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Gayle Hersch PhD, OTR^a, Jean Spencer PhD, OTR, FAOTA^a, Emily Schulz MS, OTR/L^a, Ann Wiley MOT, OTR^a, Melanie Schwartz MOT, OTR^a, Kelsey Kearney MOT, OTR^a, Fritz McDonald MOT, OTR^a, Sheri McGaugh MOT, OTR^a & Shannon Tegethoff MOT, OTR^a

^a School of Occupational Therapy, Texas Woman's University, Houston Center, USA

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Adaptation by Elders to Relocation Following Hospitalization: Evaluation of a Model

Gayle Hersch
Jean Spencer
Emily Schulz
Ann Wiley
Melanie Schwartz
Kelsey Kearney
Fritz McDonald
Sheri McGaugh
Shannon Tegethoff

ABSTRACT. This study recruited ten elders on a transitional unit and tracked their relocation experience for six months. Purposes were to

Gayle Hersch, PhD, OTR (E-mail: GHersch@twu.edu) is Associate Professor of Occupational Therapy; Jean Spencer, PhD, OTR, FAOTA (E-mail: JSpencer@twu.edu) is Professor of Occupational Therapy; Emily Schulz, MS, OTR/L, and Ann Wiley, MOT, OTR are Doctoral Research Assistants; Melanie Schwartz, MOT, OTR, is Data Manager; and Kelsey Kearney, MOT, OTR, Fritz McDonald, MOT, OTR, Sheri McGaugh, MOT, OTR, and Shannon Tegethoff, MOT, OTR are Master's Research Assistants, School of Occupational Therapy, Texas Woman's University, Houston Center.

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(a) evaluate a model of adaptation to relocation, (b) examine contrasting relocation pathways, (c) identify adaptive challenges and strategies, and (d) analyze ways adaptive outcomes including relationships, activities, and personal care were attained. A mixed design included two qualitative interviews and three structured questionnaires. Findings revealed two relocation pathways, living with family and in formal support settings. A revised model emphasizes environmental supports and limits. Implications include the importance of assistance to elders and families before and after relocation, and a need to evaluate the model in other living circumstances. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2004 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Residential pathways, adaptive strategies, environmental support

The need to relocate to new living arrangements is an increasingly common occurrence for elders following hospitalization. Such changes are typically prompted by concern that former living arrangements cannot meet future daily care and health management needs. Studies conducted at a geriatric transitional unit operated by a county hospital district revealed that as many as one-third of the elders being treated for deconditioning in preparation for returning home needed a new living arrangement following hospitalization (Spencer, Hersch, Shelton, Ripple, Spencer, Dyer, & Murphy, 2002). Such new arrangements might include living with relatives who provide informal support, or formal settings such as a personal care home or nursing home.

Past research has examined decisions about returning home versus relocation following hospitalization of elders. Some authors have examined factors that influence choices of residential options during discharge planning from clinical facilities (Cox, 1996; Morrow-Howell, Chadiha, Proctor, Hourd-Bryant, & Dore, 1996). Others have investigated factors that influence choice of particular support options such as home care (Chadiha, Proctor, Morrow-Howell, Darkwa, & Dore, 1995) or nursing homes (Stegbauer, Engle, & Graney, 1995; Tsuji, Whalen, & Finucane, 1995). A major issue that influences whether elders can return home or need new living arrangements is the level of their functional support needs (Sarwari, Fredman, Langenberg, & Magaziner,

1998; Lysack, MacNeill, & Lichtenberg, 2001). In addition to functional needs, Groger's (1993) research on low income elders similar to those in this study indicates that decisions about long-term care options often emphasize consideration of the limits of informal support, including not only who could be recruited to provide help, but also how much assistance they could realistically provide.

Early research on relocation of elders was intended to study consequences of moves following revision of urban neighborhoods (Lawton, Nahemow, & Teaff, 1975; Lawton, 1976). Later research has examined relocation among well elders who often have residential options and decision-making timeframes that may not be feasible following the life course disruption of hospitalization (Henretta, 1986; Lawton, Moss, & Grimes, 1985; Speare & Meyer, 1988). There is also a history of research on moves by elders into nursing homes (Gubrium, 1993), and on interinstitutional relocation of elders who are already living in institutional settings (Bonardi, 1989; Mirtoznik, 1984). Such studies indicate that relocation can be a stressful experience both physically and psychologically (Barnhouse, Brugler, & Harkulich, 1992; Davis, Thorson, & Copenhaver, 1990).

A few studies have examined relocation as an evolving process, which was a fundamental premise of this study (Dellasega & Mastrian, 1995; Ryff & Essex, 1992; Young, 1990). Smider, Essex, and Ryff (1996) used the term "pathways" to examine adaptation to relocation longitudinally among healthy aging women. The concept of pathway indicates both establishment of direction and progression over time. The longitudinal perspective used in this study to examine relocation following hospitalization is also supported by previous research on the transition from hospital to home which indicates that the first six months are often a critical time during which adaptations are made (Bull, 1992; Gage, Cook, & Fryday-Field, 1997).

Previous research by authors of the study reported here revealed that many elders adapted successfully to new living arrangements following hospitalization with surprising openness to new experiences and positive expectations (Hersch, Spencer, & Kapoor, 2003; Spencer, Hersch, Eschenfelder, Fournet, & Murray-Gerzik, 1999; Spencer, Hersch, Aldridge, Anderson, & Ulbrich, 2001). Indicators of successful adaptation were found to include maintenance or establishment of social relationships, engagement in valued activities, and getting personal care needs met. Comparative review and synthesis of findings of these previous studies led to development of what Miles and Huberman (1994) refer to as a "conceptually ordered display" (p. 127) or "cognitive map"

(p. 134) that graphically represents major concepts and the relationships between them. We have called this graphic display a Model of Adaptation to Relocation (see Figure 1). Its development involved an iterative process of moving between evolving graphic representations and study findings. The model was intended to focus an evolving line of research and facilitate identification of key research questions, data collection processes and tools, and analytic concepts for future funding requests.

