

“But I Am Not Moving”: Residents’ Perspectives on Transitions Within a Continuing Care Retirement Community

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Purpose: This article investigates how continuing care retirement community (CCRC) residents define transitions between levels of care. Although older adults move to CCRCs to “age in place,” moving between levels of care is often stressful. More than half a million older adults live in CCRCs, with numbers continually increasing; yet, no studies address transitions between levels of care in these communities. **Design and Methods:** I completed 23 months of live-in observation and conducted 35 face-to-face in-depth interviews with CCRC residents across 3 levels of care. I performed a thematic analysis of observation notes and interview transcripts. **Results:** Residents perceived transitions as both disempowering and final. They discussed decreases in social networks that occurred after such moves. Resident-maintained social boundaries exacerbated these challenges. **Implications:** Although the transition to institutional living is one of the most important events in older persons’ lives, transitions within CCRCs also are consequential especially because they are coupled with declining functional ability. These findings may inform policy for retirement facilities on topics such as increasing privacy, challenging social boundaries, and educating residents to prepare them for transitions.

Key Words: *Social relationships in institutions, Transitions in CCRCs, Qualitative methods*

As the American population ages, the demand for senior housing and long-term care also increases. Currently, 1.4 million older adults live in

nursing homes, with more than 900,000 in assisted-living residences (Association for Homes and Services for the Aged [ASHA], 2007). The continuing care retirement community (CCRC) has emerged as another option for senior living. Continuing care retirement communities permit residents to remain in one facility, while moving between levels of care as their needs require: independent living (IL), assisted living (AL), and nursing living (NL; Matthews, 2002). There are currently about 2,240 CCRCs in the United States (ASHA), and the number of older adults living in CCRCs has more than doubled in the past decade: from 350,000 in 1997 (Scanlon & Layton, 1997, p. 1) to 745,000 in 2007 (ASHA).

Most older adults prefer to “age in place,” staying in familiar locations (Frank, 2002, p. 2), and CCRC administrators emphasize this goal, but the social divide between levels of care in CCRCs means considerable environmental discontinuity for residents who move. Indeed, the CCRC concept (i.e., different levels of care in one facility) implies that transitions *will* take place.

The primary aim of this research was to investigate how residents perceive transitions across levels of care and how they manage social relations while moving within a CCRC. Research has shown that moving *into* a CCRC enhances older adults’ social engagement (Heisler, Evans, & Moen, 2004), but studies have not explored how moving *within* a CCRC affects social integration. The overarching research question is as follows: What individual perceptions and shared meanings do residents develop for transitions?

To investigate transitions within CCRCs, I examine two groups of residents: IL residents who have not yet undergone an intra-CCRC transition and those who have moved to AL or

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NL. This design allows me to study transitions from the perspectives of residents with different experiences.

Autonomy and Integration

The transition to retirement living is a turning point in the life course (Moen, Erickson, & Dempster-McCain, 2000), and transitions *between* levels of care may be just as crucial. These transitions may threaten residents' autonomy and integration, domains that are vital to institutionalized residents' well-being (Frank, 2002; Young, 1998). Autonomy consists of decisional control and choice in shaping one's life (Frank, 2002; Rowles, Oswald, & Hunter, 2003), whereas integration consists of one's social networks and sense of belonging (Fiveash, 1997; Haight, Michel, & Hendrix, 1998).

Relocation—into and between facilities—is one of the most stressful events older adults face, particularly because of threats to their autonomy (Coughlan & Ward 2007; Reuss, Dupuis, & Whitfield, 2005; Young, 1998). The degree to which this happens depends on the institutional restrictiveness of the setting: Autonomy is most threatened by transitions to nursing care (Kellet, 1999; Wilson, 1997). Forced relocation is especially stressful—those who are unable to choose for themselves often have the most difficulty adjusting to long-term care (Reuss et al., 2005; Young, 1998).

