Hospitalization and adaptation to various health crises are common problems elderly persons with chronic health conditions encounter. Previous research indicates that hospitalization can have negative consequences for elderly persons (Creditor, 1993), potentially beginning a downward trajectory characterized by declining function, worsening quality of life, and placement in a long-term-care setting. Other studies have documented positive outcomes of hospitalization for this population, including increased ability to perform activities of daily living (ADL) and decreased likelihood of placement in long-term care (Covinsky et al., 1998). Most research on outcomes of hospitalization examines changes in patients from admission to time of discharge from a particular facility, using quantified measures selected by health care providers, researchers, or reimbursement sources (Agency for Health Care Policy and Research, 1990; Moore, McQuay, & Gray, 1995; Wennberg, 1990). As various authors have pointed out (Kleinman, 1988; Whiteneck, 1994), this approach focuses on disease as conceptualized by health care personnel and overlooks the illness experience of patients and families and its impact on their daily lives. This approach to outcomes measurement also is based on the assumption that functional capacity as demonstrated in the hospital will be reflected directly in performance of daily activities in community settings, an assumption that is increasingly being questioned (Batterham, Dunt, & Disler, 1996).
The need to examine connections among medical status, functional abilities, and participation in daily life is reflected in models of disablement that incorporate levels of impairment, disability, and handicap (Verbrugge & Jette, 1994). Such models include the original International Classification of Impairments, Disabilities, and Handicaps (ICIDH) established by the World Health Organization (WHO, 1980). The revised version of the WHO framework (ICIDH-2) transforms these three levels into positive terms, including the body, which refers to body structure and function; activities, which refers to ability to perform functional tasks at an individual level; and social participation, which reflects performance of daily activities in “real world” social contexts of home, neighborhood, and community (WHO, 2000). The ICIDH-2 also establishes a fourth dimension of contextual factors, which incorporates environmental influences on daily life participation. Such models indicate that studying outcomes of hospitalization should include participation in daily life in community settings as well as functional outcomes that have been emphasized in past research.

For this study, elderly persons were recruited from a geriatric transitional unit intended to prepare them for returning home after hospitalization and then tracked in the community for 6 months after discharge. The purposes of this study were to (a) examine functional outcomes on the transitional unit and after discharge and (b) identify patterns of participation in daily life activities and contexts in the community. Because of potential confusion in use of terms related to activity in the ICIDH-2 framework, this article uses the term functional outcomes to correspond to the “activities” level and the term daily life activities to correspond to the “social participation” level. Examples of daily life activities in various social contexts include caring for grandchildren at home, walking to buy groceries from a neighborhood store, or learning to paint in a community day program.

Method

A longitudinal design was used to analyze individual adaptation after hospitalization by examining a relatively small number of elderly persons through multiple data sources over time, in contrast to past research that was based on limited quantitative data on a large sample. The mixed design included both qualitative and quantitative methods (Tashakkori & Teddlie, 1998). This multimethod approach is being used increasingly in clinical research because of the need to address complex clinical research questions in a variety of settings (Miller & Crabtree, 2000).

African-American elders were recruited from a transitional skilled nursing unit operated by a county hospital district geriatric program. About three fourths of the elders on this unit are African-American, with typical length of stay being 3 weeks. African-Americans who used the county hospital district system were chosen for study because this population has been underrepresented in previous research (Larson, 1994). It is widely recognized that African-Americans have greater incidence and severity of many common health problems than other elderly populations (Harper, 1992). Research has supported the expectation that these persons and their families might adapt to hospitalization in ways that differ from their Caucasian counterparts (Hines-Martin, 1992; Hinrichson & Ramirez, 1992). Their experiences thus could enrich knowledge of various ways functional outcomes and resumption of daily life activities evolve. The study received Institutional Review Board approval from the clinical facility and two universities.

