

EMPIRICAL STUDY

Transition from self-supported to supported living: Older people's experiences

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Abstract

To become dependent on professional support to accomplish the daily activities of life can be considered a turning point, involving a range of challenging changes in life. The purpose of the study was to describe the experiences of older home-dwelling individuals in transition from self-supported to supported living from a lifeworld perspective. Five women and five men were interviewed, and a descriptive phenomenological design was used. The findings showed that an attitude of acceptance was an essential characteristic for this group. An attitude of acceptance comprised: flexibility and tolerance, recognition and hopes, and valuation of self and situation. Finding themselves in a situation they had to submit to, they took an attitude of acceptance. An attitude of acceptance implied acknowledgement of the situation as well as positivity and desires to manage. This attitude may represent a significant potential for improvement. Awareness of this is crucial to support older individuals in a healthy way through the transition process. An attitude of acceptance, however, also implied an acceptance of discontinuity in their lives, renunciations, and denigration of own needs. But this aspect of the acceptance was trivialized by the participants and not equally obvious. Insight into this complexity is vital to avoid ignorance of older individuals' vulnerability in the transition process.

Key words: *Lifeworld, elder, phenomenological approach, support, transition*

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Changes in health status may result in the need for professional care and support. Older individuals are vulnerable to such changes, as for example chronic disease, functional limitations, and cognitive impairment, that affect their ability to take care of themselves. In Norway, more than 200,000 people are receiving help from municipal health care services. About 40,000 persons live in nursing homes, and a further 160,000 receive care either in their private residences or in assisted-living facilities. The majority of these people are older than 67 years, and their number is expected to increase (St. meld. nr. 25, 2006). To be dependent on professional support to manage the activities of daily life (ADL) is a result of changes as well as resulting in changes in the lives of those whom it concerns. The transition from self-supported to supported living may challenge or threaten the individual in several ways. People undergoing these transitions tend to be more vulnerable to risks that may affect their health and well-being (Meleis et al., 2000). This study focuses on how older

home-dwelling people experience the transition from self-supported to supported living. In this study, self-supported living is defined as living and managing ADL independent of support given by professional health care providers. Supported living is defined as still being home dwelling but dependent on professional health care providers to manage the ADL. Meleis and Trangenstein (1994) claimed that nursing is concerned with processes and experiences of human beings undergoing transitions. Nurses prepare and help the client to meet these challenges and facilitate the transition process where health and well-being is the aim. Nurses in diverse practice settings assist people in making a transition toward a sense of mastery as illness and change disrupts their lives (LeVasseur, 2002). Nurses constitute a significant resource in the health care offered to older people.

Older people are often exposed to multiple and simultaneous health-related transitions. This may create complex situations requiring extensive knowledge for the professionals who are caring for and

supporting them. Satisfactory support through the processes involves stressing the clients' own experiences and preferences in the situation, to maintain as high a degree of quality of life as possible (Kirkevold, 2000). Taking the experiences of those for whom we care into account is consistent with a lifeworld perspective (Dahlberg, Dahlberg & Nyström, 2008). The lifeworld is an essential concept in the philosophy of phenomenology. The term was developed by Husserl and describes the common everyday world into which we all are born and live. It is the world all human beings initially encounter in various ways (Giorgi, 2009). Illness and dependency change the lifeworld. How these changes are experienced is unique to each individual. A central perspective in phenomenological philosophy is that experiences are connected in time to the past, the present, and the future. The past events are considered to have an integrative function, in which the present situation and the past are transformed into a new whole. Bringing together past and future means that we draw on all our experiences, both past and anticipated. Such experiences become a moment in the present, as we consider meanings and import for understanding and acting (Dahlberg et al., 2008). This perspective is consistent with life histories or narratives of life. The narratives give access to the individuals' content of life, to their experiences, and meanings of life (Thorsen, 2005). The perspective is important in increasing our understandings of older people's perceptions and experiences of the transition process, and how the lifeworld is challenged in the process. Such understanding is vital to care for and support the individual in a healthy way through the transition process. Advancing this kind of knowledge is also in accordance with the national goal in Norway, which states that the health care services should contribute to an active and meaningful existence for the individual (St.meld. nr. 25, 2006).