Major components of the model are personal qualities including adaptive experiences and sense of self, making the transition including the decision to move and living arrangement options available, the process of adaptation as reflected in alternative relocation pathways, and adaptive outcomes consisting of social relationships, valued activities, and personal care.

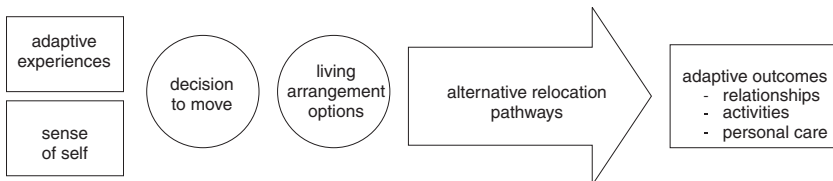
The study reported here was a continuation of a developing line of research on relocation by elders in various circumstances. Its purposes were (a) to evaluate the proposed model of adaptation to relocation, (b) to examine relocation pathways of elders who utilized contrasting informal and formal support arrangements following hospitalization, (c) to identify adaptive challenges and strategies used to address them, and (d) to analyze ways in which adaptive outcomes of relocation were attained by individual elders.

METHODS

Design

The study used a longitudinal design that integrated qualitative and quantitative methods (Tashakkori & Teddlie, 1998) in order to track elders intensively through home visits for six months after discharge from a geriatric transitional facility operated by a tax-supported county hospi-

FIGURE 1. Model of Adaptation to Relocation



tal district. Qualitative methods provided an insiders' perspective of elders and allowed intensive examination of individual adaptive processes, an issue of particular importance when studying low income elders with life experience and adaptive issues that have been underrepresented in previous research (Larson, 1994). Quantitative measures were intended to allow comparison across elders and examination of relationships between personal characteristics and contrasting relocation pathways. Although evaluation of models is often based on large-scale quantitative methods, a qualitative approach was chosen for this evaluation because of the value of detailed examination of individual cases that provides a basis for cross-case comparison (Miles & Huberman, 1994). The process of moving from coherent cases to broader cross-case analysis is commonly utilized in qualitative research (Patton, 2002). The study received Institutional Review Board approval from the clinical facility and two universities.

Participants

Participants were recruited from a geriatric transitional unit where persons are prepared for return to the community following hospitalization. Typical length of stay on this skilled nursing unit is three weeks. Selection criteria included persons who (a) had been hospitalized before admission to the unit, (b) had a diagnosis of one or more chronic illnesses, (c) were expected to be discharged to new living arrangements, and (d) had the cognitive ability in the judgment of program staff to respond to semi-structured qualitative interviews and a structured psychosocial questionnaire. Gender, ethnicity, and socioeconomic status were not formal selection criteria, though participants were typical of the "medically indigent" geriatric population on the transitional unit. This population, whose average age is 79 years, is approximately 2/3 women, with 64% being African-American, 17% Hispanic, 14% Caucasian, and 4% other ethnic background. Elders who met selection criteria were identified during weekly rounds by transitional unit personnel. Informed consent to participate in the study was obtained by a member of the project research team which included graduate research assistants trained and supervised by project faculty.

Data Collection

Components of the model of adaptation to relocation were addressed by various forms of data. Personal adaptive experience was docu-

mented through a life history interview conducted by a member of the project research team while participants were on the transitional unit. The Life History Interview Schedule developed for this project addressed (a) major experiences during various life phases, (b) adaptive challenges faced during the individual's lifetime, (c) adaptive strategies and how they were learned through life experience, and (d) things that made life worthwhile during various periods. Sense of self was assessed by interview using the 14-item scales from a structured questionnaire, the Scales of Psychological Well-Being (Ryff, 1989; Ryff & Keyes, 1995; Ryff & Singer, 1996) This instrument utilizes a Likert format to measure six dimensions of sense of self including autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. Sound psychometric properties of these scales and their parent 20-item scales have been well-established by the authors. However, in this study even though assistance was provided to elders who did not read and examples were provided to clarify language and explain the five-point rating scale, these instruments were difficult for participants to complete and often did not yield usable quantitative data from this population.

Information on reasons for the decision to move and living arrangement options was based on review of chart documentation on the transitional unit. Chart review provided information on the medical status of participants, their level of functional support needs, previous living arrangements, and family and social history, as well as data from the Mini-Mental Status Exam (Folstein, Folstein & McHugh, 1975) and the Geriatric Depression Inventory (Yesavage et al., 1983).

Relocation pathways were examined through home interviews conducted monthly for six months by pairs of project team members. An Adaptation Interview Schedule developed for this project addressed (a) the experience of moving to a new location, (b) elder's perceptions of the new living environment including both positive and negative aspects, (c) perceived adaptive challenges in becoming established in this setting, (d) adaptive strategies used and their outcomes, and (e) values and what currently makes life worthwhile. Home visits allowed observation of physical and social contexts of home and neighborhood and identified issues that might not be reported in an unfamiliar clinic setting. Observations were documented in field notes after each visit.

As indicators of adaptive outcomes, activities and personal relationships were documented using a modified version of the Self-Observation and Report Technique (SORT) (Rintala et al., 1984). This tool has demonstrated strong reliability and validity when completed either

face-to-face or by telephone (Rintala & Willems, 1991). In previous studies, interviewing techniques were developed for using this tool with low income elders similar to those in this project. The SORT documents activities and social contacts for a typical day during the past week and the locations in which activities were performed. It also gathers information about weekend or exceptional activities. An additional indicator of successful relocation, getting personal care needs met, was documented during home interviews using a modified version of the Barthel Index (Mahoney & Barthel, 1965; McGinnis et al., 1986). This tool was modified to document who provided assistance with specified personal care activities and elders' satisfaction with that provision. This brief 15 item index was chosen rather than a more fine-grained scale such as the Functional Independence Measure or FIM since capturing incremental changes in clients' independent performance of self-care was not intended.

