

Leaving Home: An Examination of Late-Life Relocation Among Older Adults

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This article describes older adults' experiences of a late-life residential relocation from a home to a long-term health care setting. Findings from 14 participants who engaged in a focus group and/or an individual interview supported 8 major themes. Thematic experiences were related to precipitating factors prior to the move, risks and protective factors in relocation, and aspects of positive aging. Implications for clinical practice with older adults who undergo late-life transitions are described.

Demographic trends over the last century in the United States reflect a dramatic population shift. The number of older adults (aged 65 years and above) has tripled from just over 4% of the population in 1900 to 12.8% in 2008 (Administration on Aging [AoA], 2009). Within the next 20 years, close to one fifth (19.3%) of the U.S. population is expected to be over 65 years old (AoA, 2009). The cohort of older adults itself is also aging rapidly, with the biggest shifts occurring among adults over age 85. At 5.7 million persons, this group is 47 times larger than it was at the start of the 20th century (AoA, 2009). In light of an American landscape increasingly characterized by an older demographic, there is a call now, more than ever before, for counselors to be educated about both the specific mental health concerns and the developmental and contextual issues facing this unique population.

Historically, older adults have been underserved by counseling professionals (Gatz & Smyer, 2001; Myers & Harper, 2004; Myers & Schwiebert, 1996). Although they make up 12.4 % of the population (AoA, 2007), older adults receive only 2% of private mental health services, 6% to 8% of community mental health services, and 7% of inpatient mental health services (Bartels & Smyer, 2002; Myers & Harper, 2004; Robb, Chen, & Haley, 2002). When untreated, diagnosable mental health disorders in older adults are related to lower levels of functioning and life satisfaction, higher levels of stress among caregivers, and higher mortality rates (Swett & Bishop, 2003; U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Institutes of Health, National Institute of Mental Health, 1999). In addition to diagnosable disorders, older adults face numerous developmental transitions that may require counseling intervention, including retirement, parenting grandchildren, and managing multiple losses (Broderick & Blewitt, 2003; Myers & Harper, 2004; Myers & Schwiebert, 1996). A developmental transition that has received little attention from counseling professionals, however, is late-life relocation (Krout & Wethington, 2003). Relocation involves more than just the move itself; it begins with the circumstances and decision-making process surrounding a move and extends

to the adjustment period after the move (Johnson & Hlava, 1994). The middle-old to older-old population (aged 75 years and above) is especially likely to experience a late-life relocation to long-term health care settings (e.g., nursing homes, which provide 24-hour health care, and assisted living facilities [ALFs], which provide support with activities of daily living). The AoA (2009) reported that 4.4% of individuals ages 75 to 84 years live in such settings, and the number increases to 15.4% for those over 85 years. When demographic trends toward an aging older adult cohort are coupled with statistics indicating that older-old adults (85 years or more) are increasingly likely to experience a residential relocation, the importance of examining late-life transition emerges. Of particular interest to counselors is that little is known about the lived experience of late-life transition and its impact on older individuals' mental health (Krout & Wethington, 2003). Understanding more about the psychogenic issues associated with late-life transitions is important for many reasons.

First, developmental opportunities present in late-life transitions are mediated by the presence of intrapersonal and environmental elements that either support (i.e., protect) or hinder the growth process (Bronfenbrenner, 2005), and research points toward numerous risks related to relocation. In general, relocation transitions are among the top 10 life stressors for people of any age (Mead, Eckert, Zimmerman, & Schumacher, 2005) and are associated with loss of social support systems and fear of the unknown (Drummet, Coleman, & Cable, 2003). Although these stressors are also documented in late-life relocation (Lee, Woo, & Mackenzie, 2002), older adults face specific risks that cause the move to long-term health care facilities to be especially taxing; these risks include impaired functioning, disturbances in behavior, grief, various physiological and immune system stress responses, and elevated mortality rates (Farhall, Trauer, Newton, & Cheung, 2003). Depression is another serious risk faced by men and women who reside in all types of long-term health care settings (Grayson, Lubin, & van Whitlock, 1995; Jones, Marcantonio, & Rabinowitz, 2003; Lawton, Parmelee, Katz, & Nesselroade, 1996). Residents of ALFs, for example, are three times more likely to experience depressive symptoms than are

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community dwelling older adults (Cuijpers & van Lammeren, 1999). Moreover, moving to a community where one's peers are predominantly aged, physically impaired, or possibly confused may be threatening to older persons who fear that their health may similarly deteriorate (Lee et al., 2002).

