

AGING ALONE IN THE FAMILY HOME:
EXPLORING PLACE ATTACHMENT AND PERSONAL ADAPTATION

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by
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AGING ALONE IN THE FAMILY HOME

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AGING ALONE IN THE FAMILY HOME

The undersigned, appointed by the Dean of the Graduate School, have examined the dissertation entitled

AGING ALONE IN THE FAMILY HOME:
EXPLORING PLACE ATTACHMENT AND PERSONAL ADAPTATION

presented by Gloria Eaton Stafford, a candidate for the degree of Doctor of Philosophy, and hereby certify that in their opinion it is worthy of acceptance.

Ruth Brent Tofle, PhD

Benyamin Schwarz, PhD

Laura Cole, PhD

Colleen Galambos, PhD

DEDICATION

I would like to dedicate this entire effort to three very important people.

First, my late father, Albert Eaton (deceased at 98), who instilled in me, by his example, an appreciation for the pursuit of education throughout one's life. He never knew that I would follow in his footsteps by achieving a lifetime of learning and of educating others. I know he would be proud of where I am today.

He taught me that education is the key to living in a world that is expansive and stimulating. "You don't want to live in a small world" he would tell me. As an educator himself, he instilled in me an appreciation and respect for learning, a desire to keep learning and the awareness that there is always more to learn. Most importantly, he said "As long as you want to go to school, I'll foot the bill."

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Finally, I would like to acknowledge the contribution of my mother, Esther, who, at 95, remains a vibrant and independent woman, and an inspiration. Although she chose not to age-in-place, she has found fulfillment, purpose, comradery and freedom from worry in a senior community. Most importantly, she has continued my father's pledge to "foot the bill" for my continuing education.

I am blessed to have had these people in my life.

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AGING ALONE IN THE FAMILY HOME:
EXPLORING PLACE ATTACHMENT AND PERSONAL ADAPTATION

Gloria Eaton Stafford

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ABSTRACT

It is generally understood that many elders wish to remain at home during their final years. A long-occupied residence holds precious memories and feels secure. To that end, both researchers, designers, and care providers have concentrated efforts on identifying best practices for extending elders' independence and reducing risk of injury while remaining at home. Within aging-in-place literature, it has been increasingly acknowledged that home modifications—such as the addition of ramps, first-level toilet rooms, non-slip flooring, grab bars, and curb-less showers—can be effective means to reducing risks, and increasing independence. Within literature, study findings often report on corresponding improvements to functioning or reductions in trauma. Such research endeavors regard the home as a physical space in which to perform tasks.

To begin to complete the picture within the knowledge base—particularly concerning the oldest-old living alone—this study shifts the emphasis from the oft-used intervention approach in aging-in-place research to one focusing on tangible environment-behavior transactions. Shifting away from regarding aging-in-place as a problem to be solved, a grounded theory approach aims to illuminate the experience through empathetic open-ended interviewing with the person's experience itself as the focus of inquiry.

Ten participants between age 88 and 100 who lived alone were interviewed and observed in their homes over several sessions to explore what creative personal adaptations and modifications—related to use of space and interaction with elements of the home—elders themselves utilized to accommodate for diminished capabilities while living in the same, long-occupied residential setting. Building theory grounded in data, the research findings elucidated the remarkably adaptive nature of older people over time and revealed enduring attachments to home.

CHAPTER ONE: INTRODUCTION

Statement of the Problem

It is commonly understood that—due to the unprecedented boom in United States births between 1946 and 1961, called the *Baby Boom*—there will be far greater numbers of retired and older people in the next several decades than has ever before existed in this country.

Compounding this, advances in medical science have caused life expectancies to increase. As the aging population grows in numbers and the average life expectancy increases, it will become very important to evaluate and understand the consequences associated with various housing options. The field of environmental gerontology—which attempts to explore the most viable environmental conditions in which elders are able to thrive—is faced with forging new solutions to house this burgeoning population. Summarizing the need for applied research, Geboy, Moore & Smith (2012) wrote:

The viability of the field of environmental gerontology depends upon whether it can make itself practically relevant by helping to resolve some of the urgent, real-world problems facing older adults. Many of the problems relate to which and how residential environments might best forward the goals and aspirations of an aging population. More attention should be directed towards improving the environments of choice of older adults, which are not institutional settings, but rather their own homes located in neighborhoods and communities.

The burden of satisfying the housing needs of our aging population can be greatly reduced if housing solutions can be developed to help community dwelling older adults remain in their homes longer, rather than necessitating relocation to institutional long term care facilities (Wang, Shepley & Rodick, 2012). The desire to grow old in a familiar home—what is colloquially articulated as “staying put” but expressed in literature as *aging in place*—is

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consistently expressed as a primary desire of both aging adults and the family members who love them (Gitlin, 2003; Parmalee & Lawton, 1990). The home environment fulfills many emotional and psychological needs regardless of age, and therefore can contribute significantly to emotional well-being as one ages. As one grows older, remaining at home may be a significant constant in a world filled with other losses, such as loss of professional identity or recognition, loss of friends and loved ones, and loss of abilities.

A survey conducted by AARP of 2000 people over the age of 55 indicated that 89 percent *strongly* or *somewhat agree* that they want to remain in their current residence as long as possible and over 63 percent believed that their current residence is where they will always live (Bayer & Harper, 2000). It is not difficult to understand a desire to remain at home in an environment that holds memories and feels secure. Marcus (2006) noted that, “A home fulfills many needs: a place of self-expression, a vessel of memories, a refuge from the outside world, a cocoon where we can feel nurtured and let down our guard” (p. 2). In addition, home can provide the most nurturing and psychologically sound environment in which to age. Chaudhury and Rowles (2005, p. 3) noted that:

It is now widely accepted that home provides a sense of identity, a locus of security, and a point of centering and orientation in relation to a chaotic world beyond the threshold. It is also increasingly acknowledged that a sense of being “at home” is related to health status and well-being and that disruption of this sense...can result in significant changes in well-being.

Considering the strong support which one’s home environment offers, it is surprising that there is not a greater proliferation of academic literature specifically related to elder’s experiences at home. Gitlin (2003) noted that in academic literature “there remains a lack of a

critical mass of studies on home environments” (p. 628), that the “home environment as a centerpiece of the individuation of the aging process warrants our careful attention” (p. 630), and that “there is a dearth of research on the dynamical processes of daily home life and a continued preference for, and proliferation of research on older people in institutional facilities” (p. 629). That home-focused research lags far behind research in institutionalized settings is unsettling because the vast majority of elders—roughly three-quarters—do live in single family homes or apartments (Gitlin, 2003; Parmalee & Lawton, 1990). A research endeavor focused on aging within home environments is challenging due to the very context being studied. As Gitlin (2003) described, “The study of home life is necessarily time intensive, requiring face-to-face contact with single individuals. The researcher may be limited as to the amount of exposure to the environment and sampling behaviors that might occur” within the observation time frame (p. 630).

Significance of the Study

Home-based research concerning the elderly may be trailing behind institutional based research in magnitude and rigor, but this is not to say that the concept of aging-in-place has not received attention over the last few decades among gerontological researchers. There has in fact been some notable concentration on this issue (Frank, 2002; Golant, 2015b; Heywood, Oldman & Means, 2002; Pastalan, 1999; Rowles, 1993; Rowles, Oswald & Hunter, 2004; Rubenstein, Kilbride & Nagy, 1992; Taira & Carlson, 1999; Tanner, Tilse & deJonge, 2008). However, the focus of such literature is often related to construction projects and built modifications performed for the benefit of the resident—such as adding ramps, adding first-level toilet rooms, eliminating shower curbs, adding non-slip flooring, lowering cabinets, adding grab bars, etc.—an *intervention* approach which regards the home as an environment to be conquered. Typically

referred to as housing adaptation or housing modification—defined as an alteration of a physical feature within the home—this strategy strives to reduce the demands of the home environment in order to increase activity performance (Fänge & Iwarsson, 2005). Research findings focus on post-intervention improvements to functioning and reductions in trauma. Within aging-in-place literature, it has been increasingly acknowledged that such modifications to homes can be effective means to removing barriers to functioning and increasing independence for older adults (Bayer & Harper, 2000; Fänge & Iwarsson, 2005; Tanner, Tilse & deJonge, 2008). Such research endeavors regard home as a physical space in which to perform tasks, and the goal of intervention is to increase competencies, safety and comfort (Tanner, Tilse & de Jonge, 2008).

Within the interior design community, programs have been initiated to train designers how to most effectively modify home environments of the elderly to be safer and more manageable—in essence, to *fix* them. Among these programs are the *Certified Aging in Place Specialist* (CAPS) program sponsored by the National Association of Home Builders and the more recent *Certified Living in Place Professional* (CLIPP) program sponsored by the Living in Place Institute. The intention of these programs is to instruct and qualify aging-in-place specialists to intervene in order to modify home environments of the elderly, thereby reducing environmental demands and increasing safety and activity. Although these interventions can certainly be effective in reducing some risk, the supposition that aging-in-place issues can be approached with a formulaic *how-to manual* approach vastly oversimplifies the inherent complexity of the issues that the oldest-old face at home.

To begin to complete the picture within the knowledge base—particularly concerning the oldest-old living alone—this study shifts the emphasis from the oft-used intervention approach in aging-in-place research to one focusing on tangible environment-behavior transactions. Shifting

away from regarding aging-in-place as a problem to be solved, this study aims to illuminate the experience through empathetic open-ended interviewing with the person's experience itself as the focus of inquiry.

Purpose of the Study

The purpose of this research was to develop a better understanding of the experience of aging-in-place from the perspective of the oldest-old who are doing it. It explored the interrelationships between one's desire to remain at home until life's end, the natural progressive decline related to aging, and the adaptiveness that is intrinsically inherent in human functioning.

While researches and practitioners have investigated the benefits and constraints of aging-in-place and have explored ways to provide support and enable extended at-home living, the study of adaptations initiated by the aging dwellers themselves has not been paralleled by equivalent consideration. Absent from the discourse has been the voice of those living the aging-in-place phenomenon. As noted earlier, the home environments of elders are challenging settings for researchers, requiring intensive periods of time and face-to-face contact (Gitlin, 2003). Perhaps due to these challenges, little has been written about the personal adaptations elders themselves make to their residential surroundings as they age in order to accommodate changing needs and diminished capabilities, which enables them to remain at home. This research effort aims to focus squarely on the preferred environment in which to grow old—the long occupied and familiar family home—and on the intrinsic personal adaptive nature of older adults.

My training and experience as an interior design has provided me with a unique awareness of person-environment transactions within any environment under consideration. This research attempted to systematically document specific adaptation behaviors and psychological adjustments—related to use of space and interaction with elements of the home—

which the research participants have utilized to facilitate further functioning. Several older adults and relatives within my close circle—who have lived very productively at home into their nineties—have inspired my interest in the everyday life and functioning in one’s older years and how capable older people experience everyday home life. One gerontologist succinctly noted “We measure what we treasure” (Hendricks, 1999; as noted in Schoenberg & Rowles, 2002, p. 10) and I believe that speaks to my personal interest in the current study.

There is no one prescription for successful aging-in-place—despite the current direction within the design community to *understand* and *solve* aging-in-place challenges. This study strives to better understand the aging-in-place experience and the environment-behavior interaction with the long-occupied home environment as seen through the idiosyncratic eyes of these research participants.

If this research focus could have an even greater ambition, it would be to contribute to the knowledge base within the field of environmental gerontology and to explicate core concepts inherent in the person-environment interaction of elders living at home, and then to disseminate those findings within the academic and design community. There is a strong need along these lines. Gitlin (2003) spoke of the need for such a focus (p. 635-636):

Potential research directions include the development of measures and methodologies that evaluate everyday adaptive responses and the specific person and environmental characteristics that contribute to living at home as well as developing and testing specific strategies to maximize quality of life at home.... Understanding home environments as a potential optimization strategy and therapeutic modality may yield knowledge about the types of strategies and environmental setups that are most helpful to older people to effectively sustain continuance.... Home environmental research can help particularize

and refine existing constructs in environmental gerontology as well as articulate new visions of person-environment transactions.

Research Questions

The purpose of this study was to explore personal adaptations, use of space, and interactions with elements in homes where elders have previously resided as part of a family unit and where they are now living alone, looking at adaptations—either behavioral, psychological, or environmental. Additionally, this study investigated feelings about the meaning of home and place attachment among the participants, exploring how they felt about their home and the experience of staying there, how the prospect of a potential move was viewed if future needs should dictate such, and how they evaluated their abilities to function and to remain in their home through advancing age. The scenario of a long-occupied, family home setting was chosen because it allowed for constancy in the physical environment which optimized the development of strong place attachment and compelled a clear progression of adaptive behaviors over time.

Questions which this research endeavor attempted to answer were:

1. What progressive and creative personal adaptations and modifications—related to use of space and interaction with elements of the home—do elders utilize to accommodate for diminished capabilities while living in the same, long-occupied residential setting into old age?
2. How do elders who have remained in the family home into old age feel about their home and the experience of living there, and how do they view the prospect of relocation or the adoption of alternate living arrangements should their needs change?

Design of the Study

The design of the current study allowed for an analysis of several compounding dimensions. The long-occupied family home was chosen as the research setting because the

person-environment relationship within that home had existed in tandem with the age-related bodily, psychological, and social changes that had taken place over the period of residence. The home itself as a structure had remained constant, but the ways in which the person interacted with the home indicated the behavioral and environmental adaptations which were made by the individual over time to compensate for age-related diminishments. It was a goal of this research that ample time be spent in the field to gather rich data from participant interviews and observations.

When initially proposed, the structure and format of this study was conceptualized using Maxwell's (2005) interactive model for research design. Appendix A includes this initial diagrammatic synopsis—which was set forth at this study's inception—showing the intended goals, methods, questions, conceptual framework, and the measures taken to ensure a high level of validity.

Organization of the Remainder of the Study

This first chapter has provided an introduction to the importance of this study. The second chapter includes a review of relevant literature in order to make known the theoretical framework on which this study was designed. A detailed explanation of the research methods utilized is provided in the third chapter. In the fourth chapter, a reporting of findings is presented along with an analysis of the data and an interpretation of emergent themes. The final (fifth) chapter provides a discussion of the relevance of these findings, and a reflection of positioning this account within the overarching broad base of knowledge on this topic.

CHAPTER TWO: BACKGROUND

Conceptual Framework: The Concepts of Competence, Autonomy, Security, Continuity, Normalcy and Efficacy— *the dimensions of adjustment as they relate to aging-in-place*

There is a need to use the views of several foundational theories to better understand and conceptualize the experiences of older people aging in place and the complexity inherent in staying put into old age. In defining conceptual frameworks and describing their role in research inquiry, Rapoport (1985) noted that their purpose is neither to describe how things work nor to explain phenomena. Rather, he noted, conceptual frameworks provide a structure which helps us to think about a phenomena and to assist us in the organization and assembling of material in order to uncover patterns. Several models and theories are applicable as a framework for this inquiry and are described below.

This purpose—to provide an intellectual backdrop for the understanding of phenomenon must be clear, or the positioning of models and theories outside of the research endeavor and related data collection and analysis may seem to contradict the methodology of grounded theory, which was utilized for this study. A leading strategist of grounded theory, Kathy Charmaz (in Wertz, Charmaz, McMullen, Josselson, Anderson & McSpadden, 2011, p. 304), noted that, “Grounded theorists avoid applying specific extant concepts because we stress emergent analysis” (p. 304). The use of grounded theory means that researchers need to avoid preconceptions as to where their data might take them, instead allowing concept and theory to emerge from the data itself. Predetermined ideas and theories should not be forced upon data, and theoretical categories should only be developed *from* data, not revealed before data collection (Charmaz in Wertz et al, 2011, p. 206). “Extant concepts must earn their way into the analysis: they should not be applied to it” (Charmaz in Wertz et al, 2011, p. 170). By positioning a conceptual framework which includes several models and theories as deferential to and

informing, rather than influencing or prescribing the data collection and analysis to come, the conceptual and theoretical descriptions below should serve to elucidate the rationale of the forthcoming study, the development of the research protocol, and the positioning of analysis.

Ecological theory of aging, aka the Competence Press Model. A fundamental theory at the heart of any study concerning older adults and their environment is Lawton and Nahemow's ecological model of aging, also referred to as the *competence press model* (Lawton & Nahemow, 1973). This model evolved from an initial quest to better understand the person-environment fit in order to improve the lives of elders by reforming design constructs for elder housing. It involves the concern for adaptive levels of functioning between a person's set of competencies and the demands made upon him or her by the environment. It posits that the level of physical functioning at which a person operates should fit the level of demands which the environment—called environmental press—exerts on him or her in order to achieve optimal outcomes. Those with higher levels of functioning can adapt to a wider range of environmental features and will experience favorable outcomes, although only up to a point. Weak press and high functioning can also have negative outcomes. However, and more applicable for the elderly, if competence is low, the press from the environment can exceed a person's ability to effectively manage it. If the press is stronger than abilities to function, that is, when the demands of the environment exceeds a person's competence to cope, behavioral outcomes may be negative. More press from the environment than is manageable is problematic and stress-provoking and can result in physical strain, falls and injuries, and inability to perform desired tasks. The less physically or less emotionally competent an individual is the more he/she is impacted by the environment. As a person resides in the same home, the home structure itself may change little, but with age, a person's physical abilities most certainly diminish.

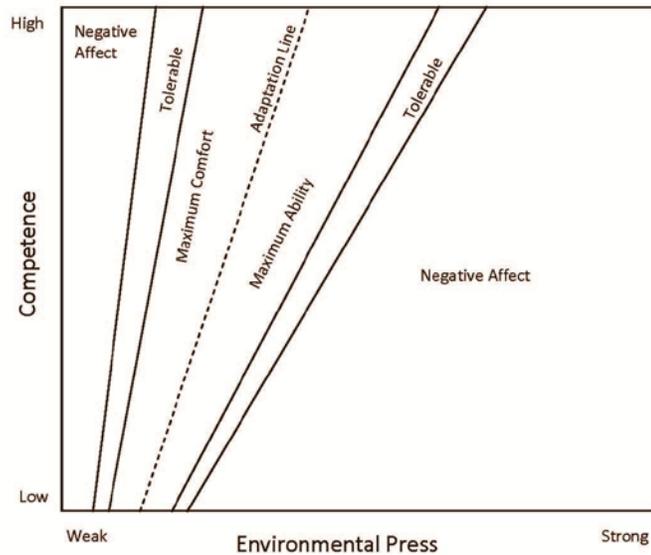


Figure #1. Lawton and Nahemow's Competence-Press Model. From Scheidt & Windley, 2003, p. 26. *Physical Environments and aging: Critical contributions of M. Powell Lawton to Theory and Practice*. New York: The Haworth Press.

This graph is used to express the relationship between the demand and stress of the environment (environmental press) and the competence of the person. Located on this graph is a central line, called an adaptation line, which—on both sides—plots the average person's ability to adapt relative to average environmental press. The ideal person-environment fit—where successful independent living is supported—is where a congruence exists between a person's abilities and the demands of the environment. Further from the adaptation line, where press is either much stronger or much weaker than competence, the person-environment transaction goes beyond being tolerable and outcomes which are negative may occur.

Environmental proactivity hypothesis. In 1989, Lawton expanded on the competence-press model to account for the impact of individual initiative relative to environmental fit. The original model sees the fit as being environmentally determined and places the person in a passive, non-responsive mode, being affected by, but not actively affecting the environment (Lawton, 1989; Scheidt & Norris-Baker, 2004). The *Environmental Proactivity hypothesis* imagines that individuals, in response to environmental press, actively use and interact with both

environmental and intrinsic resources to actively regain balance between press and ability. This hypothesis stresses the *competence* of the individual and their effective use of resources to counteract the consequences of declining capabilities towards the maintenance of physical and psychological well-being.

Both of Lawton's theories relate to the current study because they propose that key to successful and independent aging-in-place is the maintenance of a fit between a person's abilities and the demands of that home environment (Pynoos, Nishita & Perelman, 2003). When greater demands are placed on the individual—because of decreased competence—adaptive behavior must occur to regain a cooperative balance with the environment. This adaptive behavior may be in many forms and may include use of a variety of resources.

Autonomy-security dialectic. In 1990, Parmalee and Lawton proposed an organizing scheme for person-environment interactions specific to elder housing options which they called the *autonomy - security dialectic*. They noted that literature on environments and aging involved a repeated emphasis on autonomy as a desired outcome for existing or transitioning residential situations. They defined autonomy as “a state in which the person is, or feels, capable of pursuing life goals by the use of his or her own resources; there is thus minimal need to call upon other people's resources” (Parmalee & Lawton, 1990. p. 465). Equally important as a goal for environments for the elderly, they noted, is the promotion of a sense of personal security, which they defined as “a state in which pursuit of life goals is linked to, limited by, and aided by dependable physical, social, and interpersonal resources” (p. 465). Security encompasses both physical safety and psychological peace-of-mind (Parmalee & Lawton, 1990). Positioning both autonomy and security as critical for the design considerations of environments for aging, but noting that the two goals can be dynamically in opposition, they concluded “...autonomy and

security together form a dialectic that lies at the heart of person-environment relations in late life” (p. 465-466).

Practically, independent housing situations—such as aging in the family home—maximizes autonomy for the elder, but an absence of immediate assistance in the home means a lessening of personal security. A home of one’s own affords optimum autonomy: “home affords the freedom to allocate space, to decide what behavior should occur when, to avoid public scrutiny, and other functions that clearly represent psychological autonomy and efficacious action” (Parmalee & Lawton, 1990, p. 471). In contrast, age-segregated congregate housing necessitates varying degrees of organizational control and managerial oversight thereby decreasing personal autonomy. But congregate residential housing facilities offer greater security “in the form of health care and other services, a more manageable environment, and a relatively dense social-supportive environment, are achieved at the cost of some loss of choice and independence” (p. 468). Both autonomy and security are concerns and desired attributes for housing situations for adults of all ages but particularly so for elders as competencies diminish. Both autonomy and security are desired, but found in diverse settings. “The variety of environments inhabited by older people reflects the autonomy-security dialectic inasmuch as differing housing types afford differing balances between autonomy and security” (Parmalee & Lawton, 1990, p. 471). Within the continuum between autonomy and security, the goal in considering housing options is to find a person-environment congruence between personal needs and desires and the housing conditions. Consideration of the counterpoints of this dialectic—the higher autonomy-lower security inherent in living in one’s own private home, versus the lower-autonomy-higher security afforded by congregate or institutionalized settings—elucidates the choice and perhaps the will to remain for those aging alone in the family home.

Continuity theory. Atchley (1999) developed the Continuity Theory to explain empirical findings uncovered up to that time about the resilient nature of older people. Despite the unrelenting biological and physical changes that affect people over their life span, many studies had uncovered remarkable consistency within any given person's types and levels of activities, lifestyles, attitudes, environments, and social relationships over time. Older adults maintain, throughout their life, activities, behaviors and attitudes similar to those they exhibited in their earlier years of life. However, as abilities diminish due to the aging process, in order to maintain this continuity of lifestyle, older people must necessarily develop some types of adaptive strategies.

Continuity theory correlates very directly to the present study because they both relate to personal adaptation. Continuity theory illuminates why older people live as adaptive, rather than static, non-changing creatures. Evolution theory has taught us that beings and species which do not adapt to forces upon them eventually perish. One might consider that those who have lived into older age may have had to be good adapters in order to continue to thrive. Many physical, psychological, and social changes that occur throughout life alter people's circumstances, resulting in a need to adapt one thing in order to realize consistency in something else. Relative to the inquiries in this study, specific adaptations in behavior and functioning may be conceived of by older people for the very reason to allow for continuation of life within the same residence, under the same conditions, and with the same behaviors as they performed decades earlier.

Atchley (1999) explained:

Continuity theory holds that adult development and adaptation are continuous....

Continuity theory presumes that most people learn continuously from their life experiences and intentionally continue to grow and evolve in directions of their own

choosing. Continuity theory is a general theory that attempts to explain why continuity of ideas and lifestyles is central to the process of adult development in midlife and later and why continuity is such a common strategy for coping with changes in middle and later life (p. vii).

Continuity should be viewed as the “persistence of general patterns” or else it would seem to be at odds with a theory which implies that continuity is the most prevalent form of adaptation to aging (Atchley, 1999, p. 2). Continuity and change are not mutually exclusive. Therefore, continuity can be seen as existing simultaneously with inevitable change and purposeful adaptations throughout lifetimes and across life’s transitions (p. 3).

