chronic medical issues that were going on at the time and still complete the course to the level of my ability that I was, given the circumstance. (Wayne)

I guess no matter how many times you fail and fall, you always have the choice to get back up. (Wayne) I know you have struggles just like I have struggles and just like everybody has struggles. (Laura) Because things happen in life where you can't do everything, you know, all the time. (Tammy) So just taking that and moving forward. Like you can't dwell on the things you can't do, you just got to focus on what you can do and know that everybody's different. (Barbara) Everything doesn't come overnight, but if you keep pushing and not giving up and moving forward, then you'll eventually make it if you have the motivation to keep going. (Barbara) You can't fail something unless you try so I guess just to (Barbara) Keep on trying (Carl) Be inspired about the things around you and keep going forward. (Barbara) I learned to never give up and keep going and stuff and people always make mistakes and you should learn by your mistakes. (Rachelle) Everything happens for a reason. And I think if [my life] was different, I wouldn't know now what I know. So I wouldn't change. (Barbara) I've learned from what happened [to me] ... I've become so much more understanding of other people, and accepting of everybody. (Laura)

The following excerpt provides evidence of resilience in the life of one participant. It is a narrative account that begins with her returning to school after suffering from an anoxic brain injury that left her with quadriplegia. It ends with her graduating high school. This story depicts acceptance and perseverance despite the physical and emotional challenges she faced when she returned to school, as well as her courage, strength of will, and desire to succeed, that kept her going.

My accident happened my freshman year, and so I had been to the high school I graduated, and took my freshman year of high school at that school. And then my accident happened and my year in the hospital. And then I missed two years of high school. And when I came back, it's like I came back and I was in a wheelchair and I had a brain injury and I was physically not able to like manage my books and manage my stuff. And I was so terrified. Like before I even went back to high school... I mean the fact that I was able to go back with my disability and face everybody and then also I pretty much got straight A's, but that was because – I mean I wanted to get the best grades I could and then the new modifications I guess are the – that I got with a brain injury and a physical like disability – it made it – it made high school like the work like – I mean I guess easy but it was still hard at the same time. And I remember like my senior year I would like call my mom every day at lunch and I'd be like mom this is too stressful and I'd be like crying and you know I'd want to just give up and be like okay I'm done with this, you know? And the fact that when I – I know when I came back and they were like, yeah. I think I said, like, I want to go back to high school. Because I was being taught at home by a home-in hospital, like a kind of like home school, but it was like high school credits. I wanted to be back in high school. I mean I was terrified of it but I was like – (Laura) Determined (Carl) The only way I will be able to overcome this is if I face it. And so I just went to high school and it was a totally different, for me I mean it was difficult. And I just looked at it so different. Before I looked at it like I don't want to be here, let's go out, and I want to skip, and stay home, and all this stuff. But when I came back [after my accident] and I looked at it, I'm like, this is like free education. And this, we are lucky to even get this. And I took advantage of it. I was like I want to learn as much as I can and take it with me and you know I don't know. Just graduating high school was the hugest accomplishment and something I'm very, very proud that I overcame and did it. (Laura)

While Laura was sharing her story, others in the focus group listened in silence and nodded in agreement as if while hearing Laura's words they were also reflecting on their own lives. Listening intently, Carl was able to finish Laura's sentence as she struggled to find the

correct word. While they have not experienced the same hardship, it was easily observed that the other participants understood Laura's desire to persevere.

Traits that Keep Me Going

At various points throughout the focus group and interviews participants were asked affirmative questions in order to elicit positive responses. The goal was to identify key resilient attributes that have aided these individuals in mitigating adversity. The theme, "traits that keep me going," emerged from their responses. While the term resilience was never used the interview guide, one participant explicitly stated, "*I know my resiliency has held me together at times through very rocky points and has helped me keep going.*" (Richard) The participants' resilient attributes are evident in the exemplar quotes to follow.

The following quotes are sorted according to a priori categories of resilient attributes that proceed from the literature. Alone these quotes represent individual attributes of resilience that have aided these individuals in mitigating adversity in their lives, but when linked together they represent them theme *traits that keep me going*.

The following exemplar quotes represent perseverance, equanimity, emotional and physical control, fortitude, hardiness, and competence.

I would say my, my mind and my strength of will... My democratic, democratic governance of situations and my intelligence. (Wayne) I'm really strong willed and never give up. (Rachelle) I'm very determined, so if I set my mind to something, I'm doing it. (Rodger)

The following exemplar quotes represent self-reliance, competence, and problem-solving skills.

I value my intelligence. (Frank) I like that I'm intelligent, too. And also, like, [that I'm] kind-hearted and artistic, too. (Rachelle) my intelligence and the fact that I'm honest with myself (Barbara) I value my intelligence, my understanding in the world today, the people I talk to, and the environment around me, too. (Carl) I'm just a naturally smart person. Good at school subjects. (Frank) I went to a training school for a 15-week computer program...they didn't tell me that it was a self-taught course. So you was basically teaching yourself. So finally when I finished and got out of that place, honestly because it was not easy at all...[I was] proud that I finished it and actually retained something from it. And actually being able to teach myself and not have someone telling me every day what I had to do, and I can actually do it myself. (Barbara)

The following exemplar quotes represent self-determination, purpose, desire to succeed, future orientated, and self-worth.

I value that I'm very, very, very respectful and that I know exactly what I want to do in my life. And by me knowing that at such a young age, I know that I would [be] successful in it. (Tammy)

The following exemplar quote represents self-determination.

Having drive...And like passion. (Eunice)

The following exemplar quotes represent self-determination, self-worth, perseverance, self-reliance, self-efficacy.

I don't like to follow behind other people so the only option is to lead. (Barbara) I'm actually on the leadership team at my high school... you just discuss ways to make the school better...Better in general... Because it [the leadership team] really needed my input. (Frank)

The following exemplar quotes represent self-determination, self-worth, perseverance, and self-efficacy.

I'm the type of person who I like my own way. Everybody who knows me will tell you that. So I'm very much, if I want to do something, I'm gonna do it, regardless of what, that's what I'm gonna do. If you like it, you like it. If you don't, you don't. I'm gonna do it, 'cause I want to do it. So that's one of my things. I just feel like everyone should be

that way, just very determined. I want to do this, this is what I'm gonna do. There's nothing that's gonna change my focus about it. This is what I'm selling, this is what I'm doing. (Rodger)

The following exemplar quotes represent equanimity, good interpersonal skills, and emotional intelligence.

The fact that I have such a... beautiful heart and a really good heart. Yeah, but just my – how I care about people and I mean I've always cared about people, even like, you know. I understand and I'm very sympathetic, and I'm very – Just my heart and how I care about people and how can talk to people and just I'm ...a social butterfly...So yeah. I just really value that part of me that I'm so caring and like I care about people. (Laura) I feel like if I know something that I can get, or help someone else know something that they didn't know before, then I'm successful at what I'm supposed to do. (Barbara)

The following exemplar quotes represent purposeful life, future orientated, desire to succeed, purpose, and flexibility.

Since I was little, I've been interested in art, so I decided my life to become a good artist and stuff. And then over the past, over the years, I've been doing more art than ever. Like trying to do different new things to like draw in pencil, do cartoons, graphic design, 3D animation, and now I'm doing acrylic painting. So my passion right now is – my passion and my dreams relate to art and stuff. (Rachelle)

The following exemplar quotes represent self-reliance, problem-solving skills, self-sufficiency, equanimity, emotional and physical control.

I'm the type of person who I'll listen, I think before I answer, and I'm a very good problem solver. (Rodger) I help people with their problems. (Eunice)

The following exemplar quote represents sense of humor, optimistic, and good interpersonal skills.

I can make people laugh ... just to help keep people happy and positive. (Eunice)

The following exemplar quote represents existential aloneness, sense of self, acceptance, and being comfortable in own skin.

I think actually really what I found was my happiness, you know, within myself, and that's what I learned. I learned how to like channel my own happiness within myself... My joy and my inner happiness and contentness with who I am and what my life is. (Laura)

The following exemplar quotes represent self-reliance and self-sufficiency.

Well, I think I've learned – I've, like, since my accident, and then my new disability, I've really found myself a lot like being alone all the time. I mean after my whole accident, all of my prior friends like didn't have time for me because they're like in college and they're so busy and blah, blah, blah. And I found myself a lot... And I just learned where to turn when there's nobody else. (Laura)

The following exemplar quotes represent tolerance.

I've learned to be more patient with people. (Frank) I've learned to be very accepting of everybody. (Laura)

The following exemplar quote represents religious beliefs.

And I've become very spiritual since my whole incident... I found, you know, what I was missing before. I found more of the meaning of life. And I just found, I found myself in like God. And things like that. I mean I'm not going to preach to you guys and stuff but yeah. I just really found God in all of it. And since I have my friend that brought me here, she came in when everybody went out, and we've been inseparable ever since. (Laura)

The following exemplar quote represents good interpersonal skills.

I've been very good at being brutally honest and also saying it in a way that it doesn't seem like I'm trying to offend the person that I'm being honest with, so that works. (Rodger)

Well, it would have to be my voice. I'm a very good speaker. I'm very willing to sit down and talk to someone and discuss some or public speaking, I don't mind doing it. I can talk in front of a group, one person, 1,000 people, I can do it. And I'm not scared to do that. I'm willing to just go for it. (Rodger)

“Patience is a Virtue”

While only one participant identified himself as being patient, other participants spoke of patience as a characteristic they hoped to develop in themselves and also recommend it be developed in others. This created the theme, “*patience is a virtue.*” The proverbial phrase, “*patience is a virtue*” echoed throughout the shared stories of easily getting frustrated and the need to work on developing patience. When linked together, the exemplar quotes share the emotions of easily getting frustrated and identifying the need for patience, then receiving advice as to how to develop patience.

I get frustrated easily. So if I just had a little bit more patience within myself, I think I'd go a little bit farther. (Barbara) Just to be more, yeah, patient with people when I'm getting frustrated at these times when I'm frustrated with myself. (Laura) Don't get frustrated really easily...and also have the ability to try to be patient and stuff. (Rachelle) Patience, like staying calm when stuff goes wrong... Like breathe out each challenge and just like calming down and thinking about what to do instead of just reacting. (Eunice) Not to get so angry. (Frank) Stay positive. (Eunice)

“It Takes a Village”

This popular saying and emerging theme, “*it takes a village*”, comes from an African proverb, “It Takes a Village to Raise a Child.” While the original source has long been lost, the

message is timeless. “*It takes a village*”, speaks to the importance of social support resources, not only from the immediate family, but from the extended family and the community as well.

“*It takes a village*” emerged as a theme because during the interviews and focus group, participants spoke of others who were there for them - persons and services from which they received support. They also spoke of support from which they feel they would have benefitted from, had it been available. One participant shared a time when she was in need of support and felt she had no one to turn to. She said and was supported by others in focus group:

I was depressed and stuff, I was just really looking for somebody to like be like, you know, I don't know. For somebody to reach out to me and for me to actually receive it and... (Laura) To help you? (Carl) Exactly. (Laura) To know that you're going through a lot. (Rachelle)

Participants of the focus group and interviews expressed seven areas where they receive support. In most instances they reported the type of support they receive and why they value most about the person or the support. Immediate family members and friends stood out as the most prominent categories of support, with school, community, healthcare providers, work and spiritual support to follow.

The quotes are sorted according to a priori categories of social support resources that proceed from the literature.

The following quotes represent support from family:

Mom and dad and my aunt... She tends to my daily things, assisting me with medication, taking me to the medical appointments... Basically she handles all the medical stuff and she makes sure I stay on top of all that... Dad is more of the moral support, the moral advocate for me and he's kind of the cement that holds the blocks together in the family... My aunt is very much like my mom...She is also my godmother, but she's more of a friendly, more of a loving friend, a very loving friend... Very close, she travels down a lot to visit and to hang out... And talk. She provides a lot of moral support...Loving encouragement. (Wayne)

My grandmother...and my brother.... I can always call on them whenever I need something, or that they're always there to help me. To give me the best advice. (Barbara)

I think my family, the most. The one person that I care about the most is my mom, because she understands how I feel a lot and supports what's going on in my life, even school and stuff, and like hearing loss. And we have the same feelings, like our passions and stuff. (Rachelle)

My mom. I can come to her with any problem. She can help me with anything. (Frank)

The following quotes represent support from both family and healthcare provider:

I guess the most important would be family...and... health advocates, doctors, and nurses...pulmonologist I would say is also a large, large help and my immunologist is kind of my gatekeeper of all my medical things at the hospital level and he has been an astoundingly huge advocate and help throughout my entire life. (Wayne)

Pretty much my main thing I struggle with would be physical things, like taking care of myself and my hygiene and stuff. And then just getting around and getting to bed and getting up in my chair and getting to places. I live with my mom and my sisters... I have like nursing care and stuff. (Laura)

The following quotes represent support from family and friend(s):

I value the most is my family and friends. (Rachelle)

Two, three of my friends. My mom and dad. Because they push me to be the best that I can be. Yes, to do the best I can do. In college and out of college. They care about me a lot. They love me as much they love them. They understand me, how I function and stuff. Really, they do. (Carl)

I value friends and family that support me through mainly high school and through college... They help me a lot through things. (Carl)

The following quotes represent support from friend(s):

I would say my girlfriend, because we talk a lot more than me and anyone else. So she's always the one being really supportive. It's between her and my mom. They always offer

me support and say I should do this or do that, or pay attention to your schoolwork, all this, or what it is. (Rodger)

Actually [my girlfriend and I] both have the same disability, the exact same thing. That's something that we have in common and we try to talk about that more than anything else and try to figure out ways to make it better for both of us. She's very brutally honest. She's really supportive. She looks at things from both ways, so she's not one of those people that have a one-sided mind. She looks at things from both sides, wrong or right. So that's always good to have someone who can look both ways. (Rodger)

I have a lot of friends that are in wheelchairs. And I have a lot of friends that quote-unquote "normal." There's absolutely nothing wrong with them, and you can have conversations and then we're fine. But my one thing is that I like to keep in touch with my friends that are in chairs. I like to. If I have free time, I'll call them. Or they'll text and we'll sit there and we'll have a conversation for about an hour about anything. Just making sure that they're fine, 'cause in high school, my whole thing was that everyone in the school that was in a wheelchair hung out with me and we all sat down. We had lunch together and that was just and we'd talk about whatever. And it was family stuff that was going on in our lives, or stuff with doctors, or whatever it was. I make sure that we all, we ate lunch or became friends, because that so I would love to, that's one of my things I try to keep that still together. We're all on different parts in our lives. I'm in college and I'm not technically at home all the time. I make sure that we are able to get on the phone, talk, whether it's Facebook, something, I just make sure that we talk in and check in with each other every now and then. I think that's one of the things I'd like to continue doing, and hopefully one day those same people that I'm keeping in contact with will become the people that when I start that company to speak to disabled people, we'll be the same people that will go out there speak to those kids. Hopefully we can all do it together a couple years from now when we're all successful and doing what we choose to do. So that's like just one of the things I want and one of the things I can see myself doing. So, as far as things that I'm doing now to try to achieve that goal, that would be it. (Rodger)

Well, I would definitely say my friend, MR. She is – She, over the last year, she has helped me first of all physically helped me with like a lot of things. Every little thing that I need, I'm just like, when she's at my house, which is like most of the time, she doesn't have a problem helping me with anything. She's a friend... just somebody to be like young with and like laugh and be crazy and say stupid things. And somebody that isn't ashamed to offer me help. She helps me like with bathroom and like getting me ready. And she's just not ashamed of me; she doesn't have any problem helping me with things. And she really has been like a saint in my life since we kind of reunited in a way... we're like pretty much like sisters. And then I was going to say, also, my sister, my actual sister, yeah, she – we were close before my accident, but, I don't know. And when my accident happened, she didn't know how to deal with it for a little while. But now she – she really – I mean sometimes she's still a sister and she can really piss me off and get on my nerves and like we'll fight and stuff, but she will most of the time help me with little things like can you fix this, can you grab that? Just little things like that. And she helps

me a lot and she watches movies with me and she will play games with me. And her and my MR, my friend, just really – all three of us together is like crazy. We're loud and rowdy and – just keeps me, like, sane. (Laura)

The following quotes represent support from peers at school:

I learned that making new friends, as they support me through college. College friends, the ones that study a lot and stuff, but they do help me a lot...right people right stuff. (Carl)

I have great relationships with my professors now. Like this last semester I had all female teachers, so it all turned out like I had five moms... they would all pay attention. If I did something wrong, they'd all come to me, say – before it got out of control or before I had a paper due and it was late. All my teachers would know, even if it wasn't for their class. They would all know and they would all come to me and say something. (Rodger)

A leadership initiative...Through my middle school, I think. It was run by a police officer, Officer W, and I felt like that was one of the biggest things for me. I felt like it was a place where we could go and talk and speak about what was going on in school, what was going on this and how to fix it.(Rodger)

I'm in the Model _ Program for technology attendants. My Model coordinator at the time had suggested several resources. Members of my writing group had suggested resources for ways to handle the oxygen and find outlets to find outlets to manufacturers produce oxygen-assisted devices. (Wayne)

The following quotes represent support from community:

I am part of a group of women. Well, it's actually – Well, led by this one woman. Her name is SM... It's a group of women. It's called Women on Wheels, WOW, it's called WOW, and it's for women on wheels. And it's for women in wheelchair. (Laura)

The AA. They just gave me this scholarship to the pre-college. (Rachelle)

The AB helps me with stuff during school and stuff. They gave me I think an Apple laptop. This suit, they gave me. (Carl)

The following quote represents support from place of employment:

I was able to find a place to live through this lady I internshipped with and she said I could stay at her house for a while until I found a job...her name is E from the internship who I lived with and her husband giving me the most support now. Previously I had known them a year ago and they continually being like my foster parents with just gracious hearts and just amazing people... their just paternal feel that they exude to me and E is just like a natural mother and she's always wanted a child and they've been trying a lot. She just glows as a mother and not having any stable mother my whole life was really something I was drawn to, just the warmness and wanting to help me. It was great. It really was. (Richard)

The following quote represents this participant's spirituality:

Keep God first in your life (Tammy)

The following quotes represent nonspecific support:

I would say that there are a lot of people in my life who understand me a lot and they love me and they tell me to try my best and never give up. (Rachelle)

I sought some advice and I asked a lot of people "What can I do? I need a place to live." And I just really attacked the problem through help through others and people. And I had someone really help me. (Richard)

When asked what additional support they would have benefitted from or recommend for others, the participants focused on the areas of mentoring, networking and school programs. One participant spoke of just having someone to confide in.