Literature review

Literature search from 2000 to 2011 was done in the databases: ISI Web of Science, PsychInfo, and Medline. Search terms were aged, elderly, transition, transition to supported living, critical event, life change events, dependence, adaption, experience, life histories, and phenomenological studies. In this search, we were not able to find studies that emphasized the experiences of older home-dwelling people undergoing transition from self-supported to supported living within the focus of our study. There were, however, several general health- and social-related studies of transitions (Kralik, Visentin & van Loon, 2006). Regarding studies of older people in transition, they were primarily focusing on various

kinds of relocation; either between levels of care, from private residences to nursing homes or to assisted-living facilities (Seipke, 2008; Shippee, 2009; Tracy & DeYoung, 2004; Walker, Curry & Hogstel, 2007).

Methodology

To describe the experiences of older home-dwelling people in transition from self-supported to supported living from a lifeworld perspective, a phenomenological approach was chosen. In the phenomenological approach, a central aim is to seek the essence of human phenomena as lived and experienced and present them and their meanings as faithfully as possible (Dahlberg et al., 2008; Giorgi, 2009). The aim is thus to seek and describe qualities or aspects of the phenomenon of being in transition as this phenomenon presents itself through the descriptions given by the participants in the study. A qualitative, descriptive design inspired by Giorgian phenomenology was applied, and the study was based on in-depth interviews with the participants. The influence and challenges the phenomenological approach caused in the various phases of the research process will be discussed more thoroughly later in this section.

Participants

On the basis of the volume and variation of data, a sample size of 10 participants was considered justifiable in this study. A sample size from 5 to 10 participants is estimated as adequate when the experiences and perspectives within a special group are to be explored. However, it is the variation, amount, and quality of data, and not the sample size as so, which is stressed as most important in this respect (Dahlberg et al., 2008; Kelly, 2010). To get relevant data to answer the research question, age and composition of women and men were considered. As individuals more than 67 years are usually defined as elder in Norway (Statistics Norway, 1999), participants from 67 years and older were selected. Furthermore, we considered it adequate with a sample consisting of an equal number of females and males with experience of the phenomenon to be explored.

According to ethical considerations, the researcher is not entitled to take direct contact with potential participants. This contact, therefore, had to be established through the home care authorities. To prevent and avoid bias, the recruitment process was carefully considered. A representative for the home care authorities provided that all potential participants were consecutively asked for participation.

Health care professionals who were likely to be responsible for the recruitment were carefully informed about the study, both verbally and in written form. Discussions and reflections related to this procedure were thoroughly carried through by researchers and health professionals. Information and descriptions of the study were given to the patients who fulfilled certain inclusion criteria. These criteria were:

- being older than 67 years;
- being cognitively able and having consent competence;
- being able to articulate experiences verbally; and
- having received care to maintain ADL the previous 4–8 weeks.

ADL were defined as the basic ADLs, as bathing, dressing and undressing, eating, transferring from bed to chair and back, voluntarily control urinary and fecal discharge, using the toilet, and walking (Activities of daily living, 2002). Those who gave a preliminary consent were contacted by the researchers by telephone to arrange a first meeting. In this meeting, the written information was examined once more. They were reminded about the assurance of confidentiality, the nature of voluntary participation, and the right to withdraw at any time. If they still wanted to participate, they signed the informed consent form.

Five women and five men who met the selection criteria and were willing to participate were included. The youngest participant was 67 years old, the oldest 92. The provocation for the requirement of daily professional support, from now on called *the marker event*, affected their lives in various ways. The marker event was acute disease, acute injury, or severe development of chronic disease. Neither had received professional support daily to manage ADL. Some of them had been sporadically in touch with the home care services earlier, and some had received informal help from next of kin prior to the marker event. At the inclusion time, they all received professional support one to four times a day to manage their daily activities of life. Two of the participants received support extensively to maintain basic ADL, three of the participants received help for arrangements and some support to maintain basic ADL, one of the participants received care related to wounds, minor support to ADL, and general attention, whereas four of the participants received support related to medical assistance, minor support to ADL, and general attention. Further characteristics of the participants are shown in Table I.

Table I. Characteristics of the participants ($n = 10$).