Second, the protective factors and potential benefits of a transition to long-term health care have not been adequately described (Keister, 2006). Most research involving older adults focuses on the detriments of aging while ignoring aspects of wellness in the older population (Cummings, 2002; K. J. Gergen & Gergen, 2000; M. M. Gergen & Gergen, 2003). Attending to protective factors and possible benefits of relocation is important in a time when older adults are enjoying better health and longevity than have previously been seen. Theories of aging are beginning to focus on life-span development from a positive perspective (Morrow-Howell, Tang, Kim, Lee, & Sherraden, 2005) and are concerned with breaking down negative stereotypes so the aging process can be reframed as a normal, healthy, and vibrant facet of the life cycle (M. M. Gergen & Gergen, 2003; Juengst, 2005). The emphasis on reconstructing aging as a positive process fits well with counselors' attention to using clients' intrapersonal strengths and environmental resources to create constructive counseling outcomes (e.g., Myers, Sweeney, & Witmer, 2000; Sweeney & Myers, 2003).

Third, the transition out of one's home and into a long-term health care setting is an important and meaningful lived human experience. Van Manen (1997) described *home* as the place "where we can be what we are" (p. 102) and suggested that "the home reserves a very special space experience which has something to do with the fundamental sense of our being" (p. 102). Indeed, the lived space of home is often seen as an extension of the human person that is closely linked with a sense of identity (Moore, 2000). When significant social interactions and personal experiences occur in the home space over the course of time, individuals develop strong feelings that bind them to that space (Leith, 2006; Rubinstein & Parmalee, 1992). The home-leaving transition is significant for many older adults because they tend to have lived in their home much longer than other age groups (i.e., a median of 22 years; U.S. Bureau of the Census, 2002) and prefer to stay in their home as they age, even if their health becomes impaired (Fogel, 1992; Mutschler, 1992).

Professional counselors are increasingly likely to encounter older adults in their clinical practice (Myers & Harper, 2004). Because of this likelihood, an important related developmental transition deserving of their further attention is late-life relocation. In this article, I examine the experiences of middle-old to older-old adults (i.e., 75 years and older) who have transitioned from their homes into ALFs. The central research question under investigation was, How do older adults experience a late-life transition when they move from their home into an ALF? The goal of the inquiry was to create a rich description of the meaning of relocation and describe nuances in the

process that have yet to be accounted for, especially among the oldest segment of the older adult population.

Method

The research question in this study is related to a concern that developmental experiences of older adults, and in particular the phenomenon of a late-life transition, have been understudied (Myers & Harper, 2004). Patton (2003) argued that research methodology should serve the central question of an investigation. Because the goal of the inquiry was to learn more about how older adults experience relocation to assisted living settings and about the meaning they attach to leaving their homes, I chose a qualitative, phenomenologically oriented methodology (van Manen, 1997) for this study.

Participants

For this study, I interviewed 14 participants (four men and 10 women); their mean age was 85.17 years, with a range of 75 to 98 years. All but one of the participants was a widow or widower. All participants were White Americans who had completed high school; one had completed college, and two also had a graduate degree. The participants were a purposeful sample (Patton, 2003) of older adults who (a) had resided in an ALF for at least 2 months, (b) had relocated from a home residence, and (c) displayed minimal or no mental deterioration and did not live in an Alzheimer's-designated building or unit. Choosing individuals who had at least 2 months to adjust to the transition helped to ensure that they would have had opportunities to reflect on the move to assisted living. Van Manen (1997) suggested that "A person cannot reflect on lived experience while living through it" (p. 10). Moreover, to capture the meaning attached to leaving one's home, it was also essential that the participants had transitioned from a home rather than another type of facility. The five sites that were chosen as the settings for the investigation were required to be licensed residential care facilities that had no consumer complaints lodged against them.