Participants

Selection criteria for participants were (a) being treated for deconditioning after hospitalization for various acute conditions; (b) having identified themselves as African-American or Black; (c) having the cognitive ability, as judged clinically by program staff, to respond to structured questionnaires and semistructured qualitative interviews; and (d) having available scores on the Functional Independence Measure (FIM; Granger, Hamilton, Linacre, Heinemann, & Wright, 1993). Individuals who met selection criteria were identified by transitional unit personnel at weekly rounds. Informed consent to participate in the study was obtained by a member of the project research team. Persons who were unable to read or write had the consent form and structured questionnaires read to them, with answers recorded by a project research team member. Pseudonyms have been used to protect confidentiality.

Twelve women and 5 men were enrolled in the study, with ages ranging from 58 to 93 years (M = 73 years). This gender and age distribution is typical of persons on the geriatric transitional unit. Participants had multiple health conditions, including diabetes, chronic obstructive pulmonary disease, cardiac problems, musculoskeletal problems, depression, and dementia. Before hospitalization, 6 participants were living alone, 9 with family, and 2 with an unmarried partner. After hospitalization and their stay on the transitional unit, 4 of the 17 participants had new family living arrangements, 2 went to personal care homes, and 1 moved out of the city.

Data Collection

Data were gathered while participants were on the transitional unit and monthly for 6 months after discharge, alter-
nating home visits with telephone interviews. Major data sources were the following:

- Transitional unit: medical status, mental and emotional status (chart review), Life History Interviews, functional abilities (FIM), and daily activities before hospitalization (Self Observation and Report Technique [SORT; Rintala et al., 1984]).
- Community follow-up: functional outcomes (FIM by self-report), daily activities (SORT), and Functional Outcome Interviews.

Chart review provided data on participants’ medical conditions, therapy goals and progress, cognitive and psychosocial status, and functional abilities according to the FIM. While the participants were on the transitional unit, project research team members used interviews to gather information on life history, living arrangements, and other contextual factors expected to influence functional outcomes and daily activities.

A semistructured Life History Interview was developed for use in this project, following criteria identified by Frank (1996). Questions focused on important experiences during various life phases, adaptive problems encountered and strategies used to address them, and things that made life worthwhile during various periods. This interview was pilot tested with patients on the transitional unit before use in this project; prompts were added that helped participants to address the major content areas identified previously.

The FIM was chosen to gather information on functional outcomes because it is routinely administered to elderly persons by occupational therapy and physical therapy staff in this setting who are trained to conduct this performance-based measure. Another rationale for choosing the FIM was its wide use in documenting rehabilitation outcomes for persons with a variety of disabling conditions (Stineman et al., 1996). Psychometric properties of this 7-level scale have been investigated extensively, demonstrating sound reliability, validity, and stability for multiple diagnostic groups (Granger et al., 1993; Stineman et al., 1996). A synthesis of 11 previous studies reported a median inter-rater reliability for the total FIM of .95, a median test–retest value of .95, and an equivalence reliability value of .92 (Ottenbacher, Hsu, Granger, & Fiedler, 1996). For this study, the 6 items of the FIM Self-Care subscale were used—feeding, grooming, bathing, upper-extremity and lower-extremity dressing, and toileting—which yielded a total possible score of 42 (possible score of 7 on each item). Reliability of this subscale is reported to be .95 (Ottenbacher et al., 1996).

Data on daily life activities before and after hospitalization were gathered with the SORT. This tool, originally developed to document daily activities after onset of dis-

Data Management and Analysis

Qualitative Life History Interviews and Functional Outcome Interviews were transcribed from audio tapes by a
member of the project research team and checked for accuracy on a sampling basis. Thematic analysis was initiated by identifying categories that emerged from the data by three members of the project research team. Interviews from 6 participants were coded individually by these team members and compared to identify areas of agreement and disagreement. After four iterations, this process led to consistency in the structure and meaning of categories, which included activities and their meanings (past and current), illness trajectories, health care experiences, personal qualities, social support, home and neighborhood environments, mobility sphere, concerns and worries, hopes for the future, spirituality, and the research process. After establishing a commonly understood coding system, qualitative interviews were coded by individual project research team members. New or ambiguous coding issues were discussed at research team meetings where the constant comparative method was used to examine incoming interviews and to amplify or revise analytic categories as needed (Patton, 1990).

