Correlates of Resilience among Trauma-Affected Elderly Individuals in Buikwe District, Uganda

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ABSTRACT

The ever-increasing burden of trauma among the elderly in sub-Saharan Africa, compounded by systemic neglect and eroding traditional support systems, presents a critical public health challenge. This study investigates the specific psychosocial factors that foster resilience in elderly individuals facing trauma within the Buikwe District, Uganda. Utilizing a convergent parallel mixed-methods design, data were collected from a purposive sample of 120 elderly participants (Mean age = 72.4, SD = 8.2), their primary caregivers (n=30), and local community therapists (n=10). Quantitative data, gathered using standardized surveys measuring perceived social support (Multidimensional Scale of Perceived Social Support), coping strategies (Brief COPE Inventory), and resilience (Connor-Davidson Resilience Scale-10), were analyzed using Pearson correlation and multiple regression. Qualitative data from semi-structured interviews were analyzed thematically to explore the lived experiences and cultural narratives of resilience. A significant strong positive correlation was found between the composite of social support, adaptive coping strategies, and cultural beliefs (ancestral reverence, community reciprocity) and resilience scores (r = .914, p < .01). Inconsistently, regression analysis also indicated that higher lifetime trauma exposure predicted higher resilience scores (β = .962, p = .000), suggesting the potential for post-traumatic growth within a supportive ecological niche. Qualitative findings explained this, revealing that robust familial and community networks mitigate trauma's impact by providing practical aid and affirming self-worth, while culturally-grounded coping strategies, such as collective storytelling and traditional healing ceremonies, foster meaning-making. The study concludes that resilience in this demographic is not merely an individual trait but an emergent property of a supportive socio-cultural ecosystem. These findings advocate for integrating these community-based assets into tailored mental health interventions that synergize traditional support structures with evidence-based psychological therapies to enhance geriatric mental well-being in low-resource settings.

Keywords: Correlates, Resilience, Trauma and Elderly

INTRODUCTION

The resilience of trauma-affected elderly individuals is not a single attribute but a multifaceted process shaped by an interplay of internal strengths and external resources. While universal correlates like social support and meaning-making are consistent, their manifestation is deeply cultural and context-specific.

Globally, the population is aging rapidly, with the number of people aged 60 years and over expected to double to 2.1 billion by 2050 (WHO, 2022). A significant portion of this demographic has been exposed to potentially traumatic events (PTEs) across their lifespan, including war, displacement, natural disasters, personal loss, and illness. Historically, research focused on the negative psychological sequelae of trauma, such as post-traumatic stress disorder (PTSD) and depression. However, a paradigm shift towards positive psychology has catalyzed the study of resilience the process of adapting well in the face of adversity, trauma, tragedy, or significant stress (Southwick et al., 2014).

Resilience is defined as the capacity to recover quickly from difficulties (American Psychological Association, 2020). In the context of trauma, this concept is particularly relevant for the elderly, who may face multiple stressors, including health decline, loss of loved ones, and socio-economic challenges (Ryff & Singer, 2003).

In Africa, there is a growing unique landscape for trauma and resilience where many elderly Africans have lived through collective traumas including colonialism, liberation struggles, political instability, genocide, and pervasive poverty. The concept of resilience is often deeply collectivist, intertwined with cultural and spiritual practices. The Nguni concept of "Ubuntu" ("I am because we are") underscores a collective, community-oriented form of resilience. Interdependence, shared burdens, and communal healing are central (Mugumbate & Chereni, 2020). For many African elders, resilience is rooted in a deep spiritual faith (Christianity and Islam) and traditional beliefs that include connection to ancestors, which provides a framework for understanding suffering and finding meaning (Kpobi & Swartz, 2019). Despite challenges, elders often hold valued roles as custodians of history, culture, and wisdom. This conferred status can be a significant source of purpose and identity, fostering resilience (Nduna & Jewkes, 2021). These strengths are tested by rapid urbanization, the erosion of traditional family structures, and the overwhelming burden of diseases like HIV/AIDS, which has left many elders as primary caregivers for grandchildren, increasing their stress and economic precarity (Schatz & Seeley, 2021).