Procedure

I sent a letter describing the nature of the study and requesting permission to conduct the investigation to directors of 17 qualifying facilities. I made follow-up telephone calls and personal visits to sites 2 weeks after the letter of interest was sent. Administrators of five sites agreed to participate in the investigation; either the administrators or the directors of nursing or activities compiled a list of potential participants who met the criteria for the study. I explained the purpose and scope of the investigation to all potential participants, who were given an opportunity to ask questions before consenting to participate in a research interview.

Prior to data collection, I developed a semistructured interview guide for use in all of the interviews. The questions,

formulated after a review of the literature (e.g., Rossen & Knaf, 2003; van Manen, 1997), were designed to reveal how participants' lived experiences of their surroundings (i.e., space), body, time, and human relationships had been affected by their transition. I attempted, through the questions, to uncover protective factors and barriers that emerge in a transition to assisted living. Examples of questions from the interview protocol are as follows: (a) What has the move to an ALF meant to you personally? (b) How has the move had an impact on your social relationships? (c) How has the move had an impact on your physical well-being? (d) What factors helped you the most to adjust to your new living arrangements? and (e) What has been the most difficult part of moving to assisted living?

Data were collected through responses from one focus group and 10 key informant interviews, and through my own observations. Use of these three strategies can be considered methodological triangulation, which strengthened the trustworthiness of the findings (Patton, 2003). The focus group, comprising three women and two men, was 1½ hours in duration and was used to gather initial information about the transition experience. Conducting the preliminary focus group also allowed me to screen for individuals who might be able to give greater insight into the transition phenomenon through an individual interview. One female focus group participant later engaged in an individual interview. The key informant interviews, conducted after analysis of the focus group, were each 1 to 2 hours in duration and were used to investigate nuances in the rich information participants shared in the focus group (van Manen, 1997). All interviews were audiotaped in their entirety with the consent of the interviewees, and transcriptions from the interviews, along with my notes and observations, served as the primary sources of data. The entire process of data collection spanned about 2 months.

Researcher as Instrument

In the practice of qualitative research, the investigator tries to simultaneously enter into and observe the world of the participants (van Manen, 1997). Through the method of close observation, I became an instrument used to collect data about the older adults' experiences. I made a sincere effort to acknowledge the biases and passions (Finlay & Gough, 2003) that I brought to this inquiry so that I could focus on the voices of the participants. I approached the investigation as a White, female, middle-class counselor and pastoral minister who had a 7-year work history with older adults.

Analysis

Analysis essentially consisted of three major tasks. First, I transcribed all of the audiotapes verbatim and reflected on the transcriptions, in conjunction with my observations and notes, to identify recurring constructs, units of meaning (Kruger, 1979), and lived experiences (van Manen, 1997). The task of

transcribing the interviews and reflecting on the data began after the first focus group interview and continued until data collection was complete. Early analyses informed the data collection process by reshaping the interview probes I made after insights were gained through analysis. Thus, analysis could be considered iterative and recursive (Huberman & Miles, 1994). Second, I created an individual narrative, or case analysis, of the focus group and of each key informant interview (Patton, 2003). The process of completing the case analyses involved reviewing the transcriptions for patterns and constructs that seemed central to the interview and that were reflected in other interviews or in the literature. I generated a set of emergent themes and subthemes for each individual case. Finally, I conducted a cross-case comparison of the emerging themes and patterns in the focus group and key informant interviews to generate thick descriptions of the data (Denzin, 1989) and to increase the validity of the results (Patton, 2003). Cross-case analysis began after the individual analyses were completed and involved a process of comparing and contrasting themes, which added clarity to the themes and units of meaning and refined the themes and subthemes. When the cross-comparative analysis was complete, eight major themes had emerged. Analysis of data continued until no new themes emerged from the data and until the themes that did emerge constituted an integrated description of the residents' experiences (Patton, 2003).

