Elderly people's subjective experiences of relocation to residential care facilities

HANDRÉ VISAGIE

Dissertation in fulfilment of the requirements for the degree Magister Artium in Psychology

University of the Free State

Supervisor: Ms M van Dijk

DECLARATION

I, Handré Visagie, hereby declare that this study, ***Elderly peoples' subjective experiences of relocation to Residential Care Facilities***, submitted in fulfilment of the requirements for the degree Magister Atrium in Psychology at the University of the Free State, is my own, original work. I have not submitted any part of this study to any other university to obtain a degree and all sources used for this study are recognised in the reference list. I further concede copyright of this thesis to the University of the Free State, and all royalties regarding intellectual property that was developed during, and/or in connection with the study at the University of the Free State, will accrue to the University. This research may only be published with the Dean's approval.

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PERMISSION TO SUBMIT – ME M VAN DIJK

Reference: Me M van Dijk
Psychology Bulding, Room 204
University of the Free State
BLOEMFONTEIN
9301
Telephone: 051 401 2596
Email: vandijkm@ufs.ac.za

January 2019

TO WHOM IT MAY CONCERN

PERMISSION TO SUBMIT

CANDIDATE: Mr H Visagie

Degree: MA in Psychology

TITLE: Elderly people's subjective experiences of relocation to residential care facilities

With this I provided permission that this dissertation can be submitted for examination.

Kind regards
ME M VAN DIJK
Supervisor

DECLARATION BY LANGUAGE EDITOR

CORRIE GELDENHUYS
POSBUS 28537
DANHOF 9310

083 2877088
+27 51 4367975
corrieg@mweb.co.za

13 February 2019

TO WHOM IT MAY CONCERN

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“When we are no longer able to change a situation, we are challenged to change ourselves.” – Viktor Frankl

SUMMARY

In this study, the subjective experiences of older persons who relocated to residential care facilities were investigated. During Apartheid South Africa, only White elders were accommodated at most residential care facilities and the previously disadvantaged was excluded. Furthermore, previous research focused mainly on the experiences of the wealthier white groups; consequently, this study focused on the middle-to-lower income groups, including Black elders. Considering the diverse and often adverse circumstances at South African residential care facilities, it is essential to consider the relocation experiences of elders in such facilities, and what experiences contribute to their sense of home. Such information would help to equip those caring for the needs of older people with knowledge that will benefit the well-being of elders.

Literature regarding ageing and relocation during late adulthood was utilised to conceptualise the concept of relocation. Experiences and related issues regarding the process of relocation to a residential care facility were viewed from an interpretivist perspective.

A qualitative framework was chosen to give individuals experiencing this move a voice. A focus group approach was used, and semi-structured sessions were held to discuss participants' experiences of relocation openly. Twenty-five participants took part in this study. They were identified by means of a non-probability sampling method, namely purposive sampling. Data were analysed and interpreted by means of thematic analyses, and various themes and subthemes emerged from the data sets.

The findings of this study correspond with previous research that indicates that relocation experiences entail a process that encompasses factors prior to relocation, which contributed to the participants' decision to relocate to residential care facilities, generally classified under push and pull factors. Other themes that correspond with previous research are factors relating to the adaptation process as well as participants' experience of the move to, and living at residential care facilities.

Keywords: older persons, relocation, subjective experiences, culture, South Africa

SAMEVATTING

In hierdie studie is die subjektiewe ervarings van ouer persone wat na residensiële versorgingsfasiliteite verhuis het, ondersoek. Gedurende Apartheid Suid-Afrika is slegs wit bejaardes in die meeste residensiële versorgingsfasiliteite geakkommodeer en die voorheen-benadeeldes is uitgesluit. Verder het vorige navorsing hoofsaaklik gefokus op die ervarings van die meer welgestelde wit groepe. Gevolglik fokus hierdie studie op die middel- tot laerinkomste groepe, insluitende swart bejaardes. Met die diverse en dikwels ongunstige omstandighede in Suid-Afrikaanse residensiële versorgingsfasiliteite in ag genome, is dit noodsaaklik om die hervestigingservarings van bejaardes in sodanige fasiliteite in oënskou te neem, asook wat tot hulle sin van ’n tuiste bydra. Hierdie inligting kan help om diegene wat na die behoeftes van ouer persone omsien met kennis toe te rus, tot voordeel van die welstand van bejaardes.

Literatuur rakende veroudering en verhuising/hervestiging (“relocation”) tydens persone se later jare is ondersoek om die konsep van verhuising/hervestiging te konseptualiseer. Ervarings met, en verwante kwessies rakende die proses van verhuising na ’n residensiële versorgingsfasiliteit is vanuit ’n interpretivistiese perspektief beskou.

’n Kwalitatiewe raamwerk is gekies om aan individue wat hierdie skuif ervaar, ’n stem te gee. ’n Fokusgroepbenadering is gevolg, en semi-gestruktureerde sessies is aangebied om deelnemers se ervaring van verhuising/hervestiging openlik te bespreek. Vyf-en-twintig persone, wat met behulp van ’n nie-waarskynlikheid-steekproeftrekkingsmetode geïdentifiseer is, naamlik doelgerigte steekproeftrekking, het aan hierdie studie deelgeneem. Data is ontleed en vertolk met behulp van tematiese analise, en verskeie temas en subtemas het uit die datastelle na vore gekom.

Die bevindings van hierdie studie stem ooreen met vorige navorsing, wat aandui dat hervestigingservarings ’n proses is wat faktore voor verhuising/hervestiging omvat, algemeen as trek- en stootfaktore geklassifiseer. Ander temas wat ooreenstem met vorige navorsing is faktore wat verband hou met die aanpassingsproses, asook

deelnemers se ervarings van die verhuising na, en inwoning in residensiële versorgingsfasiliteite.

Sleutelwoorde: Ouer persone, hervestiging, subjektiewe ervarings, kultuur, Suid-Afrika

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CHAPTER 1: OVERVIEW AND RATIONALE FOR THE STUDY

A neglected area of research, namely the subjective experiences of older people who relocated to residential care facilities that are open to all middle- and low-income elders in South Africa is explored. In this chapter, the focus is on a discussion of the backdrop, context and rationale for the study. The need and relevance for the research will be argued and the aim stated. The chosen theoretical grounding as well as the research approach and method will be introduced briefly. Finally, a delineation of the chapter layout will be presented, followed by a short summary.

1.1 INTRODUCTION AND RATIONALE FOR THE STUDY

The elderly cohort is the fastest-growing population worldwide (Erber, 2013; Foos & Clarke, 2008; Victor, 2010). The question of who this group of people are and what their needs and especially experiences are is therefore relevant. According to the World Health Organisation (WHO) (2016), literature and scholars of ageing generally agree about what old age entails, but there are considerable variations in different cultures about the age at which a person is referred to as “old”. An international view, as posited by Newman and Newman (2018), argues that an individual reaches old age at 75. However, according to the World Health Organization (WHO, 2014; 2016), African traditions tend to use the chronological ages of 50 to 65 years of age as indicative of old age.

Grundy, Fletcher, Smith and Lamping (2007) note that the unique and individual experience of ageing “makes different views about the choice of a particular age to mark elder status” understandable. Furthermore, the subjective experience of ageing mostly does not coincide with people’s actual chronological age (Weighell, 2015). Hosokawa (2016) concludes that traditional customs of what is valuable or useful in a society are stronger indicators than chronological age, or of when people consider themselves as old. In general, however, literature and research referring to prevalence and trends (WHO, 2015) use 60 years or older as their guideline when referring to the elder cohort. In this study, we will follow this trend when referring to older people (unless clearly indicated otherwise).

Internationally, the number of persons above the age of 60 has grown exponentially in the past century (Roy, Dube, Després, Freitas & Légaré, 2018; Singh & Kiran, 2013). Currently, persons aged 60 and above comprise 12,3% of the world population (Tanyi & Pelser, 2018). Two-thirds of this elder cohort population live in less developed, low- and middle-income countries. Furthermore, the older population in these regions are growing at a faster pace than in the more developed world (United Nations DESA, 2013).

Knowledge about the nature and shape of the phenomenon of ageing is still in its infancy in Africa. Although sub-Saharan Africa's older population is smaller than in other regions of the world, it must still be considered as a real cause for concern (Indongo & Sakaria, 2016). Scarcity in resources, huge differences in living conditions and cultural traditions regarding living arrangements as well as varying levels of socio-economic development hamper coordinated efforts to understand and address the needs of the elderly (Indongo & Sakaria, 2016). As a developing country South Africa has the highest growth cohort of older persons in Africa (Statistics South Africa, 2017; Tanyi & Pelser, 2018; Westaway, 2010) and the highest percentage of older persons in Africa (8,5% of the population) (Lombard & Kruger, 2009; Mid-year Population Statistics South Africa [MYPE], 2018). The most recent census data show that almost 4 209 million South Africans are 60 years or older. In 2050, this figure is projected to rise to 10,06 million people. This growing elderly cohort will bring new challenges that need to be addressed. It will demand much of those who attend to the needs, mental health and well-being of the elderly population (Clement, et al., 2013; Van der Walt, 2011; WHO, 2016; Zikali, 2018).

Ageing populations often experience old age dependency, escalating strain on health and social care services, as well as social and economic vulnerability (Statistics South Africa, 2016). Potočnik, of the South African Society of Psychiatrists (SASOP) (Zikali, 2018) stresses that healthcare for impaired mental age problems is especially lacking and that illnesses such as depression and dementia are often overlooked and not treated. Mental-age problems such as these, together with other physical and psychosocial challenges, disrupt older people's ability to function independently in their daily lives. The WHO (2015) estimates that 38,4% of South Africans between the ages of 65 and 74 need help with activities of daily living such as eating, bathing,

dressing, getting in and out of bed, or using the toilet. The abovementioned distinctive needs and challenges of the ageing population, together with high levels of poverty, unemployment and inadequate housing (Tanyi & Pelser, 2018) increase the demand for planning of social and health services and the provision of living and care arrangements (Aboderin, 2008; Munthree & Ngyende, 2017; Pelser, 2009; Tanyi & Pelser, 2018).

Generally, older people of all cultures prefer to age in their homes (Bothman *et al.,* 2009, as cited in Tanyi & Pelser, 2018). However, research by Andersson, Abramsson and Malmberg (2018), Anikeeff and Muller (2012) clearly indicate that when individuals of the older cohort struggle to maintain a sense of security, remain independent, face challenges such as declining health, loss of a partner and experience lack of care, they are compelled to re-evaluate their living arrangements. Therefore they often opt (either by choice or circumstance) to move to residential facilities with care arrangements. Together with the fact that the MYPE (Statistics SA, 2018) confirms the increase for elder care as discussed above, it can thus be expected that there will also be an increase in the demand for adequate housing (Tanyi & Pelser, 2018), including residential care facilities that can provide specialised care for the unique demands of ageing.

To address the care needs of the rising ageing population, the South African government promulgated the *Older Persons Act (OPA)* in 2006 (Act No.13 of 2006), which "aims to improve and maintain the health, safety, and security of older persons" (Tanyi & Pelser, 2018, p.2). The OPA emphasises that older persons should have access to facilities that promote their social, physical, emotional and mental well-being. This includes the right to appropriate living arrangements. It furthermore introduces community-based solutions to meet the needs of the elderly on "a continuum of care ranging from home-based care services to residential facilities and institutionalised frail care" (Department of Social Development, Western Cape, Research Report, 2015, p.3).

Internationally, when older people can no longer rely on support, residential care facilities are often a first choice in housing for elderly people (Hertz, Koren, Rosetti & Roberston, 2008; Nathan, Wood & Giles-Corti, 2013; Roy *et al.*, 2018; Sinunu, Yount & El-Afifi, 2009; Wilson, 2001). Although residential care facilities as well as retirement

villages are available in South Africa, comparative trends for South Africa's diverse population in residential care are not yet known. Public-owned residential care facilities only became available to Black older people in post-apartheid South Africa (since 1994) when all South Africans, irrespective of race or colour (Dept. of Social Development, 2010) were allowed access.

South African research concerning elderly people living in residential care facilities is scarce, especially studies on the experience of the relocation process. The research that has been done focuses mainly on the demographic aspects (Chigali, Marais & Mpofu, 2002; Dolo, 2010; Munthree & Ngyende, 2017; Roy *et al*., 2018), psychosocial (Van Biljon, Roos & Botha, 2014; Zaaiman, 2014) and physical and mental-care needs of older people (Zikali, 2018). Furthermore, studies focusing on the psychosocial functioning of older persons residing in residential care facilities mostly involve participants of the white and more affluent population. However, little has been done to understand the *subjective experiences of older people who relocate to residential care facilities* and what has built towards the meaning and impact of relocation to residential care facilities in the South African dispensation since 1994. The aim of this study is therefore to fill a gap by *focusing on the experiences of a small group of older people who relocated to residential care facilities that accommodate low- and middle-income individuals from all our countries cultural groups – especially those who were previously excluded from such services.*

1.2 THEORETICAL GROUNDING OF THE STUDY

This study is approached from a lifespan perspective to provide a theoretical understanding of the developmental aspects that will help to understand the experiences of people that are part of the older cohort population. In Developmental Psychology, late-life is seen as part of the life cycle of human beings. It illuminates the various domains of functioning that are influenced by the ageing process. Various psychological theories that can shed light on challenges that older people face as well as on approaches and skills they may use to cope with ageing during late-life..

The process of relocation is conceptualised within the context of living arrangements and challenges from both a western/international perspective as well as an African perspective because our participants were a diverse group of people both from the

white and black cohort of older individuals who recently relocated to a residential care facility. The process of a transition and building a new life structure as proposed by Levinson, Darrow, Klein, Levinson, & McKee (1978) and the theories of Environmental Press (Lawton & Nahemow, 1973) amongst others are used to gain some understanding of older people's experiences to cope with a new living space. Self-determination theory (Ryan & Deci, 2017) is used to shed light on how older people may argue the need to relocate to a new living space. Lastly, Bronfenbrenner's (1979) systems theory is used to emphasise the importance of context in the process and choice for relocation to a new place.

1.3 RESEARCH DESIGN AND METHODS

A non-experimental qualitative study from an Interpretivist stance with an explorative design was used to investigate the relocation experiences of elderly participants. The focus was to gain in depth information on the experiences of the participants in their real world (Babbie & Mouton, 2010; Baxter & Jack, 2008). Explorative research is used to explore a research topic about which very little is known and to gain understanding of a problem that has not yet been clearly defined (Saunders, Lewis & Thornhill, 2012).

Participants were obtained by means of non-probability purposive sampling. Semi-structured focus groups interviews were used to collect data and thematic analysis (Braun & Clarke, 2006) to analyse the participant's responses. Themes and sub-themes were extracted to identify patterns that emerged from the data sets.

1.4 DELINEATION OF CHAPTER LAYOUT

In this dissertation, Chapter 1 focuses on the discussion of the backdrop, context and rationale for the study. The definition of an older person is clarified and international and national trends are highlighted. The theoretical groundings of the study are stated and the research design and methods introduced. The lack of South African research in the area of the subjective experiences of older people who relocated to residential care facilities that are open to all middle- and low-income elders in South Africa illuminates the need for this study.

Chapter 2 discusses the two main constructs of the study namely late-life and older people as well as relocation to residential care. Firstly, theoretical perspectives and

frameworks underlying experiences and challenges of older people in this life phase are discussed, followed by how the process of ageing influences domains of functioning during late adulthood. Thereafter the concept of relocation is conceptualised followed by a discussion of relocation during this life phase. A discussion of the South African context regarding residential care concludes the chapter.

In Chapter 3, a thorough and detailed explanation of the methodology employed in this study is provided. The nature of the qualitative research approach, design and methodology is discussed. The sampling and data-gathering procedures as well as data analysis procedures that were employed are explained. A discussion of the relevant ethical concerns is provided, and the trustworthiness of this study is considered.

Chapter 4 reports on the results obtained in this study, followed by a discussion regarding the participants' responses from the focus group interviews. The most significant results are discussed within the context of previous international and South African studies that were considered. Thereafter the key findings and contributions of this study were summarised. The limitations of this study are considered and recommendations are made for future research in this area.

1.5 CHAPTER SUMMARY

This chapter argued the rationale and relevance of this study. Furthermore, the aim of the study was stated and the layout for the rest of this dissertation was provided.

CHAPTER 2:
RELOCATION DURING LATE ADULTHOOD

Residential preferences and experiences vary greatly, depending on age. With regard to older people, choice of residence and the experience of moving to another home often coincide with declining health and other life-course events such as the loss of a partner or a declining income due to retirement (Andersson *et al.*, 2018). The literature review below will include a discussion of late-life and older people, followed by relevant theoretical frameworks that explain how one can make sense of experiences and challenges of older people in this life phase. This will be followed by the domains of functioning during late-adulthood. The researcher will then discuss living arrangements of older people to provide a logical link to the discussion of relocation during late adulthood. Thereafter the second concept of this study, relocation during this specific life phase, will be conceptualised, discussed and finally linked to the living realities of the South African older people.

2.1 LATE-LIFE AND THE ELDERLY

Elderly people (aged 60 and older) (WHO, 2014) find themselves in the life phase loosely referred to as late-life. This phase includes people from 60 to very old and often spans over a period of 30, and in some instances, over 40 years. More specifically, late-life encompasses the lifespan periods of late adulthood (ages 60-75) and elderhood (ages 75 until death) as conceptualised by Erikson (Newman & Newman, 2018). Older people ranging between 60 and 74 are sometimes referred to as “young-old”, those older than 75 as “old-old”, and those older than 85 as “oldest-old” (Andersson *et al.*, 2018; Hutchison, 2008). This distinction is important, because the act of change in residence (referred to as relocation) may differ for these groups and influence their respective experiences. To understand fully what the experience of relocation involves from the perspective of older people, it is necessary to understand the core characteristics of this life phase in which they find themselves. A longer life does not necessarily coincide with psychological, physical and mental wellbeing. Characteristics of this period include many adaptational, developmental

and transformational changes, one of which often entails relocation and adjusting to new living arrangements.

Since the dawn of ages, older individuals have been exposed to biological decline, loss, separation and social isolation (Sigelman & Rider, 2018). During the process of ageing, several progressive physiological and mental changes occur, often resulting in issues of physical, psychological and social adjustments coming to the fore. These include coping with a decline in functional abilities, dealing with multiple losses, and changing social relationships and roles (De Sousa, 2014; Eysenck, 2004; Newman & Newman, 2018). During this period of life, older people experience an increase in life stressors and adjustments and endeavour to maintain a purpose and well-being (Drageset, Haugan & Tranvåg, 2017). Prime indicators of emotional and mental health in people of all ages are being able to successfully adapt to and cope with the stresses and changes of life (Lerner *et al.,* 2012). Wadensten (2006) describes the psychology of ageing as the ability of the individual to adapt to changing circumstances during adulthood. A variety of psychological theories refers to typical adaptational challenges older people are confronted with, as well as to what the process of ageing implies for living arrangements during late-life. A purposive selection of these theories will be discussed next.

2.1.1 Psychological theoretical perspectives on ageing

The theoretical perspectives discussed below were chosen because they provide insight into the characteristics of the life phase(s) older people find themselves in (Wadensten, 2006) and not the theoretical worldview, paradigm or mindset these perspectives represent. It is acknowledged that much critique has been voiced against some of the paradigms and assumptions those theorists represent (Katz & Calasanti, 2015). It can, however, not be denied that all these theoretical perspectives in some way may provide insight into understanding the process of ageing and how this may illuminate and clarify experiences of relocation of older people.

Havighurst (1972, as cited in Katz & Calasanti, 2015) provides an early formulation of the process of ageing. His *activity theory* postulates that individuals progress from one life stage to the next by successfully resolving problems or mastering developmental tasks that present itself at different stages throughout the entire lifespan (Havighurst,

1972; Lange & Grossman, 2018). He states that people in the later-maturity stage (over the age of 60) adapt to declining health and physical strength, as well as adjust to retirement, to the death or loss of a spouse or significant others and have to meet civil and social obligations (Havighurst, 1972; Lange & Grossman, 2018) relevant to this life stage. In facing these adaptations, elders are often confronted with decisions about their current living circumstances. Knowledge of these crucial tasks or experiential issues that present themselves during old age are thus useful in understanding and analysing experiences that older people may have that relocate to residential care facilities.

Erikson's theory of *psychosocial development* represents the combination of eight life cycle stages, each having a developmental challenge or crisis that needs to be resolved before moving on to the next one (Erikson, Erikson & Kivnich, 1986). He postulates that human development and learning are lifelong processes and not restricted to childhood and adolescence, but continue into old age. The content of this stage is determined by the social and cultural context of the individual's reality as well as the historical past and present moment (Arnett & Tanner, 2009). After his death, his wife, Joan, who was also a psychologist, added the ninth stage of psychosocial development, namely elderhood, based on Erikson's realisation late in his own life that the eight stages were insufficient to explain life experiences of older people (Newman & Newman, 2018). She postulated that towards the late 80s and early 90s, elders were faced with new problems and greater demands. The older person then again faces all the crisis of previous eight stages, which converge simultaneously. In her (Joan's) view, negative elements dominate the person's personality in the ninth stage (Erikson & Erikson, 1997). Increasing loss of physical abilities that erodes autonomy (Arnett & Tanner, 2009) and friends passing away, elders now more than ever, begin to mistrust themselves as well as the environment. This contributes to feelings of despair (Aktu & Ilhan, 2017; Erikson *et al.*, 1986). In an article by Agronin (2013), he explains Erikson's views as a tussle between developments and being mindful of one's declining body.

Daniel Levinson's *"Seasons of Life"* theory postulates that development is a series of stages that adults go through as they progress through life (Agronin, 2013; Levinson *et al.,* 1978). The main focus of this theory is on the concept of change. Levinson views the transition to the stage of late adulthood as a time where the elder cohort start to

reflect on successes and failures in life and the decisions they have made (Levinson *et al.*, 1978). Levinson's model entails two key concepts, namely the stable and transitional periods in a person's development. The stable period is the time when a person makes crucial choices, find life goals and build a life around these goals (structure). The transitional period represents a transformation with life-altering changes that culminate in initiating a new structure with new goals (Levinson *et al.*, 1978; Aktu & Ilhan, 2017).

This concept of transition has much relevance for older people who relocate to residential care facilities. Levinson describes a transition as a turning point that holds both the promise of hope and the reality of separation and loss. The phase includes the termination or ending of the existing life structure, finding a new self within the world, and building a new life structure, a beginning (Levinson, 1996). According to Levinson, transitions involve loss, feelings of abandonment and helplessness, but also finding a greater sense of meaning and exploring new choices (Levinson, 1996; Aktu & Ilhan, 2017).

Maslow's theory of *psychosocial needs* (Maslow, 1943) postulated a five-tier hierarchy of needs that actively motivates people's behaviour, with self-actualisation being the central theme of his work (Corey, 2017). His motivational levels are organised in ascending order with physiological needs being the most basic and self-actualisation at the top (Venter, 2016). The most basic needs include the need for water, food and shelter. He proposed that, before higher needs could be fulfilled, the needs at the bottom of the hierarchy first have to be satisfied (Bergh, 2012).

In the context of older persons, this would mean that if their very basic needs for nutrition and housing were fulfilled, their "second level" of need for safety and security would be motivated. The need for safety and security encompasses the need to find protection from threats and danger (Newman & Newman, 2018) for oneself, others and one's possessions. With the high rate of crime in South Africa, it may be that older persons are actively motivated to achieve a sense of safety and security, contributing to the decision to relocate to residential care facilities (Bekhet, Sauszniewski & Nakhla, 2009).

