Describing non-death related losses of older residents in a residential care facility

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Dissertation submitted in fulfilment of the requirements for the degree *Magister Artium* of Psychology at the Potchefstroom Campus of the North-West University

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PREFACE

The Harvard referencing style has been used as referencing method in Section A, part 1 and 2. For the purpose of the article in Section B the APA referencing method has been used as it is a pre-requisite of the *Journal of Gerontology*. In light of the fact that the document is presented in English, the researcher translated data that was collected in Afrikaans and which was used as quotations in the document, into English.

TITLE: Describing non-death related losses of older residents in a residential care facility

SUMMARY

The current study formed part of a broader study that explored and described the quality of life of older residents in a particular residential care facility in Gauteng, South Africa (SA). Quality of life is a multi-dimensional concept that includes both the subjective experiences of people as well as their social interactions and the fit with the broader environment. The broader study was requested by the management of a specific residential care facility to obtain the quality of life experiences of the residents. Upon this request ethical approval to conduct the research was obtained from the Faculty of Health Sciences of the North-West University (NWU-00053-10-S1). Different themes emerged from the broader study, such as the needs of older persons, their experiences of being actively involved, relational experiences and non-death related losses.

Non-death related losses emerged from the rich data obtained during the broader study and appeared to play a major role in the quality of life of the older person. The aim of this study was therefore to explore and describe non-death related losses by means of secondary data analysis. Non-death related losses refer to an emotional response to the separation from subjectively important person(s) or things while death related losses refer to the death of a significant other. Relational losses in this study refer to the loss of a relationship between the older person and a life person, such as family, friends and also pets.

A literature study was conducted on the experience of physical, emotional/psychological, financial and social losses in late-adulthood. The Dual Process model of Stroebe and Schut as well as the Task-Based Model of Worden were used because they are regarded as comprehensive and influential theories on grief. The theories of the psycho-social developmental phase of late-adulthood as described in theories on human development as well as Bronfenbrenner's bioecological systems theory were also used.

The broader study was conducted in a residential care facility that adopted an active ageing approach, in SA. This specific facility cares for a broad spectrum of older persons varying from frail care to the older person who can still provide in their own needs and are still fully mobile. A lifestyle consultant was appointed in this residential care facility to organise and oversee activities, varying from prayer groups, bible study groups, line dancing, choir, bingo, outings and many more. In total 74 participants participated in the broader study. The participants', both men and women, age varied between 65 and 95 years with an average age of 73. The residents were white and the main languages are Afrikaans and English.

In the original study, a qualitative, descriptive design was used with the following data collection strategies: the Mmogo-method®; the World Café; semi-structured interviews; and the Listening Group technique. The Mmogo-method® was used for the rich data that emerged on a personal level as well as the group experience. The World Café gave quick information with regards to the quality of life of the older persons by involving a large group of people simultaneously. Semi-structured interviews gave information on the older persons' subjective life experiences. The Listening Group technique contributed in assisting the residents of this care facility to express their needs and experiences to Management. The rich data obtained from the broader study were used for the purpose of this study and enabled the researcher to do a secondary analysis of the original data to explore themes pertaining to non-death related losses, using thematic analysis.

Findings indicated that non-death related losses form part of the experiences of older persons' quality of life. Non-death related losses involved the loss of physical and cognitive abilities, interpersonal losses and financial losses. These losses appeared to cause a range of emotions with the older person. As a result of not having the opportunity to mourn these non-death related losses, people express the need for space to address this need. The potential misfit between an active ageing environment and the lack of space to mourn non-death related losses can potentially contribute to experiences of disengagement and distress. The findings are significant because older people often have to deal with accumulated losses during their lives and particularly vulnerable people could be prone to develop mental illness if appropriate spaces are not available to deal with non-death related losses.

The findings of the study could be used to develop psycho-education programmes or therapeutic interventions such as group therapy, or individual counselling to support older persons to deal with grief associated with non-death related losses.

KEYWORDS

Experience of non-death related loss

Gerontology/Late-adulthood

Psychosocial well-being in late-adulthood

Physical losses

Cognitive losses

Emotional losses

Social losses

Loss of financial security

Relational losses

Quality of life

Active ageing

TITEL

Die beskrywing van nie-doodverwante verliese van ouer inwoners in ’n residensiële sorgfasiliteit

OPSOMMING

Die huidige studie maak deel uit van ’n oorhoofse studie wat die lewenskwaliteit van die inwoners binne ’n spesifieke residensiële sorgfasiliteit in Gauteng, Suid-Afrika SA), verken en beskryf. Die doel van die oorhoofse studie was om die bestuur van die spesifieke residensiële sorgfasiliteit in te lig rakende die spesifieke behoeftes van die inwoners met die doel om die inwoners se lewenskwaliteit te verbeter. Die oorhoofse studie is goedgekeur deur die Fakulteit van Gesondheidswetenskappe aan die Noordwes-Universiteit onder die etiese nommer: NWU-00053-10-S1. Lewenskwaliteit is ’n multi-dimensionele konsep wat die subjektiewe ervaring van persone, sowel as hulle sosiale interaksionele aanpassing binne die breër omgewing, insluit. Verskeie temas het tydens die oorhoofse studie na vore gekom, soos byvoorbeeld die behoeftes van die ouer person, die ouer persoon se aktiewe deelname, verhoudingservaringe, asook nie-doodverwante verliese.

Deur die gebruik van sekondêre data-ontleding het nie-doodverwante verliese as ’n belangrike konsep na vore gekom wat ’n direkte invloed op die algehele lewenskwaliteit van die inwoners blyk te hê. Nie-doodverwante verliese word gedefinieer as ’n emosionele reaksie op die verwydering van subjektiewe belangrike persone of objekte. Alternatiewelik verwys doodverwante verliese na die dood van ’n betekenisvolle persoon. Binne die konteks van hierdie studie verwys verhoudingsverliese na die verlies van ’n verhouding tussen die ouer person en ’n ander lewendige wese, soos byvoorbeeld familie, vriende en troeteldiere. Nie-doodverwante verliese word in literatuur beskryf as ’n baie belangrike en bepalende faktor rakende die lewenstylkwaliteit van die ouer persoon wat die oorsaak kan wees van byvoorbeeld depressie.

’n Literatuurstudie is gedoen ten einde ’n geheelbeeld te vorm rakende die navorsingsprobleem. Die literatuurstudie fokus dus op nie-doodverwante verliese soos wat dit ervaar word in laat-volwassenheid. Dit sluit aspekte in soos byvoorbeeld die psigososiale, fisiese, emosionele/sielkundige en sosiale verliese soos ervaar deur

die ouer persoon. Die Tweevoudige model van Stroebe en Schut asook die Taakgeorienteerde model van Worden is gebruik vir die omslagtige en invloedryke wyse waarop rou in hierdie twee teorieë beskryf word. Die studie is gegrond op die lewensloopontwikkelingsteorie soos voorgestel deur Erikson en om die ouer persone se nie-doodverwante verliese in konteks te verstaan, is Bronfenbrenner se bio-ekologiese sisteemteorie gebruik.

Die oorhoofse studie het plaasgevind in ’n residensiële sorgsentrum, wat een van vele in SA is, wat ’n aktiewe verouderingsbenadering volg. Binne hierdie spesifieke sorgsentrum woon ouer persone wat nog in hulle eie behoeftes kan voorsien en hulleself kan versorg. Daar is egter ook voorsiening vir ouer persone wat behoeftig is en hulp nodig het. ’n Leefstylkonsultant het ’n belangrike funksie binne hierdie spesifieke sorgsentrum met die organisering van en oorsig oor verskeie aktiwiteite wat aangebied word. Van hierdie aktiwiteite sluit gebedsgroepe, Bybelstudie, lyndanse, kore, bingo, uitstappies en verskeie ander aktiwiteite in. ’n Totaal van 74 vrywillige deelnemers het aan die oorhoofse studie deelgeneem wat beide mans en vroue ingesluit het. Die deelnemers se ouderdomme het gewissel tussen 65 en 95 met ’n gemiddelde ouderdom van 73. Meeste van die inwoners is blank en Afrikaans- of Engelssprekend.

Gedurende die oorhoofse navorsing is gebruik gemaak van ’n kwalitatiewe, beskrywende studie om die lewenskwaliteit van inwoners in ’n residensiële sorgfasiliteit te verken en te beskryf. Die oorhoofse navorsingsprojek het gebruik gemaak van gedetaileerde, veelvuldige, in-diepte data-insamelingsmetodes soos die Mmogo-metode®, die World Café, semi-gestruktureerde onderhoude en die Luistergroeptegniek. Vanuit die toepassing van die Mmogo-metode® het ryk data te voorskyn gekom binne die konteks van die individu asook binne die groepervaring. Binne die World Café is ’n groot groep mense gelyktydig betrek ten einde vinnig en ryk inligting te bekom rakende die lewenskwaliteit van die inwoners. Subjektiewe lewenservaringe is aangespreek binne die konteks van semi-gestruktureerde onderhoude met individue. Die inwoners van die sorgsentrum het die geleentheid gehad om tydens die Luistergroeptegniek hulle behoeftes aan die bestuur van die sorgsentrum oor te dra en te verwoord. Die ryk en omvattende inligting wat bekom is tydens die oorhoofse studie het die navorser in staat gestel om ’n sekondêre analise

van die oorspronklike data te doen. Deur middel van tematiese data-analise tydens sekondêre analise van die oorspronklike data, het temas na vore gekom rakende nie-doodverwante verliese soos onder andere die verlies van fisiese en kognitiewe vaardighede, interpersoonlike verliese en finansiële verliese.

Hierdie navorsingstudie se doel was om die nie-doodverwante verliese te beskryf ten einde die rol wat dit in die holistiese welstand van die inwoners speel te omskryf. Volgens die bevindinge binne hierdie studie blyk dit dat nie-doodverwante verliese ’n omvattende uitwerking het op die individu wat kan lei tot ’n wanaanpassing binne ’n aktiewe verouderingsomgewing wat nie die spesifieke behoeftes van die ouer persoon aanspreek nie. Die nalatigheid om die emosies wat geassosieer word met die verskillende verliese aan te spreek gee aanleiding tot ondervindinge van onttrekking en kommer.

Alhoewel die bevindinge van hierdie studie huidige literatuurbevindinge onderstreep, is dit belangrik om klem te plaas op aspekte waarbinne daar ruimte gelaat word vir die rouproses rakende nie-doodverwante verliese. Hierdie studie maak dus ’n bydrae tot die veld deur bewustheid te skep rondom die realiteit van nie-doodverwante verliese asook die impak wat dit het op die lewenskwaliteit van die ouer persoon. Verder dra hierdie studie by tot die veld deur die beskrywing van die ouer persoon se lewenskwaliteit en die wanaanpassing tot die omgewing wat kan plaasvind binne ’n aktiewe verouderingsomgewing waar daar nie ruimte gelaat word vir die hantering en verwerking van verliese nie. Omdat ouer persone veelvuldige verliese moet hanteer, kan dit aanleiding gee tot die ontwikkeling van sielkundige probleme vir die reeds kwesbare ouer persoon indien daar nie voldoende beskikbare hulpbronne daargestel word om nie-doodverwante verliese te hanteer nie.

Die hoop word uitgespreek dat die bevindinge binne hierdie studie sal bydra tot die verdere ontwikkeling van programme wat die ouer persoon sal ondersteun met nie-doodverwante verliese. Moontlike programme kan die volgende insluit: groepsterapie, ondersteuningsgroepe en selfs individuele terapie waar dit benodig word ten einde die ouer persoon deur die ervaring van nie-doodverwante verliese te ondersteun.

SLEUTELWOORDE

Ondervinding van nie-dood verwante verliese

Gerontologie/Laat-volwasse fase

Psigososiale welstand in laat-volwassenheid

Fisiese verliese

Kognitiewe verliese

Emosionele verliese

Sosiale verliese

Verlies van finansiële sekuriteit

Verhoudingsverliese

Lewenskwaliteit

Aktiewe veroudering

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‘No man is an island’ is a statement that was very true during the course of my studies. My family and friends who supported me and encouraged me gave me the strength to carry on. I have to mention certain names and the first would be my three sons – the light of my life and my inspiration – of whom the older two not only encouraged me, but had to continue their lives with a mother who was constantly with her nose in some or other book. Each one of you has influenced my life and my view of life in a different way – enabling me to grow and become the person I am supposed to be. Secondly, my mom, who has been my inspiration, mentor and motivation throughout my life. She was also the one who had to ‘babysit’ hours on end so that I could attend a class or study. My stepfather, who has over the years been more than an own father to me, always supporting me and always being there. Love and appreciate you all with all my heart.

I have to express my sincere gratitude to my study leader, Issie Jacobs. You are indeed a very patient person that has stuck with me through a challenging couple of years. I do believe that without you it would not have been possible to come to this stage. May you be blessed within your own life and your studies further on.

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Nestus Venter at the library of the North-West University, Potchefstroom Campus, you were a real life saver. Thank you for all your assistance and friendly comments.

Without the research participants this study would not have been possible. It was an honour to work with the older persons, to get to know them better and understand their world from a different perspective. Thank you for sharing with us on such a personal level. It surely enriched my life.

My God has been my reason for living and my reason for carrying on through life’s challenges. Without Him there was little reason to continue with anything in my life. Only He can know and grasp the extent of my gratitude towards Him, not just for who He is in my life but also for the special people He has surrounded me with.

Proverbs 3:5-6

“Trust in the Lord with all your heart and lean not on your own understanding; in all your ways submit to Him, and He will make your paths straight.”

DECLARATION BY THE RESEARCHER

I, Sonja Teitge, hereby declare that this manuscript ***Describing non-death related losses of older residents in a residential care facility*** is my own work. All sources used for this study are referenced in the manuscript and acknowledged.

_____

SONJA TEITGE DATE: 23 July 2015

STUDENT NUMBER: 23277882

DECLARATION BY THE LANGUAGE EDITOR

Hereby I declare that I have language edited and proofread the thesis ***Describing non-death related losses of older residents in a residential care facility*** by Sonja Teitge for the degree Master of Psychology. I am a freelance language practitioner after a career as editor-in-chief at a leading publishing house.

Lambert Daniel Jacobs (BA Hons, MA, BD, MDiv)
June 2015

SECTION A

PART 1: ORIENTATION TO THE RESEARCH

1. INTRODUCTION

Even though loss can appear during any phase of one's life it is more likely to appear during late-adulthood (Schmall & Bowman, 2004:2). The life of an older person is known for the multiple death and non-death related losses that they experience (Schmall & Bowman, 2004:2). By the time that the older person has reached the age of 60 they probably have already experienced the death of a loved one such as that of a spouse and/or of a significant other(s) (Berk, 2004:620-645). Death related loss is defined as the loss of a significant other due to death (Berk, 2004:623). Berk (2004:632) continues by stating that the definition of death includes three concepts, namely that once a living thing dies, it cannot be brought back to life. Secondly, it implies that universally it is understood that all living things die eventually. Lastly, it implies that on a non-functionality basis all living functions cease at death. Death related loss thus refers to the death of a significant other. Death related losses will also include the death of a pet (Schmall & Bowman, 2004:3).

Death related loss is not the only loss that older people are subjected to. Non-death related losses refer to an emotional response to the separation from subjectively important person(s) or things as described by Yang and Lee (2012:99). Non-death related losses are described by many theorists (Bowlby, 1980:25; Goldsworthy, 2005:174; Hall, 2014:7; Sabar, 2000:152; Thompson, 1998:21) as changes experienced by the older person and which form part of life. Change in itself normally refers to some kind of loss and loss again requires some kind of change, thus also implying that there is some form of grief/bereavement involved in this process (Bowlby, 1980:25; Doka, 1989:4; Goldsworthy, 2005:170-171; Hall, 2014:7; Neimeyer, 1999:67; Sabar, 2000:154-158).

Non-death related losses can include cognitive losses such as the loss of memory (Goldsworthy, 2005:174). On an instrumental level, it can refer to the loss of income (Goldsworthy, 2005:174). Older persons, however, are also often confronted with declining health, physical changes and disabilities, which Berk (2004:592) also regards as non-death related losses. A declining income, greater dependency, health problems, and social and environmental losses such as loss of friends due to relocation (Altschuler & Katz, 2010:200-214; Berk, 2004:593-594), are also described amongst the multiple non-death related losses often experienced by older persons.

2. RATIONALE AND MOTIVATION FOR THE STUDY

The management of a residential care facility in the east of Johannesburg, Gauteng, requested the North-West University to assist them in assessing how residents experience quality of life. Within this care facility there are a wide range of caregiving facilities such as intensive care for frail and disabled residents, a specific department for mentally disabled residents such as dementia and Altzheimers, as well as individual rooms, flatlets and small homes. This specific residential care facility adopts an active ageing approach. It is the responsibility of a lifestyle consultant to organise, plan and maintain different activities in which the residents can participate. Unfortunately these activities mainly accommodate the physically able residents who are mobile to move within the residential care facility.

In the broader study, the overall aim of the researchers was to explore how the residents experience the quality of their lifestyle in a residential care facility that can be described as an active ageing environment. Following the bioecological theory, to study the fit between people and the environment is important to ensure that people experience well-being and that their use of the environment is optimal (Bronfenbrenner & Morris, 2006:793; Puren, Drewes & Roos, 2008:134-146). During the analysis of the original data different themes arose such as “Psychosocial needs of a group of older people in a residential facility” (Zaaiman, 2014) and “Exploring experiences of active ageing among older residents in a retirement village” (Tarr, 2014). Another theme that emerged spontaneously within the data gathered from the broader study, was non-death related losses. It was therefore decided to conduct a secondary analysis of the original data to explore and describe how older residents in a specific residential care facility describe non-death related losses. Findings can be used by management to enhance the optimal environmental fit of this particular group of people to better their quality of life.

The study is underpinned by the Dual Process Model of Stroebe and Schut (1999) as well as the Task-Based Model of Worden (2008). These theories are of great value describing bereavement/grief and loss. The Dual Process Model of coping with bereavement and loss proved to be important within this study as it includes grief which according to Goldsworthy (2005:169), Hall (2014:7) and Thompson (1998:21) is a response to non-death related loss in an ever changing environment. These three

theorists, amongst others, state that when change, which is an unavoidable part of life, is experienced, loss will be the normal outflow leading to grief. Neimeyer (1999:68) explains this concept very well in his statement that all changes in life involve loss and all losses in life require change. Freud (1957:244) made his own contribution to this concept by stating that grief is viewed as the cognitive process through which loss can be resolved. Another important aspect considered within the bereavement theory, also explored in this study, is the social context in which grief occurs and the meaning the individual attributes to and how they integrate their non-death related losses (Doka, 1989:1; Neimeyer, 1999:67). Attig (1991:367) and Hall (2014:7) not only acknowledge that grief is the normal path to follow with a non-death related loss due to change, but also acknowledge that the older person's identity will be transformed by this loss.

Berk (2004:549) is in agreement that non-death related losses will include change. On a physical level this change includes losses such as loss of hearing, vision, nervous system, sensory systems, taste and smell, loss in the cardiovascular and respiratory system, the immune system, sleep, as well as touch (Berk, 2004:549-556). Change on a cognitive level, according to Berk (2004:564-574), includes dementia, Alzheimer's Disease, brain deterioration, loss of language processing, loss in problem solving skills and loss of memory.

Berk (2004:584-596) furthermore includes loss on an emotional and social level in his study. With regards to the social changes experienced by the older person, Bekhet, Zauszniewski and Nakhla (2009:463) as well as Berk (2004:610-613) link retirement and moving to a residential care facility with non-death related losses and quality of life. Berk (2004:610) mentions that retirement per se involves giving up roles that are a vital part of identity and self-esteem and is therefore seen as a stressful period where loss is relevant with regards to the decision to retire and giving up a career, finances, home environment, friends, health and children. Bekhet *et al*. (2009:463) elaborate by stating that relocation to a residential care facility can enhance symptoms of stress and impair normal, everyday functioning. Normal functioning can be impaired due to for instance depression, confusion, anxiety, apprehension, powerlessness and even decreased life satisfaction (Bekhet *et al*., 2009:463). In addition, the psycho-social developmental phase of late-adulthood as described in Erikson's psychosocial developmental theory as well as Bronfenbrenner's bioecological systems theory were

also used. These theories contributed to this study as they explain the current developmental phase of the older person, the older person's needs and experiences in a constantly changing environment as well the active environment that the residents of this residential care facility live in.

The developmental phase of the older person is in accordance with the definition as provided by the Older Persons Act (Act 13 of 2006:6) for people above the age of 60. People aged 60 years and older find themselves in the developmental phase of late-adulthood (Erikson, Erikson & Kivnick, 1986:37). People in this developmental phase can either age gracefully, feeling satisfied with their achievement and as such experience quality of life or experience despair due to the realisation that their lives are a series of lost opportunities (Brown & Lowis, 2003:415-419; Erikson, *et al*., 1986:37). Following the developmental phase of late-adulthood is the gero-transcendent life stage which is known for bodily weakness, where a person's autonomy, independence and control are challenged through change and as a consequence, self-esteem and confidence weaken (Erikson, *et al*., 1986:37; Fuller-Iglesias, Sellars & Antonucci, 2008:183-184). Peck (in Berk, 2004:585) made a further contribution to this study with his inclusion of body transcendence versus body preoccupation which is also a focus point in this study.

Bronfenbrenner's Bioecological Systems Theory of human development is viewed as important in this study as the hypothesis of this theory states that one's well-being is influenced by not only social context but that development includes continuity and change in the holistic field of the older person (Bronfenbrenner & Morris, 2006:793). Change as described in Bronfenbrenner's theory forms part of the life of the older person and something the older person has to deal with on a daily basis, for example change in physical ability, environment and finances, and the function and quality of relationships (Bronfenbrenner & Morris, 2006:793). On a social level these changes could also include aspects such as moving to a residential care facility. Development *per se* is therefore seen as the phenomenon of continuity and change in the biopsychological characteristics of human beings (Bronfenbrenner & Morris, 2006:793-794). Older people are confronted with many non-death related losses. However, although literature mentioned many non-death related losses, it is still not clear what the misfit entails in an active ageing environment that does not address the

specific needs pertaining to non-death related losses of older persons. These non-death related losses appear to have an impact on the quality of life of the older person contributing to a misfit in an active ageing environment. Therefore the research question that guided this study was:

How do white older residents in a specific residential care facility in South Africa describe non-death related losses?

3. AIM OF THE RESEARCH

The aim of the current study was to explore and describe how older residents in a residential care facility describe non-death related losses. Findings will be used to inform the management of the residential care facility should they wish to implement appropriate interventions and strategies to assist the residents to deal with non-death related losses.

The findings are relevant because the theme of non-death related losses emerged spontaneously when participants were asked about how they experience the quality of their lifestyle in an active ageing environment. Research with regards to older persons are deemed necessary as the current population figures for South Africa (SA) indicate a growing young black population and an ageing and shrinking white population (Stats SA, 2013:2-3). The South African population increased from 40.5 million in 1996 to 52.98 million in 2013. The number of white South Africans however has decreased from 10% of the total population to 8.7% due to fertility and emigration (Stats SA, 2013:2-3). Of this 4.15% of the population consists of people older than 60 years.

The World Health Organisation (WHO) (1998) emphasises that the population of people aged 60 and above are growing very fast (WHO, 2002:12). Consequently, there is a need to be aware of the implications of ageing populations for society as a whole (Bradshaw & Joubert, 2006:204). A shift has now occured within the health care profession of older persons to include the concept of active ageing (WHO, 2002:12). With the ever growing population of older persons, the need to maintain and improve the functional abilities of the ageing person in order to improve the overall quality in lifestyle has become very important (Bradshaw & Joubert, 2006:204; WHO, 2002:12). This need is even greater in SA as the distribution of ethnic groups is unbalanced with

older white South Africans consisting of 21% of the entire white population (Stats SA, 2013:2-3). Due to factors such as migration the majority of residential care facilities in SA are occupied by white older people (Stats SA, 2013:2-3). Research on non-death related losses in the field of active ageing and the overall quality of life of older persons in residential care facilities within SA thus has become very important.

4. RESEARCH METHODOLOGY

4.1 Literature review

The researcher conducted a literature review to obtain a clearer understanding of the problem statement. To obtain literature the researcher used text books, local and international journal articles, and research reports. Search engines included the following databases: Catalogue – Ferdinand Postma Library, North-West University, Potchefstroom Campus, University of the Free State, EbscoHost, PsycINFO, ERIC, SAGE, Pro Quest, Academic Search Premier, NEXUS and Sage Publications.

Key words included the following:

- Experience of non-death related loss (Altschuler & Katz, 2010; Berk 2004; Erikson in Brown & Lowis, 2003; Schmall & Bowman, 2004);
- Gerontology/Late-adulthood (Berk, 2004; Erikson in Brown & Lowis, 2003; Schroots, 1996; Tornstam, 1996);
- Psychosocial well-being in late-adulthood (Berk, 2004; Heidrich & Ryff, 1993; Schmall & Bowman, 2004; Steeman, Tournoy, Grypdonck, Godderis & Dierckx de Casterlé, 2013).
    - Physical losses in late-adulthood (Berk, 2004; Heidrich & Ryff, 1993; Schmall & Bowman, 2004; Steeman *et al*., 2013);
    - Emotional losses in late-adulthood (Berk, 2004; Heidrich & Ryff, 1993; Schmall & Bowman, 2004; Steeman *et al*., 2013);
    - Social losses in late-adulthood (Berk, 2004; Heidrich & Ryff, 1993; Schmall & Bowman, 2004; Steeman *et al*., 2013).

4.2 Research design

During the broader study a qualitative research method was used to study the phenomenon inductively in its context . Data collection methods (Fouché & Schurink, 2011:309; Madden-Derrich, Leonard & Gunnel, 2002:356; Sheridan, Peterson & Rosen, 2010:146) were used to obtain an in-depth understanding of the experiences of the quality of life of residents. A descriptive research design was used (Thorne, 2008).

4.3 Research context and sampling

White South Africans represent 90% of all older people in residential care facilities (Department of Social Development, 2010). According to the Department of Social Development (2010) it appears that white older South Africans prefer to be cared for in residential care facilties as a result of deteriorating health, movable social/cultural ties, the emigration of children and grandchildren and limited financial resources in their later years (Bradshaw & Joubert, 2006:204). Apart from white older persons, those of other race groups in SA seldom reside or are cared for in residential care facilities. According to the Older Persons Act of SA, Act 13 of 2006 (Department of Social Development, 2006), there are three categories pertaining to residential care facilities, namely: Category A – focusing on independent living; Category B – focusing on assisted living; and Category C – focusing on frail care. Within the broader study done in a specific residential care facility all three these categories were relevant to this study. This specific care facility is a non-government organisation where the residents buy life rights.