Residential normalcy. Golant (2011, 2015a) proposed a model for person-residence adjustment which acknowledged various routes to achieving environmental fit, or *residential normalcy*. Simply put, this theory proposes that people just want to feel normal in the place they live. Normalcy, or fit, occurs for an older person when they are in a *residential comfort zone* and “experience overall pleasurable, hassle-free, and memorable feelings about where they live” or in a *residential mastery zone* where they “occupy places in which they feel overall competent and in control” (Golant, 2011, p. 193). When people find that they are out of these zones of comfort or mastery, they either change their activities, revise their mind-set, or modify their residential setting. Behavioral or action strategies are seen as *assimilative* coping efforts, and mind strategies of changing attitudes are seen as *accommodative* strategies. An elder may find that a residential setting achieves many of their goals, but is discordant with goals in other ways. In seeking to regain normalcy and balance, a change to the residential setting can be either a modification to a feature of the home, a change of behavior, a relocation, or another strategy. When growing older, the desire to maintain normalcy is so strong that elders are driven to find

mind or action strategies so that residential goals are met. Because relocation is the most strenuous of all coping strategies, it will not be voluntarily initiated until attempts to attain normalcy utilizing other strategies have been exhausted. Individual differences are seen as directly affecting how a person will choose to adapt. Older people aging at home who have more enriched coping repertoires are more resilient and more decisive in their thoughts and actions in attempting to regain normalcy (Löfqvist et al, 2013).

Self-efficacy theory. Self-efficacy theory—as developed by Bandura—recognizes the range of human capabilities and acknowledges differences in individuals’ beliefs about their ability to succeed and rise to meet challenges they face during life’s experiences. According to Bandura (1997), self-efficacy is "the belief in one’s capabilities to organize and execute the courses of action required to produce given attainments" (p. 3). It is one’s view of how effective one can be in achieving goals. One's sense of self-efficacy can play a major role in how one approaches goals, tasks and challenges. A person with a strong sense of self-efficacy will approach demanding situations with a strong motivation for mastery, whereas a person with weak self-efficacy will doubt their ability to succeed and may concede defeat quickly. In well-recognized terms, this theory explains why certain individuals stick with a diet or exercise regimen until goals are met while others do not. People with high self-efficacy—that is, those who believe they can perform well—are more likely to accomplish what they set out to do. Bandura (1997) further described:

Such beliefs influence the course of action people choose to pursue, how much effort they will put forth in given endeavors, how long they will persevere in the face of obstacles and failures, their resilience to adversity, whether their thought patterns are self-

hindering or self-aiding, how much stress and depression they experience in coping with taxing environmental demands, and the level of accomplishments they realize (p. 3).

Bandura's self-efficacy theory is relevant to an elder's decision to remain at home in older years, and their confidence in their own ability meet the challenges of remaining independent in the face of potential diminished capabilities in stamina, sensory functioning, intellectual agility, cognitive proficiency, memory performance, or physical competence (Bandura, 1997). Compounding these challenges is the need to continually re-adjust as children have left home, as friends have died, as care-givers enter and leave the scenario, and as a spouse has, perhaps, undergone a physical decline and ultimately has passed. "The self-efficacy issues for older adults' center on reappraisals and misappraisals of their capabilities" (Bandura, 1997, p. 198). Those who adapt and change in their later years continue to manage in ways that give meaning and purpose to their lives. "This is no easy matter given the major life transitions, biophysical changes, and social barriers with which they have to cope" (Bandura, 1997, p. 205). But being able to do things for oneself can result in many perpetuating benefits, including a renewed confirmation of self-efficacy which can in turn lead to additional confidence in managing the demands of daily life.

Bandura also explored the efficacy of elders to appropriately evaluate where specifically personal capabilities fall short and how to effectively select and rely on others to fill in for voids in abilities—what he referred to as "proxy efficacy." He noted "This can be an optimizing strategy if proxy efficacy is used in some areas of functioning to free time and effort to enhance personal efficacy in others" (p. 207). This strategy is not unique to elders, as no one person of any age can be maximally proficient in all tasks. Those who are most effective at any age select the undertakings at which they can be optimally efficient and seek other resources, or other

peoples' assistance, where those can be best utilized. If with age it becomes more challenging to maintain skill levels, the need for proxy efficacy increases (Bandura, 1997).

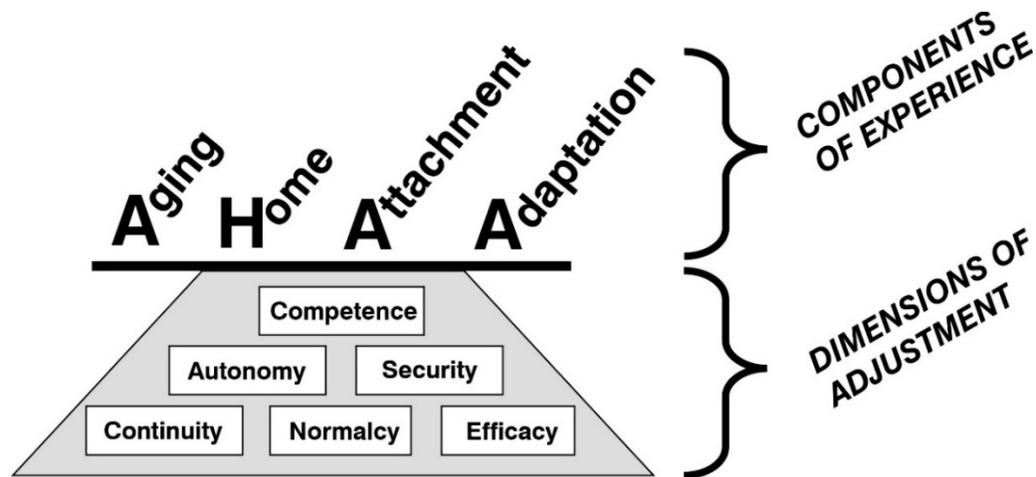
For elders, there is considerable adaptive value in maintaining both personal efficacy—a belief that one can continue to succeed despite a diminishment in capabilities, and proxy efficacy—a recognition that some assistance may be needed, and the ability to evaluate in what situations and where such aid should be sought. Maintenance of efficacy can be achieved through several adaptive strategies. When older adults refrain from making self-comparisons to younger or more able people; avoid reflection on declining capacities; shift standards of self-appraisal; reflect on areas in which high levels of control have been maintained; scale down or re-focus their pursuits; and concentrate efforts on things which are important to them and forego activities of lesser consequence—they are able to maintain high self-efficacy (Bandura, 1997). Conversely, for people who are insecure about tackling challenges—therefore have low self-efficacy—motivation, interest and skill are all reduced. Bandura summarized the ongoing positive strategies for and outcomes of enduring high efficacy: “With declining physical functioning in advancing age, control over daily life is maintained by simplifying activities, pacing them so that they are not too taxing, and restructuring the physical environment to make it more manageable” (p. 210). There is no single unequivocal explanation for why some elders strive to remain at home and foresee un-ending residence at home, while others readily relocate to housing where care and support can be provided. It is possible that self-efficacy theory can provide a framework for understanding these divergent choices.

Model of the *Dimensions of Adjustment as Foundation for the Components of Experience in Aging-in-Place*

The concepts explored above: competence, autonomy, security, continuity, normalcy and efficacy can be viewed as the *dimensions of adjustment* for older people who are aging-in-place.

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The degree to which elders possess or aspire to these attributes can significantly regulate their degree of well-being and quality of life. They can be conceptualized as the foundation—along a continuum of levels of adjustment—upon which the components of the *experience* of aging-in-place can be supported. These experiential components are aging, home, attachment, and adaptation—which an older person who is aging-in-place experiences in their lifeworld. These concepts require elucidation and definition relative to this research effort as well, which follow below. Perhaps noteworthy, these terms create the acronym AHAA. One might consider these *components of experience* the core of the aging-in-place phenomena—the exclamation point seizing the essential components which are also captured in the title of this study: *Aging alone in the family home: Exploring place attachment and personal adaptation*.



The *dimensions of adjustment* as foundation for the *components of experience* in aging-in-place.

Figure #2. The *dimensions of adjustment* as foundation for the *components of experience* in aging-in-place.

Definition of Terms – The *Components of Experience* in Aging-in-Place: Aging, Home, Attachment, and Adaptation – the AHAA

Exploration and defining of the concepts of *aging, home, attachment, and adaptation* follows as context for their consideration in the design and analysis of this research effort.

Aging. The aging experience considered in this study is that of the older extreme of the age spectrum (participants were age 88 through 100). Therefore, it is appropriate to consider what aging entails in general. Participants were aging-in-place, that is they had not relocated to age-specific congregate housing, and they were living alone. Following is a discussion of aging-specific experiences related to physical manifestations, aging-in-place, and aging alone.

Aging general. Aging in general refers to the biological, the psychological, and the social aspects of growing old. The process of aging begins before birth and continues on until the moment of death. Throughout this life course, a wide variety of factors and experiences impact our capabilities and well-being in later years (Sowers & Rowe, 2007). These developmental aspects of aging include changes to the functional capacity of our biological systems, psychological development and changes over the life course, and ongoing fluctuations in types and strengths of relationships and social networks. The consequences—due to variations along a range of outcomes in these aspects—can greatly impact the quality of life which are experienced in later years.

Physical manifestations of aging. The biological process of aging—the gradual wearing down of the body—was operationalized by Hall (1984, p. 4; Pankow & Solotoroff, 2007, p. 23) who outlined criteria for defining this process:

- a) aging may be apparent throughout life but is more noticeable in the post reproductive period;
- b) aging lowers the functional capacity of cells, organs, and entire organisms;
- c) aging results in the degradation of structural elements within the body;
- d) aging lowers the effectiveness of the response of the organism to internal and external factors;

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e) aging increases the likelihood of ultimate dysfunction: death.

Pankow & Solotoroff (2007) noted the distinction between the normal process of aging—which is simply the process of growing older and changes which subsequently happen to the body—and age-related diseases. Both normal aging and age-related diseases cause declines in functioning, but are separate phenomena. Normal changes which happen to the body, and are not considered diseases, include a decrease in strength over time, menopause, and decline in vision and hearing. These conditions, according to Pankow & Solotoroff (2007) occur due to numerous biological changes to organs and tissues that happen to our bodies over time which “manifest in the changes that are associated with aging” (p. 23). These changes—part of normal aging—do not directly cause illness, but they do make people more vulnerable to disease compared to younger people who have stronger immune systems. Diseases to which older people more easily succumb include cancer, cardiovascular disease, dementia, and strokes (p. 23), thus are termed *age-related diseases*.

The physical manifestations of aging can be easily seen in older people. The loss of collagen decreases skin’s elasticity causes skin to wrinkle and sag over time. Hair gradually thins from progressive follicle loss and turns gray due to a cessation of pigment production. After age 50, compression of the spine from loss of bone structure causes height to decrease and can cause spontaneous, painful fractures of the vertebrae. Weight gain in middle life is typical due to a slowing of body metabolism. Although muscle mass and endurance, particularly in the legs, is only lessened by about 20 percent by age 70, that loss accelerates so that at age 80, 40 percent of strength has been lost. Loss of lower body muscle strength can cause balance issues, falls, and difficulty with sitting and standing. Bone loss, which begins in the 30s but accelerates—particularly for women—in the 50s causes bones to become hollow and porous, leading in some

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cases to osteoporosis and increasing the likelihood of falls resulting in fractures. The protective cartilage in all joints deteriorates, becoming thin and cracked, potentially leading to painful and debilitating osteoarthritis (Cavanaugh & Blanchard-Fields, 2015).

The structures of the eyes change with aging, reducing the amount of light which passes through, and causing reduced acuity in low-light conditions. The lenses of our eyes become more yellow, reducing abilities to discriminate color, and more stiff, reducing the ability to focus. Other eye conditions are more prevalent with age as well: opaque spots on the lens, called cataracts; pressure due to lack of fluid drainage, called glaucoma; and the progressive and irreversible destruction of visual receptors, called macular degeneration. Progressive loss of hearing is common with age, as is presbycusis—the reduced sensitivity to higher pitched sounds (Cavanaugh & Blanchard-Fields, 2015).

Reductions in the numbers of temperature and touch receptors cause older people to have reduced sensations from the skin and increased difficulty regulating body temperature. Within the circulatory system, a progressive hardening of the artery walls as well as fatty deposits in the arteries results in a reduction of blood flow which can contribute to high blood pressure, stroke and myocardial infarction. In the heart, fat deposits accumulate and the heart muscle stiffens making the heart work harder to pump less blood. These combined effects result in a reduced ability to deal with exertion in later years, increasing the risk for heart attacks (Cavanaugh & Blanchard-Fields, 2015).

Cardiovascular disease is the leading cause of death in this country and cancer—which can affect a variety of body organs and systems—is second. Propensity for the development of cancer is related to both genetics and environmental factors such as exposure to carcinogens. Chronic conditions such as heart disease and cancer become more frequent with age and may be

more disabling. The most common chronic conditions among people over 65 are arthritis, hypertension, hearing impairment, heart disease, orthopedic impairments, cataracts, diabetes, and visual impairments—in that order (Padilia, Sterns, Feldman & Camp, 2007). Health conditions are both affected by, and directly affect how older adults live from day to day. Healthful habits can positively modify many aspects of biological aging. But declines in health can significantly impact life-style and well-being negatively in later years.

Aging in place. Aging-in-place refers to an older person continuing to live in their own home—likely one which they own and have resided in for a considerable period of time—and within their familiar community as they age. The quest within Environmental Gerontology to support such an arrangement aims to understand the necessary adaptations the mind and body undergo in response to the inevitable changes which accompany aging. Studies have found that people have higher levels of satisfaction and have better health when they are able to age at home rather than to relocate (Rowles, 1993; Rowles, Oswald, & Hunter, 2004; Rubenstein & deMedeiros, 2004). The concept is closely connected to implications that, as one ages and becomes increasingly frail, environmental modifications can serve to improve the person-environment fit (Sherman & Dacher, 2005).

Aging in place is a desirable and effective arrangement for those who can manage all of the demands this situation presents either on their own or with minimal help. But living arrangements can present problems as people age and succumb to the negative aspects of aging. As described above, many effects of aging—biological, physical, and sociocultural—have negative or deleterious consequences which reduce personal competencies and abilities to perform activities of daily living (ADLs). For example, osteoarthritis of the hands can make meal preparation and personal grooming difficult.

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As the interplay between environment and competence becomes more restrictive, elders can either change *behavior* or change the *environment* to again produce an ecological balance between personal competence and environmental press. An adaptive *behavioral* change for the potential challenge presented by osteoarthritis and meal preparation would be to use microwavable prepared foods rather than cooking meals from scratch (Cavanaugh and Blanchard-Fields, 2015). An *environmental* change would be the re-location to a housing facility where meal preparation is performed by others.

Aging-in-place necessarily reflects a successful balancing of environmental press and competence through selection, compensation and adaptation (Cavanaugh and Blanchard-Fields, 2015). As competence decreases due to a variety of bio-psycho-sociocultural factors, elders need to either adapt through behavioral changes, or adapt aspects of their environment to diminish press, or potentially succumb to negative consequences. It is precisely these types of changes—initiated by the elders themselves in order to regain balance between competence and press—that this research effort explores. Rowles, Oswald & Hunter (2004) noted that “Elders are by no means passively reduced to life at home. Rather, they are able to actively modify their environment, even when suffering from a loss of environmental competence” (p. 170). Lawton’s (1989) *Environmental Proactivity* hypothesis dealt with this concept and proposed that successful aging in place was an extension of autonomy and independence, which facilitate abilities in people to cope with impairments which affect environmental interactions, such as mobility limitations and vision loss (Rowles et al, 2004).

None of the participants of this study were affected by the most extreme conditions which have been found to be the strongest triggers necessitating nursing home placement. Those include dementia and other cognitive disorders, severe depression, reliance on a large number of

prescription drugs, diabetes, extreme functional impairments, and incontinence (Luppa, Luck, Weyerer, Konig, Brähler & Riedel-Heller; 2010).

Aging alone. For this study, participants who lived alone were specifically selected. Without another person living under the same roof, or without ongoing assistance, the intrinsic adaptiveness of the individual becomes a critical factor for ongoing well-being. In older age, living alone is most often the result of having outlived a spouse, and sometimes children and siblings, and choosing to remain in the familiar home rather than to relocate to some type of senior housing facility (Kasper, 1988). It is likely that many older people living alone had no plan to spend their later years alone. Subjected to the inevitable declines accompanying aging, and without immediate, continued assistance from others under the same roof, those older people living alone face real risks of injury, loneliness, isolation, unhappiness, and neglect.

The lifestyle and well-being of many elders living alone is largely dependent on the availability of family members who live near-by to offer assistance. In the absence of a spouse, older people most often rely on adult children for support and assistance. Without the good fortune of family members who are in proximity, available, and willing to help with household and personal care tasks, elders have to assume the burden of their own care, find community services, or procure paid help from outside sources. Neighbors can also be effective sources for assistance, if willing and able. Regular contact with family, friends, neighbors, and even paid care-givers can be very important to the well-being of older people living alone. When a reliable support network is tenuous or absent, the result can be crushing to the elder's peace of mind and quality of life (Kasper, 1988).

Widowhood is a common experience for older adults and can be one of the greatest challenges which anyone can face. It involves the loss of a life partner, the loss of the role of

spouse, the loss of companionship, and also the disruption of virtually every aspect of the survivor's life (Padilia et al, 2007).

Home. Home environments were chosen as the venue for this study. It was believed that those older-old who have chosen to remain at home may have specific manifestations of the other two components under study: place attachment and adaptation. Participants under study had spent a great deal of time living in the same home (the range for time living in the same home varied from 43 to 68 years). Therefore, the meaning that their long-occupied home and its possessions held for them was explored. Following is a discussion of the meaning of home particularly in later life, the psychological aspects of staying at home, and dimensions inherent in the sharing of a family home.

The meaning of home. In 1991, Despres analyzed the literature which had been compiled in the years' prior regarding the meaning of *home* as a construct, and published the results of this analysis. She drew upon the writings of many theorists who had attempted to define the concept and those who had studied various interpretive theories. Through her analysis she identified ten comprehensive categories of meaning for the construct of *home* and discussed various interpretations. All of these serve to explicate the distinction between *home* and other related terms. In providing this listing, Despres was attempting to provide a comprehensive categorization of meaning rather than to delineate the way in which any one dominated as a characterization of *home*. The ten categories of meaning Despres summarized were (1991, p. 97-99):

1. Home as security and control – home provides a sense of physical security against the bad forces.
2. Home as reflection of one's ideas and values – homes are symbols of how people see themselves and how they want to be viewed by others.

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3. Home as acting upon and modifying one's dwelling – a person is able to act upon his home as he chooses, home is a place for self-expression and freedom of action.
4. Home as permanence and continuity – over time, inhabitants develop a sense of having roots in the home, and the home becomes a vessel for memories of what has taken place there.
5. Home as relationships with family and friends – home is both the location for interactions with one's loved ones and a place to entertain relatives and friends.
6. Home as center of activities – the home supports a wide range of work, hobby, and leisure activities.
7. Home as refuge from the outside world – home is a sanctuary and a place for privacy, as well as a respite from the pressures of the outside world.
8. Home as indicator of personal status – the building structure and the possessions inside illustrate social and economic status.
9. Home as material structure – meaning is derived from the type of building structure, its aesthetic characteristics, the layout of the home, and the neighborhood in which it is located
10. Home as place to own—ownership entails permanence, pride, and economic investment.

Dimensions of the meaning of home can be further categorized into those which relate to the *physical* experience (layout, furnishings, ambience), the *personal* experience (memories, attachments, privacy, sense of security); and *social dimensions* of experience (relationships with family, co-residents, neighbors, visitors) (Felix, de Haan, Vaandrager & Koelen, 2015). Allen (2015) summarized similarly:

The feeling of home emerges from the feelings we have at home. These feelings encourage a sense of control and stability at three levels. For our bodies, home is the place where we seek and expect to be able to recover from the labors and challenges of the outside world. For our brains, home is the place where we feel able to rest and relax, to experience downtime that is essential (in some yet-to-be-determined way) for optimal

brain function. Finally, for everyone, home begins, or should begin, in the powerful, empathy-driven social relationship between mother and child, as well as other significant relationships involving members of a shared household (p. 53).

Because older adults have often spent a great deal of time living within the same home, the cognitive and emotional aspects within these meaning categories may be magnified because of duration (Chaudhury & Wahl, 2005). These meaning classifications serve as a base from which to explore the questions of why some elders cling to continuing residence at home in contrast to others—with similar lengths of residence and vulnerabilities—who eagerly relocate to more supportive environments (Schoenberg & Rowles, 2002).

Meaning of home in later life. In the study of Environmental Gerontology, it is appropriate to inquire whether the meaning of *home* differs substantially in regard to the experience of elders and the context of life-span development. This question has been raised, but certainly not answered. Rowles (2006, p. 29) asked “Is the creation and meaning of home substantially different for an individual as he or she approaches the end of life and frames their experience within an increasing recognition of mortality?” The meaning attached to *home* can be significant in the decision to remain there versus relocating to a different residential environment, an important decision for many elders.

Oswald and Wahl (2005) documented a need for exploration of this question and noted that the *behavioral, emotional, and cognitive* bonding which occurs over time to strengthen the sense of *home* as an extension of self may have existed longer for those who are older and have perhaps had lengthier interactions with a home environment. There is an age-related tendency for “environmental centralization inside the house,” that is, older people simply spend more time at home compared to younger people. Furthermore, “The home

acquires new meaning in old age because it serves to compensate for the reduced functional capacity of the aging individual, especially in very old age” (Oswald & Wahl, 2005, p. 25).

Therefore, meaning of home research has the potential to impact emerging findings on the significance of home in later life (p. 40).

Psychological aspects of staying at home. Among those elders who have exhibited a preference for remaining at home in their later years, there exists a wide range of reasons for such an inclination, ranging from a strong attachment to home to a strong aversion for how alternative forms of housing are perceived. A wide range of reflections, emotions, and behaviors for and against a move have been documented among community-dwelling older people (Löfqvist, Granbom, Himmelsbach, Iwarsson, Oswald, & Haak, 2013). The urge to remain independent, to maintain control over one’s life, and to preserve social connections are seen both as reasons to remain at home as well as to relocate, depending on viewpoint and circumstances. Decisions to relocate to senior housing facilities involve both push factors such as failing health and fears of trauma, as well as pull factors such as the attractiveness of social aspects and security associated with group housing. Reasons not to move have been found to reflect a strong attachment to the home and neighborhood, a fear of losing continuity of habits and routines, fear of losing independence and freedom, and avoidance of the stress of relocation (Löfqvist et al, 2013).

Decisions to remain at home or to relocate to senior housing may depend on health and functional status. Healthier, higher functioning elders may relocate in pursuit of amenities and social activities, whereas those with more impairments may be motivated to move by the need for supportive services. Older, frailer adults are much more likely to relocate for reactive reasons, in response to a crisis or a stressful life event, rather than to plan for a residential

relocation in advance (Löfqvist et al, 2013). Fogel (1992) also noted that gender and socioeconomic status may affect the psychological aspects of decisions to stay at home or to move to any one of a number of senior housing options. Women may be more inclined than men to preserve neighborhood connections and a setting for preserving possessions and memorabilia. People of higher socio-economic status may have greater attachment to home aligned with a higher economic investment.

An older person's attitude towards the necessity of ongoing home maintenance—an annoyance for homeowners of any age—can seem overwhelming burdensome with increased age and decreased capabilities. Fogel (1992) noted that “For many elderly, however, the solution is neither to move nor to hire help, but simply to maintain the home less well or to restrict themselves to a smaller part of the home....” (p. 16). Thus the passive action of coping by ignoring becomes more manageable than the external action of maintaining. Living in and accepting a less tidy home or closing off un-used rooms requires far less exertion than maintaining a more rigid cleanliness standard, and involves extensively less emotional and physical effort than the substantial planning, anticipation and activity included in a residential move. And depression—the most common mental disorder of later life—diminishes both the capacity for effort *and* the potential pleasure to be derived from pride in a nicely maintained home (Fogel, 1992).