Data Management and Analysis

Data from chart review and usable data from the structured Scales of Psychological Well-Being were entered into the project data base for each participant. Information on activities and social contacts from the SORT and on provision of care from the Barthel was scored according to guidelines developed for this project. Data from audiotaped interviews were transcribed into written text for analysis which was documented using NUDIST software (Qualitative Solutions & Research, 1997). Texts from Life History and Adaptation Interviews were coded initially by the project research team as a group. Major categories that emerged from this process included childhood experiences, adult experiences, roles, family (past and current), health issues / illness narrative, healthcare providers and settings, adaptive challenges and strategies, daily activities and settings, interests, socialization, support (formal and informal), limitations (personal and social), personal qualities and values, view over time, and the research process. After agreement had been reached among research team members on the meaning of various categories, coding of subsequent interviews was completed by two members of the project research team and reviewed for agreement or disagreement by other team members.

As the analysis process evolved, initial categories were revised and grouped into larger categories through constant comparative analysis (Lincoln & Guba, 1985), resulting in four major categories of lifetime challenges and strategies, values and personal qualities, environmental

supports and limits, and relocation challenges and outcomes. Lifetime challenges and strategies included the initial themes of childhood experiences, adult experiences, and health issues/illness narrative. Values and personal qualities included the initial themes of interests, values, personal qualities, and personal limitations. Environmental supports and limits included the initial themes of families, formal support, informal support, and social limitations. Relocation challenges and outcomes included the initial themes of roles, daily activities and settings, and view over time.

Profiles were developed for individual elders through discussion among members of the project research team which triangulated findings from different forms of data over time. Individual case profiles were then compared across participants to identify similarities and differences in persons whose relocation pathways involved different settings including informal settings living with relatives and formal support settings such as personal care homes and nursing homes (Miles & Huberman, 1994).

Trustworthiness of the data collection, management, and analysis was addressed in several ways (Lincoln & Guba, 1985). Credibility and dependability were fostered by initial training and on-going supervision of student research assistants in conducting chart review, administering structured instruments with this population, and qualitative interview techniques. Usually home interviews were conducted with a research assistant and senior team member present, although occasionally students went in pairs to locations in which security was not a concern. Most elders appeared to enjoy visits by the project research team which provided an opportunity to tell their story and discuss both problems and successes. Accuracy of scoring, transcription, and coding processes were checked on a sampling basis. The project research team met periodically to review data collection experience, check project records, and discuss emerging findings. Researchers became aware of emerging issues through ongoing interactions with elders and with fellow team members. This awareness shaped future data collection and analysis and allowed confirmation or revision of analytic themes. An on-going record of the research process was documented in fieldnotes following interviews, home visits, and team meetings, creating an audit trail.

FINDINGS

Findings are presented according to individual cases, followed by themes that emerged across cases in two relocation pathways including

informal support arrangements living with relatives, and formal support settings including nursing homes and a personal care home. Preserving the integrity of individual cases is important so that their experiences can be understood in an integrated way and not fragmented, as advocated in case study research (Yin, 2003; Miles & Huberman, 1994). Accounts are provided of the life history of each participant, followed by an account of his or her relocation experience and reflections on its significance.

Twenty participants were initially enrolled in the study, though several were lost to follow-up. The remaining 10 participants included 8 women and 2 men. Their ages ranged from 47 to 96, with an average age of 73. Six were African-American, three Caucasian, and one Hispanic. This approximates the gender, age, and ethnic distribution of persons seen on the geriatric transitional unit, including a few individuals who are younger than typical definitions of elderly persons. Before hospitalization and their stay on the transitional unit, 4 elders were living with family and 6 were living alone with various forms of assistance. Elders who were lost to follow up did not appear to differ substantially from those who were followed. Pseudonyms, gender, age, ethnicity, medical problems, previous living arrangements, and relocation settings of study participants are identified in Table 1.

Elders in Pathway One Who Relocated with Relatives

Five elders had new living arrangements with a variety of family members including a sister, son and daughter, grandniece and her family, brother, and son.

Ms. Andrews

One member of the cluster of persons who had new living arrangements with relatives was Ms. Andrews, a 68-year-old African-American woman who moved from another city to live with her sister following hospitalization for problems with congestive heart failure and diabetes. She had grown up in Louisiana, married when she was 13, and then moved to Texas where she did cleaning work and raised four children by herself. She reported that she “wouldn’t work for nobody if they didn’t have no children about the size of my kids so they could give my children their clothes.”

She described her faith in God as an important source of strength. “All you have to do is ball it up and put it in His hands and leave it there.

TABLE 1. Participant Demographics and Relocation Pathways

Participants Gender ^a Age	Ethnicity ^b	MMSE Score ^c	GDI ^d Score	Major Diagnoses	Living arrangements, before hospitalization	Living arrangements, after hospitalization
Andrews (F, 68)	AA	22/22	2/14	Congestive heart failure exacerbation, Vasculitis, Diabetes	Living alone in another city	Sister's house (now deceased)
Frank (F, 68)	AA	23/28	1/15	Left cerebral vascular accident, Hypertension, Diabetes	Living with son and daughter in a home	Same with additional care
Bowen (F, 96)	AA	10/27	0/15	Left hip fracture, deconditioning, sores on heels, dementia	Living alone	Grandniece's home
Luna (M, 69)	Hisp	21/30	4/15	Necrotizing enterocolitis, Delirium tremors	Living alone in an apartment	Brother's home in a garage apartment
Hayes (F, 49)	Cau	30/30	8/15	Chronic inflammatory demyelinating polyneuropathy	Living with son in an apartment	Wheelchair accessible apt. with son
Miller (F, 47)	AA	24/30	3/15	Cerebral vascular accident, sepsis, hydrocephalus	Lived with aunt	Personal care home
Nelson (F, 72)	Cau	23/27	7/15	Congestive heart failure, Diabetes, Chronic renal failure	Home alone with support	Daughter's house to sub-acute care facility; presently nursing home
Thompson (F, 94)	AA	26/30	8/15	Musculoskeletal weakness; Chronic heart failure; Depression	Prior to living with niece, she lived alone with support	Nursing home
Tower (F, 78)	AA	19/25	2/14	Dementia, Diabetes mellitus, Hypertension	Home alone	Nursing home
Fletcher (M, 66)	Cau	30/30	9/15	Diabetes; Peripheral neuropathy; alcohol abuse	Lived alone in efficiency apartment	Nursing home

^a F = female, M = male. ^b AA = African-American, Cau = Caucasian, Hisp = Hispanic.
^c MMSE = Mini-Mental Status Evaluation. ^d GDI = Global Depression Inventory.