Quantitative data from chart review and FIM and SORT data were entered into a computerized system that generated an individual longitudinal record for each participant. Exploratory data analysis as outlined by Tukey (1977) was used to examine quantitative data to preserve a focus on individual differences that are lost when data are analyzed on a group basis. This analysis is particularly valuable in studies where patterns are being examined in an exploratory way, in contrast to hypothesis-testing statistical procedures in which established relationships are being confirmed (Tukey, 1977). Changes in FIM scores were plotted over time for participants while on the transitional unit and after discharge. Patterns of participation in daily life activities were identified by examining SORT data on number and kinds of activities and the locations in which they occurred, combined with qualitative interviews in which participants talked about their daily life participation in various contexts.

Various methods were used to increase trustworthiness of the study. The project research team periodically integrated information from multiple sources on each participant, including qualitative interview transcripts, field notes, clinical chart review, reports from weekly rounds, and notes from project research team meetings. Triangulation of data involved comparison of information on daily activities from the SORT and qualitative interviews. Ongoing synthesis provided an opportunity to discuss emerging findings and their interpretations both at the level of individual participants and on a broader basis across participants. During the 8th month of the study, findings were examined critically in a meeting of the project research team with three peer reviewers experienced in qualitative research and with selected staff members from the transitional program. This meeting included clinical representatives from nursing, social work, and occupational therapy and the geriatric program research coordinator. Reviewers provided guidance about ongoing data collection and analysis and additional perspectives for interpreting findings.

Findings

Functional Outcomes

As expected, while they were on the transitional unit, most participants improved their scores on the Self-Care subscale of the FIM. Two improved from 16 to 20 points, 2 improved from 11 to 15 points, 4 improved from 6 to 10 points, and 7 improved from 1 to 5 points. One made no change in FIM scores, and 1 declined by 1 point.

Changes in FIM scores from the time of discharge from the transitional unit to final follow-up in the community reflected capacity to perform self-care tasks, but they were also influenced by choices participants made about how to get things done, including possible use of assistance by family, neighbors, or formal service systems. Eleven participants demonstrated improvement in FIM scores after discharge to the community, whereas 6 participants’ FIM scores declined. Thus, nearly two thirds (65%) of the participants improved in functional outcomes to some extent after their return home. Two improved more than 15 points, 4 improved 11 to 15 points, 2 improved 6 to 10 points, and 3 improved 1 to 5 points. For the 6 whose functional outcomes declined after discharge to the community, 5 decreased 1 to 5 points, and 1 decreased from 6 to 10 points.

Patterns of Participation in Daily Life Activities

Participants in the study clustered into three patterns of daily life activity participation that reflect increasing diversity in types of activities, total number of activities, and in-home or community contexts. Characteristics of these clusters were the following:

- Self-care cluster: 7 or fewer activities, less than 1/3 leisure, home-centered
- Self-care and household cluster: 8 to 11 activities, less than 1/3 leisure, home-centered
- Self-care, household, and leisure (mixed activity) cluster: 11 or more activities; more than 1/3 leisure; home, neighborhood, and community contexts

Self-care cluster: Three of the five members of the self-care cluster had physical medical problems that substantially limited their energy and capabilities. Mr. Johnson, an 89-year-old retired railroad worker, had prostate cancer and had moved in with a granddaughter who provided assistance. His FIM scores decreased 8 points after returning to
the community. Ms. Sparks had advanced lung disease and lived with her husband, who was assisted by a paid provider. Her FIM scores increased by 6 points after returning home, which reflected attempts to be more active, but she continued to be limited in activity engagement by her poor endurance. Ms. Cox had arthritis in her hips and severe temporal mandibular joint pain that limited her activities. A niece moved into her home in an established neighborhood after Ms. Cox “passed out and was found by neighbors.” Her FIM scores decreased by 4 points after returning home. Ms. Cox stated, “My daily activities depend on how I am feeling.” She valued socialization with neighbors who visited her home but no longer went to church: “I can’t get dressed up, and I can’t talk good.” Total FIM scores of these participants ranged from 12 to 35.