Social needs to belong and to be loved form the next level and include the need for interaction and being with family and friends, as well as belonging to a group (Newman & Newman, 2018). The loss of an older person's spouse, or the fact that children do not live near, are factors that influence their needs for love and belonging. The third level of needs are related to how life is experienced (Bergh, 2012). It includes needs for feeling useful (achievement), independence and self-esteem and being respected both by others and by oneself (Corey, 2017).

The upper echelon of Maslow's hierarchy refers to the needs of striving towards self-actualisation, where older people have a desire to achieve their full potential (Bergh, 2012). Some older people might have fulfilled their need for self-actualisation earlier on in life, and might now again focus on their lower-order needs (Wang, 2012). On the other hand, others may look back on their lives and ponder on whether they had in fact achieved their full potential. Such evaluations may leave them either with feelings of accomplishment or of regret (Zaaiman, 2012).

Before passing away, Maslow identified a higher, sixth level of need, namely that of transcendence (Venter, 2016), which, together with having a sense of purpose in life, includes needs of a spiritual and religious nature (Zaaiman, 2014). The importance of religion and spirituality increases as people age (Ward, Barnes & Gahagan, 2012). Older people become more aware of death, and this may contribute to the increased importance that one's life had meaning that accompanies the spiritual domain of life (Zaaiman, 2014).

As with the other theories discussed, Maslow's theory is also criticised especially for the strict focus on the hierarchical order of needs. However, the relevance for this study is to understand how fulfilment or dissatisfaction with non-fulfilment influence elders' experiences of relocation.

The *Self-Determination Theory* (SDT) of Ryan and Deci (2017) states that autonomy, competence and relatedness are universal psychological needs, which motivate human behaviour. People will function optimally if these needs are met and supported by the social environment. In the context of older people, autonomy relates to them making their own decisions, taking responsibility for their own behaviour (Ferrand, Martinent & Durmaz, 2014), and expressing their true nature (Zaaiman, 2014).

Competence relates to the need of older persons to feel effective in their interaction with the social environment (Ferrand *et al*., 2014; Zaaiman, 2014), while relatedness refers to the need for belonging, being connected to others for mutual, supportive relationships (Zaaiman, 2014).

Literature regarding the role of culture in self-determination is still undecided. Some scholars view self-determination as a dispositional characteristic (Ginervra *et al*., 2015) of individuals that is independent of culture. They do however acknowledge that self-determined behaviour may be expressed in different ways as a result of a variable such as culture. Other scholars, especially cross-cultural theorists, view self-determination as a "western cultural ideal" (Ginervra *et al*., 2015). They propose that more individualistic (independent) cultures value self-determination and autonomy by the individual, but that more collectivistic cultures (valuing interdependence) have a pattern where family or the community make decisions on their behalf (Chirkov, 2008; Church *et al.,* 2012; Ginervra *et al*., 2015).

From an African perspective Jegede (2009) states that "Africa has a communal or social autonomy". An article by Lekalakala-Mokgele and Adejumo (2013) emphasize the importance of cultural and social patterns and obligations of family and the community, in an African context. The study by Church *et al*., (2012) however concluded that self-determined need satisfaction is important for many cultures.

Bronfenbrenner's *ecological systems theory* is a model that integrates the various environments and contexts with which individuals have contact, be it directly or indirectly (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006). Bronfenbrenner defines the microsystem as the closest one with which an individual has contact, including the home, family, school and peer groups. The interconnectedness and continuous interactions between the microsystems are referred to as the mesosystem (e.g. interaction between schools, families and religious organisations). Social settings that do not necessarily involve the individual directly, such as the neighbourhood and community are referred to as the exosystem. The broad ideology of a specific culture or subculture is the outer layer, referred to as the macrosystem. Major life transitions and socio-historical events are included in the outermost layer, namely the chronosystem (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006).

In accord with Bronfenbrenner (1979), Rowe and Kahn (2015) state that the important influence of social factors on the capacity of individuals to age successfully encompasses characteristics of the individual's immediate interpersonal environment. These include social systems such as family structure and friendships, as well as the more distant but powerful macrosocial influences, such as economic conditions, access to high-quality affordable health care, public transportation, and urban design. This makes Bronfenbrenner's theory important in understanding experiences of older people within any context.

Since its commencement, the primary focus of gerontological research has been on deterioration and losses associated with old age (Lange & Grossman, 2018; Riley & Riley, 1994). However, the other side of the coin entails positive ageing, which involves vitality, growth, striving and contentment (Baltes & Carstensen, 1996; Riley & Riley, 1994), as envisaged by the *model of selective optimisation with compensation* (SOC) of Baltes and Baltes (1990). The SOC model regards experiences of successful ageing as attaining goals through increasing gains and reducing losses in response to everyday demands and declining physical and/or cognitive functioning (Carpentieri, Elliott, Brett & Dreary, 2017).

The SOC model postulates that older people utilise their remaining strengths and resources to support their well-being. It acknowledges the nature of development in ageing (Nosraty, 2018). It creates awareness for how older people focus on setting, pursuing and attaining goals, culminating in successful adaptation to ageing. The successful attaining of goals despite losses is viewed as the result of the interaction of the three processes of selection, compensation and optimisation (Carpentieri *et al.*, 2017). The mindset of their model contribute to successful aging by helping older people maximise well-being in the context of physical decline and vulnerability (Baltes & Carstensen, 1996; Carpentieri *et al.*, 2017; Timonen, 2016). It is acknowledged that individual and cultural variations will influence the process (Lang, Rohr & Williger, 2011). Elderly persons who experience limited strength and resources often find it difficult to live an optimal life in their current residences. They therefore re-evaluate their current living environments and may consider moving to residential care facilities, which offer the support needed to minimise their losses and maximise their gains.

Common threads through all the previous literature regarding theories to understand the life phase of later adulthood and elderhood (Newman & Newman, 2018) include descriptions of changes in the domain of physical and cognitive functioning, the role of psychosocial needs as well as religion or spirituality. These domains of functioning during late adulthood will be discussed briefly to gain an understanding of how they may influence living arrangements.

2.1.2 Domains of functioning in late-adulthood

2.1.2.1 Changes in physical domain

In general, late-life is associated with physical decline. The inevitable process of ageing is characterised by the progressive degeneration of organs and tissue, which are determined by genetics and influenced by environmental factors (Knight & Nigam, 2008). Studies of adult biological/physiological processes show evidence of age-related decline and a shrinkage of the brain (De Carli *et al.*, 2005). Decline of mental abilities then leads to forgetfulness, often resulting in older persons taking prescribed medication incorrectly, or confusing medication prescriptions, exacerbating their current medical situation (Okuno, Yanagi & Tomura, 2001). The cardiovascular system also loses elasticity, which often leads to heart failure, stroke or cardiac problems in the elderly (Sawabi, 2010), necessitating additional care, which is not always available at home (Davis & Bartlett, 2008) and necessitate looking elsewhere for care.

Furthermore, the decline in muscle mass and loss of muscle strength in the elderly are associated with diminished health, as well as the loss of physical independence and diminished cognitive autonomy (Tolea & Galvin, 2015). Physical decline restricts elders to perform activities of daily life independently at home; brittle bones (osteoporosis) increase the risk of falls, thus leaving them vulnerable. Understanding how changes in physical health influence why elders consider relocating to residential care facilities (Newman & Newman, 2018) is significant, as this will most certainly influence their experience of the process.

2.1.2.2 Changes in cognitive functioning

Normal ageing is often associated with decline in certain cognitive abilities (Harada, Natelson, Love & Triebel, 2013). Although mild cognitive impairment is common

amongst some older persons, many others may only encounter subtle cognitive changes associated with ageing (slower memory or decline in making sound judgements), which can affect an older adult's day-to-day functioning (Harada *et al.*, 2013). Furthermore, manifestation of dementia increases exponentially with increasing age and doubles every five years after age 65 (Jorm & Jolley, 2014). The most serious cause of neuro-cognitive disorder is Alzheimer's disease, which affects between 60 and 80 percent of all people suffering from dementia (Hugo & Ganguli, 2014). Major neuro-cognitive disorders (dementias) have consequences for individuals and their families in respect of day-to-day functioning.

Research indicates that decline in older adults' cognitive functioning is less likely when they have strong social networks (Barnes, Mendes de Leon, Wilson, Bienias & Evans, 2004). The positive emotions experienced during social interactions are some of the most important reasons why it may be beneficial to cognitive functioning (Blanchard-Fields, Horhota, & Mienaltowski, 2008). Thus, the domain of psychosocial functioning will be discussed.

2.1.2.3 Changes in psycho-social functioning

Due to the elderly undergoing major changes in their lives, they can be considered as being psychosocially vulnerable (Winocur *et al*., 2007). The psychosocial approach views people in the context of the combined influences the surrounding social environment and psychological factors have on their mental and physical wellness as well as their functioning ability (Onyekosor, 2017). Studies relating to longevity and health in older people (Cohen, 2004; Friedman & Martin, 2012; Gilmour, 2012) have found that social networks and relationships that provide meaningful social engagement with others are vital in times of change. They provide emotional support and a sense of purpose. This is supported by the psychosocial approach regarding older people that are in a period of transition.

Social networks decrease with age (Luong, Charles & Fingerman, 2011), while bereavement and loss of family or friends increase (Newman *et al.*, 2018). However, older peoples' needs for inclusion in a larger social group never decrease (Charles & Mavandadi, 2003; Snowden, 2001). Therefore, losses enhance experiences of loneliness, isolation and loss of social support resulting in anguish that disrupt elders'

physical and mental health (Charles, Carstensen & McFall, 2001; Hawkley & Cacioppo, 2010). To regain and satisfy the continuous need for inclusion and a sense of belonging thus often contribute to the decision of the older individuals to move into a residential care facility where they can enjoy community relationships and their social engagements can be enhanced (Heisler, Evans & Moen, 2004).

2.1.2.4 The role of religion and/or spiritual functioning

Because religion and spirituality are intertwined and difficult to define, it will be used interchangeably for purposes of this study. Religion and spirituality are related and have common characteristics, and both can involve personal transformation and the search for an ultimate truth (Seybold & Hill, 2001). Religion and spirituality are often considered together, particularly when relating to the meaning of life (Zimmer *et al, 2016*). Louw and Louw (2014) define religion as "an organised system of beliefs and practices that have the aim to worship and honour God or a god". On the other hand, it is postulated that spirituality "conveys the notion of a personal search relating to things sacred and transcendent" (Crowther *et al.*, 2002). Marcoen (2005) elaborates that spiritually is a response to the search for meaning in a person's life.

Various scholars in the field of gerontology found that older persons gain much from religion and spirituality, such as

(1) improved general psychological wellbeing and life satisfaction (Van Ness & Larson, 2002; Dillon & Wink, 2003);
(2) a decrease in physical health problems and a decline in mortality rates (Kirby, Coleman & Daley, 2004);
(3) a decrease in mental health problems such as depression and a lower suicide rate (Nisbet, Duberstein, Conwell & Seidlitz, 2000); and
(4) an increase in positive relationships and an improved social network from which to draw encouragement and emotional support (Rote, Hill & Ellison, 2013).

People also learn to look beyond themselves and their own problems, becoming aware of and helping others with their problems, and experience much fulfilment from so doing (Foos & Clark, 2008). Positive emotions are generated by participation in

worship and prayer. Participants accordingly experience hope and optimism, and have positive expectations of the future (Mattis *et al.*, 2017).

In a South African study with older people in residential care (Van Biljon *et al.,* 2014), the researchers found that the importance of older persons' belief systems is revealed in the way in which they refer to spirituality. Elderly participants confirmed that their spirituality strengthened their functional coping strategies in dealing with adversities they experienced. It was also found that the spiritual worldview of the elderly encouraged them to be mindful of others (Van Biljon *et al.*, 2014).

The attendance of religious/spiritual gatherings was found to contribute to older people's coping, how they adapt to adversities, but also to the process of adaptation to relocation. It is an opportunity for the experience of social interaction (Pietrukowicz, 2001), and to discuss and share life experiences with like-minded people, of the same faith, (Farinasso, 2011; Krause, Shaw & Liang, 2010). The sense of belonging enables older individuals to perceive that their feelings are accepted and understood, which leads to a feeling of welcome, acceptance and support (Chaves & Gil, 2015).

This concludes the discussion on the life phases, its characteristics and challenges that characterise the years of people older than 60. The discussion illuminates some theoretical perspectives about the process of ageing and the context within which many elderly people start to re-evaluate their living arrangements. The next section will provide clarity about the nature of typical living arrangements found with people of the elder cohort.

2.2 LIVING ARRANGEMENTS AND HOUSING IN LATE-LIFE

People's wants and needs for housing change over time as events (such as marriage, raising families, and career promotions) arise. This results in adults re-examining their living environments and making changes as needed and preferred. This is also true for the elderly cohort (Golant, 2018). However, a growing body of research indicates that the majority of older adults prefer to "age in place," staying in settings within which they are familiar (Frank, 2002; Golant, 2018). This is generally true for people of all cultures (Bothman et al., 2009 as cited in Tanyi & Pelser, 2018). Even when older individuals' health decline and they depend increasingly on care, they still prefer to age in their own homes (Szebehely & Trydegård, 2012). As people grow even older,

this re-evaluation continues, and alternative housing options may be considered because of their changing circumstances (Anikeeff & Müller 2012), or because of a life event or financial situation (Luborsky, Lysack & Van Nuil, 2011).

Golant (2011) argues that older people first try to regain “residential normalcy” by re-evaluating their current housing realities, using “accommodative and assimilative strategies” (Granbom, 2014, p.23) to cope with the challenges that their housing realities may present, especially when they are not able to relocate. This may include making environmental adaptations to the house that focus on removing barriers to independent living (Granbom, 2014). Such measures (adding ramps, adding bathroom and toilet fixtures, etc.) often enable people to age in place.

However, increasing dependency on care (Fonad, Wahlin, Heikkilä & Emami, 2006; Robison, Shugure, Porter, Fortinsky & Curry, 2012), as well as struggling with a sense of security (Breitholtz, Snellman, & Fagerberg, 2013), the loss of a life partner, a decrease in social involvement, and becoming isolated, are all factors contributing to a conclusion of change in living arrangements (Andersson *et al.,* 2018; Golant, 2018) in favour of a move to a residential care facility.

Research indicates that housing and living arrangements in societies are influenced by many factors that link to socio-economic realities and trends, to life-course events as well as to the sociocultural background of individuals (Golant, 2018; Munthree & Ngyende, 2017; Oswald & Rowles, 2007). International research (Wilmoth, 2001) has found that 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 (Newman & Newman, 2018; Wilmoth, 2001). The argument is that older persons feel more supported in collective environments (Halaevalu, Ofahengaue, Gaynell & Simpson, 2014), the argument being that the culture of rules, rituals and procedures within the society (Idang, 2015) promotes elders’ understanding of the world (Liu, Volcic, & Gallois, 2014) and creates a sense of community.

The South African black culture is known generally to embrace a collective way of life (Cherry, 2014), contributing to the welfare of the collective over that of the individual (WHO, 2014). In an early study regarding the perspectives of older black people in

institutional care, Ryke, Ngiba and Strydom (2003, p. 139) state that, “the traditional cultural perspective of black people is to keep their elderly persons with them, whilst their white counterparts go to institutions”. However, they conclude that traditional views are challenged and replaced by views that are more modern.

Presently, ageing in Africa and South Africa is predominantly a family concern (Indongo & Sakaria, 2016), with older people relying on support for care from the younger generation (Dolo, 2010; Muntree & Ngyende, 2017). Accordingly, as the older generation increases in numbers, households might increasingly include elderly persons; however, a recent trend regarding households that include older persons reveals that family members are increasingly concerned about the older persons’ dependency status, and/or the specific roles they fulfil in the family household (Hillcoat-Nalletamby, Ogg, Renaut & Bonvalet, 2010), with patterns of care-giving being challenged.

One can therefore conclude that in traditional African societies, including South Africa, extended families typically are expected and still do provide care for elders (Dolo, 2010; Schatz, Madhavan, Collinson, Gómez-Olivé & Ralston, 2015). However, changes in lifestyle of developing societies such as South Africa result in the reality that elderly persons can no longer rely on family support structures for care. This is due to urbanisation and modernisation, as well as children of all genders leaving home to earn a living (Munthree & Ngyende, 2017). This may lead to a situation where elders have to consider alternative living arrangements such as residential care facilities.

Demographical information regarding living arrangements in Africa in general, shows that more than 50% of older people live in extended households, but that there is an increase in the number of single-elderly households (WHO, 2014). The 2017 Census results (Statistics South Africa) further reveal that there is also a growing trend among all South African population groups of older persons living alone. It is furthermore concerning to note the increasing number of households comprising only poor, inactive elderly persons (Bulete, 2010; Jorgensen, 2011), who have find it increasingly difficult to cope with everyday living. Furthermore, in South Africa, 47% of rural households rely on elderly family members’ grants, pensions and allowances to meet their financial

obligations (Department of Social Development, 2010), thus leaving already vulnerable elders even more vulnerable.

Over the years, various international and national reviews of research have indicated the impact on both quality of life and subjective well-being of older people who have relocated to residential care facilities (Löfqvist *et al*., 2013; Mackenzie, 2001; Niebuur, 2014; Van Biljon *et al.,* 2014). It is therefore important to understand what relocation entails and means for older individuals. The next section will focus on the concept 'relocation' and various antecedents and consequences for older people during late adulthood.

2.3 RELOCATION DURING LATE-LIFE

As seen in the previous discussions, late-life can be considered a period of transition, i.e. a process with an end and a new beginning (Levinson *et al.,* 1978), due to unique demands of ageing. These may include changes in living arrangements and relocation, adjustment to losses, or changes and limitations in social circles (Ellis, 2010). When entering the phase of late-life, it can be expected that the unique demands of ageing (discussed in 2.1) also increase the chance of relocating to more suitable living arrangements, such as retirement homes or residential care facilities, that suit, facilitate and support their physical and psychological needs (Falk, Wijk, Persson & Falk, 2012). In the next pages, the researcher will focus on the concept of relocation, followed by theoretical perspectives regarding relocation of older people. Thereafter, the reasons and antecedents for relocation are discussed, followed by the discussion of the experiences of, and adjustment to relocation. In conclusion, the reader will be reminded of the South African realities regarding relocation and the need for this study resulting in its aim. The section ends with a summary of this chapter.

2.3.1 Conceptualising relocation

Relocation generally involves moving from one location to another, adjusting to new surroundings and experiencing a change in a life situation (Remer & Buckwalter, 1990). The move to a new residence can be for various reasons and is strongly linked to life course events. The transitional process of relocation itself can also be viewed as an important situational stage. Such transitions involve intricate person-

environment interactions entrenched in the context and the situation of the process. It disrupts the person's life as well as the person's normal responses to disruption (Rossen & Knafl, 2007). The transition or move to a residential care environment has been identified as a significant form of relocation for older people that affects their psychological well-being (Löfqvist *et al.,* 2013).

Castle (2011) and Ramashala (2001) state that older individuals can experience five types of relocation, namely

- intra-institutional (moving to another room or another floor within in a residential care facility);
- inter-institutional (moving from one to another institution, for example, from a care home to a rehabilitation facility, hospital, or moving to another residential care facility);
- residential (moving to another home);
- residential or institutional relocation, which is moving from home to an institutional care setting; or
- leaving home and moving to a long-term care unit or a residential care facility (Castle, 2011; Ramashala, 2001).

In this study, the focus is on older people moving from their home to a residential care facility.

2.3.2 Theoretical perspectives on relocation

In this section, theoretical frameworks that contribute to one's understanding of older persons' transitions in their living environments will be discussed.

Lawton and Nahemow's (1973) *ecological theory of competence and environmental press* explains the interactions between older persons with their environments (Perry *et al.,* 2014). Lawton and Nahemow's theory assists one in understanding the decision-making processes, physical and emotional well-being, and the residential environment of older people (Byrnes, Lichtenberg & Lysack, 2006) who relocate to residential care. This model entails five key factors, namely individual competence, environmental press, adaptive behaviours to press, emotional experiences to press

and elders' adaptive capacity to solve the problem. These factors will be discussed briefly to clarify what they mean in the context of relocation.

- Individual competence encompasses the individual's ability to solve problems, which involves
    - the assessment of a current situation (such as the elderly not being able to live in their current home any longer);
    - identifying a desired solution (such as living in a residential care facility); and
    - determining how to transform the current reality into a desired situation (Perry, Anderson & Kaplan, 2014).

  If the older person is competent to solve the problem related to relocation as described above, it could have a positive impact on the experience of the older individual's transition to a residential care facility. However, where individual competence is lacking, it may result in ''self-neglect'', often resulting in extreme unsanitary living conditions (Moye & Marson, 2007). Family members or other significant others then tend to "push" the person to relocate, often leading to "intense" involuntary relocation with negative results.
- Environmental press focuses on the interaction between an individual (older adult) and environmental factors (such as an unsafe neighbourhood, or home not adapted to suit their needs), resulting in certain behavioural and emotional responses. In this context, Lawton and Nahemow (1973) created the idea of *person-environment fit*, which pertains to a match between the older person and the environment (Granbom, 2014). If the environment cannot be adapted to suit the continually changing needs of the older person, or the individual cannot adapt to the physical environment, a fit between the older person and the environment is absent. This "misfit" may provide pressure on the individual and lead the person to re-evaluate the current situation and consider relocating to a new living environment.
- Lawton and Nahemow (1973) postulate three possible behavioural and emotional responses to the interaction between environmental press and individual competence

- Firstly: Adaptive behaviours – these are behaviours portrayed in response to the press exerted by the environment and represent the older person's competence. Social norms as well as personal values are determinants of adaptive behaviour (Perry *et al.*, 2014). Older people with lower individual competence may portray maladaptive behaviours as they are deemed more sensitive to environmental stressors (Wu *et al.*, 2015) and less able to cope with environmental demands (Cavanaugh & Blanchard-Fields, 2018).
- Second: Affective responses referring to the emotional reactions to the transactions between the environment and behaviour. In other words, how does the elder feel regarding their behaviour in the context of the interaction? Cognisance should be taken of every ageing person's subjective interpretation of his/her experiences of, and responses to, the environment (Perry *et al.*, 2014).
- Lastly: Adaptation capacity/level explaining the emotions of older persons in response to demands by the environment; these emotions then motivate or urge elders to make adaptations that either decrease the environmental press or increase their personal competence (Perry *et al*., 2014)

Since the publication of Lawton and Nahemow's theory, a growing body of research (Bekhet *et al.*, 2009; Capezuti *et al.*, 2006; Keister, 2006; Rossen & Knafl, 2007; Walker, Curry & Hogstel, 2007; Yeboah, Wowers & Rolls, 2013) has built upon their work and suggests that many factors influence the positive or negative ways in which older people view and experience relocation. These factors may include and relate to individual competence and environmental press, as posited by the seminal work of Lawton and Nahemow (1973, as cited in Perry *et al.*, 2014). However, functional changes, tangible and intangible resources, life events, evolving needs as well as culture (Perry *et al.*, 2014; Pruchno, 2014) also need to be taken into account in any theory trying to understand the process of relocation during late-life. These will be clarified in the next section (2.3.3).

Environmental gerontologists' theoretical lens on relocation involves continuously exploring the definitions and meanings of *place making* for older adults. In their exploration they consider on two facets: the interaction between the ageing process

and space, place and environment (Clark, 2014), and the imbedded routines and habits and moving of possessions (Clark, 2014). In accordance, the *life course model of environmental experience* explores the processes of "creating a sense of being in time and place and its relationship to well-being" (Perry *et al.*, 2014). It highlights development and change that take place over the life span, which are interlinked with the social contexts of other people, their relations, and developmental processes (Kim & Moen, 2002). From this perspective, relocation in older people is viewed as an integral part of the elder's life story and adapting to relocation and creating a sense of place follow the lines of the individual's life course patterns (Oswald & Rowels, 2006).