Transitions also can decrease social integration, including declined contact with friends (Haight et al., 1998; Regnier, Hamilton, & Yatabe, 1995) and feelings of loneliness and isolation (Johnson, 1996). Several mechanisms influence this phenomenon. Older adults face declines in mental and physical health (Hays, 2002), which decrease individuals' ability to interact. Also, residents may not want to interact with others whose functional and mental health is worse than their own (Young, 1998). Alternatively, some nursing care residents, perceiving death to be approaching, are reluctant to invest time and energy in relationships with other residents (Powers, 1996).

Older adults voluntarily move to CCRCs to protect their autonomy and increase their social integration as they age (Heisler et al., 2004; Krout, Phyllis, Holmes, Oggins, & Bowen, 2002). Transitions within CCRCs, however, primarily reflect administrative decision making and can hinder residents' sense of autonomy (Fisher, 1987). Also, the benefits of CCRCs are not equally distributed: IL residents have significantly higher social engage-

ment than AL residents (Jenkins, Pienta, & Horgas, 2002). Furthermore, CCRCs are somewhat segregated; there are limited opportunities for social interaction across levels of care (Fisher, 1987).

Although the literature provides a framework for understanding relocations in later life, there has been no direct examination of transitions within a single continuum of care. Over a decade ago, Fisher (1987) found that transitions in a multilevel care facility seemed harsher than many residents anticipated; yet, his discussion did not include the perspectives of skilled care residents. Because aging in place is a key feature of CCRCs, it is important to understand whether transitions within a CCRC disrupt the benefits of staying in a single facility. Do CCRC residents maintain social networks across levels of care? Do they still feel at home after transitions? Are transitions less stressful? How so?

In addition to its primary focus on transitions, this study is distinctive in several ways. First, it examines how perceptions of transitions differ by levels of care. Second, whereas most studies focus on new or incoming residents (e.g., Krout et al., 2002), this study considers residents who have lived in a facility for different amounts of time (1–30 years). This offers a chance to record widely varying personal experiences. Finally, in addition to interviewing residents, I lived in the facility for 2 years, which provided me with an abundance of personal experience with everyday life in a CCRC and a more detailed orientation toward the social world at Pickwick Village.

Methods

This is a qualitative study of CCRC residents' perceptions of transitions. Qualitative methods “detect, represent, and explicate the meanings of something from the viewpoint of the actors involved” (Sankar & Gubrium, 1994, p. x), and explicate the processes of “how” phenomena transpire (p. xii). Specifically, this study utilizes observational and interview methods to examine how residents experienced and defined transitions across levels of care. I determined the topic of this article inductively—by discovering the salience of transitions while living in the facility—but I worked deductively to design the study itself.

The Research Setting

Pickwick Village is a moderately upscale, nonreligious retirement facility that belongs to a consortium

of similar institutions across the country. Located in a midsized college town in the Midwest, Pickwick Village has functioned as a cultural center for local older adults over the past 30 years. All residents were White, about 75% women, with mean age at entry of 75 years. Mean age for all residents was 86 years. Many residents had college or advanced degrees.

The facility housed 272 residents, with 224 in IL, 18 in AL, and 30 in NL. Independent living included “cottages,” single-family residences on the campus (27 residents), and 197 apartments in the main facility. I focused on IL residents living in apartments because they constituted the majority of IL residents, but I also drew selected observations from cottage dwellers. Assisted living–housed residents required moderate supervision and care, whereas NL provided skilled care. At the time of the study, facility regulations stated that individuals could only enter Pickwick by moving into IL. Subsequently, as needs required, they could move into AL or NL (Figure 1). IL or AL residents could go to NL temporarily for rehabilitation, but permanent NL residents could not move back to AL or IL.

Development of this research began in 2003 when, as a part of a larger ethnographic project, I moved into a CCRC. Pickwick Village partnered with the university on a program that allowed gerontology researchers to live in the facility and establish closer relations with residents (Shippee, Schafer, & Pallone, in press). I received approval from my university’s institutional review board and the facility’s director before beginning this study. Before I moved into Pickwick, residents were informed that I would be performing research while living there. Residents provided written consent for interviews. I lived in Pickwick Village for 2 years, and in many respects, my life revolved around Pickwick and its residents during that time.