The other 2 members of this cluster had few activities other than self-care, which appeared to be due to psychosocial problems. Mr. Hanson, who lived with his son and family, had dementia. Though his FIM scores improved 12 points after returning home, he did not appear to have structured opportunities for engagement in activities other than self-care. The other member of this cluster, Ms. Conlon, moved in with her daughter and two grandchildren after hospitalization to adjust her medications for depression, an anxiety disorder, and congestive heart failure. She was uncomfortable interacting with neighbors at her daughter’s apartment: “I talk to them, they talk to me. They treat me real nice. I just don’t want to be with them.” Another member of this cluster, Ms. Hamblen, a 76-year-old former cook who lived with her son, liked to contribute to household management to the extent possible from her wheelchair by dusting, sorting clothes for the laundry, and going to the Laundromat with her son. She missed getting out more widely and described herself as having formerly been “a Greyhound bus person.” Like Ms. Barns and Ms. Hamblen, other members of this cluster also had mod-

Table 1. Activity Patterns of Self-Care Cluster for African-American Elders

<table>
<thead>
<tr>
<th>Name (Age)</th>
<th>Body Systems</th>
<th>Functional Outcomea</th>
<th>Daily Life Activityb</th>
<th>Context</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Unit  Home  Total  ADL  Work  Play  Total  Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Johnson (89)</td>
<td>Prostate cancer</td>
<td>+1  –8  12  6 (86) 0 (0) 1 (14) 7 0</td>
<td>Lives with granddaughter; has provider</td>
<td></td>
</tr>
<tr>
<td>Sparks (78)</td>
<td>Lung disease; diabetes mellitus; congestive heart failure; hypertension</td>
<td>+8  +6  35  5 (71) 0 (0) 2 (29) 7 0</td>
<td>Lives with husband; has provider</td>
<td></td>
</tr>
<tr>
<td>Cox (80)</td>
<td>Hip arthritis; temporal mandibular joint pain</td>
<td>+6  –4  32  3 (42) 2 (29) 2 (29) 7 1</td>
<td>Lives with niece who moved in; has provider; close to neighbors</td>
<td></td>
</tr>
<tr>
<td>Hanson (69)</td>
<td>Dementia; diabetes mellitus; congestive heart failure; depression</td>
<td>+9  +12  42  4 (66) 1 (17) 1 (17) 7 1</td>
<td>Lives with son and daughter-in-law</td>
<td></td>
</tr>
<tr>
<td>Conlon (70)</td>
<td>Depression; congestive heart failure</td>
<td>+3  +3  40  4 (57) 1 (14) 2 (29) 7 0</td>
<td>Moved to daughter’s apartment; neighbor helps with care</td>
<td></td>
</tr>
</tbody>
</table>

Note. n = 5; ADL = activities of daily living, including personal and instrumental tasks. Seven or fewer activities, less than one third leisure, home-centered.

Functional outcomes were changes in Functional Independence Measure (FIM) scores on the unit and at home. Total FIM scores at final follow-up. Daily life activities were the number of activities per day as identified by participant. Percentage of total activities by Self Observation and Report Technique.
generate level FIM scores, ranging from 29 to 36 points. Despite physical limitations, they reported engagement in 8 to 11 daily activities. Ms. Weston, who had a hip replacement, lived with her husband and helped with cooking. Ms. Wescott, who had a tracheostomy because of Pickwickian syndrome and Ms. Carter, who broke her hip, both lived in multigenerational households and helped with raising children as well as other household tasks. Summary information on members of this cluster are shown in Table 2.

Self-care, household, and leisure (mixed activity) cluster.
The third cluster reflected active involvement in a variety of activities, including leisure, self-care, and household management. Members of this cluster reported more than one third of their activities being leisure pursuits, and they had 11 or more daily activities. They valued getting out in the neighborhood and community. Four of these participants had substantial increases in FIM scores after discharge from the transitional unit, and by final follow-up, they had reached a maximum total FIM score of 42. Mr. Green, who was 67 years old, had been a sanitation worker. He had a history of a previous stroke and was seen on the transitional unit after another “small stroke.” Mr. Green lived with his common-law wife in a small dimly lit house, and a nurse came by weekly to check on his medications. He had a close network of friends who walked around the neighborhood, played dominos at each others’ homes, and visited a local convenience store. Mr. Green reported that trips to the convenience store were both “to get groceries and to see people.” He regretted having to give up driving, but his sister came by occasionally to take him to visit their brother in a nursing home.