I think that I would need, me personally, mentoring. I don't think I never really had like a mentor to like help me or anything like that. So I think, to me personally, I was thinking about needing a mentor, or someone who could just help me, someone who I could feel comfortable talking to if I needed. (Tammy)

Just basically networking, because you never know who knows who that can help you along the way, meeting new people, having new friends, things like that. (Barbara)
Always have a good support system and staying around positive people, because those

are the ones that help you in order to be better and succeed at whatever it is that you would like to pursue as a career. (Tammy)

I think that they should have a group specifically for people with disabilities that go to that school, even though that there's people with physical disabilities, I think there's only like three people, myself and two other people. There's also people in that school with mental disabilities, including myself. So I think that would be something that we should have in the school, because they pretty much have a group for everything else except that. (Rodger)

Get involved in your school, if you have maybe like an art, I mean an extracurricular activity. Maybe get involved in that and things around in your community area and find like little things to attend to; get into some art shows or whatever it is that you have or work to pursue....Just find a niche and get anything, like little, maybe try little stuff to take. In the meantime, of whatever it is that you would like to do in life. Maybe take classes on it or research. Get involved in your community and different things like that. (Tammy)

A counselor a guidance counselor at the school could help them, or a teacher or a family member that they feel like they can confide in. (Eunice)

The next two quotes support the importance of mentoring. This participant first speaks out against large programs, in favor of an individualized program of support. He then shares his experience as a mentor and his desire to continue mentoring others.

More programs and services that focus on working on your, like my weaknesses and strengths and really harnessing and zooming in on that on a personal level instead of just sitting in class with 500 people and saying "Hey. This is blah, blah, blah." Like really having almost like a life tutor or mentor to really help you as you go along, but be there when you need them to touch upon, to contact when you need help. (Richard)

I'm in a program where I mentor, we see all of each other once a month and I talk to them and help them through their crazy lives... And that's what I want to do. I want to continue to build upon that and maybe go on to a bigger scale of it and keep the ball rolling. (Richard)

The objective of research question three was to identify the attributes of resilience that are reported by this select group of participants and to further identify which attributes are key characteristics that come from the individual and which come from sources in the environment.

The themes *life is a journey*, *traits that keep me going*, “*patience is a virtue*”, and “*it takes a village*” emerged from exemplar quotes from the focus group and individual interview participants. They represent the attributes of resilience that have aided these individuals in managing the adversities related to transitioning to adulthood. The theme *life is a journey* represents acceptance and perseverance. Both acceptance and perseverance are individual attributes of resilience. The theme *patience is a virtue* also represents perseverance. The themes *traits that keep me going* emerged from a collection of individual attributes of resilience described by the participants. Lastly, the theme *it takes a village* emerged because all the participants spoke of a person in their life who offered them the most support.

Summary of Qualitative Findings

This collection of prominent themes was discovered through qualitative thematic analysis of the data derived from the focus group, individual interviews, and the researcher's field notes and memos. The participants spoke candidly and responded openly to questions related to their transitioning to adulthood. In doing so, they described their values, goals, challenges and resilience attributes. The following ten themes emerged and are representative of what the data signified.

1. *Standing on My Own*

Responses that lead to the emergence of the theme, *standing on my own* represented what the participants' value most on becoming an adult. Largely the participants expressed independence and freedom. They equated becoming an adult with being able to stand on their own. As emerging adults they longed for a time to be able to make their own decisions. For many, having a disability meant being more dependent on others. The theme *standing on my own* represents a purposeful life, which is an individual attribute of resilience.

2. *Longing to Create Own Meaning*

Responses that lead to the emergence of the theme, *longing to create own meaning* represented one of the goals that the participants hope to achieve when they became adults. Similar to standing on their own, the participants equated adulthood with a time to create their own meaning. The theme *longing to create own meaning* represents a purposeful life, which is an individual attribute of resilience.

3. *Altruistic Sense of Duty Towards Others with Disabilities*

Responses that lead to the emergence of the theme, *altruistic sense of duty towards others with disabilities* represented another goal that the participants hope to achieve when they became adults. A number of the participants expressed the desire to use what they have learned from their past experiences to teach others. Having experienced firsthand the difficulties related to having a disability, they longed to help others. Selflessly, the participants want to share their experiences of growing up with a disability or in one case, making a bad choice that led to her disability, so that others may learn from them. The theme *altruistic sense of duty towards others with disabilities* represents a purposeful life, which is an individual attribute of resilience.

4. *Challenges Specific to Me vs. Challenges We All Face*

Responses that lead to the emergence of the theme, *challenges specific to me vs. challenges we all face* represented the many challenges these emerging adults with disabilities have encountered. In addition to the everyday challenges faced by transitioning emerging adults without disabilities, the participants described challenges that were specifically related to their disability.

5. *I Am A Person With Abilities*

Responses that lead to the emergence of the theme, *I am a person with abilities* represented a specific challenge related to the negative impact of stereotypes and societal labeling. The participants expressed how they longed to be viewed by others as persons with abilities, rather than be viewed as someone with a disability. The theme *I am a*

person with abilities represents self-reliance, which is an individual attribute of resilience.

6. *Butterfly's Story...Our Struggles Make Us Stronger*

The theme *Butterfly's Story...our struggles make us stronger* emerged from the words of one participant who described the disadvantages of growing up never having to do for himself. Having always had things done for him, this participant feels he never had the opportunity to learn on his own. The theme *butterfly's story...our struggles make us stronger* represents perseverance, which is an individual attribute of resilience.

7. *Life Is A Journey*

Responses that lead to the emergence of the theme, *life is a journey* represented the participants' acceptance and perseverance. They have an acceptance of their current situation and an acceptance that being an adult was not going to be easy; but also have the perseverance to keep moving forward. Acceptance and perseverance have aided these emerging adults in their transitioning to adulthood. The theme *life is a journey* represents acceptance and perseverance, which are individual attributes of resilience.

8. *Traits That Keep Me Going*

Responses that lead to the emergence of the theme, *traits that keep me going* represented a collection of the individual attributes of resilience that have aided these emerging adults in their transitioning to adulthood. These quotes were organized according to a priori categories of individual attributes of resilience identified in the literature (Table 1).

9. *Patience Is A Virtue*

Responses that lead to the emergence of the theme, *patience is a virtue* represented the collective desire of the participants to have more patience. Only one participant expressed he had patience. The theme *patience is a virtue* represents patience, which is an individual attribute of resilience.

10. *It Takes A Village*

Responses that lead to the emergence of the theme *it takes a village* represented the environmental attributes of resilience that have aided these emerging adults in their transitioning to adulthood. The quotes were organized according to a priori categories of social support resources that proceed from the literature. These areas of social support are also environmental attributes of resilience (Table 1).

Open-ended, semi structured qualitative questions elicited key individual and environmental attributes of resilience of this select group of emerging adults with disabilities. Qualitative findings for this study were revealed through data triangulation of mutually supported findings from focus group and interview data. The focus group allowed for a wide range of ideas to be discussed that ultimately lead to group consensus; and the individual interviews allowed for a deeper examination of personal experiences. The combined focus group and individual interview data converged to create a triangulation of findings. These findings will be combined with the findings of the quantitative analysis for methodological triangulation; and further discussed in detail in Chapter Five.

Mixed Methods Findings

Independent findings of the quantitative and qualitative strands have been combined and analyzed in this section to answer the mixed method research question and sub-question: *Do the quantitative measures uphold the prominent themes discovered in the qualitative data? To what extent does the qualitative data contribute to an enhanced interpretation and understanding of the relationships discovered among the quantitative variables?* Products of descriptive, correlation and regression statistics used to analyze levels of resilience, physical health, mental health, life satisfaction, future orientation and quantity of social support and prominent themes discovered through thematic analysis of interview and focus group data were combined to create a frequency table, matrix and hierarchical categorization of merged findings. The findings are presented here. A detailed discussion will be presented in Chapter Five.

Mixed Methods Research Question and Sub-Question

RQ: Do the quantitative measures uphold the prominent themes discovered in the qualitative data? To what extent does the qualitative data contribute to an enhanced interpretation and understanding of the relationships discovered among the quantitative variables?

Frequency Analysis and Cross-Tabulation of Quantitative and Qualitative Data

The frequency analysis was performed to identify the number of times a particular resilient attribute emerged from a qualitative theme or excerpt. A cross-tabulation analysis was performed to compare quantitative variables and qualitative themes. A matrix of quantitative categorical and continuous variables and qualitative themes was developed. Tables 28 and 29, aid in presenting and interpreting the data in a meaningful way.

Table 28: Frequency of Individual Resilient Attributes in Themes

<i>Frequency of Individual Resilient Attributes in Themes</i>										
<i>Theme</i>	<i>TG</i>		<i>SO</i>	<i>LM</i>	<i>AD</i>	<i>IA</i>	<i>BS</i>	<i>LI</i>	<i>PV</i>	
Category	<i>f</i>	Σ	<i>f</i>	<i>f</i>	<i>f</i>	<i>f</i>	<i>f</i>	<i>f</i>	<i>f</i>	Σ All Categories
<i>Expanded Characteristic</i>										
Purposeful Life	1	13	1	1	1					16
<i>Self-Worth</i>	2									
<i>Self-Determination</i>	3									
<i>Future Oriented</i>	2									
<i>Desire to Succeed</i>	2									
<i>Meaningful life</i>	2									
<i>Religious Beliefs</i>	1									
Perseverance	2	6					1	1		9
<i>Flexibility</i>	1									
<i>Tolerance</i>	1								1	
<i>Self-Efficacy</i>	1									
<i>Hardiness</i>	1									
Self-Reliance	4	10				1				11
<i>Problem-Solving Skills</i>	2									
<i>Self-Sufficiency</i>	2									
<i>Competence</i>	2									
Equanimity	3	14								14
<i>Emotional Control</i>	2									
<i>Physical Control</i>	2									
<i>Emotional Intelligence</i>	1									
<i>Sense of Humor</i>	1									
<i>Optimistic</i>	1									
<i>Good Interpersonal Skills</i>	4									
Existential Aloneness	1	4								6
<i>Sense of Self</i>	1									
<i>"Comfortable in Own Skin"</i>	1									
<i>Acceptance</i>	1						1	1		

Note. Categories and expanded characteristics are organized according to an a priori categorization of resilience attributes with expanded characteristics as presented in the literature (Table 1). Σ = category sum. All participants expressed having at least one resilient attribute. Themes: TG = Traits that keep me going, SO = Standing on my own, LM = Longing to create meaning, AD = Altruistic sense of duty towards others with disabilities, IA = I am a person with abilities, BS = Butterfly's story...our struggles make us stronger, LI = Life is a journey. PV = Patience is a Virtue. (n = 10)

Table 29: *Quantitative Measures and Qualitative Themes*

<i>Quantitative Measures and Qualitative Themes</i>								
Mean	Standing On My Own (n = 8)	Longing To Create Meaning (n = 10)	Altruistic Sense Of Duty ... (n = 4)	Challenges Specific To Me (n = 6)	...Person With Abilities (n = 5)	Butterfly's Story ... (n = 1)	Life Is A Journey (n = 10)	It Takes A Village (n = 10)
Resilience	79.4	82.3	80	81.2	86.8	79	82.3	82.3
Physical Health	44.2	43.9	37.2	40.1	44.2	40.3	43.9	43.9
Mental Health	48.1	50.1	43	49.6	54.6	54.1	50.1	50.1
Life Satisfaction	21.6	23.6	18	21.7	28.4	19	23.6	23.6
Future Orientation	3.6	3.7	3.5	3.5	3.8	4	3.7	3.7
Quantity of Social Support	3.1	2.9	3	3.3	3.2	2	2.9	2.9

Overall the instrument measures for quantitative variables uphold the prominent themes discovered in the qualitative data. The resilience level for the qualitative sample ($M = 82.3$) was moderately high. This instrument measured the individual attributes of resilience. Prominent themes that emerged from the data also represent individual attributes of resilience. The themes *standing on my own*, *longing to create own meaning* and *altruistic sense of duty towards others with disabilities* represent the attribute purposeful life ($f = 16$); the theme *I am a person with abilities* represents the attribute self-reliance ($f = 11$); the themes *butterfly's story...our struggles make us stronger* and *life is a journey* represent the attributes acceptance ($f = 6$) and perseverance ($f = 9$); the theme *patience is a virtue* represents the attribute tolerance, which is in the category

of perseverance; and lastly, the theme *traits that keep me going* collectively represent many attributes of resilience. The frequencies of the attributes are presented in Table 28 indicates that the qualitative participants' excerpts most frequently represented the category of purposeful life ($f = 16$). According to Wagnild (2011), individuals with moderately high resilience scores, like that of the qualitative participants, also find life meaningful.

The physical health level ($M = 43.9$) for the qualitative sample is below the benchmark ($M = 47$) indicating an impairment in physical health and a greater than average disease burden (Ware et al., 1995). Seven out of ten qualitative participants reported a disability that limits their physical function, Cerebral Palsy ($n = 5$), traumatic brain injury ($n = 1$), and joint problems ($n = 1$). Five out of ten reported having difficulty walking. Table 29 shows that those participants who contributed to the theme *challenges specific to me* ($n = 6$) had a lower physical health score ($M = 40.1$) indicating that they are physically impaired and experiencing more than average disease burden on physical health. The participants that contributed to the theme *challenges specific to me* spoke about challenges they encountered that were related to their disability, some of which were physical challenges. However, these participants also reported a moderate level of resilience ($M = 81.2$), no impairment in mental health ($M = 49.6$), that they are generally satisfied ($M = 21.7$), are future orientated ($M = 3.5$), and have social support resources ($M = 3.3$). Table 29 also shows that those participants who contributed to the qualitative theme *altruistic sense of duty towards others with disabilities* ($n = 4$) had the lowest physical health score ($M = 37.2$) indicating that they are physically impaired and experiencing much more than average disease burden on physical health. These participants also reported having more than average disease burden on mental health ($M = 43$), and a slightly below average satisfaction with life ($M = 18$). However, other measures for these qualitative participants indicate a moderate resilience

level ($M = 80$), that they are future orientated ($M = 3.5$), and have social support resources ($M = 3$). Selflessly, these participants wanted to use what they have learned from their experiences of having a disability to help others.

