Use of Family Life Review with Older Adults and Families Adjusting to the Late Life Transition of Relocation

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Dissertation submitted to the faculty of the Virginia Polytechnic Institute and State University in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

in

Human Development

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March 24, 2017
Blacksburg, VA

Keywords: life review, older adults, assisted living, relocation
Late life relocation for the purpose of receiving care may be one of the more challenging transitions for older adults because of being uprooted from their long-time home and the perceived loss of independence. Of available supportive housing options for older adults, assisted living facilities are growing in popularity. A family life review intervention, with an older adult resident and a selected family member, was facilitated to support older adults’ transition to assisted living through mutual storytelling and acceptance. Sixteen dyads participated in one, ninety-minute family life review (FLR) session. A semi-structured follow up interview was conducted approximately one month later to explore the perspective of families on participating in FLR during a relocation transition. Emergent themes (e.g., raising emotions in families, seeing self in systems, and navigating the relocation transition) suggest that FLR facilitated positive connections and enhanced existing relationships, ameliorated older adults’ negative feelings, and promoted an acceptance of self and new family narratives. Participating in the FLR allowed dyads to reflect, during and after the session, on their resilience earlier in life and how this resilience prompted an easier recovery to some of the more challenging components of the relocation transition (e.g., relational challenges with decision making, disagreements with the ALF). Personal and relational factors including the older adults’ physical health status, mental health concerns (e.g., depression and loneliness), and family involvement and dynamics impacted families’ experience and openness during the FLR as well as their perspective of the overall intervention process. Avenues for future research and clinical implications include
randomized control trials testing the effectiveness of FLR on relationship satisfaction, coping, decision-making, and individual outcomes (e.g., depression, loneliness, life satisfaction) and using family challenges as opportunities for reconciliation and promoting resilience.
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General Audience Abstract

Older adults experience numerous late life transitions, such as retirement, grandparenthood, widowhood, and relocation. Relocation occurs when older adults move from their long-time home to another the home of a family member or to a retirement community, assisted living facility, or nursing home. Assisted living facilities, the fastest growing housing option for older adults in the United States, focus on supporting older adults’ independence and managing their care needs. When older adults move to assisted living they can feel unstable and alone, and desire the support of their family network. The goal of this project was to support the transition to assisted living through participation in a family life review. Family life review (FLR) is a structured tool, facilitated by a researcher or practitioner, aimed at storytelling and mutual reflection. Older adults who moved within the last six months to assisted living participated with a selected family member in one, ninety-minute FLR session. A follow up interview was conducted approximately one month later to learn more about how FLR can shape older adult and family adjustment to the facility, relationship, and perspective of future transitions. Families’ reflections during the follow up included believing the FLR provided new perspective, enhanced existing relationships, alleviated older adults’ negative feelings, and promoted self acceptance. Families were able to reflect on earlier life experiences and consider their own strength and resilience in light of the current transition. Yet, health concerns (e.g., physical mobility) and relationship dynamics (e.g., disagreements about relocation decision-making) linked to how open families were in the FLR and how they were adjusting during the relocation transition. Findings
from this research can be used with older adults moving to assisted living to support their desired level of family contact during the relocation transition and lifelong story to aid in their acceptance and adjustment to assisted living.
Dedication

This dissertation is dedicated to the sixteen families who participated in my project and to the countless clients I have worked with over the last six years. Each participant, each individual I have worked with, made a conscious choice to allow me to enter into their stories during the most vulnerable moments of their lives. Your stories are courageous, beautiful, and worthy, thank you for entrusting me with them; I do not take them for granted.
Acknowledgements

I would like to first acknowledge the substantial influence of my chair, advisor, and future colleague, Dr. Karen Roberto. I know I was wise to ask you to be my chair but I was truly blessed when you accepted. You give everything you have to your advisees and I am a stronger writer, researcher, and clinician because of your dedication to my work and interests. I value your willingness and ability to dive into a topic that was interesting and relevant to me. You helped shape this project into something valuable. I am honored to have worked alongside of you in this process and know, with full confidence, that I have produced my best piece of work yet. Thank you for your constant attention – for helping to challenge me to be the best version of myself in every academic realm.

To my committee members, Dr. Fred Piercy, Dr. Rosemary Blieszner, and Dr. Megan Dolbin-MacNab. Dr. Piercy, you edited my very first theoretical piece on the Life Validation Interview, your encouragement prompted me to trust and believe in something I held very close, for this I am thankful. Dr. Blieszner and Dr. Dolbin-MacNab, I have appreciated your wisdom, collegiality, and mentoring. Please know how much I have valued your questions about my personal life and professional journey. These exchanges remind me of the importance of being a genuine colleague, I am grateful for you both.

To my colleagues at ACU, Dr. Tom Milhollad, Dr. Jaime Goff, and Dr. Sara Salkil. You helped prepare me for what was to come – you believed in me. Jaime and Sara – you are amazing, thank you for celebrating me, empowering me, and paving the way as examples of successful, assertive, and empathic women in academia. Dr. Tom – my very first Life Validation Interview! Thank you for allowing me to hear your story. That interview was a turning point for me, I realized how much I loved the wisdom and stories of older adults – in this moment I
realized my passion for research was in gerontology. Thank you to ACU for fostering in me a passion for serving others, especially clinically. I love what I do and I do it with full confidence because of my training.

To my ever-so-loving friends: Raven, Emily, Reagan, Erica, Dana, Jaime, Meredith, Lisa, and Jess – thank you for inspiring me and being amazingly supportive. Our walks, phone calls, FaceTime chats, venting sessions, and celebrating the milestones has reminded me of the power of having a core group of women to inspire and comfort – I hope I have done the same for you.

To my family, more than anyone you all have seen the challenge of this process and supported me in every moment. You set an example of hard work and grace. I knew one day I could become something because each of you has overcome unique challenges. Your stories, especially the difficult and painful ones, have taught me that *my family is resilient*, that I am resilient. Mom and Dad, thank you both for leading the way – your examples have empowered me to continue reaching for all I desire. I am so proud of who I have become and I know you both couldn't be more proud – you constantly tell me and the world!

Jason Eric, thank you for your love and support. I appreciate that you have worked beyond hard so that I could pursue my dream. Thank you for your sacrifice, we certainly achieved this together. It is an honor to carry the O’Hora name, thank you for being my very best friend.
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Chapter 1: Introduction

Statement of Problem

Older individuals experience a variety of life transitions that shape their individual development, relationships, and future decision-making. Notable, and often normative, transitions among older adults in the United States include retirement, grandparenting, caregiving or care receiving, relocation, and widowhood. These transitions may require significant adjustment periods and are associated with positive (e.g., more time for oneself after retirement) as well as negative outcomes (e.g., loneliness, disengagement) (Jungers, 2010).

Whether a transition is a positive or negative experience depends on personal needs and desires of those individuals involved (e.g., older adult, family member, friends) as well as their understanding of the process they are going through (Freedman & Combs, 1996). For example, older adults may indicate that they would like to have an active role in their grandchild’s life. Therefore, their adult children may help facilitate additional opportunities for interactions between the grandparent and grandchild. Additionally, if older adults expected to grow old with a spouse and their spouse suddenly dies, they may struggle with sadness or loneliness.

Substantial life transitions can be both short- and long-term (Elder, 1998; Jungers, 2010). Often, individuals face immediate decisions, such as making funeral arrangements for a spouse, followed by a longer adjustment period (Jungers, 2010). Reflective of general systems theory (Umpleby & Dent, 1999) and a life course perspective (Elder, 1998) transitions also have an influence on subsequent transitions, suggesting that individual lives are fluid and interconnected across the lifespan with others.

Relocation as a transition in late life is the focus of the current research project. Older adults relocate for a variety of reasons. They may relocate because of increased care needs,
because their home no longer meets their needs (e.g., too big or too much time to manage), or due to the death of a spouse or loved one (Baker et al., 2014; Howie, Troutman-Jordan, & Newman, 2013). Although most older adults prefer to age in place (i.e., “remaining living in the community, with some level of independence, rather than in residential care,” Davey, Nana, de Joux, & Arcus, 2004, p. 133), it is not always a viable option. An inability to live independently often prompts the need to move in to the home of a child or long term care facility (Morse & Quinn, 1998).

Relocating to an assisted living facility (ALF) is the newest and fastest growing choice for long-term care in the United States. Currently, more than one million older adults live in over 31,000 ALF communities (Baker et al., 2014; Ball, Kemp, Hollingsworth, & Perkins, 2014). Providing a home-like environment and supporting continued independence, ALFs are a suitable and appealing alternative living arrangement for many older adults (Dobbs, 2008). ALFs provide residents a palate of services including transportation, housekeeping services, exercise and wellness programs, 24-hour security, meals, laundry services, recreational activities, medication management, assistance with bathing, dressing, toileting, and walking, physical therapy, hospice, and emergency care (Assisted Living Federation of America [ALFA], 2013). While the needs of persons in ALFs vary greatly, most ALF residents require some level of physical care (Ball et al., 2014).

In addition to physical or medical care services, ALFs also address the socioemotional needs of residents (Golant, 2008). ALFs often provide opportunities for group activities to encourage interaction among residents (Zimmerman et al., 2003) and facilitate the development of meaningful relationships. While some residents value opportunities for social outings and engagement with other residents, others prefer a balance of continued family support with the
development of new social networks (Kemp, Ball, & Perkins, 2013) or for their social interactions to be maintained primarily through their family ties (Tompkins, Ihara, Cusick, & Sook Park, 2015). A study of ALF residents’ perceptions of their social support network revealed that older adults were most interested in continuing their relationships with their family but were fearful of asking their family for more time together, visits to the facility, and general contact because they did not want to be perceived as dependent or unappreciative of contact or care (Tompkins et al., 2015).

Spending time with family members during the transition to ALF provides older adults with familiarity, comfort, and support. Yet, due to other factors such as health status, older adults struggle to maintain meaningful social relationships because they are limited (e.g., unable to drive, become easily fatigued, require routine medications or treatment) (Smith, 2012). Family members play an instrumental role in the experiences of adults, they are an existing “network of shared relationships” (Elder, 1998, p. 4) and often support adults through the process of late life relocation. Yet, prior research shows that family members of adults in ALFs are at most available to visit on a weekly basis (Gaugler, 2006), which can lead to feelings of loneliness and isolation for older adults who desire close family relationships and more frequent interactions. Feelings of loneliness among older adults have been linked to increased symptoms of depression, impaired health and immune systems, and decreased life expectancy (Winningham & Pike, 2007). With social losses nearly inevitable in late life, sustained (e.g., family) opportunities for connection are important. The current study explored the impact of a family life review intervention as a strategy to enhance and increase family involvement to support the needs of older adults during the transition to an ALF.
Family Involvement and Late Life Relocation

Transitions, such as relocation can be sudden or ongoing – lasting weeks, months, or years. Transitions also do not occur in isolation (Elder, 1998). They involve and impact all members of a family system (Elder, 1998). During a transition older adults and their family members can feel disjointed, unsure of next steps or what they are thinking or feeling.

Involvement with family can provide some continuity during times of change – they are the foundation and storage place for beliefs about aging, values, and loss. As older adults experience various transitions, they filter these experiences through prior notions, ideals, and expectations summoned from their experiences within their family culture and with individual family members (Erlanger, 1997; Freedman & Combs, 1996).

Throughout the life course, family involvement can also influence older adults’ sense of well-being (Perkins, Ball, Whittington, & Hollingsworth, 2012). Sechrist and colleagues (2012) suggested families in late life have varied experiences – some families are actively engaged and provide various sources of support for their older members throughout transitional times while other families are more disengaged as a result of personal changes or conflictual relationships.

For example, each family has its own perspective on grief. Some families may unite and celebrate life after the death of a loved one, whereas, other families may disengage and choose to cope independently.

For older adults who relocate to an ALF, maintaining emotional support and family involvement can be as important as addressing their health needs, safety, and activities of daily living (Baker et al., 2014; Gaugler, 2006; Zimmerman, Sloane, & Eckert, 2001). Although moving to an ALF can provide a new network of relationships, older adults often desire maintaining existing family ties versus creating new ties with residents (Perkins et al., 2012).
Some older adults resist developing these new relationships (Winningham & Pike, 2007). Even though older adults disagree with their families regarding appropriate and sufficient amount of quality time (Tompkins et al., 2015), they want support from familiar relationships (Perkins et al., 2012). Disagreements about how much family contact is enough for older adults can contribute to challenges in family communication. In addition, these disagreements may leave older adults lacking in their desired level of social involvement, exacerbating their feelings of loneliness or isolation (Winningham & Pike, 2007). Older adults who had continued family support and close ties with their family after relocation reported significantly higher subjective well-being (e.g., satisfaction with life) than older adults whose primary ties were with residents (Perkins et al., 2012). In addition, residents report feelings of joy and happiness from seeing their family, if even for a short period of time (Tompkins et al., 2015). Family involvement during transitional times contributes to enhanced communication between family members and greater understanding of their individual stories and perspectives as well as the bridging of distant family relationships. These benefits can help families healthily communicate about end-of-life care decisions (Dahley & Sanders, 2016).

Measuring family involvement through frequency of contact (e.g., number of visits) is not sufficient. Researchers need to consider the myriad of dynamics comprising family involvement, including method of communication among the family (e.g., in person, telephone, email), satisfaction in time spent together, and desired levels of involvement between the older adult and their family, that cannot be captured by a single measure. For example, Aschbrenner, Mueser, Bartels, and Pratt (2011) found that increased telephone or in person visits with family members was associated with more comorbid diseases among older adults’ and a greater number of psychiatric symptoms. They speculated that families with increased contact were assisting the
older adults with basic needs to prevent further physical decline or institutionalization. Thus, frequency of contact is not necessarily the key to improvement for the older adult and may signal increased levels of dependency or more serious health problems. Understanding the nuances of contact is vital and existing studies have only begun to address these intricacies. Thus, research seeking to understand family involvement needs to consider various means of involvement and how each aspect shapes older adults’ well-being and adjustment to life cycle transitions.

While family involvement appears important for the health and well-being of older adults experiencing relocation, less is known about how to enhance family involvement to buffer the potential negative side-effects (e.g., loneliness) of relocation to ALF (Tompkins et al., 2015). Exploring how family involvement changes throughout relocation and whether interventions can influence aspects of family involvement during relocation has the potential to protect older adults from the potential negative effects (e.g., loneliness) associated with relocation. In this study, a systemic intervention was facilitated with older adults transitioning to ALF and a selected family member to enhance relationships and adjustment.

**Use of Life Review to Explore Late Life Relocation**

For the last sixty years, mental health professionals have used reminiscence and life review interventions with older adults in community and institutionalized settings to consolidate gains and enhance well-being (e.g., decreasing depression, increasing life satisfaction) (Westerhof, Bohlmeijer, & Webster, 2012). In essence, reminiscence and life review processes promote an individual to recall and evaluate memories and have provided older adults with the hope and support needed to reflect on and consolidate gains in late life (Smith, Ruzgyte, & Spinks, 2011). Translating reminiscence and life review into tangible interventions occurred quickly within the research and practitioner community. Rather than reminiscence and life
review being an individual, internal process, they were adapted into structured interventions used to assist older adults (Haight & Burnside, 1993). Birren and Cochran (2003) argued that autobiography, a written form of life review,

gives more meaning to our lives by helping us more fully understanding our past and present. The process puts the contradictions, paradoxes, and ambivalence we might find in our past lives into new perspective. It helps us understand how our personal identity has been shaped by the crosscurrents in our lives. (p. 5)

Researchers and practitioners, particularly in nursing facilities, began using these interventions to promote positive outcomes among depressed adults or adults close to end-of-life (Haight & Burnside, 1993). For adults in late life, reminiscence and life review have been associated with increased positive emotion (Pasupathi & Carstensen, 2003), increased self-esteem and life satisfaction (Chiang et al., 2008), enhanced motivation, friendship, and cross-cultural communication (Haber, 2008), death preparedness (Webster & Haight, 1995), decreased depression and increased psychological well-being (Bohlmeijer et al., 2007; Bohlmeijer, Smit, & Couijpers, 2003), improved personal meaning (Westerhof, Bohlmeijer, van Beligouw, & Pot, 2010), improved adaptation and self-integration (Chiang et al., 2008), greater promotion and critical analysis of one’s life (Haight & Burnside, 1993), revision of positive and negative memories (Westerhof et al., 2012), enhanced ability to evaluate, make-meaning, and come to terms with memories (Latorre et al., 2015), and enhanced communication with family members as well as uniting distant families (Dahley & Sanders, 2016).

In 1963, in his seminal article, Robert Butler proposed that reminiscence and life review be viewed as a necessary and developmental task for older adults (Erikson, 1959). He suggested that the process of looking to the past was important for older adults to gain awareness of their
mortality (Butler, 1963). Butler defined life review as: “an inner experience or mental process of reviewing one’s life” (Butler, 1963, p. 65). The current research relied on a life review model to provide the framework for a family intervention addressing older adults’ transition to ALFs. Expanding on current definitions, life review is defined as:

explicitly or implicitly involves a process of evaluation in which participants are asked to examine how their memories, and the processes surrounding these memories, contribute to the meaning of their life, and they may then work at coming to terms with more difficult memories. (Latorre et al., 2015, p. 142, adaptations made in italics)

The emphasis provided in italics highlights the important components of life review within the current research. The verbal process of life review often places importance on the content of memories shared. Yet, the process of life review can be internal as well – making sense of memories (e.g., chronological ordering), highlighting important moments (e.g., choosing which memories are most salient), and exploring other processes within the memory (e.g., exploring how one feels during a memory). While the content individuals choose to explore in life review is important, the internal or implicit process is also a component of their experience. Further, while the content of memories (e.g., who, what, where, when) is important for recollection, the processes surrounding memories (e.g., historical events, sociopolitical influences, subconscious and conscious desires) provide valuable insights into the experiences of individuals and those with whom they have shared such memories (Freedman & Combs, 1996).

Yet, throughout his writings, Butler (1963) used the terms reminiscence and life review interchangeably, which has resulted in convoluted definitions in the literature that have continued to challenge researchers and practitioners seeking to clarify and replicate research and implement reminiscence and life review interventions. Early research suggested that life review
was a *form* of reminiscence (Haight, Michel, & Hendrix, 1998); in fact, the title of Butler’s (1963) article suggested such hierarchy. Thirty years later, Haight and Burnside (1993) published an article describing the differences between reminiscence and life review, including how researchers’ quick translation and implementation of the internal life review process to specific interventions led to confusion regarding the differences between each process or intervention. Based on their review of select literature published between 1963 and 1992, they also suggested reminiscence and life review are more equivalent than hierarchical. Under the larger umbrella of recall, (i.e., remembering any general fact or idea such as a grocery list or birthdays) reminiscence and life review are two distinct terms with overlapping but different qualities (Haight & Burnside, 1993).

Since Butler’s (1963) landmark article, several definitions of reminiscence and life review have been proposed. An early definition viewed reminiscence as a habitual act of thinking or relating with important and significant past events (McMahon & Rhudick, 1964). It has since been defined as: (a) expressing and remembering verbally or internally events in one’s life individually, with another person, or with multiple people (Woods, Portnoy, Head, & Jones, 1992), (b) an active or passive process (Cappeliez & O’Rourke, 2002), (c) focused on *positive* events and feelings (Bramwell, 1984), (d) involving memories from over ten years ago (Lappe, 1987), (e) personally experienced memories (Webster & McCall, 1999), and (f) a tool for creating shared identities with others (Gibson, 1989). Life review also has multiple definitions. Life review has been defined as (a) a systematic examination (Haber, 2008), (b) involving positive and negative memories (Westerhof et al., 2012), (c) facilitating self-integration (Chiang et al., 2008), (d) concretized stories influenced by the environment (Haight et al., 1998), and (e) recorded memories, usually in writing (Haber, 2008).
Similarities between reminiscence and life review include the flexibility of these interventions. For example reminiscence and life review can be structured or free flowing, involve happy or sad memories, and engage recall. They both are completed most often with older adults, and have the potential to be therapeutic (Haight & Burnside, 1993). However, the larger question of the differences between reminiscence and life review still exists. Differentiating criteria for reminiscence include a group process, spontaneity, and a focus on pleasurable memories, whereas life review involves an individual process, structure, and evaluation (Haight & Burnside, 1993). Even these criteria contradict previous assertions. For example, within the same article Haight and Burnside (1993) suggested that reminiscence and life review can be a happy or sad process that is structured or free flowing. Yet, these are the criteria they propose differentiate the two interventions.

The underlying concept that differentiates reminiscence and life review in the current study is the structure of life review – having a clear, outlined process. Rather than asking older adults to engage in an open-ended reflection, most life review interventions and approaches (e.g. life validation, autobiography) have predefined goals and follow a series of clearly articulated steps to achieve these goals. For example the Life Validation Interview (O’Hora, 2015; see Chapter 3) encourages participants to review macrohistorical and microhistorical influences in their life chronologically, starting with their birth year. Westerhof and colleagues (2012) described life review and life review therapy as a systematic revision of memories that requires processing, integrating, and revising the memory to consolidate gains, enhance personal well-being, and alleviate symptoms of poor mental health.

There is also a difference between structure and spontaneity. Structure describes a clear outlined process and trajectory. Haber (2008) implemented a structured life review intervention
with older adults living in for-profit housing. Students followed a semester long course, read appropriate materials, and systematically outlined major historical and life cycle events that impact older adults. Spontaneity involves flexibility within an intervention. For example, in a reminiscence group someone may add, “that reminds me” and continue on with a supplementary story that takes them off the topic being discussed. Although Haight and Burnside (1993) posited that spontaneity is associated only with reminiscence, life review can also have spontaneity within an intervention. During a life review session older adults may be prompted to discuss work and leisure and spontaneously connect their career to their first memory as a child – when dad grabbed his briefcase and headed off to work. In life review, such interjections and spontaneity are not discouraged, but integrated into the larger story and process. While structure is unique to life review, spontaneity can occur in both reminiscence and life review.

The second criteria differentiating reminiscence and life review proposed by Haight and Burnside’s (1993) is that reminiscence is based predominately on pleasurable memories whereas life review includes both pleasant and painful memories. Conversely, Alea, Vick, and Hyatt (2010) found that reminiscence includes affective processes involving both positive (e.g., happiness, love, pride) and negative content (e.g., fear, anxiety, anger, or sadness).

Finally, reminiscence is seen as a group process whereas life review is an individual intervention (Haight & Burnside, 1993). This differentiation is also not supported in the existing literature. For example, Westerhof and colleagues’ (2010) life review program involved group sessions in which groups of eight older adults engaged in life review with creative therapy and problem-solving that led to improvement in personal meaning compared to the control group of older adults that watched a video about growing older. Further, numerous research designs have highlighted the individual nature of reminiscence and explored reminiscence processes in
individuals versus groups (Cappeliez & O’Rourke, 2002; Maercker & Bachem, 2013; Selva et al., 2012; Westerhof et al., 2012).

By interchanging reminiscence and life review definitions, with no distinct terminology to describe the techniques, researchers seeking to expand or replicate research, or advance existing literature and theory are challenged. In addition, despite the obvious notion that most memories are made with other people, the reminiscence and life review literature has neglected to employ a systemic, family-level approach. Interventions have focused on individual interventions and outcomes (e.g., decreasing depression, death preparedness) (Bohlmeijer et al., 2007; Webster & Haight, 1995) or group interventions with individual outcomes (e.g., self-esteem, life satisfaction) (Chiang et al., 2008). A systemic intervention process incorporates both a dyadic intervention process and dyadic data (e.g., outcomes from multiple perspectives) thereby expanding the individual perspective and benefits of life review to a dyadic or family-level experience. In addition, using reminiscence or life review from an informed, systemic perspective that includes multiple family members can more adequately address memories and transitions that are linked across interpersonal relationships than an individual or group life review process.

Systemic life review extends the life review literature by incorporating multiple perspectives to a memory, which validates and further explores the mutual experience. Individuals remember events differently through lenses that are unique to their personal experience. Systemic life review integrates the various perspectives, creating a more robust understanding of a single event and tying the family members together through their individual contributions to a mutual memory. It also links the experiences of families to their current life transitions, exposing resilience and promoting self-efficacy. Finally, a systemic perspective can
unite families during transitionally challenging times by enhancing their social support (Boss, Doherty, LaRossa, Schumm, & Steinmetz, 2009; Elder, 1998; Umpleby & Dent, 1999).

**Purpose of Study and Research Questions**

Guided by tenets of life course theory (Elder, 1985) and general systems theory (Umpleby & Dent, 1999), the current study assessed whether participation in family life review can enhance family relationships in the lives of older adults who recently relocated to an ALF. Additionally, I examined how older adults in ALF and their families experience the family life review process to assess whether a family life review was a beneficial and enjoyable tool during a stressful transition period. Exploratory analyses examined the effectiveness of family life review to reduce loneliness in older adults residing in an ALF. Study findings provide insights into the support and involvement of families during transitional phases and their ability and interest in maintaining involvement despite life circumstances (e.g., scheduling challenges).

de Vries, Birren, and Deutchman (1990) propose that:

> [life review] be seen as a meaning-making exercise and an example for the lives of those who participate. That is, the act of telling one's story and listening to the story of others provides models to *buffer transitions*, to bridge historical times, and to communicate values, essential components of *family identification and adaptation*. As facilitators of [life review], family life educators can play an important role in helping families adjust to new demands and confront changing circumstances. (emphasis added, p. 6)

Building on this conceptualization, I hypothesized that family life review is a beneficial and transformative mechanism to enhance family involvement and ameliorate difficulties associated with late life relocation (e.g., responsibilities of the transition). Family life review has the potential to address and process the memories that occur within families over their life course.
and integrate these perspectives into the narratives of older adults and their families as they manage the transition of relocation together. The following questions guided the current research:

**Research Question 1:**

How does family life review influence the transition to assisted living?

- **Research Question 1a:** How do families participating in family life review respond to current issues (e.g., adjustment to an ALF, family involvement, loneliness) that they are encountering?

- **Research Question 1b:** What family dynamics are evident during and after participation in a family life review session?

- **Research Question 1c:** How does family life review compare to the individual processing of one’s life?

**Research Question 2:**

How does participation in a family life review intervention influence loneliness among older adults residing in assisted living?

- **Hypothesis 1:** Participating in the family life review intervention will reduce feelings of loneliness expressed by older adults.

**Research Question 3:**

How does participation in a family life review intervention change involvement patterns between older adults residing in assisted living and their adult relative?

- **Hypothesis 2:** Participating in the family life review intervention will lead to increases in the amount, frequency, and satisfaction of contact between older adults and an adult (non-spouse) relative from pre to post intervention.
Chapter 2: Literature Review and Theoretical Framework

Cited as one of the top ten life stressors, relocation in late life can bring about a variety of changes for individuals and their families (Jungers, 2010). While the desire to age at home is evident in the long-term occupancy of older homeowners (Davey et al., 2004), older adults often need to relocate due to unforeseen circumstances or deteriorating physical health (Baker et al., 2014; Howie et al., 2013). Relocation can disrupt meaningful relationships (Winningham & Pike, 2007). Older adults transitioning to a new living environment may experience feelings of loneliness as a result of leaving their existing environment and separating from their current social support network. Family members have an opportunity to be supportive throughout the adjustment process by visiting with the older adult and participating in the exploration and validation of their life (Tompkins et al., 2015). The current study explored how a brief family life review intervention (FLR) influenced older adult and family adjustment (e.g., loneliness, adjustment to assisted living, family involvement) during a relocation transition to an assisted living facility (ALF).