When you give Him something you have to leave it alone. And that's what I do." She did not like to depend on other people. "When you have to lean on somebody else to help you to do things and they don't do them like you think they should do it, then your feelings be hurt." Her adaptive strategies involved focusing on immediate concerns and not dwelling on bad experiences. "I don't think about the bad things. I just think about what is happening to me then and there."

Since hospitalization she has needed a wheelchair which she found "real hard 'cause I can't get up and go nowhere." At her sister's home,

she took sponge baths and used a bedside commode in her room. Her niece did her hair, and her sister prepared meals that Ms. Andrews ate in her own room. A deacon of the church came by each Sunday to take her to church, and when he did not come one week she called to remind him of her expected rides. Ms. Andrews attended a day program three days a week where she enjoyed socialization and activities such as painting, and she was disappointed when her attendance was cut to one day a week. "I don't like being here at the house by myself. Up there you be around people all day long." An unpaid helper arranged by a friend came by every weekday in the late afternoon and brought Ms. Andrews food, washed her clothes, and provided companionship. This appeared to be an important source of outside contact. Ms. Andrews wanted to have "a place by myself and take care of myself," but she stated that "I make myself content."

Six months after her enrollment in the study, Ms. Andrews had been hospitalized again and indicated that she would "like to find me a nursing home." She had spent several days in a nursing home in another city after a prior hospitalization and remembered this setting as a source of social contact. "You could have friends come and get you, take you out, bring you things. . . . I liked a lot of little things." Three months after this interview, Ms. Andrews died.

Ms. Frank

Another participant who had new living arrangements with family was Ms. Frank, a 68-year old African-American woman who was hospitalized for a stroke. She had grown up in a small town where her mother worked in private homes to raise four children after their father was killed in World War II. Ms. Frank loved school and graduated as valedictorian of her high school class. "Most of those girls dropped out, but through all those things that happened I stayed in school." She later completed a program in home economics and English at a college for African-Americans. After college she moved to a larger city where she worked for the police department. Later she answered telephones and did cleaning for a chemical company.

In raising five sons and two daughters, Ms. Frank said "I had to learn to manage with what I had, I didn't try to overdo it." She attended a church where "they had tambourines and good times and shout." Her faith appeared to be an important resource in dealing with difficulties. "I pray to God for it to be all right and try to work it out. I have to praise and thank him for letting me be the age that I am." After living in the in-

ner city for many years, she and a son and daughter moved to a home in a suburban neighborhood because of fear of violence and because she wanted a neighborhood that “did not have trash lying around.”

After her stroke and use of a wheelchair, Ms. Frank’s family developed a complex support system. Her daughter made breakfast and supervised morning hygiene, her son made lunch before going to work as a policeman, and a former daughter-in-law began coming in late afternoons to help with bathing and dinner. Ms. Frank spent mornings and evenings including mealtimes in her own room, but maneuvered her wheelchair with her feet to the living room to read, watch television, and observe neighbors during the afternoon. “I go as far as the window and peep out. The lady over there invited us to her house, kind of a welcome home, but I don’t want to wear out the welcome so I stay at home.” She was visited occasionally by members of her church. By the sixth month after her enrollment in the study, a nurse had arranged for Ms. Frank to attend a day center three days a week. “I didn’t really want to go, but one of the nurses said I should go.” After withdrawing from this program in a few weeks, Ms. Frank reported that “she (the nurse) said I would enjoy it, but I didn’t enjoy it. Some days I had other things to do.” This decision appeared to reflect the importance of autonomy and managing her own priorities to Ms. Frank.

Ms. Bowen

A third member of this cluster was Ms. Bowen, a 96 year-old African-American woman who was hospitalized for a hip fracture and who also had dementia. She grew up in a rural area, and reported that “I had to mind everybody (six sisters and two brothers). At school I didn’t get along with the teacher, and if I was bad I got a whupping.” Ms. Bowen married and helped raise children of other family members. Her grandniece reported that “she helped raise my grandmother and raise many generations after me, she helped them all.” During her lifetime Ms. Bowen did various kinds of work for other families including washing, cooking, and cleaning.

Ms. Bowen identified faith as an important source of strength. “The Lord make me lighten myself up, don’t let me stay in the dark, give me a song to sing. I couldn’t live without prayer.” She described her self-reliance as “whatever I know I got to do, ain’t nobody gonna do it but me. I just go on and do it and then I be through with it.”

After her first hospitalization at age 96, Ms. Bowen moved into the home of a grandniece and her husband and three children. Initially she

described it as “a blessing” to be there where the family provided needed care. In later interviews the grandniece described growing tension between them. Ms. Bowen wanted to return to her own home, but the grandniece felt that none of the relatives would want to live with her because “she is very controlling.” She also felt that hiring someone to stay there would be impractical because “it would be difficult to find someone to put up with her, that she would like.” In her final interview, Ms. Bowen said “I’m trying my best to get back to my home here on earth. I know where I am going for my heavenly home.”

Mr. Luna

The fourth member of this cluster was Mr. Luna, a 69-year-old Hispanic man who was hospitalized for delirium tremors and enterocolitis. He grew up in a rural area with five siblings, and said he had a “nice childhood” until age 7 when his father “took off from home and then we had it pretty rough.” He went to school through the sixth grade and began picking cotton at age 12. As an older teenager he went to Chicago and California to work and sent money home to his mother. As an adult Mr. Luna did carpentry and house framing. He had four children before separating after 8 years of marriage. “Ever since then I lived by myself. Pretty used to being by myself.” He saw his three surviving children frequently and said “we stay pretty close together. They all went to the hospital when I was over there.”