The family home. A typical life course is followed by many Americans: reach adulthood, get married, purchase a home, have children, raise them until they move away from that home (empty nest), retirement, followed by death, or widowhood and then death. The participants chosen for this study were identified because they had chosen to remain in the same home into old age, the home where they had raised their children and/or lived with a spouse throughout a

AGING ALONE IN THE FAMILY HOME

good portion of their marriage. The family home is the venue where a lifetime of activities unfolds. If decades are spent within the same home, a large range of endeavors transpire there. The home is first a place for the young couple to arrange and envision a new life for themselves. When children arrive, the focus of the home becomes that of a place to nurture, entertain, and psychologically develop youngsters. As children get older, they invite their friends into the family home for play dates and sleep-overs. Countless hours of homework, play, entertainment, grooming, eating and sleeping take place in the home as the child grows into maturity. The home is the base from which children depart for school and parents depart for work each day. The end of the day brings a reuniting of the family members to connect, eat, socialize, and rest in preparation for another day. After children complete their kindergarten through twelfth grade education, they make plans to depart the family home. Doing so is a mark of maturation, and is often cheerfully anticipated—the family home, where they have been nurtured for two decades—becomes something they are anxious to leave behind in anticipation for increased independence and autonomy. Not all young people follow this precise path, some may be unready psychologically or financially to leave the family home until a later age. Some who leave as young adults find themselves unable to meet the great economic demands of living independently and they return to the family home for additional familial support. Eventually, the couple may find themselves back where they started decades before—living as husband and wife alone. Inevitably, one spouse may pass on, leaving the other alone in the family home. An older person who outlives a spouse, may spend many years living alone in the family home. And, at an older age, they often become much more sedentary in their lifestyle. The composition of human drama which unfolds within the family home involves countless crescendos and diminuendos, from the fortissimo of large family activities to the pianissimo of the older person

living alone; the presto of life raising children, to the adagio of solitude and isolation.

Attachment. The phenomena of attachment is integral to this research exploration. The participants of this study have mindfully chosen to remain in their long-occupied home, in their familiar community, and among their accumulation of possessions. The emotional bonds felt by elders affect their decisions about the residential setting they choose to occupy, and in turn, may necessitate adaptive measures as capabilities decline over time. The narratives of the participants gathered in this study reflect first hand experiences with strong attachments which have persevered in spite of fairly dramatic shifts in family composition and in personal competence.

Place attachment. In the landmark book, *Place Attachment* (1992), Low and Altman offered an early definition of place attachment as the affective bond that connects people to places: “The word ‘attachment’ emphasizes affect; the word ‘place’ focuses on the environmental settings to which people are emotionally and culturally attached” (p. 5). This definition sets forth the basic elements of the construct: people, places, and an emotional bonding. Phenomenologist Seamon (2014) defined place attachment as “the emotional bonds between people and a particular place and environment.” Here the same three words appear: *people, place, and bond*. When a person feels a connectedness with a place, and regrets—or would regret—leaving a place, an emotional bond exists.

Relph (1976) presented early theoretical development of the construct of place as essentially intertwined with human experience. He wrote, “To be human is to live in a world that is filled with significant places: to be human is to have and to know *your* place” (Relph, 1976, p. 1). Cresswell, in 2004 in a book simply titled *Place*, expounded on the construct of place (Cresswell, 2004). He noted that, although we have adapted common jargon using the term place in a variety of ways—such as “She put me in my place” or “A place for everything,

and everything in its place”—the most meaningful and straightforward definition of the term is “a meaningful location” (p. 7). Presenting a broader perspective, Gustafson (2014) noted that “Theoretically, ‘place’ may signify a meaningful spatial unit regardless of size—from one’s favorite armchair to the whole earth” (p. 42; Tuan, 1977 p. 149).

Scannell and Gifford (2014) explored attachment theory by first describing attachment as a fundamental person-to-person experience, and then expounding, “as environmental psychologists and others have shown, most people also develop bonds with places” (p. 23). Knowledge of place attachment has been developed separately from that of the development of interpersonal attachment, due to the focus of different theorists (Scannell & Gifford, 2014). Attachment, then can be defined as deep bonds or connections—with particular people, groups, objects, and places—significantly meaningful as to be central to the human experience (Scannell & Gifford, 2014).

Theory of place attachment—connecting the constructs of place and attachment—is rather recent, having begun about forty years ago. The early theorists of place attachment include Tuan (1974) who proposed “topophilia” as a love of place, and Relph (1976) whose phenomenological approach “emphasized subjective place experience, deep emotional ties, and individually constructed place meaning” (Scannell & Gifford, 2014, p. 24). In 1992, Altman and Low propelled further theoretical discourse which marked the proliferation of theory and research in the social sciences. Since that time, theory and research relating to *place attachment* have been studied by a variety of other theorists (Lewicka, 2011).

Lewicka (2014) noted that *duration* in itself can be a predictor of place attachment – “attachment is diagnosed by declared intention to continue being in a place” (p. 49). Duration is a relative measure of time, but can be compared to norms to indicate excessive durations. If the

duration of time spent sipping coffee at a coffee shop or the length of time spent living in a home far exceeds the norm, or the measurement of duration includes dispersions of data beyond mean or median tendencies, one may conclude that place attachment exists—that there is a desire to remain in that place. However, other factors may certainly exist for lingering or persisting in a place. Economic factors may prevent a person from moving, even when one might desire to do so.

Because within the dimension of *duration* of time spent at a place, other confounding variables may exist, perhaps a truer dimension of place attachment would be a *desire to remain* in that place, regardless of whether continuation in that place exists or not. Scannell and Gifford (2014) noted that when potential separation is looming or actual separation occurs, the result can be *separation distress*—a psychological state of grief not unlike what occurs when interpersonal bonds are broken. In a study of persons who were displaced from their homes by Hurricane Katrina in 2005, emotions of anxiety, depression, and stress were present (Abraham, Stehling-Ariza, Garfield & Redlener, 2008; Scannell & Gifford, 2014).

A feeling of safety and security exists with places to which one feels aligned. Scannell and Gifford (2014) noted that “Places to which one is attached offer a *safe haven* where one can retreat from threats, problem-solve, and gain emotional relief” (p. 26). This dimension can be easily seen among children who—when they encounter stressors—often retreating to comforting places, be it their mother’s bosom or their own bedroom (Korpela, Kytta & Hartig, 2002). Research by Brown, Perkins and Brown (2003) indicated that individuals who are more attached to their homes and neighborhoods also perceive them as safer than those who are less attached to those places.

Williams and Vaske (2003) noted that place attachment is present when a certain

location provides features and conditions that *support desired goals and activities*, which are embodied in that location's physical characteristics. One's favorite golf course or the location where one typically visits with grandchildren may be places which—because they support activities which give meaning and purpose to life—foster strong emotional bonds.

Rubenstein and Parmalee (1992) stressed that *place attachment* “is not a state but a process that continues throughout life” (p. 143) and that “attachment to a particular place may also represent attachment to a particular time” (p. 142). The aforementioned various definitions suggest that a *desire to be in a place*—whether that desire is met for the long term, whether that desire varies depending on levels of stress or discomfort, or whether it relates to the events of a certain era—is an over-riding indicator of place attachment. Place attachment theory is relevant to the current study because it provides a base from which to understand an elder's desire to continue to live, or not continue to live, in a current residence, neighborhood, and town.

Attachment to home. The *meaning* that a home can hold for a person was discussed above (pages 25 to 30), but an examination of the nature of home environments in the context of attachment and life span is warranted as well. Home—particularly one occupied for an extended period of time, perhaps decades—is a space like no other. Home serves as a reference to the life behind us. Chaudhury and Rowles (2005) point to a deep level of remembrance of life experiences within the home as a reflective and evolving understanding of the self. An older person's consciousness of his or her life experiences within an enduring arena elevates home far beyond “that which is solely experientially based” (p. 16), moving the self towards full self-realization. Remembrance of a life lived within a home—the recollection of events, emotions, people and interactions—strengthens our sense of self such that the home and the realized self become inextricably interwoven. “People relate to ‘home’ because of its close relevance to their

own life experiences and everyday usage on a level far transcending merely a physical structure” (Chaudhury & Rowles, 2005, p. 10).

Oswald & Wahl (2005) called this same phenomenon *autobiographical insideness*—the sense of belonging to and having one’s life expressed within a place as a result of extended residence. *Autobiographical insideness* ensues from “the temporal legacy of having lived one’s life in [that] environment” (p. 29). Looking at the relationship of home and self within a life span context, they also noted that, because older people may have spent many years or decades in the same dwelling, this linkage of self with home can far transcend the connection a younger person may have with home. Because older people have resided in the same home for a long period, cognitive and emotional aspects of the meaning of home are often linked to biography (Oswald & Wahl, 2005).

Rowles (1984) identified like attributes of home attachment over the life course: “a sense of physical insideness, of being almost psychologically melded into the environment” which stems from the rhythm and routine of interacting within the space over many years; and the fact that close relationships as well as everyday exchanges have been played out in that place, making it the locale of “knowing others” (p. 146-147). Oswald and Wahl (2005) also noted that an integral connectedness with home can erode when the burden of maintenance exceeds one’s ability to manage, resulting in anxiety.

Attachment to possessions. The last century saw large increases in per capita disposable income, such that people had unprecedented purchasing power as had never before existed in history. Ours became a consumeristic society, with an enormous array of products available for our choosing at a wide variety of retail establishments within our neighborhoods. Interiors of U.S. homes often exhibit great accumulations of object, a result of the intense consumerism that

prevailed during the late twentieth century. Thousands of artifacts can be found in the American home, reflecting a lifetime of purchasing decisions (Arnold, Graesch, Ragazzini & Ochs, 2013). Each possession has its own complex story: where it was made, its acquisition, its placement in the home, its use, and its being observed, viewed, and tidied time and time again. People value a home brimming with personally chosen items. After a lifetime of accumulation, the density of things within household spaces can exceed what can be easily managed. Clutter can easily invade the living and storage areas of a home (Arnold et al. 2013). But this assemblage of things hold value for us, define who we are, and remind us of earlier times.

With advancing age and increasing length of residence within a specific home, many older people spend a great deal of time at home amidst this collection of accumulated possessions (Rowles, Oswald & Hunter, 2004). Csikszentmihalyi and Rochberg-Halton (1981) extensively reviewed the relationship that people have with the objects in their home. They noted:

...the home contains the most special objects: those that were selected by the person to attend to regularly or to have close at hand, that create permanence in the intimate life of the person, and therefore that are most involved in making up his or her identity....

Although one has little control over the things encountered outside the home, household objects are chosen and could be freely discarded if they produced too much conflict with the self. Thus household objects constitute an ecology of signs that reflects as well as *shapes* the pattern of the owner's self (p. 17).

Objects within the home—some which may have been acquired decades before, and may not have been moved since their original placement in the home—can provide a sense of continuity, comfort and security. Over the course of a lifetime, many items are collected,

cherished, and retained as a source of memories and connections to the past. Research confirms that the importance that a cherished possession holds for a person extends beyond its value as a memento. Such an item can include a link to personal identity and a means to conjuring memories of past events. (Sherman & Dacher, 2005). Elders can become preoccupied with concerns about how these treasured possessions will be distributed to family members or sold to strangers once they are gone, and whether new owners will have appropriate appreciation of their value as symbols of a meaningful life. Or they may give no thought to these objects' future and may simply enjoy them as markers of the past, or reflect upon memories that they may conjure.

Attachment to community. Place attachment for older people living at home extends beyond, but not far beyond, the confines of the homes' four walls. The yard within the property boundaries also likely holds memories of family times, children playing, family gatherings, etc. The neighborhood and a network of regularly and long used roads and places within the home's vicinity is another crucial dimension of place attachment (Després & Lord, 2005). The oldest-old today who are aging-in-place and who have remained in the same home for several decades, often since their child-rearing years, have likely been living in those homes since near the middle of the 20th century.

The community as well as the home is a place of familiarity. Over time, people become very familiar with the street network, the location of services, and retail establishments they have patronized countless times. It is not necessary to have to think too hard about where to go and how to get there. In addition to the physical setting of the community, a social network is established over time with merchants, clerks, clergy, service providers, as well as the neighbors who have not moved or died.

As vision and ambulation declines interfere with the ability to drive, there is a reduction

in the scale of the environment used outside the home and the frequency of venturing outside. Obstacles between home and the urban places beyond its threshold can be physical, climatic and psychological (Després & Lord, 2005). However, in the event that the form, content or functioning of community offers support to an elder's lifestyle, the environment can actually enable successful aging-in place (Hodge, 2008).

Older people living alone spend a large portion of their time indoors within their home. The colloquial term "shut in" is often used to describe one who never, or rarely leaves one's home, a condition that can be very psychologically isolating. The desire to continue to interact both physically and socially within the community may outlast their abilities to do so, and older people may have feelings of regret about not leaving the confines of home to shop or attend church as frequently as they had.

Adaptation. Due to reductions in functional capacity in older age, and in order to maintain autonomy and to avoid relocation to more supportive housing, either environmental changes or behavioral adaptations need to occur (Atchley, 1999; Oswald & Wahl, 2005). Atchley (1999) defined *adaptation* as "the process of adjusting to fit a situation or environment" (p. 76). Changes which require adaptations can occur within ourselves (such as with declining abilities), within our situations (such as widowhood or economic changes), or within our environments. Environmental changes can stem from many sources: climate, housing deterioration, relocation, and others. Discussion of the need to adapt relative to personal or environmental changes harkens back to Lawton and Nahemow's *competence press model*, which considers the fit between personal competence and environmental press.

Atchley (1999) noted that, fairly universally, people develop routine strategies for dealing with change in early adulthood. Well-adjusted adults adapt to a myriad of changes regularly and

without a great deal of effort, and sometimes with little awareness that this process is occurring. When more extreme conditions or difficulties surpass our capacity for routine change, we must utilize *coping* strategies to overcome the circumstances at hand. Thus, personal adaptation can be seen as two processes: either gradual, routine *adaptation* for conditions which can be dealt with utilizing a person's capacity to adjust, and—when more critical challenges occur—the mobilization of *coping* skills (p. 77). Many age related changes occur gradually, and can be dealt with through routine adaptation. Some changes may be dealt with routinely at first, but escalating changes of a similar nature may eventually require more extensive *coping* skills. With *coping*, a person must find ways to contend with, or overcome, the difficulty at hand. More sudden changes, such as the death of a spouse, an injury, or the onset of an illness, present the most serious coping challenges of all. Beyond mere adaptive behaviors, *coping* requires more active decision making, more conscious planning, and more support from others (Atchley, 1999).

Personal adaptive capacity. Atchley (1999) noted individual differences relative to the capacity for personal adaptation. By middle age, adults have a sense of what their own capacity for adaptation is, and what their adaptive strengths and weaknesses are, leading them to rely on those adaptive strategies which have worked for them in the past. Adaptive capacity was defined as “the extent to which an individual has the social resources and orientations needed to adapt to significant changes in physical and social circumstances.” Moreover, one's *adaptive capacity* can be strengthened by a continuity of resources such as “adequate income, good health, high physical functioning, and adequate social support” (Atchley, 1999, p. 78). When such external resources are low or declining, adaptation becomes more difficult and individuals must rely on their own capacity for coping. Capacity for coping is also related to one's own tendency towards adjustment. If a person has a strong sense of his or her own ability to be effective—*self-*

efficacy—one’s adaptive capacity is also enhanced. A strong personal adaptive capacity allows one to achieve continuation of life’s goals in later life more effectively than someone of the same age with lower adaptive capacity. A person’s adaptive capacity allows him or her to continue with long established patterns of thought and behavior, in spite of diminished capacities, as described in Atchley’s Continuation Theory (Atchley, 1999) described earlier.

Psychological versus proactive means of coping. Golant (2015b) noted two distinct means of coping among older people to address unfavorable experiences: *accommodative* and *assimilative* coping strategies. *Accommodative* coping is psychologically focused. People react to obstacles, constraints and discordant features in their residential settings by utilizing a variety of mind strategies which allow them to diminish the importance of the negative factor. By denying the significance of the adverse condition, any corresponding negative impulse to it diminishes. They rationalize that the problem within their environment is really not so bad or not so important after all. Golant (2015b) described, “Older people attempt to solve their residential problems by convincing themselves that they have been too critical of their surroundings and that, in any case, their housing problems should not be the focus of their lives” (p. 102-103).

Care providers and loved ones may regard such *accommodative* coping as irrational or dangerous. Minimizing the importance of an issue within the environment does not actually diminish its potential impact. De-emphasizing the importance of a poor heating system does not actually regulate body temperature. Overlooking clutter does not reduce the risk of falls (Golant, 2015b). But *accommodative* coping can be an effective means to reducing stress levels regarding diminishing functioning and performance.

Where *accommodative* coping is a passive means of denying negative factors, Golant’s

second identified pattern, *assimilative* coping relies on action on the part of the older person (Golant, 2015b). The person attempts to alleviate the problem by “eliminating, changing, or modifying their activities, lifestyles, capabilities, or residential or care surroundings to make them better align with their needs and goals” (p. 104). This could be the relocation of a needed item to a more centralized location, the change to how a goal is accomplished (microwaving versus the use of cooktop or oven), terminating or reducing in frequency routines which have become more difficult, or finding creative ways of accomplishing the same things using slightly modified actions.

Reduction of action range as a means of coping. Environmental gerontologists have documented a pervasive age-related tendency to centralize actions within one chosen location of the home over time. Older people, regardless of functioning level, have been found to choose a most favored location within the home—perhaps with the most comfortable piece of furniture, that affords a favorable view outdoors, and/or is central to communication devices such as telephone and television—and to spend a large amount of waking hours in that location (Oswald & Wahl, 2005; Rowles, 1981; Rubenstein & Parmalee, 1992). “Such places become ‘control centers’ or ‘living centers’ within the residence and probably serve adaptive functions such as maintaining and enhancing control over the immediate environment” (Oswald & Wahl, 2005, p. 25). A “control center” within a dwelling might typically consist of comfortable seating, a telephone, as emergency communication device, grooming items, a television remote, a cane or walker, and a notepad, all clustered in one spot of a room. Choosing to spend time in this spot, surrounded by these most used items, allows older people a feeling of control (Golant, 2015b). Many older people deliberately place furniture to allow for the best vantage point to monitor activities nearby.

Rowles (1981) called this the *surveillance zone* and noted that elders often spend a good amount of time watching what might be going on outside the windows of their home. Some monitoring has a practical purpose, such as noting the delivery of mail or the newspaper. Rowles noted that, in addition to providing engagement, the surveillance zone also can offer visual reciprocity—that is, in addition to watching, elders can benefit from being watched by their empathetic neighbors who monitor them to ensure ongoing well-being. As the activity level within the home declines over time, the surveillance zone takes on significance in an older person's life. Whether viewing the outdoor happenings from a window, or engaging in watching television or speaking on the phone, this locale of “command center” within the home represents the major area of direct contact with the outside world (Rowles, 1981).

Relative to a shrinking of the sphere of daily life, but within the context greater than just the older person's residence, Rantanen, Portegijs, Viljanen & Eronen (2012) defined the concept of *life-space mobility* as “the size of the spatial area...a person purposely moves through in daily life and...the frequency of travel within a specific time and need of assistance for that travel” (p. 4). In older age it is common that a person's *life-space* has diminished significantly from earlier years due to increase in mobility and travel. In considering macro to micro levels, extended travel is very often forfeited in older age as the navigation of airports, airplanes, and travel luggage becomes too cumbersome. Even when an older person still drives, often nighttime driving and driving outside a close circumference of home is abandoned for fear of accidents. When driving is forfeited, the necessity of depending on others for transportation often means lessening of travel for fear of seeming burdensome. Age-related diminishments can necessitate giving up hobbies and valued activities such as golf or bowling. All of these can result in reduction of social interactions, referred to as *participant restrictions* (Rantanen et al, 2012). As

with the *competence-press model*, when the demands of the environmental conditions exceed a person's capacity to manage them, either the environment or—in this case the interactions with that environment—need to be curtailed.

Adaptations initiated by others. As this study focuses on adaptations initiated independently by the elder aging-in-place, a distinction should be made between adaptive behaviors initiated by the elder themselves, and adaptive manipulations brought upon by others for the elder's benefit. A fear that the home environment contains many elements that can potentially be hazardous is common among older people and their loved ones. Consequently, the homes of elders living alone are often identified as being potentially dangerous, threatening, and in need of alteration (Sherman & Dacher, 2005). When the term 'home modification' is used in the literature it is usually focused on the physical needs of aging bodies, and specific approaches which most often require a construction professional to enter the home to perform the work.

Specific building projects which physically alter the dwelling—such as the addition of grab bars and railings, or lowering the heights of cabinets, or repairs—such as fixing a loose stair tread, or the elimination of risk items—such as loose scatter rugs are implemented to facilitate functioning and reduce the risk of injury. This approach views the home as a vessel of risk items, and home adaptation as the means to identify and eradicate them with personal safety as the end goal. Home modifications usually fall within five goal for improving home safety: minimizing trip hazards, maximizing slip resistance, minimizing overreaching, maximizing visual support, and maximizing physical support (Golant, 2015b). Some of these same approaches may be undertaken by the older person themselves, and if they are, they would fall into the category of the *personal adaptations* on which this study focuses.

CHAPTER THREE: RESEARCH METHODS

This qualitative study utilized a grounded theory methodology approach, guided by a constructionist worldview, an interpretivistic theoretical perspective, and utilized extensive open-ended interviewing, photography, and observation. Ten participants, all verbally and cognitively engaged, varying in age from 88 to 100 years were interviewed over the course of 15 months. Time spent with each participant ranged from four-and-a-half to ten hours. Data collection was done in each participants' home in four states: Iowa, Minnesota, New Jersey, and Rhode Island. Generalizability across the elder population of people aging in place is not possible from a study with such a small subject pool as was used here, but it is key to remember the strengths of qualitative research design. Rubenstein (2002) noted that "Qualitative researchers frequently use a single or few accounts to illustrate, as best examples, the experience of many" (p. 146).

Qualitative Research Study

Because the goal of this research was to examine the experiences of older people aging in place, a qualitative approach was utilized. Groat and Wang (2013) noted that "qualitative research seeks to understand settings and phenomenon in a holistic and full-bodied way" (p. 16). Speaking to the role of qualitative research in gerontological research, Schoenberg and Rowles (2002) noted that qualitative gerontology is concerned with "...describing patterns of behavior and processes of interaction, as well as revealing the meanings, values and intentionalities that pervade elderly people's experience" (p. 5). Silverman (2014) described simply that, "Qualitative research involves verbal descriptions of real-life situations" (p. 4).

Babbie (2014) suggested that qualitative field research is an extension of the general observational understanding we garner from everyday life as we navigate our way through a myriad of experiences. "In a sense, we do research whenever we observe or participate in social behavior and try to understand it, whether in a college classroom, in a doctor's waiting room, or

on an airplane” (p. 303). We observe, ask questions, and draw conclusions all very naturally in attempting to understand the dynamics at play in any life situation. Of course, in comparison, academic research is much more rigorous in its theoretical foundation, methods, documentation, reflection and analysis. For the qualitative researcher, there are skills to be honed and “special techniques that make scientific field research more useful than the casual observation we all engage in” (p. 303).

Qualitative research allows researchers to develop understanding directly from the people involved in the phenomenon under study in the setting in which the behavior takes place. “By going directly to the social phenomenon under study and observing it as completely as possible, researchers can develop a deeper and fuller understanding of it” (Babbie, 2014, p. 304). Groat and Wang (2013) emphasized that two important principles are at play in qualitative investigations: 1) that the investigator seeks to understand the dynamics of what is under investigation from the point of view of the participants, and 2) that at the same time such insider perspectives are balanced with the knowledge and background which the researcher brings to the observations he/she makes.

In approaching the current investigation, it is logical that to understand the phenomenon of aging-in-place at an older age, one should look to those who are living that experience and observe in the settings where those actions are occurring—in the homes of elders who are living alone into old age. As an investigator, I bring with me an insight into the context of residential environments through my background as an interior designer, and a theoretical foundation of gerontological investigation from my studies, through which I constructed an interpretation of what I was investigating. Because some of the primary goals of this research effort were to develop a better understanding of the experience of successful aging-in-place from the

perspective of the people who are doing it, and to understand the inter-relationships between the desire to remain at home until life's end, the natural progressive decline related to aging, and the adaptiveness that is intrinsically inherent in human functioning, a qualitative approach was most appropriate to allow for rich, person-centered and contextualized data about this topic. It is logical to look deeply into the authentic experience in the area of interest in order to begin to understand it. Leading grounded theorist Barney Glaser (1978) noted that, upon commencing a qualitative investigation, a primary question a researcher asks is simply, "What's happening here?" (Charmaz, 2011, p. 20).