The mental health level ($M = 50.1$) for the qualitative sample is above the benchmark ($M = 47$) indicating no impairment. Persons at this level are not experiencing major psychological distress (Ware et al., 1995). Table 28 indicates that the qualitative participants' excerpts frequently represented the category of equanimity ($f = 14$). The expanded characteristics of equanimity are emotional control, physical control, emotional intelligence, sense of humor, optimistic, and good interpersonal skills. Equanimity implies a balance; and means to be level headed under stress (Wagnild, 2011). Table 29 shows that those who contributed to the qualitative theme *I am a person with abilities* ($n = 5$) scored the highest on mental health ($M = 54.6$) indicating they are emotionally bothered less than most and experiencing a less than average disease burden on mental health. Although these participants reported a physical impairment and a more than average disease burden on physical health ($M = 44.2$), other measures indicate a moderately high resilience level ($M = 86.8$), a high level of satisfaction with life ($M = 28.4$), that they are future orientated ($M = 3.8$), and have social support resources ($M = 3.2$). The theme *I am a person with abilities* represents the resilient attribute self-reliance. Self-reliance frequently ($f = 11$) emerged as a qualitative category (Table 28). Self-reliant persons are confident in their abilities and understand their limitations. Similarly in Table 29, all qualitative participants ($n = 10$) contributed to the theme *life is a journey* and have a moderately high resilience level ($M = 82.3$). The theme *life is a journey* represents the resilient attributes of acceptance and perseverance. Acceptance is an expanded resilient characteristic of existential aloneness. Existential aloneness implies balance, taking the

good with the bad; being satisfied both with what may be pleasant and unpleasant about oneself (Wagnild, 2011). Perseverance is also an essential characteristic of resilience. Perseverant individuals set their sights on a goal and are determined to achieve it. Existential aloneness ($f=6$) and perseverance ($f=9$) emerged as a qualitative categories (Table 28).

The future orientation level ($M = 3.7$) for the qualitative sample indicates that on average these individuals agreed or strongly agreed with the statement, "*I am very sure that someday day I will get to where I want to be in life.*" Future orientation is individual's perception of their future (Nurmi et al., 1995); signifies one's life has meaning, motivation, and purpose (Wagnild, 2010). Table 28 indicates that the qualitative participants' excerpts frequently represented the category of purposeful life ($f=16$). The expanded characteristics of purposeful life are self-worth, self-determination, future oriented, desire to succeed, meaningful life, and religious beliefs. Having purpose and meaning in one's life can be considered the most important resilient attributes (Wagnild, 2010).

The satisfaction with life level ($M = 23.6$) for the qualitative sample indicates an average score. Individuals with an average score are generally happy; and represent the majority in developed nations like the U.S. (Diener, 2006). This level is slightly lower than the entire study sample ($M = 24.9$). The literature indicates that, satisfaction with life is associated with social relationships (Diener, 2006). All qualitative participants reported having at least one social support resource, on average they reported having two or three ($M = 2.9$). Although the literature reports that social support improves outcomes (Norbeck et al., 1981), there is a lack of information as to how many areas of support are necessary or if the amount of social support is significant. Quite possibly it is not. Quantitative analyses in this study revealed that there was no correlation between quantity social support and resilience and that quantity social support was

not a predictor of resilience. However, Table 29 indicated that all qualitative participants contributed to the theme *it takes a village* (n = 10). The theme *it takes a village* represents the environmental attributes of resilience, among them are social support resources.

Hierarchical Categorization

A hierarchical categorization of resilience attributes was created to achieve a deeper understanding of the resilient attributes expressed by the participants. This hierarchical categorization represents a collection of resilient attributes identified through an analysis of the survey questionnaires, focus group and interview data. Figure 14 aids in presenting and interpreting the data in a meaningful way.

Displayed in Figure 14, is a hierarchical a priori categorization of resilience attributes with expanded characteristics that proceed from the literature review (Table 1). The purpose of this diagram is to gain clarification of the characteristics of resilience expressed by the participants. It was developed by the researcher through statistical analyses of quantitative data and thematic analysis of qualitative data; with triangulated findings compared to resilience research. It is a comprehensive framework used to logically organize and demonstrate that resilience for these individuals comes from a combination of protective factors that exist both within the individual and their environment.

The understanding gained from this hierarchical categorization is that the resilience comes from a combination of attributes that are found both within the individual and the individual's environment. Individual attributes and environmental attributes are two broad classifications. Under each broad classification are horizontally related categories of resilient attributes. In this hierarchy, the categories serve as classifications for the subcategories that are

vertically related. The subcategories are the many different resilient attributes that were expressed by the participants either through completion of the demographic questionnaire and quantitative instruments and/or participation in the focus group or interview. Table 30 identifies where the attributes were found for this study.

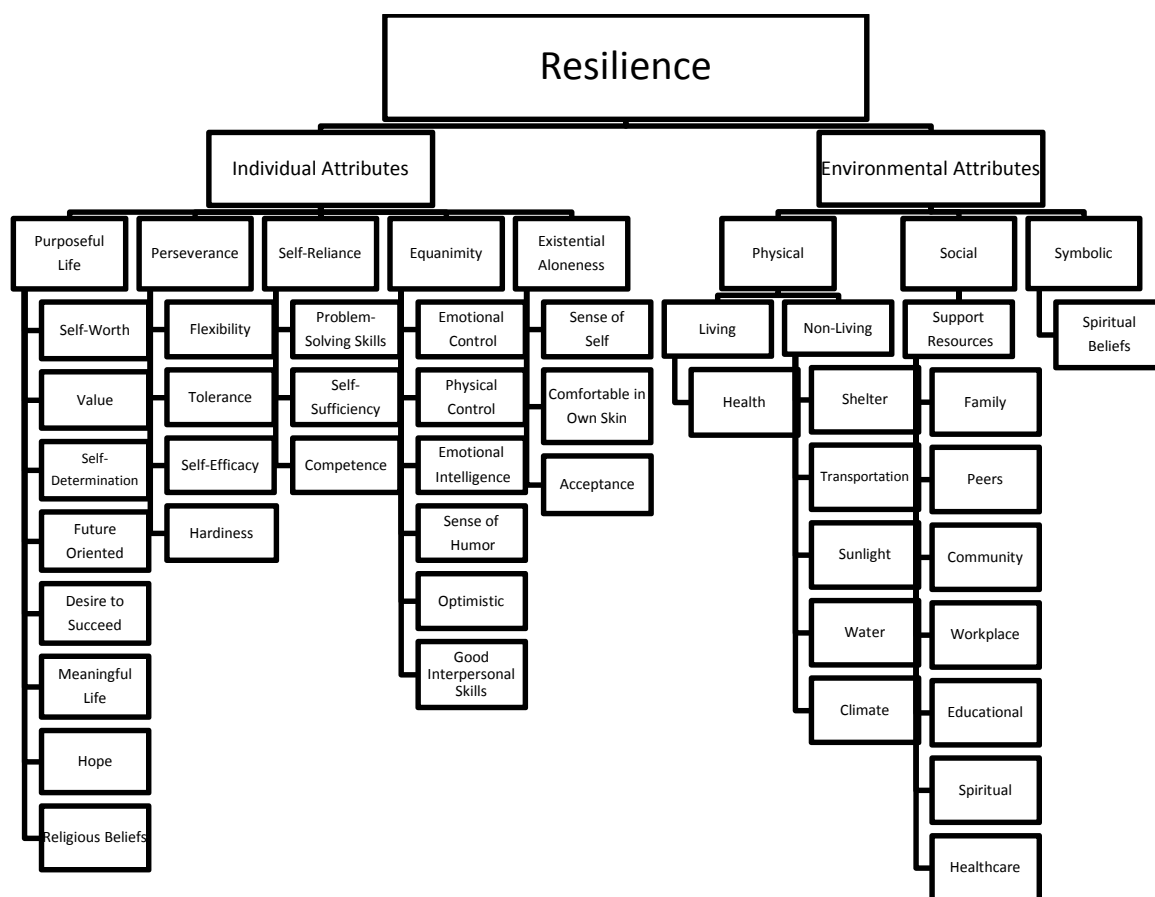


Figure 14: Hierarchical Categorization of Resilience Attributes

Table 30: Resilient Attributes Derived from Quantitative and Qualitative

Demographic Questionnaire	Instruments	Interview	Focus Group
Item subcategory Category CLASSIFICATION	Scale subcategory Category CLASSIFICATION	Themes subcategory Category CLASSIFICATION	Themes subcategory Category CLASSIFICATION
Question #4 Shelter non-living Physical ENVIRONMENTAL ATTRIBUTE	RS-14 INDIVIDUAL ATTRIBUTES	Standing on my own Purposeful Life INDIVIDUAL ATTRIBUTE	Standing on my own Purposeful Life INDIVIDUAL ATTRIBUTE
Question #5 sunlight, water, climate non-living Physical ENVIRONMENTAL ATTRIBUTE	SF-12v2: SFPCS living Physical ENVIRONMENTAL ATTRIBUTE	Longing to create meaning Purposeful Life INDIVIDUAL ATTRIBUTE	Longing to create meaning Purposeful Life INDIVIDUAL ATTRIBUTE
Question #10 transportation non-living Physical ENVIRONMENTAL ATTRIBUTE	SF-12v2: SFMCS INDIVIDUAL & ENVIRONMENTAL ATTRIBUTES	Altruistic.....disabilities Purposeful Life INDIVIDUAL ATTRIBUTE	Altruistic.....disabilities Purposeful Life INDIVIDUAL ATTRIBUTE
Question #11 living Physical ENVIRONMENTAL ATTRIBUTE	SWLS acceptance Existential Aloneness INDIVIDUAL ATTRIBUTE	Butterfly's...stronger Perseverance INDIVIDUAL ATTRIBUTE	I am a person with abilities Self-Reliance INDIVIDUAL ATTRIBUTE
Question #12 support resources Social ENVIRONMENTAL ATTRIBUTE		Life is a journey Perseverance INDIVIDUAL ATTRIBUTE acceptance Existential Aloneness INDIVIDUAL ATTRIBUTE	Life is a journey Perseverance INDIVIDUAL ATTRIBUTE acceptance Existential Aloneness INDIVIDUAL ATTRIBUTE
Question #13 future orientation Purposeful Life INDIVIDUAL ATTRIBUTE		Traits that keep me going INDIVIDUAL ATTRIBUTES It takes a village ENVIRONMENTAL ATTRIBUTES	Traits that keep me going INDIVIDUAL ATTRIBUTES Patience is a virtue tolerance Perseverance INDIVIDUAL ATTRIBUTE It takes a village ENVIRONMENTAL ATTRIBUTES

Summary of Mixed Methods Findings

The mixed method analysis was comprised of combining the data for meaningful interpretation. Quantitative and qualitative data converged to answer the mixed-methods research question and sub-question. *Do the quantitative measures uphold the prominent themes discovered in the qualitative data? To what extent does the qualitative data contribute to an enhanced interpretation and understanding of the relationships discovered among the quantitative variables?* Findings from the quantitative analyses were concurrent with the findings from the qualitative analyses. Overall the instrument measures for quantitative variables upheld the prominent themes discovered in the qualitative data. The instrument measures for the qualitative participants concludes that the qualitative sample ($n = 10$) has a moderately high resilience level ($M = 82.3$), experiences more than average disease burden on physical health ($M = 43.9$), experiences an average disease burden on mental health ($M = 50.1$), is generally satisfied with their life ($M = 23.6$), is future orientated ($M = 3.7$), and has social support resources ($M = 2.9$). The frequency analysis of resilient attributes in qualitative themes identified the number of times a particular resilient attribute emerged from a qualitative theme or excerpt. Noting the frequency of themes was beneficial in determining which attributes are considered key attributes of resilience. The attribute purposeful life emerged most frequently ($f = 16$), followed by equanimity ($f = 14$), self-reliance ($f = 11$), perseverance ($f = 9$), and existential aloneness ($f = 6$). The cross-tabulation analysis of quantitative measures and qualitative themes compared two types of data. Cross-tabulating instrument measures and themes contributed to an enhanced interpretation and understanding of the relationships among the data. Analyses showed that those who contributed to the qualitative theme *I am a person with abilities* ($n = 5$) scored the highest on mental health ($M = 54.6$) indicating they are emotionally bothered less than

most and experiencing a less than average disease burden on mental health. Although these participants reported a physical impairment and a more than average disease burden on physical health ($M = 44.2$), other measures indicate a moderately high resilience level ($M = 86.8$), a high level of satisfaction with life ($M = 28.4$), that they are future orientated ($M = 3.8$), and have social support resources ($M = 3.2$). Participants who contributed to the qualitative theme *altruistic sense of duty towards others with disabilities* ($n = 4$) scored the lowest physical health score ($M = 37.2$) indicating that they are physically impaired and experiencing much more than average disease burden on physical health. These participants also reported having more than average disease burden on mental health ($M = 43$), and a slightly below average satisfaction with life ($M = 18$). However, other measures for these qualitative participants indicate a moderate resilience level ($M = 80$), that they are future orientated ($M = 3.5$), and have social support resources ($M = 3$). Lastly, a hierarchical categorization of resilience attributes was created to achieve a deeper understanding of the resilient attributes expressed by the participants. This hierarchical categorization demonstrates that resilience for these individuals comes from both within themselves and from their environment. Chapter Five will provide a discussion of the findings from the quantitative, qualitative and mixed-methods analyses.

CHAPTER FIVE: DISCUSSION

Introduction

The purpose of this chapter is to discuss the findings of the study. The findings will be discussed in a cohesive narrative manner that integrates the study problem, purpose, aims, relevant literature, theoretical framework, implications and future research. This section will begin with a brief summary of the study. The triangulated findings are then discussed. Application of the theoretical framework and implications of this study are presented, limitations are discussed and suggestions for future nursing research are offered.

Summary of the Study

Through the integration of Transitions Theory (Meleis, 2010), this mixed methods convergent parallel study sought to explore and describe resilience in a select group of emerging adults with disabilities as they are transitioning to adulthood. Quantitative and qualitative data was combined for methodological triangulation. Quantitative data were obtained from a sample of 31 emerging adults with disabilities who were also life enrichment award recipients. Instruments were used to measure their levels of and ascertain relationships among, resilience, physical health, mental health, satisfaction with life, future orientation and quantity of social support resources. At the same time, the central phenomenon of resilience was explored in depth with a subset of the sample. Ten participants took part in the qualitative strand by sharing their personal stories in either a focus group or an individual interview that probed values and goals of becoming an adult, challenges related to transitioning to adulthood, and resilience attributes that have aided in mitigating those challenges related to transitioning to adulthood. This convergent parallel mixed methods study provided descriptive quantitative and qualitative information about

a select group of emerging adults with disabilities. From that, key attributes of resilience that have aided these individuals in mitigating adversity were discovered.

Discussion of Findings

Resilience in emerging adults with disabilities transitioning to adulthood was too complex for a single research method. Like other complex human phenomenon, this phenomenon was best explained through the use of combined data (Sandelowski, 2000). The findings for this study were drawn from a methodological triangulation of quantitative and qualitative research. In doing so, the researcher looked for mutually supported findings from equally important quantitative and qualitative strands (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 1998). Together these methods provided a more complete analysis and greater validity (Bryman, 2006; Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 1998). Methodological triangulation of qualitative and quantitative data produced a better understanding of resilience and identified key attributes that have had mitigating effects on adversity as reported by this select group of transitioning emerging adults with disabilities.

The participants' level of resilience was determined using the 14-Item Resilience Scale. This instrument provided an overall measure of the participants' essential characteristics of resilience: meaningful life, perseverance, equanimity, self-reliance and existential aloneness (Wagnild & Young, 1993a). These characteristics of resilience were discussed earlier in the context of being individual attributes. Coined by Wagnild (2010) as the Resilience Core, they are those personality characteristics that enhance adaptation. The mean resilience level for the participants fell within the moderate range. This is interpreted as neither having high nor low levels of resilience. Those who score in the moderate range have many resilient traits and also

have the ability to reach higher levels of resilience (Wagnild, 2011). The subset of qualitative participants' level of resilience falls within the moderately high range. Those who score in the moderately high range have all the resilient characteristics, but also strive to become more resilient (Wagnild, 2011). Findings from this study indicate that this sample of emerging adults with disabilities and to a greater degree the subset of qualitative participants, report having higher resilience levels than do emerging adults without disabilities of a similar age category. Resilience levels noted in earlier studies of emerging adults without disabilities fell within a low level of resilience (Wagnild, 2011). This finding follows from the purposive sampling plan that these participants were positive deviants and may not be representative of all emerging adults with disabilities.