He described his need for hospitalization as being “a minor stroke—I had it because I used to drink a lot.” After hospitalization he stopped drinking and moved into a garage apartment at his brother’s home that the two of them were fixing up. He described it as “a nice neighborhood and I ain’t never moving.” He did some of his own cooking, but his brother’s family “invite me over every once in awhile, or they bring me food over here. I am lucky to have them in my life.” He enjoyed taking care of his new apartment and drove his own truck to do grocery shopping and to see friends at his former apartment.

Mr. Luna described himself as believing in God but not belonging to any church because “once you get in some denomination you have to live exactly the way they live whether they are right or not. . . . I believe whatever I do in my life, right or wrong, is up to myself and nobody else.” In dealing with difficult times such as his hospitalization and having his former apartment burglarized, Mr. Luna said “I really think that what helps me through these times is that I am very calm, I am a patient man I guess, I don’t take things that hard.” In reflecting on his current

life, Mr. Luna said “even though I am 70 years old I still enjoy life. I am glad I am alive and everything.”

Ms. Hayes

The fifth member of this cluster was Ms. Hayes, a 49-year-old Caucasian woman who had chronic inflammatory demyelinating polyneuropathy and diabetes. She had grown up with congenital defects including kidney and heart malformations and described herself as very uncoordinated. She enjoyed music and English classes and said her disability “made me more academic than athletic . . . you make up for one thing what you don’t have in another.” Her family moved from another state to Texas when she was seven years old, and she described herself as “very shy as a child.”

With heart surgery at age 13 she reported positive expectations, an outlook that represents her current view of the future as well. “I just kept looking forward knowing that it was going to get better.” In high school Ms. Hayes became more outgoing, and in junior college she “really blossomed out.” She married at age 21 and adopted a son. After 23 years of marriage she was divorced but described herself and her former husband as “still friends” who continued to provide various forms of instrumental support for each other. At that time Ms. Hayes was living with her son, and she spent a lot of time with the child of his girlfriend teaching her stories and songs and providing other care. “I felt like the little girl was my granddaughter.” A year before her enrollment in the study Ms. Hayes’ former husband was killed in a fall. “I just went to pieces and thought I was going to have a nervous breakdown.” She reported that “talking it out with friends got me through it.”

Ms. Hayes had been using a walker for several years before an acute episode in which her legs “had gone out and were like noodles.” Friends got her to the hospital in a borrowed wheelchair. This problem was diagnosed as Guillain Barre syndrome, and Ms. Hayes was told she would have “a 90% chance of recovery.” Following hospitalization Ms. Hayes’ son got “a disabled apartment unit for wheelchair accessible people and said, ‘we are gonna do it together,’ so he has really been my strength.” She tried to provide support for their shared household and said “I know he needs me, and I guess you just have to be needed sometimes.” Ms. Hayes’ mother told researchers she was worried about the son who reportedly damaged his mother’s car and used her money without permission. In speaking about her sense of purpose in life, Ms. Hayes said “she (her son’s girlfriend’s child) was my purpose there for a long time. I

guess now it is intensely on my son and just keeping him straight.” In reflecting on her experiences and her future, she said “You just go along with what life hands you I suppose. You know, I am in a way a fighter, I hope I am.”

Cross-case issues and themes for elders who relocated with family members are summarized in Table 2.

Elders in Pathway Two Who Relocated to Formal Support Settings

Five elders relocated to formal support settings, including one who went to a personal care home and four who went to nursing homes.

Ms. Miller

One member of this cluster was Ms. Miller, a 47-year-old African-American woman who had a stroke and used a walker. She grew up with responsibilities for the household and four younger brothers while her parents both worked. She described her childhood as “sheer hell . . . anything got broken or out of place, I got blamed for it.” Her memories of school focused on sports. Ms. Miller worked as a waitress in the small town where she grew up until she moved to a city and lived with

TABLE 2. Elders Living with Families

name	lifetime challenges and strategies	values and personal qualities	environmental supports and limits	relocation challenges and outcomes
Andrews	raising 4 children alone; cleaning work; help from employers	faith “make myself content”	sister’s home day program church with deacon volunteer helper	needs wheelchair misses social contact
Frank	raised 7 children; police dept. work	“manage with what I have” faith autonomy	daughter, son, daughter-in-law church visitors	needs wheelchair meals alone withdrew from day program
Bowen	raised children of family; washing & cooking work	self-reliance “couldn’t live without prayer” autonomy	grandniece and family	growing tension with grandniece alone during the day
Luna	picked cotton; house-framing; excessive drinking	“a patient man” faith but not a church member	brother’s family; friends from old neighborhood	fixing up brother’s garage apt.; taking care of apartment
Hayes	childhood disability; death of ex-husband	“a fighter” “go with what life hands you”	apartment with son	walker to wheelchair problems with son household chores

her uncle and his family. As soon as she got a job she moved out on her own. She continued her work as a waitress which she enjoyed because "I am a people person who never met a stranger." She liked to dance, play pool and go fishing which made her feel "free as a bird."

Her stroke was a major turning point in her life, which she described as "really slowing me down." She now "takes it one day at a time" and indicated that "I need to be more patient with what I do, take my time and do it right the first time." When asked what gives her a sense of purpose in life, Ms. Miller replied simply "the good Lord" without further elaboration. After her stroke she moved to a personal care home. "It's a facility that makes you feel like you're at home. It's a good place to live." She got along well with other residents, but stated that "they are 70 or 80, so there is not a lot we can talk about." Ms. Miller had her own room with a bed, chest of drawers, and her artwork on the wall which she had painted at the day program she attended daily. She described her art as being "like a release . . . the art is me."

Ms. Miller attributed her ability to adapt to life changes to a value learned from her father. "Try it, you might like it, my daddy always used to say. And I would resist. And then when I did try it I ended up liking it. . . . I tried that here." She characterized her current view of life as "I accept everything as it is. After I have experienced what's come to me, if I can think of a better way I'll say something. If not, I just accept it."