In this chapter, I review the literature on the demographics and contextual information surrounding why and where adults move in late life and what the transition of late life relocation involves. The history and growth of ALFs will be described and how older adults adjust to living in ALFs discussed. I will then focus on how family involvement and family life review can provide support for older adults during the relocation transition. Information about the importance of family involvement and the history of reminiscence and life review will be integrated into a theoretical model that incorporates tenets of life course perspective (Elder, 1998) and general systems theory (Umpleby & Dent, 1999). Using this framework, the needs of older adults transitioning to ALFs, the potential support and involvement of families, and the
benefits of surveying one’s life experiences in the presence of and in collaboration with family will be explored.

**Late Life Relocation**

**Why and Where Older Adults Relocate**

A variety of factors contribute to why and where adults relocate in late life. Typically, a move from their current home is precipitated by a critical incident. Among older adults who relocate, death of a spouse is the most common reason for the relocation (Kennedy, Sylvia, Bani-Issa, Khater, & Forbes-Thomas, 2005; Naditz, 2003). Other antecedents of relocation include falls, injuries, or a major illness (Chen et al., 2008; Kennedy et al., 2005; Saunders & Heliker, 2008), recognition of future care needs or a steady functional decline (Cummings & Cockerham, 2004), and an inability to maintain their home, wanting to be closer to family, or not wanting to burden family (Tracy & DeYoung, 2004). Some older adults choose to downsize their home, move into a condominium or apartment, or live with a child (Chen et al., 2008). Yet, other older adults spend the remainder of their lives in retirement communities, assisted living facilities (Ball et al., 2014), or nursing homes. Where older adults relocate is often based on which option best meets their needs.

**Needs of Older Adults**

Although aging in place in their long-time home and community is the preference and expectation for the majority of older adults (National Council on Aging, 2014), chronic health problems and supportive care needs that extend beyond their own functional ability (Naditz, 2003) or the ability and time commitment of their families (Chen et al., 2008) prompt older adults to consider different living and care arrangements. As a result of limitations imposed by their chronic health problems, approximately 70% of older adults are likely to need some form of
Before relocating to an ALF, one-half of residents had between two and three chronic conditions and over 25% reported between four and ten chronic conditions (Ball et al., 2014). Further, the majority of ALF residents needed assistance with at least one activity of daily living (ADL) (e.g., bathing, dressing) prior to their relocation (Ball et al., 2014). Common daily challenges include driving and managing household tasks. Findings from a national health survey indicated that approximately 40% of seniors anticipated needing support from their community with transportation and with home maintenance (National Council on Aging, 2014). While 59% of older adults perceived that their community provided support with transportation, only 22% believed that that community provided support with home maintenance (National Council on Aging, 2014). Hence, older adults expect to need help, yet, doubt that the community will be able to provide the level of support needed.

Further, older adults with health care needs who had prior experiences with long-term care were more concerned with future health care needs and less confident in the ability of their family to provide support and care (National Council on Aging, 2014). Although the majority of older adults (61%) relied on family for support, only 36% would consider living with a family member if they could not care for themselves (National Council on Aging, 2014). Older adults (48%) reported that they would rather move to an assisted living community if they could not remain in their home (National Council on Aging, 2014). This suggests that as older adults’ needs increase and their experience with care provision becomes more routine, they recognize the likelihood of future need for assistance and the inability of their family to provide such care.

**Assisted Living Facilities (ALF)**

With the growth of the aging population and older adults’ need for medical and
supportive care, ALFs have become a viable and attractive option for adults needing assistance with activities of daily living (Chen, 2008). Prior to the establishment of ALFs in the 1980s, “boarding homes, board and care homes, domiciliary care, adult care homes, rest homes, retirement homes, and convalescent homes” were types of intermediate retirement homes for older adults (Wilson, 2007, p. 9). Although these supportive housing alternatives did not provide the level of care or meet the regulatory standards associated with nursing homes (Wilson, 2007), they served as a transition for older adults between living independently and needing the assistance of professionals because of deteriorating health. As such, ALFs were designed to offer safe and secure housing for older adults while maintaining privacy and independence. The intent was to provide a level of long-term care that integrated older adults’ needs and desire for independence (Wilson, 2007).

Influenced by her mother’s residency in a nursing home, Keren Brown Wilson began developing a model of care that would “lower environmental and organizational stress while increasing support for individual competence” (Wilson, 2007, p. 9). In 1981, working with Senior Services in Oregon, she brought together three crucial components in her conceptualization of assisted living care: a residential environment with both individual and communal areas, routine and specialized services, and a philosophy that encouraged the autonomy of residents (Wilson, 2007). ALFs became a sustainable new platform to provide care and by the late 1980’s, the term ‘assisted living’ was recognized in conference presentations and papers as well as legal settings (Wilson, 2007). This public recognition raised awareness of and legitimized ALFs as a form of care for older adults. Oregon, the first state to develop a care philosophy for ALFs, also developed clear guidelines for their service provision. These guidelines included valuing residents’ independence, ability to make their own decisions,
privacy, unique personalities, dignity, and promoting an environment that resembles home (The Senior Care Guide – Oregon, 2015).

Although ALFs have clear standards and regulations (e.g., 24-hour support, safe environment), each state designates specific mandatory service provisions (e.g., dementia care units or laundry services) (ALFA, 2013) that fulfills their philosophy of care for older adults. Most states require individualized service plans be developed upon initial assessment to determine how to best meet the needs of the older residents (ALFA, 2013). Forty-one states offer home and community-based waivers for older adults with lower incomes, but over 80% of older adults are private-pay residents (ALFA, 2013).

Typically, older adults (70%) relocate from a private home or apartment to an ALF (National Center for Assisted Living, 2010). The average age upon admission to an ALF is 85 (Ball et al., 2014). As ALFs have continued to make improvements in their efficiency, sustainability, and service provision, they have become an acceptable housing option because of their home-like environment and support of older adults’ independence compared to other, more restrictive relocation options (Wilson, 2007).

**Phases of Late Life Relocation**

Relocation is an ongoing process that requires decisions about where to move as well as the adjustment to the new environment after the move (Jungers, 2010). Several investigators have examined the phases involved in the transition process. Chen and colleagues’ (2008) retrospective exploration of the decision-making process of 28 older adults relocating to an ALF revealed three phases: before, during, and after their transition. Each phase included factors influencing the older adults’ adjustment. Before the move, residents shared that events (e.g., decreasing ability for mobility, decreasing social interaction) and cumulative losses pushed them
toward seeking alternative housing arrangements. During the move, residents spoke of various hindering and facilitating factors (e.g., cost, family proximity) as well as whether the decision to relocate included their own thoughts and desires or was made without their input. The phase after the move juxtaposed balances (e.g., gains at the facility) and imbalances (e.g., losses at the facility) that determined whether the older adult wanted to relocate again (Chen et al., 2008). Each phase of the relocation involved processing and decision-making made by the older adult considering the primary influences in their life (e.g., family, current health status).

Participants in a study by Jungers (2010) also described older adults’ transition to an ALF as moving through several phases: a decision-making process prior to the transition and an adjustment period after the transition. Jungers (2010) used a phenomenological approach to examine 14 older adult participants’ experiences of relocation to assisted living. Through semi-structured interviews with the older adults, the researcher uncovered protective factors and barriers associated with relocation. Older adults who were involved in the decision-making process spoke of adjusting well and feeling autonomous throughout their transition whereas residents who were less involved in the decision-making process felt they lost their independence or were trapped. Specifically, loneliness impacted their overall well-being. Some older adults explained that their loneliness dissipated after adjusting to the facility whereas others reported an ongoing sense of disconnection, especially as they watched others in the facility die. Older adults’ relatedness (e.g., frequency of social connection) with other residents and staff in the facility or family and friends outside the facility also was important. Residents without strong feelings of relatedness (e.g., older adults felt disconnected) were lonelier. A small portion of older adults were engaged and experienced an ongoing sense of enjoyment despite their relocation. These individuals developed new relationships and continued to strengthen existing
relationships during the adjustment phase of their relocation (Jungers, 2010).

Similar to the conceptualizations of relocation phases and evidence provided by Chen and colleagues (2008) and Jungers (2010), 35 ALF residents who participated in a qualitative study by Saunders and Heliker (2008) described the elements included in their decision to move as their independence, reflections of the past, and sense of community (e.g., lack of isolation or loneliness). Residents spoke of the challenges involved in relocation and their resilience throughout the process. Yet, they also reflected on and longed for wholeness – a time where their bodies were capable and they did not need to rely on others. Residents’ reflections involved sharing memories with the group to help facilitate unity and create a new meaningful life trajectory. Sharing memories with the group allowed residents to highlight valuable memories from the past and integrate these memories with their current transition. In recognizing the elements of the older adults’ transition, the researchers offered care strategies and suggestions organized into four phases of the relocation transition: preadmission, admission, 1-3 months postadmission and 4-6 months postadmission, the guideline of a preadmission phase, admission phase, and postadmission phase (e.g., encompassing 1-6 months) was utilized for the current project.

These three studies provide support for the distinction yet fluidity associated with each phase of the relocation transition. For example, while various factors are associated with a specific phase of the relocation transition (e.g., who makes the decision to relocate), these same variables also influence subsequent phases (e.g., how the older adult copes). Although each of the study authors’ delineated phases differently (e.g., two, three, or four phases), they all included before and after the relocation phases. Before and after phases suggest that the relocation transition involves aspects of life before the actual move and continues after the older
residents are moved into their new location. Breaking down the two primary relocation phases into more nuanced stages (Saunders & Heliker, 2008) further highlighted the intricacies of each adult’s journey. For example, Saunders and Heliker (2008) described the post-admission adjustment in two phases (i.e., one-three months and four-six months). This delineation emphasizes the differences between immediate and ongoing adjustment and coping.

The prior research also emphasized what the residents viewed as important elements of their relocation process. For example, antecedents leading to relocation (e.g., who makes the decision to move) influenced how older adults coped with their transition (Chen et al., 2008). Older adults’ experience of loneliness also contributed to their adjustment and future well-being (Jungers, 2010). Residents’ remembering and yearning for the past also was a crucial component of their transition process (Saunders & Heliker, 2008). Collectively, these findings encourage a conceptualization and research design that values the individual voices of older adults as well as their family and highlights each unique phase of the relocation process, the prevalence of loneliness, and systemic influences on older adults’ adjustment.

**Parameters Associated With Phases of Relocation**

Recognizing influences on adjustment in each phase of relocation is valuable for intervening and assisting older adults throughout their transitions. Yet, few researchers theoretically or empirically justify how they defined each phase or the entire transition, which has led to inconsistent definitions of what encompasses the relocation transition, conflicting results, and limited generalizability of study findings. Further, without a clear definition of the relocation transition researchers may struggle to test whether specific phases of the transition are linked to particular outcomes and when to intervene in the relocation process.

Previous research has used minimum inclusion criteria, such as older adults living in the
facility for at least two months (Jungers, 2010) or exclusion criteria, such as having relocated within the past month (Saunders & Heliker, 2008). Tracy and DeYoung’s (2004) study included participants who had relocated anywhere from 6 weeks (minimum) to 14 months (maximum), with the majority of adults having lived in the facility between 1 and 5 months. Researchers provided various explanations for choosing their inclusion parameters including confirming salience and proximity of older adults’ reflections (Saunders & Heliker, 2008), ensuring older adults have spent enough time in the facility to contribute opinions and experiences (Jungers, 2010), suggesting individuals cannot reflect while living through an experience (van Manen, 1997), and submitting as long as the adult has cognitive functioning they should be able to reflect on all aspects of their transition (Mulry, 2012). Furthermore, time lived in an ALF has been correlated with successful adjustment (Dobbs, 2008) and, due to recall bias, has been cited as a limitation in study design because the longer an older adult lives in a facility the less likely they are to remember their thoughts, feelings, and experiences during the relocation transition (Mulry, 2012). In light of these study recommendations, the current study included only older adults who had moved to the ALF within the last six months to ensure they were still in the midst of adjusting to their relocation.

Researchers also cite the length of time surrounding relocation as likely influencing older adults’ adjustment at each phase of relocation. In order for preventive measures to be put in place, time lived in the facility is an important intervention parameter. The goal, as with any intervention, is to quickly identify older adults who are experiencing negative ramifications associated with a relocation. Rather than wait until the individual is in the midst of a poor transition, if researchers can identify the time period most influential on older adults’ adjustment, interventions can be targeted to a particular phase in the transition process. Without an
identification of the time associated with each phase of the transition, it is difficult to discern between, create, and implement prevention and intervention efforts. For the current study, measuring family involvement and relationship satisfaction at pre-admission, admission, and post-admission allowed for the examination of how older adults’ involvement and satisfaction changed depending on circumstances and phase of the relocation adjustment process.

Adjusting to Living in an ALF

Within each phase of the relocation process, older adults’ adjustment to an ALF is influenced by various factors including their mental health (Haight et al., 1998) and interpersonal relationships (Dobbs, 2008). Even when ALFs encourage more social involvement, relocation in late life can have a significant impact on older adults’ psychosocial well-being, experience of loneliness, and relationship dynamics within their family.

Family Involvement

In addition to addressing instrumental changes (e.g., financial concerns, medical needs), older adults transitioning to an ALF may require renegotiating family relationships and involvement in their support network. Tompkins and colleagues’ (2015) qualitative design involved asking 29 older adults about their transition to an ALF. The findings revealed that residents were concerned about maintaining their connections and involvement with family members. Residents desired continued family involvement and support but felt asking for their needs may make them look weak. Residents also remarked about their desire for increased visits, calls, and time together – highlighting the various types of family involvement that can fill older adults’ needs. Further, residents who self-reported as lonely or sad desired even more family involvement than those who were not lonely, suggesting that older adults with symptoms of loneliness experience a gap in their desire and satisfaction with family relationships.
Engagement in social networks and interpersonal relationships influences older adults’ overall well-being. Positive support systems encourage autonomy among residents and help residents to embrace opportunities within an ALF (Kennedy et al., 2005). In a study of 44 ALF residents, strong, quality relationships predicted positive well-being, emotional bonding with a family member, high life satisfaction, and few depressive symptoms (Plys & Bliwise, 2013). These findings emphasized the importance of maintaining family ties and traditions for older adults (Stadnyk, Jurczak, Johnson, Augustine, & Sampson, 2013).

**Loneliness**

Loneliness is a subjective experience based on whether individuals are satisfied with relationships as determined by their own internal standard or expectation of interpersonal relationships (Russell, Cutrona, McRae, & Gomez, 2012). Loneliness is not the same as being alone, as many individuals are objectively alone but do not experience dissatisfaction with their aloneness (Russell et al., 2012). Loneliness has been operationalized as both involving different dimensions (e.g., social and emotional) and degrees (e.g., low, medium, high).

Estimates vary regarding the prevalence of loneliness in late life. Holmen, Ericsson, Andersson, and Winbald (1992) estimated that as many as 35% of older adults experience loneliness, which is estimated to be most prevalent among persons aged 80 and older due to restricted health status that can limit social involvement (Hauge & Kirkevold, 2012). In their study of 1225 adults over 65, Dahlberg and McKee (2014) examined demographic, psychological, and social predictors of social (i.e., lack of an engaging social network) and emotional (i.e., lack of an intimate relationship) loneliness as defined by the de Jong Gierveld Loneliness Scale (de Jong Gierveld & Kamphuis, 1985). While only a small percentage of participants reported severe or very severe (e.g., chronic) loneliness (7.7%), 38.6% reported
ongoing, moderate loneliness.

While the use of established scales to measure loneliness often provides a degree of loneliness score, in-depth interviews allow for a more nuanced examination of the loneliness construct. Hauge and Kirkevold (2012) used a hermeneutic analysis of in-depth interviews with 12 adults, aged 70 to 97, to explore how loneliness is described and experienced by older adults. The analysis revealed two distinct types of loneliness: manageable and agonizing. Older adults who discussed manageable loneliness, defined as temporary and fluctuating, expressed variations in their feelings of loneliness. Their experiences of loneliness were tied to their perception of their value, power, and coping. Older adults with manageable loneliness differed starkly from those expressing agonizing loneliness. Agonizing loneliness was related to ongoing, extensive feelings (e.g., not feeling valued), and feeling powerless over their experience of loneliness. The older adults did not believe that they had control over their loneliness and often felt unappreciated in their interpersonal relationships.

Despite the variable definitions exploring loneliness, loneliness does not surface without cause. Most often, loneliness in late life is precipitated by grief, bereavement, or widowhood (Adams, Sanders, & Auth, 2004; Dahlberg & McKee, 2014), retirement (Revenson & Johnson, 1984), or relocation (Brownie & Horstmanshof, 2011). These specific experiences are more prominent in late life and often associated with changes in one’s social network. For example, loneliness has been commonly associated with decreased social support or involvement (Brownie & Horstmanshof, 2011; Dahlberg & McKee, 2014; Theeke, Goins, Moore, & Campbell, 2012) decreased quality of one’s social network (Pinquart & Sorensen, 2001), and decreased contact with family (Prieto-Flores, Forjaz, Fernandez-Mayoralas, Rojo-Perez, & Martinez-Martin, 2011).
Predictors of loneliness vary depending on the type (e.g., social or emotional) and intensity (e.g., higher or lower, managing or agonizing) of loneliness (Dahlberg & McKee, 2014). Linking predictors to types of loneliness can be beneficial for understanding correlates among individuals’ experience but can also lead to more questions about the nuances of loneliness. For example, aspects of social loneliness have been associated with social outcome variables such as amount of contact with family and friends whereas emotional loneliness has been linked to well-being and mental health (Dahlberg & McKee, 2014). In addition, it is unclear whether intervening in social loneliness can influence feelings of emotional loneliness and vice versa. Still, some predictors of loneliness bridge both the social and emotional types, such as widowhood (Dahlberg & McKee, 2014), which has a social and emotional component. Using both standard measures and semi-structured interviews to assess loneliness can uncover the nuances of loneliness, which is valuable for a deeper understanding of the experiences of adults in late life.

In addition, studies linking predictors to social or emotional loneliness do not necessarily designate which type of loneliness is most detrimental to older adults’ well-being and health status. Therefore, it is unclear whether the predictor itself is linked to outcome variables or whether the type of loneliness is more concerning. For example, Heylen’s (2010) research contradicts previous assertions of the relationships between loneliness and marital status, loneliness and sex, and loneliness and chronic illness. Specifically, she found that social relationships influence social loneliness in old age. Of the 1,414 participants aged 55 and older, nearly 25% reported severe social loneliness. Significant predictors associated with lower social loneliness were not living with a partner/spouse and being female, whereas other researchers have found that being female was associated with increased loneliness (Sundstrom, Fransson,
Malmberg, & Davey, 2009). Additionally, chronic illness and loneliness were not correlated, although chronic illness has been suggested as a predictor of increased loneliness (Alpass & Neville, 2003).

The perceived experience of loneliness has been associated with a myriad of consequences including lower quality of life (Theeke et al., 2012), less emotional support and emotional well-being (Theeke et al., 2012), poor self-reported mental health (Cornwell & Waite, 2009), increased anxiety (Dahlberg, 2014), and greater cognitive decline and impairment (Wilson et al., 2015). Theoretically, loneliness may be associated with these factors because as individuals are physically (e.g., aloneness) or psychologically (e.g., feelings of aloneness) separated from their support network their life lives are less linked with those around them, which can change individuals’ feelings and thoughts regarding their life, purpose, and value of relationships. Linked lives connect individuals with their interpersonal story (Elder, 1998), providing meaning and acceptance to who they are. Therefore, as suggested in prior research, without connection to other individuals, feelings associated with general well-being (e.g., mental health, anxiety, cognition) may be compromised. In addition, loneliness and depression often co-occur in older adults (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006). Loneliness has been cited as comparable to outcomes associated with depression (e.g., decreased social involvement) – with reciprocal effects over time (e.g., loneliness influences depression and depression influences loneliness) (Adams et al., 2004; Russell, 1996; Theeke et al., 2012).

Researchers have begun to explore ways of reducing loneliness among older adults by highlighting the importance of social networks. Emphasizing active engagement of older adults in their social networks can be accomplished through participation in life review and increased family contact and support (Brownie & Horstmanshof, 2011). In addition to the understanding
the importance of social engagement, using a phenomenological design, Smith (2012) interviewed 12 community dwelling older adults aged 74 to 98 four times to explore how they coped with loneliness. Participants shared that social involvement (e.g., volunteering, visits with friends) and sharing their needs were valuable ways in which to cope with feelings of loneliness. For example, reaching out and making connections with grandchildren supplemented older adults’ desired level of contact. Smith (2012) suggested that care providers assess for loneliness to actively help older adults – doing so would allow care providers to become more aware of the differences in coping and what each older adult needs. She also suggested using active listening and promotion of social engagement to decrease feelings of isolation and allow older adults to grieve or share their stories. Sharing one’s story targets the direct needs of older adults – for their experiences to be heard and validated in the presence of others.

Studies directly assessing the relationship between relocation on loneliness are rare. Scocco, Rapattoni, and Fantoni (2006) examined the reasons for relocation and the relationship between relocation and mental and cognitive health status. They interviewed 68 residents within one week of admission to an aged care facility. Over 25% of the residents cited loneliness as contributing to their decision to relocate. All of the study participants reported feelings of loneliness upon admission. At six-month post-relocation, several participants expressed that their loneliness had become more persistent and their quality of life had decreased. The authors speculated that the transition of relocation may have increased already persistent feelings of loneliness among the residents (Scocco et al., 2006). Further research is needed to explore loneliness associated with transitions late in life, such as relocation, and how relocation further challenges older adults experiencing symptoms of loneliness.
Easing Late Life Relocation

Whether the choice to relocate is self-initiated or facilitated by their family, older adults’ experience with relocation requires some adjustment. As researchers and practitioners have sought to understand the relocation process for older adults, the majority of research has explored the reasons for relocation, what relocation is like, and how it has affected the older adults (Kennedy et al., 2005). Little attention has been given to interventions that may help older adults navigate the emotional process of relocation. One such study, conducted by Winningham and Pike (2007), assessed a cognitive enhancement intervention among older adults at six ALFs. Participants met three times a week for psychoeducation about the brain and memory. During the intervention program, participants engaged in memory exercises, learned other participants’ names in the group, and were encouraged to engage in social interactions and develop their social support. Fifty-eight residents participated in either the cognitive enhancement intervention or the control group, where participants were not deliberately exposed to any type of brain and memory information. Of the 29 residents who participated in the three-month cognitive enhancement intervention, their pre- and immediate posttest scores of social support appraisals, perceptions of support behaviors, and loneliness stabilized. For participants receiving the intervention program there was a significant interaction demonstrating that loneliness scores did not change over time whereas participants in the control group had a significant increase in loneliness scores at posttest. Participants in the intervention program also reported stabilized social support appraisals and perceptions of support behaviors, suggesting that they continued to feel social support after the intervention. In comparison, participants in the control group had a significant decrease in social support appraisals and perceptions of support behaviors, signifying that without the intervention program, participants’ perceptions of their support network
decreased. Findings suggest that participating in intervention programs can prevent further loneliness among ALF residents by providing older adults with the resources (e.g., cognitive enhancement and social support) needed to address their psychosocial well-being.

Perkins and colleagues’ (2012) survey research provides additional information about potential supports for older adults living in an ALF. They conducted interviews with 192 residents to explore the relationship between residents’ social relationships and health in nine different ALFs. During the interviews, less than one-third of the participants (29%) included coresidents in their social networks and always (99%) included family in their social networks. Residents typically placed family in the inner ring of their social network map, suggesting that emotional closeness with family was more important than emotional closeness with coresidents, whom they placed in the middle and outer rings of their map. Having a high proportion of family in their social network was the strongest predictor of well-being among the older adults (Perkins et al., 2012). During transitional times, family may often look to those closest in their network circle to provide support and care. In fact, members in the older adults’ social network are influenced by the transition as well. Systemically, if one member of a social system experiences a life transition or nodal event, other members will be impacted as well (Umpleby & Dent, 1999).

Collectively, the findings from Winningham and Pike (2007) and Perkins and colleagues (2012) suggested the importance of encouraging social interaction, involvement, and supportive family ties among residents in ALFs. While social support and family involvement continue to be a crucial influence of older adults’ well-being after relocation, the benefits of involving family in interventions designed to enhance older adults’ psychosocial and health status have not been reported in the literature. Family involved in research projects can confirm intervention
processes by being another testament to the experiences and changes occurring through the intervention. Moreover, family members are more often routinely involved in the residents’ life and can reinforce intervention techniques or outcomes by engaging in ongoing, follow up conversations from the experiences. Yet, most interventions designed to enhance social support incorporate individual residents or groups of residents within the ALF rather than incorporating residents’ most influential, systemic support – their family (Perkins et al., 2012). Based on the existing research, programs that further develop the resources older adults need to address their psychosocial well-being (e.g., psychoeducation, social support) while emphasizing the role of family throughout the relocation process have the potential to provide older adults with their preferred support network throughout their transition to an ALF. The current study facilitated a life review intervention that provided older adults with opportunities for remembering meaningful events, a lifelong consideration of social support, and family contact during the relocation transition to ALF.

**Life Review**

Over the last fifty years, researchers, clinicians, and professionals have delved into the nuances of reminiscence, life review, life validation, autobiographical memories, consolidating gains, and restoration therapy as tools to reflect and explore one’s life. These processes and related interventions are considered developmentally appropriate for use with older adults. Although Erikson’s (1959) stages of psychosocial development suggested that older adults reflect on their lives in preparation for their death, others believed that reviewing one’s life in later years involved regretful reflection or rumination (Brinker & Dozois, 2008). Butler (1963) expanded upon Erikson’s description of late life development and argued that reminiscence and life review are normal processes in late life. Several trends within the life review literature have
relevance to the current project: a) the empirical evidence supporting the benefits of life review, b) the potential to extend individual benefits to family-level benefits, and c) how intervention duration influences outcomes. In this section I will expand on these themes and provide a rationale for exploring the impact of short-term life review among older adults and their families.

**Empirical Evidence Supporting Life Review**

The short-term and long-term maintenance of life review outcomes shows that older adults gain necessary skills and perspective through the life review process that can be useful in future transitions such as relocation. Specifically, older adults’ participation in life review processes or interventions reduces depressive symptomology (Bohlmeijer et al., 2003; Bohlmeijer et al., 2007; Haight et al., 1998; Pinquart & Sorensen, 2007), decreases anxiety symptoms (Korte, Westerhof, & Bohlmeijer, 2012), and increases life satisfaction (Chiang et al., 2008). These benefits (e.g., decreased depression and hopelessness, increased psychological well-being and life satisfaction) have also been seen longitudinally (Chiang et al., 2008; Haight et al., 1998). Yet, scholars have debated the effectiveness of life review because of methodological limitations including varying sample sizes (Alea et al., 2010; Dahley, 2013) and the inclusion of sample populations without clinically significant distress levels (Ando, 2003; Chippendale, 2011; Haight, 1998; Latorre et al., 2015). In addition, the use of unstandardized intervention protocols has limited the replication of interventions and made it difficult to determine what specific aspects of the life review process lead to beneficial outcomes.