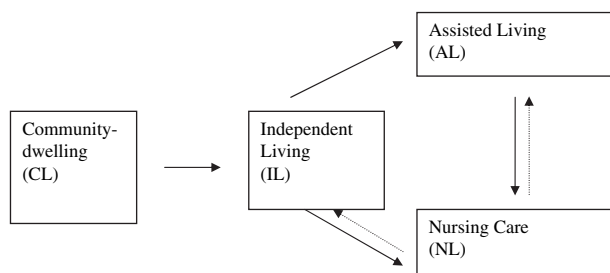


Figure 1. Pathways of transitions in Pickwick Village.
Notes. AL = assisted living; IL = independent living; NL = nursing living. ^aSolid arrows indicate the permanence of move to AL/NL. ^bShaded arrow represents temporary stays in NL for medical recovery.

Most Pickwick residents treated me as a friend, neighbor, and even “adopted” child, and wanted to contribute to my research. I was also good friends with many staff, including the director. I was in a unique position because I shared residents’ concerns but also could relate to staff and their outlook. Thus, subjectivity could have affected the analysis and interpretation of data, but my identification with residents was balanced by my friendships with staff.

The research consisted of two parts: 23 months of observation and 35 interviews with IL, AL, and NL residents. During my time in Pickwick Village, I had ample opportunity to observe and interact with residents. I lived in the same one-bedroom apartment that most other IL residents did, went to meals in the IL dining room, attended events and activities in all levels of care, and developed numerous friendships. In addition to living at Pickwick, I spent at least 15 hr per week conducting more focused observations in a variety of social settings (e.g., public areas, meals, social activities). Because I was immersed in these settings as a resident (albeit an unconventional one), I usually did not take written notes *during* observation. Instead, I made “mental notes” or took “jotted notes” to jog my memory when necessary (Bailey, 1996, pp. 80–81) and then wrote more detailed notes later, usually in my apartment at Pickwick. Overall, I utilized 25 typed pages of notes on transitions, along with other memories of my residence there and (as mentioned) interviews.

Interviews were semistructured, lasting 40–90 min. I collected them after 18 months of observation. Interviews contained open-ended questions about life before Pickwick, moving in, social relations, transitions to more skilled care, and so forth (Appendix). Although interviews had a common structure, residents were allowed to expand upon themes they thought important. I also employed probe questions to obtain greater detail. I tape-recorded each interview and took notes.

Sample

As is common in qualitative research, I used purposive sampling, which helps to “ensure that certain types of individuals or persons displaying certain attributes are included in the study” (Berg, 2004, p. 36). The criteria for the interview sample included the following: (a) obtaining a diverse group of residents and (b) including only cognitively able residents. To ensure that the sample included residents with diverse experiences, I sampled residents

based on marital status (e.g., widowed vs. married), time of residence (1–30 years), and activity level (more active vs. less involved). Second, regarding residents' cognitive ability, I consulted with the activities director and head nurse. Residents had to pass a Mini-Mental State Examination administered by the facility to be considered. Given these criteria, the sample included more IL residents than AL or NL. I had a 79% response rate for IL, 88% for AL, and 60% for NL.

Participants included 35 residents aged 76–99 years, with 22 from IL, 7 from AL, and 6 from NL. Sixteen IL residents were women, 13 were widowed, 17 were moderately to highly active in activities inside and outside of Pickwick, and 15 had lived in IL from 5 to 15 years. Two were former cottage residents. Six AL residents were women, 5 were widowed, 5 were moderately to highly active, and 5 had lived in AL from 5 to 10 years. There were equal numbers of women and men in NL. All were widowed; most were nonactive and had lived in NL from 1 to 5 years. Overall, residents in this study were representative of CCRC residents across the country (e.g., mostly White, women, mid- to upper class, with a mean age in late 70s; Moen et al., 2000).