Denzin and Lincoln (1998) noted that the richness of the qualitative approach lies somewhat in the ability to employ a multitude of tactics simultaneously for a full exploration of the issues under study, a characteristic which they called bricolage: "a pieced-together, close-knit set of practices that provide solutions to a problem in a concrete situation" (p. 3). Groat and Wang (2013) further explained, "The idea of bricolage implicitly suggests that qualitative researchers will employ a range of tactics that are both particular to the context being studied and of course appropriate to the research question(s) being asked" (p. 219-220). The current study utilized several qualitative approaches to inquiry in order to arrive at rich, person-centered and contextualized data about the topic under investigation: open-ended interviewing, observation, and photography.

Crotty's Model of Social Research

Virtually every research study is framed by a system of inquiry which involves basic assumptions about the nature of knowledge and the way that knowledge is attained (Groat & Wang, 2013). In describing the design of this research study, the four level model of social research as set forth by Crotty (1998) proves useful.

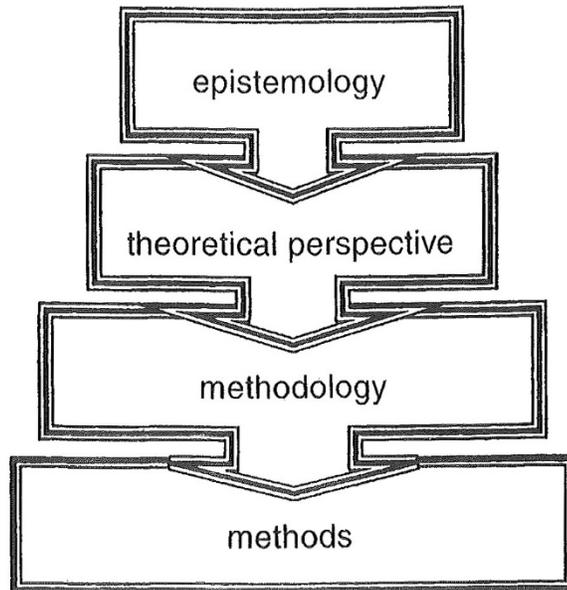


Figure #3. Crotty’s Model for Social Research. From Crotty, 1998, p. 24. *The Foundations of Social Research: Meaning and perspective in the research process*. Thousand Oaks, CA: Sage Publications.

Here Crotty proposed a tiered structure for the organization and understanding of the research process. At the highest level, the epistemology of the research endeavor is considered. This encompasses the expansive nature of knowledge, the *how* and *why* of the way our understanding of a phenomenon can exist and be explained. “Epistemology is concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate” (Maynard, 1994, p. 10). As this is an overarching viewpoint as to the nature of knowledge and of how knowledge exists, it is also often referred to as a ‘worldview.’

It is inevitable that any researcher brings to any research endeavor a life-time’s accumulation of attitudes, assumptions and beliefs acquired through education and experience. Silverman (2014) noted, “the facts we find in ‘the field’ never speak for themselves but are impregnated by our assumptions” (p. 39). We need to be clear about what this belief system is

by elaborating our theoretical perspective, as the design of our study and our choice of methodology are both embedded in this view point. The theoretical perspective guiding the design of a research study relates to a range of assumptions about the reality and existence of the research problem at hand. The particular perspective informing the study provides both a philosophical stance driving, and a logical context supporting the research process employed (Crotty, 1998).

A selection of research methodology is directly derived from our worldview and theoretical perspective. One can imagine a scaffold where each supports the subsequent element of the research perspective (in reverse order of Crotty's diagram): our epistemology supports a theoretical perspective, which in turn lies behind the chosen methodology. And the methodology, in succession, governs the choice and use of method (Crotty, 1998). It is "the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes" (Crotty, 1998, p. 3). The methodology directly impacts what specific methods a researcher will utilize for the investigation and has direct bearing on the nature of the data that will be collected.

Finally, the research methods chosen (driven by the chosen methodology) are the specific techniques and procedures utilized to gather and analyze or data. In designing and implementing a research study, one must be very precise in defining exactly how the investigation will proceed by detailing the envisioned data collection scenarios and activities and the data dissection processes by answering the question "What actions will occur during the data gathering and analysis phase?"

As described further in subsequent sections, this research study can be contextualized within a system of inquiry—utilizing Crotty's social research design model—as shown below.

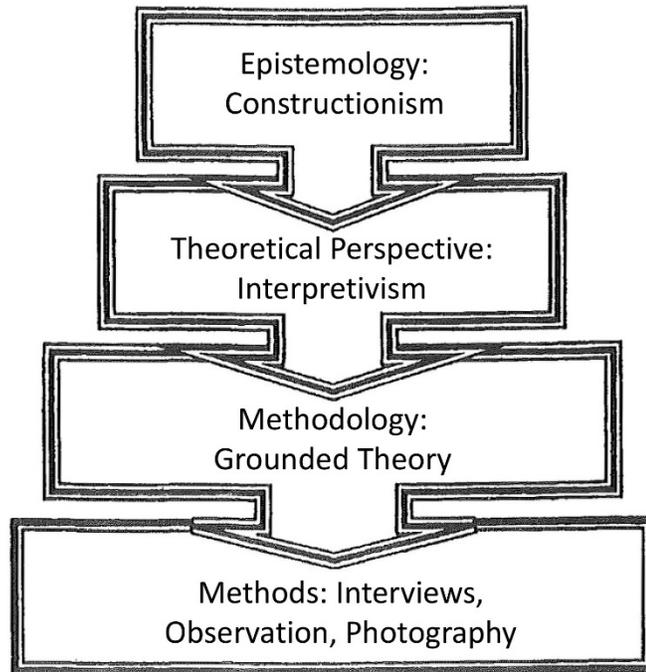


Figure #4. Crotty's Model for Social Research customized for this study.

Epistemology: Constructionism

This study proceeded from an epistemology of Constructionism, which maintains “that meanings are constructed by human beings as they engage with the world they are interpreting” (Crotty, 1998, p. 43). Constructionism suggests that humans are continually attempting to make sense of the world while they encounter it (Crotty, 1998), and are continually striving to construct a sense of self. Lawton (1989a) noted a pronounced emphasis on the construction of the self in later stages of the life-span, and noted that old age is “a time of continuing effort to manage who one is, what one does, and who one will be” (p. 15). In this way, people self-construct their perception and portrayal of self, as well as constructing their view of their function and fit within their lifeworld. People themselves *construct* their social worlds through their thoughts and actions. With a constructionist worldview, we study how phenomenon are produced, assembled and maintained in people's everyday activities (Silverman, 2013; Silverman, 2014).

Within this viewpoint, there is no one valid truth or meaning, but rather truth and meaning are *constructed* through human experience and interaction, and human practices (Crotty, 1998). Constructionism as a way of knowing about the world can be contrasted with Objectivism, where the goal is not only to report, but also to understand and explain, as knowledge is seen as unambiguous, independent of the perspectives of participants or researchers, and clearly definable (Crotty, 1998, Silverman, 2014). Objectivism disregards individualistic experiences and maintains that phenomenon exist and can be defined in their own right, that is, objectively.

Within Constructionism, there is also an emphasis on the construction of meaning on the part of the researcher. Meaning of the phenomena under investigation is not discovered, it is rather constructed by the researcher who interprets what has been observed and noted within his or her interactions with the participants (Charmaz, 2006; Crotty, 1998). A constructionist approach views both the data produced by the participant, and the analysis created by the researcher as stemming from the shared experience of the research investigation (Charmaz, 2006). This participant/researcher interaction allows for the creation of meaning. The participant brings to the table his/her creation of the lifeworld; the researcher brings an accumulation of assumptions and experiences, and the sum of the parts is the construction of meaning which the research effort fulfills. This interpretation of experience within Constructionism leads to the corresponding theoretical perspective.

Theoretical Perspective: Interpretivism and Symbolic Interactionism

The theoretical perspective of Interpretivism is well aligned with Constructionism and is concerned with the point-of-view of the individuals experiencing the phenomenon, and how meaning is constructed through the interpretation of those experiences (Crotty, 1998). The

researcher in this theoretical perspective interacts within the phenomenon taking place and interprets and explains what he experiences. Rather than the detachment and controlled quest for understanding of universal features of the world within Positivism (which along with Objectivism denies any value of speculation in a quest for the irrefutable truth), Interpretivism allows the researcher to also be interpreter by analyzing the world in which he interacts (Crotty, 1998, Groat & Wang, 2013).

In analyzing specific adaptations—related to use of space and interaction with elements of the home—that research participants have utilized to facilitate further effective functioning within their home environment, it is well understood that those solutions are highly individualized and nuanced. However, it is hoped that some collective understanding can be derived from these individualized experiences. Crotty noted that “What constructionism drives home unambiguously is that there is *no* true or valid interpretation. There are useful interpretations” (p. 47). Within this study, it is clearly recognized that my interpretations of the events witnessed within participants’ homes were my interpretations and that those interpretations were molded by all of my life experiences.

Further dissection of the philosophical stance underlying this research study approach suggest that, within the umbrella of an Interpretivist theoretical perspective, a perspective of Symbolic Interactionism applies particularly in regards to personal possessions. Symbolic interactionism according to Crotty (1998, p. 72) has three basic tenets originally proposed by Blumer (1969, p. 2):

- that humans act towards things based on their personal meanings of those things
- that those meanings are derived from social interactions
- that those meanings are continually re-interpreted through ongoing encounters.

Charmaz (2006) noted that “Symbolic Interactionism assumes that people can and do think about their actions rather than respond mechanically to stimuli” (p. 7). The relationship that elders hold with their home as well as the meanings for possessions, artifacts and memories plays an integral part in the ways in which they interact within the home setting. Crotty stressed that, for a researcher striving to understand this study’s participants’ experiences, one must endeavor to consider the situations from the point of view of the actor (i.e. participant) and understand the meanings of objects and acts in terms of what the actor understands (p. 75). This “emphasis on putting oneself in the place of the other and seeing things from the perspective of others” (Crotty, 1998, p. 76) means that a symbolic interactionist stance calls for empathetic and compassionate resolve on the part of the researcher.

Grounded Theory Methodology

A grounded theory methodology was selected for the current study to allow for the understanding of the phenomenon being studied directly from the data which was to be collected. Grounded theory methodology aims to develop emergent theoretical insights directly from research interaction which is fluid, interactive and open-ended. The researcher is highly engaged in the process and continually reflects on emerging themes and analysis, which in turn can serve to re-shape additional data collection efforts—thus a grounded theory study is a very iterative and interpretive process (Charmaz, 2006).

Although substantial conceptual stances have been described herein as background (see pages 10 to 17), those were explored as a foundational framework through which to approach the data, not as specific categories in which to classify the data. In grounded theory, the goal is to arrive at theoretical understanding through the analysis of data itself, with previous understanding forming a base from which to launch the exploration. A leader in the practice of

grounded theory, Kathy Charmaz, provided this clarifying description of this methodology (Wertz et al, 2011):

Grounded theory enables researchers to unravel the complexities of doing qualitative analysis and to understand mysteries and moments in human life.... Grounded theory is a systematic yet flexible method that emphasizes data analysis, involves simultaneous data collection and analysis, uses comparative methods, and provides tools for constructing theories (p. 165).

Charmaz also stressed the importance of researchers being as open as possible to what is specifically happening during data collection, although they also certainly bring their own viewpoints and experiential influences to interpretations. The researcher's standpoints and starting points influence how the researcher sees the project data and what is seen in that data (Wertz et al, 2011). This approach is well aligned with the previously described epistemology of Constructionism and the theoretical perspectives of Interpretivism and Symbolic Interactionism which collectively acknowledge the construction of meaning through the experiences of both the researcher and the person(s) being researched. Charmaz (2006) succinctly noted, "A constructivist approach places priority on the phenomena of study and sees both data and analysis as created from shared experiences and relationships with participants" (p. 130).

Data Collection

Data collection for this research effort transpired over a span of 15 months, from October 2014 to January 2016. Ten people ranging in age from 88 to 100 were interviewed.

Purposive and convenience sampling. This study utilized purposive sampling, which identifies particular individuals whose experiences may be particularly well-suited for, useful to,

representative of, and central to the research question (Babbie, 2011; Sommer & Sommer, 2002). In order to engage with individuals who were most likely to have some challenges to living within their home—and therefore may have engaged in a variety of adaptations in their daily lives—a minimum age of 85 was initially identified. After the pilot study, where one woman aged 88 was interviewed and found to be quite high functioning, the minimum age for study participants for the remainder of the study was raised to 90. This is not to say that a linear relationship between age and frailty exists, because certainly there are wide variations in abilities at any age, but it was felt that a higher minimum qualifying age may lead to participants in greater need of adaptive behavior in order to succeed with aging-in-place. After the pilot study the remainder of the participants ranged from 91 to 100 years. The mean of the entire participant pool was 94.5 years; the median was 94 years.

Recruitment. Several sources were employed for locating participants. As I live and work in two different states, Minnesota and Iowa, I was able to recruit participants from both areas, and later from two other states. Overall, six participants were located utilizing convenience sampling—that is, asking colleagues and relatives if they knew of potential participants meeting the parameters set forth—over the age of 90, currently widowed and living alone in the home where they had previously resided with a spouse and/or children. Of the six recruited via convenience, four were contacts known by relatives and two were contacts known by colleagues. Two of these six participants each identified another individual who ultimately become a participant, thus two of the ten participants were identified via snowball sampling (existing subjects identifying future subjects). In Iowa, I also pursued two care-giving businesses as sources for participant recruitment: The *Northeast Iowa Agency on Aging*, a non-profit, and *Home Instead Senior Care*, a franchise business. One participant each was recruited

through interactions with these companies. As my recruiting efforts approached a close, I had recruited eight of the ten participants described above from Minnesota and Iowa. As I was still short of the target of 10 participants, I cast my net a bit further, and included some travel into my data gathering efforts. A cousin of mine residing in New Jersey had a mother-in-law who was well qualified for my study, and another cousin, a physician in Rhode Island, connected me with an elderly patient. Thus, six participants were recruited across four states via convenience, two via snowballing, and two from contacts with local businesses in Iowa.

When a potential participant was identified, I asked the colleagues or contact to initially let the potential subject know about me and my study and ask permission to share their phone number with me. Then I followed-up with a phone call to briefly explain the purpose of the study and ask for an initial face-to-face meeting in their home. See the attached Appendix C - Recruitment Script.

Gender and quantity of participants. It was anticipated that because of gender differences in life expectancy, that most of the subjects would be women. In fact, seven out of 10 participants were women, three were men. Committee members overseeing this study suggested a minimum of ten subjects as an appropriate sample size, and exactly ten were ultimately involved.

Study location. The ‘family home’ was the location for this study. That entailed that all participants had previously lived in their current home with a spouse and many also with a dependent child or children. They had become empty-nesters and widows at some time prior to their selection as a study participant, leaving them living alone within the family home. Although a length of time within the residence was not dictated as a measure for qualification for the study, it was anticipated that they would have lived a significant time within the home in

AGING ALONE IN THE FAMILY HOME

order to qualify for the parameters above. In fact, the length of residency in the home at the time of interviews ranged from 43 to 68 years (mean 54.1 years, median 53.5 years)—certainly an enormity of time. The length of time living in that home alone was from 18 months to 32 years (mean and median both 15 years).

The age at which the participants in this study had moved to their current home ranged from 29 to 49 years. Some moved into the home during their child-rearing years, some moved during their 40's. Most had been residing in those homes since near the middle of the 20th century. Only one participant (#2 Leo) had lived in the home under study for *less* than half his life: he had resided there 43 of his 91 years. The other nine participants had all resided in their family home for over half their lives. Two participants (#9 Tilda, and #10 Helen) had resided in their home for over two-thirds of their lives.

Two of the participants' homes had been built after the turn of the 20th century and were over 100-year-old structures. The other eight homes had been built in the post-World War II building boom in the years from 1951 to 1971. Aligning with the 20th century patterns of community design, many of the homes of today's elders aging in place are in low density, automobile dependent post-war suburban areas (Després & Lord, 2005). This was true of the subject pool for this study. Participants lived in a range of community sizes: one participant lived in a very high density New Jersey suburb of New York city, three participants lived in suburban areas of metro locations with populations over 200,000 (Providence, RI and Minneapolis, MN), four lived in mid-sized Iowa cities with populations ranging from 40,000 to 70,000, and two participants lived in small Iowa towns with populations under 3000. Five participants still had a driver's license, but they maintained a very small area of transit in a tight circumference around their home.

Participant description summary. The chart below summarizes the attributes of all study participants.

Table #1. Summary of details of study participants.

| Participant Pseudonym | Age at the time interviews concluded* | Date home was built | Year Moved to Home | Number of years in home | Area of Residence | Home Layout | Square footage not including basement*** | Length of time widowed | Length of time living alone | Date of Death |
|------------------------------------|---------------------------------------|---------------------|--------------------|--------------------------|---|---|--|--------------------------------------|--------------------------------------|----------------------|
| Delores | 88 | 1971 | 1971 | 44 | mid-sized Iowa city with population from 40k to 70k | Single-level ranch finished basement | 1948 sf | 18 months | 18 months | |
| Leo | 91 | 1960 | 1972 | 43 | small Iowa town with population under 3000 | Single-level ranch un-finished basement | 1032 sf | 17 years | 17 years | |
| Loretta | 100 | 1960 | 1960 | 55 | suburban area of Minneapolis, MN | Three-story split level | 1296 sf | 32 years | 32 years | |
| Audrey | 99 | 1953 | 1962 | 53 | suburban area of Minneapolis, MN | Single-level ranch finished basement | 904 sf | 14 years | 14 years | |
| Gertrude | 98 | 1951 | 1951 | 64 | mid-sized Iowa city with population from 40k to 70k | Single-level ranch un-finished basement | 1012 sf | 28 years | 28 years | 3/08/2016 at age 98 |
| Ted | 91 | 1961 | 1961 | 54 | mid-sized Iowa city with population from 40k to 70k | Single-level ranch finished basement | 1176 sf | 15 years | 15 years | 12/17/2015 at age 91 |
| Margaret | 95 | 1966 | 1967 | 48 | mid-sized Iowa city with population from 40k to 70k | Single-level ranch un-finished basement | 1104 sf | 7 years | 7 years | |
| Peter | 93 | 1900 | 1966 | 49 | small Iowa town with population under 3000 | Two-story un-finished basement | 2174 sf | 2.5 years | 2.5 years | |
| Tilda | 98 | 1910 | 1947 | 68 | high density New Jersey suburb of New York city | Upper story of two-level duplex | info not available | 15 years | 15 years | |
| Helen | 92 | 1952 | 1952 | 63 | suburban area of Providence, RI | Single-level ranch finished basement | 1064 sf | 25 years | 18 years** | |
| Mean age = 94.5 Median age = 94 | | | | Mean 54.1 Median 53.5 | | | | Mean = 15 years Median = 15 years | Mean = 15 years Median = 15 years | |

*If participant had a birthday during the duration of the interview process, the older age is reported here and throughout the dissertation.

**Participant's mother and father-in-law resided with her for seven years after her husband's death.

*** Square footage information was found on either county websites or on Zillow.com.

Open-ended, semi-structured interviewing method. “Qualitative interviewing is one of the very best ways of coming to understand meaning through examining experience” (Rubenstein, 2002, p. 138). The process of interviewing can elicit meaningful data through the narrative and conversational presentation of the participant’s experiences (Rubenstein, 2002). The interview protocol for this study was established to include four to six interviews with each participant. I wanted to ensure sufficient time for key dimensions of the lives to surface. Rubenstein (2002) recognized that “There is often a direct relationship between the length of interview series and the depth of interview data” (p. 140). After gaining experience in my interview process during the first several sessions, my initial projection for time proved to be overestimated, and three to four interviews seemed to be the appropriate quantity of sessions to gather the desired data.

Preliminary questions were developed and sorted into specific topic groupings (see Appendix E - List of Initial Interview Questions). Rubenstein (2002, p. 138) defined such an interview series as “the multiple verbal interactions that constitute a complex research interaction over time.” Although a primary set of questions was developed, these were considered initial questions meant to prompt further inquiry additional questions as the interview progressed—what Rubenstein labeled “reflexive interviewing.” He noted:

In such reflexive interaction, a technique at the heart of qualitative interviewing, the investigator is free to follow each line or topic wherever it goes, to get at the core of the experience. Following a line of responses and making up new questions allows the researcher to sketch out the meaning context of the topic at hand and to be sensitive to key statements of experience (p. 143).

Schoenberg (2002) supported such a semi-structured and open-ended interviewing approach in noting that “A specific and well-crafted set of questions and a conversational exchange have the capacity to elicit the participant’s sense of meaning” (p. 133).

When I arrived for the initial face-to-face meeting at each participant’s home, I first tried to establish rapport and ease by engaging in some small talk, such as the weather or connections with mutual acquaintances. Depending on their preference, we would then be seated at either the kitchen table or on upholstered furniture in the living room (in seven cases the former, in three cases the latter). The location initially chosen always remained the same throughout the remainder of the interview sessions. I then reiterated the purpose of the study, went through the “Informed Consent Form” (Appendix D), and obtained their signature. For four of ten participants, I had to read the entire document aloud, as their eyesight did not allow them to read for themselves, even though I had typed the form using a large font.

Although I had a prepared list of interview questions (see Appendix E – “Interview Questions”), my interviewing was quite open-ended and free-flowing. Throughout the sessions, participants divulged many stories about their lives. I allowed these to fully unfold as I felt they were a critical piece of the picture of their lives. When appropriate, I would steer the conversation back to the topic at hand. The tendency of the participants to divulge life stories led directly to variations in the total amount of time spent interviewing. The least amount of time spent with a participant was about four and-a-half hours, the most about ten hours, with 5.1 hours being the mean. As I progressed through sessions with the ten participants, I became more rehearsed in the main topics to be covered, such that I eventually structured interviews and the questions from the six categories (in the list of questions in Appendix E) around three main topics: 1) their personal history, the history of the home and their feelings about remaining there; 2) a tour of the home and discussion about use of features; 3) and their daily routines and activities built around their needs. A main focus of all inquiries was adaptations—either behavioral or changes to features within the home—that participants had made as a result of diminishment of capabilities.

In some cases, where conversation was fairly succinct and focused around the main topics, I found that I could adequately cover one of the three main topics per visit. Although additional visits may have produced additional worthwhile data, in some cases there were particular constraints on my time related to being in the vicinity of the participant’s home. In one instance, a participant was not willing to meet with me more than three times. The quantity of meetings with each participant varied between three and seven sessions, with four sessions being the mean and the median. In the case of four of the ten participants, I had conversations (in person or by phone) with family members of the participants after the conclusion of the

interview sessions, which were in addition to the sessions with the participant as reported above. In three of these four cases these follow-up interviews with a loved one (in two cases a daughter, in one case a grand-daughter) were because the participant's health had declined following my time spent with them. In two of the four cases, the later conversation with an adult daughter informed me of the participant's death. Some of these subsequent conversations were recorded, some were not.

The walk-along interview method. Because typical interview sessions took place within the most convenient conversational seating area—around the kitchen table or on upholstered furniture in the living room—an additional approach was also needed to gather data about use of features and spaces throughout the home. It was critical to see and understand the participants' daily flow through the home, the areas they use most often or for personal activities, and artifacts of their long-lived experiences within this home. Some authors have written about the “go-along interview” (Carpiano, 2009) or the “walking interview” (Evans & Jones, 2011) as a method capturing data related to people's interactions with specific locations. Carpiano (2009) proposed the “go-along” interview as a method—to be used alone or in conjunction with other methods—for improving understanding of people's experiences within specific contexts. In studying the differences between interview data collected in either a sedentary interview or a walking interview, Evans & Jones (2011) concluded that walking interview content was profoundly informed by environmental surroundings and generated richer data concerning place because subjects were prompted by meanings and connections to elements in the surroundings.

At either the second or third interview, I would ask the participant to show me around their home. This typically consumed the entirety of one session—approximately 60 to 90 minutes. This walk-along interview did prove to be a significant source of data as participants

divulged their interactions with features in the home over time, changes and adaptations in patterns of usage, collectables and mementos, and unused and disregarded areas and elements.