Two other members of this cluster, Ms. Hamilton and Mr. Fielding, also valued leisure activities involving persons and locations in their neighborhoods. Ms. Hamilton had her son, who travels as a trucker, and three adolescent grandchildren living with her: “I am proud to have these kids now with me. I don’t have much to do with housekeeping. The kids, they do all that. I am teaching them to cook.” She was making a quilt for the children as a remembrance of her recently deceased sister. Despite foot ulcers that limited her mobility, Ms. Hamilton managed to get her wheelchair off the porch so she could roll down the street to see neighbors whom she had known for many years. Mr. Fielding, a retired chef, was struck by a car, which resulted in internal injuries and several fractures. He lived in an apartment with his fiancée, and had many neighbors who welcomed him home after hospitalization and regularly walked with him to neighborhood locations. He also liked to take his grandchildren on community outings: “I ride out to see my kids, and take my grandkids to a park, a zoo, because I can go find me a seat and let them play.”

In contrast to members with longstanding neighborhood connections, another member of this cluster, 79-year-old Mr. Pauls, who had been homeless, moved into a personal care home because of difficulty managing his diabetes and related foot ulcers. He formerly was a machine repairman and liked to talk with friends about memories of work. Mr. Pauls quickly established relationships with fellow residents and walked to another house that is part of the personal care home to play cards and watch ball games with new friends. He traveled by van to a day program and had started drawing and painting, which he described as “something different to do during the day.”

Two other members of the mixed activity cluster had moderate level FIM scores of 38 and 34 points. Ms. Allen, who fractured her clavicle and pelvis in a motor vehicle accident, lived with her son and helped with meal preparation as well as visited with neighbors outdoors, exercised, read, and watched television. Ms. Chase, who had degenerative joint disease and a knee replacement, lived alone with

### Table 2. Activity Patterns of Self-Care and Household Cluster for African-American Elders

<table>
<thead>
<tr>
<th>Name (Age)</th>
<th>Body Systems</th>
<th>Functional Outcome&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Daily Life Activity&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barns (75)</td>
<td>Congestive heart failure; shortness of breath</td>
<td>Functional Outcome&lt;sup&gt;b&lt;/sup&gt;</td>
<td>ADL n (%)&lt;sup&gt;d&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unit</td>
<td>Home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>+8</td>
</tr>
<tr>
<td>Hamblen (76)</td>
<td>Renal disease</td>
<td>–1</td>
<td>+22</td>
</tr>
<tr>
<td>Weston (80)</td>
<td>Degenerative joint disease; hip replacement</td>
<td>+12</td>
<td>–2</td>
</tr>
<tr>
<td>Wescott (58)</td>
<td>Tracheostomy; Pickwickian syndrome; diabetes mellitus</td>
<td>+2</td>
<td>+1</td>
</tr>
<tr>
<td>Carter (66)</td>
<td>Hip fracture</td>
<td>+3</td>
<td>+3</td>
</tr>
</tbody>
</table>

<sup>a</sup>Functional outcomes were changes in Functional Independence Measure (FIM) scores on the unit and at home. <sup>b</sup>Total FIM scores at final follow-up. <sup>c</sup>Daily life activities were the number of activities per day as identified by participant. <sup>d</sup>Percentage of total activities by Self Observation and Report Technique.
daily assistance from a paid provider. She went to church by Metrolift van and said, “It means a whole lot to me just to be able to get around a little bit.”

The seventh member of this cluster, 93-year-old Ms. Dobson, moved to a personal care home after staff members at the transitional unit believed it had become too difficult for her to manage living at home with a paid provider. She used a walker and had cardiac problems, renal insufficiency, and arthritis. Ms. Dobson formerly did “day work,” caring for children and elderly persons. She had no children, and her two sisters lived in another state. Ms. Dobson was relieved to have personal care home staff take over many personal care and household tasks: “I like living here. Some things I don’t feel like doing, I don’t feel up to it. Yes, it’s a great help.” Having staff assist with self-care is reflected in a lower final FIM score (23) than other members of this cluster because Ms. Dobson chose to spend her time and energy on other things. She attended a day program where she made many friends and enjoyed familiar and new activities: “Some of the groups there are sewing and painting. There is always something to be done….You’re never too old to learn.” Summary information on the mixed activity cluster can be found in Table 3.