To enhance the trustworthiness of the findings, two independent researchers provided an audit of the data. The first researcher, who had more than 20 years of experience in conducting qualitative research, conferred with me about emergent themes and provided critical insight into accomplishing theoretical triangulation, that is, bringing relevant literature (e.g., Bronfenbrenner, 2005; M. M. Gergen & Gergen, 2003; Ryan & Deci, 2000, 2006) to bear on the findings. The second researcher reviewed the data independently to provide a check on the accuracy of the major themes and subthemes derived from participants' experiences. Finally, I invited participants to contact me after the completion of the interview if they wished to share further comments or reflections. One participant contacted me by telephone, and her input was added to the data.

As with all research inquiries, there are limitations that must be acknowledged. First, socioeconomic information as well as details about the length of time participants had lived alone before relocation are not known. Second, the study is limited by the distinct absence among the participants of older adults with diverse racial/ethnic backgrounds. Achieving racial, ethnic, and even gender diversity may have been hindered in part because of gender differences in longevity and cultural differences in living arrangements among older adults (e.g., cultural groups that advocate individualism tend to promote residential privacy among older adults, while groups that adhere less strongly to individualism tend to encourage

older adults to live in multigenerational housing arrangements; Wilmoth, 2001). The homogeneity of the participants limits the ability to use the findings of this study to speak to the role of culture in late-life relocation.

Study Findings

Data analysis revealed eight major themes that addressed experiences that precipitated the move, risks and protective factors in relocation, and aspects or experiences of positive aging. The central themes and subthemes are described in this section.

Theme 1: Experiences With Health Challenges

All but one of the participants experienced a physical ailment(s) that limited their ability to care for themselves and their home. For some participants, relocation was an immediate response to a health crisis. For others, health setbacks began a reflective process about their future ability to live on their own. For example, one respondent stated, "That's why I'm here, 'cuz' I couldn't handle my house anymore. And the help was hard to get, and transportation was [iffy] and it was just easier." Another participant recalled, "One day, I got up in a hurry to answer the phone, and I pulled the muscle in my knee, and I was just debilitated. I couldn't drive. I couldn't get out to the grocery [store]." During the recovery process, the respondent wondered, "What if this were permanent? Suppose I had a stroke or something?" That rumination, which prompted her to begin visiting local ALFs, was the beginning of the relocation process.

Désire de ne pas être une charge/poids.

Theme 2: Desire Not to Be a Burden

The desire not to become a burden to family and friends, described by 12 of the 14 participants, is related to the experience of encountering health problems. The participants reported that while attempting to deal with their physical ailment(s), they felt hesitant about routinely asking family and friends to assist them. One respondent stated:

It was difficult to find somebody to pay to drive me back and forth to the doctor. My friends were doing it, and I just couldn't let them do it anymore, and it was a matter of pride. I thought: enough is enough. So I think that is what, more than anything else, cinched it—that I should get a facility that could take care of me.

Most interviewees reported that they did not want to impose on their family and friends' right to live their lives. For example, a participant commented, "You don't want to be a burden to your family now. They have their lives to live, and they need to be free to live them." However, two interviewees reported that the desire not to burden others was an attempt to guard their own rather than others' independence. For example, one resident stated,

Désire d'indépendance.

I guess I just felt . . . by this time I had been on my own so much, being independent about making decisions . . . but basically I was so independent that I guess I didn't want to go and live with my children because I wouldn't be independent.

Theme 3: Loss of Independence and Autonomy

The loss of independence was one of the most prominent risk factors related to relocation. On a practical level, the sense of diminished independence was related to the participants' experience of giving up their car when they moved to ALFs. One female resident stated, "I had a lot of misgivings about coming here, especially when I realized that you couldn't have a car. That takes away your freedom. That's the big thing."