Participant	Sex	Age	Marital status
A	Male	67	Divorced
B	Female	76	Married
C	Male	76	Divorced
D	Male	79	Married
E	Female	80	Widow
F	Male	82	Widower
G	Female	84	Widow
H	Male	87	Married
I	Female	88	Widow
J	Female	92	Widow

Data collection

The interviews took place in the homes of the participants during the spring, and summer 2010. The women were interviewed by the first author and the men by the second author. After some questions concerning their background and why they had started to receive help for their ADL, the main question focused on how they experienced the transition from self-supported to supported living. The participants were invited to give concrete and detailed descriptions of their experiences and also to talk about experiences from the past and about visions of the future. The interviews were audio recorded and lasted between 40 and 90 min.

Ethical considerations

The research was executed in accordance with the Helsinki declaration. Approval for the study was obtained from the Regional Ethical Committee for Medical Research in Norway and The Norwegian Data Inspectorate (November 16, 2009, number 2009/1767). Formal access to the field was made through the home care authorities. Leaders, health care professionals, and participants were informed verbally and in written form about the study, the participants were informed at least twice and were also told their rights, before they signed the consent form. They were also informed that they could contact their home care nurse if they needed to talk more after the interviews were finished.

Data analysis

The data analysis was inspired by Giorgi's phenomenological method (Giorgi, 2009). The two authors transcribed and started to analyze their own five interviews. Each transcribed interview was read to get a sense of the entire description. The interview then was reread from the start, and every time a shift in the meaning was experienced, a mark was made in the text. This established meaning units. The raw data of each meaning unit were

subsequently examined for content pertaining to nursing and rewritten in language relevant to nursing. In this transformation of everyday language to language relevant to the nursing profession, we made use of the so-called free imagination in the mind (Giorgi, 2009, p. 131–132). Through free imagination, appearances or instances of the phenomenon are varied so as to arrive at an invariant meaning in the description. Examples of such meaning units were “expresses what she hopes for in her situation,” and “describes the significance of professional help for the sake of next of kin.” This process was repeated for each of the transcribed interviews. The next step required that the meaning units of 10 interviews were combined. Together, we now used the process of free imagination once more to find the most invariant constituents of the experience. The invariant constituents were brought together composing a final unitary structure of the phenomenon. We checked and confirmed that the constituents were representative for all participants.

Rigor

An important methodological principle associated to the phenomenological approach is the bracketing of presuppositions throughout the process. All prior assumptions about the nature of the thing being studied have to be set aside, so that the phenomenon is not distorted and can be described as it appears (Ashworth, 1996; Giorgi, 2009). According to Giorgi (2009), bracketing means that we should not let our past knowledge be engaged while we are determining the mode and content of the present experience. Bracketing thus involves critical reflections on scientific and theoretical presuppositions and personal views, so that the lifeworld phenomena could be understood in terms of their own system of meaning (Ashworth, 1996). These methodological principles are challenging and hard to accomplish. We tried to meet the challenges in various ways through the research process. Prior to the interviews, we discussed how to conduct them, this included a discussion of the distinction between directing and leading the participants through the interview. The interviews were conducted as conversations where an everyday language was used. Also in the analyses, we tried to avoid the use of specific theoretical terms and expressions, although keeping a nurse’s attitude to develop the perspective of nursing. We also talked about our presuppositions that each had to further reflect and try to set aside through the research process. As we intended to do a descriptive analysis, we were especially aware of the distinction between descriptions and interpretations of data, keeping Giorgi’s statement in mind that the result of a

descriptive analysis is a second-order description (2009, p. 127). Furthermore, we aimed at recruiting individuals who had experience of the phenomenon under study and were able and willing to talk about it through a process with a minimum of bias.

Findings

An attitude of acceptance is an essential characteristic of individuals in transition from self-supported to supported living. An attitude of acceptance comprises flexibility and tolerance, recognition and hopes and a valuation of self and situation. An attitude of acceptance is present in the transition process and is characterized by flexibility and tolerance in the helping relation, by recognition of own condition as well as by hopes of maintaining and regaining health. An attitude of acceptance is important as it allows valuation of self and situation and, consequently in spite of the changes, an attitude of acceptance also allows a reconsidered understanding of oneself to grow. Older individuals in transition from self-supported to supported living find themselves in a situation they have to submit to. “To make the best of it,” they take an attitude of acceptance. An attitude of acceptance, however, also involves to tolerate discontinuation, renunciations, and denigration of own needs, but this aspect of acceptance is trivialized by the participants and therefore less obvious. Insight into this complexity is crucial to not only support older individuals’ potential of recovery but also to avoid ignorance of their vulnerability in the transition process.