Data Analysis

I began data analysis when I had completed the first five interview transcripts. I began with “line-by-line” open coding (Charmaz, 2004). Codes are shorthand names, symbols, or numbers that describe patterns in the data (Hesse-Biber & Leavy, 2004, p. 411). To develop codes, I read interview transcripts and field notes several times for recurrent and salient topics. Line-by-line coding entails examining each line of text and assigning codes to reflect the meaning(s) contained in it. This helps researchers see “the familiar in a new light” and avoid imputing their motives to the data (Charmaz, p. 506). This process produced more than 100 codes, including researcher-labeled codes and “in vivo” codes in respondents' own words. I utilized constant comparison between emerging codes and the data to refine codes and identify categories, or groupings of similar codes under one label (Charmaz). For example, researcher-identified codes such as “lack of privacy” and in vivo codes such as “staff don't knock on the door” and “not allowed to go to the toilet by myself” eventually converged into the broader category of “threats to privacy and personal space.” I further assembled categories

into overall themes—for example, categories of “being told to move,” “threats to privacy and personal space,” and “rules regarding transitions” comprise a theme of “autonomy.”

The overall categories in my study are true to the data, but I was also guided by my research questions. This follows Berg's recommendation “to keep the original study aim in mind and to remain open to multiple or unanticipated results that emerge from the data” (2004, p. 279). I stopped open coding when I arrived at saturation—that is, when I stopped finding any essentially new codes or information (Hesse-Biber & Leavy, 2004).

To improve internal validity, I compared a final code list with all observational and interview data. I also consulted with five resident “informants.” Informants typically have high status and familiarity within the group and are willing to mentor researchers on the group's culture (Eckert & Zimmerman, 2002). I selected informants who were mostly socially active and with whom I had good rapport, and who varied in their former careers, lengths of residence, and viewpoints on Pickwick administration. They aided me with pretesting questions, validating findings, and discussing my interpretations of life in Pickwick.

Results

Three major themes emerged from the data: (a) autonomy, (b) fatalism, and (c) social disengagement. These themes illuminate the importance of facility rules and social/physical boundaries in CCRCs. I frequently use AL and NL as one group (AL/NL) to accentuate differences from IL. Names are pseudonyms.

Autonomy

Most residents agreed that “independence” and autonomy, or lack thereof, were the *key aspects* of transitions. These perceptions appeared in three forms. First, participants perceived a lack of free will in being forced to move from IL. Second, moving from IL threatened privacy. Finally, residents spoke of rules in AL and NL as overly restraining.

“Being Told to Move.”—Residents frequently claimed that “nobody likes to be pushed,” particularly in transitioning to AL or NL. Although resident contracts specified that the *facility* would determine when residents should move, most said they were not adequately informed about it. Edna,

an IL resident, who was expecting to be told to move to AL, shared:

I know I signed something, and I don't know what I signed because I didn't even read it, or had the lawyer read it.

Decisions to move residents were based on their performance on the Functional Assessment Measure, a standard test of cognitive, behavioral, and social functioning. Although a committee—comprising the director, a wellness nurse, the director of resident services, and NL administrator—collectively evaluated each resident, the facility director usually made the final decision. As Emma, an IL resident, stated:

I expect any day that he [director] gets in his noodle that I can't take care of myself. How can one man, one man, make that decision?

These sentiments of resistance were most common in IL residents' accounts, especially those experiencing declining health. They were not as prevalent in the statements of AL/NL residents, except those who had moved recently and still had the experience on their minds. For many, the director symbolized facility control largely because of his role in transitions.

Residents also saw being forced to move as a threat to their sense of self; they feared accepting a "needy" identity and perceived conflict with former statuses. First, residents discussed a permanent move to AL/NL as a sign that an individual could no longer care for himself or herself and needed help. They spoke of NL residents as "sick" and "dependent," and worried about becoming the same way or being labeled as such.