### Daily Life Participation Patterns and Functional Outcomes

The FIM scores for participants in each cluster are shown in Figure 1. This display reflects changes in FIM scores during the time the participants were on the transitional unit, followed by changes in FIM scores during 6 months of follow-up in the community. After participants returned home, increases in FIM scores were found in 3 of 5 members of the self-care cluster (60%), 4 of 5 members of the self-care and household cluster (80%), and 4 of 7 members of the mixed activities cluster (57%).

### The Influence of Contextual Factors

In examining contextual factors that influenced functional outcomes and activity participation, Functional Outcome Interviews revealed that families often developed a variety of ways to meet the needs of the participants (see Tables 1–3). This variety often involved complex orchestration of several key persons’ contributions at different times of the day or days of the week. In contrast to the common assumption that one major caregiver typically exists, this study revealed involvement of many family members, including spouses, children, grandchildren, siblings, and nieces. It is notewor-

### Table 3. Activity Patterns of Self-Care, Household, and Leisure (Mixed Activity) Cluster for African-American Elders

<table>
<thead>
<tr>
<th>Name (Age)</th>
<th>Body Systems</th>
<th>Functional Outcome</th>
<th>Daily Life Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Unit</td>
<td>Home</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Green (67)</td>
<td>“Small stroke”</td>
<td>0</td>
<td>+12</td>
</tr>
<tr>
<td>Hamilton (59)</td>
<td>Foot ulcers; diabetes mellitus</td>
<td>+14</td>
<td>+12</td>
</tr>
<tr>
<td>Fielding (72)</td>
<td>Internal injuries and fractures from car accident</td>
<td>+21</td>
<td>+19</td>
</tr>
<tr>
<td>Pauls (79)</td>
<td>Foot ulcers; malnutrition, diabetes mellitus</td>
<td>+5</td>
<td>+11</td>
</tr>
<tr>
<td>Allen (71)</td>
<td>Fractures from car accident; diabetes mellitus; hypertension</td>
<td>+4</td>
<td>38</td>
</tr>
<tr>
<td>Chase (69)</td>
<td>Degenerative joint disease; knee replacement; hypertension; old stroke</td>
<td>+17</td>
<td>+5</td>
</tr>
<tr>
<td>Dobson (93)</td>
<td>Pacemaker; arthritis; bone disease; urinary tract infection</td>
<td>+9</td>
<td>+2</td>
</tr>
</tbody>
</table>

Note. n = 5; ADL = activities of daily living, including personal and instrumental tasks. Eleven or more activities, more than one third leisure, home, neighborhood, and community centered.

*Functional outcomes were changes in Functional Independence Measure (FIM) scores on the unit and at home. **Total FIM scores at final follow-up. †Daily life activities were the number of activities per day as identified by participant. ‡Percentage of total activities by Self Observation and Report Technique.
Figure 1. Functional Independence Measure (FIM) scores for members of each activity cluster: (a) self-care, (b) self-care and household, and (c) self-care, household, and leisure (mixed activity).
thly that the participants were both recipients and providers in support exchanges with other family members.

Neighbors played a key role in the daily lives of a number of participants, providing instrumental help, companionship, and a sense of safety that someone would be there if problems occurred. Formal support services also were extremely important to many participants. Support services were frequently arranged by staff of the transitional unit who had to piece together a variety of support systems before discharge, such as sources of equipment, personal and household management assistance, professional home health services, and transportation systems. Seven participants had new providers who came to their homes, and 2 received assistance from personal care home staff. Most adapted well to the need for assistance provided by persons new to them. As Ms. Dobson said, “It’s like a home here. They take good care of you. I’ve come too far to look back now.” These findings about establishing and becoming comfortable with new support arrangements are similar to previous studies that emphasized an evolving process of adaptation after hospitalization (Bull, 1992; Lough, 1996). The significance of context is reflected in the finding that many participants were glad to return to settings of home, neighborhood, and community, which represented valued social relationships and activity routines from the past.