As previously discussed, late life relocation is a period of potential crisis and vulnerability for older adults (Haight et al., 1998). To investigate the experience of relocating to a nursing home among depressed older adults, Haight and colleagues (1998) used a Solomon Four group design. Residents participated in a one-hour session for six weeks that focused on
phases of the adults’ life. Through the life review intervention process, the facilitator helped older adults reframe, accept, and empathize with their life experiences. Participants’ self-report of depressive symptoms, as measured by the Beck’s Depression Inventory, decreased significantly from baseline to the eight-week posttest. Older adults’ self-report depressive symptoms had significant decreases ($p = .05$) at the one-year follow up. Participating in the life review intervention allowed older adults “to remember how they coped with difficult times in the past, thus being reminded of their own strengths and resilience and the ability to survive” (Haight et al., 1998, p. 136).

More recently, investigators have utilized life review as a prevention strategy for depression (Chippendale, 2011; Korte et al., 2012; Latorre et al., 2015). Latorre and colleagues (2015) tested the effectiveness of a six-week life review intervention focused on specific positive events during periods of life (e.g., adolescence) in non-depressed older adults. The control group participated in a six-session media workshop focused on learning techniques in journalism. All participants completed pre- and immediate post-test measures of life satisfaction and depressive symptoms. Participation in the life review intervention significantly increased life satisfaction and decreased depressive symptoms, suggesting that an autobiographical review of the past can act as a preventative tool for well-being and depression among older adults.

Using baseline inclusion criteria of moderate depressive symptoms (i.e., Center for Epidemiological Studies-Depression (CES-D) score of 10 or greater), Korte, Bohlmeijer, Cappeliez, Smit, and Westerhof (2012) implemented a life review intervention (e.g., eight sessions, two hours each) with older adults in groups of four to six people. They found a significant decrease in depressive symptoms at post treatment and three-month and nine-month follow-ups. Findings suggests that older adults have the capability to retrospectively develop and
explore alternative stories through the life review process that work to decrease symptoms of depression. Developing alternative stories, which can occur through learning new perspectives or expanding current perspectives of the past, can be a resource for older adults coping with various life transitions and adversities before the adverse consequences reach clinical levels. Yet, studies are not clear about what processes in life review interventions facilitate change. Researchers need to continue to explore whether older adults are experiencing these results (e.g., decreases in depression) because they enjoy talking about their life story or because something occurs during the life review process that creates change.

Among the outcomes presented in the life review literature, loneliness is rarely included as a dependent variable. The presence of depressive symptomology, which is recognized in the clinical diagnosis of depression, is the most frequently measured outcome of life review among adult populations. Although loneliness is not a clinical diagnosis, its signs and symptoms are similar to indicators of depression (e.g., decreased interest in activities, decreased social contact) and has been associated with depression as well as identified as an independent risk factor for depression (Adams et al., 2004). With depression being a diagnosable disorder (e.g., DSM-V, ICD-10) in the mental health community, studies may focus on depressive symptoms to address the negative risk factors associated with a clinical diagnosis. Yet, the DSM-V is only one way of determining which variables or late life mental health concerns need attention. As such, research is needed that focuses on the feelings of older adults during transitional times. Because relocation potentially exacerbates feelings of loneliness due to changes in older adults’ social networks, this project targeted older adults’ most prevalent concerns (e.g., social relationships) by incorporating family into the life review process and exploring emotions (e.g., loneliness) and transitions (e.g., prior moves, retirement, losses) across the life course.
Extending Individual Outcomes to the Family

In 1983, Greene and colleagues suggested that throughout the life course, older adults have to renegotiate and adapt to current roles and various role changes (e.g., retirement, marital relationships, parent-child relationships). They proposed that through participation in life review, older adults could take the skills and insights gained from the intervention and relate these to relational functioning within the family (e.g., developing new social roles and engaging in emotional changes internally). The authors placed this responsibility on older adult participants and did not include family members in the life review process. Rather than expect older adults to translate skills and insights to their family relationships, perhaps incorporating an older adults’ family into the process would solidify change and understanding within the entire system (Umpleby & Dent, 1999). A systemic approach has been proposed theoretically for guided autobiography interventions (de Vries et al., 1990) and facilitated using reminiscence therapy with adults with chronic renal failure (Comana, Brown, & Thomas, 1998) but has yet to be employed with families through life review or during a relocation transition to assisted living.

There is existing evidence that participants of group life review as well as family members participating in separate but parallel interventions benefited from the life review process. For example, Chiang and colleagues’ (2008) used an eight-week life review group program with 75 elderly Taiwanese veterans to explore life satisfaction and self-esteem. Participation in the life review group program significantly increased life satisfaction and self-esteem compared to the waitlist control group and sustained these results at one-month follow up. Older adults created new definitions of success, reviewed past regrets, and promoted self-acceptance within the group due to likeminded experiences and increased empathy (Chiang et al., 2008). Sharing similarities to participants within a group has the potential to give voice to
individual experiences, empowering and uniting the group and extending benefits (e.g., increased life satisfaction and self-esteem) beyond the individual level.

Further examples of the extension of individual benefits of life review to other important people in the focal person’s life include Haight and colleagues’ (2003) three-group design used to compare life review outcomes. The first group consisted of caregivers of older adults with dementia and care receivers. Each family member, caregiver and care receiver participated in life review individually but simultaneously (e.g., the same day). The second group consisted of only the caregiver completing the life review intervention and the third caregiver and care receiver group received no-treatment. Although in the first group the older adults participating in life review had increased happiness and decreased problem behaviors, as reported by the caregiver, simultaneous participation of both caregiver and care receiver resulted in the most satisfaction with the life review process. When both care receiver and caregiver participated in life review sessions, caregivers reported increased happiness for themselves as well as less problem behavior and increased happiness among the care recipients compared to groups two and three. Caregivers in group one enjoyed the process and reported fewer problems after the conclusion of the intervention. Haight and colleagues (2003) suggest that “something occurs when people reminisce together, a spontaneous bonding, a moment of shared recall, and eagerness to participate, as like memories push themselves to the forefront of the mind” (pp. 165-166). Even though caregivers and care receivers were not together during the life review process, the benefits, through shared memories linking relationships, of dual participation extended to the family system.

Dahley and Sanders (2016) also found support for involving family members (e.g., children, siblings, spouses, and grandchildren) into the process of life review. In their
intervention, family participants primarily observed the process of life review and were encouraged not to correct the older adults’ story or interject inappropriately. Even though they were not actively engaged in the process, family members who experienced similar memories to the older adult were able to affirm these memories and display increased understanding of the older adults’ perspective. Older adults were able to explore their story in the presence of another, giving validation and legitimacy to their experiences. Content analyses, conducted separately for residents and family members, revealed four relational themes through use of the life review: creation of a living legacy, opened communication, affirmation of older adults, and bridged geographically distant relationships. Theoretically, Hughston and Cooledge (2009) suggested that families may enjoy the process of life review because of its historical nature of reviewing past successes as well as working through past mistakes. As such, through a life review process families can be encouraged to recognize developmental aspects of their family system and begin to address current challenges in light of their ability to overcome past adversities.

Increased happiness, spontaneous bonding, reviewing history, and sharing memories are all benefits of both family members participating in their own life review process and having one family member observe the life review process of another family member. I suggest that participating in a joint, dyadic life review intervention, known as family life review, can be even more beneficial than individual or simultaneous life review. Family life review can create life trajectories (Elder, 1985) that tie transitions and relationships across the life course, promoting family identity and quality time and decreasing subjective feelings of loneliness and enhancing older adult’s perspective of their family relationships and support network. Family life review, which involves at least two family members who share and integrate individual memories into family narratives, can heighten individual benefits by linking mutual experiences to each other,
extended family systems, and the larger culture. Connecting these threads promotes acceptance of an individual narrative by validating one’s story and its influence. Mutual participation gives voice to the older adults’ journey, allows them to integrate their experiences across the life course with the participation of another individual, and provides them with the social support needed decrease subjective feelings of loneliness during the transition of relocation.

**Intervention Duration Influences Life Review Outcomes**

One of the challenges of replicating life review interventions or extending life review benefits to members in the family system is knowing what factors contribute to its efficacy. A debated aspect of life review is whether the consistency and duration of life review interventions influence outcomes. The nuances of each life review intervention design are unique to the researcher and study purposes and therefore should be considered, for efficacy and validity, when planning and implementing life review interventions.

**Consistency of life review interventions.** There are a multitude of life review interventions. Interventions rely upon various theories and highlight different mechanisms (e.g., formats, duration, topics of conversation, questions) to organize the life review process and produce meaningful results. For example, Maercker and Bachem (2013) suggested that life review involves three essential ingredients: life balance, finding meaning, and an elaboration of memory. Regardless of the intervention format (e.g., session duration and frequency), the authors recommend the use of validation to prepare the older adults to review their life continually on their own. Validating participants promotes understanding of one’s own narrative (Birren & Cochran, 2003) and has the potential to encourage ongoing reflection through self-acceptance. Similarly, the Life Validation Interview (O’Hora, 2015) works to explore and connect salient memories across the life course while validating the participants’ journey and experiences to
empower their sense of self and resilience during current circumstances.

Similarly, Latorre and colleagues (2015) used significant themes across the life course (e.g., work, major turning points) to explore autobiographical retrieval practices among older adults and found that participants’ depressive symptomatology was significantly decreased compared to the control group. Although this process focused primarily on positive life events, exploring specific, salient memories that seem to influence subsequent memories across the life course can support individuals experiencing transitions and adversities (Latorre et al., 2015). Other research implementing life review has focused on particular periods in one’s life (Pot, Bohlmeijer, Onrust, Melenhorst, Veerbeek, & de Vries, 2010; Selva et al., 2012), major life course and historical events (Haber, 2008), and integrating difficult life events from the past while retrieving specific positive memories (Korte, Bohlmeijer et al., 2012). While some life review models have been empirically supported (Westerhof et al., 2010), the majority of models are designed and implemented based on theoretical propositions without a clear standardized method for practice. Currently, there is no standardized or best practice for employing life review.

Despite the varying processes associated with life review interventions, several valuable insights extend across intervention designs: the importance of focusing on nodal events in the life of the participants (Latorre et al., 2015), validation throughout the process (Maercker & Bachem, 2013), and integrating, understanding, and finding insight related to past memories (Korte et al., 2012). It is not enough for the participant to recall random memories; rather, the process should explore significant events and allow space for deeper understanding and validation throughout the process. The Life Validation Interview (O’Hora, 2015) specifically includes these techniques by organizing conversations around micohistorical moments in the participants’ lives as well as
linking the meaning of these memories to current transitional experiences through insight. In addition, the intervention design of the Life Validation Interview suggests that the facilitator place an emphasis on repeating and empathizing families’ stories to validate their individual and mutual experiences throughout the session.

**Duration.** In addition to the challenge of consistency among life review interventions, another challenging component of the life review process is how often one should engage in life review and for how long to produce significant results. Long-term intervention approaches have ranged in protocols of multi-week formats as well as session length. While the majority of intervention protocols involve one to two hour sessions for six weeks (e.g., Chiang et al., 2008; Haber, 2008; Haight et al., 1998), there is variation across life review structures. Latorre and colleagues (2015) facilitated life review once a week for six weeks loosely following Haight and Haight’s (2007) formatted structured but focusing on autobiographical memories. Selva and colleagues (2012) conducted life review therapy once per week for four weeks using Haight and Webster’s (1995) life review design, which provides fourteen question prompts. Korte and colleagues (2012) implemented eight, two-hour group life review sessions, Chippendale’s (2011) participants met once a week for eight 90-minute sessions, and Pot and colleagues (2010) conducted 12, two-hour sessions.

Empirical research has also shown positive outcomes using a short-term life review format, suggesting that session length is not always necessary for hypothesized outcomes. For example, Ando (2003) investigated young adults’ process of life review and compared short-term and long-term life review interventions. The first study used a short-term life review intervention (e.g., three-hour review with a classmate) with 77 students and measured mood state (e.g., tense and energetic arousal) before and after the intervention. The second study focused on
self-esteem and mental health, addressing somatic symptoms, anxiety, suicidality, social functioning, sleep, and dysphoria. In the second study, 149 students met on a weekly basis for four weeks. Students learned about life review, completed an individual autobiography, reviewed their life within another person, and then evaluated their life and the life review process. Participation in the four-week, long-term life review led to a significant increase in self-esteem and an improvement in general mental health. However, short-term life review also produced significant results. Students participating in the one-time, short-term life review intervention experienced a significant increase in energetic arousal, which involves an improvement in their hedonic, mood state (e.g., active, vigorous, energetic).

Results of Ando’s (2003) study provided support for Korte and colleagues’ (2012) argument that frequency of recall or the duration of life review is less important than the ways in which people review their past. Providing structure for the life review process, focusing on strengths and successes throughout the life course, and giving new meaning to past experiences are the crucial components of life review, regardless of the duration of the intervention. In fact, researchers suggesting that an entire life review can be completed in six, eight, or twelve weeks using a specific format or question prompts seems presumptuous due to the complexity of individuals’ lives and the extent of memories they have experienced and would need to process. The life of an individual, and their family, are more complex than a single or series of life review sessions that would only have time to address the basic recall of the memory without time to process or integrate these memories. The purpose of life review then, should not be to facilitate a complete review of one’s life but open the door for further individual and familial processing and reconciliation over time by beginning to link experiences and relationships across time, starting with prior life experiences and the current relocation transition.
The efficacy of short-term life review in facilitating change is an important and viable next step for enhancing prevention and intervention efforts. If short-term and long-term life reviews can both produce significant, sustained outcomes, than practitioners working with older adults struggling with mental health issues (e.g., loneliness, depression) can expedite the process of recovery. Short-term life review also has the potential to be cost and time effective for ALFs, providing a quick, meaningful intervention for older adults without draining facility resources. For older adults transitioning to ALFs, short-term life review can facilitate insight about past transitions that may help older adults adjust more easily to their new living arrangement through focusing on nodal events, validating their journey, and exploring and reconciling the past while in collaboration with their family support network.

**Theoretical Contributions and Frameworks**

Facilitating a time of mutual family reflection through the use of life review has the potential to provide older adults with the social interactions they desire, enhancing their overall relationship during the older adults’ stressful transition to ALF. The theoretical framework guiding the current study relied on tenets of a life course perspective (e.g., transitions across the life course) and general systems theory (e.g., contextual influences). In this section, I highlight relevant concepts from these perspectives to show the complexity of how transitions are influenced by past, present, and future individual and family dynamics as well as how life review can serve as a valuable intervention during late life relocation.

**Life Course Perspective**

A life course perspective purports that individuals are influenced by and experience a variety of transitional events throughout their life. Transitions influence individual development and are influenced by social and environmental contexts – creating event sequences or life
trajectories (Elder, 1985). One such event is late life relocation. Like other transitions, late life relocation cannot be viewed in isolation. Transitions need to be understood in the context of the larger life trajectory providing deeper understanding of the meaning surrounding the transition. For example, the events surrounding the transition of relocation in late life are situated in the larger trajectory of the individual’s life (e.g., death of a spouse, decreasing health status). Several concepts from a life course perspectives are key to understanding the impact of late life relocation on older adults and their families as well as how family life review can influence the relocation process.

First, a life course perspective highlights individuals’ experience of “continuity and change” (Connidis, 2012, p. 39). As people age, their life experiences mold and shift over time, relationships are severed, and new relationships begin. Using a life course perspective capitalizes on these changes and how they influence a person’s life journey. When considering personal history and biography, the context and meaning of late life relocation can be supplemented through further investigation into individual and family dynamics. Older adults have a rich history of experiences and can benefit from a life review perspective that highlights these unique nature and nurture components throughout their lives.

The second tenet of life course perspective is a focus on aging as a “biological, psychological, and social process from birth to death” (Connidis, 2012, p. 40). The life course approach utilizes these three realms to consider how individuals and families age over time. This is a valuable aspect of the current research because of the awareness of multiple perspectives of experience throughout the mutual life review process. The biological perspective considers the inherent qualities of a person and their family experience, such as, genetics and personality, which are demonstrated in how people review their life and share pieces of who they are. The
psychological perspective suggests a realm of emotional reactivity to an experience. This can involve how one processes emotions, considers resources, or copes with difficult situations. For families experiencing relocation, the emotions, resources, and coping prior in life are likely to influence current feelings. Finally, social processes focus on the interpersonal dynamics of an individual and family over time. These social processes can involve relationships beginning and ending, resources of social support, or how one manages interpersonal dynamics throughout changing circumstances (e.g., relocation). Using the life course perspective to explore families’ perspective of family life review during a relocation transition gives the research a full breadth of information when considering older adults and their families’ adjustment.

The third tenet of the life course perspective is the “historical context of social, political, and economic conditions” (Connidis, 2012, p. 40). These conditions provide context for the macrohistorical events that impact micro-level transitions. Considering how these conditions have impacted older adults’ and their families over time provides support for the use of and experience with a family life review intervention that can aid their relocation transition.

However, it is not enough to consider just the individual and their environment. Individual lives are linked (Elder, 1998) and shared experiences intricately tied to their family environment, historical time, place, and the larger environment (e.g., social networks, legal systems, historical influences). External influences on the family system shape individual experiences either directly or indirectly. Numerous direct and indirect influences inform how the relocation process impacts older adults. As individual’s experience their life course, their journey is woven together within their immediate environment (e.g., family) and macrohistorical influences (e.g., WWII). For example, older adults’ experience of relocation to an ALF is often precipitated by a critical incident (e.g., death of a spouse) and decision-making process of
multiple parties (e.g., the older adult, children). The strands weave together to demonstrate the reciprocal influences of linked lives – individual transitions and trajectories coupled with family transitions and trajectories, situated in a social and historical culture. The Life Validation Interview (O’Hora, 2015), described below, highlights historical influences culturally and personally. By reviewing significant events in history, families have the potential to connect their transitions and relationships to various points in time. Linking their resilience and mutual narrative across their lives (e.g., linked lives) to their self-reported relationship satisfaction or amount of time spent together.

The fourth tenet of the life course perspective focuses on trajectories, transitions, and timing (Connidis, 2012). Trajectories are the statuses one has kept over time. Marriage and parenthood are two examples of statuses that can be seen over time. An understanding of the concept of trajectories helps frame the current research agenda and questions by considering how the status configuration (Connidis, 2012) of each adult impacts their family relationships during a relocation transition. Similarly, transitions are those movements or changes that occur within ones experience. How these transitions occur and when they occur, timing, gives insight to how older adults conceptualize their experiences.

Prior life experiences also may influence older adults’ adjustment to an ALF. Having older adults reflect upon pivotal points throughout their life provides an opportunity for them and others to learn about experiences that have shaped who they are and how they respond to change. Historically, life course has roots in demography and life histories (Freedman, Thornton, Camburn, Alwin, & Young-DeMarco, 1988; Rindfuss, 1991) highlighting the importance of biological trends and historical events on an individual and macrohistorical level. For example, if older adults have limited experience with relocations throughout their life course, their
adjustment to an ALF may look different than for older adults who moved numerous times. Taking a life course perspective brings attention to the dynamic influences, big and small, prior to relocation. Each new experience, each foundational moment, each new memory shapes the adult and their future – involving an influential and reciprocal process between the individual and their environment (Alwin, 2012).

Life transitions are a vulnerable and risky time for all individuals (Fields, Koenig, & Dabelko-Schoeny, 2012). Yet, transitions are also definitive moments that mark and characterize the strength of an individual (Fields et al., 2012). Late life relocation encompasses numerous transitions: critical decisions before the move (e.g., who is involved in the decision to relocate, why relocation occurs, where to relocate), the physical move to the ALF, and the adjustment and development of the older adult after the move. This involves considering how the relocation decision was made and who was involved as well as the older adults’ overall well-being and ongoing family involvement after the relocation. These details of prior decision-making, family involvement, and older adult well-being may seem minor compared to the entire life trajectory of the individual (e.g., significant life events) but they shape how older adults cope with and understand the transitions they are experiencing. Understanding prior transitions important in the lives of older adults through family life review allows them to connect these memories with their current experience of relocation and use strategies and insights learned to respond to and cope with future experiences.

Often, when an individual describes a memory it includes crucial descriptive information about what happened and who was involved. For many individuals, sharing memories and transitions highlights the importance of the story and whom the memory was shared with. Family is a primary group incorporated in memories and transitions. Life course theorists suggest that
the family is a microsocial group (e.g., smaller unit with culture) engaging one another and individually developing while existing within the context of a macrosocial environment (e.g., cultural and historical context) (Bengston & Allen, 2009). This meta-perspective suggests that families operate as a unique unit inside of a larger unit that cannot be fully teased apart. The individual is always viewed in light of their microsystem and the microsystem of the family is always viewed in light of the macrosystem. To better understand late life relocation and intervene when older adults experience difficulties in making this transition requires consideration of each aspect of the relocation experience and how this transition is situated in the older adult’s individual and familial life trajectory. Given the tenets of the life course perspective, utilizing this theory to inform the current research allowed me to consider many aspects of the intrapersonal and interpersonal experience and therefore addresses concerns about late-life relocation issues and relationship changes.

**General System Theory**

General system theory suggests that individuals and families are a part of a larger, connected system that influences individual and family development. For example, an older adult experiencing loneliness may not have an internal problem but be experiencing loneliness as a result of his/her social and emotional relationships. Exploring concepts of general system theory in the current project helped conceptualize how processes within the family (e.g., family involvement, family contact, family dynamics) influence an individual and the family system (Umpleby & Dent, 1999).

First, is the concept of feedback loops. Gunner (2006) claims, “a feedback loop is a closed loop of causal links between elements of a system…. [a] feedback loop describes a system’s pattern of organisation, as distinct from it’s physical structure” (p. 143). Exploring prior
feedback loops over the lifecourse helps a family recognize their patterns and provide
advantageous information in promoting change (Hanna, 2007). All families, whether implicitly
or explicitly experience feedback. As individuals experience change, the entire family system
will have to respond to the change (Umpleby & Dent, 1999). In fact, individuals most effectively
change when his or her family changes (Olson, DeFrain, & Skogrand, 2008). When older adults
transition to an ALF close family members experience shifts in their roles and responsibilities.
Through family life review, new insights and explorations have the potential to influence and
shift family dynamics such as involvement and contact with the older adult. Family life review
then becomes the mechanism to provide unique insights into the intrapersonal and interpersonal
history and future interactions of the family. The older adult entering the transition of relocation
triggers various direct or indirect responses from the family (e.g., financial and emotional
support, shifting roles). As a result, the use of family life review with older adults relocating to
an ALF has the potential to extend the benefits of individual life review (e.g., identity formation,
continuity of self, enhanced meaning in life, a sense of mastery, and acceptance and
reconciliation) to benefit the family system (Bohlmeijer et al., 2007).

Another important concept in general system theory is constructivism and deconstruction.
Hanna (2007) states, “[c]onstructivists believe that any given situation can be interpreted in
many different ways” (p. 29). As such, participants’ lives are “shaped by the meaning they
ascibe to their experience” (Johnson, 2004, p. 223). Thus, constructivism and deconstruction
imply that knowledge is not concrete; objective claims about our reality are not valid because the
environment we live in and the humanity of each person allow us to view the world from
separate lenses, thus formulating our personal worldviews (Cilliers, 2005). These two concepts
are applied theoretically to the alliance and trust I developed with participants to hear and
validate their stories. In listening, I embraced families’ personal reality and worldview in an attempt to empathically understand how individuals and families experience their own lives, prompting an understanding of how cultural, social, family, political, and other domains impact participants’ realm of experience. For example, exploring ways of adapting, coping, and experiencing various marohistorical events across the life course provides older adults with an opportunity to recognize their strength and resilience to respond to their current relocation transition. Including a family member in the life review process to acknowledge older adults’ experiences and provide an opportunity for contact can give older adults the support and validation needed to express their life history and combat feelings of loneliness. For the purposes of the current research, potential growth in the older adults’ well-being (e.g., decreased loneliness) as a result of family life review can influence the entire family system – family involvement, contact, and satisfaction. By including a family member in what is typically an individual process, the use of family life review can encourage family members to continue ongoing conversations and contact about their intersecting lives and development. Increased contact can provide the older adult with the attention needed to meet their desired family involvement and decrease symptoms of loneliness. Further, integrating past transitions with family-level processes provides the family with the opportunity to reflect and process shared memories – capturing and remembering their lives together. Such memories and processing can ameliorate the loneliness older adults experience during a transition to an ALF.
Chapter 3: Methods

The purpose of this study was to facilitate a family life review intervention with older adults and their selected family member or friend, following the older adults’ recent transition (e.g., within the last six months) to an assisted living facility (ALF). The design was guided by the existing literature, tenets of life course perspective (Elder, 1985) and general systems theory (Umpleby & Dent, 1999), and the research questions. This chapter focuses on the site selection and participant recruitment process as well as the measures, interview protocol, family life review intervention, and analyses completed for the study. Descriptive findings relevant to the study sample and assessments used are provided. The university’s institutional review board approved this study.

Site Selection

At the beginning of the site selection process, I contacted thirty-two assisted living facilities in Harford and Baltimore County, Maryland as well as Arlington County, Virginia. I identified facilities based upon their size (e.g., 15+ beds) as well as their geographical proximity. An initial phone call was made to the administrators of the ALFs to provide them with information about a new intervention that had the potential to help older adults and their families deal with the transition of relocation to an ALF and the potential benefits of participation for the residents and the facility. A supplemental phone call or email to site administrators was made, when needed, approximately one week after the initial phone call to assess interest in the study and respond to any questions about the study. Over the course of one year, approximately fifteen facilities expressed interest in learning more about the project. Follow up appointments were made with the administrators to visit each site to determine whether they would like to participate in the project. Although ten facilities agreed to join the study, only six of the ten
facilities were able to provide eligible participants within the six-month move-in inclusion criteria.

**Participant Criteria and Recruitment**

To be eligible for this project, the older adult participant must have moved into the ALF within six months of when I contacted them. The post-admission phase of the relocation process is routinely viewed as the 3-6 months after the physical move to an ALF (Chen et al., 2008; Jungers, 2010; Saunders & Heliker, 2008), when adults have had time to process their experiences. The first two months after the physical relocation to the ALF are considered admission – the phase where older adults are moving belongings, establishing routine, and becoming adjusted. Including older adults who relocated to the facility within the past six months ensured that participants had time to experience the adjustment process and were able to still recall and describe their experiences. In addition, per inclusion criteria, participants: (a) were aged 65 or older, (b) were able to speak and read English, (c) were cognitively able to consent as determined by a score of ‘not-demented’ on the Mini-Cog (Borson, Scanlan, Brush, Vitaliano, & Dokmak, 2000), (d) had the physical stamina (self-report) to complete assessment questionnaires, and (e) agreed to participate in the life review session and follow-up interview with a non-spouse family member or close friend who was 21 years of age or older (Appendix A).