Flexibility and tolerance describe the participants’ willingness to accept and adapt to irregularity and unpredictability in the relationship with the health care providers. There are also descriptions of reasons for being tolerant and to submit to the help received.

“It is just reasonable that they come at different times. If you need their help, you also have to understand their situation” (“John”). “Johns” statement related to the irregular visits from the home care providers, which was a common experience among the participants. The participants showed great understanding for this irregularity. Flexibility and tolerance were described as both necessary and natural in relation to the professional help received, and changes and contingent renunciations as trivial. “Ruth” and “Betty” both needed support for their morning management and described new routines they had established to compensate for the more or less unpredictable visits from the health care professionals. They expressed:

You know I still manage the breakfast myself. I sit in my morning-gown at the kitchen table and have

a good time waiting for the nurse to come. So even if they come at different times, don't pity me. ("Ruth") They come when they come; I have all the time in the world. ("Betty")

Some predictability was, however, also wanted. As "Paul" who needed extensive support stressed: "I can wait, but appreciate to be informed if the nurses are delayed." But, overall the participants explained the nurses' irregularity as a matter of necessity: "the nurses have too many tasks," and "they are always exposed to unforeseeable situations." Although the participants also expressed tolerance to the fact that they had to relate to a range of different nurses, various reactions and feelings were described similarly:

There are many different nurses that come, so it is. I cannot be equally familiar with them all. I have to accept that. The worst is to be naked in front of so many different persons, but of course they are used to naked people. ("Clara")

"Henry" on his side claimed that the number of nurses was not the matter, what mattered was how they treated him.

The professional help was experienced as a relief in several ways. The significance of how much the help was valued by their next of kin was specially stressed by the participants. "Ruth," who lived on her own without relatives nearby, explained it this way: "Personally I think three visits a day is one too much. But it means so much to my son, so all right." Also "Jacob," a widower, claimed that "home nursing is good, not at least with regard to my son." "Betty," who had experienced life as more and more dependent of her family, revealed another aspect through her description: "Now I have a good everyday life, where the nurses help me with my private needs and the family with my practical needs." "Betty" described it as a relief to get professional help to meet the private needs, and at the same time the professional help made it easier to ask the family for other kinds of favors. Like more of the other participants explained it, the professional help also made "Betty" feel less as a burden to her family.

However, the participants also stressed the value of professional help for their own sake. Knowing that someone would see to them every day made them feel safe. This feeling of safety was described as crucial; likewise the fact that they could contact professionals at any time if necessary. This was specially stressed by those who lived on their own. "Vera," who was a widow and had burdensome symptoms in association with her disease, said:

"I feel so comfortable and safe knowing that I can get the help I need at any time." "Jacob" described a feeling of "being seen," and being member of a community, when the nurse shouted: "Hello, Jacob, it's only me!" "To get this feeling is equally important as the help I receive," "Jacob" stated. The participants claimed that they were thankful to receive care and support, as they could not have managed without. But, they also described various feelings of sadness and some of them also expressed feelings of despair related to the dependency. "Peter" and "Henry," who were in very different situations and the other nearly 20 years older than the other, described their feelings this way: "It is dreadful to be dependent of help when you are used to manage yourself, you have to accept it, but it is dreadful." The importance of being positive and also of a good relationship with the professional helpers was referred to by all the participants.

Recognition and hopes refer to the participants' will to recognize own recourses and condition, while demonstrating hopes to maintain and improve functions and state of health.