The broader research group made use of non-probability (Ritchie & Lewis, 2003:77) purposive sampling (Creswell, 2007:75; Ritchie & Lewis, 2003:78; Teddlie & Yu, 2007:80). This form of sampling emphasises specific characteristics (Trochim, 2001:56) that assisted the researchers in exploring the quality of life of older persons in a specific residential care facility (Leedy & Ormrod, 2005:206). For the purpose of the broader study the participating residents were between the ages of 65 and 95. The criteria for inclusion were the following:

- Voluntarily participation;
- The ability to communicate in Afrikaans or English;
- A permanent resident at the residential care facility;

- No visible cognitive impairment and able to orientate themselves in a discussion with other people; and
- Participants had to be mobile to attend the sessions that were held in the recreation centre of the residential care facility.

The number of participants included in the broader study was not predetermined as data saturation (or the sufficiency of information) is very important in qualitative studies. A total number of 74 willing participants in the end participated in the broader study, enabling the possibility for data saturation to occur or sufficiency of information to be reached as described by Greeff (2011:350).

4.4 Procedure

The intended broader research study was requested by the management of a specific residential care facility, and permission was thus received from the directing management to proceed with the research. Permission to conduct the study was also needed from the North-West University which meant that ethical approval (NWU-00053-10-S1) needed to be obtained (Appendix F). Participants were recruited by placing notices on the notice boards visible for all residents, inviting them to participate in the research (Appendix A). Willing participants had to indicate to management their willingness to participate upon which management informed the willing participants of the criteria for participation. A date was agreed upon and a pre-set program was compiled for the data gathering process to occur over a three day period (Appendix B).

Different forms of data collection methods were employed. For this purpose the participants had a choice regarding which of the data collection methods they wanted to participate in. From the 74 participants that participated in the broader study 19 formed part of the Mmogo Method® and 21 participated in the semi-structured interviews. For the purpose of the World Café four groups were formed consisting of not more than six participants in each group during the broader study. For the purpose of the Listening Group technique 10 participants represented the residents together with 10 staff members who also participated in this Listening Group technique.

On the first day of the intended research the individuals who were interested in

participating gathered in the recreation centre. Prospective participants were informed of the procedure and methods to be used during the study. After dealing with all the ethical aspects (as described in Point 5 under Ethical Aspects) the willing participants were divided into two groups for the Mmogo Method® and adjourned into two different rooms for this purpose.

On the afternoon of the first day, after the Mmogo Method®, themes that arose from the Mmogo Method® were used to act as a guideline for the semi-structured interviews. The second day started with a brief recap on the first day's happenings as well as a confirmation on the ethical aspects. The second day's intended data gathering methods were explained and the participants were divided into the different groups to begin with the World Café.

The Listening Group Technique was scheduled after the World Café on the second day. The second day of data gathering closed with a debriefing of the participants and a brief recap of the data gathering procedures. As this was the last day of data gathering and involvement with the participants the participants were thanked for their willing participation.

The third and last day did not include the participants, but a meeting was held between management, staff and the research team. The purpose of this meeting was for the research team to give feedback with regards to the previous two days and the themes that arose as the most important from the data gathering methods.

4.5 Data collection methods

Detailed in-depth data collection involving multiple sources of information, such as the Mmogo-Method®, World Café, Listening Group Technique, and semi-structured interviews were used. The World Café, Listening Group Technique, and semi-structured interviews were used to support the data collected during the Mmogo-Method® in the broader study. These data collection methods were able to accommodate any number of willing participants, including the individual, the small group as well as the larger group.

The Mmogo-Method® as a visual data collection method provided an opportunity to obtain rich data about personal and group experience of the participants (Roos, 2008; 2012). The Mmogo-method® was further used as this method gives insight, knowledge and a deeper understanding of the social, cultural and contextual aspects underlying human behaviour in order to provide in the holistic quality of life of the older person (Roos, 2009:1-3). The Mmogo-Method® is seen as a culturally appropriate method to obtain the required information. The World Café was used to uncover the wholeness, uniqueness and essence of human existence (Cowling 2001). Semi-structured interviews were used in conjunction with the Mmogo-Method® to further explore the themes identified during the Mmogo-data collection method as this contributed to the trustworthiness of the study. Semi-structured interviews gave information on the older persons' subjective life experiences (Greeff, 2005:292; Hofstee, 2006:132; May in Morse, 1991:189). The Listening Group technique was used to provide an opportunity for residents to communicate their experiences and needs to managers.

The methods of data collection enabled researchers to obtain data not only from the bigger group, but also from smaller groups and individuals. Cowling (2001) describes the necessity of a holistic composition that will include the older person's personal experience, perceptions and expressions. This holistic composition was included during the broader study to accommodate the older person's underlying pattern of life that is reflected in the individual's experience, perceptions and expressions. The rich data that emerged from the transcribed data from the broader study revealed different themes (Tarr, 2014; Zaaiman, 2014). It also provided the opportunity to conduct a secondary analysis of the original data pertaining to non-death related losses, which is the focus of this study. The data collection methods from the broader study will subsequently be discussed:

4.5.1 Mmogo-Method®

The Mmogo-Method® is a visual data gathering technique during which the researcher is able to understand the individual's subjective experiences of their lives in a residential care facility. Roos (2009:2) explains that collective experiences, which are embedded in different contexts in which experiences are formed, will enable the individual to understand the self on an extended personal level.

The following materials were available to the participants with the instruction to create a visual representation which will show their personal experience of their life in a residential care facility: a lump of clay; colourful beads; dry grass stalks of different sizes and a round piece of cloth as shown in Figure 1. Each participant was asked to build something with the given materials that represent their life within the residential care facility. After completion of the visual representations each participant was given the chance to explain his/her visual representation to the rest of the group. The group members were given a chance to share their experiences of the individual's representation.

This visual representation became the stimulus material that enabled the group to discuss the shared experience. This led to the social construction of the meaning attached to shared experiences (Roos, 2009:2; Roos & Strong, 2010:86). The data gathered from the Mmogo-Method® were used to identify themes which were further explored in the semi-structured interviews that followed the Mmogo-Method®.

Figure 1: Materials that were given to Mmogo-Method® participants

4.5.2 Semi-structured interviews

Semi-structured interviews serve as a textual data gathering technique used on a one-on-one personal level with selected individuals in a non-directive manner as mentioned by Greeff (2005:292). Semi-structured interviews are considered useful as they are used to gain a detailed picture of beliefs/perceptions or account of a particular topic (Smith, Harré & Van Langenhoven, 1995:9-26). Even though the interviews were semi-structured the researchers still allowed considerable flexibility in scope and depth

for the individuals to express themselves and elaborate on subjects of interest to them (Hofstee, 2006:132; May in Morse, 1991:189). Some of the pre-set questions asked included a description of the activities inside the residential care facility that the participants make use of. Other questions asked were if the activities contribute to add meaning to their lives. The same set of pre-set questions were asked with regards to activities outside the residential care facilities.

4.5.3 World Café

The World Café is a visual (Roos, 2009:2) and textual data gathering technique (Greeff, 2011:292) that was used to uncover the underlying pattern of life that is reflected in the individual's experience, perceptions and expressions (Cowling, 2001). The World Café allowed all the participants an equal opportunity to share their thoughts and opinions in a non-threatening way. Participants were divided into smaller groups with a representative from each of the interest groups. The aim of the World Café was to create a relaxed and informal atmosphere where every participant had an equal chance to express themselves. In order to create a relaxed and informal atmosphere, groups were gathered around different tables with something to eat. The table cloth on each table consisted of an A2-paper on which the participants could put down their contributions. Along with the representative a host was also appointed which rotated between the tables. The role of the host was to inform the next group what the previous group contributed on the table cloth to ensure continuity. The questions and commands, combined with the meaningful discussions, did provide room for possible new insights to emerge as the individuals engaged in ever-widening circles of thoughts (Schieffer, Isaacs & Gyllenpalm, 2004:5).

The proposed questions/commands included the following: the participants had to draw the people with whom they have a special relationship; they were asked to make a drawing that will represent the activities they participate in; they were asked to make a drawing of how the participant would want the residential care facility to be for a loved one in this facility; and how the participant would promote the residential care facility to family and friends. Within the World Café these leading questions offer a large group of people the opportunity to discuss the specific research questions (Roos & Du Toit, 2014:3; Schieffer *et al*., 2004:16) giving all the participants an equal opportunity to be involved with the data gathering. This way of involving the

participants stimulates ideas about the specific questions asked, thus contributing to the participants optimally relating to one another within the group (Schieffer *et al*., 2004:5).

After the completion of the group activities the bigger group gathered where all the hosts had the opportunity to share with the bigger group the experiences of the specific topic that they hosted. From these conversations aspects pertaining to the quality of life was confirmed as well as recommendations made with regards to the refinement of the current process to a better quality of life within this residential care facility.

4.5.4 Listening Group Technique

The Listening Group Technique is a textual data gathering technique used on a one-on-one personal level with selected individuals in a non-directive manner as mentioned by Greeff (2011:292). For the purpose of the broader study the Listening Group Technique consisted of two groups of participants, namely an 'inner-group' and an 'outer-group' (Roos, 2011). The 'inner-group' consisted of participants that gave feedback to the 'outer-group' (which consisted of members of management), with regards to their experiences of the past two days. The 'outer-group' (members of management) had to listen carefully as they had to reflect on the explanations given by the participants ('inner-group'). The 'outer-group' had to observe and pay close attention to the views held by the 'inner-group' about their experiences and possible improvement of the living conditions.

After a period of time the two groups exchanged places which meant that the 'outer-group' became the inner group and *vice versa.* The 'outer-group' reflected their experiences based on what they had heard from the 'inner-group's' discussion. The participants again exchanged places allowing the 'inner-group' members to reflect on the remarks of the 'outer-group' members. The changing back of places allowed the former 'inner-group' the opportunity to receive acknowledgment and feedback. During the last session the two groups united, forming one large group to discuss the aspects that arose from the discussions (Carr, 1998:500; White, 1995:8). During this combined discussion the participants and management verbalised their personal experience of the discussions that took place within the two groups and how the groups interpret each other's opinions.

4.5.5 Field notes

Field notes made by the researchers were used to support the data gathered during the data gathering methods (Strydom, 2011b:335). This was necessary to insure the integrity of findings and to enhance reliability of the broader study (Cowling, 2001:38; Kelly, 2010:301-318; Matthews & Ross, 2010:474), which also contributed to the trustworthiness of the secondary analysis of the data. During these writings noting and jotting down ideas and potential coding schemes were identified (Ryan & Bernard, 2000:780). The fact that themes emerged from all four data gathering methods that linked with each other, also made a contribution to trustworthiness as there was confirmability amongst the themes from the different data gathering methods (Cowling, 2001:38; Kelly, 2010:301-318; Matthews & Ross, 2010:474). These notes served as an account of what the researchers have listened to, viewed, deliberated upon and perceived in the field (Patton, 2002; Strydom, 2011b:335) during the broader study. The researchers also made use of reflective notes after each interview to neutralise possible bias (Elliot & Timulak, 2005:150). These reflective notes included self-reflection and reflection on ethical aspects and the research process (Ellingson, 2009:4) that were discussed and reflected upon with the group of researchers involved in the study.

4.6 Data analysis

The data analysis consists of two sections that will be discussed under this section. The first is the thematic analysis and the second is the visual analysis. The initial data obtained in the broader study were analysed by means of thematic and visual analysis. Even though thematic and visual data were obtained during the Mmogo Method® and the World Café, only the verbatim statements were used for the purpose of this study and not the actual interpretation of the visual stimuli. Direct quotes from participants were used during the secondary analysis of the data to ensure an accurate interpretation of social meanings. This was constructed through thick descriptions to provide the reader with a deeper understanding of the research topic (Ellingson, 2009:4).

Braun and Clarke (2006:87-93) identified six phases of thematic analysis that were used as a guideline. These guidelines will be discussed under Point 4.6.1 in table

format to explain how these steps were applied in the broader study as well as during the process of secondary analysis.

4.6.1 Thematic data

Six phases of Thematic Analysis by Braun and Clarke (2006:87-93)	
Broader study	**Current study**
Phase 1: During phase one the researchers familiarised themselves with the data using the audio recordings to transcribe the interviews from all the data collection methods for thematic analysis. The video recordings were used as a back-up system if anything was unclear from the audio recordings, as well as for the purpose of viewing the visual projections where necessary during the initial analysis of the data from the broader study.	Phase 1: In the secondary analysis of the original data it was important to obtain the transcribed verbatim statements made during the original data collection methods and become familiarised with all the data by reading through it ample times, even though the researcher was part of the broader study and did some of the transcriptions herself (Strydom, 2011a:123).

Phase 2: Data from the Mmogo-Method®, World Café, Listening Group Technique, and semi-structured interviews were individually transcribed after which thematic analysis was conducted by the researchers involved during the broader study to identify themes. Coding is an important part of the process where the data were read semantically and conceptually (Clarke & Braun, 2013:121-122).	Phase 2: Following Braun and Clarke (2006:87-93), initial codes were generated which led into phase three.
Phase 3: The initially identified themes were used by different researchers involved in the data gathering process to identify fields for futher exploration and study.	Phase 3: During this phase the identified codes were sorted into themes. The verbatim statements pertaining to non-death related losses were colour coded into different sub-themes, whereafter the themes were defined.
Phase 4: Phase four consisted of the review and location of the themes to the most relevant and frequent themes used. This gave the researchers a clearer idea of the relevant data and what was usable.	Phase 4: The researcher familiarised herself with the data to conduct a thematic analysis. Thematic analysis was conducted by constantly moving backwards and forwards between the collected, coded data extracts (Braun & Clarke, 2006:87-93.).

Phase 5: Defining and naming the themes formed part of phase five.	Phase 5: It was important to define and to name the different themes pertaining to non-death related losses in order to establish what is actually usable and what is not for this specific study.This enabled the researcher to obtain a clear written analysis of the different and relevant themes. The verbatim statements pertaining to non-death related losses were colour coded into different sub-themes. This enabled the researcher to obtain a clear written analysis of the different and relevant themes.
Phase 6: Different dissertations with different themes arose from the original data and are used to help the management of this specific care facility to enhance the overall quality of life of their residents.	Phase 6: The final phase consisted of producing a written thematic report for this dissertation. The purpose of this writing is to convince the reader of the merit and validity of the analysis.

4.6.2 Visual data

Even though the Mmogo-Method® and World Café presented visual data during the broader study, the visual data were not specifically used for the purpose of the current study. Visual data will be discussed briefly as it formed part of the broader study. Visual data consisted of the photos that were taken of the visual presentations made during the Mmogo-Method®. The analysis of the visual data was done for the broader study by comparing the symbolic meaning the participants attributed to their representations to the specific research question (Roos, 2008), which was to explore and describe the quality of life of older residents in a particular residential care facility in Gauteng. The rest of the group was allowed to contribute to each participant's presentations or ask questions about the projection. By using each participant's symbolic value to the unique visual presentation the command/request was answered, namely to build a projection that will be representative of the participant's life within the residential care facility, inclusive of the activities they participate in. The representations were analysed

for the broader study in terms of the research question and linked to the textual data to enrich the descriptions provided by the participants. The values attributed by the participants to their individual projections added to the interpretation of the projection as understood by the group and were then used in combination with the textual data to authenticate and enrich the recognised themes during the broader study.

4.7 Trustworthiness

The following measures were used to address trustworthiness within the broader study as well as the secondary analysis of the data as suggested by Lincoln and Guba (1985:290):

- Credibility of the research study was achieved by prolonged engagement with the participants until data saturation or sufficiency of information was reached (Greeff, 2011:292). For the broader study it entailed using different methods of data gathering over a period of three days. With the secondary analysis of the data involvement with the data over a 19 month period contributed to the credibility.
- Dependability was achieved during the broader study through the clear and logic motivation of the usage of the specific data gathering methods that were used as discussed in 4.5. The original themes that arose during the broader study were narrowed down during secondary analysis of the data that revealed the residents' experiences of non-death related losses. The secondary analysis of the data contributed to the dependability by further narrowing down the aspects pertaining to non-death related losses into sub-themes as experienced by the residents. Furthermore, the credibility of the study also contributed to the dependability of the research study through the prolonged engagement with the participants through the different data gathering methods used (Lincoln & Guba, 1985:316).
- In order to assure transferability multiple data sources were used such as the Mmogo-Method®, World Café, Listening Group Technique, and semi-structured interviews (Braun and Clarke, 2006:87-93). Field notes (Cowling, 2001:38; Kelly, 2010:301-318; Matthews & Ross, 2010:474) contributed to the transferability, credibility and trustworthiness of the study as it was used as a reflection method for the researchers to make sure that the same themes and concerns were detected within the group during the process of data gathering.

Different forms of data sources helped reduce the effects of bias from sources (Kelly, 2010:299) during the course of the broader study and increase the measure of trustworthiness of the broader study (Maritz & Visagie, 2009). By examining different types of information gathered from the Mmogo-Method®, World Café, Listening Group Technique and the semi-structured interviews from a range of participants, a thematic analysis took place to crystalise the findings, hence, examine data from different perspectives (Ellingson, 2009:4).

- Confirmability was achieved through accurate, uninfluenced and thorough data collection and analysis throughout the study (Schurink, Fouché & De Vos, 2011:421). Apart from the larger group of facilitators that transcribed and encoded the information an independent encoder was used to double check and confirm the relevant themes that arose from the original data gathered (Ellingson, 2009:4).

5. ETHICAL ASPECTS

Ethical permission for this study was obtained from the North-West University as part of the broader project: An exploration of enabling contexts under the ethical number: NWU-00053-10-S1. Permission was initially granted from a community perspective through the invitation that was received from the management overseeing the specific care facility. For the purpose of the broader study the gatekeeper was a lifestyle consultant being the mediator between the residents and the research team. The guidelines of the Health Professions Council of SA for Psychologists (Health Professions Act 56 of 1974) were followed and included:

- Participation was voluntary and the researchers neither coerced nor forced participation in the broader study (Strydom, 2011a:117).
- Individuals were invited to participate in the research via an invitation that was placed on the memorandum boards in the residential care facility. Care was taken not to withhold facts from the potential participants about the research process. Strydom (2011a:119) mentions three ways in which participants can be deceived, even if not on purpose which involves the following: it can be by disguising the real goal of the study; by hiding the real function of the actions and subjects and by miss-representing the experiences that participants will go through.

- An in-depth description of the broader research prior to its commencement, as well as a Subject Information Sheet (Appendix A & C), were provided so that potential participants could make an informed decision as to whether they wanted to participate in the study (Rubin & Babbie in Strydom, 2011a:119). Participants were further informed about the aims of the research project; what would be expected from them; what the data will be used for; the termination of their participation in the study; confidentiality; the safekeeping of records, material and recordings which also helped them to make an informed decision to participate in the study.
- Consent from the participants was obtained through their written consent as recommended by List (2008:672) (see Appendix C) before the onset of the first data collection method, namely the Mmogo Method®.
- Open groups were used for the data collection methods, except for the semi-structured interviews, therefore partial confidentiality was explained to all the prospective participants.
- The possibility that participants may experience distress during data collection is always a reality and participants therefore had the opportunity to withdraw from the study in situations like these. The researchers however took all measures to guard against physical or emotional harm (Strydom, 2011a:115) by continuously discussing the participants' mental state with the participants and reassuring the participants with every data gathering method of their right to withdraw at any stage. The participants had regular breaks with refreshments to contribute to their mental health. The researchers beforehand also arranged with a psychologist/social worker to debrief and assist the participants should any participant felt the need for such intervention. A further method of debriefing the participant occurred after each of the data gathering methods to ensure that the participants did not experience any emotional harm during the course of the data gathering. The process of member checking after each data gathering method ensured a safe space in which the participants could work through and process their experiences as recommended by Strydom (2011a:122).
- All records, recordings and verbatim transcriptions made during the broader study, as well as for the current study will be treated as private and confidential and kept safe by the Africa Unit for Transdisciplinary Health Research, North-West University for 5 years (Strydom, 2011a:123).

- During the process of secondary analysis of the data each participant was given a code in the form of a number according to the data collection method they particpated in for example M1, M2, etc. for the Mmogo Method and S1, S2, etc. for the semi-structured interviews. This was done in order to protect the identity of the participants (Strydom, 2011a:119-120).
- Several feedback opportunities took place during the whole research process. At first the research team gave feedback to management just after all the data were collected on the broad thoughts and experiences of the particpants regarding their needs pertaining to their quality of life in the residential care facility. Thereafter each researcher that partook in the broader study gave feedback pertaining to the specific focus of his or her research report. Feedback about the current research findings will be made available to the participants by distributing a short report to the management of the care facility via electronic medium (Kelly, 2010:297) after the examination process has been concluded.
- Strydom (2011a:115) recommends that the researcher's actions and competence be ethically based during the entire research process and that researchers should remain objective and respect the belief systems and values of the participants (Strydom, 2011a:124). During the broader study as well as with the secondary analysis of the material such care was taken by always considering the ethical guidelines of the Health Professions Council of SA for Psychologists. During the process of constantly making use of member checking, making sure to portray and understand the exact meaning of the participants, care was again taken to reinforce ethical guidelines.

6. SUMMARY

Section A Part 1 served as an orientation to the research study. The motivation and rationale for this study was viewed from current literature to give a description of non-death related losses as experienced by older persons. Non-death related losses included the loss of physical and cognitive abilities, as well as interpersonal and financial losses. Specific attention was given to ethical aspects with regards to the research methodology, including the secondary analysis of data. This section also included explaining the research design, the selection of participants and the procedure that was followed during the data collection methods. Four different data collection methods were made use off during the broader study. The procedure that

was followed to analyse the data was explained, which contributed to the trustworthiness of the study.

SECTION A

PART 2: LITERATURE REVIEW

1. INTRODUCTION

The following section will discuss main concepts focused upon in this study, such as describing different types of non-death related losses, what the accumulative role of these non-death related losses is on the quality of life of the older person and how that will change or not change the view on active ageing. The focus will be on the experience of non-death related losses as these losses seem to form a very important part of the older person's life, also playing a role in the overall quality of life of the older person. The accumulative role on the older person's quality of life could potentially result in the development of for instance mental illnesses such as depression. Other relevant concepts such as the psychosocial well-being in the life of the older person including active ageing, physical, emotional/ psychological, and social losses experienced by the older person and developmental theories as described by Erikson and Bronfenbrenner with regards to gerontology/ late-adulthood, will be discussed considering non-death related losses in these discussions.

2. DIFFERENT LOSSES EXPERIENCED DURING LATE-ADULTHOOD

Loss is an inevitable happening in all individuals' lives but even more so in the life of the older person. Bickerstaff, Grasser and McCabe (2003:159-160) and Schmall and Bowman (2004:2) highlight that older persons experience more non-death related losses than any other age group. To broaden the understanding of a non-death related loss the definition of Yang and Lee (2012:99) is used where they state that non-death related losses are viewed as an emotional response to the separation from subjectively important person(s) or things.

2.1 Specific non-death related losses

According to Schmall and Bowman (2004:2-3) non-death related losses will include losses such as the loss of a job through retirement, loss of roles, health, body parts, the ability to drive, independence and even the loss in ability to see or hear, to name but a few. Additional non-death related losses, according to Hudgins (2011:15-28) and Schmall and Bowman (2004:2-3), that can be experienced are a change in living arrangements which means losing familiar surroundings, long-time friends, possessions and even less control over their environment and schedule. Items of sentimental value often have to be left behind when a change is being experienced in living arrangements (Hudgins, 2011:15-28; Schmall & Bowman, 2004:2-3). Retirement

alone could involve a loss of status, friends, change in routine and reduced income, all of which will have an impact on the self-esteem of the individual who was well-known in for instance the work environment (Berk, 2004:610-611).

Leaving behind a pet when moving to a residential care facility, not being able to take care of a pet due to financial losses or loss of physical abilities, or even the death of a pet can have a tremendous consequence on the older person's sense of well-being. The loss of a pet, regardless of the reason, can even cause feelings of guilt with the older person because they could not take care of the pet any longer (Schmall & Bowman, 2004:3). When the older person experiences emotional overload due to non-death related losses it can cause mental confusion, disorientation and withdrawal (Berk, 2004:546-547).

Berk (2004:549-556) has divided the different non-death related losses that a person in late-adulthood can experience into physical losses, emotional and psycho-social losses and in social losses and these losses will subsequently be discussed.

2.1.1 Physical losses in late-adulthood

Physical losses, according to Berk (2004:549) and Whitbourne (2001:2-3), specifically refer to the loss of muscle strength, deterioration of reduced bone mass and loss of strength and flexibility of the joints and ligaments. Berk (2004:549-556) continues his view on physical losses by describing a variety of aspects under the heading of physical losses, including aspects such as physical change in the nervous and sensory system, vision, hearing, taste and smell, touch, cardiovascular problems, the immune system, sleep and physical appearance and mobility, to name but a few. Steeman *et al.* (2013:217) state that physical losses will include the loss of activities, independence and even the loss of control over reality. Sarvimäki and Stenbock-Hult (2000:1025) are of the opnion that the life of the older person is known for health problems and a decrease in functional capacity, having the result of more old persons living with chronic diseases, health problems and a decreasing capacity.

Losing physical and cognitive abilities occur gradually and as a consequence older persons are steadily losing abilities and competencies that prevent them from performing certain actions or which inhibit their interactions with other individuals. This

aspect and the accompanied consequences such as feelings of isolation and loneliness are well described in literature (Antonucci, Birditt & Webster, 2010:650; Berk, 2004:546-547; Pinquart, 2002:90-91; Schmall & Bowman, 2004:9-10; Yang & Lee, 2012:99). The concept of constant change that is accompanied by feelings of isolation and loneliness as a result of declining body functioning is also an aspect acknowledged in the developmental theories of Erikson (in Erikson *et al*., 1986:37) and Bronfenbrenner (Bronfenbrenner & Morris, 2006:793). These feelings of isolation and loneliness are accompanied by different fears, such as a fear of becoming a burden or a fear of injuries, to name a few (Minichiello, Browne & Kendig, 2000:260-266).

Liang, Krause and Bennett (2001:511-523) discuss the fear of becoming a burden by stating that when assistance cannot be returned by the needy individual, it often results in psychological distress. It can be extremely difficult for the once independent individual who has taken pride in being self-sufficient, to all of a sudden be dependent on others (Schmall & Bowman, 2004:1-5), regardless if it is due to the loss of physical abilities or with the loss of eyesight or hearing. Minichiello *et al*. (2000:265) confirm that older persons at some stage will need someone to take 'care' of them and that they will need the help of others at some stage in their lives. Schmall and Bowman (2004:1-5) mention that the loss of independence appears to cause the older person to loose self-confidence. What was interesting to note, though, was that fear also formed part of the loss of self-confidence, where fear (regardless if it was fear of becoming a burden or of the loss of physical ability to name but a few) was the actual reason for the loss of self-confidence (Minichiello *et al*., 2000:259-266; Steeman *et al*., 2013:219).