I worked with each individual facility to recruit older adult participants using a process that was least burdensome to their existing structure. After receiving approval from the ALF administrator, older adult residents were recruited through the help of the activities coordinator (or designated staff person) at each facility. The staff member verbally described the study to eligible participants and then provided me the names of residents who agreed to be contacted. I
contacted older adults by telephone and answered any questions they had about the project. Older adults were assured that their participation was voluntary and would not affect any of the services they are receiving at their new residence. Residents who were interested in participating, and who met the inclusion criteria, were asked to identify a relative or close friend, other than a spouse, who they believed also would be willing to participate in the project. In the case where older adults are married or partnered, they often make the relocation transition together and therefore have a built in support network. But, because the majority of older adults who relocate to ALF are not married, understanding the relationships between older adults and non-spouse family members or friends provided unique insights into how older adults’ ongoing support networks influence their relocation experience. I contacted the older adult’s designated family member by telephone, during which time I described the study, answered any questions, and informed the family member that his/her relative had consented to participate in the project. After receiving verbal consent from the older adult’s selected family member over the telephone, a time was scheduled for the family life review session. Each participant received a five-dollar gift card for a retail store at the beginning of the FLR and at the follow up interview.

**Sample**

Sixteen dyads were recruited through the ALF. Older adults ranged from 75 to 103 years of age ($M = 85.75, SD = 7.34$). The majority of older adults (n=13) were female and identified as Caucasian or white (n=14). Eleven older adults were widowed; three older adults were divorced and one older adult had never married. All of the older adults completed high school and six reported graduating college or having went to graduate or professional school. The older adults spent between 13 to 59 years in their previous home ($M = 31.10, SD = 16.21$).

The selected family member or friend ranged in age from 44 to 73 years ($M = 56.13, SD$
Family members were mostly female (n=11) and identified as Caucasian or white (n=14). Thirteen participants were the child of the older adult, one participant was the niece of the older adult, and two participants identified as a close family friend (referred to collectively as family throughout this document). The majority of selected family members were married/partnered (n=12) and had graduate degree (n=8). Participants traveled between 2 and 360 miles (M = 71.77, SD = 116.22) and between 5 and 360 minutes (M = 76.06, SD = 111.71) to the ALF. Two participants used FaceTime to complete the follow up interview because their distance to the facility was too far.

**Procedures**

The older adult and selected family member were asked to meet with me prior to the life review session at the ALF (e.g., common area or residents room). In one circumstance, the family member participant did not live within a reasonable driving distance to the facility and completed the measures and family life review session via a video interview. Each older adult reviewed and signed the study consent form and completed the Mini-Cog to determine cognitive vital signs (i.e., classified as demented or not demented). All older adults met inclusion criteria for the Mini-Cog (Borson et al., 2000). Explanations of consent, signing forms, and completion of the Mini-Cog took approximately ten minutes.

Once eligibility was determined, the older adults completed the study pre-test measures (i.e., health status questionnaires, CES-D, UCLA Loneliness Scale, Family Involvement Questionnaire, relocation transition questions, and demographic items) (Lewinsohn, Seeley, Roberts, & Allen, 1997; Russell, 1996) (Appendix B). Completion of pre-test measures took between twenty and forty minutes. The family member also completed pre-session measures, which included the family involvement questionnaire, the relocation transition questions, and
selected demographic items (e.g., age, marital status, work status) (Appendix B). Family members’ pre-session measures took approximately 15 minutes.

Following completion of the pre-session measures, the older adult and the family member participated in a family life review session titled, *The Life Validation Interview* (described below), which lasted between 54 and 90 minutes ($M = 69.01$, $SD = 9.82$). The life review session was audio and video recorded. Each family member received a five-dollar retail gift card as compensation at the beginning of the life review session.

After completion of the session, I scheduled a second family meeting, approximately one month after the life review session. At the scheduled follow-up appointment, families first completed another round of assessment measures and then participated in a semi-structured interview (e.g., described below) to discuss their perspective of the family life review process. After multiple attempts, two families were unable complete posttest assessments and the follow up interview. The 14 follow up interview was audio-recorded and lasted between 20 and 75 minutes ($M = 47.00$, $SD = 17.45$). Each family member received a second five-dollar gift card at the beginning of the follow up interview.

**The Life Review Session Overview**

The Life Validation Interview (Appendix C) is a multi-modality life review intervention. I developed the interview based on the work of Hargrave and Anderson (1997). The interview is typically used therapeutically with families to mutually integrate, share, reflect, and process memories. The length of the interview was informed by previous studies, which reported sessions of between sixty and ninety minutes (Chiang et al., 2008; Haber, 2008; Haight et al., 1998; Haight et al., 2003). The Life Validation Interview was originally designed for fifty-minute sessions for between one and three sessions (O’Hora, 2015). In order to have sufficient
time for the family to process their memories and experiences and to accommodate their variable geographic proximity and challenging schedules and responsibilities associated with the relocation transition, the typical session length was extended for the current study but decreased the session frequency (e.g., one, seventy minute session). Doing so allowed for adequate time for the family to reflect and process their stories without becoming burdensome. Although the interview length was to be 90-minutes, the actual length of time depended on the level of processing in which the family engaged. In most families expressed fatigue at approximately sixty to seventy minutes.

The session started with the year each member was born. I served as both the researcher and the facilitator. I asked questions regarding thoughts, feelings, and emotions during and throughout nodal events in history. During the interview, participants shared stories and circumstances surrounding various macrohistorical events. The researcher then used these events to capitalize on the interpersonal memories shared and related these memories and experiences to current transitions in the lives of the family. The interview format encourages the researcher/facilitator to probe when appropriate but also give participants space to explore and choose which memories they would like to focus on. Throughout the interview, I validated and expanded on the memories and processes that were salient to the family, doing so allowed the family to capitalize on their past resilience and consider how past coping and adjustment can aid in current or future transitions (for a full description of the interview see O’Hora, 2015). The selected family member or friend was an active participant in the life review session and contributed their own thoughts, feelings, and opinions on various events as they occurred intrapersonally and interpersonally throughout history. While completion of a life review session is not intended to be a complete family history, facilitation of a family life review prompted an
ongoing dialogue of lived transitions, coping, adjustment, and family involvement.

**Semi-structured Follow Up Interview**

The follow up interview was completed dyadically with both the older adult and their family member present. Both members were encouraged to participate and share their perspective of the family life review experience. Families were asked seven questions (Appendix D). The purpose of the questions was to explore families’ experience of the family life review session (e.g., likes, dislike, valuable memories shared, overall impression) as well as how they believed the session would influence their future (e.g., adjustment to ALF, relationship with one another, feelings of loneliness). I also had a specific interest in something families experienced together since the life review session and wanted to learn more about the similarities and differences between individual and family life review to add to the existing literature regarding the impact of life review.

**Measures**

**Inclusion Measures**

**Demographic information.** A series of single items questions was used to determine participant inclusion criteria. Specific items and measures included: age, ability to speak English, cognitive ability (e.g., a score of not demented on the Mini-Cog), self-report physical stamina, and agreement to participate in follow up interview (Appendix B).

**Mini-Cog.** The Mini-Cog was used to ensure older adult participants were cognitively able to participate in the project. The Mini-Cog involves uncued three-word recall and the clock drawing task (Borson et al., 2000). Participants were asked to repeat three unrelated words, draw a clock, and then recall the previous three words. The Mini-Cog takes approximately three minutes to administer. It is scored using a decision tree, which classifies an individual as
demented or not demented (Borson, et al., 2000). If the individual does not recall any of the three repeated words they are considered demented. If the individual remembers all three words they are considered not demented. If the individual remembers between one and two words, their clock-drawing task is assessed. A normal score on the clock-drawing task is observed when all numbers are in the correct order and placement and the hands of the clock point to the appropriate time. If the clock-drawing task is normal the individual is considered not demented. If the clock-drawing task is abnormal, the individual is considered demented (Borson et al., 2000). The Mini-Cog has been demonstrated to have a high sensitivity (99%), diagnostic value (96%), and specificity (93%) compared to the cognitive abilities screening instrument (CASI) and mini mental status exam (MMSE) (Borson et al., 2000). The measure is considered valid in comparison to the CASI and MMSE (Borson et al., 2000). All older adults completed the Mini-Cog and were categorized as not-demented.

**Study Measures**

**Demographic characteristics.** The older adults provided information about their age, race, ethnicity, sex, marital status, socioeconomic status, educational level, work status, number of children, number of years living in previous home and in the geographic area, and the distance between their prior home and the ALF (in miles) (Appendix B). Family members provided information about their employment, relation to resident, and traveling distance to the facility (Appendix B).

Older adults also completed a checklist of their current functional abilities (e.g., Katz Index of Independence in Activities of Daily Living [ADL] and Lawton – Brody Instrumental Activities of Daily Living [IADL]) (Katz, 1983; Lawton & Brody, 1969). The Katz Index of Independence in Activities of Daily Living is scored as zero or one on each item, with a total
possible score of six, indicating a greater level of independence. Participants are assessed for
independence (e.g., no personal supervision, direction, or assistance) or dependence (e.g., with
supervision, direction, assistance, or total care) on six items (i.e., bathing, dressing, toileting,
transferring, continence, and feeding). For example, marking a level of independence on
continence means the older adult would answer yes, with a score of one, to the following
question: do you exercise complete control over urination and defecation? Whereas, marking
dependence on continence indicates the older adult answered yes, with a score of zero, to the
question: are you partially or totally incontinent of your bowel or bladder? (Appendix B). The
Lawton – Brody Instrumental Activities of Daily Living is scored by rating each of the eight
items (e.g., laundry, shopping, food preparation) as zero and one. Total scores range from zero to
eight with lower scores indicating a higher level of dependence. Sample questions include: I am
responsible for taking medication in correct dosages at correct time (scored one), I take
responsibility if medication is prepared in advance in separate dosage (scored zero), or I am not
capable of dispensing own medication (scored zero). Older adults reported from one to six ADLs
\((M = 3.81, SD = 1.68)\) and reported zero to six IADLs \((M = 2.88, SD = 1.78)\).

Older adults self-rated their overall health status as well as reported on the presence of
common chronic health problems (e.g., diabetes, stroke, cancer, osteoporosis.) at the time of
admission to the ALF. The majority rated their health as fair \((n=7)\). The remainder of older adults
rated their health status as: good \((n=4)\), excellent \((n=2)\), or poor \((n=1)\). Thirteen older adults
reported having between two and eight chronic health conditions \((M = 3.06, SD = 2.50)\),
including memory problems \((n=6)\), high blood pressure \((n=5)\), cancer \((n=4)\), and osteoporosis
\((n=4)\). The other three older adults reported only one chronic health condition.

**Center for Epidemiologic Studies Depression Scale (CES-D).** The 20-item Center for
Epidemiological Studies Depression Scale (CES-D) (Appendix B) was used to assess depressive symptomatology. Older adults responded to statements about their thoughts and feelings in the past week on a 4-point Likert scale ranging from 0 (rarely) to 3 (mostly). Sample statements include: “I felt everything I did was an effort” and “I thought my life had been a failure.” Four items were reversed scored. Participants’ responses were summed for a total score. A score above 16 indicated risk for clinical depression (Lewinsohn, Seeley, Roberts, & Allen, 1997). The scale has good sensitivity and specificity and high internal consistency (Lewinsohn et al., 1997). The CES-D also shows good reliability through inter-item correlations with patient populations reporting higher scores than the general population and moderate test-retest correlations (between .45 and .70; Radloff, 1977). It has strong validity with other depression measures, such as the Hamilton Clinician’s Rating Scale (Radloff, 1977). Older adults’ pre-test depression scores ranged from 0 to 45 ($M = 13.93$, $SD = 14.11$). Post-test scores ranged from 1 to 41 ($M = 14.62$, $SD = 13.13$). Four older adults were at-risk for clinical depression (i.e., scored greater than 16) at both pre-test and post-test.

**UCLA Loneliness Scale (Version 3).** The 21-item UCLA Loneliness scale (Version 3) was completed by the older adults as a pre and posttest assessment of subjective feelings of loneliness and social isolation (Appendix B) (Russell, 1996). The scale has high internal consistency (coefficient alpha = .96) (Russell, Peplau, & Ferguson, 1978) and test-retest reliability ($r=.73$). Responses to each item ranged from 1 (never) to 4 (often). Sample questions include: “how often do you feel alone?” and “how often do you feel that there are people who really understand you?” Seven questions were reversed scored. Items were summed with higher scores indicating increased levels of subjective loneliness (Russell et al., 1978). Older adults’ pre-test loneliness scores ranged from 24 to 55 ($M = 38.75$, $SD = 10.70$). Post-test scores ranged
from 23 to 51 ($M = 37.17, SD = 9.94$).

**Family Involvement Questionnaire.** Family involvement was measured using a brief questionnaire, developed by the researcher and informed by the work of Gaugler (2006), to record the amount (hours per month), frequency (number of contacts per month), type (e.g., phone, email, in person, Facetime) and satisfaction with contact with a designated relative during phases of the relocation transition (e.g., preadmission, admission, post admission) (Appendix B). Questions captured the frequency, amount, type, and satisfaction of contact at each phase of the relocation transition based on previous research suggesting that relocation involves multiple phases (e.g., preadmission, admission, and postadmission) (Chen et al., 2008; Jungers, 2010; Saunders & Heliker, 2008). Sample questions included: how long did your in-person visits with [relative] last, what was your preferred method of contact with [relative], and how satisfied were you with your communication (in person or otherwise) with [relative]? Results are reported further in the exploratory analyses section.

**Analysis**

To consider how contextual aspects evident in a relocation transition (e.g., older adults’ physical and mental health, family involvement and dynamics) shaped family participation during a life review intervention, the family life review session was analyzed using a holistic approach (Rossman & Rallis, 2012). This approach seeks ‘thick description’ using the prompt ‘what is happening here?’ as well as considering interactions and identifying patterns for deeper meaning (Rossman & Rallis, 2012). My field notes and videos of the sessions were reviewed and analyzed to confirm the processes (i.e., fostering safety, exploring emotions, validating narratives) that occurred during the FLR and how families responded to these techniques. Illustrative examples were pulled from session videos to highlight how families responded to
various FLR techniques.

To explore how family life review influenced personal and interpersonal development during the ALF relocation, the semi structured follow up interviews were analyzed using the constant comparison method (Glaser & Strauss 1967; Strauss & Corbin, 1990). The essence and voice of participants’ experience in the life review process was identified through the organization and development of themes (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990) underlying the outcomes of participating in a family life review.

All follow up interviews were audio recorded and transcribed verbatim. Transcripts were then checked alongside of the recordings to ensure the reliability of transcription. The unit of analysis was the family. Data coding and analyses followed the approach put forth by Charmaz (2006). To begin coding, transcripts were read and potential codes or categories were written in the margins – known as open coding. Participants direct words were used, where possible, to remain true to their experience and language of the phenomenon. Transcripts were re-read and a list of potential codes was compiled based on the notes and concepts presented in the interviews. Axial coding was used after open coding to make connections between codes that further expanded and conceptualized participant experiences. A coding sheet was created that included a list of all codes across the interviews (Appendix E, Table A1). Using selective coding, the list of codes was organized into larger themes, categories, that related to the codes developed and that validated their relationships (Appendix E, Table A2). Themes are broader concepts depicting the nuances within each code. After themes reflective of the codes were developed, they were crosschecked by my dissertation chair. After resolving any discrepancies, codes and themes were edited and reviewed to ensure reliability of the participants’ experience (Appendix E, Table A3). Transcripts were reread to identify quotes or passages from participants that depicted the essence
of each theme. These supplementary quotes were used to highlight the voice and experiences of the families participating in family life review.

Several steps were taken during the qualitative analysis to establish trustworthiness. First, to consider research bias, process notes were made during data collection and analysis. This allowed me to reflect and consider biases within the research process, for example, that some people are not open to sharing their life story. To thoroughly understand the essence of the data, codes and themes were discussed with my dissertation chair, Dr. Karen Roberto, to identify and challenge bias in my understanding of family life review and the relocation transition. During the discussion, codes and themes were crosschecked to ensure consistency in understanding and to ensure participants’ experiences are being accurately portrayed. These discussions led to a better understanding of the negative and neutral aspects of family life review, in addition to the positive aspects. Additionally, I consulted with an expert in life review research, Dr. Thomas Pierce, not involved with the project, to ensure that the codes reflected the data and the project accurately mirrored prior life review research (T. Piece, personal communication, February 22nd, 2017). Following the consultation, the name of the code ‘Older Adult Staying True to Self’ was expanded to ‘Older Adult Staying True to Self During Relocation’ to more clearly specify the meaning of the code. Finally, I determined that saturation was reached (Patton, 2001) after the coding of ten interviews when no new codes emerged.

**Exploratory Analyses**

The focus of the descriptive analyses was to characterize the sample (e.g., age, sex, ethnicity, race, health status). A paired samples t-test was conducted to compare older adults’ pre-test loneliness scores and post-test loneliness scores. Due to the small sample size, frequencies were used to address the first four questions regarding hours spent in person per
month, length of in-person visits, amount of contact per month, and hours spent communicating (e.g., via phone, email, or video chat) per month to describe the data and participants’ experiences over time. Each component of older adults’ and their family members’ perspective regarding involvement (e.g., amount, frequency, type) was examined separately. Question five (e.g., What was your preferred method of contact with [relatives name]?) was used for descriptive purposes only. Question six was analyzed using a one-way ANOVA, measuring participants’ relationship satisfaction rating over time (e.g., pre-admission, admission, and post-admission) to determine if there was a statistically significant difference between each time point. Results are provided in Appendix F.
Chapter 4: Dissertation Articles

Introduction

The findings of the research are presented as articles to be submitted to scholarly journals. The submission guidelines for both journals are provided in Appendix G.

The first article, *Navigating Emotions and Relationship Dynamics: Family Life Review as a Clinical Tool for Older Adults During a Relocation Transition into an Assisted Living Facility*, will be submitted to *Aging and Mental Health*. The focus of this journal is on changes that span both psychological and aging processes. The journal also has a particular interest in strategies aimed at assisting older adults and their families.

The second article, *Facilitating Family Life Review During a Relocation to Assisted Living: Exploring Contextual Impact on Family Adjustment*, will be submitted to *Clinical Gerontologist*. This journal provides practitioners working with older adults a forum for new research and clinical comments. In addition, the journal has a specific interest in emerging professionals.
Navigating Emotions and Relationship Dynamics: Family Life Review as a Clinical Tool for Older Adults During a Relocation Transition into an Assisted Living Facility

Abstract

Objective: Relocation for the purpose of receiving care may be one of the more challenging transitions for older adults. The purpose of this study was to facilitate a family life review session aimed at enhancing family relationships and assisting older adults in coping with the challenges associated with a relocation transition.

Methods: Fourteen dyads comprised of older adults who recently relocated to an assisted living facility (ALF) and a chosen family member or friend participated in a family life review session and a semi-structured follow up interview one-month post session. Data were analyzed using the constant comparative method and triangulated with descriptive statistics.

Results: Emergent themes suggested that participating in family life review influenced families by raising emotions in families, seeing self in systems, and navigating the relocation transition. Family life review facilitated positive connections and enhanced existing relationships and promoted an acceptance of self and new family narratives. Families indicated that the mutual process of storytelling was enjoyable and reminded them of the urgency to share their story. Participating in the family life review session allowed the dyads to reflect and thus prompted a renewed perspective on some of the more challenging components of the relocation transition.

Conclusion: Study findings provide insight into how families organize their individual and interpersonal narratives and use these narratives during times of transition. Family life review can be used to aid families in making smoother and fulfilling late life transitions, such as relocation to an ALF.

Keywords: family life review, relocation transition, qualitative analyses
Introduction

Late life involves a variety of transitions that shape older adults’ individual development, relationships, and future decision-making. Normative late life transitions include retirement, grandparenthood, caregiving or care receiving, relocation, and widowhood. While common, transitions often require significant adjustment periods. Using the guiding frameworks of life course perspective (Elder, 1998) and general systems theory (Umpleby & Dent, 1999), intervening in a late life relocation transition was the focus of the current study.

Older adults relocate for a variety of reasons: increased care needs (Cummings & Cockerham, 2004), home no longer meets their needs, falls, injuries, or a major illness (Chen et al., 2008; Kennedy, Sylvia, Bani-Issa, Khater, & Forbes-Thompson, 2005), or death of a spouse or loved one (Baker et al., 2014). Although most older adults prefer to age in place (i.e., ‘remaining living in the community, with some level of independence, rather than in residential care’, Davey, Nana, de Joux, & Arcus, 2004, p. 133), doing so is not always viable. An inability to live independently and receive the level of care needed prompts a move to a more supportive environment.

Assisted living facilities (ALF) are the fastest growing choice for long-term care in the United States. More than one million older adults live in over 31,000 ALF (Baker et al., 2014; Ball, Kemp, Hollingsworth, & Perkins, 2014). To ease older adults’ transition, ALF work to mitigate the challenges of relocation by providing supplemental services (e.g., concierge services), such as having staff remind residents of mealtime. However, transitions do not occur in isolation – they can involve and impact multiple members of a family (Elder, 1998). During relocation older adults and their family members can feel disjointed in thoughts, feelings, or decision-making (Tompkins, Ihara, Cusick, & Sook Park, 2015).
Family provides a ‘network of shared relationships’ (Elder, 1998, p. 4) that play an instrumental role in supporting older adults through relocation. Maintaining family involvement throughout ALF relocation was as important for older adults’ emotional well-being as meeting their health, safety, and daily living needs (Baker et al., 2014; Gaugler, 2006). Yet, family members of residents are, at most, available weekly for visits (Gaugler, 2006) and often focus available time handling proximal needs (e.g., selling the home, organizing appointments). Residents reported being fearful of asking family for more time together or visits because they did not want to be perceived as dependent or unappreciative (Tompkins et al., 2015).

The majority of research has explored reasons older adults relocate and effects of relocation on older adults’ well-being (Kennedy et al., 2005) with little consideration regarding family adjustment to relocation (Gaugler, 2006). We hypothesized that both older adults and their family members may benefit from a structured and safe space to express relocation concerns, explore current relational challenges, and navigate the transition in light of prior and upcoming transitions. The purpose of this research was to facilitate a family life review (FLR) intervention with older adults and a selected family member (i.e., dyadically) to explore the value of FLR for families experiencing an ALF relocation.

**Life Review with Older Adults**

Life review interventions are popular and widely used in residential settings with older adults (Westerhof, Bohlmeijer, & Webster, 2012). They provide residents opportunities to review and process memories (Smith, Ruzgyte, & Spinks, 2011). de Vries, Birren, and Deutchman (1990) proposed that,

the act of telling one's story and listening to the story of others provides models to buffer transitions, to bridge historical times, and to communicate values, essential components
of family identification and adaptation. (p. 6)

While participation in life review has been associated with positive psychological (i.e., self-esteem) and personal enhancement outcomes (i.e., improved adaptation and self-integration) (Chiang, Lu, Chu, Chang, & Chou, 2008), studies of interpersonal influences of life review on individual and family relationships are limited. Facilitating life review with 13 ALF residents, Haber (2008) found that the intervention enhanced friendships and cross-cultural communication. Dahley and Sanders (2016) employed life review with nursing facility residents and family members that were encouraged to observe but not correct residents’ memories. Content analyses, conducted separately for residents and family members, revealed four relational themes highlighting the value of life review in the presence of a family member for family members’ enhanced communication, affirmation of the older adults’ story, and improved end-of-life care.

Researchers have not explored a mutual review process, honing in on the creation, reflection, or reconciliation of memories as a family unit. Further, prior research has not addressed the processes experienced while participating in mutual recall of events or how these processes influence other family dynamics (e.g., the relocation transition). Enhancing life review beyond individuals to incorporate families has been proposed theoretically (deVries et al., 1990), but only partially implemented in two published studies. Although these projects explored family-level outcomes (e.g., family coping, family interactions), Dahley’s (2013) family member participants only observed and Comana, Brown, and Thomas’ (1998) reminiscence therapy with family members did not emphasize connecting memories to current transitions.

Building on deVries and colleagues’ (1990) conceptualization, we suggest that FLR provides a forum to address and process the memories and transitions that occur within families.
over their lifespan. Families can then integrate these perspectives into current narratives to manage the relocation and subsequent transitions together. Toward this end, two overarching questions guided our study: (1) How do families participating in family life review respond to current issues (e.g., adjustment to an ALF, family involvement, loneliness) that they are encountering? (2) What family dynamics are evident during and after participation in a family life review session?

Methods

Site Selection, Participant Criteria, and Recruitment

Six ALFs in Harford and Baltimore County, Maryland, and Arlington County, Virginia were invited to participate based upon size (i.e., 15+ beds) and geographical proximity to the first author. Each ALF approved the project using an internal review system. Criteria for older adult participation were (a) aged 65+, (b) able to speak/read English, (c) cognitively able to consent (Mini-Cog; Borson, Scanlan, Brush, Vitaliano, & Dokmak, 2000), (d) had the stamina to complete questionnaires, (e) agreed to participate in the FLR and follow-up interview with a non-spouse family member or close friend aged 21 years or older, and (f) had moved into the ALF within six months prior to the FLR to have a salient reflection of the relocation experience. Older adults were recruited through the ALF. A list of potentially eligible participants was provided and then the first author called or made in-person visits to describe the project. If the older adult showed interest in the project, their selected family member was contacted to assess willingness to participate. In total, fifty-two older adults were invited to participate in the project; sixteen family dyads agreed. Reasons for refusal from either the resident or family member included disinterest in the project and scheduling challenges. The fourteen dyads who completed

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1 Two participants identified as a friend of the older adult residents. They are referred to as family members throughout the paper.
all measures and interviews served as the study sample.

Two of the fourteen older adult participants were male. Older adults identified predominately as Caucasian (n=13) or African American (n=1) and ranged from 75 to 98 years old ($M = 84.64$, $SD = 6.13$). Five older adult participants reported graduating college or beyond. They spent between 16 years to 59 years in their previous home ($M = 33.11$, $SD = 15.82$). The fourteen family member participants ranged from 44 to 73 years of age ($M = 56.21$, $SD = 7.95$). Family members were mostly female (n=9), identified as Caucasian (n=13), and had graduated college or graduate/professional school (n=11). Relationships to the older adults were biological child (n=11), niece (n=1), or friend (n=2).

**Procedure**

The Virginia Tech Institutional Review Board approved this research. Pre-session measures (e.g., Mini-Cog, UCLA Loneliness Scale, CES-D, Family Involvement Questionnaire) took approximately thirty minutes to complete. The FLR session lasted between 54 and 90 minutes ($M = 69.01$, $SD = 9.82$). The content and process used to facilitate the FLR intervention was derived from, *The Life Validation Interview* (see O’Hora, 2015), based on the work of Hargrave and Anderson (1997). This FLR explores, connects, and validates salient memories across the life course. By reviewing significant events in history, families can connect their transitions and relationships to various points in time, linking their resilience and mutual narrative across their lives (e.g., linked lives). Follow up interviews took between twenty and seventy-five minutes ($M = 47$, $SD = 17.45$). The family member was present and engaged in both the FLR session and follow up interviews. Each participant received a five-dollar gift card for a retail store at the beginning of the FLR and at follow up.