Despite having a disability, the participants in this study had higher resilience levels than did emerging adults without disabilities. This finding was to be expected because increased resilience levels are associated with having, obtaining and using attributes known as individual and environmental protective factors (Dyer & McGuinness, 1996; Garmezy, 1991; Luthar et al., 2000; Luther, 2001; Masten, 1994; Masten & Coatsworth, 1998; Wagnild & Young, 1993a). While the quantitative strand revealed the level of resilience, the qualitative strand revealed key attributes of resilience that have aided these individuals in mitigating adversity. Themes that emerged from the data exemplify the participants' use of their individual attributes of resilience and how they obtained attributes from their environment.

The theme *traits that keep me going*, emerged from a collection of quotes that represented the participants' personality traits that have positively influenced their transitioning to adulthood. The participants' quotes were categorized according to a priori attributes of resilience that have been identified in the literature (Table 1). The traits were discovered by

thematic analysis and quantified to determine which can be considered key characteristics of resilience for these individuals (Table 28). Quotes that represent the attribute purposeful life appeared most often. According to research literature, meaning in one's life may be the most important driving force behind their actions (Haase, 2004; Wagnild, 2010). Purpose "provides the foundation" for all other resilient attributes (Wagnild, 2011, p. 15). Quantitative analysis supported this finding; increased resilience was associated with increased future orientation. In regards to transition planning for youth with disabilities, evidence supports strategies that encourage youth to become more future oriented (Reiss & Gibson, 2002).

The themes *standing on my own*, *longing to create own meaning* and *altruistic sense of duty towards others with disabilities* further exemplified the participants desire to have a purposeful life. The themes *standing on my own* and *longing to create own meaning* represent the participants' desire to be independent, have freedom and create their own meaningful future; while the theme *altruistic sense of duty towards others with disabilities* represents the participants' desire help others with disabilities.

When asked the question, *What do you value most about becoming an adult?* overwhelmingly, the participants responded in terms of independence and freedom. These are just a few exemplars:

My personal freedom and independence to make decisions based on my wants, needs and dreams instead of being told what to do and maybe told to do things that would hold me back. (Richard)

Just the independence of it... Just being able to take care of myself... own my own place, become a lawyer, and one day I have my own family (Rodger).

I value my independence, because I would want to be more independent as an adult and be able to go out and do things on my own...My goals that I wish to achieve are to, one, graduate high school and become employed in my field, which is painting visual arts. And as well as to own my own home and own a car in my name. (Tammy)

Disability advocates support the goal of independence for adults with disabilities (Appendix C). When the first Center for Independent Living (CIL) was established at Berkeley, California in 1972, it made independent living for individuals with disabilities a top priority (Shapiro, 1994). Independent living was measured “by the individual’s ability to make [his or her] own decisions” (Shapiro, p. 53, 1994). Today there are over five-hundred CIL throughout the United States.

The theme *it takes a village* emerged from a collection of social support resources that have aided the participants throughout their lives. The seven categories of support expressed by the participants mirror the seven areas of social support presented in the literature, they are family, peers, community, workplace, educational, spiritual, and healthcare (Bolla et al., 1996; Hobfoll & Lerman, 1989; Hyman et al., 2003; Norbeck et al., 1981). Like the individual attributes, these environmental attributes were analyzed to determine which social support resources can be considered key resources of these resilient individuals. All participants reported family as the primary social support resource, followed in ascending order by, friends, school, health care provider, place of worship, community, and work. These findings were to be expected because socio-demographic information revealed that more than half of the participants lived with their immediate family, were currently students and were not employed.

Although mentoring programs were not the most commonly mentioned social support resource for these participants, it was the most common response to the question, “*What additional social support services do you feel you would benefit from in being able to overcome adversities related to transitioning? Others like you?*” The benefit of mentoring is cited as a means of promoting resilience in varied populations (Hurd & Zimmerman, 2010; Osterling &

Hines, 2006; Pittman, 2003). The theme *altruistic sense of duty towards others with disabilities* not only represents the desire to mentor, but is also representative of the resilience attribute purposeful life. Having experienced challenges before, the participants in this study expressed their desire to help others with disabilities.

*I've been through a lot in my life and I really value making an impact on people in my life and leaving my personal footprint that has a positive impact on a lot of people.
(Richard)*

*My first goal would be making life, or trying to make life easier for everyone else, especially the younger kids with disabilities, 'cause I remember what that's like.
(Rodger)*

I want to affect people's lives for the better. I think they can be inspired by me. (Frank)

The above quotes are exemplar of the participants' desire to share their experiences so that others with disabilities are better equipped to handle challenges related to having a disability and transitioning. The mentor/mentee relationship has reciprocal benefits. The mentee learns first hand from an experienced mentor and the mentor will build competence and enhanced interpersonal skills (Rutter, 2013; Smokowski, 1998), resulting in further development of their own resilience.

Satisfaction with life was measured using the Satisfaction with Life Scale (SWLS). This instrument provided an overall measure of the participants' cognitive judgment of satisfaction with their own lives (Diener et al., 1985). The mean satisfaction with life score for this study sample fell within the high score range. Those who scored in the high score range typically report that things in their lives are going well (Diener, 2006). Quantitative data analysis indicated positive correlations among resilience and satisfaction with life. Regression analyses further indicated that resilience is a good predictor of satisfaction with life.

Increased satisfaction with life is also associated with positive social relationships (Diener, 2006). Diner (2006) reports, “people who score high on life satisfaction tend to have close and supportive family and friends, whereas those who do not have close friends and family are more likely to be dissatisfied” (p.3). Not only do positive social relationships impact satisfaction with life, but they are also among the environmental attributes of resilience. Social support from family, friends, school, work, community, spiritual advisers and healthcare providers help the individual through challenging times and foster the individual’s ability to reach full potential (Bolla et al., 1996; Hobfoll & Lerman, 1989; Hyman et al., 2003; Norbeck et al., 1981).

Quantitative data analysis did not indicate a correlation between the variable quantity of social support with either resilience or satisfaction with life. However, the participants reported on average as having four social support resources that they can go to in a time of need; and qualitative data analysis revealed the positive impact of social support for the participants in this study. Together, participants with “very high” and “high” levels of life satisfaction, also had “moderately high” and “moderate” levels of resilience, and reported having an average of two to three social support resources which they can go to in when in need. Methodological and data triangulation indicated that all qualitative participants, regardless of their level of life satisfaction, resilience, or quantity of social support, contributed to the theme of “it takes a village.” Three qualitative participants with very high levels of satisfaction with life reported having a very close relationship with a parent. When asked the question, “Who in your life offers the most support” the responses were (1) “the one person that I care about the most is my mom, because she understands how I feel a lot and supports what’s going on in my life...”; (2)

“My mom and dad, because they push me to be the best that I can be”; (3) “I have to go with my mom...that I could come to her with any problem...She can help me with anything.” This participant went on to say if he had three wishes he would give his mom \$1 million. Two qualitative participants with high levels of satisfaction with life also reported having very close relationships with their grandmothers. When asked the question, “Who in your life offers the most support” the responses were (1) “my grandma...she takes care of me...she’s strong and independent”; (2) “my grandmother...and my brother...I can always call on them whenever I need something, or that they’re always there to help me.” Naming their mother or a maternal figure as the one who offers the most support is consistent with the findings of a study that identified a warm maternal-child relationship as having a significantly positive effect on the child’s ability to deal with adversity later in life (Rutter, 2013).

Goals and values represent the resilient attribute purposeful life and are also associated with satisfaction with life (Diener, 2006). According to Wagnild (2011), a “life without purpose is futile and aimless” (p.15). Diener (2006) reports, a “key ingredient [for satisfaction with life] is to have important goals that derive from one’s values and to make progress toward those goals.” (p.3). Diener (2006) reports, “For many people it is important to feel a connection to something larger than oneself” (p.3). The majority of the participants in this study either strongly agreed or agreed with the statement “I am very sure that someday I will get to where I want to be in life.” Quantitative data analysis indicated a positive correlation between the variables that measured satisfaction with life and future orientation. Qualitative analysis also supported that finding. The only qualitative participant, who reported an extremely dissatisfied satisfaction with life score also did not agree the statement, “*I am very sure that someday I will get to where I want to be in life.*” However, this participant still expressed a goal of transitioning to adulthood and was

making progress towards that goal. Despite numerous physical ailments, this participant was enrolled in college to earn a “*dual degree in biochemistry and biomedical engineering*” so that he could “*use [the degree] for going to medical school*”; he later went on to say, “*No matter how many times you fail you always have the choice to get back up.*” Methodological and data triangulation indicated that all qualitative participants expressed goals they hope to achieve upon becoming an adult. The theme *longing to create meaning* represents the participants shared goals of pursuing higher education and employment. One participant was already working towards her career goal by taking pre-college art classes. She said, “*[I plan to] graduate from high school, go to a good art school, and get my bachelor’s degree in the arts, do 3D animation, and work at Walt Disney Studios.*” The desire for gainful employment has been previously noted in a study of similarly aged transitioning youth with disabilities (Betz & Redcay, 2005); and the desire to pursue higher education as a means to secure gainful employment parallels the goals of college seniors and recent graduates with disabilities (Kim & Williams, 2012) and emerging adults without disabilities (Arnett & Tanner, 2005) as reported in the literature.

The participants’ level of physical and mental health was determined using the SF-12v2. This instrument measures disease burden by quantifying eight health domains that are believed to be affected by disease. Together the domain measurements yield a score for overall physical and mental health (Ware et al., 1995; Ware et al., 2010). The participants’ level of physical health was about average. These findings indicate that this samples’ physical health is about the same as that of the 2009 U.S. general population norms for 18-75+ years-old (Ware et al., 2010), but is lower than both 1998 U.S. population norms for 18-24 and 25-30 years-old (Quality Metric, n.d.). This researcher would have expected this sample to have a lower than “average”

level of physical health, given that over half of them reported a having physical disability, over one third reported having a functional difficulty in walking/carrying/lifting, there was no relationship among the variables resilience and physical health, and the theme *challenges specific to me* emerged to represent physical health challenges experienced by almost all of the participants in the qualitative strand. However, the overall measure of physical health is comprised of the constructs, physical function, role-physical, bodily pain and general health. Of the four constructs, physical function was the only construct that fell below the normed benchmark. All other constructs exceeded the benchmark. When considering that all other physical health constructs were above the benchmark, it can be concluded that although physical function was below the benchmark, this samples' physical impairments contributed negligibly to their overall measurement.

The participants' level of mental health was above average, indicating that these participants are experiencing less disease burden on their mental health than did the 2009 U.S. general population of adults (Ware et al., 2010), and ever lesser as compared to both 1998 U.S. population norms for 18-24 and 25-30 years-old (Quality Metric, n.d.). Findings from the depression screening indicated a smaller percent of this sample is at risk for depression as compared to that of the 2009 U.S. general population. These findings were to be expected. Although just under two-thirds of this sample had reported a mental disability, they had resilience levels that would help to mitigate adversity that may be related to negative effects of the disability. Quantitative data analysis indicated resilience was positively associated with mental health. Qualitative data analysis also suggested that these participants were not experiencing psychological distress, but rather they possessed equanimity, self-reliance, existential aloneness, and perseverance. All of which are individual attributes of resilience.

Research on youth with disabilities supports this finding. Resilience was associated with increased multidimensional levels of well-being in a study of adolescents and emerging adults with disabilities (Altshuler, Mackelprang, & Baker, 2008). Transitions Theory identifies a subjective sense of well-being as a positive transition outcome (Meleis, 2010). Similarly, Werner & Smith (2001) describe self-worth as a resilient attribute. Persons with a positive sense of well-being and self-worth value life and recognize the many opportunities life has to offer. Despite the following young woman's severe physical disability, she exemplifies the resilient qualities of remaining steadfast and balanced, with an acceptance and readiness to persevere and desire to succeed (Masten, 1994). She states:

I think I would say just all of the things that the world has to offer for a young disabled person. Just getting out there and like being able to like make my own choices and stuff and being independent...being independent from my mom. Doing things like on my own. (Laura has quadriplegia as a result of an anoxic brain injury)

The measures of physical and mental health and triangulated qualitative findings in this study are supported by resilience research literature. While resilience research provides evidence of both environmental (physical health) and individual (mental health) attributes of resilience as having mitigating effects on adversity, it is suggested that the individual attributes of resilience may have a greater influence as to how one handles adversity (Rutter, 2013). Resilience research posits increased personal strength contributes more to positive outcomes than does external support (Litner & Mann-Feder, 2009; Smokowski, 1998).

The theme *life is a journey* represents the individual attributes acceptance and perseverance. Participants accepted the challenges associated with becoming an adult, *Being on your own...it's not gonna be easy*; and chose to persevere *I learned to never give up and keep*

going and stuff and people always make mistakes and you should learn by your mistakes. While increasing an individual's skill set to deal with specific obstacles is beneficial, the notion of persistence is essential when handling multiple challenges (Betz & Redcay, 2002).

Resilient persons have a keen ability to persist and persevere through navigating and negotiating (Ungar et al., 2008): Navigate, such that they steer towards “positive attachments, experiences that bring self-esteem, education and participation in one's community and family” (p. 168); and negotiate which resources are attainable (Ungar et al., 2008). While there were many, the following excerpts are exemplars of the participants' ability to navigate and negotiate.

I value friends and family that support me through mainly high school and through college... They help me a lot through things...I learned that making new friends, as they support me through college. College friends, the ones that study a lot and stuff, but they do help me a lot...right people right stuff.

I sought some advice and I asked a lot of people “What can I do? I need a place to live.” ...I was able to find a place to live through this lady I internshipped with and she said I could stay at her house for a while until I found a job...her name is E from the internship who I lived with and her husband giving me the most support now.

Persistence/perseverance along with the ability to navigate and negotiate may be considered key characteristics that have aided these individuals in dealing with adversity. In addition to the economic and psychological challenges faced by many emerging adults today (Arnett & Tanner, 2005; Settersten et al., 2008), the theme *challenges specific to me* represents some of the challenges faced by this sample of emerging adults with disabilities as they are transitioning to adulthood. These are over and above the challenges faced by emerging adults without disabilities. One participant reported he often is absent from school due to illness, in fact this participant originally wanted to participate in the focus group, but was unable to attend due to medical issues. Then, at the time of his individual interview, he was on medical leave from

college with plans to return the following semester. While in school this same participant reported needing special accommodations because he was not able to attend the laboratory portion of his science courses due to his need for continuous oxygen. Two participants reported frustration with their physical limitations causing a lack of independence. Another participant reported social isolation as a result of being the only person in his high school with a physical disability. These challenges parallel the educational, independent living, and social obstacles previously cited in the literature (Betz & Redcay, 2002).

The themes *I am a person with abilities* and *butterfly's story...our struggles make us stronger* represent the negative impact of stereotyping and societal labeling, and the negative impact of coddling, respectively. Societal labels and stereotypes lead to public misconceptions that negatively impact persons with disabilities (Green et al., 2005; Link et al., 1999). This participant's sentiments were echoed through the focus group.

Challenges... just people underestimating the things I can do because I'm physically disabled, but as far as – I don't feel I'm the only one, because I know a lot of people with my disability and I feel like we go through the same things...[People], they like to do everything for me. A lot of people try to treat me, because they see I walk with a walker, like I'm helpless or I can't do anything for myself, so they do everything for me.

There is abundant evidence in the literature to support the negative impact of overprotective parenting (Betz & Redcay, 2002; LeMoyne & Buchanan, 2011). One participant shared, *I think that honestly, transitioning to adulthood for a normal teenager is easier than it is for a kid in my situation, 'cause most kids in my situation, they are so sheltered and protected.* He explains that transition to adulthood is more difficult for a person with a disability, not because of the disability per se, but because of never having to learn to do things on his own. *When you come out of that place of being sheltered and have someone there to do something for*

you, when you get out to a point that you have to do it for yourself, it's harder, 'cause there's no one to like cook for you or wash your clothes. He implies that when you are a child with a disability the adults in your life tend to all your needs. As a result, you never learn to do on your own. Like in the case of the butterfly, having too much help does more harm than good. Having always had people do for him has made his transitioning to adulthood more challenging.

The practice of overprotective parenting challenges transition for the individual because it stunts the psychological growth (Ungar, 2009). Overprotective parenting not only stunts psychological growth, but it leads to feelings of insecurity for the child. Undertones of insecurity were evident in the words of one participant. He says, *“a normal kid... You can come in the house safe and you take care of yourself. But most kids in my situation aren't able to do that,”* suggests that this individual is feeling insecure about his own transition to adulthood.