Wiseman's (1980) *behaviour model* posits that relocation decisions are determined by the older person's level of satisfaction with their current residence (Kaplan, Andersen, Lehning & Perry, 2015; Perry *et al., 2014).* "Triggers" (push and pull factors) that lead older persons to re-evaluate their satisfaction with their current residence include a change in their preference of lifestyle, or serious life events necessitating an immediate change of residence (Perry *et al*, 2014). Wiseman (1980) also refers to the presence or absence of resources as contributing factors towards relocation, which will be discussed later in this chapter. Wiseman (1980) differentiates between persons who relocate involuntarily and those who move voluntarily. Another of Wiseman's concepts pertain to involuntary stayers, which refer to older persons who are unable to relocate, despite major concerns about environmental and care needs related to financial and physical limitations (Perry *et al.,* 2014). A more detailed exploration of the "triggers" as mentioned by Wiseman will be provided in 2.3.3.

Litwak and Longino's (1987) *developmental model of migration* for older individuals who move states that decisions about relocation are strongly influenced by life events and involve the individual, family and society *(Perry et al.,* 2014). Litwak and Longino (1987) state that relocation during late-life are circumstantial adaptations to continuously changing personal priorities and needs of the elderly (Perry *et al.*, 2014). From this theoretical lens, they postulate three types of moves that normally occur after older people have retired. The first move occurs on retirement, which usually involves the enhancing of lifestyle or being closer to friends. The second transition takes place when there is a moderate decline in functional abilities, and a final relocation occurs when major disabilities force the older individual to move. The last

two moves usually involve older persons moving closer to family or to more supportive living environments (Perry *et al.,* 2014).

2.3.3 Reasons and antecedents driving relocation

The reasons for relocating differ between the “young-old” and “oldest-old” and between older people living alone versus cohabiting with other older people (Löfqvist *et al.*, 2013). However, this study will not focus on this distinction, but rather on general trends.

Scholars in the field of gerontology have identified many factors that influence people of the older cohort to relocate to residential care. Golant (2011) mentions that an important motivation for older people moving to residential care facilities includes improving their quality of life. Wahl, Iwarsson and Oswald (2012) have found that elders often find themselves at crossroads regarding their health vs. their housing and independence. This often results in a decision to relocate to residential care. For others, the motivation may be the search for a safer environment (Berg & Lune, 2013), while frailer older individuals may relocate in search of increased physical or social support (Perry *et al.*, 2014).

As posited by Wiseman (1980), generally, reasons for moving to residential care facilities can be classified under push factors, pull factors or a combination of both pulling (attracting) and pushing (pressing, coercing or repelling) factors (Bekhet *et al.*, 2009). The “push” factors generally push people away from their previous residence and entail a degree of involuntarily relocation, whilst “pull” factors pull people towards moving to a new residence; thus, the personal need and circumstances both move in the same direction (Bekhet *et al.*, 2009). However, negative push factors such as isolation, high crime rates, poor health services and unemployment can also influence the decision-making process of some elderly people to move to residential care facilities. Furthermore, Hays (2002) reports that when elderly suffer from acute, chronic or progressive illnesses that cause cognitive or functional decline, decisions are often made to relocate.

In a study at a residential care facility in Australia, Stimson and McCrea (2004) have found that push factors generally include the need for assistance, problems with maintaining a home, and the need for change in lifestyle. Other life events experienced

by the elderly that often lead to relocation include the death of a spouse, of a relative or close other, illness of oneself, relative or friend, and change in marital or economic status or residence (Tschanz *et al.*, 2013). Furthermore, Caro *et al.* (2011) report that push factors include rising property taxes and living costs, lack of social support from children living far from their parents or living abroad. Some elders are unmarried, may be living alone or have other functional impairments related to old age (Caro *et al.*, 2011).

From an environmental perspective, the dated construction, equipment and a home that is not barrier free can be push factors that affect accessibility in the present home and thus the older person's ability to maintain an independent life (Andersson, Pettersson & Sidenval, 2007; Oleson & Shadick, 1993). In trying to cope, elders might rearrange furniture or make use of an assistive device, which may fulfil or fail their needs (Caro *et al.*, 2011).

Exploring pull factors, i.e. factors that attract elders to relocate to residential care facilities, research has found that proximity to family and friends (Andersson *et al.* 2007; Oleson & Shadick, 1993), affordability, unit design, access to public transportation, services and facilities are important. Other positive pull factors identified by researchers are better health and care facilities, attractive accommodation and freedom from neglect (Krout, Moen, Holmes, Oggins & Bowens 2002). Bekhet *et al.* (2009) report that pull factors are considered therapeutic, because the move to the residential care facility is viewed by the elder as desirable and undertaken voluntarily. However, if the push factors are perceived negatively by elders, it could influence the elders' wellbeing negatively.

In section 2.3.2 (p. 21) it was mentioned that scholars in the field of relocation have found that more factors than individual competence and environmental press, as posited by the seminal work of Lawton and Nahemow (1973), influence elders' decision to relocate to and their experience of residential care. Two of these pertain to the availability of either tangible or intangible resources. If tangible resources such as health and wealth decline or social support are absent and the cost of living or the maintenance of a home increases, it may contribute to the choice or need for relocation. Relocating to a residential care facility minimises these stressors

experienced prior to relocation, and elders tend to experience the transition as positive (Gilbert, Amella, Edlund & Nemeth, 2015).

Intangible resources that affect the decision and experience of relocation to a residential care facility refer to personal relationships within the current community, own mental resources, and the perception the older person might have of possible outcomes of the relocation (Perry *et al.*, 2014). Dodge, Daly, Huyton and Sanders (2012) report that when older people experience a balance between their available resource pool and the social, psychological, and/or physical challenges faced, they experience a feeling of well-being. Thus, depending on whether elders possess the resources to meet the 'push-and-pull' challenges posed by relocation, their experience of the process will be affected. The following section will explore literature and research accounts about experiences of and adaptation to the process of relocation.

2.3.4 The experience of and adjustment to relocation

The needs of older people, as with people of all ages, are not fixed, but change over time. How individuals perceive these changes affects how they experience relocation (Andreoli, Musser & Reiser, 2014). Elders do not move frequently (Sergeant, Ekerdt & Chapin, 2008), but relocation for whatever reason remains a stressful major life event (Löfqvist *et al.*, 2013; Sussman & Dupuis, 2014) and can be perceived as positive or negative (Bekhet & Zauszniewski, 2014) by the individual involved.

Rossen and Knafl (2007) report that aspects contributing to a positive experience of relocation to residential care include satisfaction with the quality of care services, appropriate and comfortable housing conditions, a variety of social activities provided by health care staff, unexpected gains, sense of security, and finding meaning in the experience. These positive factors assist older people in becoming creative, enhancing new relationships, and developing new coping strategies when relocating.

On the other hand, relocation to a residential care facility usually involves moving into a smaller space, often requiring minimising possessions (Addington & Ekerdt, 2014), which influences the accompanying feelings and experiences. Negative outcomes of relocation to a residential care facility also include decreased independence, increased use of healthcare services, deterioration in health and quality of life, escalated health care costs, and increased risk of institutionalisation (Rossen & Knafl,

2007). Feelings portrayed as a result of these outcomes therefore include those of loss (Hodgson, Freedman, Granger & Erno, 2004), sadness, anger, depression, morbidity, loneliness, anxiety, as well as sometimes attempts at suicide and even mortality (Castle, 2011).

Researchers also report feelings of ambivalence (relief to be taken care of versus loss of autonomy (Löfqvist *et al*., 2013; Vahid, Vahid, Azad, Lynnette & Eesa, 2016), as well as feelings of uncertainty, emptiness and fear of losing their identity with the reliance on increased assistance of staff (Anderberg & Berglund, 2010). In another study (Sim, Liddle, Bernard, Scharf & Bartlam, 2012) report that elders in general wish to remain independent for as long as possible and despise being labelled as 'non-capable old'; they therefore perceive it as threatening when they feel they are losing control over daily routines in a residential care facility.

Regarding the process of transition itself Johnson and Bibbo (2014) report that older adults in transition usually experience three phases when moving to residential care. Phase 1 commences from the date of admission and could last for two weeks to one month (Lee, Woo & Mackenzie, 2002). These first four weeks after admission is the most stressful for older people, and they often feel abandoned and helpless (Kao, Travis & Acton, 2004). During this time, emotional responses of feeling overwhelmed by the new environment are often evident. This sense of being overwhelmed (Jungers, 2010; Winningham & Pike, 2007) entails feeling lonely, sad, crying, being afraid and experiencing a sense of loss. Furthermore, moving into a small room, perhaps lacking privacy and a private bathroom (Hughes, 2004) can also lead to feeling overwhelmed.

The second phase starts around the third or fourth week to about the fifth month after admission, and entails adjustment and integration into the residential care facility (Lee *et al.*, 2002) and learning the ropes. During this phase, older adults become more optimistic about the future and begin socialising (Fraher & Coffey, 2011).

The final phase is working towards acceptance in the new environment. Ellis (2010, as cited in Stevens, Raphael & Green, 2015) postulates that it can take from 6 to 12 months, or even longer, and is often achieved by residents on a subconscious level. Now older adults realise they can do something independently, such as engaging with

others and making new friends (Salvesen, 2016) to improve the adjustment experience and increase their self-confidence.

Research finds that two factors greatly enhance older persons' adaptation to a new environment, such as a residential care facility; firstly, involvement in the decision-making process to move as well as the moving process itself (Andersson *et al.*, 2007; Oleson & Shadick, 1993; Stevens et al., 2015; Vahid *et al.*, 2016). Secondly, as older individuals experience decreasing functional decline and thus increased dependence, a sense of security is most important to them (Ernsth, 2007; Fors *et al.*, 2013). Thus, if older persons consider their sense of security in the residential care facility to be better because of staff being permanently available (Bekhet *et al.*, 2009*),* they adjust better to their transition to the residential care facility.

A study by Sussman and Dupuis (2017) has discovered a complex and layered connection between conditions that shaped residents' experiences of the transitional process and final adaption. They report that conditions that contribute to positive relocation experiences of older persons include pro-active decision making, preparing for relocation, moving-day practices and post-move adjustment. Sussman and Dupuis' (2017) conclusion reveals that if a sense of control and a sense of self-nurture is fostered during the process, new residents not only "adapt and adjust, but they can thrive and flourish within the new long-term care homes" (Sussman & Dupuis, 2017, p. 156).

The process through which older individuals create and experience a sense of home in their new environment has also been found to assist adjustment to residential care living (Cooney, 2012 p. 3; Falk *et al.,* 2012; Johnson & Bibbo, 2014). This justifies a brief discussion to understand the process of how older adults may create a sense of home after relocation.

Home is described as a place "being ideal" (Johnson & Bibbo, 2014). It is reported that the living space of a person's home is often viewed as an extension of the person and is narrowly linked to a sense of identity and meaning (Moore, 2000; Rowles, Oswald & Hunter, 2008). The home thus becomes a locus of control and self-preservation and the living space becomes vital, both in terms of the amount of time spent at home, as well as the creation of a place for activities. It represents a place of safety and security,

a place where the person feels protected and safe from the outside world. Home not only reflects a person's personal preferences, but the way in which the home is furnished and decorated with the person's possessions may even portray the person's personality (Rowles, Oswald & Hunter, 2008).

Understanding older persons' meaning of relocation deepens during exploration of their relationships with their homes, belongings and feelings about the process of relocation (Ekerdt, Luborsky & Lysack, 2012; Luborsky *et al.*, 2011, as cited in Perry *et al,* 2013). Moving out of one's home into a residential care facility is a meaningful and important human experience. Because of significant social interactions and personal experiences having occurred in the home over a length of time, strong feelings develop that bind people to it (Leith, 2006; Rubinstein & Parmalee, 1992). Golant (2011, p. 194) argues that older people try to achieve "residential normalcy". 194). However, regaining a life that is similar to what it was prior to moving into a residential care facility is a complex psychological process of orienting, normalising, rationalising and stabilising (Lee *et al.,* 2002; Lee, Simpson & Froggatt, 2013). The process begins with becoming familiar with the new environment, trying to continue with the same lifestyle as before entering the residential care facility. Then older persons start dealing with the new way of living, and eventually accept their new living environment (Lee *et al.,* 2002). Golant (2018) also suggests that, if older people use their previous home as a reference, they are able to achieve a sense of home in, and adjust to their new environment.

A significant study by Rijnaard *et al.* (2016) found that the three main factors that influence whether older people are able to create a sense of home in residential care facilities are: *psychological factors, social factors* and *the built environment itself. Psychological* factors include things such as a feeling that one is acknowledged, and that one can preserve one's habits and values in the new environment, as well as the perception of freedom and mobility (autonomy) and the feeling that one is coping. *Social factors* that were found to be successful in helping elders to create a sense of home were positive interactions and relationships with staff members that really care, making them feel that they are worthwhile, sharing hobbies and talents with other residents, and having contact with one's family and even endeared pets. The last category of factors identified by the study of Rijnaard *et al.* (2016) refers to the *facility*

as a building, its look and feel, as well as how residents can incorporate personal belongings in the space. These factors are interrelated and together help residents to create a sense of "at-homeness or homeliness" (Rijnaard *et al*., 2016:1).

This concludes the literature discussion of the phenomenon of relocation and the important elements that need to be considered to understand older people's experiences of relocation to residential care and how they create a sense of home in their new living environment. In conclusion we will just briefly pull together some highlights about the realities of living arrangements in the South African context that were discussed in chapter one and earlier sections of this chapter (2.2) to give a clear picture of the reality in which this study was executed.

2.3.5 In conclusion

To understand in full what ageing and relocation to residential care in South Africa entails for all its older residents, one needs to appreciate how the South African experience has affected its people, their life experiences, needs and resources (Ramashala, 2001). The reader is reminded of the fact that residential care facilities in South Africa have only been made available to older persons of all races since 1994. Those residential care facilities that are managed by the Government and NGOs are mostly occupied by low- to middle-income individuals, who are often dependent on state grants or limited pensions while privately owned facilities are still mostly occupied by white elders (MYSE Statistics SA, 2017).

Although the number of research studies regarding the living arrangement of middle- to lower-income elders has increased, most South African studies focus on older people who live in middle-class to more affluent facilities and thus most samples comprise people from the White population group. Furthermore, various reports (Dept. of Social Development, 2008; 2010) suggest that the quality of life of many older people living in residential care facilities is far from satisfactory. Van der Walt (2011) describes the circumstances in South African residential care facilities as challenging, with residents' sense of community being low. African communities have strongly connected caring structures that maintain the quality of life for older people (Indongo & Sakaria, 2016) and it could be that moving away from caring structures may influence the quality of life for African elders in residential care negatively.

Internationally living in a residential care facility is associated with an increasing chance of mortality of many older persons (Castle, 2014).

As mentioned in Chapter 1 (p. 4), South African research concerning elderly people living in residential care facilities is scarce. The research that has been done focuses mainly on the demographic aspects (Chigali & Marais, 2002; Dolo, 2010; Munthree & Ngyenda, 2017; Roy *et al*., 2018) as well as psychosocial (Van Biljon & Roos, 2015; Zaaiman, 2014), physical and mental care needs of older people (Zikali, 2018). Little has been done, however, to understand the *subjective experiences of older people who relocate to residential care facilities* in the South African dispensation since 1994.

The aim of this study therefore is to fill a gap by *focusing on the experiences of a small group of older people who relocated to residential care facilities that accommodate low- and middle-income individuals from all our countries cultural groups – included those who were previously excluded from such services.*

2.4 CHAPTER SUMMARY

In this chapter, an overview of late-life and the elderly was provided within the context of psychological theories regarding the process of ageing. It was followed by a discussion of living arrangements during the late-life phase. Lastly, a detailed discussion regarding the concept of relocation and theoretical lenses to view this phenomenon was presented. It included a concise review of literature and research regarding international experiences of relocating to residential care, as well as how elders adapt to residential living and create e new home. The following chapter will describe the research process and methodology that were used to explore these experiences.

CHAPTER 3:
RESEARCH METHODOLOGY

In this chapter, the researcher will give an overview of the methodology used. It will commence with the rationale, purpose and aim of the study. Thereafter an overview of the research approach and design will follow. Next, a discussion of the demographic and biographic information of the participants will be provided, followed by an overview of the sampling and data-gathering procedures. After this, an explanation of the data-analysis procedures that were used in this study will be given. The second-last section will cover the ethical concerns addressed in this study; how trustworthiness was assured; and the researcher's reflexivity. In conclusion, a summary of the chapter will be provided.

3.1 RATIONALE, PURPOSE AND AIM OF THE STUDY

The late-life phase poses many challenges and changes in the life of the elderly. They often face deterioration in their physical ability and health, they need to adapt to retirement, death or loss of a spouse and meet civil and social obligations (Havighurst, 1972; Marcoux, 2001; Perry, 2012). Changes encompass physiological, psychological and role-orientated life changes, which influence older peoples' general wellbeing and their experience of wellbeing (Agronin, 2013). These changes often result in the older person choosing or sometimes involuntarily having to relocate to a place where their changed circumstances and needs are supported. An increasing popular housing choice for older individuals are residential care facilities (Nathan *et al.*, 2013) and the elderly relocate them more frequently than in previous times (Hertz *et al.*, 2008; Sinunu *et al.*, 2009; Wilson, 2001).

South Africa has one of the fastest growing aging populations in Africa (Statistics SA, 2017; Westaway, 2010) and the highest percentage of older persons in Africa (Hoffman & Pype, 2016; Lombard & Kruger, 2009; Statistics SA, 2017) placing an increased demand on those who care for the elderly (Clement *et al.*, 2013; Van der Walt, 2011). In South Africa, residential care facilities for the elderly only became accessible to all South Africans regardless of ethnic and cultural backgrounds in post-apartheid South Africa (Dept. of Social Development, 2010) and typical trends

regarding the choice of housing are not yet known. However, recent promulgated legislation (*Older Persons Act, No. 13 of 2006*, p.6, Dept. of Social Development, 2006), that emphasise the rights of the elderly, includes the responsibility to promote opportunities for emotional, physical and psychosocial well-being, such as residential care facilities. Thus, understanding how the elderly experience moving to such facilities is important to ensure the well-being of older individuals during the process of adaptation.

Transition to a residential care environment – irrespective of reason – has been identified as the most significant form of relocation affecting older people and their psychological well-being (Löfqvist *et al.*, 2013). According to research (Yeboah *et al.*, 2013), older people view relocation as either positive or negative, depending on multiple factors. These factors may include

- individual competence (the ability to solve problems by identifying a desired solution and determining how to transform the current reality into a desired situation);
- environmental pressure (interaction between the environment and an individual), functional changes (e.g. physical and psychological);
- tangible factors (e.g., health and wealth) and intangible resources (e.g. social relationships),
- life events (e.g. retirement, death of spouse),
- evolving needs; and
- culture (Perry *et al.*, 2014; Pruchno, 2014).

Various reviews of research over the years have indicated serious impact on subjective aspects of wellbeing and quality of life of those older people who relocated to residential care facilities (Richards, 2011; Niebuur, 2014). Subjective experiences in general can be conceptualised as what elderly persons experience (for instance about a process such as relocation to residential care) and how they make evaluations regarding these experiences (i.e. how it made them feel or changed their lives). (Diener, Lucas & Scollon, 2006). It involves cognitive evaluations (also referred to as satisfaction), affect (positive factors being present and negative factors being absent) and eudemonia (indicating aspects of experiencing a sense of purpose in life)

(Niebuur, 2014). Therefore, as relocation experiences are subjective expereinces, it can be used to investigate individual transition experiences during and after relocation to an elder residential facility.

However, little has been done to understand the relocation experiences of older people in culturally diverse South African residential care facilities. Furthermore, research regarding the experiences of Black older people living in such facilities in South Africa is almost non-existent (Nexus database search, 23 October 2018).

Against this background, the relocation experience of older individuals living in culturally diverse and economically challenged residential care facilities will be investigated. This study will explore and describe the subjective experiences of older people who relocated to residential care facilities. The research question that will be addressed is:

What are the experiences of older people who relocated to residential care facilities?

3.2 RESEARCH METHODOLOGY, APPROACH AND DESIGN

An interpretive qualitative research stance was taken to investigate the phenomenon of relocation experience, as it specifically allows for an in-depth investigation of personal experiences (Creswell, 2014; Leedy & Ormrod, 2005; Povee & Roberts, 2014). The research was conducted as an inductive exploration and description concerned with the subjective experiences of a multi-cultural group of older South Africans in residential care facilities after a process of relocation. An overview of the essence of this specific approach and design is provided in the following sections. The strengths and limitations of each are stated, and the reasons are given for choosing this approach and design for this specific study. An explanation of the application of this approach and design in the current study is also provided.

3.2.1 Overview of the essence of the qualitative interpretivist research stance

3.2.1.1 Qualitative research

Qualitative research holistically explores the reality created by individuals in their everyday lives (Erlingsson & Brysiewicz, 2013). This approach gains an in-depth understanding of the individual by exploring and describing the feelings, actions and

behaviours of participants (Babbie, 2016) in real-world situations (Baxter & Jack, 2008). The qualitative research paradigm focuses on the subjective view of personal realities and not on the concrete realities of objects. It supports the ontological assumption of multiple truths and multiple realities, i.e. persons understand reality in different ways that reflect individual perspectives (Erlingsson & Brysiewicz, 2013). The qualitative paradigm portrays reality as holistic, multiple and subjectively constructed (Guba & Lincoln, 1982). The focus of such research is therefore on the collection of "real-world data" rather than relying on reproduced and objective facts (Yin, 2012).

Prior to the 1990s, qualitative approaches were viewed as subjective and unscientific in nature, and accordingly avoided (Freeman, 2013), but the use of qualitative methods of doing social research has since increased (Carrera-Fernández, Guàrdia-Olmos, Peró & Jac-Cebollero, 2014).

The advantages of the qualitative research approach include the fact that data gathered are descriptive, rich and representative of real-world situations and conditions (Babbie, 2016; Freeman, 2013) of the participants. Qualitative work allows the researcher to discover inner experiences of participants from different cultures, and to figure out how meanings are shaped (Corbin & Strauss, 2008). It gives the researcher access to investigate phenomena from a perspective that would not be possible using quantitative methods (Carrera-Fernández *et al.*, 2014). Additionally, the participants' views and experiences are obtained as they construct their own realities (Denzin, Lincoln & Giardina, 2006). Furthermore, it is exploratory by nature and "tends to tackle questions on which little or no previous research has been done" (Brown, 2006).

A limitation of the qualitative approach is that generally small numbers of participants are used, which may not adequately represent the target population. Furthermore, as the researcher plays an active role in generating information gained from participants, the impression can be created that the researcher is able to influence the results in favour of the research aim. Qualitative researchers, however, do not agree with these criticisms (Carrera-Fernández *et al.*, 2014).

As participants' answers are subjective by nature, one cannot view or understand their answers objectively. Although subjectivity is seen as a negative aspect of qualitative

research, the researcher will address the aspects of trustworthiness, namely credibility, confirmability, transferability and dependability later in this chapter (3.7), to provide evidence that the research was done as objectively as possible.

3.2.1.2 Interpretivist paradigm

The interpretivist paradigm in a qualitative approach focuses on individual cases or events and allows the researcher to understand individuals' different opinions of meanings and events (Klein & Myers, 1999) rather than to speculate and predict causes and effects (Creswell, 2014; Hudson & Ozanne, 1988;). The interpretivist paradigm presupposes that reality is multiple and relative (Hudson & Ozanne, 1988). Guba and Lincoln (1982) state that these multiple realities are further dependent on other systems for meanings, which complicate the interpretation in terms of fixed realities (Creswell, 2014). The knowledge acquired in the interpretivist paradigm is socially constructed rather than objectively determined and perceived (Hudson & Ozanne, 1988). Within the interpretivist paradigm, knowledge is augmented through naturally emerging insights during the interaction between the researcher and participants (Coffey & Atkinson, 1996; Hudson & Ozanne, 1988; Richardson, 2012). Rigid structural frameworks are avoided, and more flexible and personal research constructs are applied (Carson, Gilmore, Perry, & Gronhaug, 2001), which are open to meanings forthcoming from the interaction between participants and the researcher (Black, 2006), thus making sense of what is perceived as reality (Carson *et al.*, 2001).