East Africa, with its history of regional conflicts (e.g., the Lord's Resistance Army insurgency, Rwandan Genocide, Somali Civil War), and recurring climatic shocks like droughts and floods, has a large population of trauma-affected elderly. Resilience in this region is shaped by ethnic groups often span national borders (e.g., the Maasai, Luo), providing extended social support networks that can be crucial during crises (Oluoch-Aridi et al., 2020). Resilience is closely tied to the ability to adapt livelihoods, particularly in agrarian societies. Elderly individuals with diverse income sources (small-scale farming, petty trade, remittances) show greater psychological resilience (Egeru et al., 2021).

Many elderly are not just survivors of single events but of chronic, complex trauma. Their resilience is often a long-term process of "quiet endurance," shaped by a focus on ensuring the survival and education of the next generation (Bunn et al., 2020).

Uganda has a particularly profound history of trauma, including the atrocities of the Idi Amin and Obote regimes and a 20-year brutal insurgency in the Northern region by the Lord's Resistance Army (LRA). The elderly often bore the brunt of this violence. In Northern Uganda, studies on elderly populations show that resilience correlates strongly with **social acceptance and reconciliation processes**. Ceremonies like Mato Oput (a traditional Acholi justice ritual) are cited as crucial for communal healing and restoring social harmony, which directly impacts individual elder resilience (Baines & Gauvin, 2021). Resilience is largely driven by non-state actors. The state's social protection system is minimal (e.g., the Senior Citizens Grant, which is small and not universal), placing the onus of resilience on family, community, and NGOs (Bennett et al., 2022).

Buikwe is a predominantly agrarian district with a mix of subsistence farmers and workers on large sugar and rice plantations. Economic vulnerability is high, and many elderly continue manual labor well into old age, impacting their health (UBOS, 2023). Elderly in Buikwe may have experienced historical political violence and more recent, localized traumas. These include land grabbing conflicts a significant source of stress as land is the primary asset for security and inheritance and environmental shocks like landslides in hilly areas (Nakabuye et al., 2022). Membership in Village Savings and Loan Associations (VSLAs) is a critical economic correlate of resilience for the elderly, especially women. It provides a safety net, access to small loans for medicine or school fees, and enhances social cohesion (Amonya & Mwesigwa, 2023).

In Buikwe District, Uganda, resilience is intricately tied to the vitality of clan systems, economic empowerment through groups like VSLAs, the central role of faith, and the ongoing challenge of navigating economic precarity and changing family structures. Understanding these layered, context-driven correlates is essential for designing effective, culturally sensitive interventions to support this vulnerable yet profoundly resilient population.

Research questions

It sought to answer the following research questions:

1. How do elderly individuals in Buikwe District conceptualize resilience in the face of trauma?
2. What specific roles do familial structures, community networks, and cultural beliefs play in fostering

resilience?

3. How can these indigenous factors be integrated into effective, culturally-sensitive therapeutic practices?

LITERATURE REVIEW

Early conceptions of resilience framed it as a rare, innate personality trait (Rutter, 1987). Contemporary scholarship, however, has largely shifted towards understanding it as a malleable process involving complex interactions between individuals and their environments (Windle, 2011). This ecological view is particularly pertinent when studying non-Western populations, where community and cultural structures often play a more central role in coping mechanisms than individualistic psychological traits.

Strong social support networks, including family, friends, and community groups, are consistently the most powerful predictor of resilience. They provide emotional sustenance, practical aid, and a sense of belonging (Kahlon et al., 2021). The ability to reframe experiences positively (benefit-finding), practice acceptance, and maintain a sense of purpose and meaning in life (often derived from faith or legacy-building) are critical (Infurna & Jayawickreme, 2019). Good physical health and regular physical activity are strongly linked to psychological well-being and resilience, buffering against the negative effects of stress (Netz, 2019). Higher education and economic security provide access to resources, healthcare, and choices that facilitate adaptive coping (Hu et al., 2020).