**Follow Up Interview**
Dyads were asked seven open-ended questions during the semi-structured, follow up interview. We were interested in the dyads’ experience of the FLR (e.g., influence of the FLR on their relationship, adjustment to the ALF), recollection of something meaningful and/or challenging discussed during the FLR session, recollection of something they have experienced together in the past month that has been meaningful and/or challenging, value of FLR, overall experience of the FLR process, recommendations for another family going through a relocation, and perspective of the influence of the FLR on their future. Prompts were used to help the dyad organize their thoughts and vague comments were explored further using gentle probing (e.g., ‘when you say FLR has helped you, what do you mean? Tell me a bit more about that…’).

**Analysis**

Interviews were audio recorded and transcribed verbatim. The first author made margin notes (e.g., open coding) during the interview process and wrote a reflexive account of each interview upon completion of the follow up interview. To keep with the dyads’ lived experiences, highlighting their own terminology and voice, the constant comparative method was used to organize and develop themes (Glaser & Strauss, 1967; Charmaz, 2006). Following the approach described by Charmaz (2006), codes were arranged based on emerging concepts. Connections were linked between codes and organized into categories (e.g., axial coding) and then compiled in a coding sheet and arranged into themes that highlighted the relationship between codes (e.g., selective coding). The second author crosschecked themes to validate nuances within the coding scheme. Passages from the interviews were extracted to emphasize the dyads experience within each theme (Charmaz, 2006).

To establish trustworthiness, process notes were made during data collection and analysis, codes and themes were crosschecked and reviewed by a senior life review scholar (T.
Pierce, personal communication, February 22nd, 2017). These steps allowed the authors to consider biases within the research process and ensure participants’ experiences were being accurately portrayed such as discerning whether the dyad believed the older adult was staying true to self throughout the aging process or specifically during the relocation. Saturation was reached after ten interviews when no new codes emerged. Four more interviews were completed to ensure reliability of saturation and verify the concepts that were emerging in the data (Patton, 2001).

**Family Transitions and Life Review**

Our analytical approach integrated information from both members of the dyads to develop an understanding of their mutual reflection of FLR and the relocation. We present our findings holistically, incorporating both the individual voice (i.e., older adult; family member) as well as the dyadic voice (e.g., mutual narrative). Three interrelated themes emerged contributing to the understanding of participants’ individual and collective experience.

**Raising Emotions in Families**

The most prevalent theme was raising emotions in families, mentioned 411 times. All dyads believed FLR had positive and neutral influences on their relocation transition; ten dyads also identified at least one negative aspect of FLR.

**Positive aspects of family life review.** Twelve dyads believed FLR enhanced their relationship. Participation promoted intergenerational connectivity, such as linking their story with prior and future generations as well as validated existing relationships, reinforced mutual narratives (e.g., sharing a similar story or experience), and prompted collaboration (e.g., working together to solve a problem). Natalie described traveling with her mother, Violet, and reflected on the great memories they had shared. FLR prompted them to relive these experiences and
connected their memories with greater understanding of one another.

Natalie (daughter): *Do you feel like being ninety-one right now and looking back at all those different things [makes you feel valuable]...*

Violet (older adult): *[my travel] has made an impression on me. [I have seen people explore] the world of tomorrow, and I’ve lived through all that. I love my life, it was really interesting.*

Natalie: *It’s really neat to talk about all the different things you experienced...it gives me perspective as to who she is too, what influenced her life and what made her the person she was.*

Dyads reflecting on their narrative helped shape their understanding of their individual and mutual story.

Sandra (daughter): *When we moved to Holland I approached a new country without a real sense of anxiety about it because I had been told [by my mother] that I had done this before and succeeded. . . .You [mother] gave me some life skills that could be transported. . . . It was very consistent with how you lived as well.*

In addition to enhancing relationships, twelve dyads believed FLR provided new perspective on their view of each other. Of these dyads, ten commented FLR was an enjoyable process and eleven found FLR influenced self-awareness and acceptance such as learning something new about their individual self or having their story validated by their family member, linking to their own acceptance of the experience. Perspective was gleaned through the dialogue that led to insights and the molding of existing memories. For example, Frank commented that his story was created from only his perspective, exploring memories with his mother provided another lens that enhanced his understanding.
Frank (son): *If your family is* open enough... you get a much better sense of [an] event.*

*I think of memories as notoriously imperfect in the first place. In addition, they’re all memories through a particular prism. Every single person’s prism and the way the light went through it is going to be different....So only by putting it all together would you get it right.*

Influenced self-awareness and acceptance involved participants individually acknowledging the fragility of their life, their lifelong resilience, and the gratefulness they have for their life experiences. Self-awareness and acceptance was reflected in participants’ acknowledgment of their own story such as commenting that they had not considered their own resilience across the life course.

**Neutral aspects of family life review.** While all dyads believed FLR was beneficial, they also indicated that the effects of the FLR could not be directly seen in their relationship or relocation transition (e.g., too soon to see the effects). Some dyads were clear about the lack of influence whereas others recognized through FLR there were still more memories to explore.

Steve (Son): *For me [FLR] sort of opened up, there’s things that I still, after forty something years, still don’t know and still would really like to find out....I need to make time and I need to ask those questions. I need to pursue those things, that would be a shame to never find out.*

**Negative aspects of family life review.** Ten families also mentioned a negative aspect of FLR, including challenges with the general content of memories (e.g., physical abuse) and the taxing process of sharing (e.g., reliving an experience). Gabriella shared the connection between the challenges of adapting as a community, when children were being bused to predominately White schools during segregation (e.g., relational process). As her daughter Ida noted, this
transitional time also had instrumental challenges such as inner city schools becoming vacant and desolate, as well as, navigating the economic changes within the community. Reliving this experience was challenging for Gabriella and Ida.

Ida (daughter): When you’re talking with someone else about your life a whole lot of things come up. You’re able to remember things that you don’t want to remember… some things that you just want to keep in the past, and not relive it again…. like my mom as far as talking about segregation and integration [during the FLR session]. Those types of things I try not to talk about or discuss.

While segregation was a difficult topic to remember and explore, this dyad also acknowledged overcoming other challenging situations in their life and began to view relocation as another transition they would navigate together. The extent of dyads reflecting on positive, neutral, and negative experiences during the FLR suggests FLR is not merely a positive reflection exercise but challenges families to dig deeper into lifelong and relational struggles and challenges to pull them toward a more resilient perspective of the transition.

Navigating the Relocation

The second most prevalent theme was how FLR prompted dyads to navigate the relocation. Navigation involved confronting the reality of the circumstances and engaging in relocation processes, which were often the most gripping and salient aspects of their transition experience. Family dynamics, such as the distance between the resident and family member contributed to relocation challenges. For example, family members lived between 2 miles to 360 miles ($M = 77.74, SD = 123.55$) from the ALF; these relational aspects of the transition had the potential to negatively or positively influence dyad relationships. Similarly, if the decision to relocate was made by one member of the dyad (e.g., the family member, typically) than the older
adult felt frustrated, hurt, and confused.

**Relocation processes.** Relational aspects of relocation, mentioned by all 14 families over 145 times, included disagreements about the need for relocation, family member guilt about the relocation decision-making process, caregiving role reversals from childhood to late life, and relational satisfaction or dissatisfaction throughout the transition. These concepts were deeply embedded within relationships and carried intense meaning. For example, Patty shared her concern over her mother’s satisfaction in ALF and her extended relatives’ perspective of the relocation process. Her mother, Dee, expanded on these relational relocation concerns.

Patty (daughter): *She finally used the word happy, which made me feel better that you used the word happy and not satisfied, which is what she used to describe it...that made me feel a little better...I don’t want the relatives to feel like, pardon the expression, I’m throwing my mother’s ass in a home. I don’t know that they do but I guess that’s my Catholic girl guilt.*

Dee (older adult): *The thing that I can’t say to my cousin is that this is much better being here [ALF] than it would be to rely on [my cousin] taking care of me....she wants to help but she’s really not helpful ...I can’t tell her that I really wouldn’t want to be in her hands.*

Dyads also tackled proximal future planning concerns (e.g., finances, selling a home) along with issues at the ALF. For many dyads, these concerns needed to be addressed immediately to ensure the well-being of the resident, such as one son’s frustration that the ALF would only send a male to shower his mother. Other relocation processes involved feelings of isolation and whether the older adults were staying true to themselves during the relocation, such as expressing their normal joy, humor, or engaging in typical hobbies (e.g., puzzles, reading).
when interacting with other residents, the family member, or even the researcher.

**Confronting the reality of the circumstances.** Dyads commented 67 times on the reality of the circumstances surrounding relocation, either acknowledging older adults’ increasing cognitive and physical limitations or reflecting on aspects of the older adults’ social support. Residents’ self-reported health concerns mirror existing literature on older adults’ health status when entering ALF (Ball et al., 2014; Jungers, 2010). The majority of older adults rated their health status as fair (n=7). They struggled with one or more health concerns, such as diabetes, heart problems, memory decline, strokes, and immobility. Both family members and older adults expressed urgency in planning for the future while not letting the future dominate the present. They recognized the obvious: all family members are aging and some will have cognitive and physical limitations. Frank (son) captured the sentiment of most dyads.

Frank (son): *The challenge is not recognizing her limitations but accepting them.*

Older adults reflected on decreasing social ties through death, geographical changes, or disappointment in personal relationships. They struggled to maintain positivity in the face of a dwindling network, even when encouraged by their family members. Developing friendships or romantic relationships after the relocation aided older adults’ transition, helping them feel connected to their new community.

**Seeing Self in Systems**

The third theme involved dyads seeing themselves existing and relating to various systems. Dyads were keenly aware of the dynamics unique to their relationship and extended family, the role of FLR intrapersonally and interpersonally, and the overall purpose of the research. Findings suggest dyads recognized links between the past, present, and future and internalized these links in relationship to their surrounding context.
**Family dynamics.** Family dynamics involved dyads acknowledging other influences within their own family system. Throughout their reflections, individuals saw themselves within a larger context – often the family, but also the research project and the world at-large. Dyads remarked about the value of quality time, power of memorabilia in triggering memories, benefit of life review for individual versus family processing, depth of the what it means to be a family (i.e., beyond their own relationship), and importance of relational reciprocity, self-worth, and sharing legacies. Dyads highlighted spending time together and transformed FLR into opportunities to validate and celebrate accomplishments. Half of the dyads emphasized their family values by sharing memories between and across generations, reflecting on the past, or mutually remembering as a tradition. One son connected the importance of sharing stories with the overall sense of who their family is and who they become.

Dave (son): *The kinds of things that get people together serve to find out who we are, right?...We’re the people who you know...the ‘us’ of our connectedness. This great word in Japanese, [uchī, ウチ] it’s like we, us...so there’s this we and us, the family. We and us, the neighbor. These kinds of things, weddings and that kind of stuff we use to define we and us.*

**Role of FLR process in one’s life.** Dyads also had an acute awareness of their storytelling process and their comfort in sharing with other family, friends, and the facilitator. Eleven dyads commented on their desire to share more, recommended other families engage in FLR, and maintained openness in sharing with others. One daughter highlighted the value she saw in engaging in FLR.

Molly (daughter): *Absolutely do [FLR] and take it seriously, it can be a precious opportunity to learn about your loved ones.*
Other participants were more inclined to keep stories private or within their family system. These dyads believed their story was only interesting to them or were not as comfortable sharing with outsiders. Seven dyads acknowledged FLR can be challenging due to external circumstances, such as busy schedules. They suggested that sharing their story had not crossed their minds.

Thalia (daughter): *Most of the time it probably wouldn’t come up in my head. There’s too many other things I got to think or worry about….sometimes you don’t even think about things until something happens and then you’re like oh yeah, I remember that now.*

Dyads also recognized how macrohistorical events and cultural narratives have influenced their family system. Albertina, who lived in France during Nazi Germany invasion had a unique understanding of safety, the value of family relationships, and sacrifice. Her thoughts on phases of her life tied to her son’s current perception of the relocation transition. Felix felt strongly that Albertina’s experiences be acknowledged and commemorated, which was evident in the memorabilia and artwork displayed throughout her room.

**Dyadic critique of FLR.** Dyads also had an awareness of the research system (e.g., aspects of the project). Nine dyads believed the project format was challenging (e.g., excessive paperwork). Eight dyads appreciated the intervention structure and the facilitator’s empathy. Multiple participants suggested FLR be held informally, over coffee or lunch. In general, dyads had many positive experiences and insights as a result of their participation. Although they clearly understood that the purpose of the follow up interview was to reflect back on the FLR, all fourteen dyads engaged in additional remembering during the follow up, suggesting a notion of wanting more (Tompkins et al., 2015).

Sandra (daughter): *I actually came away thinking one session probably isn’t enough. But done over a period of time…I could see where this could be a valuable way to ….get at*
things that the two of us probably couldn’t have done individually.

**Discussion**

Findings suggest FLR served as a unifying and collaborative resource for families, during relocation, especially in exploring and sharing the challenges of relocation (e.g., relational and instrumental aspects) and in enhancing family relationships. Dyads’ candid and thoughtful comments lead to a deeper understanding regarding what is salient to them throughout this transitional time and the role of FLR in their adjustment.

FLR prompted dyads to be aware of how their current decision-making (e.g., ‘Navigating the Relocation Transition) regarding relational and instrumental aspects of relocation was influenced by prior life experiences and likely will influence subsequent transitions. Relocation decision-making occurs before, during, and after the transition (Chen et al., 2008; Saunders & Heliker, 2008). As life course theory maintains, decisions and experiences are understood contextually through prior opportunities and constraints over the life course (Elder, 1998, p. 2). As practitioners intervene in the lives of families experiencing relocation, a focus on relational and instrumental concerns must be at the forefront of facilitators’ dialogue with the family.

The FLR was an opportunity to take a break from the stress of the transition to spend time reflecting on family history, a process nearly all participants enjoyed. Yet, the benefits of FLR extended beyond enjoyment. Dyads learned about one another, engaged in self-acceptance, reconciled difficult memories, and experienced relationship enhancement as evident through the categories within the theme ‘Raising Emotions in Families.’ Knowing older adults long for increased contact with their support network (Tompkins et al., 2015) and tend to invest more in family ties during relocation (Perkins, Ball, Kemp, & Hollingsworth, 2012), FLR can facilitate connection.
Although this study focused on relocation, FLR at various points in a family’s life has the potential to bring members together for future decision-making. As suggested by Kennedy and colleagues’ (2015) research on older adult adjustment to ALF, “[p]ast patterns of decision-making, forged by previous life experiences...[provides] a contextual background for everyday decision-making” (p. 22). Life review served as an avenue for open communication that facilitated conversations intended to enhance the relationship and future decisions (Dahley & Sanders, 2016). Dyads recognized by making connections between historical influences and their personal and mutual trajectory (Elder, 1998), they could make sense of the current transition. Used as a preventative tool, FLR can foster unity before transitions, perhaps preventing emotional difficulties among residents (e.g., social isolation) or familial challenges (e.g., caregiver burnout) as a result of the adjustment.

Reflecting on macrohistorical memories (e.g., historical time and place) prompted an intrapersonal and interpersonal dialogue between family members. For many dyads, exploring macrohistorical events was a launching place for discussing lifelong family living, coping, and relating. These nodal events oriented dyads (Elder, 1998). In addition, dyads commented on their values (e.g., reciprocity) and how these values were displayed during transitional moments in their lives. Elder (1998) suggests that ‘historical forces’ (p. 2) influence individual and relational systems. The value of sharing one’s story can only be understood within the individual, relational, historical, and cultural influences of life as evidenced by how dyads spoke about FLR. For a few participants, exploring their mutual story was a painful or neutral process, reinforced by internal cultural messages to suppress their story.

Decreasing social supports during relocation and adjusting to an unfamiliar environment can contribute to older adults’ overall feelings as well as their satisfaction with family
relationships (Plys & Bliwise, 2013; Stadnyk, Jurczak, Johnson, Augustine, & Sampson, 2013). Yet, FLR provided dyads with a more robust perspective of each other’s story, increased self-awareness, facilitated reconciliation, and led to an enhancement of their existing relationship. Finding avenues to connect families and address underlying concerns (e.g., via reconciliation) can support their desire for a quality relationship.

**Limitations and Future Research**

To our knowledge, this is the first study to explore the benefits of FLR. Findings provide valuable insights into how FLR shapes families during transitional times. A limitation of the study is that the homogenous sample (e.g., mostly White/Caucasian). Larger, more diverse samples are necessary to explore the influence of race/ethnicity on the FLR process. Larger, diverse samples as well as a tailored intervention format to include specific ethnic or cultural variations (e.g., Black history) as part of The Life Validation Interview (O’Hora, 2015) would promote cultural sensitivity by highlighting the importance of each family system and their unique background.

Second, although the study inclusion criteria was intended to reach a particular population and focus on the transition process, it can be argued that families within six months of the relocation transition have already completed the most difficult aspect of the adjustment process – the move. These families may be less ‘in transition’ than those who are experiencing cognitive or physical limitations but have not made the decision to relocate, are unwilling to relocate, or are looking for other long-term care options. In addition, the data suggested that dyads prioritize relational and instrumental aspects of relocation. More information is needed to determine whether FLR could aid before a relocation transition such as meeting with dyads or multiple family members through community outreach or local organizations (e.g., agencies on aging,
While FLR is a valuable tool that can be used by practitioners seeking to assist older adults and their families during relocation and other late life transitional times, a general concern is the lack of standardization for life review interventions (O’Hora & Roberto, in preparation). While there is benefit to having various interventions that explore unique aspects of individual, group, and family lives, transferability of findings is difficult across projects when the mechanisms of change are variable (e.g., discussing macrohistorical events, autobiographical processing). Future research using rigorous experimental designs are needed to evaluate FLR outcomes and identify FLR processes facilitating change.
References


Facilitating Family Life Review During a Relocation to Assisted Living: Exploring Contextual Impact on Family Adjustment

Abstract

Objectives: The purpose of this study was to explore how contextual aspects of participants’ lives before and throughout relocation to assisted living (ALF) informed the family experience of family life review (FLR).

Method: Fourteen families participated in a FLR session within six months of the older adults’ relocation. Semi-structured interviews, conducted one-month following the FLR session, were analyzed using the constant comparative method. Demographic and relational variables provided context for assessing how individual and family dynamics influenced the family relocation process.

Results: Specific techniques were used during the three phases of FLR (introduction, validation, consolidation) to encourage openness and mutual dialogue between family members. Health-related limitations challenged older adults' understanding and openness during the FLR. Family involvement and dynamics influenced how families communicated about their mutual narrative and the relocation transition.

Conclusion: FLR is an adaptable intervention to assist older adults and their family during a transition to ALF. Although contextual challenges impacted how families experienced the FLR, they enjoyed FLR as a unifying event that promoted mutual understanding.

Clinical Implications: The use of FLR facilitates enhanced understanding and communication during relocation. Older adults' health status as well as family dynamics need to be assessed prior to organizing a FLR to accommodate each families’ unique needs.

Keywords: life review, family transitions, relocation, assisted living
Introduction

Despite older adults’ preference and expectation to age in place in their long-time homes and communities, changes in personal circumstances may require them to consider moving to a more supportive home environment (Wilson, 2007). Events or life changes that precipitate the need for relocation include death of spouse, disability, and retirement (Baker et al., 2014). These events typically involve entire family systems, each adjusting and coping in unique ways. Researchers emphasize the value of an interactive relocation decision process (Levin & Kane, 2006) where family members make decisions about relocation together, especially when the older adult is cognitively able. For older adults with increasing care needs, assisted living facilities (ALF) are an appealing alternative living arrangement (Dobbs, 2008) because they provide a home-like environment and support varied levels of dependence. With over one million older adults in over 31,000 facilities, ALF are the fastest growing choice for long-term care in the United States (Baker et al., 2014).

While moving to ALF can address proximal concerns (e.g., physical health needs, instrumental needs), relocation often leaves older adults with ongoing relational needs (e.g., desiring more quality time with family). Tompkins, Ihara, Cusick, and Sook Park’s (2015) study of 29 older adults’ transitioning to an ALF revealed that residents desired on-going family involvement and support but felt asking family members may make them look weak. Conversely, family members concerns focused on older adults’ safety and finding an ALF that met the older adults’ instrumental needs that was also within their financial means (Koenig, Hee Lee, Macmillan, Fields & Spano, 2014).

Whether the choice to relocate is self-initiated by the older adult or in conjunction with family members, it requires involvement and adjustment of the entire family unit. Yet, little
attention has been given to interventions that help older adults and their families navigate the relocation process. The current study utilized family life review (FLR) to engage families in a mutual recall process connecting prior life experiences to their current transition to ALF to highlight lifelong mutual narratives that can be a source of strength for families adjusting with the challenges of a relocation transition.

**Life Review Interventions**

Over the past fifty years, life review has been translated into interventions by researchers and clinicians seeking to aid in individual reflection and exploration at various developmental phases (e.g., young adulthood, end of life). Intervention results for individual gain and fulfillment included decreased depression (Bohlmeijer, Roemer, Cuijpers, & Smit, 2007), greater promotion and critical analysis of one’s life (Haight & Burnside, 1993), revision of positive and negative memories (Westerhof, Bohlmeijer, & Webster, 2012), and greater ability to evaluate and come to terms with the past (Latorre et al., 2015).

Life review is a process that prompts an individual to share, internalize, and accept memories. For the purposes of the current research, life review:

*explicitly or implicitly* involves a process of evaluation where participants examine how their memories, and the processes surrounding these memories, contribute to the meaning of their life, *while working to come* to terms with more difficult memories.

(Latorre et al., 2015, p. 142, adaptations in italics)

In his 1963 seminal article, Robert Butler suggested that life review be viewed as necessary and developmentally appropriate. Approaches to life review (e.g. life validation, autobiography) are often structured, with clear steps and goals. For this project, the *Life Validation Interview* (O’Hora, 2015) was used to encourage families to actively process and link macrohistorical
influences with the microhistorical processes as a means for remembering and reconciliation of memories. This systemic approach addresses memories and transitions linked across time and relationships (Bengston & Allen, 2009; Elder, 1998). We were particularly interested in how contextual aspects of older adults’ life (e.g., physical and mental health status, family dynamics) before and throughout relocation influenced the family experience of FLR. Two questions guided our project: (1) How do contextual factors shape family response to a FLR intervention during a relocation transition to ALF? (2) What family dynamics are evident during and after participation in a FLR session?

Methods

Site Selection, Participant Criteria, and Recruitment

Six ALF located in Harford County and Baltimore County, Maryland and Arlington County, Virginia served as study sites. Facilities agreed to participate after an initial phone call describing the project and an in-person meeting detailing the role of the ALF in the study. The first author worked with sites to recruit older adults using an approach least burdensome to their existing structure. ALF administrators and staff identified residents who met the inclusion criteria for the project: (a) aged 65 or older, (b) able to speak and read English, (c) cognitively able to consent (Mini-Cog, Borson, Scanlan, Brush, Vitaliano, & Dokmak, 2000), (d) had the physical stamina (self-report) to complete assessment questionnaires, (e) agreed to participate in both the FLR and follow-up interview with a non-spouse family member or close friend who was age 21 or older, and (f) moved into the ALF within the last six months. After residents were identified, the first author contacted the older adult and then the family member to assess interest and willingness to participate in the project. In total, fifty-two families were invited to participate.

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2 In two cases, family-friends were selected to participate in the project; they are referred to as a family member throughout the paper.
Thirty-six families refused due to scheduling conflicts or disinterest in the project. Sixteen families agreed to participate in the project. The fourteen families who completed all measures and interviews are the focus of the analyses presented.

Older adults ranged from 75 to 98 years old \( (M = 84.64, SD = 6.13) \). Twelve older adults were female. Older adults identified as Caucasian \( (n=13) \) or African American \( (n=1) \). All of the older adults had at least a high school education. The majority rated their overall health as fair \( (n=7) \) or good \( (n=4) \). Twelve older adults reported having between two and eight chronic health conditions \( (M = 3.67, SD = 1.88) \). They spent between 16 and 59 years in their previous home \( (M = 33.11, SD = 15.82) \).

Family member participants were mostly female \( (n=9) \) and identified as Caucasian \( (n=13) \) or African American \( (n=1) \). They ranged from 44 to 73 years old \( (M = 56.21, SD = 7.5) \). Eleven had graduated college or graduate school. They lived between 2 and 360 miles from the ALF \( (M = 77.74, SD = 123.54) \).

**Procedures**

The Institutional Review Board of Virginia Tech and each ALF approved this research. Informed consent and pre-session measures took approximately thirty minutes to complete. The FLR took between 54 to 90 minutes \( (M = 69.01, SD = 9.82) \). The follow up interview took between 20 and 75 minutes \( (M = 47.00, SD = 17.45) \). Each participant received five-dollar retail gift cards after the FLR and the follow up interview.

**Measures**

The 20-item Center for Epidemiological Studies Depression Scale (CES-D) was used to assess depressive symptomatology before and after the FLR session. Older adults responded to statements about their thoughts and feelings in the past week on a 4-point Likert scale ranging
from 0 (rarely) to 3 (mostly). Older adults’ pre-test depression scores ranged from 0 to 45 ($M = 14.62$, $SD = 14.95$). Post-test scores ranged from 1 to 41 ($M = 14.62$, $SD = 13.14$). Due to small sample size, there were no statistically significant differences; however, four older adults were at-risk for clinical depression at both pre-test and post-test (total score $> 16$; Lewinsohn, Seeley, Roberts, & Allen, 1997).

Older adults also completed the 21-item UCLA Loneliness scale (V3), a subjective measure of feelings of loneliness and social isolation (Russell, 1996). Item responses ranged from 1 (never) to 4 (often), with higher total scores indicating greater levels of loneliness (Russell, Peplau, & Ferguson, 1978). Older adults’ pre-test loneliness scores ranged from 0 to 55 ($M = 36.71$, $SD = 14.65$). Post-test scores ranged from 23 to 52 ($M = 37.17$, $SD = 9.94$). Eight older adults scored higher than the sample mean at pre-test and six scored higher than the sample mean at post-test, signifying greater levels of loneliness. Three older adults’ responses regarding loneliness and depression were comorbid with high loneliness scores and scoring at-risk for clinical depression at pre and posttest. Older adults were not clinically diagnosed with depression.

A family involvement questionnaire was completed three times by the older adult and family member. They completed the questionnaire at the time of the interview reflecting back on the year prior to relocation (e.g., pre-admission). At the time of the interview they also completed the questionnaire reflecting on the first month after relocation (e.g., admission). At follow up, they completed the questionnaire again reflecting on their involvement after the FLR (e.g., post-admission, 3-6 months after the move) (Jungers, 2010; Saunders & Heliker, 2008). The questionnaire assessed amount (contact hours/month), frequency (number of contacts/month), and preferred type (phone, email, in person, Facetime) of contact as well as
relational satisfaction with their family member. Including older adults who relocated to the facility within the past six months ensured participants had time to experience the adjustment process while still able to recall and describe their experiences.