Interpretivist researchers aim to understand "the world of human experience" (Cohen & Manion, 1994, p.36). Creswell (2014) and Yanow & Schwartz-Shea (2011) support the views of Cohen and Manion (1994) in that they, too, posit that interpretivist researchers uncover reality through the participants' backgrounds, views and subjective experiences. Richardson (2012) states that the individual meaning of different events adds to the source of knowledge in this approach. Individuals are unique and interpret situations differently, depending on the diverse experiences they have had (Freeman, 2013), and as such unique knowledge is created.

A qualitative approach from an interpretive paradigm was relevant to this study because it specifically allows focusing on the participants' personal experiences of relocation to residential care facilities. By gathering quality, in-depth data regarding

personal experiences regarding relocation the researcher can gain a true understanding of the experiences of the participants (Creswell, 2014; Leedy & Ormrod, 2005), as opposed to analysing objective data sets.

Although interpretivists have some prior knowledge of the context of their study, it is insufficient to develop a fixed research design because of the unpredictable, multiple and complex nature of what is perceived as reality (Hudson & Ozanne, 1988); hence, an exploratory research approach is often followed.

3.2.1.3 Exploratory research approach

This study was designed as an exploratory investigation to collect, discover, identify, explain and generate feelings, thoughts and behaviours (Creswell, 2014) regarding the phenomenon of interest. The aim of these tasks is to uncover all the different thoughts that people have, not just those they have in common. Most of the information forthcoming from exploratory research is unique, coming from the participants' personal subjective experiences (Fern, 2001). Exploratory research is intended to explore a research topic. It does not intend to offer final and conclusive answers to research questions, but to contribute to a better understanding of a problem that has not yet been clearly defined (Saunders *et al.*, 2012).

Advantages of exploratory research are that it is flexible and adaptable to change, it is effective in laying groundwork leading to future studies and saves time in that it determines the types of research that are worth pursuing, at an early stage (Saunders *et al.*, 2012) and provide a thorough description of the findings.

Disadvantages of exploratory research are that it generates qualitative information that is subject to bias, and findings are usually not useful for making decisions at practical levels (Saunders *et al.*, 2012). Sample numbers are relatively small and therefore the findings of exploratory research cannot be transferred to a wider population (Baxter & Jack, 2008; Harry & Lipsky, 2014).

An exploratory method was appropriate for this study as an attempt was made to identify themes within a social reality that is relatively new in the social context of middle- to lower-class South African older people.

3.3 RESEARCH PARTICIPANTS AND SAMPLING PROCEDURE

The population group of interest in this research were elderly male and female, black and white participants, who are older than 60, as this age is the average accepted age defining the onset of old age within the African context (World Health Organisation (WHO), 2014). Although late-life is generally viewed by developmental theorists as encompassing individuals of 65 years of age and older (Newman & Newman, 2018), for purposes of this study the African perspective was adopted (See 2.1: Late-life and the elderly).

Non-probability, namely purposeful sampling (Duan *et al.*,2013) was used to identify male and female, black and white participants living in residential care facilities, for this study. Purposeful sampling is widely used in qualitative research to identify and select information-rich cases and is one of the most effective ways of using limited resources (Patton, 2002). It involves the identification and selection of individuals or groups that are knowledgeable about or have experience in the phenomenon of interest (Creswell & Plano Clark, 2017). Babbie (2016) and Creswell (2014) states that the aim of purposeful sampling is to engage individuals who have explicit experience of the variable being studied and can fulfil the goals of the study, rather than to focus on the proportionality of the sample itself. The researcher used a homogenous sampling focus when identifying the participants for data gathering as the aim was to focus on a particular subgroup in which all the sample members had similar experiences relevant to this study (Saunders *et al.*, 2012).

An advantage of purposeful sampling is that it is one of the most cost- and time-effective sampling methods available (Dudovskiy, 2018; Robinson, 1999). Where only a limited number of people are available to serve as primary data sources who can contribute to the study, it may be the only appropriate method (Dudovskiy, 2018; Robinson, 1999). Another advantage of purposeful sampling is that participants can be selected according to their experience and according to their willingness to provide the necessary information (Tongco, 2007). This method gives researchers control over who is to be included and accordingly yields rich and meaningful data (Babbie, 2016), that is relevant for purposes of the study.

On the other hand, the choice of participants depends on the judgement or knowledge of the researcher and is therefore subjective in nature (Cooper & Schindler, 2006; Hair, Bush & Ortinau, 2000). Researcher biases could influence the choice of participants (Sharma, 2017) and as such, errors in judgment can occur when selecting individuals for purposeful sampling (Dudovskiy, 2018). To prevent subjectivity and errors in judgement clear inclusion and exclusion criteria should be stated.

Inclusion criteria for participating in this study were that participants had to be over the age of 60, live in a residential facility accessible to middle- and lower-class socio-economic individuals who may previously have been denied access to such facilities because of apartheid in South Africa. Participants were limited to elders who had lived in the residential facility for one year or less as the phenomenon of interest is the subjective experiences associated with relocation to residential care facilities and the perceived influence on their well-being. Participants were expected to be available and willing to participate, as well as being able to describe their experiences of relocation and express their opinions in this regard in a coherent, meaningful, and insightful manner (Etikan, Musa & Alkassim, 2016).

Persons with any form of serious cognitive and emotional impairment as indicated by the respective interdisciplinary teams of the participating residential care facilities were excluded from the study. Limited cognitive impairment or some difficulties by participants to express themselves fluently in English were not used as an exclusion criterion, as this was countered by the data collection method (focus groups) employed and the opportunity to speak in their preferred language. The final sample group consisted of 25 elderly participants of 60 years or older, who had been living in a residential facility for less than one year. The group comprised 9 White, Afrikaans-speaking and 16 Black, Sotho-speaking persons. Four of the participants were male, while the rest were female.

The research was conducted at three residential care facilities in the Free State province in central South Africa, one situated in Bloemfontein, one in Bochabela, which is in the Mangaung area adjacent to Bloemfontein, and one in the rural town of Boshoff situated approximately 120 kilometres north-west of Bloemfontein. The residential care facility in Bloemfontein accommodates English- and Afrikaans-speaking residents from the middle- to low socio-economic groups. The one situated in Boshoff

and the one in Bochabela accommodate English, Afrikaans and Sotho residents from the middle- to low socio-economic groups as well as from previously disadvantaged groups where the effects of neglect of apartheid are still evident in the community. The facility in Bloemfontein is governed by a local Afrikaans-speaking Christian church and houses approximately 1 000 residents living in various types of housing, ranging from independent houses, assisted living rooms and frail care. The one in Bochabela falls under the Department of Social Development and has assisted living rooms (with shared bathing facilities) as well as frail-care rooms. The residential care facility in Boshoff is managed by a non-governmental organisation. It accommodates approximately 40 residents living only in assisted living rooms (with shared bathing facilities) and frail-care rooms. These three residential care facilities were identified to participate in this study because together they have residents who are White, as well as Black residents from the previously disadvantaged group who, prior to 1994, were not allowed to live in the same residential care facility as Whites (Department of Social Development, 2010).

3.4 DATA GATHERING PROCEDURES

In this study, qualitative data were gathered by means of semi-structured focus group interviews (Cachia & Millward, 2011). This is a qualitative method of gathering data with a group of purposefully selected individuals with certain characteristics (Dilshad & Latif, 2013), with whom group interviews are held to gain insight into the participants' thoughts, feelings, attitudes and ideas about a certain phenomenon (Silverman, 2006; Farrelly, 2013). The focus group setting is non-threatening, non-evaluative and constitutes an open environment (Stewart, Shamdasani & Rook, 2007). Focus groups are an effective method when researchers try to gain an understanding of real-life experiences (Gibson & Brown, 2009). During focus group discussions, the participation of, and interaction between group members are important for generating in-depth content. It is important that all participants feel free to participate and to be heard, including those who feel awkward or not as eloquent. To prevent collecting data of poor quality that may result in less trustworthy results, the challenges the facilitator (and similarly people with "power" or who are more proficient) pose to the group, should be addressed and carefully dealt with (Warr, 2005).

Focus groups can be distinguished in terms of the research purpose they serve. According to research (Babbie, 2013b; Babbie, 2016; Creswell, 2014) the focus group approach has, amongst others, the purpose of basic explorative research, namely to contribute to fundamental theory and knowledge. The main goal is to accumulate accurate data on a limited range of specific issues where people consider their own views in relation to others within a social context (Robinson, 1999). In this study, the context was that of a residential care facility. By implementing the focus group method, an understanding of subjective experiences of elderly people regarding relocation to residential care facilities was gained.

The methodology employed by focus groups can be described as an interview technique for small groups of participants, guided and led by a facilitator (moderator) in group discussions on some topic or phenomenon (Barbour, 2008; Berg & Lune, 2013). Futhermore fieldworkers often assist the facilitator (researcher) to ensure that data (i.e. non-verbal elements or interactive features) do not get lost because such information is not clearly captured by notetaking or audiotaping of the process (Molyneux *et al.*, 2013).

The procedures include a facilitator (often the researcher) asking a small group of individuals a series of open-ended questions (Berg & Lune, 2013). The facilitator (researcher) asks the participants a sequence of explorative, open-ended questions who are given time to reflect before answering. The participants have an opportunity to hear other individual's responses and thus they are allowed to comment as the conversation progresses. It is not necessary for the group to reach any kind of consensus, because it is neither a decision-making group nor a discussion or a problem-solving session. The discussion is recorded, and notes are taken to ensure that all data is captured.

This method is especially effective amongst disempowered populations who are often hesitant to give honest or perhaps negative feedback, or may believe their inadequacies are the cause of their experiences or problems (Kritzinger, 1995). Various significant advantages of traditional focus groups as a data-gathering strategy have been described by various sources in literature of which some that are relevant to this study are discussed below (Berg & Lune, 2013; Downs & Adrian, 2004; Marshall & Rossman, 2011; Berg & Lune, 2013).

Advantages include the relaxed setting of the focus group and that the participants may speak in their mother tongue, using their own words and context. Focus groups do not discriminate against people who are illiterate (which may be the case in lower socio-economic environments) and can inspire people who are reluctant to be interviewed to participate. The quality rather than the quantity of the responses determines the success of this approach. Accordingly, focus groups can be applied in various contexts and with a wide variety of research topics (Robinson, 1999). Positive aspects of focus groups are that rich, qualitative data can be collected (Howitt, 2010) with reasonable speed, since sessions require only moderate time commitment (Gorman, Clayton, Shep & Clayton, 2005). Participants are encouraged to interact and not merely respond to the researcher (Dilshad & Latif, 2013), which allows notes to be taken of differences in opinion. The researcher can also easily keep the participants to the topic (Gibson & Brown, 2009). During the current research process, the fieldworker who accompanied the facilitator asked participants questions in Sotho and was able to assist the researcher with notetaking, ensuring that all information gathered was captured. During the discussions, the researcher also had the opportunity of observing the interaction between participants (Morgan, 2013).

Limitations of this methodology are that participants may be hesitant in giving their opinions and can be influenced by others who have strong voices in the interactive setting. Opinions are not always readily expressed, which may result in meaningful data being lost (Dudovskiy, 2018). A limitation that presented itself in this specific study pertains to the role of hierarchy in the make-up of the group in Boshoff. One participant had been a staff member of the residential care facility. She was perceived as having power (Pope & Mays, 2013), and her involvement had inhibited participants from voluntary discussing and interacting during the focus group discussions. Accordingly, it was decided to arrange for another focus group as “data saturation” had not yet been achieved and the failure to reach saturation would have had an impact on the quality of the research conducted (Fusch & Ness, 2015).

Other limitations of focus groups include the fact that old age is a period in which fear of being judged often manifests itself and the need for acceptance is very high; therefore, the honesty of participants can be suppressed when they must share personal or sensitive information while their peers are listening (Newman & Newman,

2018). Some participants may conform to the responses of other participants, even though they may not agree (Gorman & Clayton, 2005). Furthermore, the researcher is subjectively involved in the discussion and he could possibly influence the group's opinion about the phenomenon at hand (Gibson & Brown, 2009) during the facilitation process. In this study, it was countered by the researcher allowing conversations to flow, keeping to the topic at hand and only posing the relevant questions as per the research protocol. Where participants were not clear on the meaning of the questions or probes, the fieldworker translated them into Sotho where relevant.

Some researchers believe that the size of focus groups should range from 6 to 12 participants (Anderson, 1990; Denscombe, 2010; Morgan, 1997; Patton, 2002; Stewart & Shamdasani, 1990), while other researchers (Grønkjær, Curtis, De Crespingny & Delmar, 2011) suggest that there should be no more than 10 participants. According to Krueger and Casey (2008), the ideal size of a focus group is 8 to 10 subjects, plus a facilitator and a fieldworker. However, in general, it is believed that if communication between the members is possible, the group is regarded as a focus group (Belzile & Oberg, 2012).

One limitation sometimes experienced in smaller focus groups is that one or two participants may attempt to control the conversation, resulting in the information gained not being rich and adequate (Anderson, 1990; Denscombe, 2010; Morgan, 1997; Patton, 2002; Stewart & Shamdasani, 1990). Some participants may also feel pressured and unwilling to disagree when they are the only ones who do not agree with the group (Grønkjær *et al.*, 2011). In addition, participants in smaller focus groups are selected according to similar characteristics (purposeful sampling), already resulting in some heterogeneity in the sample being lost (Belzile & Oberg, 2012). However, good facilitation can counter these limitations.

For purposes of this study, the researcher decided to use a smaller focus group sample for each session, because this would offer a more comfortable environment for participants to relate to and contribute to other group members' experiences, especially if sensitive issues arise (Gaizauskaite, 2012; Morgan, 1996; Sagoe, 2012). In general, individuals are more likely to share their thoughts when they believe that the group can be trusted, and shy individuals may express their opinions more in small groups (Lombaard, 2015).

The number of focus groups that is interviewed is also important as it affects “data saturation”. Research by Guest, Namey and McKenna (2017) has found that two to three focus groups were sufficient to discover more than 80% of all themes, and three to six focus groups were sufficient to discover 90% of all themes. They have also found that three focus groups were adequate to identify the most prevalent themes.

If data saturation is not reached, it affects the quality of the research conducted and impedes trustworthiness (Bowen, 2008; Kerr, Nixon & Wild, 2010). Data saturation is reached when there is enough information to replicate the study (O’Reilly & Parker, 2012; Walker, 2012), when the ability to obtain additional new information has been achieved and when further coding is no longer possible (Guest, Bunce & Johnson, 2006; Saunders *et al.*, 2018). Holloway, Brown and Shipway (2010) warn against gatekeepers at the research location who may affect access to information, which would hamper data saturation. During data collection in this study, it was found that the gatekeepers had influenced the compilation of the group in Boshoff, affecting the responses of the participants, resulting in only limited data being available. For that reason, a third focus group was arranged to ensure that adequate data could be collected so that the experiences of relocation to a residential care facility could be described in depth.

In this study, the researcher personally collected the data with the help of a fieldworker, as the researcher is a quadriplegic bound to a wheelchair. The researcher’s fieldworker, who is fluent in Sesotho, Afrikaans and English, assisted with data collection by taking notes of thoughts and opinions expressed during the collection process, as the researcher lost the use of his hands. She also probed for clarity when participants spoke in Sesotho.

To ensure quality and objectivity, back translation of the focus group core questions to Afrikaans, English and Sesotho was done during the planning phase to ensure reliability and validity of the process protocol (Weeks, Swerissen & Belfrage, 2007). All the sessions were recorded verbatim and transcribed for later analysis with the consent of the participants, and are available on request.

On the set date, the researcher and the fieldworker paid visits to the selected residential care facilities to meet the residents to collect data. On arrival at the

residential care facilities, the researcher ensured that the venue in which the research would take place was quiet and that the participants were at ease. At the beginning of each focus group, the topic was introduced to the participants, the research aim was explained, and informed consent was obtained. This was done verbally and by using a Focus group Consent Form (Appendix E) that each participant signed after he or she had read the information.

Semi-structured questions within the focus group format was posed to the participants (Appendix F). Examples of questions include

What was it like to move from home to the residential care facility?

How did the move affect your life?

All questions were kept open ended, and additional relevant questions were incorporated as the opportunity presented itself during the discussions. As the required data had to be subjective and rich in detail, this approach was used to keep the discussion open and free from rigid structure. This ensured that the participants were at ease and were willing to share their opinions with the group. The researcher, with the support of the fieldworker, prompted on certain cues to elicit in-depth descriptions, explanations on the experience of relocation and its effect on the participants.

As the information needed for this research was personal, a cooperative and comfortable environment was created to ensure that participants felt at ease to share their experiences of relocation. Every participant was given an opportunity and encouraged to participate in the discussion. The researcher encouraged participants to share their subjective experiences of relocation if they were willing. All participants' opinions were accepted as relevant which contributed to further discussion.

During the interviews with the participants who spoke Sotho, the authenticity of the Sotho feedback was ensured by the fieldworker translating it into English, and it was recorded using an audiotape recorder for later analysis.

3.5 DATA ANALYSIS

Thematic analysis is a qualitative data analysis method that provides a method to report people's everyday experience and meanings of their reality to gain a broad

understanding of the phenomenon under investigation (Braun & Clarke, 2006) and the potential of any issue (Marks & Yardley, 2004). It is driven by the researcher's theoretical interest (Patton, 1990). Thematic analysis (Braun & Clarke, 2006) was employed to analyse the data gathered in this study, and to identify patterns in data as main and subthemes that emerged from the data sets. The experiences, meanings and realities of participants considered as underlying ideas, conceptions and conceptualizations were investigated (Taylor-Powell & Renner, 2003).

Some advantages of thematic analysis are that it offers a flexible and accessible approach to analysing qualitative data and is a quick and easy method to use (Braun & Clarke, 2006). Thematic analysis provides the researcher with a systematic way of analysing data (Alhojailan, 2012). The thematic analysis version that was developed by Braun and Clarke was used in this study. It delivers a strong, systematic framework for coding qualitative data, and for then applying that coding to identify patterns across the dataset in relation to the research question (Braun & Clarke, 2014).

The six steps proposed in performing thematic analysis by Braun and Clarke (2013) do not necessarily have to be followed chronologically but should be viewed as a recursive process.

The audio data gathered during this study were translated from Sotho and Afrikaans to English by qualified translators. This enabled the researcher to code and analyse the data by means of thematic analysis (Braun & Clarke, 2013; Marks & Yardley, 2004).

The researcher commenced the process by actively reading and re-reading the transcribed notes to become thoroughly familiar with the data (Step 1, according to Braun & Clark, 2006). The aim was to search for patterns and meaning (Taylor-Powell & Renner, 2003). Notes were taken on behalf of the researcher (the researcher is a quadriplegic individual) for coding which could be referred to later in the process. The researcher also checked for accuracy by comparing the recording made during the focus group with the translated and transcribed text to ensure that the meaning was not lost (Braun & Clarke, 2006; 2013; Taylor-Powell & Renner, 2003).

Step 2 was then followed, by generating initial codes from the data (Braun & Clarke, 2006; Braun & Clarke, 2013). Coding is an analytical process during which every data

item is coded and all the codes and relevant data extracts are subsequently collated (Braun & Clarke, 2013). Codes are the features of the data that appear interesting and relevant to the broad research question. Data are organised into meaningful groups that are the bases on which themes are identified (Taylor-Powell & Renner, 2003). Braun and Clarke (2013) suggest that small labels with cryptic notes can be used to assist the researcher in this step, but the researcher preferred a mind map and other notes.

Step 3 started the interpretive analysis of the collated codes and the search for themes (Braun & Clarke, 2006). Braun and Clarke (2014) define a theme as "a coherent and meaningful pattern in the data relevant to the research question". Relevant data extracts were listed and then divided into overarching themes. The researcher became aware of relationships between codes and themes (Braun & Clarke, 2006). This phase ended with the researcher collating all the coded data pertinent to each theme (Braun & Clarke, 2013).

The notes taken were used to support initial codes regarding the information contained in the data. A mind map was used to organise all the different codes in meaningful ways as relations among them arose and became clear as the data was read again and coded for analysis. The researcher ensured that coherence and cohesion consisted in all identified themes and the data set by cross checking the themes identified (Creswell, 2014). The researcher named the identified themes according to broadly known and accepted terms (from literature regarding the functioning of older people – Chapter 2) that represented the themes that emerged. The documented themes are shown in the results section of this dissertation (Chapter 4).

Next, Step 4 was followed in that the themes identified in the previous step were reviewed and refined by searching for supporting or contradicting data (Braun & Clarke, 2006; Taylor-Powell & Renner, 2003). At this stage, the researcher determined whether the themes conveyed a true and convincing reflection of the data and started defining each individual theme as well as the correlation between the themes (Braun & Clarke, 2013).

During step 5, the naming and defining of the identified themes and subthemes were completed (Braun & Clarke, 2006; 2013; Guba & Lincoln, 1994; Taylor-Powell &

Renner, 2003). The researcher captured the essence of each theme and established what part of the data each theme represented (Braun & Clarke, 2006). The researcher then conducted a written analysis of each theme. Themes are to link with each other but must not lead to unnecessary overlapping (Braun & Clarke, 2006; Guba & Lincoln, 1994; Taylor-Powell & Renner, 2003). Each theme was then given an informative and concise name (Braun & Clarke, 2013).

To finalise the analysis the researcher produced a convincing report (Step 6), which is concise, coherent, logical and non-repetitive (Braun & Clarke, 2006; Taylor-Powell & Renner, 2003). The results are presented in Chapter 4.

3.6 ETHICAL CONSIDERATIONS

Research involving older persons poses risks to harm vulnerable participants (Walsh, 2009) and deserves special precaution. Research must be conducted in accordance with the approved research protocol and researchers should follow an existing ethical code (Babbie, 2016) and conform to its ethical guidelines to ensure that all participants are treated fairly, equally, with dignity and respect. Older persons rarely participate in research studies and can find the experience daunting (Hall, Longhurst & Higginson, 2009). Accordingly, the culture of older persons should also be taken into consideration (both from the symbolic and practical nature thereof) (Lekalakala-Mokgele & Adejumo, 2013).

In contrast to white middle- and lower income participants, many African elderly have low literacy rates (Lam, Leibrandt & Ranchod, 2004), often making them easy research targets as they may not be aware of their rights and the risks involved (Lekalakala-Mokgele & Adejumo, 2013). Therefore, informed decisions can only be made if accurate and balanced information is provided to the older participants. It is the responsibility of the researcher to ensure that the older participants understand the benefits and risks involved in participating in the research (Lekalakala-Mokgele & Adejumo, 2013; Israel & Hay 2006) and that they can decide objectively about participating in the research (Sherrat, Soteriou & Evans, 2007).

To ensure the principle of voluntary participation in a study, it is essential to obtain the consent of participants, either orally or in writing (Grzyb, 2017). Obtaining consent from participants sets standards of respect for the relationship between the researchers

and participants (Boddy *et al.,* 2010). Respect towards a person gives the individual the right to choose (Walsh, 2009). The older person should be respected and valued when obtaining informed consent. They should not be patronized (Lin & Chen, 2007) and their autonomy should be respected (Lin & Chen, 2007; Walsh, 2009). In this study, informed and willing consent was obtained from each participant according to the most recent guidelines for research with older people (Allan, 2011; EFGCP Guidelines, 2013; Lekalakala-Mokgele & Adejumo, 2013), as described and documentation was available in each person's language of choice. (Appendix D, E, F)

When participants are requested to reveal personal experiences during the focus group discussions, they should be given the choice of doing so (Sherratt *et al.*, 2007; Stangor, 2015). The purpose of the study, the procedures that would be followed and the expected duration of the study should be shared with participants (Stangor, 2015) and they should be informed that they are free to withdraw at any time after participation has begun (American Psychological Association, 2002). It should be made very clear to participants what they could expect or gain from participating in the study and they may never be deceived. They must know whom to contact about uncertainties after the completion of the study (Babbie, 2016; Grzyb, 2017; Stangor, 2015).