With the change in body functioning and the constant decline in physical abilities injuries are more likely to occur. An awareness of an injury due to a loss of physical ability can result in fear of reoccurrence as stated in a study by Tinetti, Speechley and Ginter (1988:1701-1707). Tinetti *et al*. (1988:1702) stated that half of older persons that had fallen before admit that they purposefully avoid activities because they are afraid of falling again. This described fear is also linked to the driving of a motor vehicle and becoming dependent on others. Messinger-Rapport and Rader (2000:32-45) did a study on the older person and their ability to drive, or not to be able to drive. They

concluded that older persons have higher rates of traffic violations, accidents and fatalities than any other age group. Owsley and McGwin (1999:535-550) mention that the higher rate of moving violations and crashes that individuals in late-adulthood have are a result of visual processing difficulties that they have. It is for instance found that the older person tries to compensate for the loss of their eyesight by becoming more cautious. Not all older persons, however, acknowledge that their ability to drive safely declined and this causes accidents (Berk, 2004:563).

When loss of physical abilities, such as the loss of flexibility and mobility, is experienced it is likely to cause fear and insecurity with the older person, affecting the individual's resilience (Berk, 2004:546-547). Fear and despair are concepts directly applied in the theory of Erikson with regards to late-adulthood (Erikson, *et al*., 1986:37). He (Erikson) as well as Fuller-Iglesias *et al.*, (2008:183-184) describe that the loss of body function will challenge an older person's autonomy, independence and control and as a consequence can lead to a loss of self-esteem, a loss of confidence and fear. Zaaiman (2014) found in her research that older persons regard their autonomy and independence as growth needs that they would like to harness as long as possible.

2.1.2 Emotional and psychological losses in late-adulthood

Emotional and psycho-social losses, according to Berk (2004:587-590), involve the loss of a secure and multifaceted self-concept, sociability and acceptance of change. With regards to psychological losses Berk (2004:591-594) and Erikson (in Erikson, *et al*., 1986:37) included aspects such as control versus dependency, negative life changes, social support and social interaction.

Berk (2004:564-566) states that the aging of the nervous system affects a wide range of complex thoughts and activities as brain weight declines to a greater extent after the age of sixty. Memory loss is seen as part of a medical condition, such as dementia, even though it forms part of a normal decline in brain functioning found in old age. Dementia is seen as the gradual loss of cognitive abilities, interfering with daily functioning, that accompanies abnormal brain deterioration (Passer & Smith, 2008). Bronfenbrenner and Morris (2006:808-809) discuss amongst others the concept of constant change in the cognitive ability of the older person. They (Bronfenbrenner &

Morris, 2006:793) state that these changes will play a role in the quality of life of the older person. Clare (2004:155-175) takes the concept of gradual loss of cognitive abilities even further and links the decline in cognitive ability to a loss of identity.

The loss of identity can have serious implications for the older person as stated by Harris and Sterin (1999:241-256). Harris and Sterin (1999:242) stated that the loss of cognitive ability threatens the security, autonomy and the older person's ability to be a meaningful member of society, which are viewed as important factors associated with identity. Steeman *et al*. (2013:216) confirm that persons with dementia actively face their cognitive decline as these persons notice the changes caused by the dementia. As the older person is aware of the dementia that is taking its toll they search for meaning by focusing on maintaining their old or new identities. Sadly, according to Steeman *et al*. (2013:216), dementia will affect the cognitive function that is necessary to cope with loss.

Pearce, Clare and Pistrang (2002:173-192) also relate the fear of loss of cognitive ability back to identity and state that it becomes a struggle to manage the old sense of self and finding oneself with a new identity during stages of dementia. Harman and Clare (2006:484-502) state that part of forming this new identity is to acknowledge that one's memory loss will get worse. According to Clare, Roth and Pratt (2005:487-520) and Robinson, Giorgi, Ekman and Wahlund (2000:1-28), cognitive changes may not necessarily be perceived but more often the change in relationships where the older person will experience an increasing dependency. This increase in dependency will challenge self-maintaining coping style and also affect the person's identity and sense of self.

In conclusion the awareness of change within the older person battling with the loss of cognitive abilities will lead to the loss of order and control. In turn the loss of order and control can be related to dependency on others which will lead to a struggle with the maintenance of identity (Steeman *et al*., 2013:219).

2.1.3 Social losses in late-adulthood

Family, friends and social interaction are important aspects of life, even in late-adulthood. Social losses are seen as the loss in interaction between family, friends

(Antonucci, Akiyama & Takahashi, 2004:353-354; Bronfenbrenner & Morris, 2006:793) and even pets (Schmall & Bowman, 2004:3). Antonucci *et al*. (2004:353-354) discuss in the Convoy Model the importance of being emotionally close and important to a significant other. The social context and the quality of relationships are incorporated in the theory of Bronfenbrenner (in Bronfenbrenner & Morris, 2006:793) stating that the quality of life and well-being of the older person will be influenced due to late-adulthood as change is also on an interpersonal level unavoidable.

It is often noted that the closeness with family and friends gives the older person a sense of belonging. According to Wong (1998:113), the presence of family and friends installs feelings of being respected, needed and being useful, thus also giving the older person a sense of identity. Bickerstaff *et al*. (2003:161) furthermore mention that the older persons' quality of life will be enhanced when they have feelings of belonging. These feelings of belonging, however, are normally absent in the life of the older person due to all the non-death related losses they have to deal with (Bickerstaff *et a*l., 2003:159-160). A struggle to be valued, therefore, seems to form part of the older person's life.

Steeman *et al*. (2013:216) interestingly note that the loss of self-confidence is seen as a struggle to be valued. According to them being valued refers to being competent enough to be in control of one's life and to be valued for fulfilling the perceived expectations of society. As the older persons fear that they are not able to fulfil these 'perceived expectations' of society they lose self-confidence (Steeman *et al*., 2013:216-218).

During late-adulthood, however, older persons become more selective in their attachment relationships and will as such reduce their attachments to others by becoming more selective (Antonucci *et al*., 2004:355). Personal and situational factors, like for instance children and family living overseas, will also play a major role in social relationships amongst older persons which in turn will play a role in their physical and mental health, life satisfaction and well-being (Antonucci *et al*., 2004:354).

One of the stressful life events experienced by older persons is isolation which is often accompanied with the sickness of a significant other or children moving away. As the older person experiences feelings of being respected and valued when needed by significant others, it can in the same sense cause isolation due to the intense caregiving of the significant other (Antonucci *et al*., 2004:355). Being useful and needed appears to be an important aspect amongst older persons, thus over-committing in the caregiving of a significant other almost happens automatically. Antonucci *et al.* (2010:650) commented in this regard that the spousal feelings of responsibility are as a result of the spouse's feelings of obligation to care and support their loved ones during illness. In addition, it also has implications for the individual that are being taken care of within the navigation in social networks and the broader environment as well as for the individuals who take care of them (Liang *et al*., 2001:511-523; Minichiello *et al*., 2000:265; Pearce *et al*., 2002:173-192; Schmall & Bowman, 2004:2; Steeman *et al*., 2013:219). These implications, according to Minichiello *et al*. (2000:265), include aspects such as the loss of self-sufficiency, individuality, retention of their decision-making ability, and choice making abilities, to name but a few. As if the isolation factor is not enough, the older person is confronted with depressive symptomatology related to resource deficits and quality of social relations (Antonucci, Smith, Baltes, Takahashi, Fuhrer & Dartigues, 2002:779). Interestingly it is social relations and high-quality relationships, according to Antonucci *et al*. (2002:770), that will assist the older person in dealing better with stressful life events.

One of the many changes some older persons need to face is the transition to a residential care facility (Bickerstaff *et al*., 2003:159). This transition is often accompanied by retiring from a career (Berk, 2004:609). According to Antonucci *et al*. (2004:354) and Antonucci *et al.* (2010:650), it is important to consider how personal and situational factors will play a role in the older person's physical and mental health, life satisfaction and well-being as custom and cultural differences are likely to have an important impact on the older person's quality of life. Tornstam (1992:319) in his study elaborates on the statements by Antonucci *et al*. (2004) and Antonucci *et al.* (2010) and mention that in the Western society people tend to value themselves in terms of productivity and effectiveness. The loss of self-confidence that impacts on the older person's sense of identity is also very closely linked with when one has to retire (Berk,

2004:609). Schmall and Bowman (2004:1) mention that when a person 'loses' something significant that the person has invested time, energy, affection, money, dreams and hopes in will cause that person to grieve the loss. If the individual's work has become their primary source of identity and worth, the loss of a career will lead to a loss in self-confidence.

Tornstam (1992:321) states that when the older person relocates to a residential care facility this has a major impact on the person's self-identity as it will implicate leaving behind that which is known to the person. The relocation to a residential care facility has the implication of less privacy as the care facility is the coming together of many people in a secluded and closed environment. To conceptualise the concept of transition and facing less privacy, the findings of Minichiello *et al*. (2000:265) may bring some understanding about the intrusion of privacy in residential care facilities. They state that as a result of ageism older persons may have the need to be respected for their knowledge and experience, thus seeking out the company of others who will value their wisdom and listen to them. In this context it appears that because of a personal need to be 'heard' the older person does not value the privacy of fellow residents.

The loss of a career due to retirement has many implications for the older person including a loss of identity, loss on a financial level, and even a loss of place and people (Berk, 2004:609). Berk (2004:612) continues by stating that financial losses even have an impact on identity and independence as the financial losses imply becoming more dependent on others. In turn it will impact on the psychological well-being, social contact and self-esteem of the older person (Berk, 2004:612-613).

Pets are seen as forming part of the individual on an interpersonal level as pets are sometimes seen 'as part of the family' (Schmall & Bowman, 2004:3). Literature confirms that pets serve as companions for older persons (Berk 2004:568), and losing pets could add to the experience of multiple losses and accompanying grief. Schmall and Bowman (2004:3) acknowledged this importance by stating that the death of a pet can be seen as very traumatic as pets are viewed as part of the family by some people. The loss of a pet is however not always viewed by society as an important factor, like for instance the death of a loved one. But for many older persons their pet is

sometimes their ‘only’ family, thus experienced as a tremendous loss (Schmall & Bowman, 2004:3).

2.2 Symptoms of losses experienced on a physical, behavioural and spiritual level

Older persons can be overwhelmed and frightened when experiencing non-death related loss (Fuller-Iglesias *et al.,* 2008:182-184; Sarvimäki & Stenbock-Hult, 2000:1025; Schmall & Bowman, 2004:9-10). This will include symptoms on a physical level such as a knot in the stomach, changes in appetite, tightness or a lump in the throat, frequent sighing, shortness of breath, muscle weakness, dry mouth, nausea, diarrhea, indigestion, to name but a few (Berk, 2004:612; Pinquart, 2002:90-91; Sarvimäki & Stenbock-Hult, 2000:1025-1026; Steeman *et al*., 2013:216-217).

On a behavioral level older persons may experience immobility, restless over-activity, forgetfulness, sleeplessness or oversleeping, inability to begin and maintain normal activities, crying and social withdrawal in the midst of a non-death related loss. Responses to grief within the individual’s thought patterns may include denial, poor concentration, disorganisation, confusion, pre-occupation with the non-death related loss, dreams about the loss, and retelling the details of the loss over and over (Schmall & Bowman, 2004:9-10).

Steeman *et al*. (2013:219) in their research confirm that loss of confidence is aggravated by fear. The loss of self-confidence leads to the older person loosing resilience and thus also a sense of identity (Bickerstaff *et al*., 2003:159). Antonucci *et al.,* (2004:366) explain loss of self-confidence in the light of being resilient. According to them late-adulthood is known for the increase of psychosocial stressors such as death of loved ones and declining physical health, but according to Antonucci *et al*. (2004:366) the manner in which the older person is able to be resilient, or then not to be, will determine their level of self-confidence. Davis, Zautra and Johnson (2007:250-266), however, state that certain forms of adversity become more normative in late-adulthood, thus being an unavoidable part of the older person’s life. On a spiritual level the individual may experience anger directed towards God (Berk, 2004:588), examining the meaning of life, seeking meaning in the loss itself, doubts, wavering of faith and even strengthening of beliefs when they experience non-death related

losses. Emotional ups and downs may be experienced in the form of shock, anxiety, intense sadness, depression, helplessness, fears, envy, including also anger and guilt which appear to be the most difficult to deal with (Berk, 2004:546-547; Schmall & Bowman, 2004:9-10). Feelings of anger can result in fear and/or feelings of injustice. Guilt may arise as a result of the individual feeling they could or should have done things differently, even regretting their past decisions when the older person experience non-death related losses (Erikson *et al*., 1986:37; Schmall & Bowman, 2004:9-10). Loneliness and sadness tend to be the longest lasting feeling of grief associated with non-death related losses and can lead to feelings of emptiness (Freud, 1957:244; Schmall & Bowman, 2004:9-10).

2.3 Factors that play a role in the consequences experienced with non-death related losses

Unfortunately there are aspects that will play a role in the consequences experienced with regards to non-death related losses. This is described by Schmall and Bowman (2004:12-17) in four major factors. The first factor includes the significance of the loss. The more important the person, object or activity the more profound will the impact on the sense of loss be and the more profound this sense of loss the more intense the grief will be experienced. According to literature grief is an indissoluble part of the word 'loss' and therefore 'loss' cannot be viewed in its entity (Freud, 1957:244; Goldsworthy, 2005:176). What is important though, and is also focused upon by Schmall and Bowman (2004:8-9) as well as Berk (2004:557-561), is how an individual responds to grief as a result of the non-death related losses suffered, as grief can cause tremendous distress in many aspects of life such as on a physical, emotional and spiritual level (Berk, 2004:576-578; Schmall & Bowman, 2004:8-9). Schmall and Bowman (2004:1) highlight the fact that even though the loss of a significant other is seen as one of the greatest losses, grief is also significant with the loss of something where one has invested time, energy, affection, money, dreams and hopes in, thus referring to a non-death related loss. Older persons can be overwhelmed and frightened with feelings such as guilt, anger and loneliness during their experience of non-death related losses (Berk, 2004:546-547; Schmall & Bowman, 2004:9-10). Feelings of anger can result in fear and/or feelings of injustice (Erikson *et al*., 1986:37). It appears from the above that experiences of non-death related loss has a

tremendous impact on the individual's life, thus influencing their holistic sense of well-being and *per se* their overall quality of life.

The characteristics of the non-death related loss are the second factor which will include the natural versus the unusual circumstances surrounding the loss (Neimeyer, 1999:68; Schmall & Bowman, 2004:9-10), or an unexpected loss compared to an expected loss. An unexpected loss will also have a more significant impact on the individual, for instance a sudden and unplanned retirement and moving to a residential care facility due to illness compaired to the planned moving to a residential care facility as part of a retirement plan; when non-death related loss is viewed as untimely the impact can also last longer; a non-death related loss viewed as temporary will play a less significant role in the individual's life compared to a permanent loss; as will multiple losses play a more significant role in the individual compared to a single loss (Neimeyer, 1999:68; Schmall & Bowman, 2004:9-10).

The third factor will include the individual's ability to cope with the non-death related loss. Past experience can be an indicating factor in how the individual dealt with past crises and non-death related losses. Social support is the last important factor as social isolation will make any adjustment more difficult (Heidrich & Ryff 1993:331; Pinquart, 2002:92; Sarvimäki & Stenbock-Hult, 2000:1027; Schmall & Bowman, 2004:9-10).

From the above it appears that experiences of non-death related losses will play a profound role in the individual's life being the cause of a variety of feelings, thus impelling on the older person's holistic sense of well-being and overall concept of quality of life. To further describe the role of non-death related losses on the quality of life of the older person the psychosocial well-being in late-adulthood pertaining to quality of life and active ageing will be elaborated on.

3. PSYCHOSOCIAL WELL-BEING IN LATE-ADULTHOOD

In the light of non-death related losses that play an accumulative part in the quality of life of the older person the researcher deemed it important to incorporate quality of life and active ageing under the heading of psychosocial well-being in late-adulthood. It

appears that quality of life, active ageing, non-death related losses, grief and change are inter-related factors that form part of the older person's life.

3.1 Quality of life

From literature it appears that there are many views pertaining to the psychosocial well-being in the life of the older person. Some of these views include those of Bickerstaff *et al*. (2003), Lawton (1991), Pinquart (2002), and Sarvimäki and Stenbock-Hult (2000). Bicherstaff *et al*. (2003:159) describe meaning in life as a central theme that allows a person to make sense of their existence. Pinquart (2002:90) defines purpose in life as having goals in life and a sense of directedness, feeling that there is meaning to present and past life, holding a belief that gives life purpose, and having aims and objectives for living. Lawton (1991:6) brings the concept of psychosocial well-being and quality of life closer to one another with his contribution to the concept of quality of life in stating that it is a multi-dimensional concept. Sarvimäki and Stenbock-Hult's (2000:1025) definition of quality of life is also very important. They define quality of life as a sense of well-being, meaning and value. Their research includes health, functional capacity and coping mechanisms as contributing factors to overall quality of life (Sarvimäki & Stenbock-Hult, 2000:1025).

Pinquart (2002:90) contributed to the aspect of quality of life with his explanation of factors that may have a negative influence on quality of life of the older person. He (Pinquart, 2002:90) states that quality of life may decrease due to non-death related losses suffered by the older person. Pinquart (2002:94) further states that quality of life may be dependable on personal attributes such as creativity, flexibility, adaptiveness, openness, intelligence, responsibility and the individual's belief system in order to contribute to quality of life. High levels of these attributes will contribute to, and give meaning in life.

3.1.1 Aspects that constitute well-being and quality of life

Important aspects that are believed to constitute quality of life, according to Bickerstaff *et al*. (2003:161) as well as Pinquart (2002:93), are that well-being is associated with the ability to help others, as is a relationship with God, a higher power, or a spiritual component to life. Another aspect that is viewed as very important by Steeman *et al*. (2013:225) involves being appreciated, which implies that one is skilled enough to be

in control of life and to be valued for fulfilling perceived expectations of society, thus improving the quality of life of the older person. With the progression of age though, it becomes more important to be valued for 'who you are'. 'Who you are' is linked to the quality of life with a view that performance is related towards those that existentially progress (Steeman *et al*., 2013:235).

Pinquart (2002:93) mentions that relationships are yet another aspect to consider. Relationships play an integral part in the meaning attributed to life and contribute to the quality of life in late-adulthood. According to Antonucci *et al*. (2004:354), Antonucci *et al.* (2010:650) and Pinquart (2002:103), the highest level of quality of life was found in social integration and the quality of social contacts within the environment of the individual in late-adulthood. In actual fact the most satisfying relationships were not amongst friends, but in the frequency of contact with family members. Family and friends give personal meaning to the older person as interaction with family and friends promoting feelings of being respected and loved, thus contributing to the quality of life of the older person. These feelings of love and being respected strengthen the sense of identity, and in turn contribute to quality of life (Antonucci *et al*., 2004:366; Bickerstaff *et al*., 2003:159; Pinquart, 2002:103).

Steeman *et al*. (2013:216), however, also mention that quality of life is formed around the concept of a struggle to be valued. Steeman *et al*. (2013:217) elaborate on this statement by linking quality of life to loss and state that non-death related losses such as the loss of cognitive ability can threaten the security and autonomy as well as the individual in late-adulthood's ability to be meaningful members of society, which are core values associated with identity. Pinquart (2002:90) is also in agreement and mentions that social integration and relational quality contribute to purpose in life, as do better health, higher everyday competence, higher socio-economic status and being married.

Aspects that will include emotional and psychological well-being are seen as an important factor in giving purpose to life (Berk, 2004:576-578; Pinquart, 2002:95; Schmall & Bowman, 2004:8-9). Pinquart (2002:95) assigns this sense of purpose to subjective well-being that will include feelings of pleasure and positive affects, and the absence of depression to contribute positively to the older person's quality of life.

Individuals with higher subjective well-being and no depressive symptoms may show higher optimism to attain future goals and even higher motivation to strive for goals that give meaning to their life (Pinquart, 2002:95). Sarvimäki and Stenbock-Hult (2000:1027), however, are of the opinion that well-being is more than just pleasure, joy and satisfaction. It is more than a life that is absent of pain and suffering in order to be called 'good'.

Even so the experience of purpose or meaning in life remains important aspects of the individual's life and will constitute an aspect of quality. Pinquart (2002:90), however, points out that the maintenance of high levels of purpose in life becomes more difficult in late-adulthood due to the increase of losses. Lawton (1991:19) explains this phenomenon by pointing out that negative affect is dependable on internal factors that will include health, while positive affect is more dependable on outside stimuli. Sarvimäki and Stenbock-Hult (2000:1025) describe these 'outside stimuli' as biophysical and socio-cultural aspects. In other words the individual's mental health state will be determined by the way negative and positive experiences are processed and associated within the individual.

Another aspect mentioned by Lawton (1991:12) is the fact that the environment plays a significant role in behavioural competence and behavioural competence, in turn, has a consequence on the perceived quality of life with the total outcome to be psychological well-being. Thus, according to Lawton (1991:10), behavioural competence is to be seen as a central aspect of quality of life.

Calhoun and Tedeschi (2001:157) take the view of quality of life in another direction. In their study they state that religious, philosophical, and folk traditions for thousands of years recognised the possibility that the struggle with major non-death related losses life can be the source of enhanced meaning in life and the impetus for positive change. Bickerstaff *et al.* (2003:164), in their study of how elderly nursing home residents transcend losses of later life, elaborated on the theory of Calhoun and Tedeschi (2001) and identified five main themes in this regard. This included a feeling of value by the self and others; responding to the needs of others; love and the memory of love; keeping mind, body and spirit active; and believing in God or a higher power. Pinquart (2002:92) highlights the fact that individuals in late-adulthood actually

enhance overall quality of life by being helpful. By creating meaning in life, according to Calhoun and Tedeschi (2001:157), includes not only the older person's good physical health, but also doing things for others. Calhoun and Tedeschi (2001:157) conclude by stating that the mentioned five themes will give meaning in suffering and loss, even facilitating transcending tremendous losses.

Work is also seen as an important source to create a sense of quality of life as it offers opportunities to fulfil needs of achievement, ability development and creativity and feeling needed (Pinquart, 2002:93). Higher levels of education lead to higher occupational status, thus providing a higher income, which in turn will be a direct source of quality of life as it reflects success accomplished (Pinquart, 2002:94, 104).

Pinquart (2002:92) is further of the opinion that high purpose in life as well as indicators of psychological well-being will play a role in immune factors. The immune factors trigger a neuro-endocrine response to challenges in order to obtain an optimal functioning to contribute to the maintenance of health and competence, again enhancing the overall quality of life of the older person. Even so, Pinquart (2002:104) associates depression as a factor that will have a subjective response to the individual's purpose in life and influence it in a negative sense, thus impacting on the quality of life of the older person.

Aspects of high levels of purpose in life are not only linked to psychological well-being and being valued. Physical losses due to illness and a loss of physical ability appear to be important concepts within a holistic view that will include quality of life and active ageing. Heidrich and Ryff's (1993:328) opinion on quality of life involved the fact that poorer health status was predictive of more frequent social comparisons across life domains. These authors actually came to the conclusion that the level of incongruity between actual and ideal self, arbitrates the relationship between physical health and mental health in late-adulthood. Heidrich and Ryff (1993:331) further concluded that lower levels of well-being are associated with poorer physical health and higher levels of distress, thus playing a negative role in the quality of life of the older person.

According to Lawton (1991:19) as well as Sarvimäki and Stenbock-Hult (2000:1027), there has to be balance between pleasure and suffering, thus both sides of the

equilibrium will contribute to the quality of life of the older person. They state that there has to be a certain amount of pleasure and satisfaction in one's life for that life to be called a good life.

3.2 Active ageing

The maintenance of quality of life in late-adulthood is often associated with actively engaging with the environment (Boudiny, 2013:1093; Bowling, 2008:294). The World Health Organisation (WHO) defines active ageing as a phase in life where a person wants the best opportunities with regards to health and participates within a secure environment in order to enhance quality of life (WHO, 2002:12).

When considering the definition provided by the WHO (2002) the word 'active' stands out and refers to not just continuous participation in society but also to retain social, mental and physical health, maintaining dignity, and self-efficacy in an age-friendly environment (Bowling, 2008:294). In other words, even though older persons are more likely at risk to face adversities that are cumulative or lifelong, for example poverty (Fuller-Iglesias *et al*., 2008:182), the determining factor for optimal quality of life will be the resilience found in the body, mind and environment (Fuller-Iglesias *et al*., 2008:184). Boudiny (2013:1087) as well as Bowling (2008:294) elaborate by including social networks, support and participation that have been associated with health, mortality and quality of life, as well as age-friendly environments and neighbourhoods to play an overall positive role in the older person's quality of life.

Sarvimäki and Stenbock-Hult (2000:1025-1026) even more so elaborate on the views of Boudiny (2013) and Bowling (2008) by adding that the reality of the older person's life is not to be freed from, for example, disease but rather to receive optimal care when needed. The life cycle of Erikson (in Erikson *et al*., 1986 and in Erikson, 1997) was used in Sarvimäki and Stenbock-Hult's (2000:1026) study to relate quality of life to the life cycle as both quality of life and Erikson's life cycle theory deal with concepts such as integrity, meaning, self-esteem, confidence and coping.

The meaning of active ageing appears to be more than just a perfect life with optimal quality of life prospects but rather to include optimal quality of life within the adversities of ailments for instance such as non-death related losses.

4. THEORIES APPLICABLE TO A DISCUSSION OF LATE-ADULTHOOD

As loss, more specifically non-death related losses, is the focus of this study the Dual Process Model of coping with bereavement and loss was used as the foundation to explain the roll of non-death related losses in the quality of life in the life of the older person. Bronfenbrenner and Erikson's theories are also incorporated to give a better understanding as they contribute to the understanding of non-death related losses and how they will impact on the quality of life of the older person.

4.1 The Dual Process Model of coping with bereavement and loss

The Dual Process Model of coping with bereavement and loss has been included in this study as this model acknowledges grief as part of non-death related losses within an environment that is constantly changing (Attig, 1991:367; Goldsworthy, 2005:174; Thompson, 1998:21). Change in itself includes non-death related losses which will lead to grief being part of this process (Goldsworthy, 2005:174; Hall, 2014:7; Sabar, 2000:152; Schmall & Bowman, 2004:2; Thompson, 1998:21).

Even though there is some agreement amongst theorists that grief is a universal reaction to a loss, there appears to be disagreement with regards to when the grief process should end, specifically pertaining to non-death related losses (Freud, 1957; Parkes, 1986; Raphael, 1984). In this debate the notion of grief, however, is seen as a private and individual experience (Neimeyer, 1999:68).

Neimeyer (1999:68) mentions the importance to acknowledge the social context and the major impact it has on how the older person assigns meaning to loss as well as integrating the loss. Doka already in 1989 made a valuable contribution in a study in this regard where 'disenfranchised grief' was proposed to refer to the "grief a person experiences when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported" (Doka, 1989:4). Within the context of 'disenfranchised grief' the impact of external influences on the internal experience of grief is prescribed by 'grieving rules'. Grieving rules attempt to specify 'who, when, where, how, how long and for whom people should grieve' (Doka 1989:4) and whether it is acceptable to grieve publicly.