This study adopted a positive psychological strength-based approach in exploring resilience in emerging adults with disabilities as they are transitioning to adulthood. This study adhered to a purposeful sampling plan enrolling participants aged 18-26 years-old with disabilities, who were also recognized for their accomplishments. In doing so, they provided meaningful insight into the central phenomena of resilience. Despite having a disability, they are resilient, emotionally healthy, satisfied with their life, and future oriented. They exemplified a “successful transition process” (p. 198) through “enhanced knowledge of the self and future vision of the self” (p. 199) demonstrated by their acceptance of self, perseverance, and future orientation; “enhanced skills” (p. 199) demonstrated by their having, using and attaining resilience attributes, such as self-determination, self-efficacy and self-reliance; “enhanced perceptions of support” demonstrated by their positive relationships with family and friends; and “enhanced knowledge of community, and more supportive environments” (p. 199) demonstrated

by their ability to navigate and negotiate towards positive attachments and attainable resources (King et al., 2005). As a whole these participants can be described as transitioning well.

Theoretical Framework

Findings from this study support the use of Transitions Theory (Meleis, 2010) to guide resilience research. The triangulated findings obtained from merging quantitative and qualitative data were congruent with the major premises underlining the theoretical framework: (1) transitions will not automatically end in a greater stability; (2) going through transitions are often difficult; (3) the state of being after transition has much to do with transition conditions; and (3) given adequate transition facilitators the end result of transition is essentially positive.

In this study, resilient attributes served as those transition conditions that facilitate transition. Just as the state of being after transition has much to do with transition conditions, the state of being after adversity has much to do with resilience (Garmezy, 1991; Luthar, 1991; Masten, 1994; Masten & Coatsworth, 1998; Meleis & Trangenstein, 1994; Meleis et al., 2000; Wagnild, 2010; Werner & Smith, 1982). Data derived from survey questionnaires and interviews were analyzed to identify key individual and environmental attributes that have had mitigating effects on adversity for this select group of emerging adults with disabilities.

The transition conditions explored in this study parallel those transition conditions that are recommended to be explored according to Transitions Theory. This study's exploration of "values and goals of adulthood" parallels Transition Theory's recommended exploration of "meaning and expectations." This study's exploration of "problem-solving skills, self-sufficiency and competence" parallels Transition Theory's recommended exploration of "level of knowledge and skill." The theme "*traits that keep me going,*" represent many resilient attributes

that demonstrate the participants “level of planning and preparation” and “cultural beliefs and attitudes.” In this study the “physical component summary” and “mental component summary” represent the participants’ “emotional and physical well-being.” The theme “*I am a person with abilities,*” represents the damaging effects of “societal labels” and parallels the concept of “societal norms” in Transitions Theory. This study’s exploration of “social support resources” parallels Transitions Theory’s recommended exploration of “community resources” (Meleis, 2010). Table 31 aides in demonstrating how the concepts explored in this study followed the concepts of Transitions Theory.

Table 31: Exploration of Transition Conditions

Exploration of Transition Conditions	
This Study	Transition Theory
Values and Goals	Meaning and Expectations
Problem-Solving Skills, Self-Sufficiency and Competence	Level of Knowledge and Skill
Theme: traits that keep me going	Level of Planning and Preparation
not measured	Socioeconomic Status
Physical Component Summary and Mental Component Summary	Emotional and Physical Well-Being
Theme: I am a Person with Abilities (Societal Labels)	Societal Norms
Theme: traits the keep me going	Cultural Beliefs and Attitudes
Social Support Resources	Community Resources

Note. Transitions Conditions for Transition Theory are adopted from Meleis, A. I. (Ed.). (2010). Transitions theory: Middle range and situation-specific theories in nursing research and practice. New York: Springer Publishing.

There is no widely held definition of what constitutes a successful transition, by whose standards and by what measures the transition goals should be evaluated (King et al., 2005; Luther, 2001). The outcome of transitioning is very much specific to the individual and to the nature of the transition. Transitions Theory suggests examining indicators that integrate subjective, behavioral and interpersonal domains (Meleis, 2010). The subjective domain was examined using the resilience scale, satisfaction with life scale, select demographic questions and qualitative questions; the behavioral domain was examined using the SF-12v2 and select demographic questions; and the interpersonal domain was examined using select demographic

questions and qualitative questions. A thorough evaluation of transition calls for these indicators to be assessed throughout the process, as well as, at the end of a transitioning period. This study assessed transitioning individuals. It examined emerging adults with disabilities at one point in time, as they were in the process of transitioning to adulthood.

Implications of the Study

Today's medical technology has improved the odds of people surviving complex medical conditions that would have in the past been considered fatal. It is expected that approximately 90% of all children living with disability will survive well into adulthood (White & Gallay, 2005). Research shows that youth with disabilities have poorer adult social and medical outcomes as compared to those without disabilities (Betz & Redcay, 2002; Blomquist, 2007; Faux & Nehring, 2010; King et al., 2005; Murray, 2003; National Research Council & Institute of Medicine, 2009; Urbano, 2010). Even though federal, state and privately funded programs are geared at improving the outcomes of persons with disabilities, the dichotomy still exists (Kessler Foundation & National Organization on Disability, 2010a; Perrin, 2012; Zirkel, 2012). Youth with disabilities face increased challenges and vulnerabilities transitioning to adulthood as compared to youth without disabilities. Youth with disabilities, not only face the everyday challenges one would expect, but they face challenges related to their disability (Urbano, 2010). As children with disabilities develop into adolescents and then on to adults, it is important that they are prepared to manage these challenges along the way. Resilience is the ability to overcome adversity through the use of attributes known as protective factors (Dyer & McGuinness, 1996; Garmezy, 1991; Luthar et al., 2000; Masten, 1994; Masten & Coatsworth, 1998; Wagnild et al., 2010; Werner & Smith, 1982). Resilience research allows for the

discussion and development of interventions that strengthen the person through the nurturing and development of resilient attributes to facilitate transitioning.

This study employed a positive psychological approach aimed at identifying resilient attributes in individuals with disabilities who have been identified for their accomplishments and are transitioning to adulthood. Rather than focusing on problems, this study focused on answers. The findings of this study provide a basis for recommending intervention programs on building resilience among emerging adults with disabilities. This study may lead to suggestions as to how education, policy, practice, and research can be used to fit the needs of emerging adults with disabilities so that they achieve a successful transition to adulthood.

Recommendations for Clinical Practice

The following recommendations are aimed at improving the process of transitioning for emerging adults with disabilities by building their resilience. These recommendations were drawn directly from significant findings and prominent themes discovered in this study.

Nurses care for individuals, particularly those with disabilities in a wide variety of practice settings. Whether in acute care, long-term care, or outpatient care they are uniquely present to intervene throughout all stages of the transitioning process. Identifying resilient attributes can play a vital role in facilitating transitions. Findings from this study and that of resilience research conclude: (1) resilience mitigates adversity and facilitates transitioning; (2) the capacity for resilience is well within reach; (3) resilience comes from a variety of individual and environmental attributes. Teaching individuals to use, or working with them to discover and develop resilient attributes will give them a range of transition facilitators to choose from when faced with adversity.

While resilience research does not directly translate into clinical practice (Rutter, 2013), examining strengths within the individual and their environment, building upon those strengths, and developing new strengths will make the individual better equipped to deal with challenges as they are transitioning (Benard, 1991; Wagnild, 2010).

Nurses can foster resilient growth and nurture the process of transitioning to adulthood for emerging adults with disabilities through nursing interventions. Nursing interventions are categorized as interventions that utilize cognitive, interpersonal, and technical skills (Craven, Hirnle, & Jensen, 2011). Cognitive skill interventions include actions such as patient teaching, creating strategies, and altering an environment; interpersonal skill interventions include actions such as coordination of patient activities, patient advocacy, and serving as a role model; technical skill interventions include actions such as providing care and performing patient assessments (Craven et al., 2011). Whether provided individually or in combination, nursing interventions are distinct actions performed by nurses that serve to improve patient transitions. Using Transitions Theory (Meleis, 2010) to guide practice, nurses have a framework for providing interventions that identify and incorporate transition facilitators that reduce vulnerability and facilitate the process transitioning.

The nurse begins by carefully collecting and analyzing information about the emerging adult. In regards to resilience, this step would include identifying which attributes of resilience already exist within the individual and which can be obtained from their environment. Likewise, the nurse could identify risk by assessing which attributes are lacking. This can be performed by asking questions and observing behaviors of the individual, and their interactions with family/caregiver(s). Careful attention should be made in assessing meaning that which the emerging adult has attributed to becoming an adult. Identifying meaning is essential, because

having a purposeful life is considered to be the foundation for all other resilient attributes and is indicative of future orientation (Wagnild, 2011).

Next, the nurse can explore the goals the emerging adult wishes to achieve as an adult. Goals that are realistic promote problem-solving skills, self-reliance and self-sufficiency. Goals within reach maintain motivation. It is important to emphasize the individual's abilities because individuals with disabilities are often seen by society as being less competent than their counterparts without disabilities (Blomquist, 2007). Keep in mind that that increased personal strength contributes more to positive outcomes than does external support (Litner & Mann-Feder, 2009; Smokowski, 1998). Therefore, encourage individuals to take a positive psychological approach in identifying their own strengths and abilities in achieving their goals. Positive psychology focuses on identifying individual strengths as opposed to one's limitations (Pascale et al., 2010).

Because individuals with disabilities often need assistance in achieving their goals, consider dividing the goals into those that are achievable independently and those that may require assistance. In situations where assistance is required, create a collaborative plan that identifies incremental steps towards achieving that goal and social support resources that may be accessed along the way. Nurses and other healthcare professionals are among the seven areas of social support resources; other areas include support that comes from family, friends, school, work, community, and places of worship (Norbeck et al., 1981). These resources help the individual through challenging times and foster the individual's ability to reach full potential (H. Kim, 2010a; Masten, 1994; Masten & Coatsworth, 1998; Rhodewalt & Zone, 1989; Rutter, 1987; Werner & Smith, 1982).

Nurses can offer assistance and guidance to the transitioning emerging adult, but most importantly, they must do so with respect and encouragement. Respect and encourage the emerging adult's right to autonomy, independence and freedom that come along with adulthood. When offering assistance and guidance understand that exposure to adversity in moderation has adventitious benefits. Resilience research shows that those exposed to moderate amounts of adversity in the past were better able to deal with newly encountered distressing situations (Rutter, 2013; Seery et al., 2010).

Nurses are also encouraged to consider referring the individual to a mentoring program. Seek to establish a mentoring relationship that pairs the emerging adults with a like adult mentor. Having individuals with disabilities serve as mentors to persons with disabilities has reciprocal benefits. The mentee often will identify with a mentor who has a disability similar to his or her own; and the mentor may further develop their own resilience while working to develop resilience in the mentee (Hurd & Zimmerman, 2010; Osterling & Hines, 2006; Smokowski, 1998).

Overall when working with emerging adults with disabilities it is important to encourage balance. Resilience is not a measure of extremes, but rather it is an ability to maintain a harmonious life by balancing the opposing forces of adversity and attributes of resilience. It is suggested that individuals "succeed to the extent that they balance different needs" (Ungar et al., 2008, p. 178). Emotional and physical control, emotional intelligence, sense of humor, optimism and good interpersonal skills are resilient attributes that promote an overall sense of balance. The Teeter-Totter Resilience Model (Figure 3) may serve as a teaching device for nurses to use in practice, especially as it graphically characterizes a simple set of principles pertinent to understanding the concept of resilience as a balance. It is important to teach emerging adults

with disabilities that even the most resilient individuals experience adversity. However, they do not let adversity control their future, but rather they seize adversity and use it as an opportunity to learn and develop strength.

In summary the recommendations for clinical practice for nurses include:

- Identify resilience and risk
- Assess meaning attributed to becoming an adult (assist in establishing if not present)
- Explore goals the emerging adult wishes to achieve as an adult (assist in establishing if not present)
- Divide goals (achievable independently vs. require assistance)
- Emphasize abilities
- Create collaborative plan
- Respect and encourage autonomy, independence and freedom
- Identify social support resources
- Consider a mentoring program
- Encourage balance

Limitations of the Study

The following are limitations of this study:

1. Sample: The intensity sampling strategy employed by this study limited the number of participants (N = 31) to one select group of emerging adults with disabilities, who all applied for and received life enrichment awards from 2007-2013. The recipients of this

award have been identified by disability advocacy organizations for their successes.

The Life Enrichment Awards Program (LEAP) is geographically limited to the Washington, DC area. As such, all participants were from that geographical area.

Although findings of this study may not be generalizable, the intensity sampling strategy allowed for a sample of participants who embodied the phenomena of resilience and were willing and able to provide insight.

2. Self-reported data: Self-reported data has inherent limitations. Response bias may have occurred. Participants may have responded in a socially desirable manner. Although focus group participants were without parents/guardians/assistants while the focus group was in session and interview participants appeared to be alone during telephone interview, it is unknown if participants were fully independent in responding to survey questionnaires.
3. Statistics: Correlation and Regression analyses cannot detect causality of relationships. Furthermore, Bivariate Linear Regression Analysis only examines the relationship between two variables, one independent and one dependent. Often more than one independent variable is correlated with a dependent variable. Although definitive causality of relationships cannot be determined, the resulting hypotheses of this study warrant further investigation.
4. Point-in-Time: This study examined transitioning at one point in time only offering a snapshot picture of the process. A complete evaluation of transition calls for indicators to be assessed throughout the process of transitioning, as well as, at the end of a transitioning period. An improvement to this study would be to conduct a longitudinal

study on this sample as they are transitioning to adulthood and at multiple points in time when they are adults to detect trajectory patterns of the variables.

5. Qualitative Design: The qualitative data collected from both interviews and the focus group followed a question format for the purpose of this mixed methods design. Other types of qualitative designs may yield different findings. Future qualitative investigation might utilize in-person interviews or several focus groups with varied informants.

Future Research

The primary purpose of this study was to explore the central phenomenon of resilience among emerging adults with disabilities as they are transitioning to adulthood so as to identify key attributes of resilience that have facilitated the process of transitioning for these individuals. Although recent resilience literature implies that resilience can be developed in adulthood, it is suggested to begin resilience teaching early in life because early experiences shape later life experiences (Rutter, 2013). Transition literature also proposes early transition planning for individuals with disabilities, such that transition planning in adolescence may already be too late (Reiss & Gibson, 2002). Perhaps future studies may look at developmentally younger age groups and their parents/guardians/advocates so that age appropriate recommendations for increasing resilience and transition planning for individuals with disabilities can begin earlier in life.

Significance to Nursing Research

A question matters to nursing if by explaining the phenomena we can improve someone's health. This study explored the central phenomenon of resilience as it relates to transitioning from a holistic nursing perspective. The holistic perspective is based upon the

premise that nursing care addresses the biological, psychological, social, physiological and cultural needs of the person as a whole (DiNapoli, 2010). This approach encourages nurses to evaluate and incorporate both individual and environmental attributes of resilience.

Transitions Theory guides nursing practice. It is a framework for providing and evaluating interventions that identify and incorporate transition facilitators to reduce vulnerability and facilitate the process transitioning. If resilience is, as it has been found to be in this study, a facilitator of transitioning, then it would be especially useful to incorporate resilience building activities in the development of holistic patient centered care interventions. Knowing which resilient attributes are most effective in facilitating transitioning would be especially useful in the development of preventative holistic patient-centered nursing interventions. Freedom from illness, disease, or disability may not always be possible; however improving the process of transitioning is achievable.

This study was an exploration into the central phenomenon of resilience. Through a mixed-methods convergent design it demonstrated the positive influence of resilience on the attitudes and behaviors of emerging adults with disabilities during their transition to adulthood. The research and practice implications of this study may suggest that resilience is a viable concept for the development of strength-based, patient-centered nursing interventions that facilitate transitioning and warrants future study.