It is also important to get the cooperation of the "gatekeepers" of the data that the researcher wants to access (Boddy *et al.*, 2010; Clark, 2011) and that host institutions approve the study prior to commencement thereof (Stangor, 2015).

To ensure that the ethical aspects mentioned above were respected and considered, ethical clearance to conduct this study was obtained from the Research Committee of the Department of Psychology and the Research Ethics Committee of the Facility of the Humanities of the University of the Free State, ethical code number, UFS-HSD2016/0481 (Appendix A). Thereafter, the researcher telephonically contacted the managers of the residential care facilities (gatekeepers) to enquire whether they had residents that would comply with the criteria and if they would allow him the opportunity to conduct his research at their facilities. An information sheet as well as a letter requesting permission were personally delivered to the manager of the facility in Bloemfontein and sent per e-mail to the managers of the facilities in Boshoff and Bochabela, respectively, explaining the aim of the study and the procedures that would

be followed. After receiving their written permission to conduct the research on their premises, dates and times were fixed for the focus groups. Prior to beginning the focus group sessions, the groups were informed about the aim of the study (Appendix D) and the residents who were identified and volunteered were given the opportunity to either accept or decline the invitation to participate. Informed consent forms were then signed by each participant (Appendix E). The voluntary nature of participation was duly stressed.

Keeping the identity of, and the information obtained from participants anonymous, was further important. Anonymity refers to not being able to link a specific response to a certain individual (Babbie, 2016; Stangor, 2015) and every effort should be made to protect the participant's specific contributions and identities (Babbie, 2016). In addition, confidentiality refers to information that is accessible to the researcher but needs to be protected from wider public access (Zygmont, 2014). For this purpose, the researcher entered into an agreement with the participants not to divulge this information (Babbie, 2016). In this study, the participants were given the assurance that all the information they shared would be kept private, anonymous and confidential. The facilitator (researcher) and fieldworker further signed confidentiality agreements to protect the participants' privacy (Appendix G). The researcher and his supervisor were the only persons to have access to recordings and the transcribed data collected in the focus group sessions. Anonymous participant identification was used in the transcriptions, which are available on request.

Having due regard for the residents' personal journeys they had travelled the researcher respected the sensitive information that was shared during the focus groups. If sensitive information is not treated with respect, it can cause psychological harm to the participants (Babbie, 2016). Sometimes participants are not aware of certain aspects within themselves, which come to the fore during participation in a study, and this can cause stress and affect their daily lives (Stangor, 2015). During this study, the researcher ensured that no harm would come to the participants, nor that they would face any risk in that he ensured confidentiality. He gave them the choice to withdraw from the study at any time. The purpose of the research was explained to the participants in detail, as well as what would be expected from them should they choose to participate, and the necessary precautions were taken to

prevent suspicion, fear and uncertainty. The researcher was always honest and authentic, and no false expectations were created, nor did any deception take place.

3.7 TRUSTWORTHINESS

In qualitative research, the purpose of trustworthiness is to support the argument that the investigation's results are "worth paying attention to" (Guba & Lincoln, 1982). Trustworthiness refers to the authentic reflection of research findings of the personal or lived experience of the phenomenon being explored. Trustworthiness is often questioned due to the subjective nature of data collection, and it is therefore imperative that the researcher ensures that the study is as reliable and valid as possible by ensuring its trustworthiness (Babbie, 2016; Guba & Lincoln, 1982; Shenton, 2004).

For purposes of this study, trustworthiness was ensured by focusing on the credibility, confirmability, dependability and transferability of the research (Marshall & Rossman, 2011; Schwandt, 2007). The researcher has chosen a deep-rooted research method of good repute, which underpins credibility, confirmability, dependability and transferability (Shenton, 2004), and applied sound research ethics to guarantee trustworthiness of the study (Tracy, 2010).

3.7.1 Credibility

Credibility means that the results of the research are credible and a true interpretation of the data gathered (Babbie, 2016). In reality, participants are the only ones who can reasonably judge the credibility of the results (Guba & Lincoln, 1982). Credibility concerns the assurance that a study assesses what is intended (Shenton, 2004). This concept depends more on the richness of the information gathered, rather than the amount of data gathered (Guba & Lincoln, 1982). Various techniques can be used to ensure the accuracy of the findings, such as persistent observation, data triangulation, member checks and researcher reflexivity (Babbie, 2016). In this study, credibility was ensured by comparing results of themes and sub-themes emanating from the three different groups.

3.7.2 Confirmability

Confirmability is ascertained by examining the "internal coherence of the research product", which is made up of "the data, the findings, the interpretations, and the

recommendations" (Zhang & Wildemuth, 2009, p.7). Guba and Lincoln (1982) posit that confirmability is the criterion for neutrality and is founded on the acknowledgement that research is never objective. Findings should signify the specific situation being investigated and not the biases or beliefs of the researcher (Shenton, 2004). To enhance the confirmability of the initial conclusion, an audit trail was kept by including the transcribed data as direct quotations to support the findings. It is crucial that confirmability is maintained by the researcher by ensuring that the findings of the study portray the perception and opinions from data collected and not from his personal biases (Shenton 2004).

3.7.3 Dependability

Dependability shows that the findings are consistent and could be repeated (Babbie, 2016; Guba & Lincoln, 1982). This means that the conclusions should be consistent if the analysis were to be repeated with the same field of study or in a similar context. The themes that emerged from the three focus group discussions supported dependability in this study, as their significance was confirmed by their repetition.

3.7.4 Transferability

Transferability of a study refers to the ability to transfer the findings of the study to other contexts and groups (Guba & Lincoln, 1982), and other samples (Babbie, 2016). Accordingly, researchers who wish to do similar studies can “transfer” the results from the research situation to other situations (Denscombe, 2010). In this study, the research design, implementation methods and context in which data were gathered were explained in detail by the researcher (Shenton, 2004). As qualitative work is subjective by nature, transferability cannot be guaranteed. In a study by Lombaard (2015, p.55), it was claimed that transferability could be achieved by “the detailed explanations and descriptions of the participants’ views and contexts.” This has been done by the researcher and therefore transferability is left to the reader to determine. However, if a thorough explanation of the views and contexts of the participants is provided, other researchers should be able to determine the transferability of the results of the study for their context.

Another important aspect to consider during qualitative research is researcher reflexivity. Reflexivity refers to the "analytic attention to the researcher's role in qualitative research" (Gouldner, 1971, p.16, as cited in Dowling, 2006), and entails self-awareness (Lambert, Jomeen & McSherry, 2010). Parahoo (2006) states that reflexivity is a "continuous process during which researchers reflect on their values". Hesse-Biber (2007, p.17) explains it as a process where researchers "recognize, examine and understand how their social background, location and assumptions affect their research practice". One of the aims of a study conducted from an interpretivist perspective would be to attend to how the researcher's feelings, thoughts, opinions and experiences might influence what he or she observes and records (Bunniss & Kelly, 2010).

The motivation in doing this specific research stems from the researcher's mother having been closely involved in the lives of older people as a manager of various residential care facilities for 17 years and his interest in the effect of relocation on the lives of the elderly. His mother (aged 67) had also recently relocated from her home in Bloemfontein to Paarl, also subjectively experiencing relocation, albeit not to a residential care facility. His grandfather, who was a world-famous Springbok rugby player, and his hero, had also relocated to a residential care facility after becoming frail.

The researcher is aware of his direct and personal role in the collection and analysis of the data in this study and he has reflected much on the research experience. The researcher has reflected on his positionality as insider/outsider to the commonality shared by the participants (Dwyer & Buckle (2009). Positionality is determined by where one stands in relation to "the other" (Merriam *et al.*, 2001).

The researcher is a quadriplegic, White, Afrikaans-speaking, 34-year-old male. The fact that he was Afrikaans speaking as well as in a wheelchair, afforded him the insider role status, sharing a common bond, as many of the participants were also in wheelchairs. In the Bloemfontein focus group, all were Afrikaans speaking, thus accepting him faster and more completely (Dwyer & Buckle, 2009) than, for instance, in the Boshoff focus group, where all the participants were Sotho speaking. The researcher has also suffered many losses in his life after his injury, including his mobility, independence and ability to perform activities of daily life, with which all the

participants could identify consciously or unconsciously. Through the researcher's reflexivity, he became aware of his contribution to the construction of meaning and of lived experiences, throughout the research process (Ackerly & True, 2010; Denzin & Lincoln, 2011). Participants were open with the researcher, which allowed him to gather in-depth data. The fact that he is disabled, and in a wheelchair, likely provided a level of comfort and safety for all the participants in this study (Dwyer & Buckle, 2009). Being a quadriplegic does not make the researcher think it makes him a better researcher; it is just that he is a different type of researcher.

Reflecting on his age in the three groups, he found himself as the outsider as he was many years younger than the participants were. Reflecting on his positionality in the Boshoff focus group, he was an outsider in the sense that he was a White male, and not able to speak a Black language. To compensate for the fact that the researcher cannot speak an African language, a multilingual fieldworker assisted the researcher when data were collected with black residents.

The fact that the researcher was an insider/outsider regarding his positionality is not the "core" to him, but rather his openness, authenticity, honesty, deep interest in the experience of his research participants and commitment to represent their experiences accurately and adequately (Dwyer & Buckle, 2009).

3.8 CHAPTER SUMMARY

An overview of the methodology used for this research project was provided in this chapter. The aim of the study was stated, and the qualitative research stance and focus group approach used in this study were explained. The non-probability sampling method, purposeful sampling, was discussed, and an overview was given regarding the biographic and demographic information of the participants. The method of data analysis, namely thematic analysis, was discussed and clarified, and the ethical considerations and the importance of the trustworthiness of this study were discussed.

CHAPTER 4: PRESENTATION AND DISCUSSION OF THE RESULTS OF THIS STUDY

In this chapter, an overview is given relating to the findings of this study. Firstly, the findings transpiring from the thematic analysis are presented. These findings are then discussed by comparing the findings with theoretical frameworks and previous research findings in the field. Ensuing from the discussion, the most significant findings of the study are summarised, followed by a discussion of the limitations and recommendations for future research. A summary concludes this chapter.

4.1 FINDINGS

In this section, the themes that emerged from the analysis of the focus group discussions are presented. The main themes that emerged in the thematic analysis are presented in the following four overarching categories: “Driving forces”, relating to participants’ realities prior to relocation that influenced their experience; „Decision making process” relating to the participants perception of control over the process of relocation; “Adaptation to residential living”, relating to ways in which participants adapted to their new environment, and finally “Experiences of residential living”, relating to how participants were experiencing the move to, and living at the residential care facility”. Each of these themes consists of various subthemes. By carefully considering each of these subthemes separately, a picture was created regarding the older peoples’ experiences of relocation to a residential care facility. A summary of the themes and subthemes is provided in Table 1.

Table 1: ***Themes and Subthemes that Emerged Regarding Elderly's Experiences of Relocating to Residential Care Facilities***

THEMES		SUB-THEMES
Driving forces/experiences leading to relocation	The ways in which realities at the time before relocation influenced their experience	Push factors: Safety and security Physical & mental decline Psycho-social and living circumstances
		Pull factors: Familial relatedness Reputation of, and available services
Decision-making process	The way in which participants' perception of control over the process of relocation influenced their experience	Self determination
Adaptation to residential living	The ways in which participants adapted to their new environment during the first year of residence	Family support Making friends Participation Religion/Spirituality Attitude Helplessness/dependency Anxiety Acceptance
Experiences of residential living	The ways in which participants experienced the move to, and living at the residential care facility	Fulfilment of daily living needs Satisfaction/Dissatisfaction Reminiscing/longing Loneliness/disconnectedness

4.1.1 Driving forces/experiences leading to relocation

From the participants' points of view, it was evident that certain realities they had experienced prior to relocation, had an impact on, and influenced their decision to relocate to residential care facilities. In this theme, the way in which participants in this

study had perceived and experienced these realities is summarised. This theme contains two subthemes, namely:

- "Push factors", or "risk factors", which refer to their experiences prior to relocation that acted as driving forces contributing to the decision to relocate to residential care facilities. These include:
    - safety and security,
    - declining physical and mental abilities,
    - psycho-social circumstances which include living circumstances, and
- "Pull factors", or "protective factors", which refer to participants' perceptions of attractive aspects that they regarded as contributing to their decision to relocate to the residential care facilities, which include:
    - living close to family members, and
    - the reputation and services rendered by the residential care facility.

These subthemes are discussed next.

(a) Push factors

(i) Safety and security

Some participants had suffered negative experiences in their previous neighbourhoods and felt that they had been exposed to danger and/or injury in their living environments, threatening their safety and security, as confirmed by Participant 2, from Focus Group 2: *"I was almost murdered in my house."* Participant 7, from Focus Group 3 also mentioned: "*You are 84 years old. You live alone. When you are sleeping in the house, you don't feel safe. Where I used to live there were two burglaries … they broke in. But when I woke up, I say God, they did not break (hurt) me."* Participant 3, from Focus Group 3 agreed by saying, *"… people were breaking into houses and doing all kinds of things … I escaped to this place …"* Another participant (Participant 9, Focus Group 3) kept the fact that they had broken into her home to herself, "*I didn't even say that people had been breaking in at the place I stayed in previously, and whatever else happened."*

However, even when older persons take care to safeguard their living space, they are still often exploited. After returning home from hospital, Participant 13, Focus Group 3 firstly considered the option of "aging in place" and hired a caregiver for herself at home. However, her possessions started disappearing and a new caregiver was found, but "*it turned out that she was not taking good care of me".* This left the participant feeling unsafe and insecure, contributing to the decision to move to the residential care facility.

(ii) Physical and mental decline

During the discussions, it was apparent that most of the participants in this study had experienced some form of physical decline or ill health prior to relocating, being a reason most often mentioned for their decision to relocate to the residential care facility. Participant A, Group 1 said, "*I broke my leg … and came here to recover."* Participant D, Focus Group 1 said, "*I had a knee replacement and was not able to look after myself. My movement was impeded."* Participant N, Focus Group 1 confirmed, *"I accidentally burnt in the shower. I became frail, but I did not want to admit it."* Participant 5, Focus Group 3 said that she had been sick and "*I need care as a patient."* Furthermore, falls were often mentioned as a driving force leading to relocation. Participant E, Focus Group 1 stated, "*I had a stroke and fell and needed care."* Participant 6, Focus Group 3 stated, "*I suffer from arthritis. I fall. I sometimes just fall".*

When older people experience early signs of cognitive decline and realise that it cannot be reversed, they come to understand the need to plan on the way forward. Participant B, Focus Group 1 had been diagnosed with onset Alzheimer's disease prior to relocating to the residential care facility, "*I was diagnosed with the beginning phase of Alzheimer's last year. Then we started to plan, how does one handle this now? It usually progresses, and then we phoned this place … if we stay here … you have direct access to the Alzheimer's (section)."*

(iii) Psychosocial circumstances including living circumstances

Psychosocial circumstances refer to situations that involve behaviour, which is the result of interconnectedness between the individual and his/her environment and social context. Participants from all focus groups mentioned that declining health necessitated an increase in support and assistance from others to attend to

themselves and their daily living needs. When support and assistance were no longer available, the individuals opted for relocating to a residential care facility. Participant A, Focus Group 1 said, *"I don't have assistance on the farm to help me in the house …,"* while Participant 5, Focus Group 2 explained, *"I don't have anyone to care for me properly."* Participant 5, Focus Group 3 specifically mentioned that she needed care but did not have people to look after her, *"I came here because I didn't have people to look after me …"* This was reiterated by Participant 13, Focus Group 3, *"I lived all by myself. I don't have children. I had one son. He died. That was why I came here."*

Participants who had lost their spouses prior to relocating stated that this had contributed to the decision of moving to the residential care facility. Experiences of widowhood accentuated the need for safety, support and care that residential care had to offer. This is confirmed by the following statements. Participant A, Group 1 said, *"I can't go back to the farm … as my husband has passed away."* Participant E, Group 1 stated, "*My husband passed away and my children said that I can't stay alone in the big house."* It was apparent that once the relation with, as well as the support and care of the partner fell away, the participants considered moving to a residential care facility.

Other participants still had living family members but could no longer rely on the traditional children's support structure for various reasons. Living alone had affected their level of independence, and increased the need for care, as stated by some participants. Participant 1, Focus Group 2 said, *"They work outside, the wife and husband work outside, and they cannot leave me alone …"* Participant 4, Focus Group 3 explained, "… *because I lived alone in the house. My daughter lives in Welkom … they could not leave me alone at home because they are working."* Participant 12, Focus Group 3 confirmed the need for support by saying, "*When they (the children) went away they left me living in the house alone."*

(b) Pull factors

The attracting and supportive factors that participants regarded as contributing to their decision to relocate to the residential care facilities included the following.

(i) Relatedness as a support

Increased needs for social support and belonging of the elderly often lead them to move closer to children. Widowhood is likely to increase social support needs from relatives. Participants who had previously lived independently and whose activities of daily living had become limited perceived that it would be positive to move to the residential care facility so that they could be closer to family members already residing there or in proximity. Participant C, Focus Group 1 confirmed that it was an attracting factor to be able to live near her daughter, *"… we stayed in Phase 7 in a house. My daughter-and-them also stay here."*

(ii) Reputation and available services of the care facility

Participants and their families viewed the reputation of, and services offered by the specific residential care facility they entered as attracting factors when deciding to which facility the individual would move. Participant F, Focus Group 1 said that her daughter with whom she had lived prior to moving into the residential care facility had encouraged her to relocate to the specific residential care facility, as she knew that the services were "*going to be very good*". Participant B, Focus Group 1, who had been identified with onset dementia, had decided to relocate to the specific residential care facility as he knew that there was a separate section for persons suffering from Alzheimer's Disease. He said, *"We knew here is a unit for Alzheimer's specifically too … and if you stay here, you have direct access to the Alzheimer (Unit)."* Participant 5, Focus Group 2's family members had opted for the specific residential care facility because, *"You will eat on time, your clothes will be kept clean. You will be comfortable."* For the daughter of Participant 4, Focus Group 3, the quality of care that her mother would receive at the residential care facility was an attracting factor, "… *if you are here you are much better because there is better care …"* Similarly, Participant 5, Focus Group 3 said, *"… she would look for a place for me to stay, so that I may be close to all the things that I need and not suffer spiritually. If you are feeling sick, you get something to calm your pain."* Participant 5, Focus Group 3 said that her family was aware of her situation at home and decided on the specific residential care facility because "*here, they are taking good care of u*s."

4.1.2 Decision-making process

The perception of control over the relocation process and the effect on participants' experiences of relocation was identified as an important theme and it will be discussed next. Self-determination regarding decision-making is aligned with the concept of control over daily experiences. Within this theme, three types of experiences were most prominent.

Findings from this study revealed that participants had different perceptions about the control they had over the process of relocation that influenced how they experienced relocation. Some participants experienced the decision-making as being outside their control and being made on their behalf, while others had been involved in the process, while quite a number were fully in control and made the decisions themselves.

Those participants who were "left out in the cold" when deciding to which residential care facility they would relocate, felt that they actually had no choice in that "*my child just simply said I have to come to this place* (Participant H, Group 1). Participant K of Group 1 experienced it similarly in that, *"My child decided for me."* Participant EE, Group 1 felt that relocation was "*a bit difficult … Then decisions are made on your behalf."* Participant 4, Focus Group 2 explained, *"My grandchild brought me; he/she is the one that decided that I come here."* One participant (Participant H, Group 1), who had relocated involuntarily and was not involved in the decision-making process had become rebellious, stating, "*I first went and lived privately outside on the streets. My child then got me a place here."*

Other participants had been involved with the children during the decision-making process and responded by saying, "*My children also decided on it. I decided with them. The decision was actually mine.*" (Participant M, Group 1). Participant N, Focus Group 1 felt that she had been given a choice by her daughter, *"I made the decision to come here. We (my daughter and I) discussed it, and she said to me, 'Mom, as you wish'."* Participant 5, Focus Group 3 affirmed that the family had consulted with her prior to deciding to relocate, *"She (daughter) came to me, and we all sat down."*

Some participants had taken control of the situation and made the decision to relocate themselves and were not coaxed or influenced by children or family members, as confirmed by Participant N, Focus Group 1, "*I also decided to come myself."*

Participant 9, Focus Group 3 had also made the decision on her own, and stated that she had seen that White people do not let the children decide for them, *"I made the decision myself … I then took the decision because of things I could see … White people – those people – even if they have children, their children don't decide for them.".*

4.1.3 Adaptation to residential living

When inquiring into how participants had managed to adapt or would assist future residents in adapting to their new environment, the following responses were forthcoming. Five facilitating factors and two process related feelings that indicate that participants' adjustment was a process were identified:

(a) Support from family

Support from family can be expressed in many diverse ways and is influenced by cultural ways of doing things. The White participants who had been frail prior to admission to the residential care facility had been physically assisted by their children with the actual move, which helped to ease their adaptation to living in their new environment. The children had made the new environment homely for their parents prior to moving in, as verbalised by Participant W, Group 1, who stated, *"I came here directly from the hospital. Then my daughter already fixed the entire room, put all the furniture in and made it the way it suited me," and "My children did everything for me, because I was still half sick when I moved in here."* (Participant Y, Group1)

Most Black participants perceived the fact that family members assisted them in finding suitable accommodation (residential care facilities) where their needs and well-being will be taken care of, as support that facilitated their adjustment. Respondent 4, Focus Group 3 verbalised this as follows, *"She (daughter) went to numerous homes … she found that they were not suitable for me … when she was here, she felt that 'if you are here, you are much better' … because here is better care."* The researcher's observation during the focus group discussion was that the experience of being well cared for unconsciously facilitated adaptation into the care facility.

(b) Friendships

Relationships and social networks provide meaningful social engagement with others and are vital in times of change. It provides emotional support and a sense of purpose. As people age, and life partners fall away, friendships become more important. However, the need for friendships may differ between individuals. Some older people may need lots of social interaction, while others may be satisfied just being in the company of others or even preferring to be on their own. However, during discussions, participants indicated that making new friends was important in the process of adapting to their new environment and added to their sense of wellbeing and satisfaction.