Within the context of the grieving process seen as a human reaction to loss, later models tried to explain grief as a process of adjustment to loss in an ever changing world (Goldsworthy, 2005:174). In the area of for example mental health, the losses that are associated with a mental illness may be ongoing and multifaceted. These losses can include physical losses such as the loss of income. On a symbolic level it can include losses such as the loss of future aspirations. These losses will not only have an effect on the individual but can also have an effect on family (Goldsworthy, 2005:176). In this context it will be important for an expanded theory to acknowledge the uniqueness of grief as an active process with limitless choices and possibilities. Grief can then be viewed as a response to loss that forms part of ever expecting changes that life brings. Grieving can be seen as a means of integrating these meanings into the life of the older person (Goldsworthy, 2005:176).

If the integration of neverending change is noted, acknowledging that loss leaves the older person and their identity forever transformed by the loss, it can also be acknowledged that loss will change the quality of life of the older person (Attig, 1991:367). Thompson (1998:21) shares Attig's (1991) and Goldsworthy's (2005) view by acknowledging that loss is an ever-present reality forming part of most big changes in life. Goldworthy (2005:177) states in this regard that the first step in this process will be to acknowledge grief as a reaction to any kind of loss.

Hall (2014:7) added his own view on grief and defines it as a response to loss in its totality. This 'totality' will include physical, emotional, cognitive, behavioural and spiritual change. Grief is thus a natural consequence within the formation of emotional bonds to humans, projects and possessions that will be lost at some stage in the life of a person (Hall, 2014:7). The Dual Process Model of Stroebe and Schut (1999) and the Task-Based Model of Worden (2008) used all the above theorists' view to come to their comprehensive and influential grief theories (Hall, 2014:9). These theorists (Stroebe & Schut, 1999; Worden, 2008) explain the process of grieving as the reconstruction of the person's world where the meaning of that world has been challenged by a form of loss (Hall, 2014:10). Stroebe and Schut (1999) as well as Worden (2008) describe grief as a process of oscillation between two contrasting modes of functioning (Hall, 2014:9). This means that the loss is focused upon from an emotional point of view where coping, exploring and expressing these emotions will

help the individual with the range of emotional responses associated with the loss (Hall, 2014:9). Stroebe and Schut (1999) as well as Worden (2008) also enhance the importance of problem-focussed coping that is required with regards to the external adjustments that are required by loss. It is interesting to note that these theorists (Stroebe & Schut, 1999; Worden, 2008) acknowledge that the focus of coping may differ, not only from one situation to another, but also from one individual to another, as well as within different cultural groups (Hall, 2014:9).

As the focus of the current study includes and acknowledges grief as part of the process when dealing with non-death realted losses, it is important to also acknowledge change as part of this process as explained by Neimeyer (1999:68). The views of Freud (1957:244) and Neimeyer (1999:68) explain the concept of grief being a natural response to non-death related losses in a constantly changing environment very well. The current study also acknowledges that the older person's identity and sense of self will be influenced during the occurrence of a non-death related loss, as also described by Attig (1991:367) and Hall (2014:7).

4.2 Erikson's developmental theory

Erik Erikson and Joan Erikson describe late-adulthood to include people older than 60 years. According to them this period in the older person's life is a stage where the older person is meant to age gracefully and feeling satisfied with achievements, thus experiencing quality of life (Erikson *et al.*, 1986:37). As the developmental theory of Erikson includes people older than 60 years, his (Erikson's) theory was used as a theoretical frame work for this study. In the light of quality of life that is viewed as an important factor in an active ageing environment, his theory is also applicable. Joan Erikson (in Berk, 2004:584) describes the final psychological conflict of Erikson's theory, ego integrity versus despair as coming to terms with one's life. When considering the work of Fuller-Iglesias *et al*. (2008:183-184), it confirms Erikson's theory of integrity versus despair as Fuller-Iglesias *et al*. (2008) also consider successful aging as acting resiliently towards the challenges and changes in the ageing body, mind and environment.

Integrity stands for a sense of wholeness and meaning in looking back upon life. Despair stands for a sense of meaninglessness, lost opportunities and failures

(Erikson *et al*., 1986:37). The resolution is offered by wisdom, “informed and detached concern with life itself in the face of death itself” (Erikson *et al*., 1986:37; Sarvimäki & Stenbock-Hult, 2000:1026). When older persons arrive at a sense of integrity they feel whole, completed and satisfied with their achievements. These achievements will include adapting to inevitable triumphs and disappointments and realisation that the paths followed, abandoned and never selected were necessary to guide and give meaning to one’s life course, thus also incorporating the view of active ageing.

The opposite, referring to when despair occurs, also needs to be addressed. When despair occurs the older persons will feel they have made many wrong decisions, yet time has run out to find an alternate route to integrity (Erikson in Berk, 2004:584-585), and this realisation has a negative influence on the older person’s quality of life. This view of Erikson with regards to despair is elaborated on by Lawton (1991:19) as well as Sarvimäki and Stenbock-Hult (2000:1027) where they incorporate the balance between pleasure and suffering to form an integral part of the active ageing environment. It is therefore believed that quality of life is accomplished when the older person is able to balance positive and negative experiences and not just focus on negative experieces. Sarvimäki and Stenbock-Hult (2000:1027) continue by stating that life does not need to be free from suffering in order to call life ‘good’, but rather the way in which negative affect is dealt with to be the determinant factor.

Peck (in Berk, 2004:585) elaborates on Erikson’s theory by stating that Erikson’s conflict of ego integrity versus despair comprises of three distinct tasks and each must be resolved for integrity to develop. These three tasks are called the Ego differentiation versus work-role preoccupation, the Body transcendence versus body preoccupation and the Ego transcendence versus ego preoccupation. The first task of ego differentiation versus work-role preoccupation results from retirement and requires ageing people who have invested heavily in their careers to find other ways of affirming their self-worth (Peck in Berk, 2004:585). The second task, body transcendence versus body preoccupation, stands for physical limitations where there is a decline in appearance, physical capacities and resistance to disease. The last task called ego transcendence versus ego preoccupation is about the acceptance of the death of loved ones.

Erikson (in Davison & Neale, 2001:491) further states that meaning is found in the way one has led one's life and despair reflects the discouragement that can come from unreached goals and unmet desires. Add increased psychosocial stressors such as for example loss of physical health leading to chronic and disabling diseases (Fuller-Iglesias *et al*., 2008:183) to this and it could leave the individual with thoughts and feelings that there are no further opportunities or another chance. In instances like these the despairing person finds it hard to accept that death is near and is overwhelmed with bitterness, defeat and hopelessness (Erikson in Berk, 2004:585), affecting the quality of life of this person. The realisation of lost opportunities, according to Pinquart (2002:95) and Schmall and Bowman (2004:9-10), could have a negative influence on the quality of life of the older person and could lead to feelings of despair, helplessness and depression. Erikson *et al*. (1986:37) stated that these feelings can be expressed as anger and contempt for others which will disguise contempt for the self.

Joan Erikson (in Erikson *et al*., 1986:37) and Erikson (in Brown & Lowis, 2003:415-419) beaded a ninth stage in the life cycle theory called the gero-transcendent stage found in extreme old age. This phase is known for bodily weakness, where a person's autonomy, independence and control are challenged and as a consequence, self-esteem and confidence weaken. Despair is constantly present, but this despair, as experienced by individuals in late-adulthood, is less concerned with past life than with daily functions and getting through one more day (Sarvimäki & Stenbock-Hult, 2000:1026). Erikson and Erikson (in Brown & Lowis, 2003:415-419) and Erikson *et al*. (1986:37) as well as Schroots (1996) and Tornstam (1989; 1992; 1996) continue to state that this is also a positive stage where the individual remains in a situation known for potential psychological and spiritual growth (Brown & Lowis, 2003:415-419; Erikson *et al*., 1986:37; Schroots, 1996; Tornstam, 1996). In the theories of active ageing the importance of psychological and spiritual growth are also acknowledged (Boudiny, 2013; Boudiny & Mortelmans, 2011).

The above concepts, as mentioned by Erikson, Erikson and Peck postulate an environment that is constantly changing in the life of the older person. The theory of Peck suggests that older persons need to move beyond their life's work, their bodies and their separate identities, accept the changes brought on by ageing, thus

incorporating quality of life, moving beyond fear of death and having a clearer sense of meaning of life (Brown & Lowis, 2003:416-417). Sarvimäki and Stenbock-Hult (2000:1026) elaborate by stating that in this perspective quality of life will deal with issues of integrity, meaning, self-esteem, confidence, and coping. Steeman *et al*. (2013:216-217) place a great deal of the focus in their study on the loss of identity during cognitive decline and the role thereof in the older person's quality of life. They state that some research indicated that identity is lost during cognitive decline in late-adulthood but in actual fact by focusing on preservation of identity it will foster care in which identity is enhanced, which in turn links with Erikson's (1997) theory of identity and self-esteem in the eight and ninth phase of his theory. Lawton (1991:10) takes it further by stating that the objective environment will influence behavioural competence and behavioural competence will influence the perceived quality of life with psychological well-being as the ultimate goal.

4.3 Bronfenbrenner's Bioecological systems theory

Bronfenbrenner's theory forms an important part of this study, not only because he recognises the importance of social interaction, but he also acknowledged that change is an inevitable part of the life of the older person (Bronfenbrenner & Morris, 1998:227). Bronfenbrenner states that development is seen as the phenomenon of continuity and change in the biopsychological characteristics of human beings (Bronfenbrenner & Morris, 2006:793), thus implying that continuity and change form an unavoidable part of the holistic field of the older person.

Bronfenbrenner accents the role of change in the system (Bronfenbrenner & Morris, 2006:793), which forms an integral part in the life of the older person. Change is a constant concept older persons need to face as change occur in their living environment, bodily and cognitive changes occur as well as change in their financial position, to name but a few. These changes will play a direct role in the quality of life of the older person (Boon, Cottrell, King, Stevenson & Millar, 2012:389; Bronfenbrenner & Morris, 2006:795-796). In the context of change the need for stability, consistency and predictability is acknowledged by referring to the role that non-death related losses will play in the older person's quality of life (Bronfenbrenner & Morris, 2006:820). This view of Bronfenbrenner and Morris enhances the view of Erikson in that the holistic field of the older person is also acknowledged to play an

important role and will change the quality of life of the older person (Bronfenbrenner & Morris, 2006:822).

5. SUMMARY

Section A, Part 2 is a literature review to explain some of the main concepts of this study. Closer attention was given to the different losses experienced during late-adulthood and what impact it has on the older person's quality of life. Active ageing formed part of this section as active ageing is a concept that appears to be of relevance in modern society. Even though the life of the older person is filled with experience and knowledge, no individual can be prepared for the actual non-death related losses that will be suffered during the life of the older person.

The quality of life of the older person forms an integral part in relation to the non-death related losses suffered as non-death related loss can be the cause of for example low self-esteem, becoming dependent on others due to physical or cognitive losses and even a financial burden to children or society as a result of financial losses, to name but a few. These losses will include losses on a physical, emotional/psychosocial and social level. The Developmental Theory of Erikson was used to further elaborate on the role that non-death related losses will play in the quality of life of the older person. Bronfenbrenner's Bioecological theory of Human Development also made a valuable contribution to this study as change is an integral concept when viewing non-death related losses. Seeing that non-death related losses are an inevitable part of the life of the older person it is very important to acknowledge these losses.

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SECTION B

ARTICLE

Describing non-death related losses of older residents in a residential care facility

Sonja Teitge

ABSTRACT

Purpose. This study formed part of a broader study with the purpose to investigate and describe the quality of life of residents in a specific residential care facility. From the broader study certain themes emerged such as non-death related losses which allowed for the secondary analysis of the data. The aim of this study was to describe non-death related losses of older persons who find themselves in a residential care facility that adopts an active ageing approach. ***Methods***. A qualitative, descriptive design was used in the broader study to investigate and describe the quality of life of residents in a specific residential care facility. The sample of the broader study included 74 participants between the ages of 65 and 95 with an average age of 73 which respectively participated in four different data gathering methods. ***Results***. Main themes that emerged during the secondary data analysis confirmed the loss of physical and cognitive abilities; a loss of self-confidence; relational losses and a loss of financial security. However, findings indicated that in the active ageing environment they do not find appropriate space to mourn their non-death related losses. Implications of the findings are that quality of life of older people should also accommodate for the grief associated with losses. Findings could be used to inform management of residential care facilities to adjust their programmes to promote a more optimal human-environment fit.

Keywords: Physical losses; Cognitive losses; Loss of financial security; Relational losses.

INTRODUCTION

This study formed part of a broader study that focused on exploring the quality of life of older persons in a residential care facility. Different themes emerged during the broader study such as older persons' experiences of being in an active ageing environment, the psycho-social needs of older persons and non-death related losses. The focus of this study was to describe the non-death related losses of the residents in the residential care facility who has adopted an active ageing approach. The definition as described in the Older Persons Act (Act 13 of 2006) was used where 'older persons' refer to any person above the age of 60.

Loss and more specifically non-death related losses are an occurrence commonly experienced by all humans, but due to their longevity, are more likely to occur amongst older persons (Bickerstaff, Grasser & McCabe, 2003; Schmall & Bowman, 2004). Literature tends to focus more on death related losses referring to the death of a living thing/person (Berk, 2004; Bickerstaff et al., 2003; Schmall & Bowman, 2004). Bickerstaff et al. (2003) as well as Schmall and Bowman (2004) however highlight the fact that even though the loss of a significant other is seen as one of the greatest losses, grief is also significant with the loss of something where one has invested time, energy, affection, money, dreams and hopes in. Non-death related losses refer to the emotional response associated with the separation from subjectively important person(s) or things (Yang & Lee, 2012).

According to literature non-death related losses on a physical level can include the loss of mobility, flexibility and balance as well as loss of hearing and eyesight due to illness or the ageing process (Berk, 2004). Cognitive loss does not only play a role when it comes to concentration, but also orientation, judgement and executive functions. Cognitive loss will also include the loss of memory, while

interpersonal losses not only include the loss of people due to death but also due to for instance the moving to a residential care facility, implying social and environmental losses (Altschuler & Katz, 2010; Berk 2004; Goldhaber & Donaldson, 2012). Due to these changes, older people can also experience a loss of privacy and autonomy and self-determination when they become fragile and dependent on others (Bekhet, Zauszniewski, & Nakhla, 2009). Financial loss is also a non-death related loss because it can have an impact on the identity and independence of the older person (Berk, 2004).

Non-death related losses tend to have an accumulative effect and if not dealt with can eventually erode the quality of life of people (Bickerstaff et al., 2003; Lawton, 1991; Minichiello, Brown, & Kendig, 2000; Pinquart, 2002; Sarvimäki & Stenbock-Hult, 2000; Schmall & Bowman, 2004). Some older persons reported to feel overwhelmed and frightened and experience feelings such as guilt, anger and loneliness due to these losses they suffer (Pinquart, 2002; Schmall & Bowman, 2004). A further consequence of not dealing with non-death related losses can be that it becomes difficult to maintain high levels of purpose in life (Pinquart, 2002). A purpose in and meaning of life are compromised by feelings of abandonment and loneliness (Yang & Lee, 2012).

Non-death related losses are also associated with a loss of sense of place when people retire or when they relocate to retirement villages (Goldhaber & Donaldson, 2012). The loss of sence of place has been linked to the exacerbation of symptoms such as depression and impaired functioning (Bekhet et al., 2009). Berk (2004) furthermore mentions with regards to the loss experienced when retirement is involved that retirement per se involves giving up roles that are a vital part of identity and self-esteem. It appears that the losses as well as the loss of roles as a result of

retirement as mentioned above (Altschuler & Katz, 2010; Berk, 2004; Bickerstaff et al., 2003; Schmall & Bowman, 2004) will affect the individual's identity and self-esteem. Dealing with different losses thus appears to be on the foreground of older persons and therefore also of health care professionals and staff of residential care facilities who are taking care of these older persons (Bartlett & Burnip, 1998).

As grief appears to be an ever important concept when it comes to non-death related losses, the Dual Process Model of Stroebe and Schut (1999) as well as the Task-Based Model of Worden (2008) are included in this study as they are of great value describing bereavement/grief and loss. Bereavement/grief, loss and change appear to be intertwined concepts that cannot be severed from each other (Hall, 2014) as also noted within this study. Change, according to theorists such as Hall (2014), Stroebe and Schut (1999) and Worden (2008), is seen as an ever present part of the process of loss. This process will include grief as a natural consequence when emotional bonds that have been formed with humans, projects or possessions will at some stage sever due to changing circumstances (Hall, 2014; Stroebe & Schut, 1999; Worden, 2008). It can therefore be expected that grief will be present within a social context where changing circumstances are expected to be part of life, such as in a residential care facility (Hall, 2014).

The view of ageing adopted in this study was based on the Bioecological theory of Human Development of Bronfenbrenner as well as Erikson's theory of the life cycle. Bronfenbrenner's theory (Bronfenbrenner, 2006; Bronfenbrenner & Morris, 1998) is viewed important as he stated that development is seen as the phenomenon of continuity and change in the biopsychological characteristics of human beings. Change is a very important concept within this study as change is directly linked to non-death related losses that the older person suffers (Hall, 2014;

Schmall & Bowman, 2004). These modifications include change in physical ability, environment and finances (Bronfenbrenner, 2006). Within the term 'bioecological' Bronfenbrenner incorporated the total field of the person in the five concepts of his theory, namely the micro-, meso-, the exo-, the macro-, and the chronosystem.

Though Erikson's theory (Erikson, Erikson & Kivnick, 1986:37) concentrates on late-adulthood as represented in the eighth and ninth stages of human development, the theory is relevant as it focuses in the ninth stage on the loss of physical abilities. During the ninth stage physical losses become very applicable as the older person's autonomy, independence and control are confronted and as a result, self-esteem and confidence weaken.

What remains unclear from literature is how older people who find themselves in an active ageing environment describe non-death related losses. The research question therefore that guided this study was: How do older residents in a residential care facility describe non-death related losses?

Methodology

Research method and design

Since the meanings of loss are ambiguous and due to the fact that the word is differently interpreted by individuals, a qualitative (Creswell, 2007; Krauss, 2005; Manso, Rauktis, & Boyd, 2008; Ritchie, 2009) approach with a descriptive design (Thorne, 2008) was used for the broader study. With a qualitative approach rich data were collected about a phenomenon (Nieuwenhuis, 2007a; 2007b), namely the quality of life of residents in a specific residential care facility. During the process of analising the original data different themes were identified, such as the needs of older persons, their experiences of being actively involved, relational experiences and non-death related losses. Due to the important role that non-death related

losses play in the quality of life of the older person in an active ageing environment it was decided to conduct a secondary analysis. The aim was to explore and describe how older residents in a residential care facility describe non-death related losses.

Research Context and Sampling

The current population figures for South Africa (SA) indicate a growing young black population and an ageing and shrinking white population (Stats SA, 2013:2-3). This makes research within the South African context with regards to older persons necessary as 4.15% of the population consists of people older than 60 years.

The specific research took place in a residential care facility in Gauteng, SA. This residential care facility adopts an active ageing approach. A lifestyle consultant is responsible for the development of specific programs on a daily basis. These activities focus on physically able residents who are mobile to move within the residential care facility. The residents are free to participate in any of the activities according to their individual needs.

There are different forms of housing available in the residential care facility such as individual houses, flats, single rooms, and also frail care and care for dementia patients. There are 350 residents in this village between the ages of 50 and 95. The residents are mainly white Afrikaans and English speaking.

The participants for the broader study were selected by means of a non-probability purposive sampling process (Teddlie & Yu, 2007). Criteria of inclusion of the participants were that they had to be permanent residents of this specific residential care facility. Participants had to be English or Afrikaans speaking. The participants could be male or female. The participants had to be mobile and able to attend the data gathering process presented in the main hall of the facility. Participants had to be able to express themselves through verbal language and be

able to hear. All participants had to sign consent forms with regards to their willing participation.

74 Participants were selected that fulfilled the inclusion criteria for the study. Of these 74 participants, N=19 participated in the Mmogo-Method®, which was divided into two groups, each consisting of 10 and 9 respectively. N=20 participants participated in the World Café which consisted of four groups with not more than 6 participants in each group. N=21 participants were involved in semi-structured interviews. N=20 participants participated in the Listening Group technique consisting of 10 participants representing management and 10 participants representing the residents.

Data Gathering and Procedure

Once permission to conduct the broader study was obtained from the appropriate authorities, namely the Faculty of Health Sciences of the North-West University and the Board of Management for this specific care facility, a pre-set programme was followed over a three day period at the residential care facility. On the first day of the intended research the individuals who were interested in participating gathered in the recreation centre of the residential care facility where they were informed on the procedure and methods to be used during the study. As most of the data gathering was done by using open groups, the importance of partial confidentiality (Strydom, 2011a) was explained as well as what would be expected of them with regards to all the different facets of the proposed study. Seeing that participation was voluntary, prospective participants were also informed that they could withdraw during any stage of the data collection procedure (Strydom, 2011a). Thereafter the participants interested completed consent forms (List, 2008). The second day started with a brief recap of the previous day. The day ended with the

formulation of the research question and preparation for the implementation meeting that was scheduled for the last day. The implementation meeting, held on the third day, consisted of the research team, staff members and management during which time a summary of the themes that arose from the data gathering methods that occurred during the first two days, was given and explained to management.

Field notes, as described by Cowling (2001), Kelly (2010) and Matthews and Ross (2010), were used to underwrite the data collected from the respective data collection methods used.

At the beginning of each method used it was explained to the participants that audio and/or video recordings would be made during all the sessions in order to transcribe the collected data afterwards. Participants were further assured that these transcriptions, even though added as an addendum to the final document, would not portray the individual's personal details, as coded numbering would be used for each participant. This will ensure that the participants are unidentifiable (Strydom, 2011a). Before data collection commenced the participants gave written consent for the recordings to take place (Strydom, 2011a). Audio and video recordings were thus used with the Mmogo-method®, the World Café and the Listening Group technique and audio recordings were made of the semi-structured interviews as this was seen to be sufficient to record the conversations. Participants were once again notified of their right to withdraw from the process at any stage.

The Mmogo-method® (Roos, 2008; 2012) was the first data collection method to be used. On the first day a brief explanation of this method was given to the interested participants. The Mmogo-method® was used for its purpose to obtain insight, knowledge and a deeper understanding of the cultural and social meanings of people about a specific social phenomenon which are often difficult to obtain

through more direct techniques (Roos, 2009). The materials used were a lump of clay, colourful beads, dry grass stalks of different sizes and a round piece of cloth as shown in Figure 1 which participants used to visually construct representations based on an open-ended prompt which in this case was: *Build something with the given materials that will be representative of your life within the residential care facility, including the activities you participate in*. After completion of the visual representations each participant was given the chance to explain his/her visual representation to the rest of the group. Group members then had the opportunity to share their views with regards to the participant's representation. This visual representation became the stimulus material that enabled the group to discuss the shared experience, thus becoming the social construction of the meaning attached to shared experiences (Roos, 2009; Roos & Strong, 2010). The data gathered from the broader study during the Mmogo-method® were used during the secondary analysis to identify themes pertaining to non-death related losses which were further explored in the World Café as well as in the semi-structured interviews that followed the World Café.

Figure 1: Materials that were given to Mmogo-Method® participants

Semi-structured one-on-one interviews were held with voluntary participants in a non-directive manner as mentioned by Greeff (2011). Detailed information of

beliefs/perceptions and account of a particular topic were gained (Smith, Harrè & Van Langenhoven, 1995), in this case themes that arose from the Mmogo-method®-data. These topics/beliefs/perceptions were further explored in the semi-structured interviews. Seeing that the data gathered during the other three data gathering methods were done in open group discussions, the semi-structured interviews were used to obtain participants' subjective experiences about the quality of their lifestyle and to explore themes obtained from the Mmogo-method® in more depth. Even though the interviews were semi-structured around themes that aroused from the above methods of data collection and pre-set questions were presented to the participants, the researchers still allowed considerable flexibility in scope and depth for the individuals to express themselves and elaborate on subjects of interest to them as is suggested by May (in Morse, 1991).

The World Café was scheduled for the second day to further explore the themes identified during the previous two methods. The World Café was chosen as it is a method used to uncover the wholeness, uniqueness, and essence of human existence and the older person's process. The wholeness, uniqueness and essence of the individual as appreciated in Cowling's work (2001), is an indication of the underlying pattern of human life that is reflected in the individual's experience, perceptions and expressions. The aim was to create a relaxed and informal atmosphere where every participant had an equal chance to express themselves. Participants were divided into four groups and each group was placed at a specific table. At each table there were three members whith one older resident who acted as a host and a researcher trained in the World Café method to assist with data capturing and to support the host. Trained field workers managed the video and audio recorders. Different questions, aimed at the quality of life, were presented by

the four different hosts. After 20 minutes of discussion, the participants rotated to the next table until all four groups had the opportunity to give their input at all four tables. The four questions included: *Draw the people with whom you have special relationships; Draw something within your environment that is representative of the activities you do; How would you like this residential care facility to be, how would you promote the residential care facility to convince your child that this residential care facility is the perfect place to be in late-adulthood*; and *illustrate something of meaning in your current life in the residential care facility*. These questions were based on the following rationale: According to Roos and Du Toit (2014) as well as Schieffer, Isaacs and Gyllenpalm (2004) leading questions offer a large group of people, such as were the case in the broader study, the opportunity to discuss the specific questions formulated for the World Café, so as to give all the participants the opportunity to be involved, thus stimulating ideas in an environment where the participants can relate to one another (Schieffer et al., 2004).

After completion of all the questions at the relevant tables the groups came together for a 'Community Caucus' to reflect on the discussions at the different tables.

For the purpose of the broader study the Listening Group technique was used as a feedback session between the residents and members of staff, thus not for the purpose of data gathering. With the secondary analysis of the data important statements emerged from the data of the Listening Group techinique which were applicable to this study. Therefore the Listening Group technique was included as a data source in this study. Carr (1998) and White (1995) describe the Listening Group technique as a specific kind of group intervention consisting of two groups of participants. First the one group forms part of the 'inner-group' and the second group

of the ‘outer-group’. Ten participants from the residents formed part of the ‘inner group’ and 10 participants from management formed part of the ‘outer-group’. A facilitator sat with the ‘inner-group’ while the ‘outer-group’ formed a circle around the ‘inner-group’. The participants of the ‘inner-group’ were then asked to give feedback regarding their personal experience and interpretation of the previous activities. The participants in the ‘inner-group’ discussed their experiences regarding their quality of life in the residential care facility while the ‘outer-group’ participants listened attentively. After a period of time the two groups exchanged places which meant that the outer group now became the inner group and vice versa. The ‘outer-group’ now had the opportunity to reflect on the experiences of the older residents and provide input on how the quality of life could be enhanced.

Visual data consisted of photos that were taken of the visual presentations made during the Mmogo-Method® and the World Café, while textual data were obtained from all the conversations of the rest of the data collection methods. The conversations were transcribed verbatim and served as textual data.