Disease and health failure had changed the participants' existence more or less, and their need of support varied. A common expression among them, however, was "we have to make the best of it." "One must have the will to accept ones faith and do the best of it," "Vera" concluded as she reflected on her situation. "To make the best of it" was described as recognizing their changed situation as well as maintaining hopes for the life to come. "Jacob" expressed it this way: "I have no choice but to accept, realities have to be accepted, but I also expect that I will recover and reckon that the need of professional support will be less." Hopes and expectations varied with the participants' conditions and were described as: "reducing the need of support," "being able to manage myself," "not getting worse," "remaining" and "regaining functions," and "improving health." Those who needed extensive support had hopes of rehabilitating functions and pushing limits to be as independent as possible. "Clara," who was eager to manage to dress herself again, explained:

You see it is very important that I manage the buttons myself, so they have to give me time. Sometimes I have to tell them that. I don't want to be a passive patient though I have to be realistic about my helping needs!

The meaning of being supported in ways that allowed them to manage was described as crucial; as for "Betty," whose physical functions were considerably reduced. "Betty" had received some new

equipment in her bathroom and expressed great thankfulness to the nurse who provided for it: "When they arranged for this special aid, I suddenly could manage to rise from the toilet myself. I was so happy!" "Betty," like more of the participants, challenged herself in everyday life, trying to reestablish or maintain activities that were valuable to her. This meant defying pains, solving problems creatively, learning by blunders and finding new solutions, struggling, and pushing their limits. "If there is something I think that I can manage, it's like I'm pushing the pains away. I say to myself, it's not dangerous to move and you don't die of the pains. I am so delighted when I manage!" ("Betty") Positive evaluation, and encouragement in this respect, given by the health care providers, was described as very stimulating by several of the participants. "Peter" mentioned the importance of not being forced to activities that he felt deemed to fail and explained: "I can't understand why I have to butter bread. I don't manage, but I don't want to quarrel with them. I would rather use my resources on other activities." Overall, the value of independency was highly appreciated by the participants as well as the help they received to manage their situation. Those who needed minor support to manage their ADL described hopes of benefiting from the kind of professional support they received so they could remain or regain health. "John" told that when only the nurses had fixed his leg, the future would be much brighter: "as I will be able to poke about and do the things I used to." But, faith in the availability of more professional support if their needs developed was also a matter of importance. "Anna," who had got a serious disease, explained:

It is so positive when the nurses come. You are more engaged in getting help than of the disease you have got; and it's a relief to know that there's more help available.

Valuation of self and situation focuses on the participants' estimation of self, their strength, and vulnerability, viewing themselves and their situation in the perspectives of past, present, and future.

The participants described an everyday life more or less changed. Experiences of changes were related to alterations in health and to the kind and amount of help received, but most of all they were related to how the changes influenced their everyday life. To which extent everyday life had been altered after the marker event was experienced as decisive. Those who no longer were capable to maintain activities that had been meaningful in everyday life experienced life as dramatically changed and described various feelings of loss, fear, and sadness. "Vera,"

who no longer was able to leave the house on her own, stated: "My life has been turned upside down. I loved to meet my friends at the café in town. I dislike the changes and miss my old life!" The experience of "having lost their old life" often generated feelings of sadness. "Clara" described feelings of being powerless and "Peter" of being "worthless" as they no longer were capable to execute activities and participate in communities the way they used to. "Henry" expressed fears of losing friends and being lonely. A common statement among them, regardless of their experiences, however, was: "we have to make the best of it." Despite seriously reductions in her functions, "Betty" experienced the changes of minor significance to her everyday life:

I still have the same persons around me. My children and grandchildren come and go as they use to. I can still manage to do things I did before. Things are not really that changed.

Descriptions of the changes as less dramatic were common among participants who maintained a relatively similar everyday life as before. This also passed for "Paul," who in spite of severe reductions in his physical functions, still experienced life meaningful: "I accept that certain parts of my life are lost. This makes it of special importance to uphold the things that make my life worth living." All the participants gave detailed descriptions of their present state of health, of thoughts, questions, and worries they had in this respect. Knowledge related to diseases and health failures was mentioned as important out of various reasons. Some of the women explained that knowledge gave them a feeling of control and helped them to legitimate the need for professional help as well as to explain their changed situation to others. "Anna" declared: "It's very important that I know what kind of precautions to take, it also make it easier to explain to my grandchildren why I have to rest." Uncertainty regarding health status and the future appeared in the descriptions, and also concerns of being frailer and in even more need of help. Worries as: "What if I get worse?" "Will there be a place for me in the nursing home?" were described by some of the participants, whereas others told that they preferred to focus on the here and now, instead of dwelling on their future needs.