The majority of older adults preferred in-person contact with their family during the relocation transition (n=10). Three older adults preferred telephone conversations to in-person contact whereas their family members preferred in-person contact. Three different older adults reported spending over 30 hours per month in-person with their family member whereas their family member indicated their in-person contact was approximately 10-20 hours per month. All older adults consistently reported that they were either very satisfied or satisfied with their family relationship. However, two family members reported dissatisfaction in the relationship before relocation. By post-admission, one of these family members reported being very satisfied. The other family member maintained dissatisfaction throughout relocation.

**Family Life Review**

The FLR session was framed after The Life Validation Interview (O’Hora, 2015), a multi-modality intervention based on the work of Hargrave and Anderson (1997). The interview is typically used therapeutically with families to mutually integrate, share, and process memories. Although it was originally designed for one to three fifty-minute sessions (O’Hora, 2015), we conducted one ninety-minute session. This provided sufficient time for family processing, accommodated geographic proximity and scheduling, and allowed time for exploration without the FLR becoming burdensome (Chiang, Lu, Chu, Chang, & Chou, 2008; Haber, 2008; Haight et al., 2003).

**Analyses**

The FLR sessions were analyzed using a holistic approach, which seeks ‘thick
description’ to consider interactions and identify patterns for deeper meaning (Rossman & Rallis, 2012, p. 270). The facilitator’s (first author) field notes and videos of the sessions were reviewed and analyzed to confirm the processes (i.e., validating narratives) that occurred during the FLR and how families responded to these techniques.

To establish trustworthiness, the authors used process notes, data crosschecking, and consulted a life review expert (T. Pierce, personal communication, February 22nd, 2017). These steps allowed the first author to consider her biases in understanding life review research, such as noting that some families shared their story, though painful, to make further sense of their experiences. Establishing trustworthiness through crosschecking the data prompted emphasis on the family voice versus the individual voice, as many participants shared within the framework of a relational voice (e.g., using terminology such as we, us, the family). Finally, consulting with an expert ensured that the codes reflected the data and the project accurately mirrored prior life review research.

Descriptive statistics were used to characterize the sample (e.g., age, sex, ethnicity, race, health status). Further, exploratory analyses were used to investigate pre- and posttest differences in regards to depression, loneliness, and family involvement. Results are provided to supplement how contextual factors impacted families’ experience of FLR and the relocation transition.

**Results**

Three phases of FLR (introduction, validation, and consolidation) are presented to explain the intervention process and techniques (e.g., <validating mutual narrative>) used to reinforce safety, provide encouragement, and elicit mutual storytelling. Phases are often overlapping, without a clear beginning or end. To illustrate how contextual factors influenced families, excerpts from the sessions are presented as well as reflections that emerged from the
follow up interviews.

The introduction phase involved explaining the purpose of FLR and reminding families that the facilitator would guide their conversation but they could focus on or skip any topic. Sessions started chronologically with each participant's birth year, promoting an interest in the beginning of their stories while creating an alliance. She started the session with their childhood, connecting these memories to salient macrohistorical events from that developmental phase (e.g., life during and after WWII). Then, she asked about thoughts, feelings, and emotions during and throughout nodal events in history (e.g., “How do you think the war impacted your sense of safety growing up?

The validation phase was organized around events in history and how they can be discussed through dyadic conversation. The goal was to encourage participants to share their unique experiences and gently probe how these experiences link with other aspects of their mutual experiences. The facilitator empathized, remained curious, privileged their voice, and explored family narratives. Narratives were woven together, reaffirming the mutual process and balancing their shared stories. The facilitator looked for similarities within their stories, connecting and expanding on their mutual experience and highlighting their resilience. The final technique involved reflecting back on macrohistorical events to provide the family with orienting (e.g., nodal events) moments in their story, linking positive moments, growth, and their ability to work together during difficult transitions.

Facilitator: …this was before the war? Your father got remarried? <tracking narrative>

Tracie Ann (family-friend): Before the war....When you were about three years old, right?

Adele (older adult): yea
Tracie Ann: *she never knew that woman wasn’t her real mother.*

Adele: *But my grandmother one time was so mad she told me, ‘you don’t have to listen to her, she is not your mother.’ And my mother was so mad that they told me. And my father said, ‘she has to know.’ It’s better now instead of later.*

Tracie Ann: *May I interject just a little?*

Facilitator: *Please! The whole time I would like to hear and incorporate your perspective...* <reaffirming mutual storytelling process>

Tracie Ann: *Her stepmother never treated her very well, right? She had other children who she treated really well. And she never understood it until her grandmother finally told her. This is not your real mother.*

Facilitator: *Wow, right* <tracking and validating their experience>

Tracie Ann: *All that time she’s thinking, why doesn’t my mother love me like she loves the others. I think it was psychologically scarring. But then when the war started your dad had to...he got drafted, right? And then what happened?*

Adele: *My father had to go off to war....but, I don’t even want to think about it.*

Facilitator: *It’s a lot to go through, you’ve been through a lot.* <validation>

Adele: *Yea*

Tracie Ann: *My father was a pilot too in the war. But not in Germany, in the Philippines...*

Facilitator: *Oh, so Tracie Ann, your father was in the war, too? Did Adele know that?* <highlighting overlap between macrohistorical events and their linked lives>

Tracie Ann: *Yes, she knows that. My dad died in WWII.*

Facilitator: *There’s some overlap.* <connecting mutual experience>
Tracie Ann: *There is, there’s overlap in the stories...*

Facilitator: *How do you think that impacted [both of] your sense of safety and resilience during your childhood[s]?* <highlighting resilience, weaving stories together>

The consolidation phase involved linking previous life experiences with the current transition. This phase highlighted family resilience despite the older adults’ health status or limitations. Families were encouraged to explore the best and hardest moments, incorporating conversations about the families’ social connections and involvement during various transitions. After summarizing the themes of the session, the facilitator thanked the family for their time and for sharing their story.

**Influence of Contextual Factors on Family Life Review**

**Physical health concerns and limitations.** The impact of health status on FLR was observed in unspoken aspects of the session. For example, ALF staff interrupted when the older adult needed medications. One older adult with oxygen became dehydrated and had to take breaks to sip water. Another participant with hearing difficulties had her daughter repeat questions because she could understand her better than the facilitator. At times, older adults questioned the accuracy of their narrative, expressed concerns about their cognitive abilities, or refrained from participating in conversation unless asked a direct question. One participant told her daughter, “my memory is going, you just tell the story.” Perhaps because of hearing and vision difficulties, older adults wanted to ensure questions were directed at them before providing input. In contrast, family members would interject, correct, or supplement a story, even when the older adult was talking.

Physical health status also influenced families’ perspective of the FLR. For example, Dale reported excellent health and slight memory problems. His, and his son, Steve’s perspective
of FLR was different than other families. They emphasized the benefit of FLR in enhancing their relationship more frequently than most other families. They also underscored the benefit of sharing one’s legacy intergenerationally.

Steve: *Now that we are the older side of the family [we need to] make sure the younger ones are acculturated and know the stories and learn the stories.*

Dale: *I think as a grandfather I have an obligation to tell [my grandchildren] what was significant in my life and what my parents did for me.*

They acknowledged Dale’s cognitive limitations but aspects of the relocation did not appear to shape their perspective of FLR, or their relationship. Because stressors of relocation were not prevalent in their experience, Steve and Dale were able to focus on the FLR and expressed that they believed it was beneficial.

Dale and Steve can be juxtaposed with Vera and her family-friend, Violet. They had a less positive view of FLR and at times believed FLR was painful (e.g., brought back difficult memories). They also reported substantial relational challenges associated with Vera’s poor physical health before and during the transition and how that impacted their perspective of the relocation.

Violet: *It’s not my fault you can’t take of yourself, Vera, you know...[Vera’s] a very stubborn lady...she’s extremely stubborn, aren’t you Vera? And, feisty.*

Vera response was short and to the point, a sentiment she shared many times throughout the FLR and follow up session, highlighting her frustrations with her health and the overall transition.

Vera: *I’ve got to get out of this place.*

Twelve older adults reported multiple chronic health conditions, including memory problems (n=6), high blood pressure (n=5), and cancer (n=4). In two families, the older adult had
cancer, but no other chronic health problems; more so than other families they struggled less with the relocation transition. During FLR, these dyads were open to continue sharing their story, emphasizing the value of quality time and family pride.

Jane (daughter): *I really enjoyed our shopping trip, my older daughter came down with the baby and the four of us went shopping...this was the first multigenerational shopping trip.*

Andra (older adult): *Oh, it’s wonderful seeing the next generation.*

Jane: *Positive experiences tend to encourage more positive experiences.*

Andra: *Talk encourages more talk.*

Although none of the older adults were identified as having dementia, six reported mild memory challenges. While all six families dealt with relational aspects of relocation (e.g., planning, caretaking), four of the families were also challenged with confronting and accepting cognitive limitations. While older adults’ overall better health often made the FLR process more fluid or smooth, varying health challenges ultimately impacted what families focused on during the FLR and their overall experience of the relocation transition.

**Mental health.** Older adults at risk for clinical depression (i.e., CES-D score greater than 16) or with high loneliness scores (i.e., above the mean) appeared to struggle with openness during the FLR. During the FLR, their exchanges with one another suggested older adults often wanted their family member to guide the conversation or only appeared confident about specific periods of their life (e.g., military service). One older adult, Joe, believed his story only was interesting to him. These older adults also exhibited a more pessimistic outlook on life, using phrases like “everything went downhill from there,” or “why bother telling the story?” when asked about specific life experiences (e.g., starting new job).
During follow up interviews, the four older adults at-risk for clinical depression emphasized in their conversations feelings of isolation and reflected on evolving family and friend relationships.

Colleen (family-friend): *Fran, you tend to cycle sometimes [in your depression]. You have good days and bad days. You have a week of good days.*

Fran (older adult): *Well, I never have a week of good days...the occasional ‘better’ day.*

Colleen: *I was wondering if all the different life events and historical events the facilitator talked about, did that make you feel connected to others in any way?*

Fran: *No, because the people that were involved are mostly dead.*

The three older adults who also had high loneliness scores were quick to bring up their lack of social connections. Fran’s abrupt comment that all her family and friends were dead led to her family-friend, Colleen, reflecting on the strengths of Fran’s relationships in the past and her ability to stay positive throughout these losses, an example of family members redirecting the older adults’ story.

For older adults with fewer depressive symptoms or feelings of loneliness, the dyads validated their family bond and enhanced their understanding of one another during the FLR session. Family members enjoyed the FLR and appeared encouraged at their parents’ strength, demonstrated through their willingness to share as well as the content of memories explored. Older adults also demonstrated thankfulness during the FLR that their child was engaged and willing to connect. Dyads where the older adult had less depression or loneliness symptoms also spent more time exploring their values and how their legacy was being translated across generations. For example, one dyad discussed a recent award the older adults grandson (e.g., family members biological son) received and how the entire family came to support him. This
conversation led to a discussion of the importance of hard work in order to succeed, something the grandson learned from the older adult resident and family member, and something the entire family valued as honoring the family name.

**Family dynamics and involvement.** During the FLR, families with relational satisfaction collaborated more, provided extra details, or validated each other’s memories. Based on responses to the family involvement questionnaire, in families expressing dissatisfaction with their relationship or who disagreed about type of contact desired the older adults typically deferred to their family member to share stories or provide details.

Facilitator: *In 1957, Russia launched Sputnik, do you remember that?*

Abe (older adult): *I do*

Todd (son): *Can I interrupt? Dad, you have to tell her the story about Sputnik and your engineering professor. This is a great story.*

Abe: *What story is that, Todd?*

Todd: *You had engineering class on the Saturday morning and this guy was a real hard ass and would lock the door at 8 o’clock and would not let you in and there was always a quiz....And so, it was... well, do you wanna tell the story or do you want me to?*

Abe: *You tell it.*

Todd: *Ok? Well, you keep me honest...*

These older adults often waited until their family member answered the facilitator’s questions then agree with their perspective, as if seeking approval. Regardless if they had disagreements or not, when exploring intergenerational connections, older adults became more engaged in conversation. Discussion of intergenerational connections led to a deeper sense of legacy and meaning beyond the older adults’ individual narrative. For example, dyads explored values
among the extended family (e.g., military service, having big families, achieving educational status) and the pride they felt as a result of these values being expressed.

Family involvement and dynamics were also evident at follow-up, especially families’ interactions and their differing perspectives of the relocation. In addition, several older adults had developed new ties during this phase of life, including friendships or romantic partnerships that made them feel more connected at the ALF. For example, Rose, whose husband had died four years prior, had met someone new she connected with romantically. Her son was not pleased with the romantic partnership or Rose sharing memories of her late husband with the facilitator, suggesting a lack of openness in their dialogue or an unwillingness to expose specific memories as well as an underlying tension in their communication.

Rose: I’ve developed this new [romantic partnership] that I didn’t have before….I know more people here, yet….I think about many things [when I am lying in bed, like] getting to see my husband before he died.

Ace: Yea, so that [memory about dad’s death] is not good. Don’t think about that.

Family dynamics were evident in how families spent their time together. Three older adults preferred telephone conversations during the relocation transition whereas their family members preferred in-person contact. At follow up, these families reported that FLR had minimal influence on their relationship, which could be related to relational dissention. Families who agreed about time spent together still navigated busy schedules and other family demands but were cooperative in their conversations, speaking with ease and comfort (e.g., “whenever you want to stop by is fine, it’s an open door.”). Degrees of reconciliation and collaboration among family members also was evident. At follow up, one older adult and her daughter deviated from the questions and discussed the relocation. Although they initially had different
perspectives, through mutually reconstructing the circumstances they came to an agreement about the timing and sequence of events.

**Discussion**

FLR provided families with opportunities to mutually collaborate and spend time together during a stressful transition despite contextual challenges relevant to their relocation experience. Intervention processes included validating feelings and experiences, prompting mutual narratives, consolidation, establishing orienting points to facilitate relationship enhancement and connection, and linking current experiences and the families’ ability to discuss controversial topics. Families reported at follow up that exploring and accepting the past, in light of their current transition, enhanced their self-efficacy and decision-making. Our findings highlight benefits (e.g., open communication, enhanced relationships) similar to other life review interventions (Dahley & Sanders, 2016). FLR strengthened families’ adjustment by tying earlier life experiences to their relocation transition. In addition, our project expanded the life review process, exploring *how* families cope and adjust (e.g., acknowledging limitations, making decisions together, spending quality together). This approach provides a new lens to understanding the nuances of FLR: particularly how families experience contextual challenges during transitional times.

Several contextual factors influenced the FLR intervention. Older adults’ chronic health conditions challenged communication during the FLR session, limiting their ability to understand (e.g., hearing difficulties) or make sense of (e.g., remembering details) aspects of the session. At times, the facilitator provided older adults assistance such as reading questions aloud to older adults with vision impairments or writing answers for older adults struggling with fine motor skills. The health of our study sample mirrors the general ALF population (Ball, Kemp,
Hollingsworth, & Perkins, 2014), which suggests using creative means to connect with older adults in meaningful ways. Acknowledging the older adults’ health concerns also provides families with opportunities to work together and rely on one another.

Depressive symptoms and loneliness influenced how older adults communicated with their families and their openness in sharing. Although many older adults demonstrated joy in their individual or mutual story, it is conceivable that participants with more symptoms of depression or loneliness were less confident or hopeful regarding their life narrative. Life review has been cited as beneficial for individuals struggling with depression (Chiang et al., 2008), but the extent of influence may not be observable in session due to the life review process involving intrapersonal exploration and acceptance.

Family dynamics were evident in the ways the families communicated during FLR. Whereas most families shared their experiences in an open, mutually supporting manner, families with relationship dissatisfaction engaged in constricted communication patterns. Communication patterns develop over time, typically beginning in one’s family of origin (Gilbert, 1992) but because we did not measure communication patterns, we can only speculate that the transition was an additional strain on their relationship. Depending on families’ longtime relational patterns, communication impacted the session.

**Clinical Implications**

Clinicians are encouraged to:

1. Use pre-assessments to determine older adults’ physical and mental health status and relational involvement.

2. Use relational disagreements (e.g., differing stories about relocation) as a launching place for problem solving and reconciliation by asking the family to share, validating
their perspectives, and creating a neutral, mutual narrative. Incorporating these elements when using FLR provides facilitators with necessary information (e.g., frequency of contact) to adapt the intervention, such as focusing on family closeness and adaptability throughout the life course, to benefit the family and take advantage of opportunities (e.g., reconciliation) that formulate healthier, open dialogue and adjustment during the relocation.

**Limitations and Future Research**

FLR served as an opportunity to unite families by enhancing their relationship through ALF adjustment. However, this research is not without its limitations. First, our study included a small, homogenous sample. Implementation with more diverse samples would ensure that results are generalizable to target groups that FLR impacts. For example, exploration of socioeconomic status on relocation would address the question of how older adults’ adjustment is influenced by their financial status or the type and size of their room.

Many ALFs that were asked to participate in the project declined, limiting access to potential participants. Reasons for declining included disinterest, invasion of privacy, and skepticism of research. Future projects need to investigate barriers to ALF and families’ participation (e.g., timing of the project) to further understand the challenges that limit access to families during transitional times.

A third limitation is the one-session FLR format. Despite benefits of FLR, families reported engaging in ongoing reflection after the session and during the follow up interview, suggesting a desire for more storytelling. Additional sessions could provide space for increased depth of processing and quality time together. Future studies are needed that span relocation duration, which would provide deeper insight into ongoing family dynamics and frequency of
contact and how these aspects of relationships link to adjustment and relational satisfaction in late life.

Finally, our project highlighted the FLR process. Future studies are needed that link FLR processes to tangible outcomes. Asking families how confident they feel in coping and adjusting to life transitions before and after the FLR would provide clinicians further insights into how FLR facilitates and influences individual and family coping during significant life transitions.
References


Dahley, L. K., & Sanders, G. F. (2016). Use of a structured life review and its impact on family


Chapter 5: Discussion

The purpose of this study was to explore how participating in a family life review (FLR) could aid in family adjustment during a relocation transition to ALF. Sixteen older adults agreed to participate in a FLR session and a semi-structured follow up interview with a family member of their choice. Families reflected that they benefited from structured quality time focused on remembering and mutual reflection. Families also reported that they saw the FLR session as an opportunity to learn more, enhance their relationship, and promote new dialogue. They emphasized the importance of sharing one’s legacy before it was too late and recognized the systemic components of life that influenced their lifelong, and relocation, adjustment (e.g., family values, reciprocity). The proximal aspects of their relocation, including the older adults’ physical and mental health status and the quantity or quality of their family relationships, shaped their interactions during the FLR session. FLR is a low-cost and short-term intervention to be used by clinical gerontologists and other mental health professionals seeking to assist older adults and their families during late life relocation.

**FLR Processes and Contextual Influences**

The process of FLR, as implemented in this study, differs from other life review interventions. Historically, life review interventions have used a myriad of formats all geared toward individual growth and processes (Bohlmeijer et al., 2003; Bohlmeijer et al., 2007; Chiang et al., 2008; Haight et al., 1998), including organizing the session around developmental phases in an individual’s life or writing an autobiography. These formats do not incorporate the family system in the review process (e.g., the adults’ parents, siblings, spouse, or children) or seek to promote future review and acceptance of one’s individual or mutual narrative. Unlike other life review interventions (Chiang et al., 2008; Haight et al., 1998), the current project did not place
emphasis on developmental phases but privileged the family-level voice in determining what moments in history were most important to them. Study participants naturally gravitated toward sharing mutual experiences, suggesting that when reviewing one’s life with another person, families want to focus on life events where they have a mutual experience. For example, parent-child dyads focused on the older adults’ parenting years when their children were young rather than memories prior to the child’s birth (e.g., experiences of their own childhood, meeting their spouse). Families weaved their story together, suggesting that when engaging in mutual review, participants are less concerned with their individual story than the linking of their story to their family member. Families see FLR as an avenue for connection, and together, integrate and process how systemic influences shape their family narrative and current transition experience.

The FLR intervention provided a launching place for microhistorical conversations through the larger scope of history (Hargrave & Anderson, 1997; O’Hora, 2015). It utilized a dyadic perspective that incorporated a significant family member that was involved in the creation of the memories and relocation transition. The intent of using a dyadic, one session format was not to have families complete their narrative, but rather to encourage ongoing dialogue within the family. Orienting families through a historical dialogue reminded them of significant events they have encountered and overcame while focusing on the relocation transition. Giving families opportunities to pick and choose salient events and relate them back to their current experiences emphasized that their individual and collective life (Elder, 1998) is still moving forward. The FLR also provided insight into the concerns families have through the topics of conversation they explored before and during relocation (e.g., financial decision making, care decisions) and the importance of validating and supporting families during stressful or transitional times in life (Hanna, 2007). Participating in the FLR gave families the opportunity
to step away from the stressors of the transition and explore the richness of their life story.

Contextual factors (e.g., physical and mental health status, family involvement and dynamics) contributed to families’ experiences of FLR. Older adult’s health limitations challenged the FLR process but also presented unique opportunities for the family to demonstrate resilience and care for one another. Consistent with previous studies (Comana et al., 1998), exploring the past while understanding current life stressors (e.g., health status) can promote a reevaluation of meanings during a transitional time, leading to family coping. In the current study, some families discussed physical limitations and then explored action-plans such as deciding whether to purchase adaptable equipment for the older adult’s shower. Family adjustment and planning can be understood systemically as a process in which individual change leads to change within the entire family system (Umpleby & Dent, 1999).

As documented in other relocation studies (Kennedy et al., 2005; Winningham & Pike, 2007), some of the older adults participants expressed symptoms of depression and loneliness. Older adults were keenly aware of their changing social networks and often looked to family members to supplement their social desires (Tompkins et al., 2015). FLR connected families and supported their relationship by linking specific memories and experiences to their mutual bond. In addition, FLR reminded families that social networks are ever-changing (e.g., during prior relocation transitions, job changes, educational opportunities, retirement, death or loss). Family members affirmed older adults’ feelings of isolation or loss but also redirected these feelings to emphasize resilience and strength. Families were able to use the FLR as an opportunity to process and accept that relocation was another transitional time that required the adjustment of social expectations.

Most families appeared to enjoy the FLR experience and did not engage in arguments or
become combative during the session. Families who expressed dissatisfaction with their relationship shared their differing perspectives on events in the past or the relocation transition, which provided opportunities for familial reconciliation, which can lead to greater life satisfaction (Bohlmeijer et al., 2007). These families appeared to need space to explore the aspects of the relocation during the FLR and spent time sorting out how the relocation came to be and how they were going to move forward. One family discussed the idea of not holding resentments but trying to remain positive during this season of life. Other families had disagreements about shared experiences from the past. Processing these memories and incorporating each individual’s lens added room for a more comprehensive narrative that cannot be derived only from an individual lens.

The ways in which families communicated (e.g., interrupting each other, supplementing stories, or remaining quiet) highlighted underlying relationship dynamics. It is unclear whether participation in FLR fostered or provided a safe space where both positive and negative interaction could occur or if other factors (e.g., personalities, stress, long-term interaction patterns) were the underlying impetus for the ways in which families interacted. Regardless, the life review process provided opportunities for families to reconcile and address relationship concerns. Dahley and Sanders (2016) found that life review in the presence of a family member can bridge geographically distant relationships. However, they did not explore whether these relationships experienced tension or dissatisfaction as a result of the distance. Family members in the current study who reported dissatisfaction with their relationships also described benefits of the FLR (e.g., enhanced their relationship, promoted family values, enjoyable), suggesting that while FLR may not change family members’ satisfaction with their relationship, FLR may be a stepping-stone toward relational satisfaction or healing.
The format of the FLR allowed families to touch on relocation decisions or needs without becoming overwhelmed or emotionally taxed. In prior research, older adults with greater acceptance of their circumstances (e.g., physical health status, relocation decision-making) and an existing network (e.g., social support that was available before the transition) expressed more confidence in decision-making and in adapting to the facility (Kennedy et al., 2005). Similarly, families in the current study who expressed greater acceptance of the circumstances and stronger connection with one another appeared to navigate decision-making with greater confidence as evident by their mutual ability to discuss and problem solve the instrumental and relational aspects of relocation. During the FLR, families surrounded relocation conversations in the strengths they saw in one another, their resilience in overcoming other transitions together, and in general positive storytelling. Findings suggest the value of the FLR as a tool for de-escalating as well as merging decision-making into life gains.

**Limitations and Future Research**

The parameters and limitations of the current research provide insight into avenues for future research. The study sample was small and fairly homogenous with respect to age, gender, race, and socioeconomic status. Although a benefit of homogeneity is to provide an accurate and rich description of a particular group of people (Patton, 1990), results are more generalizable when implemented with diverse samples because the project covers breadth of background and experience. For example, exploration of socioeconomic status on relocation may provide insight into how older adults’ adjustment is influenced by their financial status, the size of their room, or level of care received. In addition, the events used to facilitate the FLR targeted mostly relevant United States history. At times, families who had lived abroad or grew up in another country focused on relevant historical events from other countries. As such, the FLR can be adapted for
cultural relevance including information from the specific country, origin, or culture most important to the family.

Although the study sample was small, findings from the exploratory analyses suggested that family dynamics present before a relocation transition are maintained throughout the late life relocation process. The majority of older adults and family members agreed on the amount, type, and frequency of contacted they had as well as satisfaction with their relationship throughout the relocation transition. Understanding more about family dynamics would provide insight into how FLR benefits families during relocation and other late life transitions.

All of the families in this study participated in the same FLR process. Without a comparison group, it is difficult to discern whether outcomes of the FLR session were a result of the intervention or other variables. Randomized control trials are needed to statistically test the influence of FLR on the relocation transition. Use of an intervention group, active control, and no treatment group would provide such an opportunity.

Knowing when and how to intervene with families can be challenging. For this study, the FLR was facilitated in the midst of the relocation. Projects facilitating FLR before the relocation transition or substantial decision-making (e.g., which ALF to choose) are needed to further explore the effectiveness of the timing of the intervention. It could be argued that employing FLR after the actual move to ALF means that families have already overcome one of the most challenging aspects of the relocation. Comparing FLR implementation and outcomes at different phases of the adjustment would help practitioners identify when it is best to intervene with families. Similarly, research is needed to explore how session length influences long-term results. Employing a comparison study with FLR in single and multi-session format is needed to assess if similar results are produced in a shorter format. Further, studies exploring short term
and long term results are necessary to examine whether the benefits of FLR are sustainable throughout the relocation transition and into subsequent transitions.