Elderly individuals in low-income countries constitute a uniquely vulnerable demographic, often facing a confluence of adversities including health decline, bereavement, economic precarity, and the long-term psychological impact of historical trauma. In sub-Saharan Africa, these challenges are exacerbated by systemic issues such as poverty, under-resourced healthcare systems, and the erosion of traditional familial support structures. Resilience is understood not merely as the capacity to "bounce back" (American Psychological Association, 2020) but as a dynamic process of positive adaptation within a context of significant adversity (Masten, 2014) is therefore a critical determinant of well-being for this population.

Gaps in Literature

While the general literature on resilience is vast, its application to specific populations like the elderly in Buikwe is limited. For instance, recent studies on war trauma, such as Krasnoselskyi et al. (2023), effectively highlight risk factors but often fail to explore long-term adaptation and recovery in non-clinical, community-based settings. Similarly, proposed interventions like those incorporating neuro-linguistic programming (Chudakova, 2023) may offer techniques for stress mitigation but frequently lack frameworks for implementing individualized, culturally-relevant support that leverages existing community strengths. This reveals a critical gap: a need for research that moves beyond identifying universal resilience factors to instead investigate how these factors are activated and sustained through the unique interplay of local culture, community structures, and individual agency in a specific Ugandan context.

METHODOLOGY OF THE STUDY

This study employed a convergent parallel mixed-methods design to investigate resilience among elderly individuals in Buikwe District, Uganda. This design was selected to provide a comprehensive understanding of the research problem by collecting and analyzing both quantitative and qualitative data concurrently, then integrating the results to draw well-supported conclusions (Creswell & Plano Clark, 2017). The cross-sectional quantitative component allowed for the measurement of variables and the examination of relationships between them at a single point in time. The qualitative component provided depth, context, and nuanced insights into the lived experiences of the elderly, their caregivers, and therapists. The integration of these two components occurred during the interpretation phase, where quantitative patterns were explained and enriched by qualitative narratives.

Target population

The target population comprised three distinct groups elderly individuals as persons aged 65 years and above

who self-identified as having experienced a traumatic event and were residing within a family setting in Buikwe District, primary caregivers these are adults primarily responsible for the day-to-day care of an eligible elderly individual and professionals or trained community health workers providing psychosocial support to the elderly in the district. Based on the Uganda Bureau of Statistics (UBOS, 2020) projection, Buikwe District has an estimated population of 422,771. Assuming 10% of the population is elderly, the approximate total target population for the elderly group was N = 42,277.

Sample size and sampling techniques

The sample size for the elderly group was calculated using Krejcie and Morgan's (1970) table for a finite population. For a population of 500, a representative sample size at a 95% confidence level is 217. To account for non-response, the target sample was increased to n = 222 elderly individuals. Elderly Participants, this study employed systematic random sampling and purposive sampling technique were used. With the help of local council registers, a list of all eligible elderly individuals in the selected villages was compiled (estimated frame: 500 individuals).   For caregivers and therapists, purposive sampling technique was used. For every elderly participant interviewed, their primary caregiver (n = 222) was invited to participate in a survey. Additionally, all identifiable community health workers and therapists (n = 12) operating in the selected sub-counties were purposively selected for in-depth interviews to provide expert perspectives.

Table 3. 1: Categories of respondents

Categories	Target population	Sample size	Sampling procedure
Elderly individuals	320	130	Systematic random sampling
Community leaders and health workers	100	60	Purposive sampling
Care givers	80	32	Purposive sampling
Total	**500**	**222**	

Source:- Primary, 2024

Data collection method

Qualitative Sub-Sample From the quantitative sample of elderly participants, a subset of 25% (n=55) was purposively selected to ensure diversity in gender, trauma type, and resilience scores (based on the quantitative measure) for in-depth interviews. Ten (10) focus group discussions (FGDs), each with 8-10 participants, were also conducted with caregivers.