Participant III, Focus Group 1 enjoyed the company of new friends he had made: "there are three here that I have befriended." Participant R, Focus Group 1 felt that her neighbour was a dear friend who cared about her well-being, "*There is one, my neighbour next to me, who comes every morning and every evening and then she asks how I am doing … I am happy that I am here*." Participant S, Group 1 was supported by her friends, which contributed to her well-being, *"I am happy, mates around me as well."* Participant 1, Focus Group 2 stated that there was nothing troubling him and that he had found friends and that, *"We make jokes, we laugh …"*

Participants in this study also suggested that they would assist new residents to adapt by welcoming them and motivating them to make new friends, to "hang in there" and ensure them that it would get better. Some stated that they would highlight the positive aspects that they were experiencing at the residential care facility. This behaviour was eloquently voiced by Participant III, Group 1, who stated that he had made three new friends and would support newcomers as follows, *"I feel that when new people arrive, to make it easier for them – go and say welcome to them. Go and encourage them when they get discouraged or they did not want to come. Try and make them feel positive, that it will become better. There are three here that I have befriended. Do not just sit in your room. Make friends. Go out and talk to each other and give each other a smile because then you make another person's day."*

(c) Active participation

Some of the participants mentioned the importance of active participation as a method of easing adaptation to relocation. Life still offered them opportunities for involvement despite the inability to be involved in everything, as confirmed by Participant EE, Group 1, *"People are so friendly, and you connect, it depends on if you want to … but here are many ways to connect, many."* One of the ways to join in was related to participating in spiritual activities. Participant E, Group 1 said, "*Everyone are Christians and we attend the prayer hours together and we visit each other, and we talk."*

(d) Religion/Spirituality

Participants often mentioned their gratitude towards the Lord in assisting them during the challenges of relocation. Prayer was important for some participants during this trying time. Participant G, Group 1 mentioned that she felt *"that the Lord decided I should come and live here … I made it a matter of prayer, and the Lord guided me … to now leave the house and to come here for care and help. And I thank Him for it."* Participants portrayed humble feelings and deep gratitude for their accommodation and being able to adapt. Participant N, Group 1 stated, *"I say thank you to the Lord every day for the lovely, sunny room He gave me, because everything is what the Lord gives us. We deserve nothing."* Being dependent on the grace of God in assisting residents adapting to their new environment was portrayed in Participant PP, Group 1's words, "*The grace from Above is the big thing which helps us adapt here, otherwise we wouldn't be like this (happy)."* Participant 14, Focus Group 3 thanked her Saviour for the privilege of living in a residential care facility by stating, *"… I thank God that he showed light to the people who do things like this."*

(e) Attitude

For participants to be able to adapt to their new living environments, they realised that it depended on themselves, as well as that their attitude also played a vital role. This was portrayed by various participants, as stated by Participant JJJ, Focus Group 1, *"You can make yourself happy or unhappy."* Participant LLL supported the previous participant by saying, *"It largely depends on yourself."* Participants felt that they also needed to adjust as confirmed by Participant 1, Focus Group 2, *"It needs to be an adjustment from your side …"*

The next three sub-themes regarding the ways in which participants adapted to residential living emphasise the fact that adaptation is a process with different phases.

(f) Helplessness/dependency

During the discussion on how the participants experienced the move to residential care, it became clear that the physical ailments experienced by the participants prior to moving to the facility limited their ability to care for themselves independently and negatively influenced their initial experiences of residential care living. (Refer to 4.1.1 (a)(ii).) These limitations suddenly left some participants dependant on others to perform activities of daily living more than before and increased the feeling of helplessness. This was eloquently expressed by Participant II, Focus Group 1 who said, "*I felt like I was completely dependent on the help I received here because I was so helpless when I arrived here. I could not walk. I could not look after myself."*

(g) Anxiety

Feelings of anxiety in a new environment are normal and strongly linked to the meaning a person ascribes to the situation. It is linked to the structure and unfamiliarity with the new situation/environment, uncertainty about how the processes work and is generally time bound.

Initially a few participants felt anxious after moving into the residential facility. Participant HH, Group 1 confirmed that he was anxious in his new environment, *"Sometimes (I feel anxious). You live it, you know."* When entering the dining room of the residential care facility for the first time Participant JJ, Group 1 explained, "*When everyone sat there looking at me when I came in, it was not such a nice feeling …"* Participant 9, Focus Group 2 was concerned and anxious about her health and that there was no immediate available doctor, *"… I didn't get a doctor … there is no doctor."* Participant QQ, Group 1 verbalised her anxiety about passing away in a hospital and expressed her desire to die in the security and comfort of the residential care facility, "*I once asked a friend, where am I going to die one day? Do you die here ... or do you go to another place? Where do you die? How do you know that you are going to die here? I say, just not in a hospital. I can stay here, but just not in the hospital."* One participant had been anxious about not receiving her medication at the correct time and came into conflict with one of the staff members, "*I asked that I must take my*

tablets after eating (and not before meals) ... she said a few negative things … I forgave her ..." (Participant 2, Focus Group 3).

(h) Acceptance

The feeling of acceptance relates closely to a process of inner work that facilitates adjustment and often oscillates between "fighting against", and accepting "what is". To illustrate this, subtheme examples of the two sides of the coin that lead to acceptance are quoted in support for this subtheme.

Initially some participants were unhappy on arrival. This was strongly verbalised by Participant 2, Focus Group 3, *"… I would tell them (the children) that I am moving out of here … After that I would not be coming back … I would never return."* Another participant, Participant 3, Focus Group 3 supported this by stating, *"I also didn't feel good when I first arrived here."*

However, accepting one's current circumstances and understanding the organisational processes and structures of one's environment help one to adjust to one's reality. The participants expressed that the act of acceptance and letting go helped them to adapt to their new environment. Participant 7, Focus Group 3, explained that she had initially felt like a child getting a new school uniform, having children mock and bully her, and thus not liking to go to school, but as time passed, she had adapted. Her conclusion was, *"But as time went on you would go to school and pass your classes. Now, here we have passed."* Parting with some of their personal possessions was inevitable for the participants, as space in their new environment was limited. Participant BB, Group 1 said, *"I think the big thing is that the Lord helps you to let go of the things that you were so attached to, and you just let it go."* Realising that they had possibly moved for the last time, participants accepted that there was "no turning back", as confirmed by Participant E, Group 1, "*So, I am very happy here. I don't miss my old life, it is over. Now I am here to die."* Participant GG, Group 1 confirmed this, "*You accept the situation in which you are. A person accepts that your life changes."*

4.1.4 Experiences of residential care living

Whatever the realities prior to the move were, and irrespective of who had made the decision to move, participants' emotions regarding the experience of relocation varied around a variety of things from experiences related to daily living and daily hassles, adaptive issues that influenced how they felt as well as feelings related to needs for connectedness. Hence, in this theme, these experiences of participants' lives that are closely linked to the time of relocation to the residential care facilities are discussed.

(a) Fulfilment of daily living needs

Participants were experiencing a strong sense of safety, security, care and support at their new living environments. Some of the Black participants had previously been exposed to risks and dangers, the transition to the residential care facility meant a relief, and they regarded their new home as a shelter, as confirmed by Participant 2, Focus Group 2, *"I am happy because you are sure you are in a safe haven."* Participant 15, Focus Group 3 supported this thought by saying, *"I feel happy living here, better than when I am outside."*

The care and support that participants were receiving at the residential care facilities were key factors contributing to their positive experiences of their current living environments. Participant KK, Focus Group 1 verbalised her feeling of being loved and cared for, "*… you feel the passion that the people (staff) have for someone who is sick, or fell, you know, they are there to help you. That passion, love passion, I would say. You definitely find it here."* Staff were complimented for the way in which they were caring for the participants as Participant OOO, Focus Group 1 confirmed, *"My experience here is that you are cared for with the greatest patience and love."*

Residents experienced that they were being supported in their activities of daily living in that services were being rendered regarding feeding, personal, and medical care. This was supported by Participant 14, Focus Group 3, *"They feed us, dress us, wash for us, iron for us. They do everything for all of us."* Participant 15, Focus Group 3 confirmed, *"… we get food on time and we get our pills and medicine on time and we wash on time and dress clean every day and our washing is being washed.*" Knowing that they were getting "good" food and a balanced diet contributed to their positive

experience. Participant D, Group 1 stated, "*I am satisfied with what I got here … you get care and good food. Your nutrition condition is very good here."*

The following more specific feelings characterise the overall attitudes that were displayed/expressed within the experiences of daily living.

(b) Satisfaction vs dissatisfaction

Most participants expressed that they were satisfied in their new living environment, as confirmed by the following. Participant C, Focus Group 1 said, *"I am happy here. I really enjoy staying here."* For Participant OO, Group 1 the atmosphere at the residential care facility was a contributing factor to residents being happy, "*We are all happy here … The place has a happy atmosphere."* Participants 2 and 3 of Focus Group 2 indicated their satisfaction by answering in unison, *"I am satisfied."* Participant 14, Focus Group 3 experienced that she is happy in that she was being respected and not being stereotyped, by saying, *"I am very happy here … they have made us feel like proper people. I haven't the smallest complaint. I don't want to leave this place".* Participant 15, Focus Group 3 verbalised that being well cared for, contributed to her happiness, *"I am happy living here, they look after us well."*

On the other hand, some participants indicated that they sometimes experienced dissatisfaction with the lack of, or timely availability of services, the crude behaviour of some nursing staff and structures (strictness) of the residential care facilities. Resident 15, Focus Group 3 said, *"There will always be things that we are not satisfied with."* There was no doctor available at one residential care facility as stated by Participant 9, Focus Group 2, *"… I didn't get a doctor ... there is no doctor."* Participant 3, Focus Group 3 felt that she was being bullied and discriminated against, *"There is a little discrimination. There is another care sister who doesn't like me. They make my life here miserable … She gave them all their socks, she leaves me out,"* and further, "*We haven't come to be bullied. They insult our mothers"*. This was supported by various 'Voices' in Focus Group 3.

Regarding the structure of the residential care facility, residents experienced that their freedom of movement was restricted in that they had to have a "pass out" before being allowed to leave the premises, as verbalised by Participant 2, Focus Group 3, "*I want a pass out."* The lack of flexibility in the structure, rules and routine in one residential

care facility was highlighted by Participant 10, Focus Group 2, "*People go to bed at a set time, and we are given pills at a set time."*

(c) Reminiscing/longing

Some of the participants found it comforting to be able to ponder over the past and to relive the highlights of days gone by. Participant E, Focus Group 1 explained as follows, "*For 60 years I lived in Road X here in Bloemfontein … We then moved to Y ... We made our own food, and everything. It was very nice there … made many good friends, Christian friends and it was lovely."* Some participants reflected on relationships and activities that they had shared with their bygone friends, *"… André P Brink went to school with me in Jagersfontein … we held children's church…"* (Participant YY, Focus Group 1). Respondent 1, Focus Group 2 said, "W*e grew up here, we went to school here."*

(d) Loneliness and disconnectedness

Older persons' needs to be loved and belong include being with family and friends, the need for interaction, and belonging to a group. The loss of an older person's spouse, or the fact that children live far, are factors that influence their needs for love and belonging.

During discussions, some participants described their loneliness and feeling of disconnectedness. Some were longing to where they had previously lived. Participant UU, Focus Group 1 said "… *the many friends I had there. I miss those friends of mine ... I don't know what they are thinking, but they just never come here, and we were good, good friends. I kind of miss that.*" Others longed for their children and wished to visit them at their home, as confirmed by Participant 10, Focus Group 2, who expressed this clearly, "*I miss my children; I just need to visit and see my children at home."*

4.2 DISCUSSION OF THE FINDINGS

The purpose of this study was to understand the subjective experiences of older persons from middle to lower socio-economic groups who relocated to residential care facilities. The research question that directed the study was: What are the experiences of older people who relocated to residential care facilities? Considering the

presentation of the findings in 4.1, a discussion linked to the theoretical perspectives of this study and the findings of previous research in the field follows.

Older persons are faced with many challenges as they age, which include relocating to a residential care facility (Perry, 2012). Various realities contribute to this action: from elders' experiences of involvement or not in the decision-making process, their experience of the actual move, to their adaptation and eventually their settling down and accepting their new living environment. Four themes were identified that clarify the pattern that emerged from the experience of relocation for this group of participants, i.e. life realities, solving the problem, adapting to the solution and making sense of the experiences they had. These will be discussed under the headings below.

4.2.1 The influence of realities

In this study, it was found that the realities the older persons were facing at the time before relocation were an integral part of the experience of relocation and contributed to their decision to relocate to the respective residential care facilities. Elders in this study experienced that there was no longer a fit between their needs and what the environment offered in terms of fulfilling those needs. They needed care with activities of daily living, often because of physical decline, or were no longer safe in their living space. This finding is in accordance with the ecological theory of Lawton and Nahemow (1973) that state that environmental press forces the elder to evaluate the situation, find a solution and then act in accordance (Granbom, 2014; Perry *et al*., 2014), in this case relocating to a new living environment. Wiseman's (1980) *behaviour model* refers to "triggers" (push and pull factors) that spur elders on to start the process of evaluating their circumstances.

Triggers or driving forces in this study that lead the participants to relocate correlate with push factors (i.e. declining health, no care), pull factors (i.e. location, familiarity and reputation of the facility), or a combination of both pushing (pressing, coercing or repelling) and pulling (attracting) factors, as confirmed by numerous studies (Andersson *et al.,* 2007; Andersson *et al*. 2017; Bekhet, Zauszniewski & Nakhla,2009) as reasons to relocate to residential care facilities. The most significant ones that emerged from the data are discussed below.

Security. Security is an important risk factor for the elderly (Ernsth, 2007; Fors, Lennartsson, Agahi, Parker & Thorslund, 2013). When experiencing that a very basic need, i.e. that safety and security is not fulfilled (as proposed by the hierarchical needs of Maslow, 1943) and their personal security is threatened (Fagerström, Gustafson, Jakobsson, Johansson & Vartiainen, 2010), elders often opt for relocation. Accordingly, the environment and the unsafe neighbourhood in which some of the participants in this study had previously lived had contributed to the decision to relocate. Although a comparison of the two different cultural groups (Black & White) was not the purpose of the study, it was apparent that security was an important consideration for the participants in Focus Groups 2 and 3. This may be understood within the context that South African Black residents largely live in poor or rural areas, while the White population live in areas that are more affluent (Ferreira, n.d.).

Declining health. Increase in ill health, as well as mental and/or functional decline were negative push factors identified by participants as affecting their decision to relocate. In the participants discussion they linked this to the loss of support after the death of a spouse or children having moved on, which often resulted in them living alone. This had the effect that they opted to seek residence in residential care. This finding is strongly supported by an experimental study by Caro *et al*. (2011), who found that the combination of declining health with living alone has the greatest impact on decisions of older people to find residence in residential care facilities.

Psycho-social aspects. Although declining health was strongly linked to the reality of loss of care (as discussed above), this theme also provides insight into other facets of changing social realities. From and African perspective, Munthree and Ngyende (2017) report that elders in 21st century cannot as a rule rely on the typical African value that family support structures will take care of their elders. This is due to urbanisation and modernisation, as well as children of all genders leaving home to earn a living. Participants in this study also alluded to this trend when mentioning that their children work and/or live elsewhere and they cannot take up the role of taking care of them. Furthermore, this theme indicates that the family structure still is concerned about care for their older people by emphasizing the need for high quality services. The provision of quality health and care facilities is in line with the findings of

Krout *et al. (*2002), who also found that proximity of services near family and friends is important, as was the case in the current study (i.e. theme-relatedness as support.

The emerging of driving factors as a theme that influenced participants' experiences of relocation is aligned with Bronfenbrenner's idea that individuals are part of various systems at the same time that influence their functioning (Bronfenbrenner & Morris, 2006). This ranges from the microsystem of their home, the mesosytem of their extended family and friends, the work realities (excosystem) of their children to the pattern and values of the context from which they come, i.e. culture (macrosystem). Although it is not the purpose of this study to focus on differences between cultures, it can be noted that the experiences mentioned by participants of different cultures often differed, as was pointed out under the subtheme 'security'.

4.2.2 Self-determination in decision making

In line with the theory of self-determination, autonomy and control over the relocation process are important to older persons (Ryan & Deci, 2017; Neubauer, Olivier, Schilling & Wahl, 2017). This freedom of choice and being able to make decisions about their own future can be infringed upon by children or significant others that want to protect and help them (Neubauer *et al.,* 2017). Literature indicates that such infringement generally has a negative impact on elders' well-being. In this research, study participants had a variety of experiences regarding whose decision it was to relocate to residential care. Participants who were excluded from the decision-making process experienced the lack of control negatively, whilst those who were able to take control expressed that they were satisfied to be in the residential care facility. This is in support of the findings by numerous researchers (Chirkov, 2008; Church *et al.,* 2013; Givevra *et al.*, 2013; Neubauer *et al*., 2017; Ryan & Deci, 2017) that suggest that the fulfilment of the psychological need for autonomy is essential for positive affect and a person's well-being.

Although some participants had made the decisions themselves, they had found themselves in situations in which they had no other choice but to move. These findings are in accordance with previous findings of Stoeckel (2011) that participants who suffer from ill health and are socially isolated, need the support services the residential care

facilities have to offer. Accordingly, having no choice and self-determination often become opposite sides of the coin

Literature on self-determination often also investigates the role of culture in self-determination needs of people i.e. more individualistic (independent) cultures versus those of cultures more collectivistic in nature (valuing interdependence) (Chirkov, 2008; Church *et al*., 2012 & Ginevra *et al.,* 2015). In this context, Ravindran (n.d., as cited in Lekalakala-Mokgele & Adejumo, 2013) emphasises that in the African context, individual autonomy and the power of decision-making are entrenched in the cultural and social patterns of family relations and community obligation. His view is supported by Jegede (2009), who states, “Africa has a communal or social autonomy as opposed to individual autonomy in the West.” Although cultural comparison was not the focus of this study it is interesting to mention that in this study it was clear that culture, as indicated by race, was not a determining factor in either White or Black older person’s participation in the decision-making process to relocate to residential care. It depended on the individual’s and or their families’ preferences and realities irrespective of their culture.

4.2.3 Adapting to a new environment

Adapting to life in a residential care facility entails three phases (Johnson & Bibbo, 2014), which are not necessarily clearly delineated. The first phase generally entails a feeling of being overwhelmed by the new environment as posited by Winningham *et al.* (2007) and Jungers, (2010). Despite a few participants having been frail prior to relocating to the residential care facilities, participants had not indicated/mentioned that they experienced being “overwhelmed”. However, on arriving at the residential care facility a few participants had experienced personal helplessness (inability to care for themselves) because they were totally dependent on the assistance and care of staff as they had been frail on admittance. This finding is in accordance with Levinson’s (1996) views that transitions involve feelings of loss, abandonment and helplessness during the initial phase.

Furthermore, other participants felt anxious and experienced apprehension, tension and excessive worrying about day-to-day issues or about the future (Kwan & Wijerante, 2016). Some examples related to needs regarding the distribution of

medication, feelings of uncertainty, and even questions regarding where they would die. Feelings of anxiety are normal as the fears and concerns mentioned represent real and serious threats to the safety, security and quality of life of older people (Covinsky *et al.*, 2003; Szcsepura, Wild & Nelson 2011). The findings in this study are in accordance with Hodgson, Freedman, Grange and Erno, (2004), who identified negative emotions such as anxiety during relocation.

The second phase of adjustment and integration into the residential care facility can be achieved using many coping strategies. In assisting to ease the adaptation process, some participants' children had physically helped their parents with the actual move, while others supported their parents in finding a suitable residential care facility. These findings support those of a study by Johnson and Bibbo (2014) that reports that if older persons perceive being supported as opposed to being directed by family members it is more important for adjustment than whether or not they had participated in the decision to move to the residential facility. .

Behaviour such as making new friends and becoming more positive about the future that were used by participants in this study as a strategy to adjust to residential care living is supported by many researchers (Johnson & Bibbo, 2014; Fraher & Cofffey, 2011 & Salvesen, 2016) as behaviours that indicate that older people have started to adjust and integrate into their new living environment.

Actively participating in activities and encouraging new residents to "join in" and participate actively in activities that are offered by the residential care facility was a way in which some participants adapted and thought they could assist new residents to adapt to their new living environment. This supports the findings of Lin and Yen (2018) that participation in leisure activities helps elderly people to adjust psychologically and socially to life in residential care. In addition, Newman and Newman (2018) mention that continuous active participation contributes to the fulfilment of needs of belonging to a group.

The importance of religion and spirituality increases as people age (Ward, Barnes & Gahagan, 2012). Some participants confirmed that their coping strategies were strengthened through the grace of God and praying for guidance to adjust to their new environment. This in in line with findings of Van Biljon and Roos (2015) that older

persons' spirituality strengthened their functional coping strategies when dealing with adversities of relocation. This study also supports the findings of Vitorina and Vianna (2012) who report that participants, through their spirituality, belief or religious behaviour, try to understand and/or deal with important personal or situational challenges of life in a residential care facility. Lastly, some participants stated that their personal attitudes also played an important role in adaptation to live in their new living environments. This supports the views as posited by Falk, Wijk, Persson and Falk (2012) that individual attitudes determine whether older persons fail or succeed in creating an attachment to residential care facilities.

To conclude the discussion of the theme regarding adaptation to life in a residential care facility, the last phase of adaptation, namely working towards acceptance in the new environment, is highlighted through the subtheme "acceptance". A study by Dahlan, Nicol and Maciver (2010) indicates that adjustment to a new environment requires acceptance, a feeling of happiness and some degree of contentment. The findings in this study support these findings in that participants' discussion indicated that they had settled in well, have accepted their new living environment as their future home and were generally satisfied and happy with their current circumstances.

4.2.4 Experiences of living at a residential care facility

The results of this theme regarding the day-to-day experiences of living in a residential care facility centres generally around the *individual person* and the fulfilment of his/her needs on the one hand, and *feelings regarding the facility or staff* on the other hand. This is in support of a study by Chou, Boldy and Lee (2003) regarding factors that influence residents' satisfaction in residential care. On an individual level, participants' experiences in this study are linked to needs such as food, shelter, security, care and being respected, as encompassed by Maslow's (1943) physiological, security and safety, as well as belonging and esteem needs (McLeod, 2017). The participants indicated that the fulfilment of these needs added to feelings of satisfaction with their living environment (they are happy). This finding is supported by the study of Fonad *et al.* (2006) that indicates that fulfilment of needs facilitates the well-being and quality of life of elders. On the other hand, the finding that some participants felt lonely and disconnected due to longing for old friends, their old homes or the need to connect with their children confirms findings as mentioned by McLeod (2017) that if the need

to belong and be loved are not fulfilled, older people's well-being and satisfaction with life suffer.

Regarding their feelings in respect of the facility and or staff, feelings of both satisfaction and dissatisfaction were voiced. In this study, participants reported positive feelings toward the staff, how they were cared for and how they were treated and respected. These findings support the study of Rijnaard *et al.* (2016) that found that interaction and relationships with the staff strongly coincide with feelings of a sense of home in residential care. It also supports the view of ecological systems theory that harmonious reciprocal relationships between residents and staff – interaction between the microsystems (Bronfenbrenner, 1979) – facilitate elderly people to thrive in residential care facilities (Bergland & Kirkevold, 2008; Jacelon, 1995).

Some participants indicated negative feelings either towards some of the staff or about the rules and structure within the facility. Their experiences of how they were treated and the language used towards them, made them dissatisfied and unhappy about their life in the residential care facility. In their research, Rijnaard *et al.* (2016) report that negative feelings towards staff members were found to have a negative influence on residents' ability to create a sense of home in residential care environments, while positive feelings of being cared for becomes a source of feeling at home. The results of this study thus support his findings.

Furthermore, some participants revealed that unfamiliarity and uncertainty about the organisation and structure of the residential care facility accounted for their dissatisfaction, including the fact that they were not allowed to leave the premises without receiving approval (''pass-out") of staff. This had a negative impact on their needs for autonomy, in line with the Self-Determination Theory of Ryan and Deci (2017). This finding is also supported by the research of Rijnaard *et al.* (2016), who report that autonomy and control during late adulthood. as well as the findings of the study by Jones (Klever, 2013, p. 36) that indicates that reminiscence is "an important and therapeutic aspect of aging", that give older persons a sense of fulfilment and comfort as they take control, as well as perceptions of freedom and mobility are very important to establish a sense of "at-homeness" (Klever, 2013. p. 8) in residential care.

This theme also revealed that participants find the time to reminisce over the past and to tell stories about their lives enjoyable. This supports Erikson's views on finding meaning, as opposed to despair (Erikson & Erikson, 1997). The study by Bjornestad and Brown (2017) also confirms that being able to recall and reflect assists older adults in remembering who they used to be and to define their current identity. Rijnaard *et al.* (2016) also report that memories and emotions about personal experiences help to create a sense of home.