**Clinical Implications**

For practitioners working with family systems, FLR is an easy to use tool and opportunity to assist families during late life transitions. Despite the often challenging and discouraging components of transitions, families are resilient. Families in this study demonstrated during the FLR an ability to work together, to share memories, and to reflect on their mutual life stories. These processes led to families reflecting on feeling empowered, validated, and positive. As evident in the FLR, dyads were able to frame the transition as comparable to other life transitions thus encouraging their adjustment process. Clinicians implementing FLR in late life have the opportunity to provide families time to pause from their current stressors and focus on their connection as a family unit across the life course.

Clinicians already working with a family during a transitional time (e.g., retirement, caregiving, relocation, death of spouse) can use prior knowledge to adapt the FLR in meaningful ways for the family system. Having this knowledge, or completing an assessment before the FLR, provides clinicians with valuable information regarding when to intervene and how to empower the family. In addition, incorporating these elements when using FLR provides facilitators with necessary information (e.g., relationship satisfaction) to adapt the intervention in ways that benefit the family and takes advantage of opportunities (e.g., reconciliation) to formulate healthier dialogue and adjustment during the relocation.

A strength of the FLR intervention is its brevity. Many life review interventions occur over six to ten weeks. Similarly, working with families in a private practice or group setting, or facilitating in-home therapy often involves numerous sessions. The 90-minute, one session FLR
intervention format, provides families with an avenue to review without overwhelming them during the stressful transition of relocation. FLR interventions may provide families with a positive boost that provides them relief from proximal needs while giving encouragement. As such, the benefits of this intervention format are both cost and time effectiveness for practitioners, researchers, and families. Knowing that transitional times are heightened with anxiety, stress, and responsibilities, clinicians can facilitate FLR briefly during the transition, giving families an opportunity to decompress, connect, and feel encouraged early in the process. Facilitating FLR during the transition, and encouraging longer and more FLR sessions later during the adjustment, could provide families with necessary relief to address instrumental and relational concerns.

Although I acknowledge that having a background in mental health may have aided in my ability to work with families in this project, there is benefit to the simplicity and brevity of the intervention. FLR can be facilitated by nurses, social workers, activities coordinators, or other professionals working directly with older adults. With basic FLR training, including session dynamics and skill building such as reflective listening, validation, and drawing parallels between mutual stories, practitioners can incorporate FLR into existing programs within ALF and elsewhere in a time and cost effective way.
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*Seniors Housing & Care Journal, 21*, 21-35.


27.1.6

Appendix A
Inclusion Criteria Measures

Inclusion Criteria Checklist

1. Age 65 or older: yes/no
   a. Age:

2. Able to speak and read English: yes/no

3. Cognitive able to participate as determined by the Mini-Cog: demented/not demented

4. Physical stamina (self-report) to complete assessment questionnaires: yes/no

5. Agree to participate in the life review session and follow-up interview (intervention group only), with a non-spouse family member who is 21 years of age or older: yes/no
   a. Identified family member:
   b. Contact information:
Instructions – The following questions are designed to gather background information about you. Please circle the response that best describes you.

1. Please circle:
   a. Male
   b. Female

2. Which of the following best describes your ethnic background?
   a. Hispanic or Latino (includes persons of Cuban, Mexican, Puerto Rican, South American, Central American, or Spanish culture)
   b. Not Hispanic or Latino

3. Which of the following best describes your race? (circle all that apply)
   a. White/Caucasian
   b. Black or African American
   c. Native Hawaiian or other Pacific Islander
   d. American Indian or Alaska Native
   e. Asian
   f. Other (specify)______________________

4. How old are you? _____ years

5. How many years of school did you complete?
   a. 1-8 (elementary school)
   b. 9-12 (high school or GED)
   c. Trade, vocational, or community college program
d. 1-3 years of college

e. College graduate

f. Graduate school/professional school

6. What is your current marital status?

a. Married/partnered

b. Widowed _____ years

c. Divorced/separated

d. Never married

7. Are you currently...

a. Employed full-time for pay

b. Employed part-time for pay

c. Retired

d. Unemployed

e. A homemaker

f. Something else (specify) ________________________

8. Number of children? _______ children

9. Number of years living in previous home? ______ years

10. Distance between previous home and assisted living facility? ______ miles
Katz Index of Independence in Activities of Daily Living

Instructions – Please read the following narratives and place a checkmark in either the independence or dependence column for each activity.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Independence</th>
<th>Dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BATHING</strong></td>
<td>NO supervision, direction or personal assistance.</td>
<td>WITH supervision, direction, personal assistance, or total care.</td>
</tr>
<tr>
<td></td>
<td>Do you bathe yourself completely? Or, need help in bathing only a single part of the body such as the back, genital area or disabled extremity?</td>
<td>Do you need help with bathing more than one part of the body, getting in or out of the tub or shower? Or, do you require total bathing?</td>
</tr>
<tr>
<td><strong>DRESSING</strong></td>
<td>Do you get clothes from closets and drawers and put on clothes and outer garments complete with fasteners? Do you need help tying shoes?</td>
<td>Do you need help with dressing yourself or need to be completely dressed?</td>
</tr>
<tr>
<td><strong>TOILETING</strong></td>
<td>Do you go to the toilet, get on and off, arrange clothes, and clean your genital area without help?</td>
<td>Do you need help transferring to the toilet, cleaning self or use a bedpan or commode?</td>
</tr>
<tr>
<td><strong>TRANSFERRING</strong></td>
<td>Do you move in and out of bed or chair unassisted? Do you use mechanical transfer aids?</td>
<td>Do you need help in moving from bed to chair or require a complete transfer?</td>
</tr>
<tr>
<td><strong>CONTINENCE</strong></td>
<td>Do you exercise complete control over urination and defecation?</td>
<td>Are you partially or totally incontinent of your bowel or bladder?</td>
</tr>
<tr>
<td><strong>FEEDING</strong></td>
<td>Do you get food from a plate into your mouth without help? Does someone help prepare your food?</td>
<td>Do you need partial or total help with feeding or require parenteral feeding?</td>
</tr>
</tbody>
</table>
Lawton – Brody Instrumental Activities of Daily Living Scale (IADL)

Instructions – Please read the following statements and circle the item description that most closely resembles your highest functional level.

**Scoring:** For each category, circle the item description that most closely resembles your highest functional level (either 0 or 1).

<table>
<thead>
<tr>
<th>A. Ability to Use Telephone</th>
<th>E. Laundry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I operate a telephone on my own initiative—look up and dial numbers, etc.</td>
<td>1. I do my own personal laundry completely</td>
</tr>
<tr>
<td>2. I dial a few well-known numbers</td>
<td>2. I launder small items—rinse stockings, etc.</td>
</tr>
<tr>
<td>3. I answer the telephone but not dial</td>
<td>3. All my laundry is done by others</td>
</tr>
<tr>
<td>4. I do not use telephone at all</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B. Shopping</th>
<th>F. Mode of Transportation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I take care of all shopping needs independently</td>
<td>1. I travel independently on public transportation or drive my own car</td>
</tr>
<tr>
<td>2. I shop independently for small purchases</td>
<td>2. I arrange my own travel via taxi, but do not otherwise use public transportation</td>
</tr>
<tr>
<td>3. I need to be accompanied on any shopping trip</td>
<td>3. I travel on public transportation when accompanied by another</td>
</tr>
<tr>
<td>4. I am unable to shop independently</td>
<td>4. My travel limited to taxi or automobile with assistance of another</td>
</tr>
<tr>
<td>5. I do not travel at all</td>
<td>5. I do not travel at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Food Preparation</th>
<th>G. Responsibility for Own Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I plan, prepare and serve adequate meals independently</td>
<td>1. I am responsible for taking medication in correct dosages at correct time</td>
</tr>
<tr>
<td>2. I prepare adequate meals if supplied with ingredients</td>
<td>2. I take responsibility if medication is prepared in advance in separate dosage</td>
</tr>
<tr>
<td>3. I heat, serve and prepare meals, or prepare meals, but do not maintain adequate diet</td>
<td>3. I am not capable of dispensing own medication.</td>
</tr>
<tr>
<td>4. I need to have meals prepared and served.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D. Housekeeping</th>
<th>H. Ability to Handle Finances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I maintain my house alone or with occasional assistance (e.g., “heavy work domestic help”)</td>
<td>1. I manage financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collect and keep track of income</td>
</tr>
<tr>
<td>2. I perform light daily tasks such as dish washing, bed making</td>
<td>2. I manage day-to-day purchases, but need help with banking, major purchases, etc.</td>
</tr>
<tr>
<td>3. I perform light daily tasks but cannot maintain acceptable level of cleanliness</td>
<td>3. I am incapable of handling money</td>
</tr>
<tr>
<td>4. I need help with all home maintenance tasks</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>5.</td>
<td>I do not participate in any housekeeping tasks.</td>
</tr>
</tbody>
</table>
Older Adult Health Status

1. Overall, how would you rate your current health status? (circle one)

<table>
<thead>
<tr>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

2. Do you have any of the following health conditions?

1. cancer, a malignant tumor or leukemia? 1. Yes 0. No
2. chronic lung disease such as chronic bronchitis, emphysema, or asthma? 1. Yes 0. No
3. depression? 1. Yes 0. No
4. diabetes or high blood sugar? 1. Yes 0. No
5. heart attack, by-pass/valve surgery, stroke, etc? 1. Yes 0. No
6. high blood pressure or hypertension? 1. Yes 0. No
7. memory problems? 1. Yes 0. No
8. osteoporosis? 1. Yes 0. No
9. stomach or intestinal disorders? 1. Yes 0. No
10. Do you have any other health problems that have not mentioned? 1. Yes 0. No
The Center for Epidemiological Studies Depression Scale (CES-D Scale)

Instructions: Below is a list of the ways you might have felt or behaved during the past week. Please indicate how often you have felt this way **during the past week** by checking the appropriate box.

- Rarely or None of the Time (Less than 1 Day)
- Some or Little of the Time (1-2 Days)
- Occasionally or a Moderate Amount of Time (3-4 Days)
- Most of All of the Time (5-7 days)

<table>
<thead>
<tr>
<th>During the past week</th>
<th>RARELY or none of the time (less than one day)</th>
<th>SOME or a little of the time (1-2 days)</th>
<th>OCCASIONALLY or a moderate amount of time (3-4 days)</th>
<th>MOST or all of the time (5-7 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I was bothered by things that usually don’t bother me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I did not feel like eating; my appetite was poor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I felt that I could not shake off the blues even with help from my family or friends.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I felt that I was just as good as other people.*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I had trouble keeping my mind on what I was doing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I felt depressed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I felt that everything I did was an effort.</td>
<td></td>
<td></td>
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<td>---</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>I felt hopeful about the future.*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I thought my life had been a failure.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I felt fearful.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>My sleep was restless.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>I was happy.*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>I talked less than usual.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>People were unfriendly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>I enjoyed life.*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td>I had crying spells.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td>I felt sad.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
19. I felt that people dislike me.

20. I could not get “going.”

Scoring:
Asterisked (*) items are reversed (i.e., Rarely = 3, Some = 2, Occasionally = 1, Most = 0).
Responses to each item are summed; higher scores indicate greater degrees of depression.
UCLA Loneliness Scale (Version 3)

Instructions: The following statements describe how people sometimes feel. For each statement, please indicate how often you feel the way described by circling a number in the space provided. Here is an example:

How often do you read the newspaper?
If you never felt happy, you would circle “1”; if you always feel happy, you would circle “4.”

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>NEVER</th>
<th>RARELY</th>
<th>SOMETIMES</th>
<th>ALWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How often do you feel that you are “in tune” with the people around you?*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. How often do you feel that you lack companionship?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. How often do you feel that there is no one you can turn to?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. How often do you feel alone?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. How often do you feel part of a group of friends?*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. How often do you feel that you have a lot in common with the people around you?*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. How often do you feel that you are no longer close to anyone?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. How often do you feel that your interests and ideas are not shared by those around you?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. How often do you feel outgoing and friendly?*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. How often do you feel close to people?*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. How often do you feel left out?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. How often do you feel that your relationships with others are not meaningful?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
13. How often do you feel that no one really knows you well?  1  2  3  4

14. How often do you feel isolated from others?  1  2  3  4

15. How often do you feel you can find companionship when you want it?  1  2  3  4

16. How often do you feel that there are people who really understand you?  1  2  3  4

17. How often do you feel shy?  1  2  3  4

18. How often do you feel that people are around you but not with you?  1  2  3  4

19. How often do you feel that there are people you can talk to?*  1  2  3  4

20. How often do you feel that there are people you can turn to?*  1  2  3  4

**Scoring:**

Asterisked (*) items are reversed (i.e., 1 = 4, 2 = 3, 3 = 2, 4 = 1). Responses to each item are summed; higher scores indicate greater degrees of loneliness.

Adult Family Member Demographic Information

Instructions – The following questions are designed to gather background information about you. Please circle the response that best describes you.

1. Please circle:
   a. Male
   b. Female

2. Which of the following best describes your ethnic background?
   a. Hispanic or Latino (includes persons of Cuban, Mexican, Puerto Rican, South American, Central American, or Spanish culture)
   b. Not Hispanic or Latino

3. Which of the following best describes your race? (circle all that apply)
   a. White/Caucasian
   b. Black or African American
   c. Native Hawaiian or other Pacific Islander
   d. American Indian or Alaska Native
   e. Asian
   f. Other (specify)______________________

4. How old are you? _____ years

5. How many years of school did you complete?
   a. 1-8 (elementary school)
   b. 9-12 (high school or GED)
   c. Trade, vocational, or community college program
   d. 1-3 years of college
e. College graduate
f. Graduate school/professional school

6. What is your current marital status?
   a. Married/partnered
   b. Widowed _____ years
   c. Divorced/separated
   d. Never married

7. Are you currently...
   a. Employed full-time for pay
   b. Employed part-time for pay
   c. Retired
   d. Unemployed
   e. A homemaker
   f. Something else (specify) ________________________

8. Number of children? _______ children

9. Relation to resident? _______

10. Travel time to facility? _____miles _____ minutes
Family Involvement and Contact Questionnaire: Pre-admission

Instructions – please read the questions below and circle the response that most closely resembles your experience.

Thinking about the year prior to your or your family member’s move to the assisted living facility, approximately:

1. How many hours did you spend, in person, with your family member per month?
   a. 0-10 hours per month
   b. 11-20 hours per month
   c. 21-30 hours per month
   d. 30+ hours per month

2. How long did your in-person visits with your family member last?
   a. Less than one hour
   b. 1-2 hours
   c. 2-3 hours
   d. 3+ hours

3. How many times per month did you have any type of contact with your family member?
   a. 0-5 times per month
   b. 6-10 times per month
   c. 11-15 times per month
   d. 15+ times per month

4. How many hours per month did you spend in communicating with your family member by:
   a. Telephone
i. 0-2 hours per month  
ii. 3-5 hours per month  
iii. 5+ hours per month  

b. Emails  
   i. 0-2 hours per month  
   ii. 3-5 hours per month  
   iii. 5+ hours per month  

c. Facetime, Skype, or video chat  
   i. 0-2 hours per month  
   ii. 3-5 hours per month  
   iii. 5+ hours per month  

5. What was your preferred method of contact with your family member? Circle one.  
   a. Telephone calls  
   b. Emails  
   c. In person visits  
   d. Facetime, Skype, or video chat  

6. How satisfied were you with your communication (in person or otherwise) with your family member? Circle one.  
   a. Very satisfied  
   b. Satisfied  
   c. Dissatisfied  
   d. Very dissatisfied
Family Involvement and Contact Questionnaire: Admission

Instructions – Instructions – please read the questions below and circle the response that most closely resembles your experience.

Since your or your family member’s move to the assisted living facility, approximately:

1. How many hours do you spend, in person, with your family member per month?
   a. 0-10 hours per month
   b. 11-20 hours per month
   c. 21-30 hours per month
   d. 30+ hours per month

2. How long do your in-person visits with your family member last?
   a. Less than one hour
   b. 1-2 hours
   c. 2-3 hours
   d. 3+ hours

3. How many times per month do you have any type of contact with your family member?
   a. 0-5 times per month
   b. 6-10 times per month
   c. 11-15 times per month
   d. 15+ times per month

4. How many hours per month do you spend in communicating with your family member by:
   a. Telephone
      i. 0-2 hours per month
ii. 3-5 hours per month

iii. 5+ hours per month

b. Emails
   i. 0-2 hours per month
   ii. 3-5 hours per month
   iii. 5+ hours per month

c. FaceTime, Skype, or video chat
   i. 0-2 hours per month
   ii. 3-5 hours per month
   iii. 5+ hours per month

5. What is your preferred method of contact with your family member? Circle one.
   a. Telephone calls
   b. Emails
   c. In person visits
   d. FaceTime, Skype, or video chat

6. How satisfied are you with your communication (in person or otherwise) with your family member? Circle one.
   a. Very satisfied
   b. Satisfied
   c. Dissatisfied
   d. Very dissatisfied
Family Involvement and Contact Questionnaire: Post-admission

Instructions – please read the questions below and circle the response that most closely resembles your experience.

In the past month, approximately:

1. How many hours did you spend, in person, with your family member per month?
   a. 0-10 hours per month
   b. 11-20 hours per month
   c. 21-30 hours per month
   d. 30+ hours per month

2. How long did your in-person visits with your family member last?
   a. Less than one hour
   b. 1-2 hours
   c. 2-3 hours
   d. 3+ hours

3. How many times per month did you have any type of contact with your family member?
   a. 0-5 times per month
   b. 6-10 times per month
   c. 11-15 times per month
   d. 15+ times per month

4. How many hours per month did you spend in communicating with your family member by:
   a. Telephone
      i. 0-2 hours per month
ii. 3-5 hours per month
iii. 5+ hours per month

b. Emails
   i. 0-2 hours per month
   ii. 3-5 hours per month
   iii. 5+ hours per month

c. FaceTime, Skype, or video chat
   i. 0-2 hours per month
   ii. 3-5 hours per month
   iii. 5+ hours per month

5. What was your preferred method of contact with your family member? Circle one.
   a. Telephone calls
   b. Emails
   c. In person visits
   d. FaceTime, Skype, or video chat

6. How satisfied were you with your communication (in person or otherwise) with your family member? Circle one.
   a. Very satisfied
   b. Satisfied
   c. Dissatisfied
   d. Very dissatisfied
Appendix C
Family Life Review Intervention

The Life Validation Interview

Directions: Begin the session with an introduction of The Life Validation Interview. Proceed through the significant events in chronological order asking questions and allowing clients to elaborate on specific memories, even if not connected to the macrohistorical event. Personal stories, memories, and connections with relationships and events are encouraged. Consider adding or taking out specific events when appropriate.

1945  Hilter commits suicide.
       Hiroshima & Nagasaki are bombed.
1948  Margaret Sanger founds the International Planned Parenthood Federation.
1953  Color television is introduced in the U.S.
1954  Brown versus Board of Education unanimously bans racial segregation in public schools.
       The World Series is broadcast in color for the first time.
1955  Rosa Parks refuses to sit at the back of the bus in Montgomery, Alabama.
1957  Russia launches Sputnik I.
1959  Alaska and Hawaii become states.
1960  John F. Kennedy becomes president.
       Vietnam War.
       Black sit-in at Greensboro, NC diner
       90 percent of US homes have a television set.
       Alfred Hitchcock’s Psycho comes out in the movies.
       Harper Lee’s To Kill a Mockingbird is published.
1961  The United States breaks diplomatic relations with Cuba.
1962  Marilyn Monroe dies at age 36.
       William Faulkner dies.
       Eleanor Roosevelt dies.
1963  US Supreme Court rules no locality may require recitation of Lord’s Prayer or Bible verses in public schools.
       President John F. Kennedy shot and killed in Dallas, Texas.
1965  Martin Luther King Jr. arrested in Selma, Alabama.
       Malcom X shot to death at Harlem rally.
1966  The Sound of Music premieres.
       Star Trek episode premiers.
       The birth control pill is considered safe for use.
       Walt Disney dies.
1968  Martin Luther King Jr. dies in Memphis.
       Helen Keller dies.
1969  First man on the moon.
1970  Kent State killings, four students die.
       The Beatles break up.
Jimi Hendrix & Janis Joplin both die.
IBM introduces the floppy disk.

1971
Voting age is lowered to 18.

1972
US Supreme Court rules that death penalty is unconstitutional.
M*A*S*H premieres on CBS.
The Godfather movie comes out.
Prozac is developed.
Watergate scandal.

1973
Roe V. Wade

1974
Richard Nixon announces resignation (first president to do so).

1975
President Ford escapes two assignation attempts.

1977
Star Wars released in movie theaters.
Elvis Presley dies.

1980
Ronald Reagan elected.
John Lennon is killed.

1981
First female is elected to US Supreme court.
AIDS is identified.
MTV “Video Killed the Radio Star” is the first music video to be broadcasted.
IBM introduces its first personal computer.

1982
Michael Jackson releases “Thriller.”
E.T. comes out in move theaters.

1984
The Cosby Show debuts.

1985
Ronald Reagan is 73 when he sworn in his second term.
Titanic wreckage is found.

1986
Challenger space shuttle explodes.
FOX news launched.
The Oprah Winfrey show is launched.

1987
DNA is used for the first time to convict criminals.
Prozac is introduced.
Biggest stock crash in history; Black Monday

1988
George Bush wins the election.
U2 wins album of the year.

1989
Berlin Wall falls.
San Francisco Bay experiences an earthquake of 7.1 magnitude.
Lucille Ball dies.

1990
Hubble space telescope is launched.
Nelson Mandela freed after 27.5 years.
B.F. Skinner dies.

1991
Collapse of the Soviet Union.

1992
Rodney King is beaten in Los Angeles.
Bill Clinton is elected as president.

1993
Michael Jackson is accused of fondling a 13-year old boy.
World trade center bombed with a van in the bottom garage.
OJ Simpson is arrested in for killing his wife.
Major league baseball players strike.

1995
Oklahoma City Bombing.
1997  Princess Diana dies in high-speed car chase.  
Titanic is released as a movie.  
Ellen DeGeneres announces to the public that she is gay.  
Harry Potter and the Sorcerer’s Stone novel comes out.  
Mother Theresa dies.  
1998  President Clinton accused in sex scandal.  
1999  Columbine high school massacre.  
2000  Mad cow disease alarms Europe.  
Elian Gonzalez, Cuban boy, reunited with father.  
George Bush Junior wins election with the closest race in history.  
2001  World Trade Centers are hit by terrorists.  
First anthrax scare.  
2002  DC Snipers kill ten people.  
Johnny Unitas dies.  
2003  Baghdad falls to U.S. troops.  
Johnny Cash dies.  
2004  Gay Marriage is legalized in Massachusetts, the first state in the country to legalize such unions.  
2005  Hurricane Katrina strikes New Orleans.  
London bombings.  
2007  Virginia Tech shooting takes 32 lives.  
2008  President Obama is elected.  
2009  Michael Jackson dies.  
2010  Haiti earthquake strikes.  
Earthquake in Chile.  
BP Oil explosion in the gulf.  
Obama proposes the new American health-care system.  
2011  Osama Bin Laden is assassinated.  
Kate Middleton marries Prince William.  
Joplin tornado wrecks small town.  
New York passes a law to allow same-sex marriage.  
Japan hit by major earthquake.  
Elizabeth Taylor dies.  
2012  Whitney Huston dies.  
2013  Prince George is born to the Royal family.
Appendix D
Follow Up Measures

Semi-structured Follow-up Interview Questions

Instructions for the researcher – Use the following questions as guiding conversation starters regarding the experience of family life review, relocation, loneliness, and family involvement.

1. Sometimes when we participate in something like a family life review it can influence other aspects of our lives. Tell me how participating in the life review has influenced you (older adult/family member) and your relationship with one another.

   Probe (older adult): How did your participation influence how you feel about living in this facility…

   Probe (family member): How did your participation influence how you feel about your loved one living in this facility…

   Probe (older adult/family member): Perhaps the life review influenced your involvement with family members…

   Probe (older adult/family member): How did the life review influence how you think about yourself . . .

   Probe (older adult): How did the life review influence how you think about your experience with loneliness…

2. There were a lot of interesting things we talked about when we did the life review. Tell me more about something from that day that stands out that was __________ (meaningful; challenging).

3. Perhaps something has come up since our life review session that you and (family member name) have gone through, that is __________ (meaningful; challenging). Tell me about this experience. Why does it stand out? How has it influenced the way you interact...
with one another?

4. Sometimes when we talk about things in front of another person it can be similar and/or different than if we just think about it. Tell me how participating in life review with family is similar or different than just thinking about your life by yourself . . .

   Probe (older adult/family member): Tell me how participating in life review with family is similar or different than sharing events with me or others who don’t know you well...

5. Tell me what your liked best or liked least about the session…

6. What, if anything, would you share with a family who is interested in participating in family life review as they go through a relocation transition?

7. How do you think the family life review session will influence your future…[adjustment to living here, family involvement in your life, experience of loneliness]?
Appendix E
Qualitative Content Analysis

Table A1

*Qualitative Codes*

<table>
<thead>
<tr>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Life review is enjoyable</td>
</tr>
<tr>
<td>1.2 Life review provides new perspective (e.g., new insights, memories evolve/change)</td>
</tr>
<tr>
<td>1.3 Life review influences self-awareness and acceptance (e.g., fragility of life, one's own narrative/story, endure circumstances, reinforces resilience, less sadness, grateful for life)</td>
</tr>
<tr>
<td>1.4 Life review enhances relationships (e.g., promotes intergenerational connectivity, validates relationship, reinforces narratives, prompts collaboration)</td>
</tr>
<tr>
<td>1.5 Life review prompts re-storying and reconciliation</td>
</tr>
<tr>
<td>1.6 Life review prompts new conversation (e.g., triggers, conversations about planning, what's coming in the future?)</td>
</tr>
<tr>
<td>1.7 Make time before it's too late to share the memories</td>
</tr>
<tr>
<td>2.1 Life review brings back difficult memories (e.g., content of memories)</td>
</tr>
<tr>
<td>2.2 Life review process is taxing (e.g., process of sharing memory, recognizing good memories are gone, acknowledging people have died and social supports are decreasing)</td>
</tr>
<tr>
<td>3.1 Life review has minimal influence (e.g., older adult forgot, effects cannot be directly seen)</td>
</tr>
<tr>
<td>3.2 Life review has minimal influence on self (e.g., perspective, daily routine, emotions, historical events have little influence on personhood)</td>
</tr>
<tr>
<td>3.3 Life review has minimal influence on family relationship and/or involvement</td>
</tr>
<tr>
<td>3.4 Life review has minimal influence on living in ALF</td>
</tr>
<tr>
<td>3.5 There is more to explore (e.g., memories)</td>
</tr>
<tr>
<td>4.1 Quality time enhances families</td>
</tr>
<tr>
<td>4.2 Memorbilia triggers memories</td>
</tr>
<tr>
<td>4.3 Giving to one another (e.g., reciprocity in relationship)</td>
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<tr>
<td>4.4 Family pride (e.g., values)</td>
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<tr>
<td>4.5 Observing emotional state</td>
</tr>
<tr>
<td>4.6 Recognizing self-worth</td>
</tr>
<tr>
<td>5.1 Keeps some things private (e.g., painful memories, not open to process, no point, memories w/ people who are dead, OAs feel story is only interesting to them)</td>
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<tr>
<td>5.2 Continue sharing (e.g., open to sharing, wants to share more, obligation to share legacy, recommends others do LR, positive experience, already engaging in self-processing)</td>
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<tr>
<td>5.3 Less value with stranger</td>
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<tr>
<td>5.4 Stranger is unbiased</td>
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<tr>
<td>5.5 Not engaging in individual life review (e.g., too busy, not a lot of triggers to prompt recall)</td>
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Table A2

*Qualitative Categories and Code Numbers*

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<td>5.1 – 5.5</td>
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<td>Relocation Processes</td>
<td>7.1 – 7.3</td>
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<tr>
<td>Confronting reality of circumstances</td>
<td>8.1 – 8.3</td>
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Table A3

**Qualitative Categories and Themes**

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<td>Family Dynamics</td>
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<tr>
<td>Role of life review process in one's life</td>
<td>Seeing Self in Systems</td>
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<td>Critique of the research</td>
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<tr>
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Appendix F
Exploratory Analyses

Research Questions 1 & 2

Research question 1: How Does Participation in a Family Life Review Intervention Influence Loneliness Among Older Adults Residing in Assisted Living?