Second, the difficulty in accepting AL or NL affiliation was partially influenced by residents' former statuses. Most had wielded substantial control in their former careers and saw AL/NL residents as completely lacking this quality. I witnessed this role incongruity for one of my floor neighbors, Bob, who had been a university basketball coach. Bob had the school banner of his former employer on his door, wore school clothing, and told stories about coaching experiences; other residents introduced him as "Coach Bob." However, his health declined, and he needed to move to more skilled care. He resisted the transition and finally moved out of Pickwick rather than go to AL. Kathryn, another neighbor, expressed her view: "He thought he didn't need all that care, that he was just fine. He had been a coach for basketball, so he thought he knew what was best for his health." She went

on to note that Bob was always fit and that moving to AL would mean relinquishing control over his own health.

Threats to Privacy and Personal Space.—Residents had strong feelings about privacy, particularly as it related to being independent, having personal space, and having one's own room.

Residents expressed different views on privacy and personal space based on their level of care. Cottage residents, for instance, felt that moving to the IL apartments already meant a loss of freedom. One resident, a cottage dweller for more than 10 years who had recently moved into an apartment, said:

Most of us over in the cottages call this [the main building] the "Big House." It sort of puts it down, really, because I think in the old days they called prisons "The Big House." Most people in the cottages think of being here as a sort of imprisonment, really.

Independent living apartment residents, conversely, expressed concern about losing privacy once in AL/NL, frequently related to wanting a private room. Because most NL residents shared a room with another person, and AL residents lived in studio apartments, transitioning from IL meant a substantial reduction of personal space. Unsurprisingly, AL residents, and NL residents who paid for private rooms, frequently framed the loss of privacy as the worst thing that could happen. One NL resident stated, "Going back to a semiprivate room is like telling me to go to the black hole of Calcutta."

Comparing shared rooms to a hospital, residents noted not being able to "think of anything worse than to spend the rest of my life in a room with a stranger" and claimed it was even harder to not have one's own space when ill. Consequently, many residents used their remaining finances to preserve personal space during this stage. As one NL resident said, "I paid the entire assets of my life for the right to be private." For Pickwick residents, privacy symbolized both autonomy and ownership of their own living space.

Rules Regarding Transitions and Life in AL/NL.—All residents spoke of rules for AL/NL, and rules about transitions, as further threats to independence. Residents made three main claims about rules: (a) rules in AL and NL hindered residents' independence, (b) rules regarding transitions were unclear and ambiguous, and (c) rules about transitions

were applied inconsistently. Residents in AL/NL emphasized the first of these; IL residents focused on the latter two.

Regarding rules as constraints on everyday life, AL/NL residents spoke of eating meals at times determined by the facility (“I have to get up at 6:30 in the morning for them to take me to breakfast” [AL resident]), limits on what they could have in their apartments (“I’m not allowed to even have bandages here” [AL]), and overcare of personal needs (e.g., having to wait for staff to take one to the bathroom despite his/her ability). Such regulations, which frequently seemed nonsensical to residents, made them feel stripped of even basic decision making. One AL resident said, “Having to conform to their rules, that’s not freedom.”

Independent living residents, in contrast, spoke of unsuccessful efforts to understand the rules regarding transitions and their inconsistent application. An IL resident stated, “Residents have tried to talk to administration, including the director, about the rules for moving, but the answers are confusing.” Also, IL residents perceived unfairness in the application of facility rules. Some spoke of preferential treatment for residents with prestigious former careers. As one IL resident said, “Think of Tom. Now, if anybody needs to go to AL it would be Tom. He can’t even walk from one place to another.... But because he is who he is, they are not going to tell him to move.” Residents stressed that social status could be more important than health status, implying that transitions were indicators of standing. Thus, transitions could shape self-perception, if one were to internalize this belief.

Fatalism

Residents’ perceptions of disempowerment were closely related to feelings of fatalism. Although residents expressed this theme in several ways, the most central concerned death and the irreversibility of moving to AL/NL (Figure 1).