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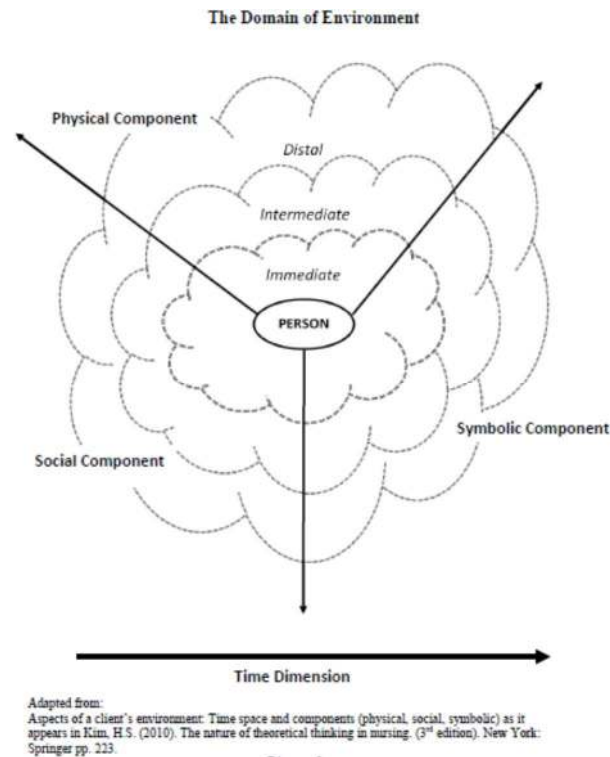
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Appendix A: Kim's Theoretical Domain of Environment



The concepts of resilience and transitioning fall within Kim's (2010) theoretical domain of environment. The domain of environment explores the notion that one's surroundings are a powerful force influencing their existence. Environment is present external to a person and is the source of forces placing influences on the existence of that person. Studying Kim's (2010) theoretical domain of environment is an examination of the relationship between external forces and the individual in regards to human wellness.

Kim (2010) defines environment as having three characteristics: spatial, temporal and qualitative. The spatial environment can be visualized as three concentric spheres of varying degrees of influence surrounding the person. Those entities with the greatest influence fall

within the immediate ring closest to the person i.e. nuclear families, home, finances..., while those entities with only marginal influences are the farthest. The temporal environment, represented by an arrow stretching across bottom of the diagram, refers to the “duration and manner of presence” (p. 222) that which a person is exposed to an entity. The qualitative environment is divided into the physical, social, and symbolic entities influencing the person. The physical environment refers to the “energy-generating and matter-based aspects of milieu” that present in living and non-living forms (p. 222), i.e. living as physical health, causes of disease, etc.; or non-living as shelter, sunlight, climate, water, etc. The social environment includes individuals with whom the client interacts, i.e. family, friends, acquaintances, etc. The symbolic environment refers to an ideology. An ideology does not exist in reality like the social and physical environment, but rather it is the principals that which the client holds true, i.e. spiritual beliefs, cultural norms, their philosophy.

The theoretical domain of environment, offered by Kim (2010), serves as a model to identify the elements in ones surroundings. These elements are vital to both the individuals own well-being and the care nurses provide. Kim’s theoretical domain of environment is consistent with research findings the suggested the ones environment may contribute to both resilience and adversity (Anthony, 1974; Benard, 1991; Cicchetti & Rogosch, 1997; Garnezy, 1991; Luthar et al., 2000; Ungar et al., 2008; Werner & Smith, 1982).

Appendix B: Goals of Major Legislation in United States

Major Legislation	Year	Goals
Social Security Act	1935	Overview: The original Social Security Act and its current version, as amended over the years, encompass several very significant social insurance programs that have special relevance for individuals with disabilities including: Federal Old-Age, Survivors and Disability Insurance; Medicare; Medicaid; State Children's Health Insurance Program (SCHIP); and Supplemental Security Income (SSI)
Rehabilitation Act (Rehab Act)	1973	Overview: The Rehabilitation Act authorizes (a) the formula grant programs of vocational rehabilitation, supported employment, independent living, and client assistance (b) a variety of training and service discretionary grants administered by the Rehabilitation Services Administration of the U.S. Department of Education and (c) research activities administered by the National Institute on Disability and Rehabilitation Research (NIDRR) and the work of the National Council on Disability (NCD). It also includes a variety of provisions focused on the rights of individuals with disabilities. *Section 504: prohibits discrimination against qualified individuals with a disability under any program or activity that receives Federal financial assistance
Americans with Disabilities Act (ADA)	1990	Overview: Guarantees the civil rights of people with disabilities by prohibiting the discrimination against anyone who has a mental or physical disability in the area of employment, public services, transportation, public accommodations, and telecommunication. It protects people who currently have a disability or a history of one; people who are regarded as having a disability by others, whether or not they actually have a disability; and people who are not themselves disabled but who encounter discrimination on the basis of their association or relationship with a person who has a disability—such as parents of children with disabilities.
Individuals with Disabilities Education Act (IDEA), IDEA Amendments, Individuals with Disabilities Education Act (IDEIA)	1991, 1997, 2004	Overview: Generically called “special education,” this legislation requires public schools to make available to all eligible children with disabilities a free appropriate public education (FAPE) in the least restrictive environment (LRE). Part B of the law requires schools to work with eligible students ages 3-

		21 to develop an appropriate Individualized Education Program (IEP) and Part C authorizes early intervention services for infants and toddlers with disabilities and their families from birth to age two. Part D funds activities to improve the education of children with disabilities, including pre-service and in-service training for general and special educators and related services and early intervention personnel.
Workforce Investment Act (WIA)	1998	Overview: WIA established a national workforce preparation and employment system to meet the needs of businesses, job seekers and those who want to further their careers. It was designed to provide customers easy access to information and services through a One-Stop Career Center system and requires that customers with and without disabilities are served together.
Developmental Disabilities Assistance & Bill of Rights Act (DD Act)	Last amended 2000	Overview: The DD Act focuses on the estimated 4.5 million children and adults in the U.S. who have developmental disabilities. Its purpose is to assure that individuals with developmental disabilities and their families have the opportunity to participate actively to design community-based programs and to have access to the full array of community services, individualized supports, and other assistance that promotes and creates opportunities for independence, productivity, and self-determination.
Ticket to Work & Work Incentives Improvement Act (TWWIIA)	2008	Overview: TWWIIA was designed to modernize the employment services system for people with disabilities and make it possible for millions of Americans with disabilities to no longer have to choose between taking a job and having health care.

Information reprinted from: <http://www.jpkf.org/JPKF-Policy-Guide/docs/part1.pdf>

Appendix C: Disability Rights and Advocacy Organizations

Organization	Goal/Mission/Objectives/About
Abilities Network	to challenge the community to acknowledge the value and equality of people of all abilities.
American Association of Persons with Disabilities (AAPD)	Nation's largest disability rights organization. Promotes equal opportunity, economic power, independent living, and political participation for people with disabilities. Our members, including people with disabilities and our family, friends, and supporters, represent a powerful force for change, equal opportunity, economic power, independent living, and political participation
American Disabled for Attendant Programs Today (ADAPT)	Ultimate goal of having all people with disabilities live integrated in the community, not locked away in segregated settings (nursing homes). Independent living.
The Arc Montgomery County Prince George's County Southern Maryland	Promotes and protects the human rights of people with intellectual and developmental disabilities and actively supports their full inclusion and participation in the community throughout their lifetimes; world's largest grassroots organization committed to the welfare of people with developmental disabilities and their families.
Center for Independent Living (CIL) (1972 Berkeley, CA)	Independent living was measured by the individual's ability to make their own decisions and the availability of assistance necessary to make those decisions. Chief goal: integration into the community
Community Services for Autistic Adults and Children (CSAAC)	To enable individuals with autism to reach their highest potential and contribute as confident individuals to their community." CSAAC's founders saw a future where adults with autism lived and worked in the community and not in institutions, and they were the pioneers of this effort. to be integrated into community, work, classroom Integrate, Integration integrated
The Coordinating Center	Committed to children, young adults and older individuals, as well as their family members, who have the most challenging health care needs, disabilities, and related concerns. Our services are as diverse as the people we serve, and intended to help people to thrive in the homes and communities of their choosing.
Cornerstone Montgomery, Inc.	People living with mental health and co-occurring substance use disorders to live, work, and integrate successfully within the community.

<p>Disabled In Action of Metropolitan New York (DIA)</p>	<p>To raise consciousness among people with or without disabilities concerning ableism, paternalism and derogatory attitudes, as well as laws and customs that oppress disabled individuals in American society. To enact and enforce effective legislation and budget initiatives promoting our ability to live independently by mandating equal access to: Education, Employment, Entitlements, Health Care, Housing, Personal Assistance Services, Public Accommodations, Telecommunications and Transportation. To provide the organizational basis for disabled activists to join in effective unified political action</p>
<p>National Disabilities Rights Network</p>	<p>Through training and technical assistance, legal support, and legislative advocacy, NDRN works to create a society in which people with disabilities are afforded equality of opportunity and are able to fully participate by exercising choice and self-determination. Equal opportunity, choice and self-determination.</p>
<p>People First</p>	<p>We train, inform, and support all people with developmental disabilities to help our peers learn to: speak up for themselves, know our rights and responsibilities. Make decisions and solve problems, self-advocate, self-advocacy.</p>
<p>TransCen, Inc.</p>	<p>Dedicated to improving educational and employment outcomes for people with disabilities. Our work is driven by the belief that there is a job for everyone who wants one, regardless of the nature of their disability, or other barriers to employment, their need for workplace support and accommodation, or economic circumstance. Our associates develop, implement, and research innovative practices regarding school-to-adult life transition, career and workforce development, and inclusive community participation.</p>

Appendix D: Invitation to Participate

September 30, 2013

Hello,

My name is Jennifer Mannino. I am a registered nurse and doctoral candidate from Molloy College, NY. I am conducting a study to learn more about how young people with disabilities handle challenges. (Name and agency affiliation) gave me your name and contact information because you received an award through the Life Enrichment Awards Program (LEAP). As a LEAP recipient I believe you can provide valuable information.

If you agree to participate, you will be asked to complete questionnaires and will be invited to join in a focus group that will be held at the HSC National Youth Transition Center in Washington, DC. As a token of my appreciation, you will be mailed \$15 upon return of all study questionnaires and will receive an additional \$25 if you take part in the focus group. There will also be a pizza party reception after the focus group.

Your participation in this study is voluntary. No information that could identify you or your family will be included in the results. If you choose to participate please sign the enclosed "Informed Consent" form and return it to me along with all four completed study questionnaires. If you choose not to participate or to withdraw from the study at any time, there will be no penalty.

Thank you in advance for your consideration,

Jennifer Emilie Mannino, PhD(c), RN
Molloy College Division of Nursing
1000 Hempstead Ave, PO Box 5002
Rockville Centre, NY 11571-5002
Office: 516-323-3702 Cell: 516-695-8797
Email: jmannino@molloy.edu

Appendix E: Informed Consent

INFORMED CONSENT

Title: Resilience and the Developmental Trajectory of Transitioning To Adulthood among Emerging Adults with Disabilities: A Mixed-Methods Study

Researcher: Jennifer Emilie Mannino, PhD(c), RN

You have been selected to participate in a research study. The purpose of this study is to learn more about how adolescents and emerging adults with disabilities handle challenges related to becoming an adult and being more independent. There are two parts to this study. The first part consists of completing questionnaires and the second part consists of a focus group.

Your participation will involve answering four questionnaires. It will take approximately 45-60 minutes to answer all four questionnaires. In addition to completing the questionnaires, you will be invited to participate in a focus group held at the HSC National Youth Transition Center in Washington, DC. It is anticipated that the focus group will last approximately 1.5-2 hours. The first to return consent and questionnaires will be selected to participate in one of two focus groups.

There are no direct benefits of participating in this study. However, upon completion of the four study questionnaires you will be mailed \$15. You will receive an additional \$25 if you participate in a focus group. We will also have a pizza party reception after the focus group. Indirect benefits may include the valuable information gathered about better understanding the adolescents' and emerging adults' sources of resilience as it aids in transitioning.

No risks are anticipated, however if emotional discomfort from taking part in this study is expressed, assistance with referrals to professional care can be provided.

Although the results of this study and direct quotes may be presented and/or published. No information that could identify you or your family will be included in presentations and/or publications of the study's findings.

In order to participate in this study you must: be/have been aged 13-26 at the time of receiving a LEAP award, be able to communicate in English and be able to understand and comprehend 4-6th grade reading, be able to understand study instructions, be able to complete the survey questionnaires that are written at a 4-6th grade reading comprehension level, be able to participate in focus group if desired and be able to provide own consent (parent/guardian if minor) and assent to participate.

Your consent to participate is being given voluntarily. You may refuse participation at any time without any negative effect on your relations with HSC or any other participating institution or agency. No service of that which you and/or your family are currently receiving will be lost or jeopardized if you choose not to participate in this study.

This study will be conducted by me, Jennifer Emilie Mannino through the Molloy College Division of Nursing. It has been review and approved by the Molloy College Institutional Review Board and is supported by HSC Foundation, as well as _____ (contact agency name) who provided me with your contact information. Questions about this study may be directed to me at 516-323-3702 or 516-695-8797. My dissertation director, Dr. Veronica Feeg may be contacted at 516-323-3653 with any questions regarding your rights as a participant in this study.

If you agree to participate please complete the "Informed Consent Signature Page", read the instructions and complete the study questionnaires.

Thank you in advance for your consideration,

Jennifer Emilie Mannino, PhD(c), RN
 Molloy College Division of Nursing
 1000 Hempstead Ave
 Rockville Centre, NY 11571-5002
 Office: 516-323-3702
 Cell: 516-695-8797
 Email: jmannino@molloy.edu

Appendix F: Informed Consent Signature Page

INFORMED CONSENT SIGNATURE PAGE

An explanation of the procedures to be employed in this study, in which I have voluntarily agreed to participate, has been offered to me. All my inquiries concerning the study have been answered to my satisfaction. I understand that the information collected will be held in confidence, and that my name will not in any way be identified. I understand that additional information about the study results will be provided, at its conclusion, upon my request. I know that I am free to withdraw from this study without penalty at any time.

The above information has been provided to me (check one): In writing Orally

I agree to be contacted to participate in a focus group: Yes No

Signature of participant

Date

Signature of Parent/Guardian (if participant is a minor)

Date

Signature of Researcher

Date

Complete the following if you wish to receive a copy of the results of this study or If you prefer to have the questionnaires administered by telephone or email.

NAME: _____

(Typed or printed)

ADDRESS: _____

(Street)

(City)

(State)

(Zip)

TELEPHONE: _____

(Best time to call)

E-MAIL: _____

Appendix G: Informed Consent for Focus Group

INFORMED CONSENT: FOCUS GROUP

Title: Resilience and the Developmental Trajectory of Transitioning To Adulthood among Emerging Adults with Disabilities: A Mixed-Methods Study

Researcher: Jennifer Emilie Mannino, PhD(c), RN

You have been selected to participate in a research study. The purpose of this study is to learn more about how adolescents and emerging adults with disabilities handle challenges related to becoming an adult and being more independent. There are two parts to this study. The first part consisted of completing questionnaires and this part consists of a focus group.

Your participation in this focus group is completely voluntary. It is anticipated that the focus group will last approximately 1.5 hours. The focus group will be audio-recorded in order to accurately capture what is said. You may request that the recording be paused at any time. You may choose how much or how little you want to speak during the group. You may also choose to leave the focus group at any time. The information you provide during the focus group will be grouped with answers from other people so that you cannot be identified. All participants will be asked that the discussion during the focus group be strictly confidential.

There are no direct benefits of participating in the focus group. You will receive \$25 plus travel expenses for your participation in the focus group. Indirect benefits may include the valuable information gathered about better understanding sources of resilience as it aides in transitioning. No risks are anticipated, however if emotional discomfort from taking part in this study is expressed, assistance with referrals to professional care can be provided.

Although the results of this study and direct quotes may be presented and/or published, no information that could identify you or your family will be included in presentations and/or publications of the study's findings.

In order to participate in this study you must: be/have been aged 13-26 at the time of receiving a LEAP award, be able to communicate in English and be able to understand and comprehend 4-6th grade reading, be able to understand study instructions, be able to complete the survey questionnaires that are written at a 4-6th grade reading comprehension level, be able to participate in focus group if desired and be able to provide own consent (parent/guardian if minor) and assent to participate.

Your consent to participate is being given voluntarily. You may refuse participation at any time without any negative effect on your relations with HSC or any other participating institution or agency. No service of that which you and/or your family are currently receiving will be lost or jeopardized if you choose not to participate in this study.

This study will be conducted by me, Jennifer Emilie Mannino through the Molloy College Division of Nursing. It has been review and approved by the Molloy College Institutional Review Board and is supported by HSC Foundation. Questions about this study may be directed to me at 516-323-3702 or 516-695-8797. My dissertation director, Dr. Veronica Feeg may be contacted at 516-323-3653 with any questions regarding your rights as a participant in this study.

If you agree to participate please sign the "Informed Consent Signature Page: Participation in Focus Group".