Ms. Nelson

A second member of this cluster was Ms. Nelson, a 72-year-old Caucasian woman who had congestive heart failure, renal failure, and diabetes. She described her childhood in a large city as "going to school and working all the time." She married but was deserted by her husband, leaving her with six children. "I raised them all by myself with the good Lord's help." She worked as a waitress "because that was all I learned but I says at least it's a decent job and I had a good manager who helped me out." Her children took care of each other and "that way I didn't have to pay for a babysitter to come in." She often "worried where the next meal will come from, but the good Lord provided." The people on her son's paper route "would give me clothes and whatever else they could spare. And I managed. I was just thankful there were people like that in this world." Faith was an important source of strength. "When you believe in the Lord and try to do right in all, you will get that joy. So that is the way I lived."

Ms. Nelson had been “in and out of the hospital for the past two years.” She indicated that “when the fluid came back it just slowed my legs down and I wasn’t able to do much for myself.” After her initial enrollment in the study she lived for six weeks with a daughter and her husband who provided morning and evening care and meals. A granddaughter would “come in from school and she usually made sure I had a sandwich and then she goes back to work and I am there by myself.” She usually had her meals in the living room watching television, though “occasionally I’ll sit down at the table if some are home.” She reported that “the children all get together and they do the things I need. But they was always like that. That makes me feel so good, I says I done something right.” However, she also recognized the limits of what family could provide. “I said, well, I didn’t get sick for you all to stop what you are doing. I will take care of myself the best I know how. . . . They have needs as well as mine.”

Because of increasing medical problems and support needs, Ms. Nelson had moved to a nursing home at the time of final follow-up. When asked how she keeps going, she said “with God’s help because if He wasn’t with me I don’t think I could manage as well as I do.” In looking back on her life, Ms. Nelson said “Everything I did I worried, did I do the right thing or did I do this and that, but I am pleased with the way things turned out for me.”

Ms. Thompson

A third member of this cluster was 94-year-old Ms. Thompson, an African-American woman with arthritis and musculoskeletal weakness. She was raised in a city and described a happy childhood growing up with two step-brothers after a sister passed away. In school she reported being “active in everything that I could be in,” and said “I had to go to church whether I wanted to or not ‘cause I was raised by a stepfather and he was a minister.” She went to school through the eighth grade, and after school she worked doing laundry and washing dishes for other families. Ms. Thompson was married for about 5 years, and had several children but “they all passed in infancy.” She lived on her own since she and her first husband separated, and she liked “the freedom to go when I get ready, I don’t have to report where I am going and when I am coming back.” She developed a relationship with another man and had two children with him, a daughter who “passed” and a son who currently lived in another city.

Her arthritis began in her 60's with hand involvement. Initially she "worked when I could and did a little babysitting when I lived at home." She indicated that "I was never wanting what everybody else had, only what the Lord would bless me with." Ms. Thompson moved to a nursing home "when I was taking care of my house and my legs started giving away on me and I started to fall."

She reported that faith was an important resource in adapting to difficulties. "I pray to the Lord God to have a little strength to still get around so I can do some of the things, you know I can't do all of the things by myself." She reported that "I miss going to church" and valued visits by church members. In reflecting on the future, Ms. Thompson said "I ain't going to take nothing with me but the Lord. He has control and I pray and ask him please don't let me lay down and suffer."

Ms. Tower

A fourth member of this cluster was Ms. Tower, a 78-year-old African-American woman who had diabetes, hypertension, and dementia. She grew up in a city as the oldest child of a family of four boys and one girl. Her father had a cleaning and pressing shop and her mother did laundry and cooking for other families. Ms. Tower went to school through the ninth grade. "I had to drop school because mama was working and I was the girl and had to take care of the boys." She got married to get away from home to a person who "was ten years older than me and wasn't my type of guy." After a miscarriage and divorce, she lived by herself, worked in private homes, and raised two children of her brother. She described herself as "a Christian and a family person. And my dad made me independent."

Ms. Tower had a childhood friend who summoned her sister after she was hospitalized and her brothers were "not doing anything." Her sister came from California to make quick arrangements for Ms. Tower to move to a nursing home. "She just come after me and she is packing up my stuff 'cause she got to go home Wednesday." After getting to the nursing home, Ms. Tower spoke about the reasons she needed to move. "I didn't want to come here but I could not stay by myself. I set the house on fire. And then I had some scalding hot water that got on my shoe. That was out of the question for me to stay by myself." At the nursing home being able to call friends and going out occasionally to have her hair done were important outside contacts. Ms. Tower was pleased to receive support from a former associate. "Yesterday a lady called me I used to work for. I am gonna send you a little gift. I want you

to keep it for yourself to buy little things you need.” Ms. Tower went to therapy mornings and afternoons and was working on using a walker. She preferred to eat in her own room and did not participate in activities because “I don’t have time right now being in therapy most of the time.” After cataract surgery she was looking forward to “being able to read and sew up the things that need sewing. . . . I am used to doing, using my hands.”

In follow-up interviews, Ms. Tower said “I’m very dissatisfied with my sister. She just did anything to get me out of the way.” In dealing with her circumstances, Ms. Tower said “I know I can’t help myself, not right now. I pray to God and whatever He see fit for me to do, He will make it visible, He will let me know.” Three months after her enrollment in the study, Ms. Tower was no longer going to therapy “because I got promoted.” When asked whether she attended nursing home activities, Ms. Tower reported that “they play games in the daytime, but I don’t know where I’m going and they haven’t picked me up.” At the time of her final follow-up interview, Ms. Tower said that she was going to an exercise group, attending church in the nursing home, sitting out on the porch, and eating in the dining hall rather than in her own room. She was frustrated by staff who “don’t be talking to me, but they be talking among themselves. They get me down because I can’t do nothing about it.” She reported that her brothers stopped visiting. “This is going on a year now and they get tired of fooling with me. They quit coming.” In reflecting on her life, Ms. Tower regretted her loss of autonomy and sense of direction. “I always knew where I was going, I knew where I was. I don’t know what I am going to do now. . . . You don’t know what you got to do before you leave this earth.”