This concludes the discussion of the theme regarding the experience of life in the residential care facilities, as well as the results of the study as a whole. From these findings, one can conclude that older people's experience of relocation is complex and influenced by many factors. It influences their well-being and satisfaction with life. To understand the meaning of relocation to residential care for older people is a first step in finding solutions to enhance the quality of life for older residents in residential care facilities.

4.3 SUMMARY OF THE MOST SIGNIFICANT FINDINGS

The aim of this study was to investigate the subjective experiences of older people who relocated to a residential care facility. The most significant findings that emerged from the data were as follows:

The experience of relocation to residential care is a complex experience that encompass experiences before relocation, the decisions about relocation, adaptation to the facility as well as the "lived" experience of the day-to-day life in the facility. These aspects were identified as the four main themes that together with their sub-themes formed the basis of our discussion of the results.

The "triggers" (Wiseman, 1980) that put the process of relocation in motion included various push-and-pull factors. Push factors related to needs of daily living that had to be addressed such as safety, security, care for declining health and changes in living circumstances (Maslow, 1943). The pull factors were easy access to family and relatives and the quality of services that was available. Where the fit between older persons and their living environment was absent, they were "pushed" towards making the decision to relocate (Lawton & Nahemov, 1973). The non-fulfilment of safety and

security needs (Maslow, 1943) was found to be a major contributing factor, especially for Black participants moving to safer environments, such as residential care facilities.

Involvement regarding the decision to relocate varied for participants and indicated that the concept of self-determination is complex (Ryan & Deci, 2017). It was clear that culture was not a determining factor affecting involvement in the decision-making in this diverse group of elders. The process of adapting to living in residential care facilities related to a process of adaptation. Initially some participants had experienced feelings of helplessness, dependency and anxiety but eventually came to terms with, and accepted their current circumstances in the residential care facilities. The process of adaptation was also eased by support received from family members, by making new friends, and involvement in activities, supporting Maslow's (1943) theory positing that older persons have social needs to belong and to be loved, and include the need for interaction and being with family and friends, as well as belonging to a group (Newman & Neman, 2018). The importance of religion and one's personal attitude also emerged as important strategies to ease adaptation.

The ways in which participants experienced the move to, and living at the residential care facilities revealed some negative aspects but mostly included positive feelings of satisfaction with their new living environments. Participants revealed that their daily living needs, as postulated by Maslow (1943), were fulfilled by the various services that were rendered and that they felt respected and loved. The negative aspects related to feelings of dissatisfaction by some participants with the attitude of staff and perceived rigid structures (rules and regulations) of the residential care facilities. Participants enjoyed reminiscing over the past, which added meaning to their lives, (Levinson, 1996,) while some longed for their erstwhile friends and close family members, leaving them lonely and disconnected.

4.4 LIMITATIONS OF THE STUDY

Even though this study revealed insightful findings, there were limitations that have to be considered when interpreting the results that were obtained. The next few paragraphs will highlight these limitations.

Interviewing three diverse cultural groups of older people was a challenging experience. The researcher met the participants on one occasion only, which made it

difficult to build rapport and instil trust, especially with the Black groups in Boshoff and Botchabela. Factors such as different cultural backgrounds, education, language and personality influence the degree in which rapport may be created (Svidén, Wikström & Hjortsjö-Norberg, 2002).

Although participants knew that they could communicate in their mother tongue, the fact that it was indicated that the primary mode of communication was English or Afrikaans could have had the effect that some of the Black participants had refrained from taking part in the study or offering their opinions. Older persons find it more comfortable to express themselves and provide richer descriptions in their mother tongue, than first having to translate their thoughts. There were instances during the focus group discussions where Black participants found it difficult to express themselves in English or Afrikaans. They then expressed their views in Sesotho. These were then translated by the fieldworker back to English, which could have led to meaning being lost.

The differences between the researcher and the Black participants' language and culture should be considered, as well as the fact that a fieldworker often was the "go-between" in ensuring that the researcher understood what was said. With the fieldworker translating the questions into Sesotho and the answers back into English or Afrikaans in the focus groups that consisted of Black participants, it could have resulted in different understandings than those that were expressed. However, care was taken with the transcribing of the participant's conversation and answers from the audiotapes to ensure that the true meaning of questions and answers were captured.

It is furthermore quite possible that participants in both the Boshoff and Botchabela focus groups had never experienced being interviewed before. It was noticed that even though they could answer in Sesotho, they found it difficult to formulate their feelings and experiences and to verbalise them. The Bloemfontein group (who were all White) was more comfortable with being interviewed, and participants were able to share their experiences.

Even though clear inclusion and exclusion criteria were specified prior to the study and agreed upon by the gatekeepers of the facilities, one of the Black focus groups included a staff member of the residential care facility in the group, who insisted on

being part of the discussion. This had an impact on how freely participants were willing to share their experiences and opinions and resulted in limited and superficial data being gathered during that specific focus group. To counter the lack of quality data to investigate the research question, a third focus group from another facility was interviewed to ensure data saturation.

Irrespective of the limitations mentioned, useful insights into the experiences of a culturally diverse sample of older persons regarding relocation to residential care facilities were obtained. The most significant findings were summarised in Section 4.3.

4.5 RECOMMENDATIONS FOR FURTHER RESEARCH

Considering the findings and limitations of this study, recommendations can be made for future research.

Only meeting the participants on the day of the focus group discussions, had made it virtually impossible to build rapport and trust. This hurdle could be overcome if an informal personal meeting with the residents of the residential care facilities could be arranged prior to the formal focus group discussions.

Although a fieldworker who is proficient in the same mother tongue as participants was available during the cross-cultural data-gathering process, it is recommended that the fieldworker should also be a professional facilitator, with background in psychology to help build rapport in a cross-cultural setting. Furthermore, the use of a data-gathering research tool such as the Mmogo method (Roos, 2012) that combine a projective technique (clay modelling) with semi-structured focus group interviews seem useful to assist previously disadvantaged groups in expressing their subjective experiences of relocation. This mode of data gathering would enable those participants who are not able to verbalise their feelings to express their experiences in a creative way. The Mmogo method has been shown to be particularly useful in cross-cultural contexts (Roos, 2012).

It is recommended that in culturally diverse settings, extra care should be taken with communication to gatekeepers, specifically in the South African context where many disadvantaged communities are not familiar with the importance of adherence to research criteria.

Although time-consuming, individual interviews with participants could possibly render richer, more meaningful discussions and voluntary information. This method of research could instil deeper trust between the researcher and participants, elicit personal experiences that would possibly not be shared in a group and eliminate the possibility of feeling intimidated by other participants.

4.6 CHAPTER SUMMARY

The various key findings of this study were discussed with the aim to contribute to the limited body of research regarding the experiences of older South Africans from the middle to lower socio-economic groups who relocate to residential care facilities. The four themes, together with the sub-themes that emerged in answer to the research question, were highlighted and discussed against the background of theoretical perspectives and knowledge in the field of relocation during late-adulthood. The main findings were summarised. Furthermore, the limitations of the study as related to problems experienced were noted. Lastly, recommendations were made regarding methodological considerations for future research in this area in a cross-cultural setting.

In conclusion, it can be noted that the aim of the research to gain an in-depth understanding of the relocation experiences of a diverse group of older adults in residential care living was achieved. Light is shed on how the phenomenon of relocation to residential care facilities is experienced from a cross-cultural perspective although comparisons were not the aim of the study. A deeper understanding of the processes involved during relocation of older people to new living environments was obtained. Generally, the findings of this study support the results of previous international studies in this field. More research is however needed to understand fully how older people who relocate to residential care facilities make meaning of their new home in an African and South African context.

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APPENDIX A: ETHICAL CLEARANCE BY RESEARCH ETHICS COMMITTEE (FACULTY OF THE HUMANITIES)

UFS·UV

Faculty of the Humanites

07-Jul-2016

Dear Mr Visagie

Ethics Clearance: **Relocation to residential care facilities: The subjective experiences of elderly people**

Principal Investigator: **Mr Handré Visagie**

Department: **Psychology (Bloemfontein Campus)**

APPLICATION APPROVED

With reference to your application for ethical clearance with the Faculty of the Humanities. I am pleased to inform you on behalf of the Research Ethics Committee of the faculty that you have been granted ethical clearance for your research.

Your ethical clearance number, to be used in all correspondence is: **UFS-HSD2016/0481**

This ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the ethics office to ensure we are kept up to date with your progress and any ethical implications that may arise.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely

Prof. Robert Peacock
Chair: Research Ethics Committee
Faculty of the Humanities

Office of the Dean/Kantoor van die Dekaan/Ofisa ya Dine
T: +27 (0)51 401 2240 | F: +27 (0)51 401 7363 | E: beukeshs@ufs.ac.za
P.O. Box/Posbus 339 | Bloemfontein 9300 | South Africa/Suid-Afrika | www.ufs.ac.za

APPENDIX B: PERMISSION TO CONDUCT RESEARCH

APPENDIX B.1

Permission to conduct research

Topic: Relocation to residential care facilities: The subjective experiences of elderly people

01.07.2016
The General Manager
Mr/Mrs xxxxxxx
Mooihawe/Ons Tuiste Retirement Home
Bleomfontein
9301

Dear……..

I, Handré Visagie, am currently a Psychology Masters student at the University of the Free State, doing research under the supervision of Ms M van Dijk in the Department of Psychology. As part of my research, I have to obtain data on the subjective experiences of elderly people who recently relocated to residential care facilities such as yours. The facility under your management has been selected because we are interested in the experiences of elderly people from low to middle-income residences. We are therefore inviting you to participate in this study.

It would be greatly appreciated if you could assist in providing me with access to the facility under your management to obtain a diverse sample of 30 residents (either English, Afrikaans or Sotho-speaking) for my study. Participants will have to participate in one group interview session (called a focus group) to a maximum of one and a half hour. Our focus group will consist of 6-8 participants and I will therefore have to run 4 to 5 such focus group sessions in total.

The participants should be older than 60 years and should have lived in the facility for one year or less, as we are interested in their experiences associated with the move. Persons with any form of serious cognitive and emotional impairments (as identified by the interdisciplinary management team of the facility involved) will not be able to participate. This research will not interrupt meal times or any other extra-curricular activities, unless otherwise agreed to by the manager and/or relevant supervisory staff of the facility. Residents' participation is completely voluntary and all personal information and research data will be kept confidential

at all times. At no time will your facility be identified in the research report or will any resident be identified from the data.

Participation in the research will contribute significantly to the understanding of the subjective experiences of the elderly who relocate to old-age homes and the improvement of their lives. The research project has been approved by the Research Committee of the Faculty of the Humanities as well as the Ethics Committee of the University of the Free State (Ethical clearance number: ……..). At the completion of the research, we will provide you with a copy of the research finding and the Thesis.

Should you have any questions in this regard, please feel free to contact my supervisor, Me M van Dijk at 051 401 2596 or VanDijkM@ufs.ac.za

Sincerely

…….
Handré Visagie

I, ……. (name of Chairperson of the Board) do/do not consent to Handré Visagie conducting research at the facilities under my management.

…… (signature of the Manager)
General Manager

APPENDIX B 2

Toestemming om navorsing te doen

Onderwerp: Verskuiwing na residensiële versorgingfasiliteite: Die subjektiewe ervarings van bejaarde persone

01.07.2016
Die Algemene Bestuurder
Mnr/me XXXX
Mooihawe-/Ons Tuiste-aftreeoord
Bloemfontein
9301

Beste .....

Ek, Handré Visagie, is tans 'n meestergraadstudent in Sielkunde by die Universiteit van die Vrystaat. Ek doen navorsing onder leiding van me M van Dijk in die Departement Sielkunde. As deel van my navorsing moet ek data verkry oor die subjektiewe ervarings van bejaarde persone wat onlangs na residensiële versorgingsfasiliteite, soos die van u, verskuif het. Die fasiliteite wat u bestuur is gekies omdat ons belangstel in die ervarings van bejaarde persone in lae- tot middelinkomste verblyfplekke. Ons nooi u daarom uit om aan hierdie navorsing deel te neem.

Dit sal baie waardeer word indien u my kan help om toegang te verkry tot die fasiliteit wat u bestuur, om 'n uiteenlopende voorbeeld van 30 inwoners vir my navorsing te kry. Die persone kan Engels-, Afrikaans- of Sothosprekend wees. Deelnemers sal aan een groeponderhoudsessie van 'n maksimum van een en 'n halfuur moet deelneem. Dit word 'n fokusgroep genoem. Ons fokusgroep sal uit 6 tot 8 deelnemers bestaan en derhalwe sal ek 4 tot 5 sulke fokusgroepsessies in totaal moet hou.

Die deelnemers moet ouer as 60 jaar wees en moet reeds vir een jaar of korter in die fasiliteite gewoon het, aangesien ons belangstel in hul ervarings wat met die verskuiwing vereenselwig word. Persone met enige vorm van ernstige kognitiewe en emosionele verswakking (soos geïdentifiseer deur die interdissiplinêre bestuurspan van die betrokke fasiliteit) sal nie in staat wees om deel te neem nie. Hierdie navorsing sal nie etenstye of enige ander buitemuurse aktiwiteite onderbreek nie, tensy dit andersins met die bestuurder en/of ander betrokke toesighoudende personeel van die fasiliteit ooreengekom word. Inwoners se deelname is geheel en al vrywillig en alle persoonlike inligting en navorsingsdata sal ten alle tye vertroulik gehou word. U fasiliteit sal nooit in die navorsingsverslag geïdentifiseer word nie, en verder sal geen inwoners uit die data geïdentifiseer word nie.

Deelname aan die navorsing sal 'n betekenisvolle bydrae lewer tot die begrip van die subjektiewe ervarings van bejaarde persone wat na aftree-oorde verhuis, asook tot die verbetering van hul lewens. Die navorsingsprojek is goedgekeur deur die Navorsingskomitee van die Fakulteit Geesteswetenskappe, asook deur die Etiekkomitee

van die Universiteit van die Vrystaat (Etiese-klaringsnommer: .....). Na die voltooiing van die navorsings sal ons aan u 'n afskrif van die navorsingsbevinding en die verhandeling verskaf.
Indien u enige vrae hieroor het, kontak gerus my studieleier, me M van Dijk, by 051 4012596 of VanDijkM@ufs.ac.za.

Beste wense

.....
Handré Visagie

Ek, Ida Britz, (naam van die bestuurder) **verleen/verleen nie** toestemming aan Handré Visagie om navorsing te doen by die fasiliteite onder my bestuur **(nie)**.

.....(handtekening van die bestuurder)
Algemene Bestuurder

11/9/17

Afskrif vir skrifsie asb.

APPENDIX B.3

Tumello ya ho etsa phuputso

Sehlooho: Ho falella ditsing tsa tlhokomelo tsa mahae a maqheku: Maikutlo a maqheku ka ho fapana

01.07.2016
Mookamedi-Kakaretso
Mong/Mof xxxxxxx
Lehae la Maqheku la Mooihawe/Ons Tuiste
Bleomfontein
9301

..... ya kgabane

Nna, Handré Visagie, hajwale ke moithuti wa lengolo la Saekholoji la Masters Yunivesithing ya Foreistata, mme ke etsa patlisiso tlasa bosupisi ba Mof. M van Dijk Lefapheng la Saekholoji. E le karolo ya patlisiso yaka, ke lokela ho fumana lesedi le mabapi le ka moo maqheku a sa tswa fallela mahaeng a maqheku ka ho fapana a fumanang ketsahalo ena e le ka teng ditsing tsa tlhokomelo tse jwalo ka sa heno. Setsi se tlasa tsamaiso ya heno se kgethilwe hobane re na le kgahleho ditebellong tsa maqheku ho tswa mahaeng a bodulo a maqheku a amohelang meputso e tlase ho ya ho e mahareng. Ka hona re o memela ho nka karolo phuputsong ena.

Nka thaba haholo ha o ka nthusa ho fihlella setsi se tlasa tsamaiso ya hao hore ke fumane sampole ya badudi ba fapafapaneng ba 30 (ekaba ba buang Senyesemane, Afrikanse kapa Sesotho) bakeng sa phuputso yaka. Bankakarolo ba tla lokela ho nka karolo puisanong e le nngwe ya sehlopha (e bitswang sehlopha sa tjhebisiso) ya botelele bo ke keng ba feta hora e le nngwe le halofo. Sehlopha sa rona sa tjhebisiso se tla ba le bankakarolo ba 6-8 mme ka hona ke tla lokela ho tsamaisa dipuisano tsa tjhebisiso tse 4 ho fihla ho 5 ka kakaretso.

Bankakarolo ba tlameha ho ba boholo ba dilemo tse kahodimo ho 60 mme ba tlameha hore ba be ba dula setsing sena nako ya selemo se le seng kapa ka tlase hobane re batla ho tseba maikutlo a bona mabapi le ho falla ha bona. Batho ba nang le sebopeho sefe kapa sefe sa mathata a kelello a mahlonoko (jwalo kaha ho tsebahaditswe ke sehlopha sa tsamaiso sa mafapha a fapafapaneng a setsi se amehang) ba keke ba dumellwa ho nka karolo. Patlisiso ena e keke ya sitisa nako ya dijo kapa diketsahalo dife kapa dife tse ding tsa tlatsetso, ntle le haeba ho dumellanwe le mookamedi le/kapa basebetsi ba bosupisi kapa setsi. Bonkakarolo ba badudi ke ba boithaopo bo phethahetseng mme tlhahisoleseding yohle le lesedi la patlisiso di tla bolokwa ka sephiring ka dinako tsohle. Ka nako efe kapa

efe setsi sa heno se keke sa tsebahatswa tlalehong ya patlisiso mme ha ho badudi bafe kapa bafe ba tla tsebahatswa ho tswa leseding lena.

Bonkakarolo ba hao patlisisong bo tla tlatsetsa ka tsela e kgolo kutlwisisong ya ka moo ho falla ha maqheku ka ho fapana ho ya mahaeng a maqheku le ntlafalo maphelong a bona di bileng ka teng. Projeke ya patlisiso e dumeletswe ke Komiti ya Patlisiso ya Lefapha la Dithuto tsa Maphelo a Batho (Humanities) la Yunivesithi ya Foreistata (Nomoro ya tumello ya tsa boitshwaro tshebetsong: ……..). Ha patlisiso ena e phethetswe re tla o fa khopi ya ditshibollo tsa patlisiso le Thesise. Haeba o na le dipotso dife kapa dife mabapi le sena, ka kopo ikutlwe o lokolohile ho ikopanya le mosupisi waka, Mof. M van Dijk ho 051 401 2596 kapa VanDijkM@ufs.ac.za

Ka boikokobetso

…….
Handré Visagie

Nna, ……. (lebitso la Modulasetulo wa Boto) ke dumela/ha ke dumele hore Handré Visagie a etse patlisiso setsing se tlasa tsamaiso yaka.

……(tshaeno ya Mookamedi)
Mookamedi-Kakaretso

APPENDIX C: PERMISSION LETTERS MANAGERS

Permission letter: Managers

01/02/2016

Mr/Mrs xxxxx

Mooihawe/Ons Tuiste

Bloemfontein

Re: Permission to conduct research

I, Handre Visagie, am currently a Psychology Masters (Research) student at the University of the Free State. As part of my research, I need to conduct a study on the subjective experiences of elderly people who recently relocated to residential care facilities such as yours. Your assistance in providing me with access to a sample of eight to ten (8-10) residence (preferably English, Afrikaans or Sotho-speaking) for my study would be greatly appreciated. This research will not interrupt meal times or any other extra-curricular activities, unless otherwise agreed to by the manager and/or relevant staff involved. Resident's participation is completely voluntary and all details and information will be kept confidential at all times. Participation in the research will contribute significantly to the understanding of the subjective experiences of the elderly people and the improvement of their lives. Should you have any questions in this regard, please feel free to contact my supervisor, Mrs M van Dijk at 051 401 2596 or VanDijkM@ufs.ac.za.

Sincerely

.....

Handre Visagie

I, G. Pieters (Name of manager) of Mooihawe/Ons Tuiste, do/do not consent to Handre Visagie conducting research at this facility.

Huis Gealiersary.

.....

Permission letter: Managers

03 April 2018

Ms C Mosala
Boikhuco Old Age Home
Bloemfontein

RE: PERMISSION TO CONDUCT RESEARCH

I, Handre Visagie, am currently a Psychology Masters (Research) student at the University of the Free State. As part of my research, I need to conduct a study on the subjective experiences of elderly people who recently relocated to residential care facilities such as yours. Your assistance in providing me with access to a sample of eight to ten (8-10) residence (preferably English, Afrikaans or Sotho-speaking) for my study would be greatly appreciated. This research will not interrupt meal times or any other extra-curricular activities, unless otherwise agreed to by the manager and/or relevant staff involved. Resident's participation is completely voluntary and all details and information will be kept confidential at all times. Participation in the research will contribute significantly to the understanding of the subjective experiences of the elderly people and the improvement of their lives. Should you have any questions in this regard, please feel free to contact my supervisor, Mrs M van Dijk at 051 401 2596 or VanDijkM@ufs.ac.za.

Sincerely

.....

Handre Visagie

I, Madichaba Christine Mosala (Name of manager) of Boikhuco Old Age Home do/do not consent to Handre Visagie conducting research at this facility.

1 Z.C. Jacobs.
.....

Signature of the manager

MANGAUNG SOCIETY
FOR THE CARE OF THE AGED
002 - 806 NPO
P.O. BOX 2509 BLOEMFONTEIN

APPENDIX D: RESEARCH COVER LETTERS FOR FOCUS GROUP INTERVIEWS

APPENDIX D.1

Research cover letter, informed consent form for focus group interviewing and recording consent.

Dear prospective participant

My name is Handré Visagie, and I am currently a Master's student of Psychology at the University of the Free State. I am conducting research to understand the personal experiences of elderly persons, like yourself, who have relocated to residential care facilities. The title of this study is:

Relocation to residential facilities: the subjective experiences of elderly people

You are hereby kindly invited to participate in the research as stated above.

You are regarded as a key informant for this study based on your first-hand experience of relocation to an old-aged home. Your participation in the research will contribute significantly to the understanding of the experiences of the elderly people and the improvement of their lives.

Participation in this study will involve participating in a group interview (called a focus group) facilitated by a fieldworker assisting me and by myself. As I am wheelchair bound. The duration of the group discussion is expected to be approximately one and a half hours. Participation is voluntary, and you will not be advantaged or disadvantaged in any way for choosing to participate in the group interview. You will also not be rewarded for participating. Everything you say during this interview will be kept confidential. The interview will be tape-recorded and only the transcriber and I will have access to the tapes. The tapes and transcripts will be kept in a lock cupboard in a safe. Although your identity would be known to me, the highest level of confidentiality will be maintained at all times by not disclosing any information that is of a personal nature in the report. A pseudonym will be assigned to your information in the report, for example, Participant A or Respondent B. You have the right to withdraw from the study at any time. You also have the right to refrain from answering any questions should you wish to do so.

If you fell distressed on completion of our group session, or if you know of a group member who feels distressed, the persons mentioned below may be contacted. (These persons are based in Bloemfontein and they provide support and counselling with regard to this research project without cost.)

- Mrs Velma Jansen (Registered Psychologist) – 084 500 8223
- Mrs Santa Oosthuizen (Registered Social Worker) – 071 864 783

Before starting with our group session, I will read the contents of this form to you and you can also read the form yourself and then sign the accompanying permission (consent) form. This is to confirm that you are aware of, and understand everything that we have discussed concerning confidentiality, feedback and privacy.

Please detach and keep this sheet in a safe place for your reference.

Kind regards

Handré Visagie

……

083 950 3649

visagiehandre@yahoo.com

Magriet van Dijk (Supervisor)

……..