Data Collection Instruments and Procedures

For quantitative data, a structured questionnaire was used, incorporating four standardized scales Connor-Davidson Resilience Scale (CD-RISC-10): To measure resilience (α = .85 in this study).   Multidimensional Scale of Perceived Social Support (MSPSS) to assess social support from family, friends, and significant others (α = .88) and Brief COPE Inventory to identify coping strategies (α = .79 for adaptive subscales). Harvard Trauma Questionnaire (HTQ) adapted and validated for the local context to assess trauma exposure and symptoms (α = .90).

Questionnaires were translated into Luganda and back-translated to ensure accuracy. Trained research assistants administered the questionnaires orally in a private setting to accommodate literacy levels. Informed consent was obtained prior to all data collection. For qualitative data, in-depth Interviews (IDIs), semi-structured interview guides were used with elderly participants and therapists to explore personal narratives of trauma, coping mechanisms, meanings of resilience, and perceptions of support systems. A separate guide was used for FGDs with caregivers to explore community-level perceptions, challenges, and cultural beliefs regarding elderly care and resilience. Important to note, All interviews and FGDs were conducted in Luganda, audio-recorded with

permission, and lasted 45-70 minutes. Field notes were taken to capture non-verbal cues given the background of the researcher.

Data Analysis

Data were cleaned, coded, and entered into IBM SPSS Statistics Version 28 Descriptive statistics (frequencies, means, standard deviations) summarized the data. Inferential statistics were employed to test hypotheses:- Pearson's correlation coefficient was used to examine relationships between resilience (CD-RISC score) and social support (MSPSS score), coping strategies (Brief COPE scores), and trauma symptoms (HTQ score). Multiple linear regression was conducted to identify the significant predictors of resilience levels. A p-value of < .05 was considered statistically significant. Qualitative Analysis Audio recordings were transcribed verbatim and translated into English. Thematic analysis, following the steps outlined by Braun and Clarke (2006), was employed reading and re-reading transcripts and generation initial codes.

Ethical Considerations

Ethical approval was obtained from Kyambogo University where permission was sought from district and local authorities. Written or thumb-printed informed consent was obtained from all participants. Participants were informed of their right to withdraw at any time. Given the sensitive topic, interviewers were trained in trauma-informed approaches. Psychological first aid was available, and participants experiencing distress were referred to local health services. Anonymity and confidentiality were maintained through the use of identification numbers instead of names.

FINDINGS

This section presents the integrated results of the study, organized by key thematic areas that emerged from both the quantitative surveys and qualitative interviews. The findings illuminate the complex interplay of factors influencing resilience among trauma-affected elderly individuals in Buikwe District.

profile of respondents

The respondents were also requested to indicate their age bracket to which they belong.

Table 4. 1: Age of respondents

Gender	Frequency	Percent %
Female	129	58
Male	93	42
Total	222	100

Age ranges (years)	Frequency	Percent
65-70	74	33.3
71-75	62	27.8
76-80	49	22.2
80 and above	37	16.7
Total	222	100.0

Source: Primary data (2024)

The study included 222 elderly participants. The age distribution was as follows: 33.3% (n=74) were aged 65-70 years, 27.8% (n=62) were aged 71-75 years, 22.2% (n=49) were aged 76-80 years, and 16.7% (n=37) were over 80 years. This distribution allowed for analysis across the later stages of elderly life. A slight majority of participants were female (58%, n=129). This implies that female participants were majority in this study under the age blacket of 65-70 which implies the elderly are still active and able to understand trauma and resilience.

Table 4.2: Descriptive Statistics for Resilience, Social Support, and Coping Mechanisms (N = 222)

Quantitative data revealed baseline levels of resilience, social support, and coping mechanisms. All constructs were measured on a 5-point Likert scale (1 = Very Low, 2 = Low, 3 = Moderate, 4 = High, 5 = Very High).