Thank you in advance for your consideration,

Jennifer Emilie Mannino, PhD(c), RN
 Molloy College Division of Nursing
 1000 Hempstead Ave
 Rockville Centre, NY 11571-5002
 Office: 516-323-3702
 Cell: 516-695-8797
 Email: jmannino@molloy.edu

Appendix H: Informed Consent Signature Page for Participation in Focus Group

INFORMED CONSENT SIGNATURE PAGE: Participation in Focus Group

An explanation of the procedures to be employed in this study, in which I have voluntarily agreed to participate, has been offered to me. All my inquiries concerning the study have been answered to my satisfaction. I understand that the information collected will be audio recorded, that the information collected by the researcher will be held in confidence, and that my name will not in any way be identified. I understand that additional information about the study results will be provided, at its conclusion, upon my request. I know that I am free to withdraw from this study without penalty at any time.

The above information has been provided to me (check one): _____ In Writing _____ Orally

Signature of participant

Date

Signature of Parent/Guardian (if participant is a minor)

Date

Signature of Researcher

Date

Appendix I: Informed Consent for Telephone Interview

INFORMED CONSENT: TELEPHONE CONSENT

Title: Resilience and the Developmental Trajectory of Transitioning To Adulthood among Emerging Adults with Disabilities: A Mixed-Methods Study

Researcher: Jennifer Emilie Mannino, PhD(c), RN

“Hello, my name is Jennifer Mannino. I am a doctoral candidate at Molloy College in Rockville Centre, NY. I am asking you to volunteer to take part in a telephone interview as part of a research study. The purpose of this study is to learn more about how adolescents and emerging adults with disabilities handle challenges related to becoming an adult and being more independent. The interview will take approximately one half hour of your time. Your participation in this interview is completely voluntary. This means you do not have to participate if you do not want to. If you agree to participate, you have the right to only answer the questions you choose to answer. This telephone interview is being audio recorded to assure accuracy. The potential risks of this research are minimal and confidentiality of private information that you share with me will be maintained to the highest level. You have the right to stop participation at any point during the interview if you so choose.”

“Do you have any questions or concerns regarding this research?”

- [] No If No ... continue
- [] YES If Yes ... answer questions as needed

"Do you agree to voluntarily participate in this survey process?"

- [] Yes If Yes ... continue
- [] No If No ... “Thank you for your time, Good-bye”

Appendix J: Informed Consent Verbal Consent for Participation in Telephone Interview

VERBAL CONSENT DOCUMENTAION FOR PARTICIPATION

This consent serves as documentation that the required elements of informed consent have been presented orally to the participant or the participant's legally authorized representative.

Verbal consent to participate in this telephone interview has been obtained by the participant's willingness to continue with the telephone survey by providing answers to a series of questions related to how adolescents and emerging adults with disabilities handle challenges related to becoming an adult and being more independent.

Name of Participant (Printed)

Name of Researcher (Printed)

Signature of Researcher

Date

Appendix K: Instructions

Dear Participants/Parents/Guardians,

Thank you for agreeing to take part in my study. Please complete the questionnaires on the next few pages and return them to me along with the signed “Informed Consent Signature Page” in the self-addressed stamped envelope I provided. If you prefer, I can administer the questionnaires to you by telephone; or they can be sent by email. If you choose to complete the questionnaires by telephone or email please just return the signed consent in the self-addressed envelope and include your telephone number with best time to call or email address. I will also accept a scanned consent via email to jmannino@molloy.edu.

The questionnaires are written in English at a 4th-6th grade reading level. Participants may use assistive technology for reading, such as an Intel Reader or similar. Questionnaires may be read to participants and answers may be recorded by a parent/guardian or assistant. It is important that although the participant may receive assistance in completing the questionnaires, the responses must be their own. The choices should reflect the participant’s point of view and not that of their parent/guardian or assistant.

Thank you again. I am looking forward to receiving your questionnaires. Please contact me if you have any questions.

Sincerely,

Jennifer Emilie Mannino, PhD(c), RN
jmannino@molloy.edu

516-695-8797

Appendix L: Demographic Questionnaire

Please select the answer that best describes you.

1. What is your gender?
 - Male
 - Female

2. What is your age?
 - 13-17
 - 18-26
 - >26

3. What is the highest level of education you have completed?
 - Grammar School
 - Middle School/Junior High School
 - Some High School
 - High School Graduate or GED
 - Some College
 - College Graduate
 - Trade/Technical/Vocational Training

4. Who do you live with?
 - Immediate Family
 - Extended family
 - Friends
 - Foster Family
 - Group Home
 - Community Shelter
 - Independently

5. What type of community do you live in?
 - Urban
 - Suburban
 - Rural

6. What is your employment status?
 - Employed for wages
 - Self-employed
 - Out of work and looking for work
 - Out of work but not looking for work
 - A homemaker
 - A student
 - Military
 - Retired Volunteer (non-paid)
 - Unable to work

7. Have you ever been told you had the following? select all that apply
- Attention Deficit Disorder (ADD)
 - Attention Deficit Hyperactivity Disorder (ADHD)
 - Depression
 - Anxiety Problems
 - Behavioral or Conduct Problems, such as Oppositional Defiant Disorder or Conduct Disorder
 - Autism, Asperger's Disorder, Pervasive Developmental Disorder, or other Autism Spectrum Disorder
 - Any Developmental Delay that affects your ability to learn
 - An Intellectual Disability
 - Asthma
 - Diabetes
 - Epilepsy or Seizure Disorder
 - Migraines or Frequent Headaches
 - A Head Injury, Concussion, or Traumatic Brain Injury
 - Heart Problem, including Congenital Heart Disease
 - Blood Problems such as Anemia or Sickle Cell Disease
 - Cystic Fibrosis
 - Cerebral Palsy
 - Muscular Dystrophy
 - Down Syndrome
 - Arthritis or other Joint Problems
 - Allergies
 - Other _____
8. Select the services that you currently receive. select all that apply
- Speech Therapy
 - Physical Therapy
 - Occupational Therapy
 - Other _____
 - I do not receive any therapies
9. Do you have difficulty with any of the following? select all that apply
- Seeing
 - Hearing
 - Having my speech understood
 - Walking
 - Carrying or lifting 10 lbs.
 - Walking up a flight of stairs
 - I do not have difficulties in these areas

10. When you need to go somewhere you most often: select only one:

- Walk, ride bike, roller blade, use scooter
- Use wheelchair or other assistive device (walker/braces/crutches)
- Drive myself
- Get a ride from a family member
- Get a ride from a friend/co-worker/employer
- Carpool or vanpool
- Take public transportation
- Take transportation provided by service agency
- Use a dial-a-van service
- Other _____

11. I am able to do the following all by myself: select all that apply

- Get around inside the home
- Get into or out of a bed/chair
- Take a bath
- Get dressed
- Eat
- Go outside the home
- Keep track of money or bills
- Prepare meals
- Do light housework
- Use the telephone
- Use a computer

12. When I am in need, the following are there to support me: select all that apply

- My Family
- My Friends
- My School
- My Work
- My Place of Worship (Church, Temple, Mosque, Other)
- My Community
- My Healthcare Provider

13. Please indicate your level of agreement to the following statement:

"I am very sure that one day I will get to where I want to be in life."

- Strongly Disagree
- Disagree
- Agree
- Strongly Agree

14. Please use the following space* to include anything else you may want to share about

yourself. (*space was provided on back of this page for the individual to write)

Appendix M: Interview Guide with Probes

1. What do you value most about becoming an adult?
 - a. What are some of the goals you wish to achieve as an adult?
2. What are some of the challenges you face as you are preparing for adulthood?
 - a. What are some of the challenges you feel others adolescents/emerging adults face as they are preparing for adulthood?
3. What are some of the things you have learned that has allowed you to overcome adversities?
4. Looking at your experiences in the past year tell me about a time when you felt most proud of yourself.
 - a. What in particular do you remember about that time?
5. Who in your life offers you the most support?
6. What things do you value most about that person? Why
7. What do you value most about yourself?
8. Imagine this... you are the leader in an advocacy movement for persons with disabilities. Others are looking to you as an exceptional example of leadership.
 - a. What inspired you to become a leader?
 - b. What do you most hope to contribute?
 - i. Which of your strengths and talents were used?
 - ii. What/Who contributed most to the success of the effort?
 - c. How can we support and learn from your accomplishments?

- i. What programs/support services have you been a part of that have been most encouraging?
9. As you reflect on some of the ways you (and/or others you know with disabilities) are currently managing challenges related to transitioning to adulthood, what stands out as being exceptionally promising in helping others become successful in their transitioning as well?
 - a. If you could pass on one thing to others about what you have learned about managing adversity what would it be?
 - b. What additional knowledge, skills and attitudes do you feel you would benefit from in being able to overcome adversities related to transitioning? Others like you?
 - c. What additional social support services do you feel you would benefit from in being able to overcome adversities related to transitioning? Others like you?
10. If you had three wishes what would they be?
 - a. What small changes do you think we could make right now to help
 - b. How would you like to personally be involved

Appendix N: Butterfly Story . . . our struggles make us stronger!

“A man found a cocoon of a butterfly. One day a small opening appeared. He sat and watched the butterfly for several hours as it struggled to force its body through that little hole. Then it seemed to stop making any progress. It appeared as if it had gotten as far as it could, and it could go no further.

So the man decided to help the butterfly. He took a pair of scissors and snipped off the remaining bit of the cocoon. The butterfly then emerged easily. But it had a swollen body and small, shriveled wings.

The man continued to watch the butterfly because he expected that, at any moment, the wings would enlarge and expand to be able to support the body, which would contract in time. Neither happened! In fact, the butterfly spent the rest of its life crawling around with a swollen body and shriveled wings. It never was able to fly.

What the man, in his kindness and haste, did not understand was that the restricting cocoon and the struggle required for the butterfly to get through the tiny opening were God’s way of forcing fluid from the body of the butterfly into its wings so that it would be ready for flight once it achieved its freedom from the cocoon.

Sometimes struggles are exactly what we need in our lives. If God allowed us to go through our lives without any obstacles, it would cripple us. We would not be as strong as what we could have been. We could never fly!”

–Author Unknown

Appendix O: Interpretation of RS-14

Range	Meaning
14-56	Your resilience level is very low but this doesn't mean you have zero resilience. Everyone is resilient to some degree. Others who have scored between 14 and 56 have reported depression. Finding meaning is sometimes a problem for individuals who score between 14 and 56. You may be lacking in energy. You may doubt your own abilities and see the glass as half-empty. You may be overwhelmed. You may feel as if no one in the world can understand what your life is like and therefore feel isolated and alone. It can be very difficult to keep going at times like these. You can strengthen your resilience and doing so will make a significant and positive change in your life.
57-64	Your resilience level is low but this doesn't mean you have zero resilience. Others who have scored between 57 and 64 have reported feeling somewhat depressed and anxious about their life. Meaning may be lacking in your life. You may feel dissatisfied in general and feeling needs to make some changes. Some who score between 57 and 64 say they tend to be pessimistic. Maybe you have a lot going on in your life and you feel a little out of control. You can strengthen your resilience and doing so will make a significant positive change in your life.
65-73	Your resilience level is on the low end this doesn't mean you have zero resilience. Everyone is resilient to some degree. Others who have scored between 65 and 73 reports some depression and anxiety in their lives. If you are like others, you are experiencing some problems in your life and are trying to resolve them. Some people have trouble letting go of things they have no trouble over. Maybe you feel unappreciated. Life may not seem very fulfilling but there are times you can see the light at the end of the tunnel. You can strengthen your resilience and doing so will make a significant positive change in your life.
74-81	Your resilience level is moderate; neither high nor low. The good news is that you possess many characteristics of resilience and can build on those to keep strengthening your resilience. Others who scored between 74 and 81 have reported that while they are satisfied in general, many aspects of their life are not satisfactory. But you may be thinking that you need to make some changes. You're probably able to keep moving forward though you may not do so with enthusiasm. You may feel tired and emotionally drained at the end of the day. Overall, you are probably experiencing ups and downs. You can see the good things in your life if you work at it, but tend to dwell on things that aren't going well. Your sense of humor may still be intact but you would like to laugh a little more and fret little less. You can strengthen your resilience in doing so will make a significant and positive change in your life.
82-90	Your resilience level is moderately high, which means you are doing well but you believe you can do better... You possess all the characteristics of a solid resilient personality but would like to strengthen your resilience. Others who scored between 82 and 90 find life meaningful in general and are rarely or only sometimes depressed. There may be many aspects of your life with which you are not satisfied such as your

work, personal and/or professional relationships, how you spend your leisure time, and physical health, for example. You recognize that there is room for improvement. Most of the time you have enough energy to get through the day and then some. You probably have a balanced life perspective in which you recognize that sometimes things go well, and sometimes they don't. You enjoy your own company most of the time. You are dependable. You would benefit from recognizing your strengths and resilience but also areas where you are not as strong. You know from taking the Resilience Scale where you probably scored lower.

91-98 Your resilience level is high, which means that you are doing very well in almost all aspects of resilience. Others who scored between 91 and 98 reported that they are rarely if ever depressed or anxious about their lives. When you score high in resilience, it usually means it defined my very purposeful and you are eager to get on with each new day. You tend to see life as an adventure and others describe you as optimistic and upbeat. You enjoy your own company and the company of others. Your life is balanced between work and play. Like everyone else, you sometimes have difficult and painful events and illness, death of family and friends, unemployment, and so forth. But unlike less resilient people, you are able to regain your equilibrium and forward. You have weathered many storms before and you are confident that you will manage again. You are dependable. You are definitely resourceful. Others seek you out because you are able to look at situations in a number of ways and therefore have a healthy perspective on life. You are self-confident. Overall, you're satisfied with your life.

Note. Copied with permission. Wagnild, G. (2011) The Resilience Scale User's Guide for the US English version of the Resilience Scale and the 14-Item Resilience Scale (RS-14). Worden, MT: The Resilience Center, pp. 76-78.

Appendix P: Interpretation of SWLS

Range	Interpretation	Meaning
30-35	Very high score; highly satisfied	Respondents who score in this range love their lives and feel that things are going very well. Their lives are not perfect, but they feel that things are about as good as lives get. Furthermore, just because the person is satisfied does not mean she or he is complacent. In fact, growth and challenge might be part of the reason the respondent is satisfied. For most people in this high-scoring range, life is enjoyable, and the major domains of life are going well – work or school, family, friends, leisure, and personal development.
25-29	High score	Individuals who score in this range like their lives and feel that things are going well. Of course their lives are not perfect, but they feel that things are mostly good. Furthermore, just because the person is satisfied does not mean she or he is complacent. In fact, growth and challenge might be part of the reason the respondent is satisfied. For most people in this high-scoring range, life is enjoyable, and the major domains of life are going well – work or school, family, friends, leisure, and personal development. The person may draw motivation from the areas of dissatisfaction.
20-24	Average score	The average of life satisfaction in economically developed nations is in this range – the majority of people are generally satisfied, but have some areas where they very much would like some improvement. Some individuals score in this range because they are mostly satisfied with most areas of their lives but see the need for some improvement in each area. Other respondents score in this range because they are satisfied with most domains of their lives, but have one or two areas where they would like to see large improvements. A person scoring in this range is normal in that they have areas of their lives that need improvement. However, an individual in this range would usually like to move to a higher level by making some life changes.
15-19	Slightly below average in life satisfaction	People who score in this range usually have small but significant problems in several areas of their lives, or have many areas that are doing fine but one area that represents a substantial problem for them. If a person has moved temporarily into this level of life satisfaction from a higher level because of some recent event, things will usually improve over time and satisfaction will generally move back up. On the other hand, if a person is chronically slightly dissatisfied with many areas of life, some changes might be in order. Sometimes the person is simply expecting too much, and

		<p>sometimes life changes are needed. Thus, although temporary dissatisfaction is common and normal, a chronic level of dissatisfaction across a number of areas of life calls for reflection. Some people can gain motivation from a small level of dissatisfaction, but often dissatisfaction across a number of life domains is a distraction, and unpleasant as well.</p>
10-14	Dissatisfied	<p>People who score in this range are substantially dissatisfied with their lives. People in this range may have a number of domains that are not going well, or one or two domains that are going very badly. If life dissatisfaction is a response to a recent event such as bereavement, divorce, or a significant problem at work, the person will probably return over time to his or her former level of higher satisfaction. However, if low levels of life satisfaction have been chronic for the person, some changes are in order – both in attitudes and patterns of thinking, and probably in life activities as well. Low levels of life satisfaction in this range, if they persist, can indicate that things are going badly and life alterations are needed. Furthermore, a person with low life satisfaction in this range is sometimes not functioning well because their unhappiness serves as a distraction. Talking to a friend, member of the clergy, counselor, or other specialist can often help the person get moving in the right direction, although positive change will be up the person.</p>
5-9	Extremely Dissatisfied	<p>Individuals who score in this range are usually extremely unhappy with their current life. In some cases this is in reaction to some recent bad event such as widowhood or unemployment. In other cases, it is a response to a chronic problem such as alcoholism or addiction. In yet other cases the extreme dissatisfaction is a reaction due to something bad in life such as recently having lost a loved one. However, dissatisfaction at this level is often due to dissatisfaction in multiple areas of life. Whatever the reason for the low level of life satisfaction, it may be that the help of others are needed – a friend or family member, counseling with a member of the clergy, or help from a psychologist or other counselor. If the dissatisfaction is chronic, the person needs to change, and often others can help.</p>
<p><i>Note. Available in public domain. Diener, E. (2006) Understanding Scores on the Satisfaction with Life Scale.</i></p>		

Appendix Q: U.S. 1998 Population Norms for SF Scales

Scale Norms for Age Groups

Tables 8.2 (standard form) and 8.10 (acute form) present national SF-36v2™ scale norms for seven different age groups among males and females combined. These age groupings were selected (1) to be large enough to satisfy minimum standards for precision; (2) to correspond with standard practices for defining age-specific groups; and (3) to correspond with age groupings used by others in reporting norms for the SF-36 (Brazier et al., 1992; Jenkinson et al., 1993, Ware et al., 1993, Ware et al., 1994) and that are forthcoming from other countries.