051 401 2596

VanDijkM@ufs.ac.za

APPENDIX D.2

Navorsingsdekbrief, ingeligte besluitvorm vir fokusgroep-onderhoud en toestemming vir bandopname.

Beste voornemende deelnemer,

My naam is Handré Visagie en ek is tans ’n meestersgraadstudent in Sielkunde by die Universiteit van die Vrystaat. Ek doen navorsing om die persoonlike ervarings te verstaan van bejaarde persone, soos uself, wat na residensiële versorgingsfasiliteite verskuif het. Die titel van hierdie navorsing is:

Verskuiwing na residensiële versorgingfasiliteite: Die subjektiewe ervarings van bejaarde persone

U word hiermee vriendelik uitgenooi om deel te neem aan die navorsing wat hierbo genoem word.

U word as ’n sleutel-informant vir hierdie navorsing beskou, gebaseer op u eerstehandse ervaring van hervestiging na ’n ouetehuis. U deelname aan die navorsing sal ’n betekenisvolle bydrae lewer tot die begrip van die ervarings van bejaarde persone en die verbetering van hul lewens.

Deelname aan hierdie navorsing behels deelname in ’n groepsonderhoud (wat ’n fokusgroep genoem word) en dit word deur myself gefasiliteer en ’n veldwerker wat my bystaan, aangesien ek in ’n rolstoel is. Daar word verwag dat die groepsbespreking ongeveer een en ’n half uur sal duur. Deelname is vrywillig en indien u besluit om aan hierdie groepsonderhoud deel te neem, sal u op geen manier bevoordeel of benadeel word nie. U sal ook nie vergoed word vir u deelname nie. Alles wat tydens hierdie onderhoud gesê word, sal vertroulik gehou word. Die onderhoud word op band opgeneem en net ek en die transkribeerder sal toegang tot die opnames hê. Die bande en transkripsies sal in ’n toegesluite kas of kluis gehou word. Alhoewel u identiteit aan my bekend sal wees, sal die hoogste graad vertroulikheid ten alle tye gehandhaaf word deur geen inligting van ’n persoonlike aard in die verslag bekend te maak nie. ’n Pseudoniem sal vir u inligting in die verslag toegeken word, byvoorbeeld, Deelnemer A of Deelnemer B. U kan uself in enige stadium van die navorsing onttrek. U het ook die reg om, indien u dit so verkies, sekere vrae nie te beantwoord nie.

Indien u na die voltooiing van ons groepsessie ontsteld voel, of as u weet van ’n groepslid wat ontsteld voel, kan u die onderstaande persone kontak. (Hierdie

persone is in Bloemfontein en sal gratis ondersteuning en voorligting ten opsigte van hierdie navorsingsprojek verskaf).

- Me Velma Jansen (Geregistreerde sielkundige) – 084 500 8223
- Me Santa Oosthuizen (Geregistreerde maatskaplike werker) – 071 864 783

Voordat ons met ons groepsessie begin, sal ek die inhoud van hierdie vorm voorlees, en u kan die vorm ook self deurlees en daarna die bygaande toestemmingsvorm onderteken. Dit is om te bevestig dat u bewus is van alles wat ons oor vertroulikheid, terugvoer en privaatheid bespreek het, asook dat u dit verstaan.

Verwyder hierdie bladsy asseblief en hou dit in 'n veilige plek vir u verwysing.

Vriendelike groete

Handré Visagie (navorser)

……

083 950 3649

visagiehandre@yahoo.com

Magriet van Dijk (studieleier)

……..

051 401 2596

VanDijkM@ufs.ac.za

APPENDIX D.3

Lengolo le tekang patlisiso, foromo ya tumelo e bontshang kutlwisiso bakeng sa dipuisano tsa sehlopha sa tjhebisiso le kgatiso ya tumelo.

Ho motho ya ka bang monkakarolo

Lebitso la ka ke Handré Visagie, hajwale ke moithuti wa lengolo la Master's thutong ya Saekholoji Yunivesithing ya Foreistata. Ke etsa patlisiso ya ho utlwisisa ka moo maqheku, jwalo ka wena, a fallisetswang ditsing tsa tlhokomelo mahaeng a maqheku a fumanang sena se le ka teng. Sehlooho sa phuputso ena ke:

Ho falella ditsing tsa tlhokomelo tsa mahae a maqheku: Maikutlo a maqheku ka ho fapana

O mengwa mona ka boikokobetso ho nka karolo patlisisong e boletsweng kahodimo mona.

O nkuwa jwalo ka mohlaha-leseding wa bohlokwa bakeng sa phuputso ena ho ipapisitswe le ka moo o fumaneng bofalli ba hao bo le ka teng ho ya lehaeng la maqheku. Bonkakarolo ba hao patlisisong bo tla tlatsetsa ka tsela e kgolo kutlwisisong ya ka moo ho falla ha maqheku ka ho fapana ho ya mahaeng a maqheku le ntlafalo maphelong a bona di bileng ka teng.

Bonkakarolo patlisisong ena bo tla ba mabapi le ho nka karolo puisanong ya sehlopha (se bitswang sehlopha sa tjhebisiso) e hlophisitsweng ke nna le mosebetsi ya nthusang. Hobane ke dutse wiletjhereng. Botelele ba nako ya puisano ya sehlopha bo lebeletswe ho ba nako e ka bang hora e le nngwe le halofo. Bonkakarolo ke ba boithaopo, mme o keke wa fumana monyetla kapa ho kena mathateng ka tsela efe kapa efe ka lebaka la ho kgetha ho nka karolo puisanong ena ya sehlopha. Hape o keke wa putswa bakeng sa ho nka karolo. Dintho tsohle tseo o di buang nakong ya puisano di tla bolokwa sephiring. Puisano e tla hatiswa ka lebanta mme ke nna feela le mofetoledi ba tla ba le phihlello ho mabanta ana. Mabanta ana le dingolwa di tla bolokwa ka khaboteng e bolokehileng. Leha ke tla tseba boitsebiso ba hao, boemo bo phahameng ka ho fetisisa ba sephiri bo tla tswelletswa ka dinako tsohle ka ho se senole tlhahisoleseding efe kapa efe ya sebopeho se mabapi le motho tlalehong. Lebitso le seng la nnete le tla sebediswa bakeng sa tlhahisoleseding ya hao e tlalehong, ho etsa mohlala, Monkakarolo A kapa Moarabi B. O na le tokelo ya ho ikgula phuputsong ka nako efe kapa efe. Hape o na le tokelo ya ho se arabe dipotso dife kapa dife haeba o sa batle.

Haeba o ikutlwa o kgathatsehile kamora puisano ya sehlopha, kapa haeba o tseba setho se seng sa sehlopha se kgathatsehileng, o ka ikopanya le batho ba boletsweng ka tlase mona. (Batho bana ba dula Bloemfontein mme ba fana ka tshehetso le dikeletso mabapi le projeke ena ya patlisiso ntle le tjeo.)

- Mof. Velma Jansen (Setsebi se Ngodisitsweng sa tsa kelello) – 084 500 8223
- Mof Santa Oosthuizen (Mosebetsi wa Setjhaba ya Ngodisitsweng) – 071 864 783

Pele o qala ka puisano ya rona ya sehlopha ke tla bala dikateng tsa foromo ena mme hape o ka ipalla foromo ka bowena ebe o saena foromo ya tumelo (tumello) e tsamayang le yona. Sena ke ho netefatsa hore o tseba ka, o utlwisisa dintho tsohle tseo re di tshohlileng mabapi le sephiri, tlalehelo le lekunutu.

Ka kopo tabola leqephe lena mme o le boloke sebakeng se bolokehileng bakeng sa boikgopotso ba hao.

Ka ditakaletso tse molemo

Handré Visagie

……

083 950 3649

visagiehandre@yahoo.com

Magriet van Dijk (Mosupisi)

……..

051 401 2596

VanDijkM@ufs.ac.za

APPENDIX E: FOCUS GROUP CONSENT FORMS

APPENDIX E.1

Focus Group Consent Form

My name is Handré Visagie, and I am currently a Master's student of Psychology at the University of the Free State. I am conducting research to understand the personal experiences of elderly persons who have relocated to residential care facilities. My Psychology Master's research supervisor, Ms Magriet van Dijk, is overseeing this research project and can be contacted at 051 401 2596 should you have any further questions. Thank you for agreeing to consider participation in this research project. In this group interview (called a focus group), we are going to discuss information about your experiences of relocation to this old-age home with each other. As this is a group discussion it is important that we agree to some ground rules that will ensure that we treat each other and each other's information with respect.

Although we are looking forward to listening to your views, I would like to emphasise that:

- Your participation in this group should be entirely voluntary.
- You are free to not respond to any question/s.
- You are requested to respect each other's views.
- You are required to treat all information shared in this group with confidentiality and not to talk to anyone inside or outside this group about what you have discussed
- You should refrain from interrupting each other.
- You are free to withdraw at any time without any negative consequences.
- None of your identifiable information will be included in the research report.

This group interview (focus group) will be tape-recorded and a fieldworker will assist me as I am wheelchair bound, but the data will be kept strictly confidential and will be available only to me. Your responses will be used to analysis, reporting and a possible publication or conference presentation. However, under no circumstances will your name or any identifying characteristics be included in any reports, presentations or publications.

CONSENT TO PARTICIPATE IN THIS STUDY

I, …….. confirm that the person asking my consent to take part in this research has told me about the nature and benefits of participation.

I have reach (or had explained to me) and understood the study as explained in the information sheet. I have had sufficient opportunity to ask questions and am prepared to

participate in the study. I understand that my participation is voluntary and that I am free to withdraw at any time without penalty. I am aware that the finding of this study will be anonymously processed into a research report, journal publications and/or conference proceedings.

I agree to the tape-recording of the interview session.

I have received a signed copy of the informed consent agreement.

Full name of Participant:

……

Signature of Participant: ……..

Date: ……

Full name of Researcher:

……

Signature of Researcher: …….

Date: …….

APPENDIX E.2

Fokusgroep-toestemmingsvorm

My naam is Handré Visagie en ek is tans ’n meestersgraadstudent in Sielkunde by die Universiteit van die Vrystaat. Ek doen navorsing om die persoonlike ervarings te verstaan van bejaarde persone wat na residensiële versorgingsfasiliteite moet verskuif. Me Magriet van Dijk is die studieleier vir my magisternavorsing en hou toesig oor hierdie navorsingsprojek. Indien u enige verdere navrae het, kan sy by 051 4012596 gekontak word. Dankie dat u toegestem het om deelname aan hierdie navorsingsprojek te oorweeg. In hierdie groepsonderhoud (wat ’n fokusgroep genoem word) gaan ons met mekaar inligting bespreek oor u ervaring van die verskuiwing na hierdie ouetehuis. Aangesien dit ’n groepsbespreking is, is dit belangrik dat ons oor ’n paar basiese reëls ooreenkom, wat sal verseker dat ons mekaar en elkeen se inligting met respek hanteer.

Alhoewel ons daarna uitsien om na u mening te luister, wil ons graag die volgende beklemtoon:

- U deelname aan hierdie groep moet heeltemal vrywillig wees.
- Dit staan u vry om op enige vraag/vrae nie te reageer nie.
- U word versoek om mekaar se menings te respekteer.
- U word versoek om alle inligting wat in die groep gedeel word vertroulik te hanteer en om met niemand binne of buite die groep te gesels oor wat u bespreek het nie.
- U moet mekaar nie onderbreek nie.
- Dit staan u vry om in enige stadium te onttrek sonder enige negatiewe gevolge.
- Geen van u identifiseerbare inligting sal in die navorsingsverslag ingesluit word nie.

Hierdie groepsonderhoud (fokusgroep) sal op band opgeneem word en ek word deur ’n veldwerker bygestaan, aangesien ek in ’n rystoel is. Al die data sal egter streng vertroulik bewaar word en sal net vir my beskikbaar wees. U respons sal gebruik word vir ontleding, verslaggewing en ’n moontlike publikasie of lesing by ’n kongres. U naam of enige identifiseerbare eienskappe sal egter onder geen omstandighede in enige verslae, aanbiedings of publikasies ingesluit word nie.

TOESTEMMING OM AAN HIERDIE NAVORSING DEEL TE NEEM

Ek, ... bevestig dat die persoon wat my toestemming vra om aan hierdie navorsing deel te neem, my oor die aard en voordele van deelname ingelig het.

Ek het die inligting oor die navorsing in die inligtingsblaai gelees (of dit is aan my verduidelik) en ek verstaan dit. Ek het voldoende geleentheid gehad om vrae te vra en ek is bereid om aan die navorsing deel te neem. Ek verstaan dat my deelname vrywillig is en dat dit my vry

staan om in enige stadium te onttrek, sonder enige nadeel. Ek is bewus daarvan dat die bevindings van hierdie navorsing anoniem in ’n navorsingsverslag, vaktydskrifartikel en/of kongresvoordrag verwerk gaan word.

Ek stem toe dat die onderhoudsessie op band opgeneem word.

Ek het ’n getekende afskrif van die ingeligte toestemmingsooreenkoms ontvang.

Volle naam van deelnemer:

……

Handtekening van deelnemer: ……

Datum: ……

Volle naam van navorser:

…….

Handtekening van navorser: …….

Datum: …….

APPENDIX E.3

Foromo ya Tumelo ya Sehlopha sa Tjhebisiso

Lebitso la ka ke Handré Visagie, hajwale ke moithuti wa lengolo la Master's thutong ya Saekholoji Yunivesithing ya Foreistata. Ke etsa patlisiso ya ho utlwisisa ka moo maqheku a fallisetswang ditsing tsa tlhokomelo mahaeng a maqheku a fumanang sena se le ka teng. Mosupisi waka bakeng sa patlisiso yaka ya lengolo la Master's, Mof Magriet van Dijk, o disitse projeke ena ya patlisiso mme ho ka ikopanngwa le yena ho 051 401 2596 haeba o na le dipotso dife kapa dife tse ding. Ke a leboha ha o dumetse ho inahana mabapi le ho nka karolo projekeng ena ya patlisiso. Dipotsong tsena tsa sehlopha (tse bitswang sehlopha sa tjhebisiso), re tlo tshohla tlhahisoleseding e mabapi le ka moo o fumaneng ho le ka teng ho fallela mmoho lehaeng lena la maqheku. Kaha ena e le puisano ya sehlopha ho bohlokwa hore re dumellane ka melawana ya motheo e tla netefatsa hore re tshwarana borona le tlhahisoleseding e mabapi le borona ka tlhompho.

Leha re tla thabela ho mamela ditjhebo tsa hao, ke batla ho thathiseletsa hore:

- Bonkakarolo ba hao sehlopheng sena e tlameha ho ba ba boithaopo ka botlalo.
- O lokolohile ho se arabele di/potso efe kapa efe.
- Le kotjwa ho hlompha maikutlo a batho ba bang.
- O hloka ho tshwara tlhahisoleseding yohle sehlopheng sena ka sephiri mme o se bue le mang kapa mang kahare le kantle ho sehlopha sena mabapi le seo re buisaneng ka sona
- O tlameha ho se kene batho ba bang hanong.
- O lokolohile ho ka ikgula patlisisong ena ka nako efe kapa efe ntle le ditlamorao tse mpe.
- Ha ho tlhahisoleseding ya hao e ka o tsebahatsang e tla kenyeletswa tlalehong ya patlisiso.

Puisano ena ya sehlopha (sehlopha sa tjhebisiso) e tla hatiswa ka lebanta mme mosebetsi o tla nthusa hobane ke dutse wiletjhereng, empa lesedi la hao le tla bolokwa ka sephiri mme le tla fumaneha ho nna feela. Dikarabelo tsa lona di tla sebediswa ho manolla, ho tlaleha le mohlomong phatlalatso kapa ho tekwa sebokeng. Leha ho le jwalo, ha ho maemo ao tlasa oona lebitso la hao kapa dintlha dife kapa dife tse o tsebahatsang di tla kenyeletswa ditlalehong, ditlhakisetsong kapa diphatlalatsong.

TUMELO YA HO NKA KAROLO PATLISISONG

NNA, …….. ke netefatsa hore motho ya kopang tumelo yaka ho nka karolo patlisisong ena o mpoleletse mabapi le sebopeho le melemo ya ho nka karolo.

Ke badile (kapa ke hlaloseditswe) le ho utlwisisa patlisisong jwalo kaha e hlalositswe pampitshaneng ya tlhahisoleseding. Ke fumane monyetla o lekaneng wa ho botsa dipotso mme ke ikemiseditse ho kenela patlisiso ena. Ke utlwisisa hore bonkakarolo baka ke ba boithaopo mme ke lokolohile ho ka ikgula ka nako efe kapa efe ntle le kotlo. Ke lemohile hore ditshibollo tsa patlisisong ena di tla sebetswa ntle le ho senola lebitso la motho tlalehong ya patlisiso, diphatlalatsong tsa dijenale le/kapa diketsahalong tsa diboka.

Ke dumela hore puisano e hatiswe ka lebanta.

Ke fumane khopi e saennweng ya tumelo e bontshang kutlwisiso.

Lebitso la Monkakarolo ka Botlalo
……

Tshaeno ya Monkakarolo: ……

Mohla: ……

Lebitso la Mofuputsi: ……

Tshaeno ya Mofuputsi: ……

Mohla: …….

APPENDIX F: PROCESS PROTOCOL

APPENDIX F.1

Process protocol

Question/s to the Focus Groups

Welcome to our meeting this morning/afternoon and thank you very much tor your willingness to participate in my research. Our meeting will take more or less one and a half hours.

The aim of our meeting here today is to discuss how you have experienced the move from your previous place of residence to a residential care facility (or old-age-home) such as this one. There are no good or bad, right or wrong answers or views. Every view is valuable to help me understand your experience. I invite you to freely discuss the reasons for your move to this facility and how you have experienced the process up to now.

Who wants to start our discussion?

If the group has trouble to offer information from their own accord, the researcher will probe by asking more specific semi-structured question such as these below to get the conversation going.

1. What were the main reason/reasons why you (relocated) decided to move to this residential care facility?
2. Was it your decision to (relocate) move to this residential care facility or was the decision made for you, example by your children?
3. How do you feel about the decision?
4. How have you experienced the move into this residential care facility? And why?
5. What kind of emotions/feelings have you experienced after or during your move to this residential care facility?
6. What are your current emotions/feelings?
7. What do you think or what in your opinion can or should be done to make a move to such a residential care facility more appropriate or acceptable?

APPENDIX F.2

Proses-protokol

Vraag/vrae aan die fokusgroep

Welkom by ons vergadering vanoggend/vanmiddag en baie dankie vir u bereidwilligheid om aan my navorsing deel te neem. Ons vergadering sal ongeveer een en ’n half uur duur.

Die doelwit van ons vergadering vandag is om te bespreek hoe u die verskuiwing ervaar het vanaf u vorige woonplek na ’n residensiële versorgingsfasiliteit (of ouetehuis) soos hierdie een. Daar is geen goeie of slegte, regte of verkeerde antwoorde of menings nie. Elke mening is waardevol om my te help om u ervaring te verstaan. Ek nooi u uit om vrylik die redes te bespreek waarom u na hierdie fasiliteit verskuif het, asook hoe u die proses tot nou toe ervaar het.

Wie wil met die bespreking begin?

Indien die groep sukkel om uit hul eie inligting aan te bied, moet die navorser hulle aanpor deur meer spesifieke, semi-gestruktureerde vrae (soos hieronder) te vra om die gesprek aan die gang te kry.

1. Wat was die hoofrede(s) waarom u hervestig het of besluit het om na die residensiële versorgingsfasiliteit te verskuif?
2. Was dit u eie besluit om na hierdie residensiële versorgingsfasiliteit te hervestig of te trek, of was die besluit vir u geneem, byvoorbeeld, deur u kinders?
3. Hoe voel u oor die besluit?
4. Hoe het u die verskuiwing na hierdie residensiële versorgingsfasiliteit ervaar? En hoekom het u dit so ervaar?
5. Watter soort gevoelens/emosies het u ervaar na afloop of tydens u verskuiwing na hierdie residensiële versorgingsfasiliteit?
6. Hoe voel u tans daaroor/wat is u emosies tans daaroor?
7. Wat dink u, of wat kan of moet, na u mening, gedoen word om ’n verskuiwing na so ’n residensiële versorgingsfasiliteit meer geskik of aanvaarbaar te maak?

Prothokole ya tshebetso

Di/potso ho Dihlopha tsa Tjhebisiso

O amohetswe kopanong ya rona hoseng/thapameng ena mme ke o leboha haholo ka maikemisetso a hao a ho nka karolo patlisisong yaka. Kopano ya rona e tla nka nako e ka etsang hora e le nngwe le halofo.

Sepheo sa kopano ya rona mona kajeno ke ho tshohla ka moo o fumaneng ho le ka teng ho falla ho tloha sebakeng sa hao sa bodulo sa pele ho tla setsing sa bodulo sa tlhokomelo (kapa lehae la maqheku) jwalo ka lena. Ha ho dikarabo kapa maikutlo a mabe, a nepahetseng kapa a fosahetseng. Maikutlo a mang le a mang a molemo ho nthusa ho utlwisisa ka moo o ikutlwang ka teng. Ke o memela hore o tshohle ka bolokolohi mabaka a ho fallela ha hao lehaeng lena le ka moo o fumaneng ketsahalo ena e le ka teng ho fihlela jwale.

Ke mang ya batlang ho qala puisano ya rona?

Haeba sehlopha se na le bothata ba ho fana ka tlhahisoleseding ka boikgethelo ba bona, mofuputsi o tla batlisisa ka ho botsa potso e qollehileng ya sebopeho se sa fellang jwalo ka tse ka tlase mona hore puisano e tswelle.

1. Le/mabaka a sehlooho a hore ke hobaneng ke entse qeto ya ho fallela setsing sa bodulo sa tlhokomelo?
2. Na e ne e le qeto ya hao ho fallela setsing sa bodulo sa tlhokomelo (lehae la maqheku) kapa ke qeto eo o e etseditsweng, mohlala ke bana ba hao?
3. O ikutlwa jwang mabapi le qeto eo?
4. O fumane ho fallela hoo ha setsing sa bodulo sa tlhokomelo ho le jwang? Mme ke hobaneng?
5. Ke maikutlo afe ao o bileng le oona kamora ho fallela setsing see sa bodulo sa tlhokomelo?
6. What are your current emotions/feelings?
7. O nahana hore ke eng kapa maikutlong a hao ke eng se ka/kapa se tlamehang ho etswa hore bofalledi setsing se jwalo sa bodulo sa tlhokomelo bo tshwanelehe kapa bo amohelehe le ho feta?

APPENDIX G: CONFIDENTIALITY AGREEMENT FIELDWORKER

Confidentiality agreement: Fieldworker

This is to certify that I, _____, a fieldworker of the research project (Relocation to residential care facilities: The subjective experiences of elderly people) agree to the responsibilities of the administration and collection of any information from participants or additional tasks the researcher may require in my capacity as fieldworker.

I acknowledge that the research project is conducted by Handre Visagie, a registered Masters student at the Department of Psychology at the University of The Free State.

I understand that any information (written, verbal or any other form) obtained during the performance of my duties must remain confidential and in line with the University's policy on Research Ethics.

This includes all information about participants, their employees, their employers, their organisation, as well as any other information I observe or that is shared by participants.

I understand that any unauthorised release or carelessness in the handling of this confidential information is considered a breach of the duty to maintain confidentiality.

I further understand that any breach of the duty to maintain confidentiality could be grounds for immediate dismissal and /or possible liability in legal action arising from such breach.

Full Name of Fieldworker: _____

Signature of Fieldworker: _____ Date: _____

Full Name of Primary Researcher: _____

Signature of Primary Researcher: _____ Date: _____

Pp: for Handré Visagie  M van Dijk is the Research Supervisor

APPENDIX H: TURN IT IN