Data Analysis

For the broader study all the gathered data were used and subjected to thematic and visual analysis (Braun & Clarke, 2006).

For the purpose of the secondary analysis only the textual data of the broader study were used and not the visual data.

Thematic analysis (Clarke & Braun, 2013) is a step-by-step guide, constantly moving backward and forward between the collected, coded data extracts (Clarke & Braun, 2013). Braun and Clarke (2006) identified six phases of thematic analysis that were used as a guideline during the process of secondary analysis of the data. Phase one started with the researcher that familiarised herself with the audio

recordings that were verbatim transcribed during interviews from the four different methods used for content analysis during the broader study. During phase two initial codes were generated by writing codes for the noted themes/patterns. Phase three consisted of the identified codes that were sorted into themes. Appropriate visual representations were used to sort the potential themes identified. During phase four the themes were reviewed and located to the most relevant and frequent themes used. The allocated themes gave the researcher a clearer idea of the relevant data and what data were usable. Defining and naming the themes formed part of phase five. The defining of the themes enabled the researcher to obtain a clear written analysis of the different and relevant themes. The final phase consisted of producing a written thematic report in order to convince the reader of the merit and validity of the analysis. Codes were assigned to each participant in order to protect their identities. Given the emotive nature of the research topic, and hence to prevent possible preconceived ideas from the researcher direct quotes from participants were used to ensure an accurate interpretation of social meanings. The direct quotes were constructed through thick descriptions in order to provide the reader with a deeper understanding of the research topic (Braun & Clarke, 2006; Ellingson, 2009).

Trustworthiness

The following measures were used in the broader study, as well as the secondary analysis of the data, to address the trustworthiness within the study as suggested by Lincoln and Guba (1985). The broader research team made use of multiple sources of data to derive themes from (Kelly, 2010), which contributed to the trustworthiness of the findings (Ellingson, 2009; Maritz & Visagie, 2009).

Greeff (2011) describes the credibility of the actual research context in the light of the accuracy of the reflecting results. The gathered data from the broader

study were summarised and discussed with the participants to detect any discrepancies (Morse, Barrett, Mayon, Olson, & Spiers, 2002). Credibility of the broader research study was further achieved by prolonged engagement with the data until data saturation or sufficiency of information was reached (Greeff, 2011). For the purpose of the secondary analysis of the data involvement over a period of 19 months as well as prolonged involvement with the relevant literature contributed to the credibility of the study (Greeff, 2011; Morse et al., 2002).

Field notes were used during the broader study (Cowling, 2001; Kelly, 2010; Matthews & Ross, 2010) as an account of what the researchers have listened to, viewed, deliberated upon and perceived in the field (Patton, 2002; Strydom, 2011b). The field notes did not form part of the data gathering methods, but were used to ensure that the researchers' summaries of what were being said were a true reflection of what the participants intended to say. These reflections from the researchers were later used for member checking to confirm the participants' point of view. This demonstrated transferability along with the greater group that was involved in the data gathering and transcribing of the data. Reflective notes were made after each interview to neutralise possible bias (Elliott & Timulak, 2005). The reflective notes included self-reflection and reflection on ethical aspects and the research process (Ellingson, 2009).

Transferability was done in a specific context (Ellingson, 2009) as explained in the methodology section. As prescribed by Krefting (1991) ethical considerations ensured that participation was voluntary and not pre-determined.

By examining different types of information (transcriptions from four different data gathering methods) obtained from the participants, a thematic analysis has taken place to crystallise the findings, hence, examining data from different

perspectives (Ellingson, 2009). This was necessary to ensure the integrity of findings.

The objectiveness and trustworthiness of the findings were enhanced by the crystallisation process where the presented data was combined with the theory as to verify the data according to literature as suggested by Ellingson (2009). Themes were thus identified incorporating confirmability. An in-depth understanding of the collected data was obtained during the broader study by using more than one method of data analysis (Ellingson, 2009), such as transcribing the recordings, encoding themes and interpreting the visual data collected during the broader study. Morse et al. (2002) suggest peer review to first of all ensure that data analysis was properly done as well as to ensure that the presented data reflected a true meaning of the collected data. Apart from the larger group of facilitators that transcribed and encoded the information an independent encoder was used to double check and confirm the relevant themes arising from the data gathered during the broader study. During the process of the secondary analysis the encoded themes were double checked and confirmed by an independent encoder.

Ethical Considerations

The North-West University was contacted by the management of a residential care facility in Gauteng to conduct a very specific investigation to describe the quality of lifestyle of the residents of the residential care facility. Permission was granted by the Faculty of Health Sciences of the North-West University (NWU-00053-10-S1) to conduct the research.

Participation was voluntary and the researchers did not coerce nor force participation during the data gathering methods (Strydom, 2011a). Ethical guidlines were further followed by thoroughly explaining the procedure and what would be

expected of the participants, as well as by gaining the participants' written permission (List, 2008). Individuals were invited to participate in the research via an invitation that was placed on the memorandum boards in the residential care facility.

The participants were informed about the aims of the research project; what would be expected from them; what the data will be used for; the termination of their participation in the study; confidentiality; the safekeeping of records, material and recordings.

All records, material, recordings, and verbatim statements were treated as private and confidential and are being kept safe by the Africa Unit for Transdisciplinary Health Research (AUTHeR), North-West University by electronically storing the data on an external hard drive that will be stored in a lockable steel cabinet for five years (Strydom, 2011a).

The researchers did not deceive the participants in any way. An in-depth description of the broader research project prior to its commencement was provided to management as well as the residents, as well as a Subject Information Sheet, so that potential participants were able to make an informed decision as to whether they would like to participate in the study (Rubin & Babbie in Strydom, 2011a).

Numbering of each participant was used as a form of 'pseudo names' during the secondary analysis of the data to protect the identity of the participants. For this study numbering the individuals, for example M1, M2, etc. for the Mmogo Method, S1, S2, etc. for the Semi-structured interviews, L1, L2, etc. for the Listen Group techqnique and W1, W2, etc., for the World Café, was used. Confidentiality was contracted within the groups (List, 2008; Strydom, 2011a) as another form of the protection of the identity of the participants.

All measures were taken to guard against physical or emotional harm that could occur during the data gathering (Strydom, 2011a). Participants were informed that help would be available after the gathering of the data in the form of a psychologist/social worker if any pariticipant felt traumatised during the data gathering process. If the interview process triggered emotions that overwhelmed the participant it would have been recommended that the participant withdraw from the process and receive emotional support.

In order to ensure that all ethical strategies were kept, the researchers also followed the guidelines of the Health Professions Council of SA for Psychologists (Health Professions Act 56 of 1974).

As recommended by Kelly (2010), a short report containing the research findings will be distributed to the management of the residential care facility after the examination process has been concluded.

Findings

Table 1

Themes and subthemes

THEME	SUB THEME
Loss of physical capabilities and functionality	• Nature of loss of physical capabilities and functionality • Consequences of physical decline and loss of functionality • Emotional and physical consequences • Disengagement of social environment and recreational activities • Consequences for other people • Dealing with physical declining capabilities
Loss of cognitive abilities	• Emotional response to the loss of cognitive abilities • Consequences of losing cognitive capacity • Consequences for other people
Interpersonal losses (Relationship with people, places and animals)	• Loss of relationships • Loss of place and privacy • Loss of status • Loss of a pet
Financial losses	• Loss of financial security

Loss of physical capabilities and functionality

Nature of loss of physical capabilities and functionality. The loss of physical capabilities and functionality refers to a loss of mobility, flexibility and

balance due to illness or ageing process. Participant S24 described it as follows: "… as you age your heart isn't good anymore, your lungs get rotten, your muscles collapse and eyesight will go." It is with age that people noticed the decline: "you [just] know when you get older your abilities [physical abilities] are not the same anymore" (Participant M1).

Consequences of physical decline and loss of functionality. Different consequences have been identified such as emotional consequences; disengagement from the social environment and recreational activities; and consequences for other people.

Emotional and physical consequences. Declining physical capabilities and functionality are associated with feelings of fear, particularly when participants were required to rely on their physical skills, for example to participate in sport activities. In this regard, Participant S28 explained feelings of fear that resultated from declining physical capabilities as follows: "I wanted to take part in their sports last year, but I was scared of falling [due to a loss of mobility, flexibility and balance]."

Participant S29 also referred to activities where he no longer wanted to participate as he was frightened he would fall. His fear arose from his awareness of fellow residents who had fallen, causing injuries. A fear to fall often seems to link with a previous occasion where the older person had a fall or probably also knows of someone that had fallen. This was also the case with Participant S30 who avoids certain activities as she had a fall before that has changed her whole life.

The fear that the loss of physical abilities may cause a fall, or be the reason why one might not be able to drive a motor vehicle or the fear of having a stroke and not being able to walk or talk, regardless if it was only an awareness of fellow residents' loss of physical abilities or a personal experience, this fear of loss of one's

physical abilities played a major role in the participants' life. The anticipation of engaging in actitivities that require physical skills such as driving a motor car, is so anxiety provoking that participants fear to perform such activities. Participant S30 mentioned that the fear of driving all by herself will for instance keep her awake at night. She further mentioned, "I will worry about it [driving on her own]. I don't like driving on my own."

Consequences of physical decline can also result in injuries that aggrevate existing losses. Some participants reported that due to the loss of their physical abilities they had injuries which caused losses in other areas such as a loss of hearing for instance. Participant S13 remarked that due to a loss of his physical abilities he recently had a fall which caused a head injury and as a result, he lost his hearing. The fall also caused a certain percentage of brain injury and therefore Participant S13 considers himself to be "not with it altogether". Participant S6 also mentioned that she, due to a loss of her physical abilities had a serious accident after which she "can't hear …" as her "hearing is going away."

Disengagement of social environment and recreational activities. The physical decline of capabilities and functionality contribute to older people's disengagement from activities. For example, one of the participants explained that a problem with his leg caused him to withdraw from many activities that he previously engaged in (Participant S23). The physical decline also limits participants to perform duties that they could previously perform. For participant M1 it became quite difficult "… to do the garden and see that the house's repairs are always done …" due to the loss of mobility and flexibility. Participant S1 also mentioned that it became difficult for her to see to household chores as a result of a loss of physical abilities. Participants highlighted that their physical losses contributed to withdrawal from

activities because they can no longer perform some actions required for participation. Participant S4 used to play snooker but mentioned: "… I couldn't do that now, because you got to bend over and I can't bend over." Participant S5 shared how she refused to participate in an activity where they had to bend over and due to the fact that the floor was slippery she just refused to partake and mentioned "… no, I didn't want to fall … I'm not steady on my legs."

Consequences for other people. Participant M3 referred to a resident who had a stroke and as a result he is not able to walk or talk anymore. This particular resident depends on his wife for support and consequently his wife is also restricted to their home because she cares for her husband most of the time. Participant M13 mentioned that she is more or less in the same position, as she needs to help her husband get dressed as he is not able to do that due to a stroke. It appears that the participants feel an obligation to care for their partner. One participant (Participant M3) in this regard referred to her life partner that had a stroke and as a result needs permanent care: "… it [the life partner that had a stroke] complicates my life so that I am not able to go out anymore …" This is causing her to be home bound to the extent that she cannot go out or visit with friends anymore as she has to attend to her partner day and night. Another participant (Participant S32) stated that:

> … I will feed her [his disabled wife] in the night again, make tea for her and that sort of thing, so most of my time is spent here with her, we used to do a lot of dancing at one time, the two of us, but now she's completely uh … it's on the last stages of Alzheimer's disease. Her brain is shrinking all the time. She battles to speak as well. Basically that is what I do all the time.

It appears that the caregiving of a significant other leaves the caregiver with feelings of helplessness and perhaps even feelings of incompetence. To see a loved one deteriorate in this way, even to the extent that the caregiver is not recognised any more, causes great distress.

Dealing with physical declining capabilities. Some participants regulate their social environment by drawing on the social support of other people to satisfy their needs. Participants M12 and S27, for example ask other people to drive them where they need to go as they themselves cannot drive themselves any more. However, even though some participants utilise people resources in their environment to assist them, some participants realised that the physical decline of capabilities and functionality impact on those people closest to them. For example, even though most of the participants are still in a position to care for themselves, they all mentioned some sort of physical losses that they are experiencing such as loss of mobility, flexibility, hearing and eyesight.

Loss of cognitive abilities

Emotional response to the loss of cognitive abilities. The findings showed that loss of concentration, orientation, judgement, executive functions, and loss of memory all formed part of loss of cognitive abilities. It appears that participants expressed strong emotions in relation to the loss of their cognitive abilities. Participant M10 felt so strong about losing his cognitive abilities that he is an advocate for euthanasia. He states "… that's what I would want to do if I am in a state of losing my cognitive abilities, plus as I told the people this morning, that … I would like them to introduce euthanasia in this country, 'cause I would hate to be in this condition [state if dementia]. To me this is one of the worst things that you can have [dementia/Alzheimer disease], is people being like this [not being able to care

for yourself due to cognitive decline] … so I told my family to get me to Switzerland or Holland very fast …"

Consequences of losing cognitive capacity. The loss of cognitive capacity is also linked with disengagement and becoming dependent. Three participants (Participants M9, S20 and S21) stated that due to their forgetfulness they withdraw from participating in activities. For example, Participant S21 said: "… I was a proper participant [in activities] before [losing executive functioning] …"

The loss of concentration seems to contribute to a loss of self-confidence. One participant (Participant S14) reported in this regard: "I used to knit a lot. … I'd had a stroke before I came here and I just find I start a thing and I make mistakes so I just left it."

Other participants (Participant S7, S14, S16, S20, S21, and M9) made statements about their awareness of their loss of executive functioning as stated by Participant M9 who stated that he: "… forget about stuff [since dementia set in] …" and Participant S20 who stated that he is: "… very forgetful now [since he experience loss in his cognitive ability] …" Participants tend to experience a loss of executive functioning as degrading as stated by Participant S20 that he was a very different man before he became dependent on his wife to be his "memory".

The fear of 'losing one's mind' is a very relevant aspect amongst older people causing immense feelings of fear of becoming dependent on others as they will not be able to fulfil their daily tasks themselves. The fear of becoming delusional or losing one's ability to concentrate is also the cause of participants losing their self-confidence.

Consequences for other people. The loss of cognitive capacity also impact on other people. Participant S17 referred to her "husband who was diagnosed with

Alzheimer's disease and that he is not going to get better." The prolonged effects of Alzheimer's disease were enhanced for Participant S17 as she realised she is "not going to get better." This realisation caused her to fear the future and the impact that something like Alzheimer's disease would have on her and her loved ones' life. She even feared that this may become part of her own life, with also being diagnosed with Alzheimer's disease. The awareness of fellow residents or even friends that loose their cognitive abilities causes great concern with some of the participants. Participant S15 verbalised her concern with regards to a childhood friend whose cognitive abilities are declining and how vulnerable the friend has become, not being able to dress herself or go to the cafeteria for lunch. This participant (S15) has realised her own vulnerability by seeing her friend, causing her to fear that she may also become like her friend, and thus becoming dependant on others to function on a daily basis.

The fear of losing one's cognitive abilities is enhanced by the awareness of others losing their cognitive abilities. Participants S8 and S9 talked about loved ones who can no longer form part of a conversation, not knowing where they are and what is happening in the moment, even losing time, not knowing if it is day or night or Christmas or New Year's. Along with the fear of 'losing one's mind' is the fear of not recognising family or friends as stated by Participant S19 saying that: "… no matter how far the brain has gone, they [people suffering from dementia or Alzheimer's disease] may not recognise their own children …" It appears that the participants' sense of fear of losing their cognitive ability, orientation, judgement and executive functioning are enhanced when they see a fellow resident losing their mental ability. This fear leads to the loss of self-confidence. In this regard Participant S8 mentioned that one of her friends is also a resident at the particular facility. Participant S8 is

very much aware of her friend's state of losing her cognitive abilities. This is causing fear with Participant S8 that she may lose her mind too. As a result Participant S8 experiences a loss of self-confidence.

Interpersonal losses

Interpersonal losses for the purpose of this study refer to the loss of relationships with people, places and pets, as well as the loss of space and privacy. Interpersonal losses refer to the loss a relationship that can also include loss due to the death of a significant other.

Loss of relationships. Many of the participants mentioned children and grandchildren who live far and how this causes distress, as for instance Participant M18 who stated: "… many of our children moved overseas and as a result we have little contact with them …" As a result of the children moving away they have no one to visit them. Others lost a spouse, a child, a family member or friend to death (Participant W2, W3 and M19). Participant W4 not just lost her husband due to death but also three children, with a fourth being in a wheelchair.

Some participants noted that their spouse is not dead but they have to care for them day and night which is the cause of isolation and loss of relationships.

Loss of space and privacy. The transition to a residential care facility is also seen as a great loss of privacy and independence. Participant W16 in this regard shared how, "at times you just need your own space, but you are not able to." Participant M28 elaborated by mentioning that, "… there are times where you want to be by yourself and you hear a knock at the door and you think 'oh my goodness, who can that be? But you have to let them in … although they are invading your space …" These comments are supported by Participants W17, W18, M28 and M29,

with Participant W17 summarising it very well with his statement: "… yes, sometimes you need your own space …"

Loss of status. It appears that identity was formed prior to a life in a residential care facility that was associated with, among others, a role and status in the community or perhaps a job title. When the older person enters a care facility they are no longer judged according to a once held title or a position held in life. Participants L2 and L3 stated that it is expected of the retired individual moving to a care facility to throw their title into the fishpond at the residential care facility. The motivation for this activity is because at the residential care facility a title does not mean anything and everyone is considered to be equal. The meaning of this is very well captured in the words of Participant L2 stating that: "… you come from all walks of life and now, entering a care facility, you need to forget that you were a police officer or teacher. You are not in control anymore and you need to adjust to a new environment, forming a new identity." In this regard and according to the participants, it appears that the loss of self-confidence is also linked to losing a sense of identity.

Loss of a pet. Amongst all the non-death related losses suffered by the person in late-adulthood, it appears that the loss of a pet due to death or the leaving behind of a pet when moving to a residential care facility is a very traumatic experience to the participants. One participant (Participant M20) stated, "you know you get so attached [to your pet]". Participant M21, among others, stated that they miss the presence of a pet in the care facility. For others (Participants M20, M23, M24 and M27) the realisation of not being able to care for a pet is very relevant and on their foreground. To summarise this realisation the quote of Participant M27 is appropriate: "… it is so sad we can't have pets … you can't look after them properly, can't run after them, clean after them …" Even although the participants seem to be

very aware of the loss of a pet, whether it is due to them moving to the care facility or not being able to care for the pet, this loss still has a great impact on the older person.

Financial losses

It appears that loss of a career, support of family and friends and incorrect planning contribute to financial concerns. From the interaction with the participants in this particular residential care facility it appeared that financial decisions played a very important part in the decision making process to move to a residential care facility.

Loss of financial security. Some of the participants moved to the residential care facility early in their retired years. Their retirement savings were calculated incorrectly and did not keep up with inflation, and they therefore do not have enough money to see them through their lifespan. Participants M20, M30 and W10 mentioned that some of the residents that bought in long time ago will not be able to afford the escalating costs as their retirement investments did not keep up with inflation as stated by Participant M20: "… some of the people bought in long time ago did not anticipate frail care where the cost of living is very high … they will have to make another plan as they do not have the funds to keep up with the daily cost of the frail care …"

Some of the participants had to move back to children as they could not afford life in a residential care facility anymore (Participant M21, S19, W21).

For some of the older persons affording a proper meal per day can even become a major problem and concern. Participants M22, M31, S20 and S36 reported that Sunday lunch, for instance, is open to all the residents, they just have to book for it. Even so it appears that not all residents can afford these meal tickets

and that some residents donate meal tickets. Participant S36 stated in this regard: “If I maybe got to get a bit of change I say to her (staff member) ‘[give the meal tickets to someone who cannot afford a meal] for that money.” There appears to be a great awareness amongst the participants of the financial implications with regards to life in a residential care facility.

Discussion and Conclusion of Findings

Loss has been found, according to Hall (2014) as well as Schmall and Bowman (2004), to be of an accumulative nature since many older persons on a daily basis are confronted with all kinds of losses, from a loss due to death to a loss due to change in their circumstances. Relevant themes that became evident in this study and with regards to non-death related losses included on a physical level the loss of physical capabilities and functioning due to an illness or the ageing process as well as the loss of hearing and eyesight. On a cognitive level the non-death related losses the older person are subjected to will include the loss of concentration, orientation, judgment and executive functions, as well as the consequences of losing cognitive abilities and the consequences for other people. Interpersonal losses included children moving overseas, moving to a residential care facility, as well as the loss of place and privacy, loss of status and the loss of a pet. Financial losses, implicating financial security was amongst the most relevant themes that arose from the study.

The route of non-death related losses appears to start with unavoidable change that forms part of the older person’s life (Hall, 2014; Schmall & Bowman, 2004). According to Pearce, Clare and Pistrang (2002), changes in the older person’s life is to a certain extent unpredictable and it will depend on the individual person how this change will contribute to the individual’s ability to adapt to the new

circumstances caused by non-death related losses. Even though not discussed as separate main themes, the loss of self-confidence was a very important aspect and along with fear surfaced in about all the themes.

Schmall and Bowman (2004) as well as Steeman, Tournoy, Grypdonck, Godderis, and Dierckx de Casterle (2013) did exstensive studies on the relation between fear and a loss of self-confidence. The fear of for instance falling or losing cognitive abilities has an impact on the older person's self-confidence in a negative manner. The loss of self-confidence was often accompanied by fear of for instance getting hurt, or the fear of forgetting important aspects of life (Minichiello et al., 2000), or for instance the participation in activities, even in the execution of executive functions (Tinetti, Speechley & Ginter, 1988), such as walking to the main building.

Bronfenbrenner and Morris (2006) confirm that the loss of physical and cognitive abilities is a very important factor pertaining to older persons. In this regard the loss of physical abilities can play a role in the older person's involvement in activities, to the extent that it can limit the older person's ability to take part in activities (Antonucci, Birditt & Webster, 2010; Berk, 2004; Fuller-Iglesias, Sellars & Antonucci, 2008; Pinquart, 2002; Schmall & Bowman, 2004; Yang & Lee, 2012). The older person, for instance, is not just cautious with regards to being injured but they also reduce risk taking by avoiding activities that may include a potential form of being injured. The involvement in activities, however, gives them a sense of belonging and contributes to the quality of life (Bronfenbrenner & Morris, 2006; Erikson et al., 1986).

The hypothesis of the Bioecological theory of Human Development of Bronfenbrenner (Bronfenbrenner, 2006; Bronfenbrenner & Morris, 1998) states that one's well-being is influenced by social context and the function and quality of

relationships. Recreational activities appear to play a major role in most of the residents' lives and are seen as important, not just to socialise but also to stimulate the self (HulterAsberg, 1990; Pinquart, 2002).

The overall feeling amongst the older persons, however, is that loss robs them of their dignity and independence (Bronfenbrenner & Morris, 1998; Erikson et al., 1986). The fear of losing dignity and independence, thus becoming dependent, equals, according to Minichiello et al. (2000), becoming a burden to others. Losing independence is mentioned in the same breath as not being able to, for instance take a bath or a shower without assistance or driving where one needs to go (Messinger-Rapport & Rader, 2000; Owsley and McGwin, 1999).

Another aspect that surfaced during the discussions pertains to the fact that the 'world' of the older person has the potential to become smaller in a residential care facility as it is a bounded system, which to a certain extent is isolated from the outside world (Bekhet et al., 2009; Golhaber & Donaldson, 2012). Furthermore, due to physical decline the older person in some intances cannot take part in activities as presented in an active ageing environment (Bronfenbrenner, 2006; Bronfenbrenner & Morris, 1998) which means that the older person is forced to spend more time indoors, restricting their ability to interact with peers (Bickerstaff et al., 2003). The 'world' of the older person therefore keeps on shrinking, excluding the older person from the active ageing environment (Antonucci, Akiyama & Takahashi, 2004). Within this world of the older person that is becoming smaller and smaller vs the active ageing environment, the older person may get lost in an own world of isolation (Bekhet et al., 2009).

Taking care of a loved one is also a contributing factor that isolates the older person from the outside world, thus also contributing to the 'world' of the older

person becoming smaller (Minichiello et al., 2000; Schmall & Bowman, 2004). According to Clare, Roth and Pratt (2005), as well as Robinson, Giorgi, Ekman and Wahlund (2000), the caretaker may even battle with a body that is declining in ability, straining the ability of the caretaker to take proper care of a loved one suffering from loss of cognitive abilities such as dementia.

Antonucci et al. (2004) elaborate on the interaction between the older person and family, especially children and grandchildren and state that family interaction plays a very important role in the older person's life. It appears that family involvement gives the older person a sense of belonging, also enhancing their level of self-confidence, to have loved ones who visit them and are interested in their lives (Antonucci et al., 2004; Bronfenbrenner, 2006; Bronfenbrenner & Morris, 1998). In most instances, however, children and other family members are living their own lives or have moved abroad, influencing not only the older person's sense of belonging or level of self-confidence, but also to an extent contributing to the older person being isolated from interpersonal relationships and interaction.

The active ageing approach entails that the older person will partake in the different activities available (Boudiny, 2013) such as Bingo, line dancing, choir, to name but a few. Isolation, as discussed above, very often seems to occur as a result of non-death related losses such as physical loss (Bronfenbrenner, 2006; Bronfenbrenner & Morris, 1998), regardless if it is due to a physical loss experienced by the self or that of a partner. This isolation is also inclusive of cognitive losses (Clare et al., 2005), once again of the self or that of a partner. Regardless if the isolation is due to interpersonal losses (Brownie & Horstmanshof, 2012) or financial losses, the isolation occurs within a context of an active ageing approach for the

once active older person (Bronfenbrenner & Morris, 2006). It is thus ironic that residents experience isolation amidst this supposed active ageing approach.

The moving to a residential care facility is part of the loss of space and privacy (Antonucci et al., 2004; Antonucci et al., 2010; Minichiello et al., 2000; Tornstam, 1992). It appears to be a traumatic experience for the older person, creating a sense of loss of identity and also of self-confidence (Antonucci, Smith, Baltes, Takahashi, Fuhrer & Dartigue, 2002). It seems that most of the residents that moved to the residential care facility did so after they retired from their career. According to Schmall and Bowman (2004) and Tornstam (1992), giving up a career, the giving up of a position held in the career field and leaving this position behind when moving to a residential care facility may cause a lot of fear and also a loss of self-confidence as a new identity needs to be formed within the residential care facility.

Part of moving to a residential care facility can mean leaving a pet behind as pets are normally not allowed in all residential care facilities. Pets are an important part of most people's lives and are sometimes experienced as part of the family structure and thus valued in the same sense. It is, therefore, as traumatic to leave a pet behind as it is leaving a known environment, a job title or loved ones (Schmall & Bowman, 2004).