Death.—It is not an exaggeration to say that the most prevalent theme in AL and NL residents’ accounts was death. Many spoke of death as something they accepted or looked forward to, frequently describing it as an escape. Anna, an AL resident, stated:

My life is over as far as I’m concerned. I just feel it’s time to say goodbye. I really feel it’s time for me to go. I’ve had some good times here in Pickwick, but then I fell. And it is just like that.

Most references to death as escape suggested a desire to avoid further health decline or implied boredom and apathy. Katie, a higher functioning NL resident, said:

Mealtime is the most depressing hour of the day. I do it because I’m required to. No one says anything, nobody talks. At the table of 8 people, only 2 might say something. It’s like a monastic table, with most people quietly praying. I just look around and see what might be in store for me. I think: My God, is this what I have to do, eat with these people every day?

Having shared hundreds of meals with IL residents, I observed that dinners had special significance as the main outlets for interaction and community building. Residents dressed semiformally for dinners and felt strongly that certain attire (e.g., shorts) should not be worn to make dinner a special occasion. Consequently, the deterioration in social interaction in AL and NL reflected an even greater loss.

Residents also described feeling useless, not being able to do much for themselves or others. In such circumstances, they seemed to feel that death was beneficial. Interestingly, IL residents had similar views; they indicated that moving to AL/NL meant adopting a “dying” role. Kathryn, an IL resident, shared that she was “getting used to the idea that people have only one way to leave from here [Pickwick]. They are either going to live here or they die.” Moving to AL/NL reflected a greater acknowledgment of death than staying in IL. Clara, an IL resident, expressed a similar thought:

They don’t like to move. They know it’s one more step... they know it is all downhill. You know you are going to die. And that gives you a different outlook on death, and you become aware of it.

She went on to say that she did not want to die and wanted to stay active as long as possible to remain in IL. In a sense, IL was a symbol of retaining control, whereas a permanent move to AL/NL meant relinquishing control and embodying a dying role.

Irreversibility of the Move.—Irreversibility was another expression of fatalism. Residents described social boundaries between IL and AL/NL, regardless of facility rules. They claimed that once the move occurred, one could never go back. Thom, an NL resident, said:

I have accepted it. There is no point in me beating against the wall, I’m not going to move [out], I can’t get rid of my disease, it is irretrievable. Not to accept it would be just asking for torment.

Residents also spoke of the “irony” of moving into a CCRC: They had been drawn to it as an IL retirement community and had not anticipated spending the rest of their lives in AL or NL. One IL resident noted, “Having to think of moving makes them [residents] wonder if they should have put their stock elsewhere.”

It is important to recognize that residents maintained the same social boundaries that they feared. Residents in better health expressed displeasure regarding others with walkers and wheelchairs eating in the IL dining room. They described wanting to separate themselves from those with visible signs of disability. Thus, wheelchairs and motorized carts actually carried stigma. Still, it was common for IL residents’ views to change based on their own health status. One IL woman said that she had initially viewed Pickwick as an “old people’s home” because she had seen residents with walkers there and that she had not wanted to move in for that reason. However, her husband later laughed and said: “Yeah, but now she’s the one in the wheelchair. And guess what? Now she doesn’t want to go to the dining room, ‘cause then people will think that she doesn’t belong. I have to cook for her quite a bit in the apartment.” This points to how disabilities created barriers between residents: They isolated themselves or risked being shunned by others who did not want to be confronted with a stigma that could happen to any resident. Jim, an IL resident, supported this idea:

It is irritating for many individuals that there are so many wheelchairs, pushcarts, powered wheelchairs, electric wheelchairs in the dining room. And that kind of accommodation has to be made. And it may exhibit a bias, even a bigotry on our part, you know, but I think mostly, a lot of us don’t want to be reminded that we may be only a few years from that ourselves.

Social Disengagement

Social disengagement was a substantial component of residents’ perceptions of moving to AL/NL. Residents noted changes in the amount and the nature of social interaction.