Reflecting on their lives in the perspective of the past, the participants referred to stories of great losses and challenges earlier in life, and of ways they had dealt with them. In these stories, the participants drew various pictures of themselves, from being strong and firm to being small and helpless.

They all, however, described previous experiences as significant, as they had taught them to cope with challenges and made them stronger. These memories reminded them of the strength they knew they had. "Ruth" explained it this way:

Life has given me many challenges and each time they have made me stronger. Compared to earlier, I am much stronger now and adversities do not hurt that much any longer.

A range of personal qualities were, in this way, described as part of the past with meaning for their present view on themselves. "Knowing that I have managed to survive so far makes me ready to meet the future," "John" declared, describing how his former life experiences influenced his present perspectives on life. Based on earlier life confrontations, all the participants had experienced the fact that "life had to go on" and submitted to the life-motto "one has to take one day at a time." The participants also explained that former suffering and loss gave them perspectives to the life here and now, and made them more capable of separating the insignificant from the significant.

Discussion

A main finding in this study was that the transition from self-supported to supported living was characterized by an attitude of acceptance. Acceptance in terms of older people receiving help has been described earlier by Roe, Whattam, Young, and Dimond (2000). In their study, three styles of acceptance were discussed and defined: positive acceptance, resigned acceptance, and passive acceptance. The attitude of acceptance referred to in our study is in accordance with the positive acceptance described by Roe et al. (2000) as an attitude shown by those who could see the benefit of the help they received. Our findings, however, revealed that a positive attitude of acceptance in the transitions process also has aspects of vulnerability. This vulnerable side appeared in the descriptions as feelings of fear and loss, of renunciations, and denigrations of own needs, but was more or less trivialized by the participants hidden behind their efforts "to do the best of it." A flexible and tolerant attitude toward the help and the professional helpers reflected hopes to benefit from the help received but also a willingness to be patient and put their own needs away. The professional support the participants received was crucial as it sustained hopes of remaining and regaining health, it made them feel safe and was also valuable to their next of kin. Thus, good relationships with the helpers were vital. The participants'

positive approach to the changes and challenges they faced was significant, although the alterations they experienced also had some costs. Costs related to a changed everyday life and feelings of loss and sadness were blurred in their assurances of recognizing own condition as well as in the hopes and endeavors they demonstrated to manage and improve their changed life. Being aware of the complexity in the attitude of acceptance is critical to avoid ignorance of older individuals' needs and feelings and to provide sufficient support and understanding in the transition process. At the same time, it is crucial to take advantage of their positive attitude and desires of managing. This attitude may represent a significant potential for improvement and of great importance for health care professionals to be attentive to.

The participants in this study experienced their everyday life to be more or less changed. Those who maintained continuity perceived their everyday life to be less changed than those who experienced seriously disruptions in their preferred activities. This was necessarily not related to the kind and amount of help they received. As for instance, "Betty" who needed more professional support than "Vera" to maintain her ADL still experienced her everyday life less altered than "Vera" did. "Betty" as opposed to "Vera" maintained most of the activities she did prior to the marker event. Maintenance of familiar activities will, according to Atchley (2000), allow the individual to maintain continuity. Physical changes that allow continuity at a reduced level have much less potential for affecting the self-concept and self-esteem than changes that disrupt the continuity of preferred activities. A sense of coherence, mastery, and self-esteem influence the health of the older individual and are important in terms of health status and perceived health (Antonovsky, 1987). To which extent meaningful activities are threatened and affected is, therefore, a critical point in the transition process and a significant focus for nursing. To master and maintain activities, the individuals' resources must be taken into account. Schumacher, Jones, and Meleis (1999) pointed at the mobilization of resources as an important aspect of nursing practice. When older individuals in transition face new situations and demands for which their resources no longer are adequate, enhancement of personal as well as of environmental resources is necessary. The significance of this was confirmed through the participants' descriptions in our study. Mobilization of resources was appreciated. This increased mastery and also hopes of remaining and regaining continuity in everyday life. But as "Peter" pointed out priority of which resources to mobilize must be carefully

considered by the health care provider together with the individual. Referring to both Antonovsky (1987) and Achtle (2000), mobilizing available resources will be of importance for the continuity, self-esteem, and the perception of health. This supports and stresses the significance of the statement of Schumacher et al. (1999) pointing out mobilization of resources as an important aspect of nursing practice. In the transition process from self-supported to supported living, where continuity and values are threatened, awareness of this is crucial.