Other participants reported a loss of overall self-directedness that occurred with the transition. For example, participants stated that they were not able to set their own schedule or make decisions about day-to-day living. It became evident through this theme that home was a symbol of autonomy to the interviewees. One resident stated:

Meaning of home.

What I miss about not having my own home is the ability to get up when I want to get up—to eat breakfast or lunch or dinner when I want to eat. In a facility like this, there's no way they could do that. You have to have regimentation. So, it's the same old, same old everyday routine. I go to the dining room at 7:30, whether you're hungry or not, and lunch is at 11:30, whether you're hungry or not.

Residents who experienced the loss of autonomy seemed to feel powerless over the administrative system and unable to control rudimentary decisions. One respondent said, "We have choice, but it's only temporary as far as I'm concerned." Another declared, "I have no independence. I have to do what I'm told to do—when I am told to do it." These residents also did not seem at peace with their life in assisted living. One participant stated, "Let's say I'm contented. I won't say happy. I would say contented. I say contented because this is the way it's got to be, but I'm not at home. I'm not doing what I'd like to do."

An extreme aspect of this theme is the lived experience of being imprisoned. One resident, when talking about the impact the move to assisted living had on her children, said, "I think they feel relieved that they don't have to pay any attention to me because now I'm locked up somewhere, and they know I'll get three squares a day." Another participant said,

I always said this is a first class jail! It's all dressed up, but you eat when they tell you to eat, when they tell you to go to bed, when they tell you to get up. And when you [are] in jail, they have rules. At a certain time they march 'em in there to eat, and the food—they call it slop—only this is done in a delicate way.

Theme 4: Loneliness and Disconnectedness

Interviewees also talked about loneliness as a risk of transitioning. For some participants, the feeling of loneliness was strongest during the beginning of the adjustment process, but it eventually decreased when they met other residents. For others, the experience of being disconnected was more long lasting. One participant, who lived in a facility for a year and a half, said, “You don’t know what loneliness is until you come to one of these places!” Another stated:

A lot of the people that were here have passed away. The people I was accustomed to. Now, I hardly know any of the people. New ones coming in and I don’t know ‘em. And I stay in my room more. I never stayed in my room like I do now. I used to get out and mingle . . . but that’s out the window.

Prédominance de la mort. pensées. This resident explained the impact of having witnessed the deaths of acquaintances in the ALF: “It’s terrible,” she said. “All you think about is dying. I just don’t want to mingle and meet new people anymore. I would rather be in here [her room].”

Theme 5: Experiences Related to Stereotypes About Aging and Older Adulthood

Participants described living with the effects of stereotypes that are often related to older adulthood and the aging process. For some participants, relocation was perceived as contributing to a sense of uselessness. One respondent stated that with the move to assisted living she “became more useless. At least I was self-sufficient where I was. I had that satisfaction of being self-sufficient.” Several participants addressed their perception of being seen as senile or incompetent. In a statement about the activities, one resident declared,

They have different things they do, and it reminds me of being in the kindergarten. I’m not interested in the kinds of stuff they do. I don’t want to waste my time. I call it simplistic. They treat us like we can’t think . . . just ‘cause we’re old doesn’t mean we can’t think!

Sentiment d’être considéré comme un enfant.

A second participant said she felt “patronized” by the activities, while a third respondent did not want to participate in activities in which she was asked to “take stickers and put ‘em on buckets and boxes and tie ribbons—dumb stuff like that.”

Theme 6: Relatedness as a Support

Despite the risks related to relocation, residents reported important protective factors, one of which was a sense of relatedness to family, friends, and residents and staff at the facilities. One resident stated, “I still have my friends. I pick up the phone and call them. They call me. You know, we keep in touch.” Receiving telephone calls, mail, and personal visits from friends all played a role in residents’ ability to adjust.

Forming new and meaningful relationships in the ALF was also a factor in the older adults’ sense of connectedness. One male resident described his friendship with a woman at the facility:

I have a woman, well, she’s a resident here. Boy, she’s helped me out a lot. She and I just got friendly. The girl . . . my girlfriend, well, I guess she is my girlfriend, she was lonely when I got here. We get along famously.