Amount of Social Interaction.—Although IL residents had mostly strong relationships and frequently spoke of each other as family, social interaction decreased once one made a transition. Independent living and AL/NL residents differed in the causes to which they attributed this decrease. Independent living residents attributed the dearth of social inter-

action with AL/NL residents to their own busy lives, lack of proximity, not wanting to be exposed to the depressing AL/NL environment, and not wanting to face their own mortality. Ken, an IL resident, said: “If you see other people who have gone on further than you, you don’t want to admit that you are the same way, so you stay away from them.” This relates back to the social boundaries maintained by residents, partially to distance themselves from future health declines and impending death.

Assisted living/NL residents seemed to accept social disengagement as (a) unsurprising and (b) based on visits by IL residents to AL/NL, not vice versa. One AL resident said, “First thing that you know [once moved], there are fewer visits by IL people.” Thom, an NL resident, when asked about his former IL friends, stated, “No, I don’t see any of them. I think they say, ‘The heck with them living there [in NL]!’ And you don’t make new friends here. You think you would, but you don’t.” One IL resident accounted for this, saying, “[T]here are few who go to AL to preserve friendships... It could be depressing to be around AL and NL residents for longer periods of time.”

Also, IL residents did not want to resemble AL/NL residents, whom some described as lacking control and *choosing* not to be active. Some IL residents noted that, even when staff wheeled AL residents out to the hallways, many did not speak to each other. They also claimed that the facility used the AL living room for other purposes because residents were not utilizing it. Some IL residents described this as a mindset of “not participating” and emphasized that it was not necessarily created by the facility or by disabilities but rather by the AL (or NL) residents themselves.

It was common for IL residents to also speak of their own disengagement from relations with those who moved. As Troy puts it, “It is basically the fault of us who live here [in IL]. Our lives go on, our activities go on. And those in AL, their activities are more narrow and limited.”

Although AL and NL residents agreed that there was a decrease in social interaction, they did not blame their IL friends or expect them to behave differently. Rather, they took it as a part of “the package” or “something that had to happen.” Evan, an NL resident, noted:

Here you are alone, unless your wife or somebody with close family relation comes up to see you. That’s one of the disadvantages. But I don’t know how you change that. It’s just the way that it works out.

Evan's statement reflects a common grim acceptance of undesirable circumstances. This fatalism may underlie the "nonparticipation" mindset discussed by IL residents, but it also suggests an implicit norm of marginalization after transitions.

Nature of Social Interaction.—Assisted living and NL residents also expressed changes in the quality of interaction. Although present for long-time friendships (e.g., "I just feel obligated to go and visit her. I feel so sorry for her" [IL resident of her NL friend]), the change in social interaction was mostly related to making new friends in AL or NL. When asked about a lack of close friends, AL/NL residents either spoke of a small pool of potential friends to choose from (e.g., "there are only four of us here [in NL] who are more active") or explained limited relationships as common to their condition (e.g., "as close as you can get with a person this age"). It did appear, though, that residents were ambivalent about developing new friendships in AL and NL. They framed their lives as "different" than their IL friends'. One NL resident said, "I just made up my mind that things had to change, so I just erased from my mind these other relationships."

Discussion

This study indicates that despite the promise of "aging in place" offered by CCRCs, Pickwick residents described within-facility transitions as disruptive to their sense of home, their social interaction, and their sense of autonomy. During observations and interviews, residents expressed resentment—they had been drawn to Pickwick as an IL community, not anticipating the disempowerment and social death they might face in AL or NL. Although focused on transitions within a CCRC, these findings echo previous research on relocations in later life. Social disengagement and disempowerment also occur when moving into or between institutions (Coughlan & Ward, 2007; Frank, 2002).

In Pickwick, these challenges reflected not only facility regulations but also resident-maintained social boundaries and stigmas that accompanied moves to advanced care. For many IL residents, the realization that they would have to move was discouraging because of the fatalism they associated with AL and NL. Transitioning to more advanced care meant accepting "needy" and "dying" identifications, precisely when residents felt the greatest need to protect their sense of

self-worth. Indeed, visible signs of disability (e.g., wheelchairs) were stigmatized as reminders of declining health.