The participants in our study gave extensive descriptions of their past, valuing their present situation in the perspectives of former experiences. Former experiences were described as important to accept another transition in life and also as a way to emphasize the personal power they had developed in the undergoing of earlier transitions. This can be associated to the assumptions that individuals create biographical narratives to create a sense of coherence and self-identity (Longino Jr. & Powell, 2008). Narratives are statements of who we are. The narratives of old individuals become more compressed meaningful and may strengthen old interpretations of "who we are" (Randall, 2001; Thorsen, 2005). This seemed to be the case for the participants in our study as their narratives allowed a reconsidered understanding and strengthened view on themselves to grow. As Schumacher et al. (1999) pointed out, transitions must be viewed within the context of the older individual's life. The context encompasses past, present, and future. Older individuals' life histories should, therefore, be of great interest to nursing. Studies indicate that older individuals wanted to have their personal biographies recognized and valued as basis for care, and that they also enjoyed talking about their lives, and that being listened to rendered identity and significance to the older individual (McKee, 2003; Nolan, Davies, & Grant, 2001). The latter was an impression we got in our study. The participants gave rich descriptions of their past and were also eager to talk about their present, as the state of health, medication, treatment, and the like. The interview seemed in this way to fill a need for talking about experiences of the past as well as of the present, which was also expressed by some of the participants. This may raise questions of how these kinds of needs are addressed in general and to which extent old individuals, often single and living alone, get the opportunity to share thoughts and experiences that are vital to them. In the transition process, where the everyday life may be experienced as dramatically changed, awareness of this is crucial. Use of life histories may be a useful tool in the care of older individuals undergoing the transition from self-

supported to supported living. This will, as Clarke et al. (2003) suggested, require working more closely with the practitioners to explore ways in which these kinds of approaches can be undertaken as part of standard practice and become part of the culture and management of care in the clinical area.

In the present study of how older individuals experienced the transition from self-supported to supported living, we found that the participants realized their situation and need of support and also accepted their situation in a positive way. However, this did not necessarily mean that they were content with their lives. The need of support created a potential for vulnerability and the values were at stake. Examining the transition experience in light of personal values may be crucial as resources of strength as well as of vulnerability could be equally obvious and considered. This is vital to maintain and find meaning in the present situation and to support older individuals in a healthy and caring way in the transition process.

Limitations

Patients in this study agreed to participate and can be characterized as resourceful in describing their experiences. The findings may have differed if patients with, for example, mental disorders or less capability to carry through a conversation had been interviewed. Using health care providers to recruit the participants may have influenced the study. Participants considered as positive may have been chosen by the health care providers. Being in a state of dependence, those who were asked may have felt obliged to participate and also reserved to advance possible critique of the professional support. These circumstances were, however, carefully considered and are described thoroughly in the section "Participants."

Conclusion

Older individuals in transition from self-supported to supported living find themselves in a situation experiencing their everyday life to be more or less changed. Common among the participants were, however, desires and ambitions to make the best of a situation they had to submit to. To benefit from the help received and attend to hopes of maintaining and regaining health, they took an attitude of acceptance. But their attitude of acceptance was complex as it also involved discontinuation and renunciation and feelings of loss and sadness. However, this side of the acceptance was trivialized by the participants and, therefore, less obvious. To be aware of this complexity is important for health care providers. To support

the individual in the transition process resources as well as feelings of loss and sadness must be taken in to account. An attitude of acceptance thus must be further examined by the health care provider as it may not necessarily mean that the old individual finds his or her life meaningful and satisfactory.

Further research on the experiences of older individuals in transition is needed. A lifeworld perspective is useful in this respect as it provides insight into the complex and intertwining processes of the existence of humans.

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