To be able to retire in a residential care facility, a substantial package is needed in order to be able to afford the living costs within such a facility for an unpredictable period of time (Berk, 2004). Being financially independent until the end of one's life can be a challenge and needs careful planning and specific considerations (Moen, Fields, Quick & Hofmeister, 2000).

As independence plays an important part in the life of the older person, financial independence is thus very important (Berk, 2004; Moen et al., 2000). Not

being able to care for one self can play a role in the older person's self-confidence and even cause tremendous fear of becoming dependent on others or even on children (Minichiello et al., 2000; Steeman et al., 2013). The move to a residential care facility may include the possibility of intensive care if the older persons have lost their physical abilities to the extent of becoming dependent or in the case of dementia or Alzheimer's disease where the older persons are not able to take care of themselves (Harris & Sterin, 1999; Passer & Smith, 2008). Intensive care is very expensive and if not provided for can deplete the older person's pension fund at an alarming rate. According to Berk (2004) it may cause tremendous fear with the older persons if they realise that they are not able to afford food or a meal ticket or even medical care at the residential care facility when needed.

Furthermore, stressful experiences such as widowhood, illness and financial strain can compromise the older person's well-being and even cause depressive symptomatology (Antonucci et al., 2002). It is thus very important to assist older persons with non-death related losses as it has a direct consequence on their quality of life (Antonucci et al., 2002; Bronfenbrenner, 2006; Bronfenbrenner & Morris, 1998; Harris & Sterin, 1999; HulterAsberg, 1990; Steeman et al., 2013).

Recommendations

It appears that environments adopting an active ageing approach, such as professionals working with people in residential care facilities and the management of care facilities, have little awareness with regards to dealing with the non-death related losses that older people are confronted with. It furthermore appears that there are very few, if any, programmes available to assist the older person who suffers from non-death related losses. In the light of this and using the research study as a foundation the following recommendations are made:

Retirement village management: Management should take notice of the participants' 'strong' verbalisation with regards to the non-death related losses that they feel they do not receive guidance for, even though non-death related losses play a major role in the transition from when the participants were still living by themselves, up to when they moved to a residential care facility. It is therefore recommended that management should implement information sessions to discuss the transition from pre-residential care to post-residential care. During these sessions dealing with and adapting to non-death related losses, such as a decline in health, loss of independence, loss of flexibility, loss of privacy, and even loss of hope, to name but a few, should receive attention.

Guidance can be given to the older person with regards to how to identify depressive symptoms that are due to the losses suffered, as well as on coping mechanisms to deal with these non-death related losses. Attention should also be given to induction programmes to facilitate the adaptation of older persons who relocate to residential care facilities, as older people are required to adjust into new groups and settings. It is, therefore, important that management of residential care facilities assess the experiences of their residents regarding non-death related losses so that appropriate programmes can be developed and implemented to promote the quality of life of their residents. Examples of such programmes can include support programmes involving supplementary care to relieve spouses of some of their caring responsibilities; or involve residents to share their grief experiences. It can even be beneficial to have counsellors and onsite psychological intervention available on the premises to assist the older persons with personal trauma, specific non-death related losses and transitional issues. It could further be beneficial to implement programmes and care groups who can meet on a weekly

basis especially for those residents who are not mobile any more. The same can be said of onsite occupational therapy for older people who suffer from for instance the consequences of a stroke. The more help is provided within the residential care facility the less the older person needs to travel to seek the help of these professionals.

All these interventions could assist those residents who suffer from non-death related losses to also experience quality of life.

Professionals in practice: Professionals in general working with the older person should receive special guidance and training to enable them to understand and accommodate the specific needs of the older person. These professionals will include speech therapists, occupational therapists, psychologists, to name but a few.

Further research: The loss of identity of older persons who relocate to residential care facilities are not well researched, and it is recommended that more research be conducted on this aspect, specifically in light of the older growing population. The loss of identity that causes the older person to withdraw and become isolated is but one of the aspects that appears to be associated with the loss of identity. More research on this topic can provide guidance and information to professionals with regards to the impact the loss of identity has on the older person's quality of life and psychological well-being. It is recommended that similar studies are conducted in other residential care facilities to broaden the view of non-death related losses and the impact it has on the life of the older person.

Limitations

Limitations of the research were found in the open-ended form of data accumulation. Within this method of data accumulation the focus was not on non-death related losses, thus restricting the information that could have arose should

specific questions have been asked with regards to non-death related issues experienced by the older person in a residential care facility.

The second limitation that was experienced was based on the inclusion criteria namely that participants needed to be mobile and not cognitively challenged. The inclusion criteria in other words excluded older persons that could have contributed to the broader study. Participants were chosen on the basis of being functionally well, meaning the older person with cognitive challenges or who were physically immobile were not included in the data collection methods used for the purpose of the broader study. This aspect limited the study to only focus on active residents, excluding the frail residents. Frail residents can also have a valuable contribution to the study. Alternative approaches should therefore be explored.

Conclusion

Late-adulthood is not a time in life that the older person should be excluded from the community as the older person has gained a lifetime of experience and knowledge that they could share with the younger generation. If the older person thus withdraws from society as a result of the trauma caused by non-death related losses it would be a great loss as the older person has contributed to the community during their productive younger years and deserves some respect for that contribution. As the older person is a human being they are meritorious of care and the focus should be on meeting their needs on all levels, including their need for assistance and acknowledgment of non-death related losses they suffer. From this study it appears that non-death related losses have a major impact, not only on the quality of life of the older person, but also in the way they contribute to society. It appears therefore to be very important to assist older people with non-death related

losses as this appears to be an area of specific need when considering the overall quality of life of the older person.

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SECTION C

PERSONAL REFLECTION AND CONCLUSION

1. INTRODUCTION

Loss is an unavoidable life event associated with ageing. It is actually a given fact that a person will experience loss in some or other form and that it will accumulate as the years continue nearing to late-adulthood. Non-death related losses of older persons are not always visible as major life changing events, although the impact is noticed in how older persons continue to function in relation to other individuals. The following section will give an overview on the researcher's personal reflection with regards to this specific study, ending with a conclusion.

2. PERSONAL REFLECTION

During the analysis of the secondary data the researcher became aware of the importance of an active ageing environment where older persons are encouraged to be actively involved. It also appeared that by being actively involved contributes to the overall well-being of the older person. Even so there appears to be a side to this active ageing environment that is not always acknowledged and easily overseen by the community as well as health care professionals and which involves the non-death related losses that older persons are confronted with.

It became apparent during the secondary analysis of the original data that the concept of active ageing not nesseceraly includes the individuals that cannot be part of an active ageing environment due to non-death related losses or as a result of these issues not being addressed. This does not mean that the concept of active ageing is incorrect or that the researcher does not agree with the concept of active ageing. It only means that in a setting where an active ageing approach has been adopted, careful consideration should be given to accommodate those older persons who, due to specific non-death related losses, are not able to participate in or benefit from this active ageing environment. The findings of the study could be used to develop psycho education programmes or therapeutic interventions such as group therapy, or individual counselling to support older persons to deal amongst other issues, with grief associated with non-death related losses, or to assist them with their lost identity, loss of self confidence and experiences of isolation. In doing so these programmes will not only contribute to the overall quality of life of the older person but also contribute to them living an optimally more healthy life.

The usage of the rich and multiple data gathering strategies made it possible to formulate a secondary research question using the original data. The multiple data methods also contributed to the validity and transferability of the study, making the study trustworthy. The study also made a contribution to the field of non-death related losses as experienced by and affecting the older person's quality of life in an ever changing world.

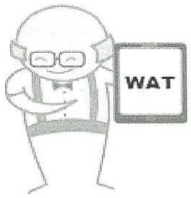
3. FINAL COMMENT

The implications of non-death related losses are that they have a gradual but complex nature, impacting not only on that part where the loss is experienced by the individual but also impacting on other systems such as the interpersonal and the environmental systems. The accumulative impact that non-death related losses have on the older person therefore has the potential to play a vital role in the quality of life of older persons, making the sum of the losses more than the individual parts.

APPENDICES

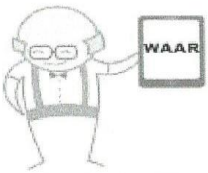
APPENDIX A

U WORD GENOOI OM DEEL TE NEEM



Aan 'n navorsingsprojek om te kyk hoe die leefstyl van inwoners in residensiële sorgfasiliteite lyk.

U deelname sal behels dat u, u ervarings kan deel in fokusgroepe asook aan iemand verduidelik tydens individuele onderhoude.



XXX
Aftreeoord

25 – 27 Maart

SKRYF U NAAM HIER AS U BELANGSTEL

NAAM	VAN	KONTAKNOMMER

TRANS50 AUTHER NORTH-WEST UNIVERSITY YUNIBESITI YA BOKONE-BOPHIRIMA NOORDWES-UNIVERSITEIT POTCHEFSTROOM CAMPUS

APPENDIX B

BEPLANNING VIR DATA-INSAMELING BY XXX

VOORBEREIDING

- Lees asb die aangehegte dokument oor die metodes wat gebruik gaan word en hoe dit inpas by kwalitatiewe navorsing.
- Kyk ook asb weer na Gemeenskapsielkunde riglyne oor die ingang tot gemeenskappe en hoe om ’n verhouding met deelnemers te bou.

PROGRAM

DAG 1		
07:00 – 09:00	Vertrek vanaf Potchefstroom met PUK bussie	Almal ontmoet in JCC parkering
09:00 – 10:00	Oriëntasie t.o.v Navorsingskonteks	Prof Roos en alle studente
10:00 – 12:00	Data-insamelingsessie 1: Mmogo-Metode	Navorsers en 16 deelnemers
12:00 – 13:00	MIDDAGETE	Saam met die deelnemers
13:00 – 16:00	Individuele onderhoude	2 navorsers met 1 ouer persoon
17:00 – 18:00	Nabetragting-vergadering	Prof Roos met studente
18:30 – 19:30	AANDETE	By die gastehuis
DAG 2		
08:00 – 09:00	ONTBYT	By die gastehuis
09:00 – 12:00	Data-insamelingsessie 2: World Cafe	Navorsers en 32 deelnemers
12:00 – 13:00	MIDDAGETE	Saam met die deelnemers
13:00 – 15:00	Luistergroep-tegniek	Deelnemers en Bestuurslede
16:00 – 17:00	Nabetragting-vergadering	Prof Roos met student
17:00 – 18:00	Formulering van Navorsingsvraag	Individuele studente met Prof.
18:30 – 19:30	AANDETE	By die gastehuis
DAG 3		
07:00 – 08:00	Pak die PUK Bussie	Almal se goed in die bus
08:00 – 09:00	ONTBYT	By die gastehuis
09:00 – 11:00	Implementeringsvergadering	Navorsers, deelnemers, bestuur
11:00 – 13:00	Vertrek na Potchefstroom	Laai almal af by die JCC.

APPENDIX C

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Faculty of Health Sciences
SCHOOL FOR PSYCHOSOCIAL BEHAVIOURAL SCIENCES
PSYCHOLOGY
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2520
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Geagte Deelnemer

Ingeligte toestemming – Leefstyl-navorsingsprojek vir ouer persone by XXX, Boksburg

U word gevra om betrokke te wees by ’n navorsingsprojek wat poog om die leefstyl van ouer persone wat in plekke soos XXX bly te verstaan.

Die navorsingsprojek word waargeneem deur Meesterstudente in Psigologie wat geregistreer is aan die Noordwes-Universiteit se Potchefstroomkampus. Etiese toestemming om hierdie navorsing te doen, is verkry vanaf die etiese komitee van die Noordwes-Universiteit.

Deur hierdie vorm te teken verklaar u dat:

Ek ingelig is rakende die doel van die navorsing en dat my deelname:

- ‘n Data-insamelingsessie insluit waar ek ’n visuele voorstelling maak rakende my leefstyl deur klei, stokkies en krale te gebruik.
- ’n Bespreking in ’n fokusgroep waar vrae rakende my leefstyl gevra sal word.

- Deel vorm van ’n interaktiewe gesprek waar ek geleentheid sal kry om my standpunt te bespreek in ’n groep.

Ek verstaan dat daar geen voorsienbare risiko’s of ongemak is, wanneer ek toestemming vir die studie gee nie. Ek verstaan dat die resultate van die studie gepubliseer kan word, maar dat my naam of enige indentifiserende inligting nie bekend gemaak sal word nie. Die Noordwes-Universiteit sal konfidensialiteit van alle rekords, materiaal en bandopnames behou. Ek is ingelig dat ek nie vergoed sal word vir my deelname nie, maar dat die inligting wat uit hierdie navorsingsprojek spruit voordelig kan wees vir my en my mede-inwoners.

Ek is ingelig dat alle vrae wat ek het rakende die navorsing of my deelname daaraan voor en na my toestemming, beantwoord sal word deur die navorers van hierdie studie. Ek verstaan dat ek my toestemming kan onttrek en deelname kan staak op enige stadium tydens die proses, sonder enige penalisering of verlies aan voordeel vir myself. Met die teken van hierdie toestemmingsbrief, gee ek geen wettige eise, regte of regsmiddels op nie.

_____ _____

Deelnemer handtekening Datum

APPENDIX D: RAW DATA

Non-death related losses as experienced by older residents in a residential care facility: Semi-structured interviews

THEME	SUB-THEME	DIRECT QUOTATIONS
Physical abilities	Loss of mobility, flexibility and balance due to illness or ageing process	**Participant S1:** He couldn't drive anymore, he was a golfer. **Participant S2:** I used to play snooker, but there again I couldn't do that now, because you got to bend over and I can't bend over. **Participant S3:** You know they do things and you've got to bend over and the floor was slippery and I said no, I didn't want to fall … I'm not very steady on my legs.
	Loss of hearing and eyesight	**Participant S4: H**e lost his eyesight. **Participant S5:** My eyesight is very bad. I haven't got sight in this eye. **Participant S6:** I can't hear. I had a serious accident. I split my kop open and did something to my kop, so I'm hard on hearing. My hearing is going away.
Cognitive abilities	Loss of concentration, orientation, judgment and executive functions	**Participant S7:** I used to knit a lot. When I came, I'd had a stroke before I came here and I just find I start a thing and I make mistakes so I just left it. (Loss of concentration) **Participant S8:** Hier's 'n vriendin … ek het haar geleer ken toe ons kinders was. Toe sien ek sy het baie deurmekaar geraak …

		Participant S9: She won't get in a motor car, since we've been here, I used to run Participant XX all over. **Participant S10:** … as half the time they are not, they (*are*) with you, but they are also not with you. They could be riding in a train, even though she's talking to you, but they want to know where's the next station when they going to stop or something like that. So it's as they say most of the time it's not there and they battle to speak and eat and ugh … **Participant S11:** My hearing is going away and so is my brain, so I'm not with it altogether. Without Participant XX I'd be lost. **Participant S12:** … They may not recognise their own children …
	Loss of memory	**Participant S13:** I'm very forgetful now since the … something so.

Psychological dimension	Loss of self-confidence	**Participant S14:** I wanted to take part in their sports last year, but I was scared of falling. **Participant S15:** You know they do things and you've got to bend over and the floor was slippery and I said no, I didn't want to fall. I put my name down and then I took it off again, because I was scared … **Participant S16:** Cause I'm frightened I'd fall, …

		Participant S17: … Participant XX is frightened she'd fall. She's had a fall before the wedding, but it changes your whole life. Funny enough it's difficult to explain it, but I hate it, that's the only way I can put it in, I hate it. In fact I detest the life I'm living now, it's not like I used to be. I don't uh, like if I know if I've got to go down to Xx tomorrow and I've got to use my car otherwise I've got no transport, it will keep me awake at night. I will worry about it. Loss of self-confidence. I don't like driving on my own. I like driving when Participant XX is sitting next to me, but now …
Interpersonal dimension (Relationship with people places, and animals)	Loss of people	**Participant S18:** I will feed her in the night again, make tea for her and that sort of thing, so most of my time is spent here with her, we used to do a lot of dancing at one time, the two of us, but now she's completely uh … it's on the last stages of cafalgism??(*unclear*). Her brain is shrinking all the time. She battles to speak as well. Basically that is what I do all the time.

Financial dimension	Loss of financial security	**Participant S19:** Ja, ek het my eie pensioen en goed en my seun het nou die dag gekom en gesê: “Luister pa ek gaan vir jou elke maand ’n R1000 gee, as jy kort kom … jy moenie geld vra of vir my geld vra nie, dit moet daar wees”. Ek het darem ’n belegginkie van my eie ook, wat ek gehad het, jy weet en so aan. **Participant S20:** Somebody comes along and says: "I can only have 4 meal tickets this week, I’ve only got that much money left" then she can give them an extra one.

Non-death related losses as experienced by older residents in a residential care facility: World Café (Relationship with people, places and animals)

THEME	SUB-THEME	DIRECT QUOTATIONS
Interpersonal dimension	Loss of people	**Participant W1:** … You lost a child. **Participant W2:** I lost my husband. **Participant W3:** I lost two husbands. I lost three children. I've got one remaining child in a wheelchair.
	Loss of space and privacy	**Participant W4:** At times you just need our own space. **Participant W5:** Yes, sometimes you need your own space. **Participant W6:** So in the morning when I get up I open my back door and she opens her front … uhm … windows. **Participant W7:** And then she says I can immediately see you are not working or you are working because the door is open …

	Loss of a pet	Participant W8: Dis ’n ou prentjie van die familie en daar’s nog ’n ou hondjie. Nou hier mag ek mos nie ’n klein diertjie aanhou nie, maar ek het mos afgesien en dit was hartseer, maar daar is soveel wat ’n mens terugkry dat jy nie daaraan dink nie. Yes. **Participant W9:** We haven’t got many dogs here. Mine was the very last dog who got permission to come here, otherwise I would not have moved here.
Financial dimension	Loss of financial security	**Participant W10:** Because everything is getting more expensive and more expensive and more expensive. I know that nothing can stay the same and so this place has also got to add up in the money that we’ve got to pay to stay here. But I hope it will always be so that we can afford. Some people bitch about the levy and all that but if they stay in their own home … **Participant W11:** He can’t afford, he can’t afford to phone? This is a joke with him. No he can’t afford to phone. Meanwhile back at the ranch there is nothing wrong with that, but anyway. As you say, you can pick your friends but not your relations (everybody laughs).

Non-death related losses as experienced by older residents in a residential care facility: MMOGO METHOD

THEME	SUB-THEME	DIRECT QUOTATIONS
PHYSICAL SECURITY	HEALTH	Participant M1: Daar is mense,.ek weet van ’n man wat 13 jaar bedleênd was, nooit daar uit gegaan en niemand het by hom gekom nie. By sy huis, maar sy vrou is daar, hulle is almal oor tagtig sy het hom versorg. Vir 13, 14 jaar ek weet nie want ons het later maar hier ingetrek. Participant M2: Sy is self nie gesond nie. Gehoor: That’s right Participant M3: Ander persoon: Don’t know which is worse Gehoor: hm hm Participant M4: Ander persoon. Not hearing, not seeing is dreadful. That’s right Participant M5: Maar jy leer hier om nederig te wees, want jy is so gesond. Ons is nog baie gesond en net die volgende persoon kan nie loop nie, is bedleênd, so jy leer om nederig te wees en jy leer ontsaglike dankbaarheid. Participant M6: Nou het hy beroerte gehad en hy kan nie praat nie en sukkel om te loop, wat haar lewe nog meer eee kompliseer in die opsig, sy kan glad nie uitgaan nie. Participant M7: Ja, ek probeer nie my werk huis toe vat nie en ek probeer nie my

		huis werk toe bring nie. Ek het uh, my man is uhm (gestrem) gestrem. Hy het ’n uhm beroerte gehad op 49, so hy het nie die gebruik van sy linkerhand nie. Hy kan loop en so aan (okay) uh, uh maar ek trek hom aan elke oggend voor ek werk toe kom, maar hy is ook deel van die huiskomitee so hy is ook deel van ons almal hier en uhm (so) hy bak nog saam met ons pannekoek en hy bak nog maak nog saam (so) tee, so uh, ek het maar net die voorstelling so gemaak dat dat uhm (mmm, mmm Ek verstaan) dat alles daar is. Dit is waar ek is. Ek bly in XXX Park Fasiliteerder: Is daar iets buite XXX Park? Mense of uhm Participant M8: Dis TLC ag as jy ’n pyntjie (haha) in jou groottoon het en jy gaan soontoe … ons het ’n dans hierso, bv. gehad en toe sit ek met ’n gout toon (van al die dans?) nee nog voor ons gaan dans het, maar ek gaan oki want dis my maatjie daai en oho ons kan so lekker saam dans en toe sê ek weet jy ek ek ek wil nou nie wegbly nie ma ek sleep (opi toon) hy nou oki op toon nie hys langs die toon. Man, hulle het daar so ’n lekker pleister opgeplak en hulle het hom vir my toegemaak en ek het die heel aand gedans en ek het nie eers geweet ek het ’n seer toon nie. (En toe wou

		ek nou nog op hom trap ook en toe wil sy ni he ek moes nie). As jy iets nie lekker bloeddruk, het ek seker nou 3 of 5 keer soontoe gegaan in die 5 jaar wat ek hier bly. Participant M9: Dan gaan jy soontoe. Jy leer daar iets. Hulle skryf alles neer, jy weet wat jou bloedtelling is, jou bloeddruk en in dan weet hulle volgende keer as hulle jou sien jy weet wat wat van dan. Maar nog nooit het iemand ek is nou te besig ek kan nie … Kom later terug of iets nie jy weet … en jy kry 'n pilletjie as jy iets nodig het, of hulle kan sien jy's nie lekker. Participant M10: Harry is mal oor visvang (dis mooi, okay) hengel, kompeterende hengelaar … al hoewel ek moes nou bietjie briek aantrek, was so bietjie siek gewees, bietjie baie siek gewees vra maar vir antie Annette sy't sommer bo op my bed geklim ha ha ha om my te help optel ha ha ha maar toe lê ek daar en weet nie of ek wil leef en of ek wil dood gani maar in elk geval dis nou Harry by die dam daar's sy skerp net, daar's sy visstok.
	PHYSICAL ABILITY	Participant M11: Hy het geval, byvoor-beeld, en sy het gevra ons moet help, maar ons kan nie en moes iemand kry om dit te doen. Fasiliteerder: Goed

		Jy weet, ek voel mense gaan nie self as jy op daai stadium kom gaan jy nie self uitreik vir hulp nie. Participant M12: I can't drive anymore so I have to wait for my friends to come to collect me. Participant M13: Voel omtrent jou of was jy miskien sou val en jy kan nie die persoon optel nie. Daar is 24 uur, iemand wat vir jou sal kom help. Participant M14: Jy sien daar moet 'n aanpassing wees dat ek dink almal sal saam met my kan stem dat op 'n stadium in 'n mens se lewe het jy baie meer krag om baie ding te doen and you can work outside a facility like that with ease but there come a time when you do not have the physical strength to do something and many times that's a problem for us because here you don't grow old you grow younger and then to get that in sequence with the rest of your body is sometimes a problem because you still want to do what you done 5, 10 years ago (almal stem saam) but but but one thing I can say is if you keep your mind busy for me it works if you're active you can lengthen your life you can't just sit and ledgutate (no no)

	SAFETY	Participant M15: Ek voel baie veilig hier maar die hek is ook oop vir my gaan om te kom en gaan soos ek wil daarom het ek die motortjie daar gesit. Participant M16: Die hek is oop dat, want ek is veilig maar die hek is oop ek kan sou nou nie kan sê ek kan escape nie maar ja hy is oop vir jou jy kan kom en gaan en doen wat jy wil en hulle hou jou nie vas nie en sê jy **moet** iets doen nie. Jy kan maar kom en gaan soos jy wil. Dat jy hier. Jy kan nog. Ons slaap party aande met die voordeur oop ons vergeet om die voordeur te sluit en jy is veilig. Fasiliteerde: Fisiese veilgheid? Jy is veilig, Sekuriteit Ja, fisiese sekuriteit Participant M17: And this is my bed, were I relax and of course sleep and have lovely night and they wake us in the morning round about 6.30 and if you don't answer they know there is something wrong and it is all very good. Participant M18: Daar is kaartjies as jy alleen woon wat die dae van die week op het wat jy elke keer die dag se raad dae se naam dan hang buite aan jou deur. As dit dan twee dae gelede is dan is daar iemand wat sal weet iets is fout, verkeerd of jy werk of jy is vergeetagtig …

		Participant M19: Put a card … something wrong Ha ha Fasiliteerder: Did you know about this card system? Jolly good idee Fasiliteerder: Did you know about this card system? No, I didn't. If I don't go for a meal, if I don't go for breakfast then they will come looking for me. It I don't go for lunch they will come for me, and they bring me my tablets, my medication and it is so wonderful to know that you are being in room you being so well it took me a long time to get used to it believe me being in a room I would say at least about four months. I reconciled but I was not happy but now I am, because I know everybody is there for me. Yes, I have to tell them where I am going. Participant M20: Dit is veilig hierso, jy kan in die aande sit en jou deur kan oopstaan. Ja, tot voor jy gaan slaap en jy voel nie asof, jy weet in soos jou groot huis is ja jy moet jou hekke sluit, jy moet jou alarmstelsel aansit. Participant M21: Ja, met hierdie veiligheid-storie wat ook lekker is hier, ons het almal 'n panic button. En en, en dis baie belangrik dat jy weet sou, want hy het 'n hartprobleem, sou hy nou 'n

		hartaanval kry, jy druk net ’n knoppie en hulle’s binne minute hier om vir jou te help. So dag en nag kan jy hm hm veilig voel omtrent … Fasiliteerder: So dis amper ’n gedeelde verantwoordelikheid? Dis reg ja hier is, huisies, 119 huisies hier bo, dis ‘n dorp. hm Die huisie, huise, eenhede wat meeste van ons nou in bly daar bo, so ons is ingedeel in die onderste groep so ons is dis so eintlik drie afdelings, die middel wat daar bo in die huise bly ons het ook…dit is vir ons…..knoppies het so as jy hom druk kan iemand jou onmiddelik kom help. Participant M22: Ons kan ry wanneer ons wil, jy sluit toe daar is nie ’n probleem nie. Participant M23: Die hek wat oop en toe gaan soos ons kan in en uit beweeg met die aktiwiteite. Participant M24: Baie van mense van die mense loop swaar … Ek wil nou net sê hulle is fisies nie in staat om dit te doen om so ver jy weet dis ver hoor enne jy moet self da jy loop hierdie paadjies bederf ons hulle het meer paadjies aangelê. En nou die dag het iemand vir kom kuier wat lank laas by ons was want hy het hierdie outomatiese karretjies en hy kan ry amper tot by ons huis. hmm Hy ry ’n draaitjie dan is hy by ons huis.