Mr. Fletcher

A fifth member of this cluster was Mr. Fletcher, a 66-year-old Caucasian man who was hospitalized for diabetes, peripheral neuropathy, and alcohol abuse. He grew up in a city and had problems with endurance as a child. “About the next to last block to the school I almost couldn’t make it sometimes.” After moving to another city, he reported finding it difficult to make friends. “Never had any (friends) here. It’s almost as if, in the other city, we knew every one. And here, no one knows you.” In his youth Mr. Fletcher was in Boy Scouts and built model airplanes which he said as an adult was “something I had to let go.” After high school, he attended one university for a year that he found difficult and disliked. “That first year about ruined my life. It’s like a lost year to

me.” Later he went to another university for a year, and then got a job loading and unloading trucks.

Problems with his peripheral neuropathy and difficulty getting around prompted his hospitalization and then move to a nursing home. He described this setting as “nice as can be, it has everything I need. The employees are nice and don’t seem to criticize me too much.” He reported that “when I was first here I couldn’t find my way around, it’s like my mind wore out.” At the time of his first follow-up interview, Mr. Fletcher felt as though “I am a lot better than when I was at that hospital, but I still need pain pills for my leg.” He reportedly gets along with women residents at the nursing home but described many of the men there as troublemakers. “I spend a lot of time trying to be out of the way of people here.” In reflecting on what he had learned in life, Mr. Fletcher said “I learned once that you should treat every new place as if it was your home. I try to do the things I can do for myself.”

Cross-case issues and themes for elders who relocated to formal support settings are summarized in Table 3.

TABLE 3. Elders Living in Formal Support Settings

name	lifetime challenges and strategies	values and personal qualities	environmental supports and limits	relocation challenges and outcomes
Miller	raised 4 brothers; waitress work	“never met a stranger” the good Lord	personal care home staff day program	stroke; misses people her own age painting
Nelson	raised 6 children alone; waitress; employer helped	“good Lord provided” proud of children	daughter, husband, and granddaughter moved to nursing home	meals alone growing medical needs
Thompson	several children died in infancy; laundry & dish- washing work	“never wanted what everyone else had” pray to good Lord	nursing home staff church member visits	legs giving out arthritis progressing misses attending church
Tower	raised children of her brother; worked in private homes	dad made her indep. “always knew where I was going” Christian & family person	dislikes nursing home former employer sent money; hair done by friend; brothers don’t come	nursing home decided by sister wanted to sew after cataract surgery gradually started nursing home activities
Fletcher	hard to make friends; problems at university; truck loading work; alcohol abuse	do what I can for myself; “treat every place like your home”	nursing home staff gets along well with women residents	pain from neuropathy men at nursing home are troublemakers

REFLECTIONS

As noted above, major themes that emerged from the analysis and interpretation process across cases included lifetime challenges and strategies, values and personal qualities, environmental supports and limits, and relocation challenges and outcomes.

Lifetime Challenges and Strategies

In speaking of how they adapted to life changes prompted by relocation, elders described adaptive experience they had used over a lifetime to manage difficult times. For six of the participants, this involved a history of working and raising children of their own or of family members without help from spouses, a reflection of their determination and perseverance. In addition to mutual support among family members, adaptive strategies often included helping relationships with others such as church associates or persons for whom elders had worked. In spite of valuing help to and from others, most elders also emphasized doing what they could for themselves. They reported having modest needs over their lifetimes which continued in the present. Religious faith and prayer were identified as important sources of strength by seven of the ten participants. Often this was reflected in church involvement, though Mr. Luna preferred not to become affiliated with any church denomination.

Values and Personal Qualities

These elders reflected a strong sense of personal history and continuity with the past. They were proud to tell about lifetime experiences throughout the study, as well as in formal life history interviews. They had thought about values that had been important in their lifetimes and that they sought to continue to live by in the present in spite of more limited capabilities. For many, faith provided a sense that their life had a purpose. And most thought about their lives and situations in ways that reflect a sense of coherence (Antonovsky, 1987) or resilience (Fine, 1993). These concepts emphasize finding meaning in current circumstances and believing that one can influence responses to such circumstances. Ms. Tower was an exception who at final follow-up appeared to reflect a sense of despair about her life and its direction, in spite of increasing involvement in the social life and activities at her nursing home.

Sense of self appeared extensively in most qualitative interviews. However, an important finding of the study was difficulty of this population in responding to a structured Likert-format questionnaire on psychological well-being intended to document aspects of sense of self. Some persons reacted quite negatively to this instrument and other participants expressed confusion, responding "I don't know what I am supposed to say." A number of participants adapted to the interview questions by giving their own interpretations of what the statement had meant in their own lives. For example, when asked about the extent to which she agreed with the statement "I gave up trying to make big improvements in my life a long time ago," Ms. Nelson said "I try to keep on improving because I always wanted the children to have respect for me."

Despite difficulty with the instrument, elders in this study strongly reflected several of the dimensions of sense of self identified by Ryff and her colleagues (Ryff & Singer, 1996) including autonomy, positive relations with others, purpose in life, and self-acceptance. The importance of autonomy was reflected in a desire to make one's own decisions, as exemplified by Ms. Frank who chose to leave a day center, and by Ms. Tower who strongly regretted her inability to choose her own living setting. The importance of positive relations with others was reflected in appreciation for family and their needs as exemplified by Ms. Nelson and Ms. Hayes, in enjoying social activities as exemplified by Ms. Miller and Mr. Luna, and in valuing personal contacts outside their living settings as exemplified by Ms. Andrews and Ms. Tower. Purpose in life was connected by many participants with religious faith, but also included a strong commitment to values such as helping others. The dimension of environmental mastery was seen by most participants as being contingent on their current level of personal capabilities, as well as outside influences. Personal growth was not emphasized by most of these elders who were content to reflect on their past experience and who they had become.

Environmental Supports and Limits

Relocation pathways of study participants often reflected attempts to manage needs of elders by various family members, including a sister, a brother, a son and daughter, a daughter and granddaughter, and a grandniece. This support emphasized daily care needs and typically did not include involvement of the elder in other family activities except for Mr. Luna who occasionally ate and socialized with family groups. Un-

like former studies in this line of work, none of these participants had spouses who provided support. Formal support settings were used by persons who did not have family available (Ms. Miller, Ms. Thompson, and Mr. Fletcher) or whose needs were too extensive to manage by family (Ms. Nelson and Ms. Tower).