TABLE 8.2 NATIONAL NORMS FOR SEVEN AGE GROUPS, MALES AND FEMALES COMBINED

Ages 18-24 Males & Females (N=207)	PF	RP	BP	GH	VT	SF	RE	MH
Mean	53.46	52.65	51.83	49.48	47.11	49.16	49.80	46.87
25 th Percentile	52.82	51.96	46.06	43.40	39.60	45.94	44.22	41.56
50 th Percentile (median)	57.03	56.85	53.67	50.55	45.85	51.40	55.88	50.00
75 th Percentile	57.03	56.85	55.36	56.15	55.21	56.85	55.88	55.64
Standard Deviation	6.80	7.55	8.40	9.28	9.30	9.65	9.71	10.16
Range	14-58	17-57	24-63	16-64	20-68	18-57	17-56	19-65

Ages 25-34 Males & Females (N=1038)	PF	RP	BP	GH	VT	SF	RE	MH
Mean	53.81	52.75	52.36	51.73	49.93	51.04	51.34	49.64
25 th Percentile	52.82	51.96	46.06	48.17	45.85	45.94	48.10	44.38
50 th Percentile (median)	57.03	56.85	55.35	52.93	52.09	56.85	55.88	52.82
75 th Percentile	57.03	56.85	62.12	57.70	58.33	56.85	55.88	55.64
Standard Deviation	6.69	7.91	9.19	9.05	9.45	8.82	8.48	9.62
Range	14-58	17-57	19-63	18-64	20-71	13-57	09-56	07-65

Summary Measure Norms for Age Groups

Tables 8.6 (standard form) and 8.14 (acute form) present PCS and MCS general U.S. population norms for seven different age groups among males and females combined. The age groups are the same as those used for the presentation of normative data for the eight scales.

**TABLE 8.6 NATIONAL NORMS FOR SEVEN AGE GROUPS, MALES AND FEMALES COMBINED:
PCS AND MCS SCALES**

Ages 18-24 (N=207)	PCS	MCS
Mean	53.50	46.19
25 th Percentile	50.51	40.90
50 th Percentile (Median)	55.35	49.26
75 th Percentile	57.70	53.97
Standard Deviation	7.11	10.40
Range	22-68	12-64

Ages 25-34 (N=1038)	PCS	MCS
Mean	53.57	49.20
25 th Percentile	51.35	45.17
50 th Percentile (Median)	55.43	51.97
75 th Percentile	58.37	55.78
Standard Deviation	7.27	9.42
Range	17-69	02-68

Appendix R: Molloy College IRB Approval



1000 Hempstead Avenue
Rockville Centre, NY 11571
www.molloy.edu

Tel. 516.323.3653
Tel. 516.323.3801

Date: October 9, 2013
To: Professor Jennifer Mannino
From: Kathleen Maurer Smith, PhD
Co-Chair, Molloy College Institutional Review Board
Veronica D. Feeg, PhD, RN, FAAN
Co-Chair, Molloy College Institutional Review Board

SUBJECT: MOLLOY IRB REVIEW AND DETERMINATION OF EXPEDITED STATUS
Study Title: Resilience and the Developmental Trajectory of Transitioning To Adulthood among Adolescents and Emerging Adults with Disabilities: A Mixed-Methods Study
Approved: October 9, 2013

Dear Professor Mannino

The Institutional Review Board (IRB) of Molloy College has reviewed the above-mentioned research proposal and determined that this proposal is approved by the committee. It is considered an EXPEDITED review per the requirements of Department of Health and Human Services (DHHS) regulations for the protection of human subjects as defined in 45CFR46.101(b) and has met the conditions for conducting the research.

You may proceed with your research. Please submit a report to the committee at the conclusion of your project.

Changes to the Research: It is the responsibility of the Principal Investigator to inform the Molloy College IRB of any changes to this research. A change in the research may change the project from EXPEDITED status that would require communication with the IRB.

Sincerely,

Kathleen Maurer Smith, PhD

Veronica D. Feeg, PhD, RN, FAAN

Appendix S: HSC Foundation Letter of Support



THE HSC HEALTH CARE SYSTEM
The HSC Foundation

Caring. Serving. Empowering.

September 13, 2013

Ms. Jennifer Emilie Mannino PhD(c), RN
100 Papermill Road
Manhasset, NY 11030

Re: Dissertation Titled: Resilience and the Developmental Trajectory of Transitioning to Adulthood
among Adolescents and Emerging Adults with Disabilities

Dear Ms. Mannino,

As representatives of The HSC Foundation in Washington D.C., we hereby support your research efforts
as a doctoral candidate from Molloy College in Rockville Centre, NY.

If you have any questions or concerns, please do not hesitate to contact us.

Sincerely,

Ryan Easterly
Manager,
National Youth Transitions
Initiative
The HSC Foundation
2013 H Street NW. Suite 300
Washington, DC. 20006
phone: (202) 454-1258
fax: (202) 454-1251
email: REasterly@cscn.org

Son Park McBride
Director,
Grants and Network
Development
The HSC Foundation
2013 H Street, NW. Suite 300
Washington, DC 20006
phone: (202) 454-1248
fax: (202) 454-1251
email: spark@cscn.org



The HSC Foundation 2013 H Street, NW, Suite 300, Washington, DC 20006 202-454-1220, www.hscfoundation.org

The HSC Pediatric Center 1731 Bunker Hill Road, NE, Washington, DC 20017 202-832-4400, www.hscpediatriccenter.org

Health Services for Children with Special Needs, Inc. 1101 Vermont Avenue, NW, Suite 1201, Washington, DC 20005 202-466-8483, www.hscsn-net.org

HSC Home Care, LLC 1731 Bunker Hill Road, NE, Washington, DC 20017 202-635-5756, www.hsc-homecare.org

Appendix T: Permission to use RS-14

INTELLECTUAL PROPERTY LICENSE AGREEMENT Students & Residents of Developing Countries

This Intellectual Property License Agreement ("Agreement") is made and effective this 24 May 2013 ("Effective Date") by and between The Resilience Center, PLLP ("Licensor") and Jennifer Mannino ("Licensee").

Licensor has developed and licenses to users its Intellectual Property, marketed under the names "the Resilience Scale", "RS", "the 14-Item Resilience Scale", and "the RS-14" (the "Intellectual Property").

Licensee desires to use the Intellectual Property.

NOW, THEREFORE, In consideration of the mutual promises set forth herein, Licensor and Licensee agree as follows:

1. **License.**
Licensor hereby grants to Licensee a 1-year, non-exclusive, limited license to use the Intellectual Property as set forth in this Agreement.
2. **Restrictions.**
Licensee shall not modify, license or sublicense the Intellectual Property, or transfer or convey the Intellectual Property or any right in the Intellectual Property to anyone else without the prior written consent of Licensor. Licensee may make sufficient copies of the Intellectual Property and the related Scoring Sheets to measure the individual resilience of an unlimited number of subjects, for non-commercial purposes only.
3. **Fee.**
In consideration for the grant of the license and the use of the Intellectual Property, subject to the Restrictions above, Licensee agrees to pay Licensor the sum of US\$50.
4. **Term.**
This license is valid for twelve months, starting at midnight on the Effective Date.
5. **Termination.**
This license will terminate at midnight on the date twelve months after the Effective Date.
6. **Warranty of Title.**
Licensor hereby represents and warrants to Licensee that Licensor is the owner of the Intellectual Property or otherwise has the right to grant to Licensee the rights set forth in this Agreement. In the event any breach or threatened breach of the foregoing representation and warranty, Licensee's sole remedy shall be to require Licensor to do one of the following: i) procure, at Licensor's expense, the right to use the Intellectual Property, ii) replace the Intellectual Property or any part thereof that is in breach and replace it with Intellectual Property of comparable functionality that does not cause any breach, or iii) refund to Licensee the full amount of the license fee upon the return of the Intellectual Property and all copies thereof to Licensor.
7. **Warranty of Functionality.**
Licensor provides to Licensee the Intellectual Property "as is" with no direct or implied warranty.
8. **Payment.**
Any payment shall be made in full prior to shipment. Any other amount owed by Licensee to Licensor pursuant to this Agreement shall be paid within thirty (30) days following invoice from Licensor. In the event any overdue amount owed by Licensee is not paid following ten (10) days written notice from Licensor, then in addition to any other amount due, Licensor may impose and Licensee shall pay a late payment charge at the rate of one percent (1%) per month on any overdue amount.
9. **Taxes.**
In addition to all other amounts due hereunder, Licensee shall also pay to Licensor, or reimburse Licensor as appropriate, all amounts due for tax on the Intellectual Property that are measured directly by payments made by Licensee to Licensor. In no event shall Licensee be obligated to pay any tax paid on the income of Licensor or paid for Licensor's privilege of doing business.
10. **Warranty Disclaimer.**
LICENSOR'S WARRANTIES SET FORTH IN THIS AGREEMENT ARE EXCLUSIVE AND ARE IN LIEU OF ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE.

11. **Limitation of Liability.**

Licensor shall not be responsible for, and shall not pay, any amount of incidental, consequential or other indirect damages, whether based on lost revenue or otherwise, regardless of whether Licensor was advised of the possibility of such losses in advance. In no event shall Licensor's liability hereunder exceed the amount of license fees paid by Licensee, regardless of whether Licensee's claim is based on contract, tort, strict liability, product liability, or otherwise.

12. **Support.**

Licensor agrees to provide limited, e-mail-only support for issues and questions raised by the Licensee that are not answered in the current version of the *Resilience Scale User's Guide*, available on www.resiliencescale.com, limited to the Term of this Agreement. Licensor will determine which issues and questions are or are not answered in the current *User's Guide*.

13. **Notice.**

Any notice required by this Agreement or given in connection with it, shall be in writing and shall be given to the appropriate party by personal delivery or by certified mail, postage prepaid, or recognized overnight delivery services.

If to Licensor:

The Resilience Center, PLLC

PO Box 313

Worden, MT 59088-0313

If to Licensee:

Name: Jennifer Mannino

Address: 100 Papermill Road

Manhasset, NY 11030

UNITED STATES

14. **Governing Law.**

This Agreement shall be construed and enforced in accordance with the laws of the United States and the state of Montana. Licensee expressly consents to the exclusive forum, jurisdiction, and venue of the Courts of the State of Montana and the United States District Court for the District of Montana in any and all actions, disputes, or controversies relating to this Agreement.

15. **No Assignment.**

Neither this Agreement nor any interest in this Agreement may be assigned by Licensee without the prior express written approval of Licensor.

16. **Final Agreement.**

This Agreement terminates and supersedes all prior understandings or agreements on the subject matter hereof. This Agreement may be modified only by a further writing that is duly executed by both Parties.

17. **Severability.**

If any term of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, then this Agreement, including all of the remaining terms, will remain in full force and effect as if such invalid or unenforceable term had never been included.

18. **Headings.**

Headings used in this Agreement are provided for convenience only and shall not be used to construe meaning or intent.

IN WITNESS WHEREOF, the Parties hereto have duly caused this Agreement to be executed in its name on its behalf, all as of the day and year first above written.

Licensor	The Resilience Center, PLLC
Signature: 	
Printed Name: Jennifer Mannino	Gail M. Wagnild, PhD
Title: Student	Owner and CEO
Date: 20 May 2013	20 May 2013

Appendix U: Permission to use SWLS

The screenshot shows the Ed Diener website. The header includes the name 'Ed Diener' and his titles: 'Joseph R. Smiley Distinguished Professor Emeritus of Psychology' and 'Senior Scientist for the Gallup Organization'. A navigation menu contains 'Home', 'Contacts & Links', 'Ed Diener & Lab', 'RESEARCH', 'SCALES', and 'Inquiries'. A search bar is present with the text 'FIND STUFF' and a search button. The main content area is titled 'Satisfaction With Life Scale (SWLS)' and is divided into two columns. The left column lists various scales: Overview, Satisfaction with Life Scale (SWLS), Scale of Positive and Negative Experience (SPANE), Flourishing Scale (FS), Scales for Children and Teenagers, Affect Intensity Measure, and Inventory of thriving (CIT & BIT). Below this is a section for 'SWLS Translations' with a list of languages: Arabic, Arabic2, Chinese, Czech, Dutch, English, French, and German. The right column contains the 'Permission to Use' section, which states that the scale is copyrighted but can be used without permission or charge by professionals, provided credit is given to the authors (Ed Diener, Robert A. Emmons, Randy J. Larsen, and Sharon Griffin) as noted in a 1985 article in the *Journal of Personality Assessment*. Below this is the 'About SWLS' section, which describes the scale as a short 5-item instrument for measuring global cognitive judgments of life satisfaction. It includes links to 'SWLS_English.doc' and 'Understanding the SWLS scores (.pdf)'. A note mentions that for a 5-point scale, users should refer to a paper by Kobau et al. (2010) for norms.

<http://internal.psychology.illinois.edu/~ediener/SWLS.html>

Appendix V: Permission to use SF-12v2



NON-COMMERCIAL LICENSE AGREEMENT Office of Grants and Scholarly Research (OGSR)

License Number: QM019225

Effective Date: 07/01/13

Licensee Name: Jennifer Mannino

Licensee Address: 100 Papermill Road Manhasset, NY 11030

Approved Purpose: Non-commercial academic research and/or thesis – Unfunded Student.

Study Name: An Exploration of Resilience and the Developmental Trajectory of Transitioning to Adulthood among Adolescents and Emerging Adults with Special Healthcare Needs

Study Type: Thesis/Dissertation Study Only

Therapeutic Area: Wellness & Lifestyle

Royalty Fee: None, because this License is granted in support of the non-commercial Approved Purpose

Other Definitions: As indicated on Appendix B "License Agreement – Details", including without limitation: Licensed Surveys, Modes, Fees, Administrations, Services, Approved Languages and (if applicable) License Term

Licensee accepts and agrees to the terms of this Non-Commercial License Agreement (the "Agreement") from the Office of Grants and Scholarly Research (OGSR) of OptumInsight Life Sciences, Inc. (f/k/a QualityMetric Incorporated) ("OptumInsight") as of the Effective Date.

Subject to the terms of this Agreement, including the OptumInsight Non-Commercial License Terms and Conditions attached as Appendix A: OptumInsight grants to Licensee, and Licensee accepts, a non-exclusive, non-transferable, non-assignable, non-sublicensable worldwide license to use, solely for the Approved Purpose and during the License Term, the Licensed Surveys in the authorized Modes and Approved Languages indicated on Appendix B and to administer the Licensed Surveys only up to the approved number of Administrations (and to make up to such number of exact reproductions of the Licensed Surveys necessary to support such Administrations) in any combination of the specific Licensed Surveys and Approved Languages and Modes and to use any related software provided by OptumInsight.

Capitalized terms used in this Agreement shall have the meanings assigned to them above, or in Appendices A and B attached hereto. Appendices A and B attached hereto are incorporated into and made a part of this Agreement for all purposes.

EXECUTED, as of the Effective Date, by the duly authorized representatives as set forth below.

OptumInsight Life Sciences, Inc.
[OptumInsight]

Signature: Michelle White

Name: Michelle White

Title: Director of Consulting Science

Date: 23 MAY 2013

Jennifer Mannino
[Licensee]

Signature: Jennifer Mannino

Name: Jennifer Mannino

Title: PHD RN

Date: 5/2013



an OptumInsight company