Reflections

By examining individual elderly persons in detail over time, this study revealed complex relationships among the ICIDH-2 domains of body systems, functional outcomes, and participation in daily life activities in community contexts. The correspondence between functional outcomes and activity participation is not simple and straightforward. For example, some participants in this study had high FIM scores but engaged in few daily activities, whereas others had relatively low FIM scores but engaged in many daily activities. Participants had a variety of medical problems, some of which (e.g., injuries, acute urological problems) were resolved during the course of the study. However, most had chronic conditions that required ongoing management. Despite these issues, many participants found ways to return to daily activities they valued in the community, as reflected in data on members of each activity cluster. Some chose to spend time and energy on self-care and household management because they reflected a sense of independence and pride in their personal abilities. However, a number of participants who had various forms of assistance available chose to spend their time on other valued activities, such as playing dominos; quilting; painting; socializing with friends; and visiting community locations to attend church, to shop, or to see friends and family.

These findings suggest that the importance of ADL in the lives of elderly persons may be quite variable (Christiansen, 1998) and indicate a need for broader consideration of outcomes of interventions that reflect the value preferences of elderly persons themselves (Spencer, Hersh, Eschenfelder, Fournet, & Murray-Gerzik, 1999; Whiteneck, 1994). This consideration is reflected in growing recognition of subjective well-being in outcomes research (Fuhrer, 1994; Kendig, Browning, & Young, 2000). Making choices about use of time and energy in various activities is thus a complex process that involves trade-offs among what is feasible given the person’s health status; availability of various forms of support; and what is most meaningful and valued in contexts of home, neighborhood, and community.

Participants who found ways to return to valued activities generally had a history of adapting to difficult life circumstances, such as loss of work, death of family members, or previous illnesses. Most described themselves as glad to be alive in spite of difficulties and being content with their lives and what they had. Spiritual faith was an important source of strength that helped many participants view adaptation to short-term problems as part of a longer life history.

Participants who did not return to valued activities tended to have more serious medical conditions, including those with a history of depression. Some attributed their limitations to external factors, such as difficulty with medications, rather than affirmed that they could influence their own lives. These findings are consistent with literature on such concepts as resilience (Fine, 1991), sense of coherence (Antonovsky, 1987), and sense of psychological well-being (Ryff & Keyes, 1995), which have emphasized finding meaning and value in current circumstances and believing that one can influence responses to such circumstances.

Findings about diverse family support arrangements are consistent with previous studies of a strong tradition of family support among African-Americans (Hines-Martin, 1992). In this study, several family characteristics were found that were similar to those identified by Turner and Alston (1994), who examined the role of the family in adaptation to physical disabilities for African-Americans, including strong kinship bonds, role flexibility, and religious orientation.

The relatively small sample size in the study means that generalizability of findings to other persons and circumstances must be investigated in future research. African-Americans who used the county hospital district system were chosen because of their potential to illustrate adaptive processes that may differ from those of “mainstream” elderly persons, as reflected in their diverse support arrangements.
with family and neighbors. Difficulty in locating a few participants consistently resulted in some missing data.

Strengths of the study were tracking the adaptive processes of elderly persons over 6 months using triangulation of multiple data sources, including qualitative interviews and FIM and SORT data. Examining a relatively small number of persons in depth revealed issues that may not be identified in large-scale quantitative studies in which individual differences are lost. The study also emphasized visiting participants in their own contexts, allowing observations and discussion of their local worlds of home, neighborhood, and community rather than relying solely on interviews in an unfamiliar setting in which taken-for-granted aspects of life may not be reported. At ongoing project research meetings, team members affirmed the importance of setting aside clinicians and researchers’ commonly held expectations and attempting to see things from the point of view of insiders in their own local worlds. Although the African-American elders in this study had limited material resources and lived in modest circumstances, they possessed a rich stock of adaptive experience and a wealth of valued relationships and occupations. These study participants frequently expressed appreciation for what they had despite losses and major life disruptions: “I feel content. Yeah, very content. There are things I wish I could, but I know I can’t. I’m just glad to still be living.”

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References


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