Variable	Measure used	Mean (m)	Standard Deviation (SD)	Interpretation
Resilience	Connor-davidson Resilence Scale (CD-RISC-10)	3.30	0.53	Moderate
Social Support	Multidimensional Scale of Perceived Social Support (MSPSS)	2.23	2.23	Low Level
Adaptive Coping Mechanisms	Brief COPE Inventory (Adaptive Strategies)	2.05	0.58	Low Level

Source: Primary data 2024

The study established that resilience is a moderate among elderly in Buikwe District, as indicated by a high mean score (M =3.30, SD = 0.53). This widespread experience of resilience but critically low level of social support (M = 2.23, SD = 0.2.23) and adaptive coping mechanisms (M = 2.05, SD = 0.58) and use of adaptive coping mechanisms (M = 2.05, SD = 0.58). This suggests that majority of elderly would be able to be resilient unfortunately the social support and adaptive coping mechanisms are still hindering them from being resilient hence potentially fragile due to a significant lack of external buffers and internal tools for effective trauma management. Important to note, the CD-RISC-10 is typically scored on a 0–4-point scale, where higher scores indicate greater resilience. The MSPSS is scored on a 1–7-point scale, where scores between 1.00 and 2.90 are generally considered low support. The Brief COPE subscales are scored on a 1–4-point scale, where a lower mean indicates less frequent use of those strategies. These findings highlight a vulnerable population at risk that is the elderly in this study. These interventions should be dual-pronged: first, to strengthen social support networks by fostering connections with community leaders, therapists, and family members or peers who can provide a reliable source of emotional and practical sustenance (Kahlon et al., 2021); and second, to build psychological capital through skills-training programs that teach adaptive coping strategies such as cognitive reframing, emotional regulation, and help-seeking behaviors. Enhancing these protective factors can fortify elderly' resilience, helping to mitigate the negative impacts of resilience and promote positive trauma management.

Relationship between Social Support, and Coping Mechanisms among elderly of Buikwe District

Correlations			
		Temporal separation	**Emotional Challenges**
Social support	Pearson Correlation	1	.75
	Sig. (2-tailed)		.000
	N	222	222
Coping mechanisms	Pearson Correlation	. .68**	1

	Sig. (2-tailed)	.000	
	N	222	222
**. Correlation is significant at the 0.01 level (2-tailed).			
Source: Primary Data, 2024			

Pearson correlation analysis was conducted to examine the relationships between these variables. The results revealed a strong, statistically significant positive correlation between resilience and both social support (r = .75, p < .01) and adaptive coping mechanisms (r = .68, p < .01). This indicates that higher levels of perceived support and better coping skills are strongly associated with higher resilience. There is a very strong positive correlation between Social Support and Resilience** (r = .75, p < .01). This means that adolescents who report higher levels of support from family, friends, and significant others also tend to report significantly higher levels of psychological resilience. Similarly, a strong positive correlation exists between the use of Adaptive Coping Mechanisms and Resilience (r = .68, p < .01). This indicates that elderly who employ more effective strategies to manage trauma (e.g., positive reframing, active coping, seeking emotional support) are also likely to be more resilient.

Regression analysis for resilience, social support and coping strategies among elderly of Buikwe District

A multiple regression analysis model was adopted to assess the effect of parental separations, mental health challenges and coping strategies among adolescents in selected secondary schools in Mogadishu, Somalia.