Audio recording and later transcription. All interviews were audio recorded using a hand-held digital recorder and later fully transcribed for analysis. Charmaz (2006) noted that the use of a recording device during interviews—rather than extensive note-taking—plays the very important role of allowing the researcher to maintain full attention to the participant and to maintain steady eye contact (Charmaz, 2006). Strong engagement between researcher and participant is important for continued strong rapport and candid response to inquiry. While seated with the participants, the recorder required no manipulations, but when we walked through the home extensively discussing the use of features, it sometimes become difficult to manage the recorder while also taking photographs. This resulted in many starts-and-stops of the recording device, but no critical content was missed being recorded. A transcription service (www.rev.com) was used to create full, typed transcriptions of all recordings. Fifty-one hours of recorded data was fully transcribed, in addition to about one-an-a-half hours of conversations with loved ones which transpired after the interview sessions with that participant had been completed.

Photography of notable home features. In discussing the use of photography in gerontological research, Shenk and Schmid (2002) noted several useful purposes: in data collection photos can serve as visual field notes and memory aids for the researcher, they can provide an artifact for capturing details which can be later studied and analyzed, they can be used for the purpose of reporting on phenomenon, they can add richness to data beyond mere written descriptions, and they can provide a reader with realistic data about the research findings.

During the walk-along interview, I would take photographs of many features in every room, both to note where specific features in the home indicated explicit adaptive behavior or physical modifications, and as a means of remembering the condition of each space. A total of 963 photos were taken during the course of this study of the interior and exteriors of participants' homes, which proved very valuable in both coding and reporting.

Observation and note taking. During interviews, I would jot notes about participant behaviors or reactions, home features and conditions, or of points which required further clarification with participant. Following each interview, after leaving the participant's home, I wrote reflective notes regarding general observations and particular recollections regarding the exchange. These notes proved helpful both in preparing for the subsequent interview, and as an additional source of data. Following the walk-along interview session with each participant, I also made sketches of the general floor plan of each participant's home as a reminder of layout and space usage.

Ziesel (2006) stressed the need to observe immediate happenings, but also to perceive "physical traces" which indicate previous activity, manipulations to the environment made before the interview, or general clutter from day-to-day activities as critical to the understanding of home life. "From such traces designers and environment-behavior researchers begin to infer how an environment got to be the way it is...how people actually use it, how they feel about their surroundings, and generally how that particular environment meets the needs of its users" (p. 159). Observation of the condition of the home was a critical part of data collection.

Pilot study. The interview sessions with the first participant (pseudonym Delores) comprised the pilot project for this study. This initial endeavor which began in October of 2014 allowed me to acquire ease with the process of going to participants' homes, to rehearse

interview questions, and to practice operating the digital audio recorder. Delores proved to be a very gracious and engaged participant, which assuaged any trepidation I had in launching the process. At 88, Delores was quite high functioning, which led to a change to the study protocol—an increase in the minimum qualifying age to 90, in hopes that future participants would exhibit a greater propensity for adaptive changes within their home environment.

Data Analysis

Converting over 51 hours and nearly 1500 pages of interview transcriptions, almost a thousand photographs, and dozens of pages of written memos into a report of findings was a considerable task. Groat & Wang (2013) noted that “For research to be research, it necessarily involves reducing lived experience or observed phenomena to chunks of information that are noted and categorized in some way” (p. 8). The following is a description of the process used in data analysis.

Participant narratives. The initial task in converting data into written findings was to summarize the particulars about each person’s situation separately, as an accounting of that individual’s experience. The story of each of the ten individuals (pages 78 to 159 herein) was written to synopsize the critical history within each narrative. It was felt that if all descriptive aspects of each person’s experiences were expounded upon within the discussion of themes, the necessary corresponding accounts would become too verbose within that discussion to arrive at a succinct summary of thematic content. Therefore, the first portion of CHAPTER FOUR: FINDINGS includes a written account of each of the ten participants’ story as well as noteworthy photographs that were taken of each home. The subsequent coding of data was performed solely on the typed interview transcriptions, not on the content written within these

narratives. This means of communicating the study's content was deemed most appropriate to best and most clearly articulate all data and findings.

Analytic memo writing. Preliminary jottings about emerging themes (memos) were made throughout the research process, not just during the coding process. While writing post-interview notes or while pondering the content in the data, I would make spontaneous notes of emerging tentative themes. Many of these initial thoughts held true as valid for analysis while additional data was being gathered, many evolved into more complex notions over time, and many were just discarded as more highly-developed insights surfaced. This is consistent with the accounting from Charmaz (2011): "In grounded theory practice, we write memos throughout the research process and make them more analytic and precise as we learn about our topic and focus our research" (p. 166). The act of writing the memos proved to facilitate the formulation of personal insights into the topic, and was likely instrumental in the improvement of my interviewing skills over the course of this study.

Later, after about two-thirds of the interview sessions were finished, I began to make notes about content which had been emerging repeatedly across participant interviews. Based purely on my remembrances of the interviews and not while looking at any transcriptions or photographs, I would write words and themes that came to mind, and experiment with sorting them into categories of meaning. I continued to add to these memos throughout the remainder of the interviews. While the first level of analytic memos was based on specific interview content, these later memos occurred as I began to develop insights into the patterns which were emerging across interviews.

Coding. A helpful definition of a "code" was offered by Saldaña (2013): "A code in quantitative inquiry is most often a word or short phrase that symbolically assigns a summative,

salient, essence-capturing, and/or evocative attribute for a portions of language-based or visual data” (p. 3). Initial coding categorizes segments of data, then subsequent re-coding enables the development of more specific categories, the analysis of connections, and the sorting of codes according to meaning content (Saldaña, 2013). Such organizational coding serves to link raw data to theoretical insights and contextual explanations in order to uncover emergent patterns of meaning. A succinct description of the coding process suggests the following steps: 1) identify initial categories based on readings of the transcripts, 2) write codes alongside the transcript text, 3) review the accumulated list of codes to arrive at categories, 4) look for themes and findings in each category (Brinkman & Kvale, 2015; Harding, 2013). This straight-forward summarization closely aligns with the process used for this study.

A manual process of coding was selected as this was my first major undertaking in research analysis. Saldaña (2015) recommended such an approach for novice researchers (p. 26):

Trying to learn the basics of coding and qualitative data analysis simultaneously with the sometimes complex instructions and multiple functions of CAQDAS programs can be overwhelming for some, if not most. Your mental energies may be more focused on the software than the data.

Once all interviews and transcriptions were completed, I began the manual process of coding the 1497 pages of transcriptions (in .doc format), my written memos, and the 963 digital photographs. I coded on hard-copy print-outs of the transcriptions, using sticky notes pasted to and overlapping the edge of the page. Along with the *text find* function in Microsoft Word, this method proved useful later during the reporting of findings when I needed to go back and locate the transcribed text corresponding to a specific code. The vast majority of codes were

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descriptive, that is, a word or brief phrase summarizing the content of the excerpt. Saldana (2013) provided a definition: “Descriptive Coding summarizes in a word or short phrase—most often as a noun—the basic topic of a passage of qualitative data” and also noted “Descriptive coding is appropriate for virtually all qualitative studies, but particularly for beginning qualitative researchers learning how to code data” (p.88). A few examples are given below:

| | <u>DESCRIPTIVE CODE:</u> |
|---|-----------------------------------|
| Participant: The hardest part about living alone is the lonesomeness | LONELINESS |
| Participant: Oh at times I go over different things in my mind. You have to think, especially before you go to bed. I like to think good thoughts and that'll put you to sleep better – faster than the TV. I think about all of the family times, holidays and things. | REMEMBRANCES |
| Participant: I pass through here to go in and out or whatever. The kitchen is the main livable space for me. The dining room or the living room, I have nothing to do in there. The only time I go in is to pick up the mail that the girl brings in when she comes. | ROOMS NOT USED |
| Participant: I have just this constant pain of arthritis that gets me down but it doesn't put me out. I push. I find that the more I move, the better it is. | MANAGING PAIN |
| Participant: Jerry says, “Come live with me.” I don't want to live with them. What would I do in their house? They're gone all day. I'll be with the dog. I hate dogs. | NOT WANTING TO LIVE WITH CHILDREN |
| Participant: I worry. I worry about everything. I worry about people, not people I know even. | ANXIETY |
| Participant: To try to vacuum and run a walker with the other hand don't work too good. | DIFFICULTY WITH HOUSEWORK |

After all of the transcription pages, written memos and the collection of digital photographs were thus coded, each code from each sticky note was typed, double-spaced, into a WORD document. This multi-page document was printed, and cut into small strips of paper, each code on a separate strip. The process of sorting involved selecting one code, then finding all strips of paper with similar thematic codes and putting them into a pile. Later, codes and categories which did not directly relate to the interview questions were eliminated. In the end,

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27 piles (categories) of codes were established. Then, identical code strips were eliminated within each pile: if there were two or more code strips saying *cleaning*, or one strip with the code *cleaning* and another strip with the code *housekeeping*, all but one was eliminated.

A category heading was given to each of the 27 piles, and all of the code strips' text were typed into an additional WORD document in paragraph form. For instance, twelve code strips with the following code text were sorted into a pile given the category heading STEPS:

STAIRS – 12 codes

Pain with climbing stairs, slowness with climbing stairs, has to climb/descend stairs for either bathroom, going up and down steps, going downstairs facing backwards is easier, getting to the basement, being told by children not to go to the basement, saying prayers while climbing stairs, hasn't gone downstairs/upstairs for years, moved bedroom to main level, maintains bedroom on lower level, rug at bottom of stairs to visually mark last step

Next, the category headings were grouped into themes. Thus the category themes: *physical mobility, falling and balance, vision and hearing, and pain, illness and medications* were put into the theme: "PHYSICAL FUNCTIONING." Eight themes were established.

In total, 319 codes were identified (although certainly not without some redundancy), which were sorted into 27 categories which were then arranged into eight themes. As analysis progressed into the theory building phase of this project, the eight themes were further consolidated into three assertions. These codes, categories, themes and assertions are further described starting on page 160 herein.

This process was guided by Saldaña's (2015) code-to-theory model for qualitative inquiry. Shown below is this model with the addition of corresponding counts from this study. He noted that "qualitative codes are essence-capturing elements of the research story that, when clustered together according to similarity and regularity (a pattern), they actively facilitate the development of categories and thus analysis of their connections" (p. 8).

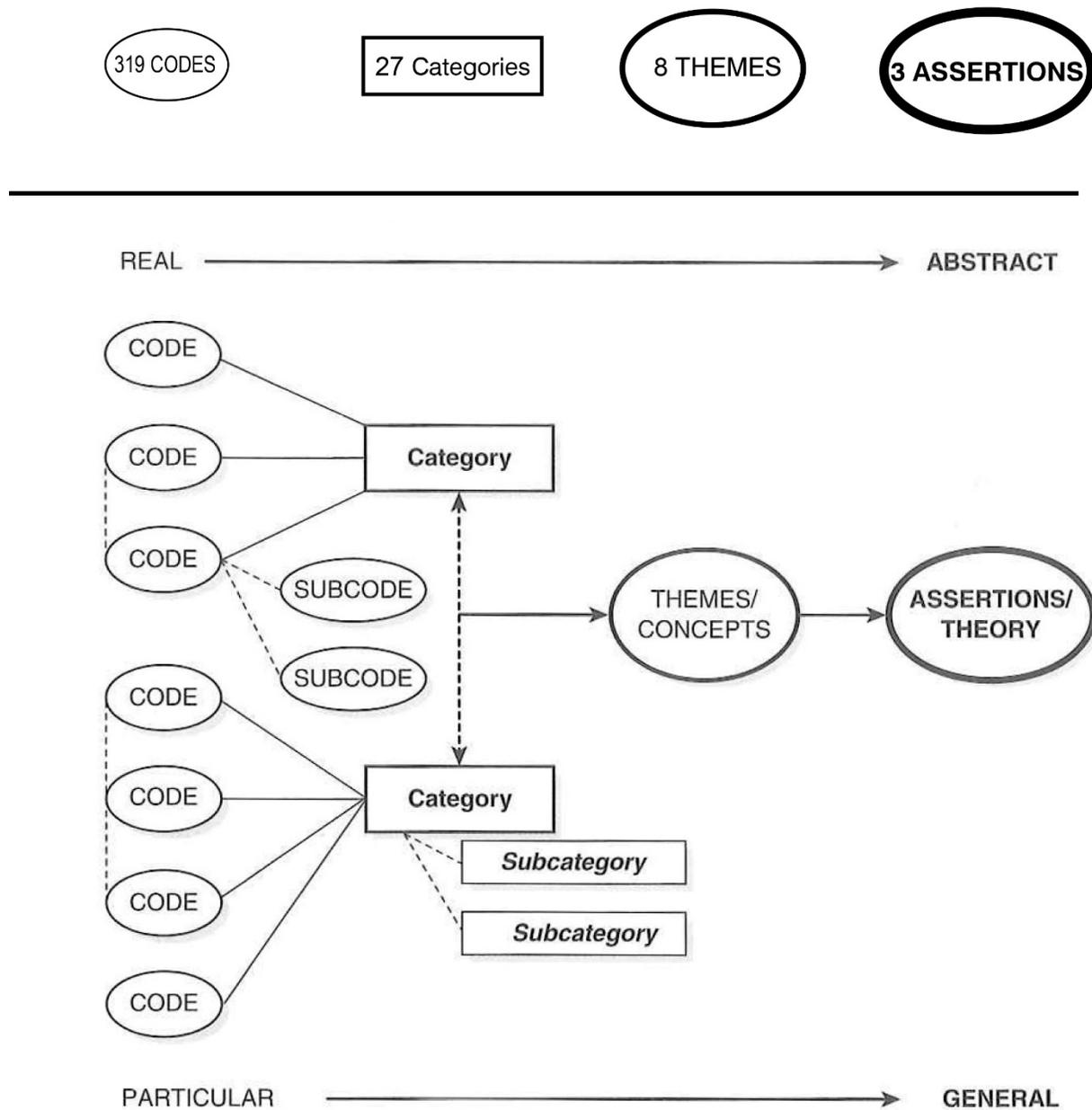


Figure #5. Saldaña's Codes-to-Theory Model for Qualitative Inquiry shown with counts for the present study above. From Saldaña, 2013, p. 13. *The coding manual for qualitative researchers, 2nd ed.* Thousand Oaks, CA: Sage Publications.

The counts shown above with Saldaña's model (319 codes, 27 categories, 8 themes, and 3 assertions) although they certainly encompass redundancies, comprise considerably large quantities within these groupings, but these quantities were confirmed as relatively standard by a coding specialist. Saldaña (2015) noted recommendations of 150 to 300 initial codes which are

organized into 15 to 40 categories, which then net five to seven themes. The content of these codes, categories, themes, and assertions and are further discussed in CHAPTER FOUR:

FINDINGS starting on page 160 herein. A listing of all 316 codes within the 27 categories can be found in Appendix F.

Ethical Issues

Schoenberg and Rowles (2002, p. 16) stressed an ethical stance in regards to interactions with participants: “With the acknowledgement of the inherently reflexive nature of qualitative research methods comes responsibility toward the people within whose lives we insert ourselves.” To this end, a thorough “Informed Consent Form” was developed to fully inform participants in plain terms what was to be involved in the study and its contribution to a greater good (see Appendix ?). This form was reviewed with each participant at the beginning of the first session, their signature was obtained, and a copy was left with them. Participant confidentiality was rigidly maintained throughout data gathering, transcription, analysis and reporting. It was anticipated (and described within the Research Protocol) that a numerical descriptors such as “Participant #1” would be used in lieu of actual participant names for reporting of data. However, as I began writing the “Participant Narratives” I found the use of such a term to be awkward for the composition of the prose, so I reverted to the use of pseudonyms, which, being more succinct, resulted in better flow.

Where ever a photograph was used of a participant within this document, the face was blurred. Care was taken so that photographs used contained no content that would allow for the location or specific subject matter to be identified.

Creswell (2014) noted an ethical need to establish rapport and trust in the researcher/

participant relationship, to fully disclose any intended use of data and even to provide feedback on the findings. Such strong rapport was certainly appropriate in the current study as it involved questions pertaining to intimate actions within the home. I always avoided discussion about daily actions, such as toileting, bathing and dressing to at least the second of the interview sessions when a rapport had been established.

Schoenberg (2002, p. 134) expressed concern for the inevitable finality of the relationship: “there has been concern expressed by in-depth interviewers about how to ethically withdraw, how much the researcher ‘owes’ the participants, and how to exit without abandoning people with whom rapport has been established.” I never felt that I could sufficiently express thanks at the end of the sessions for the time and energy participants had contributed, but I always brought a small gift to the final interview session and, to those who did not have extremely limited vision, I also sent a thank you note in the mail after the final session. The small gifts I brought at the final interview were either flowers or desserts. In several instances, participants had mentioned their favorite pie during the course of our interviews and that became the item which I brought. In one instance, a participant mentioned that she did not own a grabber device but could certainly use one, so that became her gift. I attended a funeral of one of the participants who had passed away after my interviews, to offer my condolences to the family. For the other participant who passed away, I was not aware of his passing until after the services, at which time I send a condolence card to the family.

Validity

Qualitative validity—the extent to which what was *actually* measured is what we *intended* to measure, or that the measure adequately reflects the actual concept under consideration—necessitates that the researcher ensures accuracy of the findings (Babbie, 2011; Creswell, 2014). Creswell (2014, p. 201-203) proposed eight strategies for validity which both

enhance the researcher's ability to access accuracy as well as provide sufficient content to convince readers of that accuracy. This study utilized six of these eight strategies, as described below to elevate the validity of this study.

1. Triangulation of data. Creswell suggested that validity is increased if different data sources are used to build coherent justification for themes. In the current study, semi-structured, open-ended interviewing, observation, note-taking, and photography, were all used for data collection and evidence from all was analyzed together to find support of conceptual themes. On the topic of qualitative validity, Babbie (2011) noted that when measuring a concept which has complex or disputed operational definitions, various measurements are needed. "If there is no clear agreement on how to measure a concept, measure it several different ways. If the concept has several dimensions, measure each" (p. 158). For instance, the tendency for participants to establish a central location, called *command center* within the literature, where they spent a good deal of time, and where often used items were kept, was both described by the participants, and captured with photographs.
2. Member checking. Creswell (2014) supported the process of asking participants whether interpretations made are accurate. He suggested—both during data collection and after producing the final report—to go back to the participant and inquire whether specific descriptions or themes ring true from their perspective as a means for ensuring accuracy. I utilized this strategy during data collections, but not following data collection. Open interviewing easily lent to the ability to ask questions such as, "Let me see if I have this right." during sessions which allowed the participant to either concur or clarify. At times,

a request for clarification lent to a more elaborate answer, or a more quotable quote from the participant.

3. Use a *rich, thick description* to convey the findings. According to Creswell, “When qualitative researchers provide detailed descriptions of the setting, for example, or offer many perspectives about a theme, the results become more realistic and richer” (p. 202). Within the writing of this document, interview content was substantiated through detailed recounting of participant details, both through the narratives telling each participants’ stories, and through the discussion of themes found among participants’ experiences.
4. Clarify the *bias* the researcher brings to the study. Creswell suggested that researchers who reflect on and write about their own background, biases or possible assumptions will create an “open and honest narrative that will resonate with readers” (p. 202). Qualitative research promotes the use of personal reflection on the part of the researcher regarding how background, gender or culture may influence interpretations. This study was of strong personal interest to me as many older relatives have also lived the phenomenon under investigation. In the section that follows titled **Research Bias**, I have attempted to achieve transparency regarding any potential bias.
5. Spend *prolonged time* in data collection. Creswell suggested that more data-gathering time equates to higher quality, more credible data: “The more experience that a researcher has with participants in their setting, the more accurate or valid will be the findings” (p. 202). Fifty-one hours of interview time, plus a small amount of additional time corresponding with some of the participants’ loved ones was the accumulated effort of this endeavor. It is felt that this is a sufficient amount of time to procure useful insights into this area of investigation.

6. Use *peer debriefing* to enhance the accuracy of the account. Creswell stressed the importance of working with others who can review and ask questions about the study to ensure its resonance and comprehension for other readers, which ultimately adds to overall validity. The very nature of this study as a doctoral dissertation means that a committee of advisors have been instrumental in the planning, design and reporting of this work. Their input and suggestions have molded many aspects of this study and written dissertation. Prior to completion, the findings were presented and discussed with my teaching colleagues, at the Environmental Design and Research Association (EDRA) conference, and at a workshop of graduate student peers. Feedback from these encounters enlightened the ongoing interpretation of findings.

Strengths and Limitations of the Study

The 10 participants within this study represent a small population pool which may not be entirely representative of the older aging-in-place population at large. A qualitative study with a small sample population does not aim to provide generalizability across the population, but rather provides descriptions of the particular cases under study. Therefore, the small population size of this study should not be viewed as a constraint with regards to findings.

However, and perhaps more relevant to this study's limitations, because most participants were located via convenience, they may not be a representative sampling of the population of 90+ year-olds aging alone at home today. They quite possibly represent a more affluent and educated portion of this population, because the sources through whom they were located were generally well-educated and higher middle-class. Only one participant, Peter, (who was not located via convenience but rather through a service provider, the North East Iowa Area Agency on Aging) was a recipient of Medicaid benefits, indicating a low income. After the Affordable

Care Act (ACA) was enacted in 2010, Medicaid is available to individuals with an income at or below 138% of the federal poverty level, or about \$16,245 annually. Elders living with economic constraints may necessarily be driven towards more extensive adaptations than those with comfortable means. Also, all participants were Caucasian, which is not representative of the aging-in-place population at large.

Strengths of this study include that participants were drawn from four different states, from varying types of communities, had a high average age (94.5 years) meaning they were representative of a population likely compelled towards adaptations to accommodate for limitations due to aging.

Researcher Bias

Within qualitative research and constructionist grounded theory methodology, it is recognized that the researcher brings with him or her an accumulation of knowledge and background which necessarily influences what he/she observes within the setting and the way he/she interprets findings (Groat & Wang, 2014). Therefore, to a large degree, a qualitative researcher need not be apologetic about matters of interest, expertise or belief. But, in the interest of validity, it is good practice to be quite clear about what those belief systems might entail.

My background as an interior designer allowed me to take careful note of the conditions of the spaces of the homes I was viewing. Through our training and experience, we become very adept at being cognizant of many details of the built environment. However, designers have a tendency toward strong judgements about what comprises a virtuous interior environment: that it be stylistically current, that it be free from clutter, and that it be thoughtfully composed. None of these designer-ly biases may be consistent with the objectives of elders who have lived in the

same residential environment for many decades and are motivated to remain there in spite of many constraints, and care was taken to ignore these biases for the duration of the study and its analysis.

The very nature of the design of this study supposes that older people often remain in their home due to attachment to it as a preferred place, and that, because of declining abilities, adaptations may have had to occur in order to allow for continued functioning. These suppositions are grounded in the conceptual framework discussed earlier herein, regarding theories of place attachment and personal adaptation. During interviews, I tried to avoid leading questions and wording bias, in simple terms—putting words into the mouths of participants. The questions, “You must feel very attached to this home?” is certainly leading, and even “Do you feel attached to this home?” includes wording bias, because the word “attached” is already incorporated into the reflection that this sentence triggers. The wording of my questions may have demonstrated some bias. Only through extended dialogue was I able to capture the intended meaning of participants’ responses.

CHAPTER FOUR: FINDINGS

As noted, I felt the best way to present findings was to first present the critical details of participant's stories, a description of the setting and events which were explained to me by the participants, and observed while I was in their home. These accounts aim to be more descriptive than interpretive, but are certainly not free of inferences on my part, as I was an active player in the interview sessions. These accounts are under the heading: **Participant Narratives**. They are essentially their *place biographies*, describing how they came to live within their particular home, and what they had experienced while there. It was challenging to provide the appropriate level of detail about the life and circumstances of these ten participants: to be comprehensive but not too exceedingly verbose; to provide in-depth descriptions of noteworthy details, but to do that succinctly; to give voice to these participant's stories, but to temper thoroughness with attention to the art of storytelling (Wolcott, 2009), but a strong attempt was made to do so.

To arrive at the most solid foundation for description, these narratives are presented first, and separate from the subsequent section: **Codes, Categories, Themes and Assertions**. It was felt that if all descriptive accounts of participants' lives were interwoven within this reporting of themes, the resulting re-counting would be overly complex and excessively multifarious. These codes, categories, themes and assertions were derived through the coding process, and reflect the essential core of these findings. This section includes more interpretation than the participant narratives, the mere categorization into thematic subheadings was in itself an interpretive endeavor. But it still aligns with the true descriptive reporting of the data, and as a summation of findings. In the subsequent section: **Analysis of Findings: Summing Up and Adding On**, these findings are more thoroughly analyzed and discussed relative to the theoretical implications of this research.