Relationships with caring staff members also acted as a support to the older adults. One resident stated of the staff, “The staff here is amazing. There are two women here that I’m especially thankful for—they have that way of coming into a person’s room and you know it’s going to be OK.” Another resident stressed the importance of the site administrator calling residents by name. She said, “It means to me that she knows who I am, and I certainly know who she is. It means a real family.”

Theme 7: Experiences of Decision Making and Personal Choice

The residents who had positive transition experiences and adjusted well were those who fully engaged the decision-making process and who had ongoing opportunities to act autonomously after the transition. The benefit of being involved in the decision-making aspect of relocation was described by one participant:

This sounds crazy, but I never encountered any difficulty in making the transition. See, I made the decision. The kids didn’t come and say, “We think you ought to be moving into something.” I made the decision. I’m queen of the mountain here!

Residents who contemplated and researched the move were invested in the decision to relocate. However, not every participant was involved in the decision-making process prior to the move; some had family members act on their behalf and initiate the transition. For these individuals, making personal choices still was important to their well-being. One respondent stated, “I think I’ve lost my sense of being independent. Not altogether, I still have independent thinking.” Another resident who reported feeling imprisoned said, “You don’t have any say so, but I don’t do everything they tell me to!”

Theme 8: Experiences of Positive Aging

A small cohort of participants seemed to thrive after the transition. They reported engaging in activities that enhanced their own sense of pleasure and enjoyment, forming new relationships, and serving others. One resident, who emphasized the importance of creating many interests for oneself, took up gardening and decided to learn how to paint with watercolors after relocating. She also became actively involved in the ALF’s library as soon as she moved; she shared, “When I first arrived, they asked what your special interests are and I put down library, so I’m one of the co-librarians now! And I enjoy that.” Another resident who stated of the move, “I can’t say that I regret it,” formed a close

Participation selon leurs intérêts permet de voir positivement la transition.

friendship with a resident who became his daily Scrabble partner, volunteered to be the resident council president, attended daily religious services, and maintained his commitments to various community and church organizations.

Discussion

The findings from this inquiry indicate that the circumstances preceding a transition to an ALF nearly always involve health challenges; these findings are consistent with prior research (e.g., Cummings, 2002). However, the pace of participants' transition experiences varied, depending on varying health ailments and the extent to which they were involved in the decision-making process. Residents who described being actively involved in the relocation decision seemed to have the most positive transition experiences. The initial phase of the relocation decision was characterized, additionally, by participants' desire not to become a burden to others. This theme seems to be a reflection of the multidimensional nature of human development in which distal elements, such as cultural values, can influence individual growth (Bronfenbrenner, 2005). Specifically, the theme highlights the often-binding effect of individualism, a mainstream American value, on older adults. K. J. Gergen and Gergen (2000) suggested that in cultures that value individualism, aging adults who are not in good health become a burden or a deadweight on family members. Wilmoth (2001) noted similarly that in countries that value individualism, there is a high incidence of residential privacy among older adults. To prevent becoming an imposition, some older adults, such as those in this study, may prefer living in an ALF to asking for assistance from family and friends.

Variations on the theme of independence were evident throughout all phases of the study. One of the most notable risk factors related to late-life relocation to emerge was loss of independence, a finding that has been noted by other researchers examining transitions to long-term health care settings (e.g., Lee et al., 2002). For some participants, independence referred to the way they lived out values related to individualism; thus, loss of independence reflected the loss of self-sufficiency. However, loss of independence also referred to loss of agency. When limitations on autonomy were felt, participants seemed especially frustrated and expressed a sense of powerlessness over the assisted living system. This theme illustrated the biggest contrast to what *home* meant to participants: Home was the space of freedom and individuality, while the ALF had the potential to feel constricting and regimented, even to the point of being perceived as imprisoning for a few. Self-determination theory (Ryan & Deci, 2000, 2006) identifies autonomy as a basic psychological need that must be met for human development to occur, and it provides one frame of reference for understanding how living in a residential care environment that is not perceived as autonomy-supportive can present a challenge to growth. By contrast, residents who consistently engaged in self-directed actions throughout the

entire relocation process, and whose proximal environment (e.g., staff in the ALFs) supported their need for autonomy, were able to tap into an important supportive factor for continued growth.