		Fasiliteerder: So, die omgewing het dit makliker gemaak? Participant M25: En toe gaan ek na ’n enkelwoonstel, eintlik paleisie, skryf maar weet jy, jy kan nie vir ’n mens in … vertel al die geluk en die vrede. Jy is nooit 1 aand onrustig of bekommerd of jy, jy bekommer jou oor iets nie. Dis net my vlaggie moes eintlik net wit gewees het. Vrede Dis my vlaggie daai Maar weet jy dis al wat jy hier kry. Dit is, dit is … En hier sal ek wil bly tot ek langbome toe gaan. Fasiliteerder: Nee, ek sien hom maar net raak toe ek dis … Nee, hy’t soontoe gerol toe dog ek los hom dis ek daai Fasiliteerder: Hy lyk warm en veilig Ja, hy’s mooi gecover Fasiliteerder: Would you say that your life here at XXX kind of offers you that lock up and go freedom (yes) so that you can travel, (yes) you can go away and not worry about your things (that’s right). Participant M26: Tannie: Because at home we would always be concerned about see if the alarm’s on, make sure that everything is closed you’ve got the house that you got to keep clean where here you have a smaller facility, uhm you have to always worry see that the garden gets cleaned and

		you know when you get older you your your abillaties are not the same anymore so it was quite difficult for me to do the garden and see that the house's repairs are always done and so it's it's been a, what do you call it, it's a good change. (A complete change it's not just retirement a life long holiday) you're really busy, we're actually more busy now because we haven't gone on retirement now it's like a holiday …

EMOTIONAL SECURITY	CONTROL	Participant M27: Dis reg, jy kan hom oopdraai of toedraai. Dit is, draai jy hom oop is almal daar, draai jy hom toe dan is almal bymekaar. As jy hom oopdraai, is almal daar of toedraai, dan is almal bymekaar. Fasiliteerder: Goed, het 'n kraan spesifieke betekenis vir u hier? Is, ja hier by ons as jy jou eie blomtuintjie het of jou eie plantjies en goed kan jy hulle natgooi, soos jy voel hulle is nodig om water te kry, enne … Fasiliteerder: Hoor ek iets van jy het beheer, dat mens beheer het oor jou eie omgewing en te besluit hoe dit kan wees? Enne die water is belangrik vir ons hier in die oord en buite, sonder dit kan 'n mens nie klaarkom nie. Met dit, kom jy klaar enne as jy 'n kraan oopmaak dan kan jy ook deelneem aan baie aktiwiteite binne-in die

		oord asook buite die oord soos sy ook nou gesê het. Enne, jy as familie is saam met die kraan. Fasiliteerder: Goed.

	PETS	Participant M28: Fasiliteerder: Ek's net, het net iets gehoor van daar is ook nie meer honde om te versorg nie. Is dit dan ook lekker hier om net die …? Gehoor: ha ha Nee, ons mis dit! Dit was voorheen so, die mense kon hulle oorlewende hond, saambring, maar ek het gesien dat hier 'n vrou moes jaag en gehardloop hy het baie keer … Ee, dit het toe nou gestop, maar jy kan maar jou pappegaaitjie bring of jou vissie. 'n budjie of 'n vissie. Fasiliteerder: Is troeteldiere, hm, pets are they an important part of …? Dit, dit mis ek! Participant M29: Hulle bring is dit 1 keer 'n week is dit die mense van Paul's, maar nie by ons nie net by die siekeboeg, Ek dink nie die siekeboeg maar die mense, TLC. En in ons omtrek net die huise om ons was,party mense het 7 honde gehad. En hulle vashou moet in die huis bly as jy hulle wil uitvat moet jy hulle uitvat. Dis 'n probleem

		Ek sien iemand met katte, met ’n kat het maar die katjies op en met ja met ’n ja Gehoor; Ja.

		Participant M30: Ons huis wat ons gehad het voor ons hiernatoe gekom het, nou ons het nie diere gehad nie ons het nou maar, soos hulle wegval het ek ons hulle maar gelos enne ’n ou raak te geheg aan die goed en dan is dit ’n groot probleem. Gehoor: Ja Participant M31: It’s so sad, so we can’t have pets, you can’t look after them properly, can’t run after them, clean after them.
	STAFF SUPPORT / RESPECT	Participant M32: Enne, ek is en regtig waar, hm, almal hier is so behulpsaam, wat die mense wat hier werk en so aan, so **ek** het rerig niks om oor te kla nie. Participant M33: Wat ook baie gelangrik is die staf staan nie terug nie, hulle deel met ons, absoluut in baie dinge en jy voel so veilig, want jy weet dit is goed georganiseerd. Ons staan nie op ons eie nie. Selfs die mense wat die vloere hier skrop … hulle is absolute uitreikend, as jy by hulle kom, so ons is baie bevooregte mense … Fasiliteerder: So, dis nie net die fisiese omgewing nie, ek hoor ook van die emosionele omgewing?

		Absolute, Absolute. Gehoor: Ja Ja

		Participant M34: En ek dink die feit dat elkeen oor homself, sy belange gepraat het. Participant M35: Okay, dit is nou baie persoonlik vir my wat ek op die oomblik deurgaan. My man is 2 weke, ag 2 maande gelede oorlede en op hierdie stadium voel ek baie hartseer oor sy dood en tog het ek in hierdie tyd met sy siekte en sy dood, het ek almal om my het my soveel onderskraag en bygestaan sodat ek nooit regtigwaar alhoewel ek eensaam en alleen voel was daar altyd mense rondom my wat my bygestaan het en hulle vriendskap vir my aangebied het. Fasiliteerder: Shame, so dit was eintlik ’n baie positiewe ervaring? Ja, alhoewel ek nog deur die verlange gaan en ek is eensaam in my plekkie in die aand, ek mis dalk my man, het ek altyd iemand om my vir wie ek kan gaan kuier as die eensaamheid te veel raak. Fasiliteerder: Sê my hoekom dink mevrou is dit belangrik om mense te hê en daai ondersteuning? Weet jy ek voel dat as ek nie daardie hulp het nie en as ek nie uitreik na mense nie, mense reik nie na my toe uit nie gaan ek in

		depressie in gaan en, uhm, ek wil dit nie hê nie en ek is so bang dat ek kan depressief raak oor dit wat nou met my gebeur het sodat ek voel ek moet altyd my hand uitsteek na ander mense en nie net aan myself dink nie. Participant M36: En dan het ek ook hier is nie, hier is jy weet jy wat vir my hier ook baie belangrik is, as jy ’n hartseer probleem het of jy’t slegte nuus, jy kan altyd na jou vriende toe gaan en, en jy kry ondersteuning daar. Al gaan drink jy net ’n koppie tee, sonder enige bedoeling dan het sy miskien ’n nood of ons praat net ietsie of die Bybel. En jy kry weer daai krag as jy daar uitstap. Ek het nou weer iets binnekant wat ek saam my kan dra. Dit is wat vir my daai rykheid beteken. O, almal, almal wat wat jy mee kennis maak hier en dan moet ek ook vir jou sê met uitsondering daai … daar onder is vir my my trots. Die bestuur, hulle verstaan … as jy ’n rede het of jy’t iets of jy gaan na hulle toe, hulle, hulle bespreek dit met jou, hulle wil jou gelukkig maak. lekker na hulle gaan jou nooit wegstuur nie. En dit beteken vir ’n mens so baie..... daar’s almal gee om vir jou. Dan wil ek sommer 110 word nie net 100 nie (haha)!

		Ja, maar al gaani mens net daar en jy loop verby hulle kantoor dan ‘hallo’. Ja, Ja, hulle gesels net so ’n paar minute … dan’s dit weer lekker, nee, ja. Participant M37: I want to just agree with the lady who spoke about the wonderful people that actually serve in this place. You know the staff they are absolutely fantastic, they treat you with so much dignity, they really are a very nice, uh, quality of people. But even the people that stay here, as I said, we’ve only been here a short while but if I walk past her we had to come down the road to get to our car before we got a garage up that way, so I’ll miss you (ahhh sweet) because she’s so lucky she’s always friendly … I think we’re probably maybe of the youngest people here, but we have a terrible job with our friends and family to get them to understand it’s not an old age home (no), it’s a residential care facility, there’s a difference between an old age home and a residential care facility but then I say on this side here you can probably class it as the old age group but you can’t say it’s an old age home, because it’s not like the conventional old age home, it’s really really nice to be here.

	MEMORY / BRIAN ACTIVITY	Participant M38: Wat die aktiwiteite is, dit stimuleer jou, dit stimuleer jou brein, sal ek sê, en dit is baie belangrik. Participant M39: Ek het ook van goed vergeet. Participant M40: She's in the last stages of Parkinson's. Participant M41: Well, yes, to occupy euthanasia ourselves, I mean that mainly but uh 1 thing that I've, huh, feel good about, I like to what I call in S.A. because its ah when I go to the frail care and see the people suffering, to me they should have introduced euthanasia a long time ago. I've told my family if I ever get near that they must get me to Switzerland or Holland (it's legal). They could put me to sleep there because I would hate to be like those people on that side. They don't have a clue what they're doing. They've everything gotta be done for them and uh to me that's not a life, I'm sorry.

	PURPOSE IN LIFE	Participant M42: Kan ek net iets noem? Sheila is also an ordained minister. She, hm, takes sometime, takes the services when they need someone. Participant M43: They have put me on the roster now, hm for preaching here once a quarter which I enjoy I thoroughly and also, mm funerals I have done here, which I had to get permission from my rector to see if I could do it and he said, yes why not. So I am also doing that. So, I am quite busy and I love it, I love it. As long as I can, I will do it. Fasiliteerder: But there is a specific purpose to what you do and that is meaningful for you? Oh, absolutely, absolutely my church, being a Christian and and I know that I have been saved by the Lord, well we all know because that particular day is coming up now, and it could do it and he said, yes why not. So, I am also doing that. So, I am quite busy and I love it, I love it. As long as I can, I will do it. Fasiliteerder: But there is a specific purpose to what you do and that is meaningful for you? Oh, absolutely, absolutely, my church, being a Christian and and I know that I have been saved by the Lord well we all know

		because that particular day is coming up now, and it means the everything to me.

		Participant M44: My grootste gedagte wat ek gehad het toe ek hier by kom is, om mense te bemoedig. As mense siek is wil ek graag daar instap en ek glo niemand stop my nie, want ek klop en sê kan ek inkom dan sê hulle, ja, dan stap ek in en as jy sien jy is nie welkom nie dan praat jy net so bietjie, ek vat aan die hand en hardloop weer weg. Participant M45: We have to encourage them to do things and we have to lead them and I feel so sorry for people because they can't read. We have to read things to them, we must sign out for them and I feel so sorry for people who can't see. Participant M46: En as ek kan help. Fasiliteerder: En dit werk goed, is dan baie meer met die mens. Participant M47: Vir my vir die oord as sulks (mm), want uh so genereer ons weer geld.

	FAMILY RELATIONSHIPS	Participant M48: Hierdie twee gesiggies, dis my man en myself, hm Ek is baie familievas en ek is nog bevoorreg dat ek my man in my lewe het. So, we're really joint at the hip. Ek kan nie sonder hom nie, en ek hoop hy kan nie sonder my nie. En dan hierdie verlenging, my kinders, my twee seuns is vir my baie, baie belangrik en my twee skoondogters en dan my drie kleinseuns en my kleindogter. As ek net vir hulle om my het, is die ander goed in my lewe, dis die dat ek dit so gescatter het, is die ander aktiwiteite bo en behalwe wat ek nou in die oord in het dis vir my amper, bysake. Ons, ee, moet 'n eenheid wees. Fasiliteerder: Is dit nou mense in die oord of is dit nou belangrike ander naby familie? Participant M49: Dit is ons, is baie familievas, jy kan maar die vrou ook vra, as ek die naweek die kinders nie sien dan is daar probleme, dan is ek so half opstandig. Ek moet hulle sien. Jy moet hulle sien, al sien jy hulle net en kom net bymekaar soos gister dat jy almal bymekaar het dan is jy tevrede, sien jy hulle nie dan het jy maar 'n probleempie. Waar is hulle, hoekom kom hulle nie, stel hulle nie belang nie? En jou gedagtes dwaal.
		Participant M50: En, hm, dan ook, ek het drie dogters en hulle is baie na aan my

		hart. Ek kon nou net nie al my kleinkinders hier sit nie. Participant M51: Nee nee, dit was basies ’n verlange na haar kinders. Jy weet baie van ons kinders, nie van ons s’n nie, maar van die mense se kinders, woon oorsee. Participant M52: Ons kinders gaan saam met ons hierdie dinge kyk. Jy weet hulle ry saam, voëls kyk saam met ons voëls kyk, saam die sport kyk en ons saam en die kleinkinders gaan saam het hulle leef enne, met die tyd soos ons dit sal sal ons beleef. Met die tyd wat ons sal beleef. Participant M53: Ek dink alweer wat moet ek vanaand vir die kinders kook O, hi hi … Participant M54: It is. I think it can possibly be because I grew up with no brothers and no sisters. Very small family and nothing upsets me more than to hear about you come and tell me you’ve had a fight with your sister. That upsets me and I don’t even know who your sister is. For God’s sake I never had one, don’t fav with the one you’ve got, and I think this affects me very closely. Participant M55: Dis, dit is, uhm, my kinders en wat dit ook erger maak is my kinders is oorsee, ek het net een dogter hier uit my man se vorige huwelik en sy staan my baie by en ook dan nou my

		vriende buitekant en, maar veral, veral hierso binnekant.

		Participant M56: Dis ek en my pasiënt en daar's, daar's ek by die huis. Ek lees baie. Ja, daar's my boek (A)okay en ek speel rekenaarspeletjies (A)o lekker. En, uh, daar is my aktiwiteit. Ek is op die huiskomitee. Ons skink tee vir alle, uh, funksies soos, eh, vanmôre en begrafnisse, eh, en ons bak baie pannekoeke (lag lag). Hulle moet daar wees … (pannekoeke). Participant M57: Want my kinders kom eet nog by my. Fasiliteerder: Okay, en die stoof het saam gekom om vir hulle kos te maak? Stoof het saam gekom, ja, ek het nou nie veel om te vertel nie, so ja. Ek leer die mense nog hier ken. Ek ken nog nie baie van hulle nie en, hu. Fasiliteerder: Die stoof, dis alles saam met (saam met die koor saam). Die stoof saam met die kinders … Ja, maar nou ek hou my maar besig. Ek is baie lief om ou resep, resepte uit te toets of so jy weet, maar ek word nog nie huh uh gourmet, uhu, kok nie.
	FAITH / RELIGION	Participant M58: Ek, ek weet nie of ek Godsdiens hier mag inbring nie, maar dit is vir my belangrik dat my lewe en my man

		se lewe, ons kleinkinders van, hm klein tot groot en ons kinders kan nog beïnvloed. Participant M 59: But the main thing for me is being able to get to church on a Sunday morning. Participant M60: And I'm spending the whole weekend with friends so I that I can be there at the church where I want to be. Fasiliteerder: Is spirituality a big thing in this context or not for everybody, can they can participate when they want to? Absolutely, any any one can come at any time. Fasiliteerder: So, daar is aktiwiteite waarby julle kan inskakel? Participant M61: En dit is my Bybel, Jesus eerste. Lekkerste en jou Bybel … Ons het Pieter, het vir Pieter hier, ons fantasties bid op Woensdae. Hier's geweldig baie predikers wat ons kom besoek. So, as iemand nie naby 'n kerk kan kom nie, hier is daar altyd iemand wat jou kom help. Hier begint my Bybel, hoor dis nommer een.

		Participant M62: Baie gebid oor die saak en die Here het my hiernatoe gelei. Wat die Here lief het soos wat ek Hom liefhet. Participant M63: Christelike norme wat hier is. Alles wat ons doen, word geopen met gebed en nnn ’n dit is baie belangrik. Participant M64: This is one of the bad things, yes about our Christians we’re not, we;re not outspoken enough we don’t go and advertise our Christianity, we tend to sit back. Participant M65: Gehoor: hm That’s right … But on your own way they can see who you are. … By your life, by the way shares … They can see how you react your Christian view. Wat my die meeste opgeval het is dat hm, dat jou geloof, dat almal lyk my ’n is Christene. Fasiliteerder: Jy het dit nie voor die tyd geweet nie? Ek dink nie mens, jy het so ’n, you we we’re so aware of it as we spoke hm … Ons gaan na ons eie kerke toe … Yes, … not enough, it is nice to know that everybody, you are on a spiritual level, a very good one and was so glad when, when, hm, Sheila said that we were saved by the Son and is his day is Friday because you we as Christians we are

		sometimes too scared to say something because you don't know how that person is going to react to your Christian view.

SOCIAL SECURITY	ACTIVITIES	Participant M66: Baie, ek is aktief, ek moet afskakel. Participant M67: Dan doen ek naaldwerk en ek doen kralewerk en dan doen ek verhuring van rolstoele, kieries, looprame, enige ding. Dis maar my, my doen en late hier. Ek is 'n baie aktiewe mens, ek kan nie stilsit nie. Ekke doen alles en nog wat. Ek neem deel aan die uitstappies wat ons doen buite die oord en dit is omtrent al. Participant M68: Hm, dan studeer ek nog. Ek het verlede jaar klaar gemaak met 'n kurses by HBI in Bybel- en Godsdienskunde en ek doen hierdie jaar hierdie en volgende jaar 'n kursus besig en volgende jaar Christelike etiek. Participant M69: I study and every day. Participant M70: Saam het hulle gym doen en toe begint ek ook as 'n gym liggaamsinstrukteur vir hulle ook help as die ander dame nie tuis is nie. En hier het my nuwe lewe begint en dit is gym.

		Al die speletjies is die lekkerste. Mm, dis eintlik jou biblioteek, ek lees baie, baie graag, maar … Participant M71: Ja, ek is ook ’n persoon wat daarvan hou om besig te wees. Hmm Ek, hmm ekk, .dis my kitaar hierdie. Ek speel so ’n bietjie kitaar. Inne, ek en ek speel ’n bietjie blokfluit en ’n bietjie mondfluitjie en klavier. Participant M72: Ek doen naaldwerk. Ek doen loodwerk en ek maak lampe en glaswerk en, ja, dan neem ek deel, hm, aan die lyndans hierso, stap, ene koorsing, enne, ek moet sê hier is ek baie gelukkig. Ek wil twee goed vra, een ding ding wat ek wil vra is, wat staan vir julle uit in aktiwiteite wat hier gedoen word, die betekenisvolheid daarvan, wat is die betekenisvolheid van al hierdie aktiwite wat jy by betrokke is, wat beteken dit vir julle, hoekom dit belangrik is? Participant M73: Ek sal sê dit gee vir jou ’n vv ’n vv ryker lewe, jy weet, hm, en wat vir my opval met elke aktiwiteit en so aan is die … Kan ek ook hoor, die aktiwiteite wat julle hier doen, hoor ek dan julle kan vrywillig kies waartoe julle betrokke kan wees?

		Participant M74: Hier is ook ’n legkamer, daar is legkaarte wat jy kan bou of jy kan uitneem soos ’n biblioteek. Daar is sitplek om te sit ook, jy weet, daar is baie, daar is baie … kaartjies, bordspeletjies en kaartjies en mense wat nou daaraan belangstel, jy weet hulle kan as hulle kan regtig. Participant M75: Ons spesifieke omdat ons nog uitbeweeg. Ons, ek ontvang baie mense hierso nog wat by my kom eet en ons gaan weg naweke weg saam met mense … Dit is nou ons rede, dis hoegenaamd nie omdat daar fout is nie. Ons sal integreer so met die tyd saam. Daar is sekere dinge soos sportdae, dis heerlik. Marita, eintlik ek het dit nie eers genoem in my … Persoon 2: Daar is sportdae waar daar kompetisies is … Daar is rolbal ook … ons gaan … Mense stap, hulle stap hulle buite of stap binne ons stap gereeld en hy stap elke dag as ons voor ons huisie begin die muur omstap is dit 1 kilometer as jy twee keer is dit 2 kilometer. Jy kan nie sê nie. Participant M76: I think everybody was pretty busy. Participant M77: Okay, uhm, we’ve got a club, plays 3 matches against 4 other visitors. I’m the secretary of our club and the league and the treasury same time,

		now this is just one or two things we play snooker on the Tuesday and Thursday mornings. Now I'll give you my time table. On a Monday if we're not playing a league match, cause that's when we play 12 matches, 6 matches against other clubs on 1 day.

		Participant M78: Uh, dis die 1 aspek van my lewe, my my my meeste tyd is ek besig met die boeke, glo dit of jy wil ons is nog besig om teologie te studier, ons is besig met 'n BA Ministry, ons is amper klaar en as ek nie daarmee besig is nie dan sit ek en ek lees ook boek, maar ek lees nie, uhu, hierdie (Fictional) love stories, ek het mos my lovey ek hoef nie nog te lees nie. Uhm, ons gaan deur op die international school of ministry wat van Amerika af is … International university en dit is nou gelink op 4 of 5 universiteite, Engeland en Amerika wat ons mee besig is Maar die Afrikaanse goed sal ek nie kan doen nie. Jy kry verskriklike goed wat die ouens nou weer … en en, dis ons lewe oppie lyn soos ek sê, ek begin stadig maar seker die mense leer ken, ek wil nog eendag saam met oom A gaan snooker speel in my jong jare toe ek poeliesman was het ek snooker gespeel, maar ek het nog nooit daarna kans gehad nie, ek is te besig so ja, want

		een van my maats uhu ja, en soos ek sê, verder is ons geweldig besig in ons gemeente uhu uhu ek is een van die hoofpastore daar, that's our life.

	ISOLATION	Fasiliteerder: So, dit is moontlik om mensself so te isoleer? Participant M79: Ja kyk, sy, ek bedoel ek voel by sulke mense moet daar interaksie wees van die, van die personeel. Want niemand het nooit by daai mense gekom nie. Dit was vir my verskriklik, ek was geskok toe ek dit hoor. Participant M80: I am very lucky I have friends and family who come to visit. Participant M81: Baie mense raak nie betrokke nie bloot omdat dit hulle geaardheid is. Ek ken nou wel terwyl dit nou baie konfidensieel hier is kan vir ek jou sê my suster en haar man bly hier. Ander persoon: Dit is baie swaar en van die begin af was hy, was sy hele lewe lank was hy eintlik 'n alleenloper. Hy soek nie mense om hom nie, wat die natuurlik, wat haar lewe beïnvloed. Hier by ons is besoek elke dag aan haar gesit het, maar ee, dit is werklikwaar mense wat nie uitreik nie, wat nie eee wat net by alleen in hulle huise bly, is uit eie keuse.

		Participant M82: Ek sal net vir u sê ’n mens, jy word eintlik kwaad, jy bly nou in aftreeoord, jy krepeer seker nou. Participant M83: Om, om terug te kom na jou vraag toe hoe ’n mens hulle kan betrek, hhh, ek wonder soms of dit nie, ee, jy weet ag sê maar nou jy is nou jare getroud met iemand, hm, en die kinders is uit die huis uit. Jy moet so waak daarteen om nie selfsugtig te raak nie. Nou wonder ek, of die mense wat nie wil deelneem aan aktiwiteite deelneem nie, nie ook voel, you’re going intruding my space, hm and I don’t want that. I, I am here and hh I don’t need anything.” Maar dan as hulle die dag nou wel na ’n aktiwiteit toe gaan dan kom hulle agter ek het eintlik baie gemis. Ja. Wel, dan is dit miskien al te laat, hm, en dan die gesondheid is dan nie meer so goed. Ek dink nou aan ’n spesifieke een dame, ek het vir haar gesê nou al ’n paar keer vir haar gesê ek sal saam met jou gaan, jy kan die aktiwiteit kies ek sal saamgaan, sy wil nie. Nee, sy sal nie. Sy wil glad nie. Participant M84: I just wanted to say that it works both ways, hm, if you are intruding into someone else’s space and they don’t

		like it. People also intrude into your space and you don't like it. There are times where you want to be by yourself and you hear a knock at the door and you think, oh my goodness, who can that be? But you have to let them in. It it, you have to let them in although they are invading your space and make it known that there are some times of the day when you want to be alone. Fasiliteerder: But that is also ok Yes it is important that you be alone sometimes. Look, you get people who are very, really they chatter, they chatter all the time and you have to accept that, but you also have people who who need their own time, their own space and that you have to accept it too. If I let people in and visit but know when people want to be alone.
		Fasiliteerder: You touched on something just for five minutes in terms of the interaction of skills which you have to be able to in the sense. You talking about accepting people's invitation to come in or you to go to them but … Die interpersoonlike vaardigheid wat mense het of nie het nie om betrokke te raak by hierdie aktiwiteite of by hierdie omgewing.

		Persoon 1: Ekskuus ek kon nie mooi hoor.

		Fasiliteerder: Die interpersoonlike vaardighede, hoe mens met ander mense omgaan wat of mense nader trek of mense afstoot. Wat is julle belewenis daarvan? Participant M85: Ek dink nou aan een spesifieke persoon wat, ee, regtig ’n front opsit van, ek het niemand nodig nie, ek wil niemand in my spasie toelaat nie maar kom ’n bietjie nader hier na my toe dat ons bietjie kan praat. Sy is werklik … ja … enne, maar haar, haar woorde sê nie wat haar lyftaal sê nie. ParticipantM 86: Sy kan nie ophou nie so met die gevolg is, ek sukkel nie meer om met haar te gesels nie. As sy my sien dan begin sy die storie oor en oor te vertel. Gehoor: Ha ha. Ekskuus, ek het ook gevoel daar is mense wat ’n front opgesit soos Bets gesê het. Ek dink aan ’n spesifieke dame wat hier in die sitkamer sit. Ons maak sy sit maar by haarself omdat sy nie met iemand kan praat nie, enne, ek het nou al ’n paar maal het ek vir haar gegroet, ene, een of twee maal het sy my net so gekyk maar en elke keer as ek by haar verby loop gegroet ek en naderhand het ek by haar gesit.

		Toe kom ek agter maar sy, as sy eers begin praat dat praat sy jy weet sonder ophou.

	PEER INTERACTION	Participant M87: Die aktiwiteite insigself wou ons mens stimuleer ons, maar wat is daar nog aan die aktiwiteite, is daar nog iets aan die aktiwiteite wat vir julle betekenisvol is, dat julle soontoe gaan, om iets te kry, wat kry julle? Persoon 2: Die saamwees tussen ons medemens jou … genoeg van ons. Daar is party mense wat nie lank wil sit nie so om saam met ’n groep te wees en hulle waardeer en geniet dit en ons geniet ook die wat net daar wil kom sit. Fasiliteerder: Is daar ruimte vir die mense wat dan nie deel nie, wat net wil saam …? Persoon 2: Absolute, absolute ons gaan haal hulle ons ons, ja ons wil hulle daar hê.