Although this division of content; first the **Participant Narratives**, and then the **Codes, Categories, Themes and Assertions** provided a useful means of relating the data in a logical format, it also presented a challenge, in numerous instances, of determining the best location for a myriad of details. I endeavored to not be overly redundant in relating duplicate details in both sections. Often a decision needed to be made; does this detail relate more strongly to a participant's narrative, or to the discussion of a theme? In some cases, a particular event or detail in a participant's story was necessarily covered in both sections, as part of their narrative and as a discussion of a theme, but a concerted effort was made to avoid exact repetition in the re-counting, or to be overly verbose or redundant.

The participant narratives are presented sequentially in the order that I began interviewing these participants. The actual names of all participants, and participants' relatives and friends have been changed to protect their anonymity. All proper names used throughout this document are pseudonyms.

Participant Narratives

Participant #1: Pseudonym Delores, age 88. The first participant for this study, the interaction with whom comprised the pilot study, was an 88-year-old woman who lived in the neighborhood of a colleague. From the moment I entered Delores' home, I felt at ease, due to her gracious and outgoing nature. She initially expressed concern about the anonymity of the study because of her extensive financial assets. She did not want it to be known that she, an elderly woman with significant assets, lived alone at her address. I assured her that neither her identity nor her location would be divulged in any associated report. She shared with me a bit about her history, which focused on her wonderful love-filled marriage and the sudden death of her husband at age 92 about 18 months prior. She briefly described their meeting, courtship,

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their 68-year life together, then an anguished decision not to pursue intensive therapy following his diagnosis of a fatal condition. He died just three weeks later and she had continuing difficulty adjusting to the loss.

Delores' home, a large ranch style, three bedroom, two bath home, had been built in 1971 when she and her husband and her two teen-aged children moved to a mid-sized Iowa town for the purpose of purchasing a motel to operate as his livelihood. It appeared that neither the décor nor furniture had been changed since that time. Although the home's décor would have been very tasteful in the early 1970s, it was now extremely dated, although in excellent condition and very neat, clean and orderly.



Image #1 Delores's kitchen, dining room, living room, and bedroom.

I learned that Delores had a very sound financial situation, and had ample monetary resources for all of her needs, even if those needs dictated future long-term care. She communicated that due to her husband's successful business and savvy investing, she often found herself so cash-flush from annuity payments that she continually re-invested so as not to

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have overly large checking account balances. She was able to engage all the services needed: both a cleaning woman twice-monthly and a lawn-care service weekly during the summer. A next-door neighbor did all snow shoveling for her and had indicated that he was very happy to do so.

Delores was certainly in an enviable position financially, the upper stratum of middle-class elders living alone in their later years. She had no monetary concerns, other than how to manage her fluid assets. She was a very high functioning 88-year-old and I felt her experiences presented data which was not as rich as I hoped relative to the challenges of aging-in-place. As a result of my interaction with Delores and in hopes of encountering further participants with greater need to adapt within their long-occupied living environments, I increased the age requirement for participants for the remainder of the study to over the age of 90.

Delores was dealing with strong feelings of grief during the time I interviewed her, 18 months following her husband's death. She spoke of becoming emotional when events led her to reflect on the finality of his death. She spoke also of not yet having closure concerning his death. She described his vacancy in their king sized bed: "Invariably I wake up in the morning and look over there and think 'Oh Mitchell is up already, he's probably out making coffee,' and then it hits. Just for a split moment I'm sure he is out there making coffee." And she spoke of the desire to remain in her home, as it held precious memories of their life together. She described to me: "This is where he sat at the table. That's where I sat and it just, I just feel like he is all over this house. That's what makes me want to stay here." She also described despondency when she looked out her front window about dinner time and saw male neighbors drive into their driveways after their day's work, because, for many decades, her husband's return from work before retirement had provided with the happiest moments of her days.

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maintenance tasks and record-keeping after his death, and bill-paying and gas-filling responsibilities did not seem to bother her.

Her husband had made a down payment to reserve a spot at one of the local senior housing facilities, which would ensure them an apartment should they decide or need to move from their home. Delores felt comforted knowing this option was available to her but expressed, at the time of the interviews, no desire (nor apparent need) to move away from her home. She said that the home had memories for her and fulfilled all her needs, both physical and emotional. Being in the home provided a sense of connection to her deceased husband. She spoke of how her children and grandchildren enjoyed coming to visit and to occasionally spend the night. She spoke of strong neighborhood support and connections.

Because the down payment had been made at the local senior housing facility, she did actively ponder the pros and cons of staying in her home versus relocating. She had thought about how her current furniture could be divided among relatives if she moved to a new apartment but she had always concluded that she could not give up her home and the remembrances of her husband which it held.

During one session, she pointed out an issue with the door jamb such that the door had started to become stuck, but noted that she knew of a lock-smith she intended to call first thing the next morning. As her husband had operated a motel, he maintained a thorough list of handy-men and repair services on which she still relied. In the short span of time between his diagnosis and his death (approximately three weeks) her husband had made sure to communicate several maintenance directives: to keep the lawn service, to call so-and-so to change furnace filters, etc. In fact, on his death bed, he told her not to bother to drive all the way to Walmart for toilet paper and sundries simply to save money, but to rather always just go to the grocery store down the

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street, which, although more expensive, was a much safer excursion. Consequently, due to both monetary and labor resources, she was able to keep up on all home maintenance issues.

Delores subscribed to a 24-hour monitoring service for any emergencies and utilized an alert device she wore around her neck on a string. She had occasion to use it only once – when she locked herself out of the kitchen onto a second story deck without stairs to the ground level. She pressed the button. Before help arrived, a neighbor did appear, and fetched the copy of her door key which she had given him for emergencies. They called the service to report that aid was no longer needed. The service spoke with Delores on the phone and asked her, “if you are under any coercion from the neighbor who is presently in your home, just say the word “Yes.” The service called her again in about an hour to ask if everything was alright. She felt that the company’s approach in trying to ensure nothing negative was happening in the situation was very effective and felt very comforted and safe knowing that help was only a push button away at any time.

Many of her close neighbors had lived in their home for many years as well, and she was well acquainted with them. A woman in her sixties who lived across the street watched Delores’s front room window to make sure the blinds were opened every morning and drawn closed every evening. Another next-door neighbor, whose bedroom window was less than 20 feet from Delores’s master bedroom window assured her that if she needed help at night and just yelled out, they would hear her and would come over. Several of these trusted neighbors had copies of Delores’s house key so they could enter her house if necessary. A few months before our interviews, Delores experienced extreme pain due to a bowel blockage. She called another neighbor, a nurse, who determined that a trip to the emergency department was needed. Treatment there eliminated the blockage. Delores had a very amiable relationship with this

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neighbor and felt comforted knowing a nurse was in such close proximity. This nurse owned a red convertible sports car which she only drove during the summer. She kept it in Delores's second garage stall and Delores felt glad that she could offer this reciprocal assistance. Delores described the mutually beneficial arrangement: "When I said to her, 'What would I do without you?' she says, 'Well what would my little red convertible do without you?'"

There were minimal concessions made within the home for needs related to diminished capabilities. At some time previously, grab bars had been installed both at the entrance from the garage to the back door (where there were two steps) and at the toilets and showers in both bathrooms. Because she suffered from Meniere's Disease (dizziness, nausea, and vertigo), she kept a neatly arranged bucket and towels at her bedside in case of vomiting, as well as bottled water and cups.



Image #3 Grab bars installed on the door leading from garage into kitchen, and in the bathroom.



Image #4 Bucket, towel, water, and cups.

About ten months after my interview sessions with Delores, my colleague (who was Delores's neighbor and who had referred me to her) told me that a For-Sale sign had been put up in Delores's yard. I telephoned Delores to inquire, and she told me that she had decided to sell

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the house and move into the senior housing facility where she and her husband had long since put down a deposit. I wanted to further understand her motivation, so I asked if I could return to her home to interview her one additional time.

During our interviews the previous year, Delores had strongly expressed how she felt she belonged in her home and how the home was a part of her relationship with her deceased husband. But she had also pondered life in senior housing. So I wanted to discover her process in deciding to relocate. She explained:

After I lost [Mitchell], I just felt real comfortable about being here. I have never been afraid and I just knew this is where I wanted to stay for years.... I had lonely times but I knew this is where I wanted to be.... But there were several days last winter when I didn't want to drive the car. About maybe as many as four times last winter, I'd go a couple of days without seeing a person.

For Delores, alone-ness had come suddenly and unexpectedly into her life at the age of 88 following her husband's death. She seemed to be very sociable, thriving on interaction with others. Both the grief of his death and the sudden state of being perpetually alone after 68 years of marriage had been very difficult adjustment for her to make. She continued:

Then I started doing a better job of taking care of myself and handling things, and I felt good with myself that I was doing so well and everything, until those sieges came the second winter. I just felt lonely.

Delores spoke with her adult children, and they helped her evaluate all options, including converting the lower level of her home into an apartment, whereby she could exchange room and board for assistance and companionship. Ultimately she was drawn to a facility with a large 1400 square foot, 2 bedroom unit with also included a den, a dining room and two bathrooms,

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and a view of a grassy knoll. This facility provided group dining options, a convenience store, a theater, an exercise room, a hair salon, a library and a chapel. They also sponsored many social activities and outings. She wrote a \$15,000 check to secure the unit that day, called a neighbor who was a realtor and put her house on the market.

She was due to move about a month after this meeting. She had begun giving furniture items to adult grandchildren and had determined which furniture pieces she was going to move and which she was going to sell. She had hired a service to organize and operate an estate sale and to manage the entire move. She seemed exhilarated about the upcoming life change.

Delores's experience was unlike any of the nine other participants in this study. She was the only one to have decided to move willingly. She had become widowed at a more advanced age, and her ongoing grief and loneliness propelled her to make a change. Additionally, she was amply able financially to purchase a high-end retirement unit in one of the premiere facilities in the area. Thus, this move was not regarded as a compromise or step backwards from the experience of living at home. Delores happened to be a very social person, one who would prefer the concentration of others inherent in congregate living. For her, in spite of strong feelings of place attachment, this was the right thing to do.

Participant #2: Pseudonym Leo, age 91. My first participant, Delores spoke often of the grief support group to which she belonged and spoke to her group about the experience of being interviewed for my study. The group leader, Carol, had a 91-year-old father living alone in a near-by town and he became my second subject. Leo lived in a small Iowa town, in a home he had purchased in 1972. He had moved to this home following a career as a farmer. Later, he happened upon an opportunity to become an insurance adjuster for farm insurance, which he did for thirteen years until retirement. Leo had met his future wife when they were both young and

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became engaged prior to his enlisting and serving in World War II. In 1998, she developed multiple brain tumors and passed away ten months to the day after the diagnosis was made. He had two adult daughters in their 50's.

Early in the interview process, Leo asked me, "Have you ever interviewed a combat vet before?" which was his segue to allow him to disclose the amazing story of his war experience. He also let me read an account written several years earlier by his daughters, who wanted to commemorate what their father had encountered during the war.

On what is now known as D-Day, June 6th, 1944, Leo's unit was in the second wave of those to land on the beaches of Normandy in the early morning hours, about 30 minutes following those troops who arrived first. They had trained in advance, but had been told little about where their mission was to take place. Each soldier had been given a quantity of French francs, a clue about their landing destination and that they may be stranded in France, if they were to survive. Leo felt that the soldiers were told to depart the landing craft further from land than planned and, while carrying heavy gear through the deep water, some men he knew had drowned before reaching the beach.

Several years before my interview, Leo had seen the movie "Saving Private Ryan" which is renowned for its opening 27 minutes graphically depicting the intense horrors of that morning. Leo felt that the film's portrayal was very accurate. He described to me that intense noise, chaos, and death were everywhere, and that by some miracle he escaped harm from the unrelenting bombardment of German artillery fire. I felt honored that he shared this story with me. He told me "I remember everything, but I don't often talk about it."

In the days following, the job of the survivors at Normandy was to dig a ditch several hundreds of feet long to bury the decomposing and swollen bodies of the fallen. The bodies

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would be unearthed later and given proper burial, but to lesson further decomposition, they were buried a few feet underground. General Eisenhower was to arrive seven or eight days later and more infantry troops were to arrive, so the mission became one of clean-up and temporary interment. This task proved to be another horrifying facet of war, due to the sickening condition of the injured and rotting bodies.

Veteran's organizations had provided social engagement for decades for Leo and his wife, but now, he said, there were no more WWII vets left in the area: "Everyone is gone". Throughout the decades, Leo had participated in social activities and events at the local VFW club. Memorial Day and other national holidays always provided activities and get-togethers with other veterans and he missed being physically able to participant in as many activities. Additionally, the lack of any other veterans of his age left him feeling isolated. Six months prior to my interviews with him, on June 6, 2014, Leo had participated in a 70th year anniversary of D-Day put on by several local VFW organizations. One of the things that happened during the day-long festivities were back-to-back re-playing of both the movies "The Longest Day" and "Saving Private Ryan." Leo sat down in the room where the movies were being played but after a time, due to the significance of the day and the other veterans in near proximity, he had to leave: "I started to watch but it brought back too many memories. I couldn't watch anymore."

Leo rose early, a residual habit from his farming life. He had an arrangement with his closest next-door neighbor, a male retiree: should the front room curtain not be opened by mid-morning, he would use his copy of the key to come into Leo's house and check on him. The neighbor also had Carol's phone number to call her. Leo also utilized a 24-hour alert service and an activation device which he wore. A spare house key was also kept under the front stoop should service providers need to get into the house.

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He had recently had a false alarm with his alert system which assured him of their prompt response. He had accidentally pushed the device button while getting out of bed and he heard a voice from the dining room – where he kept the system receiver: “Leo, are you all right?” It took him a minute to realize what had happening, but he responded affirmatively. They asked again and asked him to confirm his address. He felt comforted knowing how quickly he could be connected to another human voice should something happen.

Leo’s compact two-bedroom home was very orderly and neat. He had an arrangement with his daughter, Carol, to clean the house and he paid her for this service. She was thankful for the extra spending money and, after the cleaning was done, Leo would take her out to dinner so they could chat. Sometimes when Carol came she would bring a casserole dish she had prepared which Leo could freeze and eat over several days. Two years previously, Carol had told him he should no longer use a ladder, so when she came she would also change lightbulbs. It frustrated Leo that he had become incapable of doing the things he had always done. Leo’s son-in-law, Arthur, married to his second daughter who lived out-of-state, would visit occasionally and would do some minor repairs such as gluing down a loose corner of vinyl flooring or fixing a doorknob. Leo would keep a list of these items which needed to be fixed for Arthur’s next visit.

There was no dishwasher in the house, but Leo said he did not mind washing the dishes. He was quite organized. He was so fastidious that he always shredded any piece of mail which had his name on it. Sometime before, his grand-daughter had convinced him to purchase a used computer and had trained him to use it, so that they could correspond via email. Leo also knew how to check on his investments in the stock market.

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Image #5 Leo's orderly office, paper shredder and computer.

Leo still drove. Within his small town, he could easily get to the local grocery store once a week and to the barber shop every few weeks. He would make the trip early in the morning where there was not much traffic and he had a handicapped parking permit so he did not have far to walk. His mailbox was at the end of his block and he drove there daily to pick up the mail. And, he had developed a method to getting the garbage bags to the end of the driveway on pickup day: he would put the bags in the trunk of his car and drive them the short distance to the end of the driveway, thereby eliminating the need to carry them any distance.

During nice weather, Leo loved being outdoors. Lawn care had been a favored pastime and Leo regretted not being able to manage as he had previously. Up until two or three years prior, he had used a push mower, but when that became too difficult, he traded his push mower for a riding mower. His daughter had recently told him that she felt trimming with the electric trimmer had become too difficult for him, so she had taken to doing that along with doing his house cleaning. Besides mowing, one thing he was able to manage and enjoyed doing was to sit outside and pull dandelions or pick up sticks in the yard. He would either sit on the seat of the riding mower, on an over-turned bucket, or on the ground and put weeds and sticks into a five-gallon bucket. He would pick sticks up by hand or sometimes use a grabber device to pick them up from the ground. He was aware though that when he was outside, his neighbors would keep a watchful eye on him, causing him to feel self-conscious about his compromised abilities. More

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than once, while he was outside picking weeds or sticks and enjoying being outdoors, a neighbor had come outside to ask him if he was alright. He did not like being a cause for concern to others.

His two adult daughters called him most every day. When needed, Carol, who lived fairly close, took him to doctor's appointments. Recently he had a doctor's appointment. He arrived and parked just outside the door in handicapped parking, but then was told he had to walk to a different entrance at the other end of the building. By the time he arrived his heart was racing and he remarked that he should have requested a wheelchair.

Leo had had open heart surgery and had a cardiac stent implanted. He had two bad knees, but he did not think he could survive knee-replacement surgery. His knees caused him much pain and limited his mobility. He had in-home physical therapy, prescribed by a physician and covered by Medicare. He had difficulty rising from a chair and relied on a cane to walk. He had given up walking outdoors, both because pavement was uneven on the streets and, if he walked up and down in his driveway, neighbors would spend needless time watching his every move for fear of mishap. In an attempt to stave off further deterioration, Leo walked for a half hour every morning in a circular path around his unfinished basement, using a walker for support and an egg timer to track time. Occasionally, he would need to take a rest at the 15 minute mark by sitting briefly before finishing his circular route for the allotted time.

Leo very much enjoyed watching sports on TV and missed the time when he had been able to attend sporting events in person. Watching sports was his primary means of daily entertainment. The last time he had attended a live sporting event, he managed to get to his seat in the bleachers but several people had to help him get back down the steps to ground level, an experience that convinced him he could no longer attend. He had been an occasional church goer

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but had abandoned that within the previous year. He noted that at the time he stopped attending, he was the oldest attendee in his parish. He read the daily paper and he also enjoyed doing word search puzzles, a testament to his good eyesight following cataract surgery a few years earlier.

Leo bathed rather than showered. He used grab bars to get in and out of the tub and washed his hair while sitting in the tub. He kept a stool in the bathroom so that he could sit at the sink to brush his teeth and to shave. For the last two years, a neighbor did his snow shoveling or, if that neighbor was out of town, another neighbor replaced him. His old wall oven did not work, but he had difficulty finding one to fit in the same cabinetry space. So he relied heavily on the microwave for meal preparation. He would buy canned vegetables and pre-packaged meats to prepare for meals.



Image #6 Leo's wall oven.

Leo noted a few times that he felt that, with the continued deterioration of his knees, he would need to move to a senior housing facility at some point in the not too distant future. When asked how he would feel about leaving his home and parting with possessions, he appeared to have already come to terms with this inevitability. His 100-year-old sister-in-law resided in a facility in an adjacent town so he felt that he would relocate to this facility when the time was right. When asked specifically how he would feel about leaving his home and making that move, he said "It would be okay." At another time during the interviews, I asked him if he

would feel emotional about selling the home where he had lived for 43 years. He said, “Not too much, I don’t think. No. It was harder to move from the farm because that was my life.” He expressed that he wanted to be able to decide for himself when he would move from his home to senior living and not wait until the point where he was forced to move.

As I would wrap up our interviews, Leo would always find another story to tell or subject to discuss, I assumed, in an effort to prolong the conversation. He would walk me to the door as I was departing, and find yet another story to disclose to keep the conversation going. But finally, after all the sessions were completed, I said goodbye. I learned about six months after our interviews had concluded, that Leo had taken a bad fall and had moved to a care facility, but hoped to return home. I contacted his adult daughter, Carol. She said that Leo had fallen a few months earlier (about four months after the conclusion of interviews) while climbing the two steps from the garage to the kitchen. She said that he had become more dependent on his cane, so she had started to do all his grocery shopping for him. But this day, he had bought something at the store and was trying to carry it into the house. The difficulty of using the cane and carrying bag while he climbed up two stairs had caused him to fall.

He had his “First Alert” device around his neck but did not want to push the button as he did not want to bother anyone, so he crawled into the house to the phone in the living room and called Carol. He had dislocated his leg quite badly and was in a lot of pain. He was in a short term rehabilitation facility but relocated to an Assisted Living facility as soon as he was able. He underwent regular physical therapy. Carol commented that things were lonelier for him after regular PT ceased and he was in his apartment.

Carol and her sister, who lives in Minneapolis, decided to sell his home. They first disposed of things—each taking what they wanted. They took both his extensive pipe collection

and WWII memorabilia to an auction house and then they sold the remainder at a yard/estate type sale. I asked how Leo had felt about the divestiture of his belongings and she said he had not asked a lot of questions about where things had gone. She felt that he did not experience a great deal of remorse about the abruptness of the events or that he would not see his home or possessions again. He seemed to miss his connection to his community more than his home or possessions. The house sold quickly, as soon as it was put on the market, to a descendent of the person who had originally built the house.

Carol said he seemed fairly content with his new arrangements, that it seemed like a bit of a relief that he would not have to worry about “what if” or try to figure out when he should move. He always felt that he could hang on there for another winter, then for another summer, and the next winter, and so on, but that he could never define the time when a move might be appropriate. Although his decision when to move to supportive housing was not entirely his choosing, he seemed to adjust reasonably well, and has continued to reside there.

Participant #3: Pseudonym Loretta, age 100 Loretta was an amazing woman by anyone’s standards, remarkable in her gracious and affable nature. During our interview sessions, she celebrated her 100th birthday. I came into contact with her because she attended the same church as my aunt. When I phoned her to arrange the first interview, she asked that I phone her again the day prior to the interview to offer her a reminder, as she was very nearly blind so could not rely on written notation as a prompt. Also, she said, when calling, make sure to allow the phone to ring several times before expecting an answer as she moved very slowly and it took her time to reach the telephone.

Loretta had an amazing life story to tell which, as with Leo, was heavily impacted by the events of World War II. Loretta had a brief, unsuccessful marriage at a young age which

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resulted in the birth of her only child, her beloved son, Jack. She did not share anything about the dissolution of that marriage. After her divorce and while in her mid-20s, when Jack was just a toddler, Loretta was living in Hawaii with her parents. Her father was in the Air Force and stationed at Wheeler Army Air Field near Pearl Harbor. The year was 1940, and she found herself in an enviable position. Because of the pre-World War II buildup of GIs on the Hawaiian bases, the ratio of young single men to young single women was 50 to 1. She met her future husband of 44 years, Gary, at a dance and before long they were making arrangements for their wedding day, which was to be December 7, 1941, the day that would “live in infamy.”

Because it was her wedding day and she had many arrangements to make, Loretta rose very early that Sunday morning, early enough to be outside when the first Japanese planes flew low overhead towards Pearl Harbor to her east. She described her location, their home on the base, as being about two blocks from where some of the inland bombs were hitting. The noise of the bombs dropping awoke the rest of the household. Her father, an Air Force pilot, quickly understood the severity of the situation. The Japanese planes were flying so low, she said, “You could see the rising sun. You could see the pilot’s faces. You could see the kamikaze stars that were [on the planes].”

Loretta’s father quickly reported to Wheeler Army Air Field and, although he told the family to stay in the house, Loretta, her mother and little Jack ran to an embankment for shelter until the bombing ceased some two hours later and then returned home to gather some belongings. The magnitude of food prepared in advance for the wedding celebration proved to be a godsend in the days to come. It was shared with family and friends. They walked to the home of a friend where they stayed for the next four days as the barracks had been destroyed, so family homes were needed to house the soldiers.

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Loretta's fiancé, Gary, was at the army barracks that morning. Following the attack, the mission of his unit was to guard the shoreline in anticipation of a Japanese landing. On December 10, three days after the attack, Gary was able to get a three-hour pass and a ride on a supply truck. He called Loretta and instructed her where to meet him. They walked to a small church and found a pastor who they asked to perform a quick, impromptu marriage ceremony. Then Gary was off to get back to where he was stationed. After an additional four or five days, Gary was able to get a lift on the supply truck and see Loretta before his unit was transferred to a small island near Guadalcanal. He spent the remainder of the war stationed in various locations in the South Pacific and, after the war, served in several locations around the United States. He remained in the military until his retirement.

Within a few weeks following the attack on Pearl Harbor, a program to get military wives, children and family members shipped off the island and back to the mainland for their safety was initiated. Loretta and Jack were among the last of the military family members to be shipped out, about six months after Pearl Harbor. They were shipped back to California in a troop ship, then travelled to Minneapolis. The family lived in military housing in Florida before they made their home permanently in Minnesota where Gary served the remainder of his military career.