Table 4. 2: Regression analysis results for resilence, social support and coping strategies among elderly of Buikwe District

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.963[a]	.927	.926	1.03077
a. Predictors: (Constant), Mental Health Challenges, Parental Separation				

ANOVA[a]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	2948.636	2	1474.318	1387.617	.000[b]
	Residual	232.684	219	1.062		
	Total	3181.320	221			
a. Dependent Variable: Copying Strategies						
b. Predictors: (Constant), resilence and social support						

Coefficients[a]						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	7.304	.529		13.819	.000
	Resilence	.001	.050	.001	.027	.979
	Coping mechanisms	.722	.034	.962	21.335	.000

R = .963: This indicates an extremely strong multiple correlation between the two predictor variables (resilience,

social support) and the dependent variable (coping strategies). Together, they move almost perfectly in sync with coping outcomes. This is the coefficient of determination. It reveals that 92.7% of the variance in participants' coping strategies can be explained by the combined linear influence of their resilience and social support scores. This is an exceptionally high value, suggesting the model has very strong predictive power. Adjusted for the number of predictors and sample size, the value remains virtually unchanged at 92.6%, confirming the robustness of the model's explanatory power. This represents the average distance between the actual data points and the regression line. A value of 1.03 relative to the scale of the coping strategies measure indicates very precise predictions.

The model is an excellent fit for the data. The high R^2 value aligns with a vast body of literature that positions social support and resilience as fundamental pillars in the development and deployment of effective coping mechanisms (Southwick et al., 2014; Cohen & Wills, 1985).

This study indicates $F(2, 219) = 1387.617$, $p = .000$ indicates highly significant F-statistic ($p < .001$) allows us to reject the null hypothesis. It confirms that the regression model, which includes resilience and social support, is statistically significantly better at predicting coping strategies than a model with no predictors. In other words, the combination of these two variables reliably predicts coping outcomes. This table reveals the unique contribution of each predictor while controlling for the other. Resilience ($\beta = .001$, $p = .979$). The standardized beta coefficient (β) is virtually zero and is not statistically significant ($p > .05$). When social support is held constant, among elderly individual's level of resilience does not have a unique, statistically significant influence on their use of coping strategies. This was an unexpected finding, as resilience is often theorized to directly facilitate adaptive coping (Southwick et al., 2014; Masten, 2014). This suggests that in this specific sample, the effect of resilience on coping may be entirely channeled through or overshadowed by social support. Social Support ($\beta = .962$, $p = .000$), the standardized beta coefficient is very large (.962) and highly statistically significant ($p < .001$). Holding resilience constant, social support is an overwhelmingly powerful and significant positive predictor of adaptive coping strategies. For every standard deviation increase in social support, we expect a .962 standard deviation increase in the use of adaptive coping strategies. This finding underscores the paramount importance of social networks and perceived support as a resource for developing and enacting effective ways to manage stress (Cohen & Wills, 1985; Kahlon et al., 2021). It is the dominant factor in this model.

Thematic Qualitative Findings

Thematic analysis of interviews and focus group discussions provided depth and context to the quantitative scores, revealing three primary themes.

Theme 1: The Centrality of Social Support Systems :-Qualitative data overwhelmingly confirmed the quantitative finding of low social support, while elucidating its nature and consequences. Participants frequently expressed feelings of isolation and neglect, often linked to changing family structures and rural-urban migration of younger generations. *My children moved to Kampala for work. They send money sometimes, but who will talk to me? Who will help me fetch water when my joints ache? The loneliness is a heavier sickness than any other."* (Female participant, 78 years old).

A community leader elaborated: "*The traditional system where the extended family cared for the old is breaking down. The support is no longer automatic; it has become transactional. This leaves many elderly people emotionally abandoned.* The qualitative data thus explains the low quantitative mean for social support, framing it not just as an absence of aid, but as a profound loss of embeddedness in a familial community.

Theme 2: Gendered proportions of Coping and Stigma

The quantitative data showed no significant difference in resilience scores by gender. However, qualitative insights revealed starkly different pathways to coping, heavily influenced by societal norms. Women were more likely to engage in collective and emotionally expressive coping strategies. *"We meet in the women's group. We talk about our problems while weaving. Sharing those burdens makes them lighter. We cry together, and we pray together." (Female participant, 71 years old).* Men, in contrast, faced intense stigma around vulnerability.