		Participant M88: A lot of people companionship. Fasiliteerder: And tell me, why is it important to you now? Participant M89: Their friends, their neighbours, their strangers, I don’t know you, don’t know you but were all together and sharing something. Having fun together, having laughs together, sharing

		experiences, sharing the good things in their life, not the bad, only the good. Fasiliteerder: And tell, me are they friends, are they neighboors? I think I can speak just for myself and everybody else. There's nothing worse than loneliness. That's true. We all know that. Fasiliteerder: And what are these people doing to get that?
	YOUTH / MEMORIES	Participant M90: Ja hulle sê mos as jy ouer word you're going back to the secondary childhood stage. Fasiliteerder: So, dis dan eintlik meer herinneringe? Participant M91: O ja, definitief. Fasiliteerder: Om te dink aan ander goetertjies buite XXX, maar ook hier binne nuwe herinneringe te kan hê. Is dit so vir julle ook?

		Ja, dis herrinneringe As ek verskriklik verlang, dan kyk ek na my foto's en ek kyk hoe lekker het ons uitgekamp. Fasiliteerder: Okay, is dit vir julle ander ook so met die herinneringe?
	SOCIAL SKILLS	Participant M92: Toe ek dit agterkom, het ek haar bietjie besoek, maar sy is so, dat sy kan meer kommunikeer, jy weet nie, nie sommer nie. Maar, sy het my gesê ek is die eerste persoon seker in 12 jaar was wat iemand hulle besoek het. Sy het kinders hier rond wat hulle ma nou baie bystaan, maar dit was vir my vreeslik erg dat niemand ooit by hom in die kamer was nie … Die keuse om betrokke te raak soos jy wil? Participant M93: Gehoor: Hm ja … Daai mense … Aanvanklik, maar ek voel iemand moet darem gaan ondersoek instel. Participant M94: Ja, maar sy praat maar ek dink haar houding sit ander mense af en ek dink daar is baie sulke mense wat miskien nie gewoonlik … dat jy moet net sit jy hoef niks verder te doen nie, jy kan maar net sit en luister … Participant M95: Ek het uitgevind, dametjie, dat as jy in die kamers inkom dan is daar party mense wat weet daar is verfwerk, maar hulle weet nie wanneer om te gaan nie al is dit opgeteken, Ja. Al wat jy moet

		dan doen is om bietjie vroeër te gaan, in te stap en sê, kom saam met my en dan geniet hulle daai verfklasse saam met jou. … Jy sien om met ’n maatjie saam te vat … ja, ja … Dis waar … They need a hand … Jy moet hulle gaan haal of hulle gaan nie kom nie … Ja, dis ’n baie goeie idee. … Ja, want hulle sal sê was dit aan gewees? … Ja, ja, ek het nie geweet nie … Ja, ja … Lees jy nie die bord nie? Ja, maar hulle vergeet … Die dae gaan aan, jy weet jy is onbetrokke en as jy hoor is dit verby, ja veral as jy alleen is.

		Fasiliteerder: And it sounded like, julle ook soms doen met die naby julle verhoudinge, dis vriende, dis bure, dis almal is deel van ’n gesamentlike groep. Participant M96: Jy word altyd versterk as jy dink jy’s af, jy gaan net by jou buurvrou in dan kry jy weer daai krag wat jy nodig het. It’s a very good atmosphere. That’s good … nee, maar jy weet sy’s daar. Ja, jy het die vrymoedigheid om hello te sê en om sê, kom drink ’n koppie tee of gesels ons bak so min hier, maar as jy ’n eier nodig het en jy het nie een nie dan gaan haal jy een, jy vra nie.

		Participant M97: Is dit so vir julle ook, het julle al ook so gevoel dat selfs in baie moeilike omstandighede is hier ondersteuning hier? Gehoor: Definitief. Gehoor: Jaah.
	ADJUSTMENT	Participant M98: This is my new world. I am just still very new and in a bachelor's flat. Participant M99: We moved here after my husband got ill, we let the children stay in our house, because it's better for him here, but what I set out here is me and my husband love to galavant, we've done a lot of riding, spent most of our time at church, because we are really involved with the church. Then we loved to go have tea and coffee. Fasiliteerder: Vertel my van die aanpassing met die sing en die jaffels en die … Participant M100: Ja, well, uh dit help 'n mens om mense te leer ken en om uit te vind, okay jy's oraait en jy's oraait maar vir jou gaan ek maar bietjie sidestep jy weet, 'n mens; jy leer mense ken. Regtig waar. Fasiliteerder: Deur betokke te wees? Ja … en … ja … ek dink ''n mens se oordeelsvermoë en jou takt word hier getoets.

		Fasiliteerder: Vertel my. Letterlik getoets. Kyk, jy's nou nie meer in jou eie huis nie; jy't bure en jy moet aan … ek wil nou baie saggies wees in die oggende met my radio, want ek gaan die bure pla of so iets, jy weet. Fasiliteerder: Ek verstaan. En ook, almal het nie dieselfde belangstellings nie. Hulle huishoudings is nie dieselfde nie en skielik kom ek agter oh! Ek kan nie … oh, hier's dinge bietjie anderste, jy weet … daai een doen so en daai een doen so en dan leer jy sommer 'n ding of twee. Fasiliteerder: Is hier plek vir sulke verskillende mense en style? Oh, Jahh … jahh, … jahh, luister, ons is tuff, vir hulle moet ons hande klap(ja) hulle is 'n geduldige klomp dat ek vir jou sê (absoluut) (hulle word op 'n troontjie geplaas) (Nee, dit is so absoluut, absoluut). Fasiliteerder: En al die verskillende persoonlikhede …? Nee, ons … Die staf, huh, het ek gevind is regtig, waar ek al lankal … Jy weet … ek is maar 'n bietjie kort van draad partykeer. Dis ongelukkig 'n sonde en dan dink ek 'oh, ek sou jou lankal reg gesê het … Dan is hulle 'n (dan smile).

.

		Fasiliteerder: Ek wil net gou bietjie hoor, die saam met wie want die sing en die Ja, dis nou die koorsing? Fasiliteerder: Nee dankie, baie dankie, maar die aanpassing was oor die algemeen … Participant M101: Die aanpassing was vir my die 1ste maand baie swaar … kyk, ek kom vêr. Ek is nie van hierdie wêreld nie. Ek kom (van die see), ek kom van Port Elizabeth af en dit is, ek het ‘n klomp baie geliefde mense daar agtergelaat en daai wortels … want ek was baie bedrywig daar en daai wortels was ’n bietjie moeilik gewees, maar nou ja, ek is hier. Participant M102: Alles, alles hier jy’t nie nodig om oor iets te kla nie. En die mense is so geneig om altyd negatief te wees oor ’n aftreeoord (mm). En, soos ek sê, ek sal moet leer kook. Die kinders het nou die dag gesê, wanneer laas het ons by ma geëet, maar weet jy … ek en ek kook nie vir myself nie, want hoekom sal ek as ek vir my drie 2 soorte groentes, ’n hele dag ’n volledige ete kry? Jou belangrikste ete in die dag en jy kry al jou groente in. En vanmôre ’n ietsie vir ontbyt en vanaand ’n vruggie of ’n gekookte eiertjie of what you have.

		Participant M103: Dis ’n wonderlike plek hierdie. En ek kan enige een wat oor 65 is. En jy moenie te oud word. 78 as jy in die huis bly en dan dink nou moet ek maar ’n plan maak dan dans jy ook verlore. Want jy moet van jou … bietjie jonger soos ek sê 65 maar ons kan inkom van 50, maar jy … as jy … jy weet … kom en kom skakel in, leef en werk saam, ken die mense en op daai manier (bevestiging in agtergrond). Raak betrokke en ons het so baie hier, ons het uhu jou eie kerk, Bybelstudie van elke kerk. Ons het elke Woensdag ’n gesamentlike diens in dieselfde saal van al die verskillende pastore … en, en dit, jy word regtig geestelik verryk. Participant M104: Hoor hier, ek is nou nog nie baie lank hier nie, ek is so vyf maande hier, so ek is nog besig om in te pas en aan te pas en my voete te vind en dis nou ek daai wat so bietjie sing en … nou nie ek is nie ’n sangeres nie, maar ek, dit is nou maar net wat ek hier by die kooroefening … om aan te pas en daardie is ’n bakseltjie jaffels wat ek nou saam met hulle nou. Dis ook aanpassing daai. Hierdie is my stoof.

FINANCIAL SECURITY		Participant M105: En die mense is nie in ’n posisie nie, om oor so te reis nie. En dit is nogal iets wat my pla. Van die mense wat lank ingekoop, het lank gelede hier ingekoop het gaan nie dit nie kan bekostig nie, enne waar hulle in versorging moet wees nie, want dit is ’n hele baie, baie geld. Daai mense se pensioen het nie trek gehou met die onkostes wat nou vir ’n bedleênde persoon hier gaan wees nie. Hulle sal ’n ander plan moet maak. Hierdie is mense wat lankal hier ingekoop het … het nie fondse om dit te doen nie. Fasiliteerder: En die finansies, is een van die kommers wat vir julle …? Dit is daai mense, dis hulle moet net teruggaan na hulle kinders toe. Ek weet al van verskeies wat terug is na hulle kinders toe. Ek praat nou van mense wat 15, 16 jaar gelede hier ingekom het, met ’n klein pensioen. Wel, genoeg gewees toe. En die plekkies het hulle maar so R2 000, R 200 000, R 250 000 gekos. Plekkies kos nou hier aan die R800 000, ek dink so ek weet nie want ons het ’n hele ruk gelede gekoop, maar die mense wat daai tyd het al gekoop het, al verkoop jy, kry jy maar net die terug wat jy ingesit het. Nêerens kan jy jouself weer vestig nie. Jy moet maar na die kinders toe gaan. Dit is wat ’n bekommernis vir baie van die alleenlopers

		hierso, werklikwaar hulle hou maar aan en aan en aan in daai ou huisie en hulle raak naand onversorgd, maar hulle klou aan daai huisie, net waar hulle is waar hulle is waar hulle onafhanklik kan wees.

		Fasiliteerder: Kan wees Maar dit is ’n groot, groot probleem vir baie mense. Participant M106: Sunday lunch here is open, you can go, just got to book, but I believe here are people that can’t afford it and that’s why some people donate a, you know, a meal ticket and I think it is important to think about you know of others, because I realy believe that here are people that haven’t got it and I think she knows it as well. It is only sixty rand to to join the club the the Help Mekaar. There is people who can pay and they ask if they can pay in off a year. So, we must one way or the other we must take note of people. Who can’t afford I think there are people which were brought in long ago that realy battles.

Non-death related losses as experienced by older residents in a residential care facility: LISTEN GROUP TECHNIQUE

MAIN THEME	SUB-THEMES	DIRECT QUOTATIONS
PHYSICAL SECURITY	SAFETY	**Participant L1:** Jy weet, soos deurskemer wat jy nou vrae gevra het en daai tipe dinge, is almal baie gelukkig hier. Die hoofsaak is die veiligheid. **Participant L2**: And the second was that we are in a secure environment. **Participant L3:** Hoofsaak is dat, uhm, om hier te kan bly is die eerste jy voel veilig. Toe ek hier ingetrek het, het die kinders vir my gesê, moet nie vergeet om die deur te sluit nie en agterna het ek gedag, wel ek weet nie, hulle kan maar hulle deure sluit, maar hier voel ’n mens veilig. Jy kan gaan stap waar jy wil, ons geniet dit. **Participant L4:** Die veiligheid en dit is ook ’n aspek wat deurgaans deurgekom het, was die veiligheid, dat ons so veilig voel hier binnekant. Ek het op ’n stadium gesê ek voel ons is miskien ’n bietjie; ly aan vals sekuriteit, omdat ons dink dit is so veilig en dat dit hulle altyd vir ons vra om tog maar ons deure gesluit te hou. Alhoewel ons partymaal dink; ag dit is nie nodig nie. Die hele buitekant van die gebou met die paadjies waar ons veilig tussen die geboue kan deurloop. Participant L5: Ek kan net byvoeg, met die paadjies wat hulle vir ons nou aangelê het.

		Wat fantasties is, daar's mense wat moeilik geloop het op die gras en aan julle almal kan ons sê baie dankie, want ek dink dit help vir baie mense wat met wieletjies moet loop en dit vind hulle baie makliker nou om te beweeg. Participant L6: Living in a room the way I do, is it wonderful to know that if you don't wake up in the morning they will know, because they come to wake you up. And if there is no response then they will know that there is something wrong. And that is, uhm, it is good to know. It is also good to know that my medication is delivered to me, uhm, after breakfast, after supper, and at night. From our point of view is, we are in a secure environment, eee

EMOTIONAL SECURITY	STAFF SUPPORT / RESPECT	Participant L7: ... en die vriendelikheid en die behulpsaamheid en die simpatie wat jy hier kry en behandeling, uhm en die netheid en so aan. Participant L8: we only have to ask for… for something to be, to be looked at to maintain, and the people are there to help us.

		Participant L9: Ek maak ek vir my ’n rondawel en met ’n vlaggie langsaan met vrede en liefde; dis wat ek hier kry. Jy’s nooit bekommerd nie, jy’s nooit onrustig nie, daai vrede wat ’n mens in jou hart het kan jy nie vir ’n ander een vertel hoe jy werklik voel nie. En as ek nie hiernatoe gekom het dan kon dit nie so gewees het nie, so dankie XXX vir julle liefde wat julle vir ons en daai vrede wat ’n mens kry as jy hier kom, dit gaan mens nie op ’n ander plek kry nie. Participant L10: Daar word soveel moeite gedoen, selfs vir mense wat nie meer so lekker kan beweeg nie, uhm, hulle word met liefde behandel. Ee, die kantoormense is altyd vriendelik en, ee, ons bestuurder is altyd ’n goeie glimlaggie en ’n vriendelike groet. Participant L11: As ek by die kantoor kom is dit ook altyd vriendelikheid, selfs by die kliniek, Marita, “Rowyda”-?, Alwyn. Maar almal van hulle was net altyd vriendskap en glimlaggies en hulle help waar hulle kan; ons het nooit nodig om te wag of te vra asseblief kan jy nie nou kom help of kan dat nie. Daar is altyd, hulle is altyd reg om te kan help in enige opsig met wat ookal daar is.

		Participant L12: And it is just good to know that we are so well looked after by the clinic, by the caring staff and, and by the, by everyone. Participant L13: En dan, uhm, Sheila had a lovely one where she (but they wouldn't work together) her little, uhm e e … dolls that she made were holding hands. Hoe ons hande vat en mekaar ondersteun.
	PURPOSE IN LIFE	Participant L14: Dit was 'n kwessie, en dit het ook toe gekom met die hanteer van verliese en die behoefte om mense te ondersteun. Hierdie was half 'n gesprek want mense wil betrokke raak, maar hulle het baie pyn en verliese en u het hierdie behoefte om mense te ondersteun, maar hulle hou jou partykeer terug. So as daar dalk 'n ondersteuningsgroep of 'n plek waar mense kan kom praat, maar ook mense kan kom ondersteun. Miskien iets van daai behoeftes van beide kante, jy wil ondersteun word, jy wil ook ondersteuning bied en daar is nie altyd 'n formele plek daarvoor nie. Dit gebeur in die paadjies, en dit gebeur toevalig, maar daar is nooit rerig 'n formele geleentheid daarvoor nie. Participant L15: En mense is maar al te gewillig dat jy jou talente gebruik om ander gelukkig te maak. Ek sê dankie vir al die aktiwiteite, want ek geniet dit baie.

	FAMILY RELATIONSHIPS	Participant L16: Uhm, Ek het so bietjie geskryf oor vrae, hulle het ons gevra skryf of teken iets wat op die oomblik betekenisvol is in julle lewens en wat deurgaans uitgekom het was godsdiens, familie, kinders, kinders, kleinkinders, eggenote.
	FAITH / RELIGION	Participant L17: … En, ee, dan het hulle vir ons gevra teken mense met wie jy 'n spesiale verhouding het. En daar weereens was dit God. Uhm, ek het so bietjie geskryf oor vrae, hulle het ons gevra skryf of teken iets wat op die oomblik betekenisvol is in julle lewens en wat deurgaans uitgekom het was godsdiens. Participant L18: But everyone has a wonderful in our Lord Jesus and that is so … so wonderful, that is the biggest thing that came out of it for me. Participant L19: Ek kan maar net daar aanvul by wat Sheila nou gesê het van die Christenskap, want lyk my so deurlopende draad wat hierso werk. Jy kan met enige persoon praat, hulle praat van hulle kerk, ongeag van watter kerk dit is, hulle praat van hulle kerk, hulle neem deel daaraan, hulle glo, hulle … hulle … as hulle probleme het soos die een dame vanoggend gesê het; haar probleme lê sy

		aan die voete van die Here en help haar want sy alleen kan dit nie doen nie. Participant L20: En hoofsaak is dat, ee dat almal soos wat daar gesê is die geloof het en … uhm, hulle vertroue is in die Here en elke ene moet ek sê is so dankbaar vir die personeel wat hier is. Participant L21: Vooraan was godsdiens en ek moet sê regdeur ons besprekings het ons bevind dat godsdiens baie belangrik was.

SOCIAL SECURITY	ACTIVITIES	Participant L22: En dan die verskillende aktiwiteite waaraan die verskillende mense deelneem, soos die line-dancing die snoeker, huiskomitee. Ons het baie huiskomiteelede op ons groepie gehad en dan die stap ensovoorts. Uhm, en wat hulle in hulle eie huise doen soos byvoorbeeld kook, bak, lees, brei, TV kyk, TV-speletjies speel en dan buite die oord waar hulle gaan fliek, koffiewinkels besoek, eetplekke besoek, kerk, visvang party van hulle. Participant L23: Ons groepie was, uhm, ek en Evet as man en vrou en daar was nog meneer en mevrou Nel. So, ek wil ee … meer op die ee … pare konsentreer, hulle is bevoorreg genoeg om nog saam te gaan voële kyk, eee … voëls kyk en hulle gaan oorsee. Hulle was laasweek suid

		(inaudible) van Rusland so, met die idee, even though they stay in a residential care facility they are still able to go out and enjoy life as it is … … numerous activities that are given here, but we are still able to go out with our little car. A car, which I may have to go (inaudible) so I am able to do that. Dit was ’n openbaring vir ons wat nou nie so lank hier is nie, om te sien hoe betrokke is die mense en wat hulle talente eintlik is. En, uhm, … ek het dit agtergekom met verlede jaar se konsert uh … en nou weer met hierdie uitbeelding wat ons gister gehad het. Baie van ons het baie hidden talents en van ons moes afgetree het om dit eers te ontdek. Participant L24: Vir Marita-hulle wat die uitstappies reël, ons geniet dit verskriklik baie. Particpant L25: En ek is baie gelukkig en hier is baie aktiwiteite wat hier vir ons is en ons geniet elke een van hulle. En jy wil partykeer hê hulle moet ’n bietjie meer vir ons inpas (loud laughter). Participant L26: En dan die aktiwiteite wat aangebied word, die netheid van die plek. Participant L27: It is just so wonderful to know that we are not, we don’t have to sit in our rooms if we don’t want to. We … There is so much activity going on if we

		want to and it is just so good to know. We are very well looked after.

	ISOLATION	Participant L28: Goed, en dan vyf is om onsself oop te maak en mense te leer ken. Dit skakel baie in by leer mekaar ken maar ook die ander kant daarvan, om oop te wees, om sigbaar te word, om jou storietjies te deel, dat daar plek is om te kan praat oor waardeur jy gaan, wat vir jou belangrik is nou. Participant L29: 'n Voorbeeld as ons iemand nou het wat jy kom ons sê in 'n rolstoel sit, kan mens bv 'n speletjie probeer kry en dit soontoe na hulle toe neem, sodat hulle hulle kan self besig hou en vermaak. Dit is wat mens oor wonder, is daar iets wat 'n mens daarmee kan help vir hulle? Want hier is miskien heelwat paar wat graag wil deelneem aan iets, maar nie kan nie omdat (inaudible).

		Participant L30: Ek hoor daar is twee kante, die een is iemand wat nie iets wil deelneem nie, moet nie gedwing word nie. Maar as hulle nog graag wil, moet hulle nie op grond van immobiliteit gediskwalifiseer word nie, al is hulle in 'n rolstoel moet hulle gehelp word om dit te kan doen. Inwoner: Dis reg, dis hy.

		Participant L31: Dit, dit sluit baie aan by die volgende ene, wat is vrye keuses en voorkeure. As jy dan net by die mense in jou … jou bure wil leer ken dan is dit goed en wel, as jy van kruis tot dwars hieroor wil kuier by almal dan is dit ook goed en wel. So die vrye keuse. En ook deelname teenoor nie-deelname, party mense is baie meer privaat. Hulle is baie gelukkig met ’n boek, by hulle huis en (inaudible). En ander mense wil aan alles deelneem, soos (inaudible). Particpant L32: En dan met die vrye keuses, uhm … as jy vir iemand genooi het na ’n aktiwiteit toe en hy stel nie belang nie. Dan moet jy e groot genoeg wees om dan nou ’n tree agtertoe te gee en te sê, uhm, ek het nou, ek het nou probeer en nou is die bal mos in daai persoon se afdeling, hy moet nou besluit wat hy, wat hy wil doen of wat hy nie wil doen nie. ‘Cause you can take a horse to the water, but you cannot always make him drink. “Om mense te sien met hulle voorkeure en behoeftes in hulle omstandighede, so as iemand dalk minder mobiel is dan moet hy nie gedwing voel om deel te neem nie, dit is ’n keuse, dit is ’n voorkeur. So, die behoefte is dan om sensitief te wees vir mense waar hulle is, hulle omstandighede.

	YOUTH / MEMORIES	Participant L33: The biggest thing that came out of it for me is the fact that, I don't know whether it is because people are getting older and we all know that it is going to happen one day very soon.
	SOCIAL SKILLS	Participant L34: Uhm, ek het so bietjie geskryf oor vrae, hulle het ons gevra skryf of teken iets wat op die oomblik betekenisvol is in julle lewens en wat deurgaans uitgekom het was godsdiens, familie, kinders, vriende, kinders, kleinkinders, eggenote en vriende. Participant L35: Maar dan wil ek ook graag sê, daar is mense wat jy byvoorbeeld mee kan praat en dan's daar ander persoon wat net, van jy kan net jou arm om hom sit, of haar sit en 'n drukkie gee en daai persoon weet presies hoe jy voel (inaudible) saam met jou.

		So daar, in daai opsig voel ek meer daai deel (inaudible) en dan die samesyn met ander inwoners en dan die dienslewering in algemeen. Participant L36: Uhm … ek het dadelik toe ek hier ingetrek het tuis gevoel, ek het wonderlike bure gehad, hulle het my dadelik kom hulleself voorstel en koek gebring om te eet en dit het my sommer dadelik tuis laat voel, hulle is nou nog goeie bure. Ek het baie … uhm …

		liefdevolle vriendinne gemaak hierso wat in enige tyd wat jy wil kan met hulle praat, jy kan tot laat in die aande bel en, ee, hulle kan luister. Participant L37: Die interaksie met ander inwoners en om gelukkig in hulleself te wees. Participant L38: … jy geniet dit, jy hou daarvan, jy hou van die mense, almal is vriendelik, niemand is in jou spasie in dat hulle partykeer sê nie, jy gaan aan. Dit is lekker hierso.

	ADJUSTMENT	Participant L39: Dit is, want verder aan het ons gepraat van, ee … as jy hiernatoe kom, you come from all walks of life and now, om nou in te tree by die aftree-oord, moet jy nou vergeet daarvan dat jy ’n polisieman was, dat jy ’n generaal in die weermag was, dat jy ’n onderwyseres was. Jy is nie meer in beheer nie, so jy, jy moet nou inskakel, geleidelik. Amonè: Participant L40: Op daai punt het ons gesê en hier het ek die aanhaling neergeskryf, gooi die titels in die visdam. Ja, so voor jy inkom moet jy amper jou titel en dit pas aan by behoefte nommer 4 wat is: hulp dalk met die aanpassing en die transisie vanaf vorige beroepe om hier in te pas. As daar dalk aan die nuwe intrekkers spesiale aandag gegee word

		om hulle te laat inpas hier, om hulle titel in die visdam te gooi en dat daar dalk mense afgevaardig word om hulle in te trek, net help met daai aanpassing om nou in te tree by die aftree-oord in. Participant L41: En dan't ek ook … uhm … in ons groepie wat ek … e … iemand mee uitgekom het was dat daar 'n hunkering was na dit wat gewees het en wat hulle gedoen voordat hulle by die oord gekom het.

FINANCIAL SECURITY		Participant L42: Uhm, Ek het so bietjie geskryf oor vrae, hulle het ons gevra skryf of teken iets wat op die oomblik betekenisvol is in julle lewens en wat deurgaans uitgekom het was godsdiens, familie, kinders, vriende, gesondheid, finansies, beweeglikheid.

APPENDIX E – INTENDED JOURNAL'S GUIDELINES FOR AUTHORS

The intended journal for publication is the *Journal of Gerontology*.

Guidelines for Research Papers

Title page: The title page should include complete contact information for each author, including (at a minimum) affiliation, mailing address, e-mail address, and phone number. The corresponding author should be clearly designated as such. APA recommends that a title be no more than 12 words.

Manuscript length: Most articles present the results of original research. These manuscripts may be no longer than 6,000 words. The text is usually divided into sections with the headings: Introduction, Design and Methods, Results, and Discussion. Subheads may also be needed to clarify content. Qualitative manuscripts may be no longer than 7,000 words.

Manuscript style: *The Gerontologist* uses APA style. Refer to the *Publication Manual of the American Psychological Association* (6th ed.) for style. References in text are shown by citing in parentheses the author's surname and the year of publication.

Manuscript preparation: All parts of the manuscript should be typewritten, double-spaced, with margins on 8-1/2" x 11" paper using 1" margins. Number pages consecutively for the abstract, text, references, tables, and figures (in this order).

Abstract and key words: On a separate page, each manuscript must include a brief abstract, and double-spaced research articles. Submissions should be approximately 200 words (the web-based system will not accept an abstract of more than 250 words), and must include the following headings: Purpose of the study, Design and Methods, Results, and Implications. Below the abstract, authors should supply three to five key words that are NOT in the title.

Tables, figures and illustrations: Tables are to be double-spaced, numbered consecutively with Arabic numbers and have a brief title for each. Footnotes should be placed immediately below the table, using superscript letters (a, b, c) as reference marks. Asterisks are used only for probability levels of tests of significance ($*p < .05$). Figures and illustations should be uploaded and embedded in the word processing file. For line drawings, the resolution should be 1200 d.p.i. and for color and half-tone artwork, the resolution should be 300 d.p.i.

Reference list: Type double-spaced and arrange alphabetically by author's surname. There must be no numbering. The reference list includes only references cited in the text.

APPENDIX F: ETHICAL CLEARANCE TO CONDUCT THE RESEARCH

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14 Junie 2010

AANBEVELING: ADDISIONELE VERSOEK NWU-00053-10-S1 (V. ROOS)

Hiermee word aanbeveel dat die etiese toestemming vir projek NWU-0005-10-S1 (Prof Vera Roos) verleng word soos deur prof Roos in haar brief van 23 April 2010 versoek word.

Die uwe

Este' (H.H.) Vorster

Prof. H.H. Vorster