Loretta's son, Jack, was 79 years old at the time I interviewed her and was a very important person in her life. He visited every Tuesday. She called that her "special day" and would make no other plans so that she could focus on Jack's visit. Throughout the week, as she noted items needed at the grocery store, she would write them down. She could write, but was not able to see to read her own writing. On Tuesdays, Jack would take her to the grocery store with her list, which he could read. They would laugh when the same item would appear on

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Loretta's list two or three times. They would also make stops at the pharmacy or bank as needed. After shopping, Jack would take Loretta to Perkins Restaurant for lunch or they would return to her house for a home-made lunch. Jack would also write out any checks and address the envelopes any needed to pay utility bills and insurance and she would sign the checks. Her time with Jack was precious to Loretta. Unfortunately, he was not the type of person who was handy at fixing things, so he did not assist with small repair or household projects. Loretta did not have a strong relationship with Jack's wife who rarely visited. She was frustrated and dismayed that her daughter-in-law had never once offered, over several decades, to help her with any cleaning task.

Loretta's home was a split level. The main level included a living room, large kitchen and screened-in porch that had not been used in years and was in poor condition. The kitchen was the hub of the house. An addition had been added at some point in the past, but Loretta could not recall when as "time doesn't mean anything within my age." Up one half flight from the main level were three bedrooms and a bathroom. Down a half flight was the rec room and a bathroom, and down another half flight, below the main living floor was the basement where laundry and storage was located.



Image #7 Loretta's large kitchen and adjacent dining area.

The split-level home configuration was quite popular around 1960 when the home was built, but proved to be a substantial detriment to her at the current phase of life. She spent most

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of her waking hours on the main living area, in the kitchen or living room. A bathroom was either a half flight up or a half flight down, and the laundry was two half flights down. The lower level, one half flight down from the main level, had been the location for family parties and get-togethers throughout the years. Loretta called it the rec room.

It was difficult for Loretta to stand from a seated position, but insisted on doing it on her own. She would rock back and forth several times to build some momentum. Using her hand on the table as leverage, she would push herself up, sometimes falling back a few times before she found success. A trip up or down the half flight of stairs took ample time. Each step was agonizing for her. She described: "It's the most painful thing. Every step I take I can feel those bones grating against each other and it really hurts." I commented that she was remarkable in her ability to manage the steps several times daily, and she replied, "But if you only knew how it hurts!"

Her closest next-door neighbors had lived in their home for 30 years, so were close friends. Their initial meeting, shortly after they had moved in marked another remarkable event in Loretta's life. The evening of their oldest grand-son's wedding, 32 years previously, Loretta and Gary, returned home after the wedding about 10:30 pm. Gary went into the bathroom and Loretta heard a thud. She found him unconscious on the bathroom floor and called 911. Having seen the ambulance arrive, the new neighbors came to the door to offer assistance. Gary died very suddenly, but this proved to serve as the introduction to the neighbors who would offer assistance and friendship for the upcoming 32 years. Loretta felt comforted knowing how happy Gary's last hours had been. The weekend after my first interview was the neighbor's son's wedding and Loretta was invited but regretted that she could not attend, as she had no one to provide transportation for her.

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The year previously, another neighbor had approached Loretta about having her young sons do her lawn mowing, feeling this would provide a good life lesson about helping neighbors to her young boys, a win-win. Loretta relied on a friend for transportation to church each week, and the same woman would drive her for her hair appointments every six weeks. Loretta colored her hair a beautiful caramel color, and wore lipstick every time I saw her.

Loretta enjoyed listening to the television, although she could not see the actions on the screen. As with the telephone, she counted the numbers on the dial pad of the remote when changing channels. Loretta needed to have the telephone numbers of the five people she called often memorized, as she could not see a written listing or directory. She laughed that she often dialed wrong numbers as her fingers are larger than the small telephone keypad, but she would persist until the correct number had been dialed. She would apologize nicely to the people she mistakenly called and felt they gave her latitude because she sounded old. She had an excellent memory, but advised her friends to call her rather than waiting for a call to them. She also listened to books on tape for entertainment. She would borrow them from a woman in her church congregation.

At some time previously, an aging-in-place specialist visited Loretta to give her advice about potential retrofits to her home. The specialist made two suggestions. The first was to add grab bars in the bathtub/shower where none existed. Jack had since become convinced that, because the wall tile around the bathtub was plastic rather than ceramic, this could not be accomplished because the bars would have insufficient support. This is irrelevant, because the framing behind the wall board would have provided the needed support. The other suggestion was that Loretta purchase a camping toilet and put up a folding screen in the corner of her

kitchen, creating a private toileting area, on the main level, an idea that Loretta found distasteful and immediately dismissed

Loretta was known for her Christmas cookies. In her prime, she had regularly produced as many as 300 dozen each year but the Christmas previous to my interviews, she had made far fewer. She continued to enjoy baking and knew the recipes by heart. Because she could feel the numbers on the measuring cups and spoons, she was able to measure the ingredients without problem. Her difficulty was with setting the oven dial. She had a few markings on the oven dial, one at 350 degree and the other at 450. Her other issue was with timing. She used a watch designed for the blind which, when its button was pushed, would audibly announce the time. Knowing the length of cooking time needed, she would add that to the present time and continue to check the time until the correct duration had been reached. Because Loretta had only one son who had two sons, each of whom also had two sons, she had never had a young girl in the family to teach how to bake.

Loretta relied on an elderly friend who voluntarily came over every other week to help her with her laundry. This friend would come, put a load of laundry in the washer, sit and talk with Loretta over a cup of coffee, put the load in the dryer, chat some more, then fold the completed laundry and go home. Loretta hoped that this altruistic arrangement would continue endlessly, but feared that at some point either this friend's generous spirit would expire, or this friend's ailing husband might need more constant care, also preventing this arrangement to continue. Loretta wanted to do all she was capable of, and only rely on others to do what she could not. At the conclusion of one visit, I offered to load our cake plates and coffee cups into the dishwasher, but she stopped me insisting, "I've got to do something, you know."

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Her house was tidy, although not well dusted or vacuumed, as Loretta was not able to manage those tasks. She said “I try to keep it up, but if you look in the corners you’ll see cobwebs, and on the furniture, you’ll see the dust.... I can’t see it so I won’t let myself worry about it.” She had recent experiences of trying to dust and organize her belongings, but had knocked things down and broken items due to her very limited eyesight. She had surgeries for glaucoma, cataracts and macular degeneration and she wore glasses, but she could see very little. Her mother had always trained her that, if you take something out, you put it away. She said this habit was critical for her, as she could not see things, she needed to rely on memory regarding their whereabouts.

Loretta would have benefited from a house cleaning service, but she was unaware of where to find one. At the time I met with her, she was anticipating an upcoming meeting with a case worker from the local area agency on aging who she hoped could align her with a cleaning service. Loretta lived in a populated suburban area of Minneapolis, where there were likely many house cleaning services, but neither she nor her son had effectively aligned her with such a service, even as she neared her one hundredth birthday. I pressed her about this again, why she had not engaged a house-cleaning service and she replied, “I don’t know, but the reason I haven’t done it yet I guess is I’m too darn stubborn. I’m going to do things myself.”

Loretta described herself as a packrat and she certainly did have a proliferation of items in her house. In showing me her garage where, when the kitchen remodel happened decades earlier, the old cabinets had been relocated, she commented, “Why did I save all these little cups that butter came in?” And she described, “Well, another thing is Tupperware. I’ve got all of my Tupperware and all of my mother’s Tupperware. Nobody needs six cake safes, but I’ve got six

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cake safes, and besides I have the one that I took a cake to church in very recently that [hasn't been returned].”



Image #8 Storage in Loretta's garage.

One of Loretta's indulgences was to take a foot bath. She described her enjoyment of this and her determination in managing the device:

You could plug it in and it keeps the water hot and vibrates. The only thing is, it feels wonderful and I do it once in a while, but the trouble is for me to empty it. I can get the water in in, but to get that out, it is difficult. For that reason, I don't do it as much as I would like to. Once in a while I just feel desperate enough to say, "I'm going to do it anyway!"

When I suggested that she take her whirlpool foot bath on Mondays, so that on his weekly visit on Tuesday, Jack could drain the water for her, she replied about her orderliness standards, "I could do that, but I couldn't stand the water sitting there. I'm too much of an old granny."



Image #9 Loretta's whirlpool footbath stored in the shower, an indication of how infrequently she now used the shower.

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Loretta had a strong desire to remain in her home. “I’ve lived here for over 50 years now, I want to continue to live here.” In fact, she had resided there over 55 years. Others, likely with good intentions, had tried to convince her that other housing arrangements had merits. “I want to stay here, but I’ve got an awful lot of people that have been trying to get me to go to assisted living and they’re still giving me a hard time.” Loretta exemplified strong determination in managing to stay in her beloved home.

Participant #4: Pseudonym, Audrey, age 99. Audrey was a 99-year-old woman whom my mother knew from church. Audrey and her 69-year-old daughter, Jan, served as the greeters for Sunday mass each and every week, which necessitated standing for about thirty minutes prior to the beginning of mass. They also carried the communion gifts up to the altar at communion time. Audrey enjoyed the interaction and sense of community this responsibility gave her. She was the only charter member of the church—which had opened in 1943—who was still living. She reflected about her long life, “I don’t know, I just go on and on and on and on.”

Audrey had three adult children, two sons and a daughter. One son lived nearby and the other out-of-state. Audrey’s circumstance was a bit unique in that her youngest child, 69 year-old Jan, had become Audrey’s constant companion. Jan had never married and she and her mother had settled into a pattern of daily companionship. The arrangement benefitted them both greatly. They were together for about eight hours daily, which provided friendship, support, and assistance for both.

Audrey and her husband had moved to their small two-bedroom house when Jan was a freshman in high school, 53 years prior. The two older boys had already graduated and left home. Both Audrey and her husband, Andrew, worked for the post office, he as a letter carrier and she as a clerk. As an adult, Jan had worked as a State Patrol dispatcher for many years, but

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found the job stressful and demanding. In 1997, when Audrey's husband, Andrew, had become housebound due to prostate cancer and suffered from severe bouts of depression, Audrey had offered Jan an opportunity. Audrey would pay Jan to become a daily care-provider for Andrew. This allowed Jan to quit her job. With the compensation from Audrey, she was able to get by financially. When Andrew died in 2001, Audrey offered to continue to provide monetary assistance to Jan in exchange for companionship and help around the house. Audrey felt this arrangement would allow her to remain in her home indefinitely, which she strongly desired. She said, "I always wanted to be here. I never wanted to leave. I'm kind of a homebody."

Jan also did cleaning services for the apartment building in which she lived, which was about a fifteen-minute drive from Audrey's home. Her duties in the building allowed Jan a reduced rental rate on her apartment to \$200 per month. With the additional money Audrey provided, Jan was able to manage financially. A typical day for Audrey and Jan started early. Both rose about 7:00 am in their separate homes: Audrey in the family home where she had resided for 53 years and Jan in her apartment. Jan would call her mother first thing to make sure all was well. Then Jan would do an hour or two of cleaning duties at the apartment building and would then drive to Audrey's house, arriving about 10:00 am. The only day which deviated was Sunday, when Jan would pick Audrey up so that they could attend mass and perform their greeter duties before service began.

It had been about 18 years that Jan had spent her days at the house, making meals, doing cleaning and yardwork, and providing companionship and care, first to both her parents, and, since Andrew's death, just to Audrey. Both she and Audrey were very contented with the arrangements; they both had their own homes and privacy and both had the resources—personal and financial—needed.

They had settled into a comfortable co-existence and camaraderie. Jan was ever-watchful and doting. At one point during an interview, Jan interrupted, “What did you do, did you bite your lip again?” Then she wiped her mother’s lip with a tissue, and lovingly scolded her to be careful not to do that. At other times, they cajoled each other, Audrey calling Jan a “knucklehead,” and Jan calling her mother a “goofball” and “ornery.” They would badger each other good-naturally, Audrey telling Jan she could not understand what she was saying, because she slurred her words, and Jan retorting that no, the problem was really that Audrey was losing her hearing. Jan would often finish her mother’s sentences, but she noted that the relationship offered mutual benefits: “We take care of each other.” It was clear that there was strong love and caring flowing in both directions of this relationship. Although the obvious care was done by Jan for her mother, Audrey confided, while Jan was out of the room, “I always kind of figured that, because she doesn’t have no [husband, and] she never got married, she had to have a place, and I had to make her feel like she belongs.”

Audrey appeared to be in excellent health considering her age. She said that “I didn’t start going downhill until I was 96.” In that same year at age 96, three years prior, she had given up her driver’s license, feeling “I just couldn’t do it anymore.” She had good eyesight and hearing. She had stiffness in her hands due to arthritis and carpal tunnel syndrome. Walking had become a bit more difficult for her, although she did very well. Up until a few years prior, in nice weather, Audrey and Jan would take outdoor walks together. Now she said, “That’s about the worst thing, is my walking.” Her right hip gave her problems and pain. She dismissed the possibility of hip replacement surgery, as she was fearful of having surgery at her age. Always on the short side to begin with, Audrey’s height had declined so that she was only about 4’ 9” tall. She had a very slight build, but was dressed very nicely every time I saw her. She wore

very stylish glasses with embellished bows, frames that would have expected to be seen on a much younger person. She had a few skin biopsies on her face, leaving minor scars, but otherwise had beautiful skin for a woman her age.

Audrey had two strokes in the span of about two months just two years prior to our interviews. The first time Jan had gone into Audrey's room in the middle of the day to find her lying in bed. Jan asked her what was happening, and she replied, "I'm so weak, I'm going to die." Janet called the doctor's office immediately, although calling 911 directly may have been a more expeditious call. An ambulance was finally summoned and Audrey was taken to the hospital where tests were performed. All tests proved negative, but an MRI was not done, and she was sent home. About a month passed, and another stroke ensued, this time leaving Audrey unconscious. It was unknown how long Audrey had been unresponsive when Jan arrived that morning. Audrey had not answered Jan's 7:00 am call, so she went immediately to the house and called 911, and Audrey was again taken to the hospital for tests, including an MRI. The MRI revealed that Audrey had, in fact, suffered about seven small strokes in recent years and she was prescribed medication for high blood pressure. Fortunately, there were no apparent residual effects of these episodes. Audrey was the only one of the participants of this study to not utilize an alert service, and had been very fortunate that Jan had been present just when needed.

The first thing Jan would do when she arrived every morning at Audrey's house was administer her eye drops and her daily pills and medications. They would trade off responsibility for dinner preparation and clean-up. Both had breakfast alone before Jan's daily arrival and dinner, their one and only big meal of the day, happened daily about 3:00 in the afternoon. Jan was meticulous about cleaning the house and maintaining the yard. During one interview, Jan talked about having recently completed washing all the windows, inside and out. Both women

seemed to be very industrious, a characteristic for which Audrey attributed her present ability to be capable. When I asked her what things were most difficult for her, she replied, “Not a lot of things. Everything is fairly easy, because I’ve always been, I don’t know how you would say it, ambitious.” At another point in the interview she expressed her opinion about being industrious, “You are born to work. You weren’t born to sit.”

Jan stayed at Audrey’s house daily until about 4:00, after which she went back to her apartment. They both felt that their relationship worked well, not only because of their daily time together, but also because they had their own homes and had time each evening to be alone. Jan joked at one point that they got along almost like a married couple, each managing their own portion of the household chores. She explained, “We each have our own little chores, you know, that we do. She knows what I do, and I know what she does. I don’t monkey with her stuff, and she don’t monkey with mine, usually.” When asked how she would cope when Audrey was no longer a part of her life, Jan said, “I don’t know, I’m going to be pretty lost without her, I’ll tell you that,” but then jokingly added, “but I’m pretty lost anyway. I’ll just be more lost.”

Both Audrey and Jan loved being outdoors. Jan enjoyed mowing and manicuring the lawn and planting, weeding and maintaining a garden. Their yard and garden was indeed very beautiful. Audrey had enjoyed gardening as well, until she became too old to do those tasks easily. She bemoaned, “It drives me nuts because I can’t do those things anymore.” However, she still did weeding from time-to-time, by walking through the yard and bending over to pick the ones she found. She explained, “I just got to get rid of those weeds!!!” When indoors, they both loved to sit at the kitchen table where they could look out both the back and front picture windows at the flowers and birds. They kept a pair of binoculars handy on the kitchen table to

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look at the birds or sometimes, they admitted, at their neighbors and passersbys, “if we want to snoop.”



Image #10 Command central for Audrey and Jan (left), and the card table which was set up permanently for jigsaw puzzles.

They also enjoyed doing jigsaw puzzles together and always had one going on a card table set up in the living room. Jan described it as “A filler. It’s a filler. When you get tired of everything else.” After Jan went home, Audrey would watch the evening news, sometimes have a light evening meal, sometimes skip it, perhaps work the jigsaw puzzle a bit more, then retire early. She reported that she rarely watched any television programming, but when she did, reruns of “The Lawrence Welk Show” were her favorite. I asked her if she thought doing jigsaw puzzles was fun, and she replied, “I don’t know if it’s fun, but it’s almost necessary. You’re idle and then you’ve got something to do.” Audrey felt fortunate that her eyesight was sufficient that she could do jigsaw puzzles and also read the newspaper daily. However, stiffness in her hands sometimes made it difficult to put the individual pieces into place.

For many decades, Audrey enjoyed what has come to be known as scrap-booking and she would spend much time during the day pursuing this interest. She enjoyed mapping the family tree and organizing and documenting old family photographs. She would painstakingly compile these onto notebook pages, which she could look at time and time again. After his retirement, and before his illness, Andrew had enjoyed life and liked to travel. He took Audrey to Europe

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twice, to the Bahamas twice, and all over the United States. Audrey had lovingly arranged and labelled all of their vacation photos. Audrey described this—arranging and recording family history—as her passion.

Several years earlier, Audrey’s oldest son (Jan’s older brother) had added railings to the front and rear outdoor steps leading to the front and rear entrances of the house. Audrey was very careful to hold onto them when accessing the house so as to avoid risk of falling. Jan provided all of her transportation: to and from church, to doctor’s appointments and to the hair salon. Audrey was very cognizant of the dips and ridges in the concrete between the garage and the house in order to prevent tripping. She described that, as she moved about no matter where she was, she felt she had an ever-present tiny voice inside her head, always warning herself, “Don’t fall now, come on, don’t fall. Walk careful so you don’t stumble on anything.”



Image #11 Audrey was careful while entering and exiting the house and garage to lift her feet above ridges in the concrete and hold on to the hand rails on the steps.

Jan did all of the grocery shopping for the household on her way to Audrey’s house in the mornings, so it was never necessary for Audrey to shop. Jan also did most of the laundry. The washer and dryer were located in the basement. Audrey was well able to manage going up and down the stairs, albeit slowly and she often did her scrapbooking at the desk in the basement. Climbing the stairs left her, she said, “A little out of breath, but not bad, by golly.”

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Image #12 The basement laundry and desk where Audrey sometimes did scrapbooking.

Due to my travel schedule, it happened that my fourth and final interview with Audrey occurred three months after the initial three. In this gap of time, Audrey had been diagnosed with gall bladder disease and needed surgery. One day when she had intense abdominal pain, Jan had called an ambulance and Audrey was taken to the hospital. Initially Audrey and Jan had planned to delay the surgery two months so that it would not interrupt the Christmas holidays. But continued abdominal discomfort prompted a decision to move forward in mid-December. Audrey was hospitalized for several days following surgery, then recovered at home under Jan's constant care. Jan spent the nights at Audrey's for about two months, leaving only in the morning when she needed to perform her cleaning duties at her apartment building. After about two months, it appeared Audrey had made a full recovery from the surgery. She was happy to resume her greeting functions at the church.

Near the end of this fourth and final interview, just as I was about to wrap up, feeling I had sufficiently absorbed Audrey's account of her life and present circumstances, a new and interesting piece of information came forth. Audrey commented that she had read something in the newspaper about a woman who had lived to be one hundred and ten, and that she attributed long life to eating bacon and eggs and having an occasional cocktail. She laughed that the cocktail portion of this story was familiar to her and her own daily shot of scotch. What?!? I wondered how this could have not been divulged during the several hours I had spent with her.

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As I now learned, everyday about 1:30 or 2:00, Audrey would announce to Jan, “It’s happy hour time.” This was Jan’s cue to mix up one ounce of Dewar’s scotch, “No more, no less” with water on ice. Then she would sit at the kitchen table and enjoy her drink, sometimes accompanied with peanuts and popcorn. Jan did not enjoy drinking, so this was Audrey’s solitary pursuit, every day, seven days a week, just before their early dinner at 3:00. There was never a second drink, even on holidays. Jan did have the responsibility, while shopping for other necessities, to always make sure the Dewar’s was stocked in the kitchen cabinet. That, despite direct questions about her daily life, Audrey’s daily cocktail had never come up during interviews indicated how deeply ingrained it had become to her life and routine. It clearly provided her with daily enjoyment and relaxation and did not affect her ability to function.

Participant #5: Pseudonym Gertrude, age 98. Gertrude was a 98 year old grandmother of a colleague, living in a midsized Iowa city. She was quiet and frail, but kindhearted. Her home had many feminine touches, it was decorated in pink and pale blue and displayed a collection of dolls and cat figurines. A great love of cats was apparent, and she had shared her home with many cats during her lifetime. At the time of our interviews, she owned two cats whom she liked to hold and pet endlessly. One cat, who had only one eye, had been adopted from a shelter, and although it had been abused, it was a friendly and affectionate cat now, likely due to Gertrude’s nurturing. She had named it Colleen because, she explained, “I liked Colleen, the name Colleen. When I was young I used to call myself Colleen when I was playing in my playhouse.”

Gertrude had worked as a nurse before she had gotten married. The local Red Cross sent her to St. Louis to learn how to set up and operate a blood center, and she was instrumental in establishing the American Red Cross blood center in her Iowa town in 1949, where she worked

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for several years thereafter. She spent the last several years of her nursing career as an RN in the psychiatric unit of a local hospital. After her marriage in 1951, she and her husband opened a restaurant. They had two children, a girl and a boy. Her husband had passed away from complications of a heart condition 28 years prior to our interviews and, since that time, she had been living alone.

She had arthritis and had knee replacement surgery which left her without knee pain, but with worse knee function than before the surgery. She had also had shoulder surgery on her right shoulder two or three years previously. Although she was able to reach over her head her horizontal range of motion was limited. She had breast cancer surgery (lumpectomy) on both breasts about ten years prior. Also within the last several years, she had neck surgery to implant a plate at the top of her spine to alleviate migraines. She took a variety of medications for hypothyroid, high blood pressure and acid reflux.

Gertrude had enjoyed sewing, gardening, and bowling. Our interviews took place in the late fall of 2015, and she had just given up bowling six months previously at the age of 97. Prior to that, she had been a league bowler for over 60 years, and for the 14 years prior to my meeting her, she had bowled in a league three times a week with her adult daughter, Trish. She had given up this much-loved sport because she felt she had become too frail and risked falling and injury. “My balance is bad” she said. “I thought I’d quit while I was ahead.”

At the time of our interviews, her two adult children who, were in their 60s, lived nearby. Her daughter Trish had become an almost daily visitor, and provided much companionship and assistance. Her son mowed the lawn and did any necessary repair work around the house. He had installed railings throughout her home to aid in mobility.

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Image #13 Stair rail installed on the wall to assist Gertrude in the hallway leading to the bedroom and along the two steps leading to the back door and garage.

At 98, Gertrude still drove. She had purchased a new car just the year before I met her. She admitted that for anything other than up-close distances, she had double vision. “I hate to think when I can’t drive, because you’re independent this way. I drive to church and I can drive to get my hair done and I get groceries. But I don’t go on the [busy roads].” I interviewed her in the fall, and her adult children had implored her not to attend church during the upcoming winter months to eliminate the risk of being on the road in icy conditions, but she said, “If it isn’t too bad I can drive, but I’m not going to take chances.” Trish still drove her once weekly to the bowling alley so that she could watch her old league-mates play the game. Trish also took Gertrude to meetings of the Red Hat Society, a women’s group supporting fun and friendship.



Image #14 Jigsaw puzzle on the kitchen table, and TV watching chair with needed items nearby.

Trish visited often and sat with Gertrude at the kitchen table to do jigsaw puzzles, a pursuit they enjoyed together. Gertrude also liked to read romance novels – sometimes several in a month. With reading glasses, she was able to read the print. Her leisure activities included

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jigsaw puzzles, crossword puzzles, reading, watching news on TV and petting her cats. She rose early, made her bed, had a small breakfast, skipped lunch and then made herself dinner.