To address these challenges, facility administrators and staff could better inform residents about transitions in workshops or marketing materials (also relevant for AL facilities; Carder, 2002). To facilitate communication between residents, CCRCs could (a) provide mixed activities for IL, AL, and NL residents; (b) include AL and NL residents on committees with IL residents; and (c) identify liaisons (e.g., activities directors or socially active residents) to promote resident integration. By encouraging interaction, especially for AL/NL residents, facilities could upgrade the image of AL/NL among IL residents and improve the lives of AL and NL residents. Finally, facilities could work to maintain privacy and personal space. For example, CCRCs could consider hospice care to allow IL residents to die in their apartments or offer more private rooms in NL. Of course, administrators would have to creatively manage funding concerns.

Some of the negative attitudes residents expressed may have reflected the timing of the study: Pickwick was remodeling during data gathering. Other limitations include a lack of diversity among participants on the basis of race or ethnicity and class. Studies should examine transitions in other communities (e.g., government-subsidized facilities) with more diverse populations. Also, this is a case study of one facility in the Midwest, which limits transferability of findings; transitions in other CCRCs require further study. However, findings regarding role incongruity, the stigma of disability, and within-facility social barriers seem quite applicable to other settings.

There are three main implications for this research. First, studies have called for deeper understanding of how residents' perceptions develop in different housing contexts (e.g., Rowles et al., 2003). The few studies on life in CCRCs have primarily focused on new or future residents (e.g., Heisler et al., 2004; Krout et al., 2002; Sugihara & Evans, 2000). This study compares perceptions of transitions among residents in different levels of care and with differing lengths of residence. Also, this study tapped into social boundaries and status changes that would be difficult to observe otherwise.

Second, research on transitions between levels of care in CCRCs is almost nonexistent; yet, these transitions represent a fundamental microcosm of the aging process in general. Residents' physical decline calls for administrative action (moves to

higher levels of care), although various processes (e.g., declining interaction and impending death) represent things everyone experiences in later life.

Third, findings demonstrate that Pickwick residents saw little distinction between AL and NL; the transition that mattered most was moving away from the relative freedom of IL. This may reflect the overly institutional nature of AL in Pickwick during the study, but it also has implications for CCRCs' ability to maintain "smooth" transitions. It is an empirical question whether this would vary among other CCRCs.

This study's findings illustrate the utility of studying transitions within CCRCs and have potential implications for administrators and policy makers. Although most residents described negative attitudes toward transitions, they were also mindful of the benefits CCRCs can offer. As many said, the main point is to be cognizant of what is ahead, "making up your mind that this is what you will do."

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1. Tell me about your life.
2. What made you consider moving into Pickwick Village (PV)?
3. Before you came to PV, what did you think it would be like?
4. Who were the most important people in your life before you came to PV?
5. Who are you closest to now?
6. How do you feel about your life right now?
7. Now that you've been here for ____, does it feel like home? Why?
8. What would have to change for it to be like home?
9. Do you often think about the future? Make plans?
10. What do you usually look forward to during the day/week?

11–19 differ for IL versus AL/NL residents

IL residents

11. How do you feel about people moving to AL?
12. How do you think they feel?
13. How would you feel if you had to move to AL?
14. How about moving to NL?
15. Do you think your views differ from others' in PV?
16. Have you had any friends/neighbors move to AL/NL?
17. How did you feel about it?
18. How did it influence your relationship?
19. What is the biggest difference between moving to AL versus NL?

AL/NL residents

11. How did you feel about moving into AL/NL?
12. Has your opinion changed since you've been here?
13. Do you think your views differ from those in IL?
14. What about those in NL/AL?
15. How did moving influence your relationship with friends from IL?
16. What is the biggest difference between moving to AL versus NL?

Note: AL = assisted living; IL = independent living; NL = nursing living.