Two other themes—loneliness, a barrier to well-being, and relatedness, a supportive factor—played significant roles in residents' well-being. In this study, loneliness seemed to be related to numerous factors, including length of stay and the death of other residents in the facilities. Social relatedness, like autonomy, has been identified as a basic psychological need without which people are less able to activate their innate motivation toward growth (Ryan & Deci, 2000). This seemed to be true of participants in the study: Adults who felt lonely or disconnected from others evidenced less success in adjustment, whereas those who formed relationships within the ALF or maintained active relations with family and friends were more adequately supported after relocation. Similar findings were noted by Cummings (2002), who reported that ALF residents who described higher levels of perceived support had correspondingly higher levels of life satisfaction.

Perceptions of or experiences related to stereotypes about older adults posed limitations for many participants. Noteworthy among such experiences were residents' descriptions of some ALF-sponsored activities. Rather than being seen as a way to express a sense of competence, some activities seemed to minimize the potential for residents to make a meaningful contribution to the ALF community. Unfortunately, this aspect of residents' experiences enforced unspoken beliefs that the natural life course is necessarily defined by a period of decline in older adulthood. K. J. Gergen and Gergen (2000) and M. M. Gergen and Gergen (2003) proposed, however, that the process of aging need not be naturalized into a period of degeneration. When older adults resist succumbing to the culturally constructed worldview that aging is a period of decline, new possibilities for positive aging emerge. The participants who sought out opportunities for their own pleasure created new relationships, enhanced existing relationships, and served others in the ALF community stand as strong examples that human development is a lifelong endeavor. The perspective of decline in old age that has negatively influenced cultural beliefs about older adults was reshaped by residents who lived vibrant, active lives in the ALF.

Croyance populaire et leurs impacts sur les personnes âgées.

Implications for Professional Counselors

Working competently with the middle-old to older-old population who undergo a late-life residential relocation first requires counselors to reflect on their own attitudes and beliefs about older adults and the aging process so that they do not impose limitations on clients. Espousing stereotypes such as senility, incompetence, and uselessness pose a particular risk to the positive development of older adults. Second, because of the importance of autonomy to participants' well-being and motivation toward growth, I recommend that counselors assess resident-clients' level of self-

perte d'autonomie

directedness throughout the relocation process. Residents who make a transition in immediate response to a health crisis with little time to explore the many aspects of the decision may face greater difficulty tapping into internal motivation for psychological growth and development during this process. Counselors can help these clients by empathizing with the feelings of distress that are often created when people do not feel in control of their life. Assisting residents to identify hidden opportunities for acting autonomously can help them foster internal motivation and regain a sense of personal control. Third, professional counselors can respond to residents' apparent need for relatedness. One explanation for the participants' disengagement from interpersonal relationships with fellow residents was their heightened awareness of death and loss. Implementing strategies, such as grief and loss groups and memorial ceremonies for ALF residents who have died, may help older adults to deal with the loss of friends in the assisted living community and renew their desire to create new relationships. Finally, counselors should be open to advocating on behalf of older clients. Advocacy efforts are appropriate when clients are unable or are limited in their ability to self-advocate for systemic change. The disparity in power that some participants in this study felt (e.g., as seen in the metaphor of assisted living as a prison) suggests that advocacy may be appropriate when working with residents of ALFs. Specifically, counselors can create workshops for ALF staff members and administrators about the risks and supportive factors related to the transition to long-term care sites. Other strategies might involve practitioners in direct consultation with site coordinators or directors about ways to increase opportunities for positive aging within ALFs. As counselors continue to become aware of the needs of older adults, especially regarding late-life transitions, they will become increasingly well-positioned to collaborate with older individuals and, when needed, to advocate for their quality of life.

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