Pathways of elders reflected changes over time as daily experience evolved in new settings and family members as well as elders themselves discovered both possibilities and limits. By final follow up, Ms. Andrews preferred to move to a nursing home rather than living in her sister's home, Ms. Bowen and her grandniece were considering other living options, Ms. Nelson had moved from her daughter's home to a nursing home, and Ms. Tower was dissatisfied with the nursing home where her sister had placed her though she did not have other options to consider. These findings are similar to Groger's (1993) work on discovering limits of informal support, and to research on family caregivers of chronically ill low income elders reviewed by Hines-Martin (1992).

Relocation Challenges and Outcomes

In examining attainment of outcomes of relocation identified in previous studies, it is noteworthy that many of these elders did not appear to establish a sense of place that included engaging in valued activities and maintaining or establishing social relationships, in addition to getting care needs met. With the exception of Ms. Andrews and Ms. Tower, most were satisfied with provision of basic care needs. However, findings about activity engagement and socialization were mixed. For elders in the family support pathway, engagement in activities beyond personal care was a common challenge. Ms. Andrews was disappointed when her attendance at a day program was cut back. However, Ms. Frank did not like going to a day center and chose to withdraw after a few weeks. Several elders in this pathway reported spending most of their time in their own rooms, and for these persons outside contacts were often important. These included afternoon visits by an unpaid helper and rides to church with a deacon for Ms. Andrews, and visits by church members for Ms. Frank. Mr. Luna, who had greater mobility, appeared to enjoy taking care of his new garage apartment, doing errands such as grocery shopping, and seeing former friends in his old neighborhood.

For elders in the formal support pathway, activities were often more readily available than for persons living in relatives' homes. For these elders, establishment of new social relationships was often a particular challenge. Most developed positive relationships with staff at their new

settings, with the exception of Ms. Tower who continued to distrust nursing home staff. In addition to relationships within the residential setting, outside social contacts were often important for this group. These included outings with a friend to have her hair done for Ms. Tower, and visits from church members for Ms. Thompson.

Examples of elders' experiences that illustrate major themes are summarized in Table 4.

IMPLICATIONS

In examining implications, it is important to identify strengths and limitations of the study. This research provided in-depth information from multiple sources on the relocation experiences of a relatively small number of low income elders who were expected to differ from other populations that have greater financial means and different values and life experiences. Thus applicability of findings to others must be investigated in future research. However, the ten participants represented a range of experiences in both family living arrangements and formal support settings, and provided enough cases for each relocation pathway to observe redundancy in findings. Limitations include some missing data when persons could not be found for follow-up interviews, as well as difficulty of many participants in responding in expected ways to a Likert-format questionnaire. The study did not examine elders who returned home after relocation was recommended and their success and satisfaction with this decision.

The proposed model of adaptation to relocation was partially affirmed by the experience of study participants who represented the circumstances of relocating due to health problems and a need for hospitalization. The study supported the importance of past adaptive experience and sense of self in shaping relocation experience. It also supported the

TABLE 4. Cross-Case Illustrations of Major Themes

lifetime challenges and strategies	values and personal qualities	environmental supports and limits	relocation challenges and outcomes
child rearing	faith	family support	lack of equipment
laborious work	autonomy	church support	unsettled routines
financial concerns	self-reliance	neighborhood support	family tensions
	resiliency		medication needs
			social isolation
			new activities

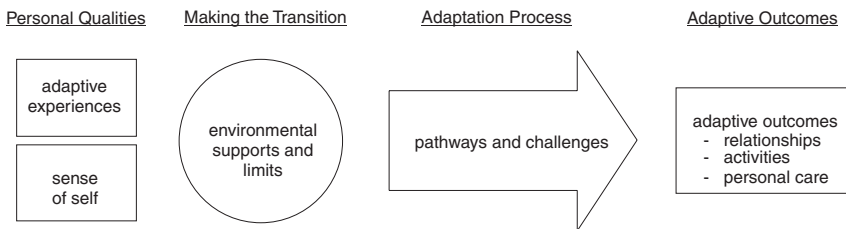
importance of the adaptive outcomes of personal relationships, valued activities, and personal care. An important finding that emerged from this evaluation was the significance of environmental supports and limits. Consequently, a revised version of the model now gives greater attention to this aspect of relocation experience, as represented in Figure 2.

Further evaluation of the model is needed for persons whose circumstances differ from those of the elders in this study who relocated following the life course disruption of hospitalization. Additional studies are planned of elders who relocate voluntarily to a growing variety of support systems that provide various levels of assistance, social contacts, and forms of organized activity to residents. Future studies will also address factors that prompted consideration of relocation by elders prior to the move.

For service provision, findings indicate the importance of evolving daily life experience of both elders and family members in adapting to new living situations. To many families it is important to try new arrangements and discover possibilities and limits, rather than making hasty decisions that may later be regretted either by family or by elders. Healthcare practitioners can provide assistance to elders and families in considering alternative relocation settings and evaluating their implications for social relationships and activity engagement as well as personal care. Practitioners also can play a crucial role in identifying and solving problems that arise during the process of adaptation in new settings after relocation has occurred. The study revealed the importance of fostering outside contacts for many persons whose lives are now more restricted to a small residential space and local world.

The study affirmed the value of letting elders tell about themselves and their experiences in their own way through open-ended qualitative interviews. Persons often had rich stories to tell and vivid metaphors to represent ideas important to them, in spite of the fact that they may have

FIGURE 2. Revised Model of Adaptation to Relocation



had difficulty using formal structured instruments designed to generate reliable and valid quantitative data. As emphasized in the narrative tradition (Gubrium, 1993; Kleinman, 1988), this study illustrated the value of viewing adaptation to hospitalization and relocation as part of a longer-term life narrative that shapes the meaning of experience and the ways in which it is incorporated into a larger whole.

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