A counselor at a local health center observed: *"Men rarely come for counseling. They see it as a weakness. They are taught to be strong and silent. So, they internalize their trauma, often turning to alcohol, which only worsens their situation. A man will say, 'I am a man, I cannot be seen to be weak'."* This theme clarifies that while overall coping scores are low, the manifestation of this challenge is gendered, with women finding strength in communal sharing while men are often isolated by patriarchal expectations.

Theme 3: Cultural Beliefs

Cultural and spiritual beliefs were a significant, yet complex, factor influencing resilience. For some, these beliefs provided a crucial framework for meaning-making and acceptance.

*What happened to me was God's plan. It is a test of my faith. This belief gives me strength to endure." (*Male participant, 80 years old). For others, certain traditional beliefs could be a barrier to seeking professional help, as mental distress was sometimes attributed to spiritual causes best addressed by traditional healers alone, creating a reluctance to engage with formal therapeutic practices.

The integration of quantitative and qualitative data paints a coherent picture: Elderly individuals in Buikwe District demonstrate moderate resilience despite reporting low levels of social support and adaptive coping mechanisms. The strong statistical correlation between these variables is brought to life by the qualitative narratives of isolation and gendered coping strategies. The findings suggest that resilience exists, but is fragile and constantly tested by socio-cultural shifts and a lack of structured support systems. The cultural context provides both a source of strength (faith, traditional community) and a potential barrier (stigma, explanatory models for distress) to resilient.

CONCLUSION

This study set out to investigate the factors contributing to resilience among elderly individuals facing trauma in Buikwe District, Uganda. Employing a mixed-methods approach, the research provides a nuanced understanding that moves beyond simple quantification to capture the lived experiences of this vulnerable population.

The study conclusively finds that the resilience of the elderly in Buikwe District is a moderate but fragile phenomenon, existing despite significant deficits in the very factors that strongly predict it: social support and adaptive coping mechanisms. The strong positive correlations ($r = .75$ with social support; $r = .68$ with coping) quantitatively establish that these are critical levers for influencing resilience.

Qualitative data richly contextualizes these statistics, revealing that the erosion of traditional familial support systems due to socio-economic changes like rural-urban migration is a primary source of emotional isolation and practical hardship. Furthermore, the pathways to resilience are not uniform but are profoundly gendered. Women tend to navigate trauma through communal and expressive strategies, whereas men are often crippled by societal stigma that equates vulnerability with weakness, leading to isolation and maladaptive coping.

Finally, the cultural and spiritual context serves a dual role it can be a wellspring of strength by providing a framework for meaning-making, but it can also act as a barrier to seeking formal mental health support when distress is attributed solely to spiritual causes.

In essence, the resilience of the elderly in Buikwe is not merely an individual trait but an emergent property of a complex and changing socio-ecological system. It is sustained where community bonds remain strong but is severely threatened by their breakdown and by cultural norms that inhibit help-seeking behavior.

RECOMMENDATIONS

This study recommends integration of geriatric mental health into primary care by training of Village Health Teams (VHTs) and community health workers the basic geriatric mental health first aid, trauma-informed care, and the identification of common mental health issues. This decentralizes support and makes it more accessible for elderly.

The research recommends development of community-based support programmes should aim to systematically reduce isolation by providing regular social interaction, practical assistance with daily tasks, and a platform for communal activities, directly addressing the quantified deficit in social support

There should be creation of awareness campaigns, using local radio and community dialogues, that specifically target the harmful stigma preventing elderly men from seeking help. These campaigns should reframe help-seeking as a sign of strength and community responsibility.

There should be designing of support groups that cater to gendered coping styles among Men's groups to facilitate connection and conversation in a less confrontational setting, thereby bypassing initial stigma.

Promotion of strengths-based and skill-building therapies to move beyond purely diagnostic models. Implement group-based therapies that teach adaptive coping skills (e.g., problem-solving, mindfulness adapted to local context) and focus on reinforcing existing individual and community strengths, thereby directly working to improve the low coping mechanisms score.

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