Hypothesis 1: Participating in the family life review intervention will decrease loneliness in older adults. A paired samples t-test was conducted to compare older adults’ pre-test loneliness scores and post-test loneliness scores. Although mean loneliness scores were lower following the family life review session, the difference in older adults’ loneliness scores before ($M = 39.42, SD = 9.88$) and after ($M = 37.17, SD = 9.94$) the family life review session $t(11) = 1.02, p = .328$ was not significant.

Research Question 2: How Does Participation in a Family Life Review Intervention Influence Family Involvement Between Older Adults Residing in Assisted Living and Their Adult Relative?

Hypothesis 2: Participating in the family life review intervention will increase amount, frequency, type, and satisfaction with contact between older adults and an adult (non-spouse) relative. Due to the small sample size, frequencies were used for questions one through four to describe the data and participants’ experiences over time. Each component of older adults’ and their family members’ perspective regarding involvement (e.g., amount, frequency, type) was examined separately.

For question one regarding how many hours older adults and family members were spending together, in-person per month, the majority of older adults reported spending between none and ten hours with their family member at pre-admission (n=6) and admission (n=9) (e.g., Table F1, Table F2). At post-admission older adults scores were more evenly distributed across
0-10 hours (n=4), 11-20 hours (n=3), 21-30 hours (n=4), and over thirty hours (n=1) (e.g., Table F3). Similarly, at pre-admission the majority of family members reported spending between none and ten hours together in-person per month (n=7) (e.g., Table F4), which was consistent at admission as well (n=7) (e.g., Table F5). At post-admission, family members reported spending between 0-10 hours (n=5) and 11-20 hours (n=5), only two family members reported spending between 21-30 hours together. One family member reported spending over thirty hours together a month at post-admission (e.g, Table F6).

Question two targeted the length of time family members spent together during their in-person visits. At pre-admission, older adults were split mostly between reporting spending 1-2 hours (n=5) and over three hours (n=5) (e.g., Table F7). Yet, at admission the majority (n=9) of older adults reported spending between 1-2 hours together (e.g., Table F8), which slightly decreased by post-admission (n=6) (e.g., Table F9). Contrary to older adults, the majority of family members (n=11) reported spending over three hours together during any designated visit (e.g., Table F10). During admission family members (n=7) reported spending less time together (e.g., 1-2 hours) during a visit (e.g., Table F11). This could be related to older adults needing more care prior to relocation but being able to rely more on the ALF during the actual move. Yet, by post-admission the majority of family members (n=6) reported 2-3 hour visits with the older adult (e.g., Table F12).

Question three sought to understand the frequency of contact (e.g., How many times per month did you have any type of contact with your family member?). Expanding upon question two, I wanted to better understand the quantity of contact versus the duration or quality of contact. At pre-admission and post-admission the majority of older adults (n=6) reported fifteen or greater contacts with their family member per month (e.g., Table F13, Table F15). At
admission the number of older adults reporting contact of fifteen times of month or more temporarily grew (n=9) (e.g., Table F14). For family members, frequency of contact with the older adult was split. Six family members reported zero to five and seven reported fifteen or more contacts per month at pre-admission (e.g., Table F16). At admission, family members (n=6) were mostly reporting between 6-10 contacts per month (e.g., Table F17). Whereas, at post-admission family members’ responses were more evenly spread: 0-5 contacts per month (n=4), 6-10 contacts per month (n=4), fifteen or more contacts per month (n=5) (e.g., Table F18).

Question four explored the amount of time spent using a particular form of contact (e.g., telephone, email, or video chat). Older adults and family members reported, other than in-person visits, most frequently telephone contact. Email and video contact was rare for both older adults and family members. Older adults (n=7) reported spending over five hours a month at pre-admission on the telephone with their family member (e.g., Table F19). At admission (n=7) and post-admission (n=7) older adults reported spending less time on the telephone together (e.g., Table F20, Table F21). Family members’ responses mirrored older adults’. The majority of family members (n=8) reported spending more than five hours on the telephone at pre-admission (e.g., Table F22). At admission, family members’ reports were spread between 0-1 hours per month (n=6), 3-5 hours per month (n=6), and more than five hours per month (n=4) (e.g., Table F23). Yet, at post-admission family members (n=9) were strongly reporting between 0-2 hours on the telephone per month (e.g., Table F24).

Question five (e.g., What was your preferred method of contact with [relatives name]?), was used for descriptive purposes only and was not be used to test hypothesis two. Frequencies demonstrate that older adults and family members prefer in-person contact with their relative during each phase of relocation (e.g., Tables F37-42).
Question six was analyzed using a one-way ANOVA, measuring participants’ relationship satisfaction rating over time (e.g., pre-admission, admission, and post-admission) to determine if there was a statistically significant difference between each time point. There was no statistically significant difference between older adults’ pre-admission, admission, and post admission scores ($p = .836$) (e.g., Table F43). There was also no statistically significant difference between family members’ pre-admission, admission, and post admission scores ($p = .29$) (e.g., Table F45). Participants’ relationship satisfaction scores were plotted to show change over time (e.g., Table F44, Table 46).
Table F1

Number of Hours Older Adult Participants Spent In Person With Adult Family Member During Pre-Admission

<table>
<thead>
<tr>
<th>1. How many hours did you spend, in person, with your family member?</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
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<tbody>
<tr>
<td>Valid</td>
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<td></td>
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<tr>
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<tr>
<td>11-20 hours per month</td>
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<td>21.4</td>
<td>64.3</td>
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<tr>
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<tr>
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<td>12.5</td>
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<tr>
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Table F2

Number of Hours Older Adult Participants Spent In Person With Adult Family Member During Admission

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<th>1. How many hours did you spend, in person, with your family member?</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
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<tr>
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<td>56.3</td>
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<tr>
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<td>30+ hours per month</td>
<td>3</td>
<td>18.8</td>
<td>21.4</td>
</tr>
<tr>
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<td>14</td>
<td>87.5</td>
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<tr>
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<td>12.5</td>
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Table F3

*Number of Hours Older Adult Participants Spent In Person With Adult Family Member During Post-Admission*

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<th>1. How many hours did you spend, in person, with your family member?</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<tr>
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<td></td>
</tr>
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Table F4

*Number of Hours Family Member Participants Spent In Person With Older Adult During Pre-Admission*

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Table F5

**Number of Hours Family Member Participants Spent In Person With Older Adult During Admission**

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<th>Valid Percent</th>
<th>Cumulative Percent</th>
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Table F6

**Number of Hours Family Member Participants Spent In Person With Older Adult During Post-Admission**

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Table F7

*Older Adult Participants’ Length of In Person Visits with Family Member During Pre-Admission*

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<td></td>
</tr>
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<td>7.1</td>
<td>7.1</td>
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<tr>
<td>1-2 hours</td>
<td>5</td>
<td>31.3</td>
<td>35.7</td>
<td>42.9</td>
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<tr>
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<td>35.7</td>
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<tr>
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Table F8

*Older Adult Participants’ Length of In Person Visits with Family Member During Admission*

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<td>2-3 hours</td>
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<td></td>
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</tr>
</tbody>
</table>
Table F9

*Older Adult Participants’ Length of In Person Visits with Family Member During Post-Admission*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valid</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one hour</td>
<td>2</td>
<td>12.5</td>
<td>16.7</td>
<td>16.7</td>
</tr>
<tr>
<td>1-2 hours</td>
<td>6</td>
<td>37.5</td>
<td>50.0</td>
<td>66.7</td>
</tr>
<tr>
<td>2-3 hours</td>
<td>2</td>
<td>12.5</td>
<td>16.7</td>
<td>83.3</td>
</tr>
<tr>
<td>3+ hours</td>
<td>2</td>
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<td>16.7</td>
<td>100.0</td>
</tr>
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<td><strong>Total</strong></td>
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<td>100.0</td>
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</tr>
<tr>
<td><strong>Missing</strong></td>
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</table>

**Total** 16 100.0
Table F10

*Family Member Participants’ Length of In Person Visits with Older Adult During Pre-Admission*

<table>
<thead>
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<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
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<tr>
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<td>2</td>
<td>12.5</td>
<td>12.5</td>
<td>12.5</td>
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<tr>
<td>2-3 hours</td>
<td>3</td>
<td>18.8</td>
<td>18.8</td>
<td>31.3</td>
</tr>
<tr>
<td>3+ hours</td>
<td>11</td>
<td>68.8</td>
<td>68.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
<td>100.0</td>
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</tr>
</tbody>
</table>
Table F11

*Family Member Participants’ Length of In Person Visits with Older Adult During Admission*

<table>
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<tr>
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<th>Percent</th>
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<td>12.5</td>
</tr>
<tr>
<td>1-2 hours</td>
<td>7</td>
<td>43.8</td>
<td>43.8</td>
</tr>
<tr>
<td>2-3 hours</td>
<td>5</td>
<td>31.3</td>
<td>31.3</td>
</tr>
<tr>
<td>3+ hours</td>
<td>2</td>
<td>12.5</td>
<td>12.5</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table F12

*Family Member Participants’ Length of In Person Visits with Older Adult During Post-Admission*

2. How long did your in-person visits with your family member last? (1. less than one hour, 2. 1-2 hours, 3. 2-3 hours, 4. 3+ hours)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one hour</td>
<td>2</td>
<td>12.5</td>
<td>15.4</td>
<td>15.4</td>
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<tr>
<td>1-2 hours</td>
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<tr>
<td>2-3 hours</td>
<td>6</td>
<td>37.5</td>
<td>46.2</td>
<td>92.3</td>
</tr>
<tr>
<td>3+ hours</td>
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<td>7.7</td>
<td>100.0</td>
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<td>Total</td>
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<td>Missing</td>
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</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table F13

*Older Adult Participants’ Number of Contacts Per Month with Family Member During Pre-Admission*

3. How many times per month did you have any type of contact with your family member? (1. 0-5 times per month, 2. 6-10 times per month, 3. 11-15 times per month, 4. 15+ times per month)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valid</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 times per month</td>
<td>3</td>
<td>18.8</td>
<td>21.4</td>
<td>21.4</td>
</tr>
<tr>
<td>6-10 times per month</td>
<td>4</td>
<td>25.0</td>
<td>28.6</td>
<td>50.0</td>
</tr>
<tr>
<td>11-15 times per month</td>
<td>1</td>
<td>6.3</td>
<td>7.1</td>
<td>57.1</td>
</tr>
<tr>
<td>15+ times per month</td>
<td>6</td>
<td>37.5</td>
<td>42.9</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td><strong>87.5</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>999</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>System</td>
<td>1</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
<td><strong>12.5</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
<td><strong>100.0</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table F14

**Older Adult Participants’ Number of Contacts Per Month with Family Member During Admission**

3. How many times per month did you have any type of contact with your family member? (1. 0-5 times per month, 2. 6-10 times per month, 3. 11-15 times per month, 4. 15+ times per month)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 times per month</td>
<td>4</td>
<td>25.0</td>
<td>26.7</td>
<td>26.7</td>
</tr>
<tr>
<td>6-10 times per month</td>
<td>2</td>
<td>12.5</td>
<td>13.3</td>
<td>40.0</td>
</tr>
<tr>
<td>15+ times per month</td>
<td>9</td>
<td>56.3</td>
<td>60.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
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<td>93.8</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
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<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table F15

*Older Adult Participants’ Number of Contacts Per Month with Family Member During Post-Admission*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valid</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>0-5 times per month</td>
<td>4</td>
<td>25.0</td>
<td>33.3</td>
<td>33.3</td>
</tr>
<tr>
<td>6-10 times per month</td>
<td>2</td>
<td>12.5</td>
<td>16.7</td>
<td>50.0</td>
</tr>
<tr>
<td>15+ times per month</td>
<td>6</td>
<td>37.5</td>
<td>50.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12</td>
<td>75.0</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
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<td>25.0</td>
<td></td>
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<tr>
<td><strong>Total</strong></td>
<td>16</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table F16

*Family Member Participants’ Number of Contacts Per Month with Older Adult During Pre-Admission*

3. How many times per month did you have any type of contact with your family member? (1. 0-5 times per month, 2. 6-10 times per month, 3. 11-15 times per month, 4. 15+ times per month)

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 times per month</td>
<td>6</td>
<td>37.5</td>
<td>37.5</td>
<td>37.5</td>
</tr>
<tr>
<td>6-10 times per month</td>
<td>2</td>
<td>12.5</td>
<td>12.5</td>
<td>50.0</td>
</tr>
<tr>
<td>11-15 times per month</td>
<td>1</td>
<td>6.3</td>
<td>6.3</td>
<td>56.3</td>
</tr>
<tr>
<td>15+ times per month</td>
<td>7</td>
<td>43.8</td>
<td>43.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
### Table F17

**Family Member Participants’ Number of Contacts Per Month with Older Adult During Admission**

3. How many times per month did you have any type of contact with your family member? (1. 0-5 times per month, 2. 6-10 times per month, 3. 11-15 times per month, 4. 15+ times per month)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 times per month</td>
<td>2</td>
<td>12.5</td>
<td>12.5</td>
<td>12.5</td>
</tr>
<tr>
<td>6-10 times per month</td>
<td>6</td>
<td>37.5</td>
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<td>50.0</td>
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<tr>
<td>11-15 times per month</td>
<td>3</td>
<td>18.8</td>
<td>18.8</td>
<td>68.8</td>
</tr>
<tr>
<td>15+ times per month</td>
<td>5</td>
<td>31.3</td>
<td>31.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Table F18

*Family Member Participants’ Number of Contacts Per Month with Older Adult During Post-Admission*

3. How many times per month did you have any type of contact with your family member? (1. 0-5 times per month, 2. 6-10 times per month, 3. 11-15 times per month, 4. 15+ times per month)

<table>
<thead>
<tr>
<th>Valid</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 times per month</td>
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<td>25.0</td>
<td>30.8</td>
<td>30.8</td>
</tr>
<tr>
<td>6-10 times per month</td>
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<td>25.0</td>
<td>30.8</td>
<td>61.5</td>
</tr>
<tr>
<td>15+ times per month</td>
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<td>31.3</td>
<td>38.5</td>
<td>100.0</td>
</tr>
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<td>Total</td>
<td>13</td>
<td>81.3</td>
<td>100.0</td>
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</tbody>
</table>

| Missing | 999 | 3 | 18.8 |
| Total   | 16  |   | 100.0 |
### Table F19

**Older Adult Participants’ Hours Per Month of Telephone Contact with Family Member at Pre-Admission**

<table>
<thead>
<tr>
<th>4. How many hours per month did you spend in communicating with your family member?</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Telephone (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)</td>
<td>Frequency</td>
<td>Percent</td>
<td>Valid Percent</td>
</tr>
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<td></td>
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</tr>
<tr>
<td>0-2 hours per month</td>
<td>2</td>
<td>12.5</td>
<td>14.3</td>
</tr>
<tr>
<td>3-5 hours per month</td>
<td>5</td>
<td>31.3</td>
<td>35.7</td>
</tr>
<tr>
<td>5+ hours per month</td>
<td>7</td>
<td>43.8</td>
<td>50.0</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>87.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
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<td>6.3</td>
<td></td>
</tr>
<tr>
<td>System</td>
<td>1</td>
<td>6.3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>12.5</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
Table F20

*Older Adult Participants’ Hours Per Month of Telephone Contact with Family Member at Admission*

4. How many hours per month did you spend in communicating with your family member?

a. Telephone (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-2 hours per month</td>
<td>7</td>
<td>43.8</td>
<td>46.7</td>
<td>46.7</td>
</tr>
<tr>
<td>3-5 hours per month</td>
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<td>5+ hours per month</td>
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<td></td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table F21

*Older Adult Participants’ Hours Per Month of Telephone Contact with Family Member at Post-Admission*

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valid</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-2 hours per month</td>
<td>7</td>
<td>43.8</td>
<td>58.3</td>
<td>58.3</td>
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<td>3</td>
<td>18.8</td>
<td>25.0</td>
<td>83.3</td>
</tr>
<tr>
<td>5+ hours per month</td>
<td>2</td>
<td>12.5</td>
<td>16.7</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12</td>
<td>75.0</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td><strong>Missing</strong></td>
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<tr>
<td><strong>Total</strong></td>
<td>16</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. How many hours per month did you spend in communicating with your family member?

a. Telephone (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)
Table F22

*Family Member Participants’ Hours Per Month of Telephone Contact with Older Adult at Pre-Admission*

4. How many hours per month did you spend in communicating with your family member?
   a. Telephone (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-2 hours per month</td>
<td>3</td>
<td>18.8</td>
<td>18.8</td>
<td>18.8</td>
</tr>
<tr>
<td>3-5 hours per month</td>
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<tr>
<td>5+ hours per month</td>
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</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
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</tbody>
</table>
Table F23

*Family Member Participants’ Hours Per Month of Telephone Contact with Older Adult at Admission*

4. How many hours per month did you spend in communicating with your family member?

   a. Telephone (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
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<td>0-2 hours per month</td>
<td>6</td>
<td>37.5</td>
<td>37.5</td>
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<td>3-5 hours per month</td>
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<td>37.5</td>
<td>75.0</td>
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<td>5+ hours per month</td>
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</tr>
<tr>
<td>Total</td>
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<td>16</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
**Table F24**

*Family Member Participants’ Hours Per Month of Telephone Contact with Older Adult at Post-Admission*

<table>
<thead>
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Table F25

*Older Adult Participants’ Hours Per Month of Email Contact with Family Member at Pre-Admission*

<table>
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<th>Percent</th>
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</tr>
</thead>
<tbody>
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<tr>
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<td>7.1</td>
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<tr>
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<td>100.0</td>
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</tr>
<tr>
<td><strong>Missing</strong></td>
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</table>

4. How many hours per month did you spend in communicating with your family member?

a. Emails (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)
Table F26

*Older Adult Participants’ Hours Per Month of Email Contact with Family Member at Admission*

4. How many hours per month did you spend in communicating with your family member?

a. Emails (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)

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<th>Cumulative Percent</th>
</tr>
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<td>Valid</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>0-2 hours per month</td>
<td>14</td>
<td>87.5</td>
<td>93.3</td>
<td>93.3</td>
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<tr>
<td>5+ hours per month</td>
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<td>6.7</td>
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<tr>
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<td>15</td>
<td>93.8</td>
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<tr>
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<td>Total</td>
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Table F27

*Older Adult Participants’ Hours Per Month of Email Contact with Family Member at Post-Admission*

<table>
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<th>4. How many hours per month did you spend in communicating with your family member?</th>
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<td>a. Emails (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)</td>
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Table F28

*Family Member Participants’ Hours Per Month of Email Contact with Older Adult at Pre-Admission*

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</tr>
</thead>
<tbody>
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<td>100.0</td>
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</table>

4. How many hours per month did you spend in communicating with your family member?

a. Emails (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)
Table F29

*Family Member Participants’ Hours Per Month of Email Contact with Older Adult at Admission*

<table>
<thead>
<tr>
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<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
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<td>16</td>
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<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table F30

*Family Member Participants’ Hours Per Month of Email Contact with Older Adult at Post-Admission*

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</tr>
</thead>
<tbody>
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<td>a. Emails (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)</td>
<td>Frequency</td>
<td>Percent</td>
<td>Valid Percent</td>
<td>Cumulative Percent</td>
</tr>
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<td>13</td>
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<tr>
<td>Missing 999</td>
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<td>18.8</td>
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<td>Total</td>
<td>16</td>
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Table F31

*Older Adult Participants’ Hours Per Month of Video Contact with Family Member at Pre-Admission*

4. How many hours per month did you spend in communicating with your family member?

a. Facetime, Skype, or video chat (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)

<table>
<thead>
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<th></th>
<th>Frequency</th>
<th>Percent</th>
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<tr>
<td>3-5 hours per month</td>
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<td>6.3</td>
<td>7.1</td>
<td>92.9</td>
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<tr>
<td>5+ hours per month</td>
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<td>6.3</td>
<td>7.1</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
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<td>87.5</td>
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<td>100.0</td>
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<tr>
<td><strong>Missing</strong></td>
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<td>6.3</td>
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<td>6.3</td>
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<tr>
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<td>12.5</td>
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Table F32

*Older Adult Participants’ Hours Per Month of Video Contact with Family Member at Admission*

4. How many hours per month did you spend in communicating with your family member?

a. Facetime, Skype, or video chat (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)

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<th>Frequency</th>
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<th>Cumulative Percent</th>
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<td></td>
<td></td>
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<td>0-2 hours per month</td>
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<td>100.0</td>
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<tr>
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<td>81.3</td>
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</tr>
<tr>
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<td>Total</td>
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Table F33

*Older Adult Participants’ Hours Per Month of Video Contact with Family Member at Post-Admission*

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<th>4. How many hours per month did you spend in communicating with your family member?</th>
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<th>Valid Percent</th>
<th>Cumulative Percent</th>
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</thead>
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<td>100.0</td>
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<td>Total</td>
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Table F34

*Family Member Participants’ Hours Per Month of Video Contact with Older Adult at Pre-Admission*

4. How many hours per month did you spend in communicating with your family member?

a. Facetime, Skype, or video chat (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)

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<td>87.5</td>
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<td>6.3</td>
<td>6.3</td>
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</tr>
<tr>
<td>5+ hours per month</td>
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<td>6.3</td>
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### Table F35

**Family Member Participants’ Hours Per Month of Video Contact with Older Adult at Admission**

4. How many hours per month did you spend in communicating with your family member?

a. Facetime, Skype, or video chat (1. 0-2 hours per month, 2. 3-5 hours per month, 3. 5+ hours per month)

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<tbody>
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<td>93.8</td>
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Table F36

*Family Member Participants’ Hours Per Month of Video Contact with Older Adult at Post-Admission*

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<th>Percent</th>
<th>Valid Percent</th>
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</tr>
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<td>16</td>
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Table F37

*Older Adult Participants’ Preference for Contact with Family Member at Pre-Admission*

5. What was your preferred method of contact with your family member? (1. Telephone calls, 2. emails, 3. in person visits, 4. facetime, skype, or video chat)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<tr>
<td>Valid</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>93.3</td>
</tr>
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<td>6.7</td>
<td>100.0</td>
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<tr>
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<td>6.3</td>
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Table F38

*Older Adult Participants’ Preference for Contact with Family Member at Admission*

<table>
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<td>100.0</td>
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Table F39

*Older Adult Participants’ Preference for Contact with Family Member at Post-Admission*

5. What was your preferred method of contact with your family member? (1. Telephone calls, 2. emails, 3. in person visits, 4. facetime, skype, or video chat)

<table>
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<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<td>100.0</td>
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<td>18.8</td>
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Table F40

*Family Member Participants’ Preference for Contact with Older Adult at Pre-Admission*

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<td>25.0</td>
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<td>68.8</td>
<td>93.8</td>
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Table F41

*Family Member Participants’ Preference for Contact with Older Adult at Admission*

<table>
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<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<td>26.7</td>
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<tr>
<td>In person visits</td>
<td>11</td>
<td>68.8</td>
<td>73.3</td>
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<td><strong>Total</strong></td>
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</table>
Table F42

*Family Member Participants’ Preference for Contact with Older Adult at Post-Admission*

5. What was your preferred method of contact with your family member? (1. Telephone calls, 2. emails, 3. in person visits, 4. facetime, skype, or video chat)

<table>
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<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<tr>
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</tr>
<tr>
<td>Telephone Calls</td>
<td>2</td>
<td>12.5</td>
<td>15.4</td>
<td>15.4</td>
</tr>
<tr>
<td>In person visits</td>
<td>11</td>
<td>68.8</td>
<td>84.6</td>
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</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>81.3</td>
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<tr>
<td>Missing</td>
<td>999</td>
<td>3</td>
<td>18.8</td>
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<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
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Table F43

*Older Adult Participants’ Relationship Satisfaction*

<table>
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<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
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</thead>
<tbody>
<tr>
<td>Corrected Model</td>
<td>5.511&lt;sup&gt;a&lt;/sup&gt;</td>
<td>17</td>
<td>.324</td>
<td>2.661</td>
<td>.011</td>
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<tr>
<td>Intercept</td>
<td>69.239</td>
<td>1</td>
<td>69.239</td>
<td>568.348</td>
<td>.000</td>
</tr>
<tr>
<td>Participant_ID_Nu m</td>
<td>5.456</td>
<td>15</td>
<td>.364</td>
<td>2.986</td>
<td>.006</td>
</tr>
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<td>Time</td>
<td>.044</td>
<td>2</td>
<td>.022</td>
<td>.181</td>
<td>.836</td>
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<td>Error</td>
<td>3.289</td>
<td>27</td>
<td>.122</td>
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<td>Total</td>
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<td>Corrected Total</td>
<td>8.800</td>
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</tr>
</tbody>
</table>

<sup>a</sup> R Squared = .626 (Adjusted R Squared = .391)
Table F44

Older Adult Participants’ Relationship Satisfaction Graph

![Graph showing the relationship satisfaction over time for older adult participants. The graph includes a legend for participant ID numbers from 1 to 16.]
Table F45

*Family Member Participants’ Relationship Satisfaction*

<table>
<thead>
<tr>
<th>Source</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
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<td>17</td>
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<td>618.438</td>
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<tr>
<td>Participant ID Num</td>
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<td>6.424</td>
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<td>Error</td>
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<td>Total</td>
<td>120.000</td>
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<tr>
<td>Corrected Total</td>
<td>19.478</td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

$^a$ R Squared = .781 (Adjusted R Squared = .648)
Table F46

*Family Member Participants’ Relationship Satisfaction Graph*

Mean: How satisfied were you with your communication (in person or otherwise) with your family member? (1=Very Satisfied, 3=Dissatisfied, 4=Very Dissatisfied)

Time (Pre-Admission, Admission, Post-Admission)

Participant ID Number:

1. 214
2. 46

Family Member Participants’ Relationship Satisfaction Graph
Appendix G
Journal Requirements

Aging & Mental Health Journal

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Clinical Gerontologist Journal

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