Gertrude had a favorite chair in one bedroom which had been converted to a TV room. This chair had a lift function to help her to stand, although she said she did not always need that assistance. Beside the chair was a weather radio on the floor, an afghan, a magnifying glass, pens and pencils, crossword books, a few 3-ring binders which Gertrude's daughter had put together for her and, on the table, the comb for combing the cat. As Gertrude worked on the crossword puzzles, she would write down all the words whose definitions she did not know. Trish then alphabetized the words and wrote out their definitions to create customized handwritten dictionaries in 3-ring binders that Gertrude used as she worked through additional puzzles. Both of Gertrude's adult children seemed willing to provide assistance and enrichment to Gertrude's life in any way they could. For example, Gertrude's son had recently added a wooden backing to the decorative metal cat statue that sat on the right of her dresser so that it would no longer topple over as it was inclined to do. He had converted a broom closet in the kitchen into a pantry for canned goods so that she would no longer have to go downstairs to retrieve such items.

In spite of the railings leading to the back door, she had taken a fall a few weeks before our first interview. She lost her balance and then her footing, but she kept hold of the door lever which prevented her from tipping over head first. As with nearly all other study participants, she wore a Life Alert device. She had never utilized it, but at one point there had been an accidental alarm and two firemen appeared at her door. She thought that perhaps, because she was short, the device had hit the toilet seat when she sat down to use the toilet and that was what had triggered the alarm.

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Image #15 Examples of fixes done by her son.

Gertrude had lived in her home 64 years. She said “Imagine what they’ll have to get rid of when I die.” About housekeeping she said, “I’m not the good housekeeper I used to be, but it gets done.” Her concession to home cleanliness over time was that she did not always put things away:

I have to leave things out. Like I put my medicines in my containers for the day and night, and I leave them on the kitchen table or the counter for the day or night so they’re handy and so I remember to take them. I might leave my toothbrush and paste on the sink so remind me to be sure to do it. In the TV room, it’s cluttered because I have pencils and scissors and everything that I want so I don’t have to get up and get it.

She prided herself on doing most things around the house. She kept the litter box in the kitchen, to lessen her need to go downstairs but was conscientious about emptying it often since it was in the kitchen. She took pride in cooking her own meals, but she did so only in the microwave. She was fearful of accidental fires caused by cooking on the gas range. The stove top had become a storage area. She described a typical dinner: “Well, I might eat chili or my cucumbers or those grapes I told you about I have every day so I’m sure I got a fruit, or tomatoes. Sometimes I eat pot pies, or sometimes I make spaghetti. That about covers it. Some beans sometimes.” She kept notes about appointments right on the stovetop where they are easy for her to see. The note on the bottom: “October 6th Lady here Tuesday 1:00” referred to me.

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Placement of items on the cooktop indicated that she seldom used the burners. She did not have a dishwasher, so did her own dishes.



Image #16 Gertrude's range top was used as storage, not cooking.

Her shower was well equipped with grab bars, a shower seat, a hand-held shower head and slip resistant decals on the bathtub bottom. She had an elevated toilet seat with grab bars which made it easier for her to stand after using the toilet. She also used this seat as a location to sit when she dressed every day, insuring that she would not fall.



Image #17 Assistive devices in Gertrude's shower.

When I arrived for my third interview with Gertrude at 1:00 in the afternoon—which was two weeks after the second session—I was greeted on the front porch by Trish who informed me that Gertrude had taken a fall that morning about 9:15. She had been able to get back up to standing again. She had not pressed the button on her Life Alert device, but she had an upgraded model which was both more costly and more complex and was equipped with a velocity sensor which detects a falling motion, so the company was alerted and called her on the telephone. She made it to the telephone to answer it and reported that she was fine and that they need not

respond further. Gertrude also chose not to call Trish either. Rather, she decided to just wait until Trish arrived several hours later, since a visit had already been scheduled.

The injury Gertrude had suffered was perplexing. She had fallen to the ground while walking around the foot end of her bed. There was nothing that she hit on the way down nor on the floor, but she had suffered a large gash on her forearm near her elbow which had been bleeding. It was a gaping wound, and she was in considerable pain. This injury was possibly the result of fragile skin common in the elderly. When Trish arrived about 12:30—not knowing anything out of the ordinary had occurred—she contacted Gertrude’s physician and scheduled an appointment for 2:00. Consequently, I cut short my visit and made arrangements to visit the following week.

The following week when I arrived for the rescheduled session, Gertrude had her arm in a sling. She had been diagnosed with a third degree torn muscle, but the doctor felt that the standard surgical solution was not appropriate due to Gertrude’s age. The wound had continued to bleed for a week, and she had considerable arm pain. The injury was to her right arm and she was right-handed so activities of daily living such as brushing her teeth and feeding herself were difficult. Trish had moved in to Gertrude’s home the night of her fall—staying in the spare bedroom—so that she could help Gertrude with dressing, bathing, grooming, getting in and out of bed, meal prep, taking care of the cats, and changing the dressing on her arm wound. She planned to stay as long as she was needed, but had no idea how long that would be. As it turned out, this fall, seemingly an isolated incident from which Gertrude would have been expected to recover, proved to be the onset of a snowballing of dismal diagnoses which would lead quickly to end-of-life.

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Images #18 Gertrude one week after her fall. In the intervening week, Gertrude's son had removed the headboard from the bed in the spare room, and put it on Gertrude's bed as a footboard, giving her something to hold on to for the future.

One week following the fall, Gertrude and Trish were anticipating the upcoming doctor's visit, and hoping the doctor would advise surgery on the arm, as they felt that would alleviate pain and mobility issues. Gertrude seemed disheartened about the whole incident, and frustrated that it had happened. She said, "I'm a mess. A problem and a mess." She feared needing to have to go into a rehab facility.

This concluded my interview interaction with Gertrude in late October of 2015, but through follow up with Trish I learned that shortly after this final session, her doctor had advised the surgery, but when Gertrude went for pre-op health screening, it was discovered that she was experiencing kidney failure, low levels of hemoglobin and elevated levels of creatinine. Her doctor hospitalized her and further discovered bone marrow cancer. Due to her age, no further treatment was advised, except chemo pills. Gertrude returned home, and Trish continued to live with her to provide for all of her needs. Trish communicated that she felt there seemed to be a cognitive decline which accompanied her return home—perhaps attributable to physical manifestations or even due to depression about her future. The services of a home health nurse were utilized three times weekly. She needed to be catheterized which Trish was not capable of doing. She was taking chemo pills for the cancer, which caused nausea, diarrhea, and fatigue.

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Gertrude was hospitalized briefly again on December 1st, so that doctors could attend to her declining health. After a few days, she returned home again. All the while Trish remained at the house and administered loving care, and tried to make Gertrude as comfortable as possible. Trish decorated the house for Christmas, and the grandchildren visited. On January 2nd Gertrude was re-admitted to the hospital, never to return home, and doctors discerned that the bone marrow cancer had progressed very rapidly. With no hope remaining for improvement, and the end of life appearing imminent, Gertrude was admitted to a nursing home hospice unit on January 9th. Trish was at her side constantly. Family members thought that Gertrude was holding on to see the arrival of her new great-grandchild. After little Luke was born on January 26th, he was brought to the hospice and placed beside Gertrude in her bed. Thinking that this may have been what Gertrude was holding on for, the family braced themselves for the end. Surprising to all, Gertrude remained in hospice for nine weeks, passing on on March 8th, only five months after I first met and began interviewing her.

While she was hospitalized, Trish had bought Gertrude a little toy stuffed cat to offer her comfort. She named it Marrow because of her bone marrow cancer. She took to sleeping with it in the hospital and hospice, and taking it with her whenever receiving treatment. This little stuffed cat, Marrow, was put in her coffin with her prior to her burial.



Image #19 A myriad of cat memorabilia in Gertrude's home.

Participant #6: Pseudonym Ted, age 91. Gertrude's daughter provided a referral which led me to Ted. She said that a friend of hers, Kathy, had a father, age 91, living nearby and that the families were acquainted. When I reached Kathy by phone, she happened to be at her father's home for a visit. I explained the purpose of my call. Putting me on hold she conveyed my request to her father, got his agreement, and an initial meeting time was arranged.

When I arrived for my first meeting, another adult daughter, Anne, answered the door. It was clear that she was not expecting me and, as I stumbled over the complex explanation of the reason for my visit, Ted came in from another room and explained that he hadn't yet conveyed information about his participation in my study. Despite this awkward initial beginning, both Ted and his daughter were quite gracious during this and my subsequent visits. Shortly before the interview sessions began, Anne, a nurse, had begun frequently staying overnight at her father's home. Less than one year prior, he had begun to take a few falls, which led Anne to decide her father needed more help. Her relocation into her father's home began when she started stopping by after her shift to make him dinner. Then, gradually, she started spending more and more time at his house to watch over him until she eventually began spending many overnights there, even though her own home was not far away.

At the first interview session, Ted was very soft spoken, but was quite engaged. He knew exactly what year he had moved to the house (1961), what year each of his six children had been born, the year of his first heart attack (1976), and what year his wife passed away (2000). Anne commented that her father's memory had always been as "sharp as a tack."

Ted had a cardiac defibrillator implanted in around 2001 and a recent change to his heart medication left him feeling frequently dizzy. Within the 10 months prior to my first visit, Ted had taken three falls, had been hospitalized once for injuries sustained in a fall, once for

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Influenza A, and once following his defibrillator firing (Ted knew the exact date – February 3rd). One of the falls had occurred when he was carrying groceries from the garage into the house. He fell on the two concrete stairs which led from the garage to the back door. He could not get up, so used the cell phone he carried in his pocket to call the neighbor, who then took Ted to the hospital. Ted continued to drive for errands, although for the doctor's visits which took place around the time of my interviews, his daughter drove and, because of a bad ankle, she had to help him in and out of the car. Four months prior, he had stopped going to church on Sundays due to increased aches and pains in his back, hips and legs. At the time of the first interview he said, "If I keep improving another month or so, I might try it again."

He took pain medications for severe pain in his ankle. He had been going to the chiropractor for back pain twice a week and to a skin doctor. Ted commented that he had gone to more doctor's visits in the last 12 months than he had in the previous seven years. He reported that the previous night, he had severe pain in his ankle for which, for the first time in his life, he took a strong dose of pain medication, giving him the best sleep he had had in years. He optimistically said "The important thing is that it helped. I had a complete turnaround. I'm recuperating."

Ted had a clear wry sense of humor. At one point during the first interview, he abruptly stood and announced, "I have an urgent call!" meaning that he had to go to the bathroom. When I was leaving I said, "I'm so looking forward to getting to know more about you" and he replied, "I hope it stays that way, I hope I don't disappoint you"

I discerned a marked decline in Ted just a week later when I came for the second interview. His daughter answered the door. Ted was fully reclined on the recliner with a blanket covering him. He did not move from this position for the full length of the interview – a little

over an hour. He said he did feel not well and that his ankle was very painful. I said we could reschedule but he felt it would be fine to go ahead since I was there. He seemed engaged, but spoke very slowly and softly. After an hour he closed his eyes for a bit and I wrapped up the interview.

When I arrived for the third interview, I asked how he was and he replied, “Well, I’m still kicking. I can’t say much more than that.” He lay horizontal on the recliner with a blanket for the duration of the third and fourth interviews as well, at times unable to keep his eyes open. He apologized for his lack of energy. “I’m sorry to be such a dud” he said.

Ted had worked for 38 years as a sales manager for big ticket items at Sears. He reported that his store was consistently number one for sales out of the 53 stores in the region. He commented several times about his physical decline. At the start of one interview, when I asked how he was, he said, “I’m feeling my age.” Another time he said, “By the time I get up and brush my teeth and shave and shower, it’s all downhill from there.” He was woeful about his recent rapid physical decline: “It seems to me like the last, well 2 or 3 months ago I could walk up to the corner and back, that was ½ mile and I couldn’t hardly shuffle up to the end of my lot now and I’d be exhausted. I can’t believe that. I had no idea it would turn into this.” I asked about the rhythm of his days, “Do you find that you mostly just sit?” He replied, “Yep and I’m ashamed of that”

When I asked to tour the home, Ted said he would not be able to stay on his feet that long, so Anne took me through each room. Ted’s home included two bedrooms and a bath on the main floor, and two bedrooms and a bath in the lower level. One main level bedroom was large and had been used by Ted and his wife. At some point, soon after the family moved into the home in 1961, a very large bedroom had been completed in the basement for the “boys”—the

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three sons, a small room for the eldest daughter, Anne, and a bathroom with a shower. Thus the other main level bedroom next to the master was reserved for the youngest two sisters. The bathroom on the main level had only a tub and once the lower level bathroom had been installed (roughly in the mid 1960's), Ted started using it to shower and shave rather than the one near his bedroom on the main level. Thus the main level bath was primarily used by the wife and daughters, and the lower level bath by Ted and his sons. At some point following the death of Ted's wife in 2000, he decided that since he was living in the home alone, he would move to the large basement bedroom, to be on the same level as the shower. At the time of my interviews, Anne, the daughter, indicated that she and her siblings had urged Ted to move upstairs to avoid needing to climb the stairs daily, but that he preferred to remain downstairs. Grab bars had been installed in the lower level shower at some point, but it was unclear why the main level bathtub had never been retrofitted with a shower head and grab bars. "We're working on getting a shower up here" Anne said during one interview. Whether cost or construction/plumbing logistics was the issue was not clear, but no progress was even made to get a shower installed in the main level bathroom.

The bedroom that Ted used in the basement of the home had three single beds, which had been used by the three sons when they were growing up and a pool table which was now used to layout clothes, medicines, and lotions that Anne used for massaging his painful ankles and legs. Ted used the bed nearest the door and utilized a long pillow to assist finding comfortable nighttime positions. Ted's bed was loosely made. He said that he always made his bed daily first thing in the morning, living up to the longstanding family saying about bed-making: "make it while its hot."

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Image #20 Ted had used the downstairs “boy’s” room for his bedroom for many years to be on the same level as the home’s only shower, even though the main level master bedroom had a queen-sized bed.

Two days prior to my final interview, Ted’s defibrillator had fired and Anne had taken him to the doctor for a follow-up. I asked him how he was feeling and quietly and haltingly, he said “Rotten. But what do you expect at this age.” We only spoke for about 20 minutes at that final session. From his recliner, he directed me to look at several family photos on the shelf – one of him standing and grinning between his two adult grandsons, one of him dancing with his adult grand-daughter at her wedding. He seemed to want me to see him with the vitality he had once had.



Image #21 Happier times – Ted with his two adult sons (left) and at a grand-daughter’s wedding (right)

Sadly, Ted passed away on December 17, 2015, just a little over a month after my final interview with him. During the span of my sessions with him, from early October to mid-November, 2015, he had declined markedly. His daughter Anne, contacted me in early January

2016 to let me know of his death. Ted had finally moved to the main level bedroom around Thanksgiving. Anne took a leave of absence from her job around December 1st so she could be with him constantly. In his last three weeks, he went from walking on his own, to using a cane, to using a walker, to not being able to walk at all. A hospice service brought a hospital bed which was put in the living room so that his children and grandchildren could visit and attend to him. During his last night, he asked for assistance to be turned on his side, after which he took his last breath.

Participant #7: Pseudonym Margaret, age 95. In an effort to locate participants in the northeast Iowa, I had contacted the owner of the local *Home Instead Senior Care* franchise business. *Home Instead* offers a broad range of in-home services including ADL assistance, grocery shopping and meal preparation, house cleaning and maintenance, transportation, and companionship services. The franchise owner spoke with one client, Margaret, who she felt matched my criteria and Margaret agreed to speak with me.

When I first called Margaret, she said she could not schedule a meeting right then due to having “water problems.” Later, she explained that she had a leaky pipe under her sink that her son had attempted to fix. It proved to be a bigger job than anticipated, and he called a plumber. The distress this caused left her feeling unable to address my request to meet with her until all was fixed.

Margaret was 95 years old. She utilized a wheelchair and propelled herself around the house by scooting with her feet rather than wheeling herself. When in the living room, she would transfer herself to one chair which was more comfortable for watching TV. She had chronic stiffness, pain, arthritis, high blood pressure and a bad hip. “I need a hip replacement,

but they tell me I'm too old." The constant pain she felt diminished her appetite and she said she had lost quite a bit of weight in the last year. She was quite thin.

Seven years before our interviews, Margaret's husband died after a long illness during which she was his caretaker. He had cancer and was committed to remaining at home, so Margaret had become his primary care giver. Like Margaret, he had no interest in leaving home, so he stayed there until his death. "He said they're going to have to carry me out of here, well they did," she explained.

She reported having ever-present pain. In order to get out of bed each morning, at about 8:00, she first put a heating pad under her hip. Once warm, she could manage to elevate herself using the bed rail and transfer herself onto the wheelchair. As with all other participants in this study, she was a daily bed maker, in spite of being unable to stand and having upper body stiffness and pain. She explained, "Oh it's not easy. It's hard. I take the grabber with me." She used her grabber device for many tasks. She had pain medication that she chose to take sometimes and avoided taking at other times. Although the medication alleviated some pain, she felt that these pills made her mind numb and slowed her reactions. She described, "It makes you like you're slow. If you'd ask me something, you'd have to repeat it. I try not to take them. If I know I'm going to be here by myself, then I take them because I don't have to reply. I hate that." She intended to have cataract surgery at some point in the past, but when she arrived for the surgery it was discovered that she had a bladder infection and the surgery was cancelled but not rescheduled. "I haven't attempted it since." She had a visiting nurse come out once every two weeks to check blood pressure and draw blood for lab tests.

Before using the wheelchair, she had utilized a walker for three to four years, until she felt it no longer offered sufficient support. Her wheelchair caused her many concerns. The one

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she used, which she augmented with a cushion on the seat, felt comfortable and familiar to her, but the rubber had worn off the wheels and the wheels left black marks on the carpeted floors. The carpet, although in fairly good condition, appeared to be decades old, but these marks bothered her enough to try a new wheelchair. The new one was less comfortable and the breaks were more difficult to manage, but it was narrower, therefore easier to maneuver around corners and through doorways. The decision about which one to use perplexed her, but she mostly defaulted to the older one.

Margaret was unable to lift her arms above her head. She could not pull the window shades up or down and could not tear the page off the wall calendar. I visited her a few days after daylight saving time ended in November and she explained that she was unable to turn the hands on her wall clock and she would have to remember to have her son do it on one of his upcoming visits.



Image #22 Margaret showing how she used her grabber, which she kept ever-ready. She used it to make the bed, get things out of cabinets, pick things up off the floor, get clothes out from the closet and also to put them away. Margaret's range of motion did not allow her to turn back the hands of the clock when daylight saving time ended.

Because of her difficulty in raising her arms, she wore button-up shirts that she could get on and off without needing to lift her arms up. Seated in her wheelchair, she could not use the upper cabinets so items she used frequently had been moved to the lower cabinets and drawers or

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sat on the countertop. A newer countertop microwave was used instead of the one installed above the stove.



Image #23 Although tidy, everyday items sit on the counter rather than in upper cabinets.

Margaret had stopped attending church several years ago when she started using the walker because the front entrance of her church was not accessible. Although a ramp has since been added to the church, she did not want to bother her son Mark with requests to be taken to church and helped up the ramp and into the church early on a Sunday morning so, although she had been a regular church goer throughout her life, she stopped attending services. Her congregation had volunteers who were willing to provide transportation and assistance to older people but she said, “I don’t want to put that responsibility on [anyone]. If I should fall, I don’t want someone to feel bad.”

Margaret’s son, Mark, was 71 and lived just three miles away. Her daughter was 68 and lived two hours away. Mark came to Margaret’s house every day. He picked up the newspaper and the mail from the mailbox across the road from the end of her long driveway. She read the paper and mail using a magnifying glass. Between Mark’s daily visits, the home services person who came weekly and the visiting nurse who came every other week, she had people in her home most every day. Mark also went grocery shopping for her on Saturdays. In addition to getting the mail and paper daily, Mark stayed on top of home maintenance chores such as putting salt in the water softener and changing the furnace filter.



Image #24 The chair lift which had been installed a year earlier, and Margaret's car which she has not driven for five years.

Margaret had given up driving about five years before our interviews. About a year before our interviews, her son had a chair lift installed in the garage. The height of the floor within the home was several steps higher than the garage slab, and the lift allowed Margaret to get to the level of the garage floor and driveway so that she could get into the car when Mark drove her places. Often, they utilized her car instead of Mark's because he had an SUV, the height of which made it more difficult for her to transfer to the vehicle.

Margaret had four grandchildren and six great grandchildren. When asked how often they come to visit, her response was "Not enough. They're busy, I realize that. It's not.... I can't do much so it's not a very exciting place to come."

Margaret spoke about her family member's wishes in general terms: "They banned me from the basement" and "They'd like to make me move." When asked for specifics she said, "My son is pretty easy on me but his wife would like to see me move. My daughter's been after me for years." I asked why she thought they had held these opinions, she replied, "It relieves them of responsibility." She seemed not to appreciate the pressure put on her by family members and she attempted to lessen it by not voicing her needs, "I try not to bother them."

Mark had expressed repeatedly to her that he was afraid that he would arrive one day to find her on the floor. He often told Margaret "I just hate the thought of coming down and you

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had passed away someplace in the house.” This left her feeling guilty and when she told her home care worker about it, she tried to assuage Margaret’s feelings of guilt. She said “Don’t worry. Just tell him he won’t have to do anything. Just call me and I’ll come over to take care of everything.” Relaying this to Mark seemed to relieve Margaret of some of the responsibility she felt to follow his wishes to consider relocation.

The home care worker from the *Home Instead* service visited once a week. For some time, Margaret had the same woman, Pat, from the service and Margaret felt very comfortable with Pat. Pat picked up groceries, changed and laundered the sheets, vacuumed, and cleaned up the kitchen and bath. Margaret herself was able to put clothes into the washer (located on the main floor near the kitchen), but could not reach in to get them out. Pat did that and put clean clothes away. Just after I first interviewed Margaret, Pat was to have knee surgery and another worker was scheduled to take her place for weekly services. This distressed Margaret greatly. She felt ill-at-ease having a new person come to the house. A replacement came and Margaret did not find her to be helpful or a hard worker. “She just came in and she sat down, that’s all she did.” She expressed several times that she hoped Pat would return after recovery rather than to quit. She wanted to regain the ease she had with Pat, on whom she had come to depend.

Occasionally, she had the pharmacy deliver her medications. She instructed them to go to the back door which was easier for her to open than the front and to call when they were nearby. Then she opened the garage door and maneuvered herself onto the chair lift to wait for them. “They got really nice delivery guys. They do. He always talks for two or three minutes when he comes.”

On a typical day, Margaret stayed in her nightwear until about 10:30 when she either took a shower and then got dressed, or just got dressed. She said that these chores took a long time

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because she moved so slowly. Many years earlier, grab bars were installed on the shower walls and a seat was put in the shower. She remarked that, when this had been done for her husband, she never expected that someday she would rely on these showering aids as well. She would transfer herself onto the bench, rotate her legs around, and close the curtain behind her. She showered and washed her hair a few times weekly. She watched “Let’s Make a Deal,” “Family Feud,” “Shark Tank” and “The Lawrence Welk Show” reruns on television. She used to like watching cooking shows until she felt they were all using too much garlic, which she did not like, so she stopped watching the cooking shows. She herself did very little cooking any longer. She had a fear of burning herself using the gas cooktop while seated in the wheelchair and reaching across the cooking surface, so she relied solely on using her microwave and slow cooker. She had enjoyed sewing her entire life, making clothing and quilts. Although she was no longer able to do it, she kept her sewing machine in the spare room where she watched television.



Image #25 Margaret’s shower had a seat which straddle the tub, and grab bars. Margaret’s sewing machine remained set up, with pins, pin cushions, and sewing machine oil, even though she had been unable to sew—due to back pain—for many years.

Margaret expressed both attachment to home and aversion to senior housing. About her home she said, “Not that it’s anything special. It’s not a great house or anything, it’s just home. I can practically do [anything] in the dark.” She had considered moving, perhaps only because “sometimes other people know what’s better for you.” She described, “I went to a rest home and looked. Not nearly as handy as what I have here. You have to bundle up all your clothes and

take them heaven knows where to wash them.” She also expressed this thought about senior living facilities: “If you go to a nursing home then they have Bingo and crafts. I’ve been there, done that, I don’t want to do it anymore. I don’t know if I... I’m not trying to be negative but I just don’t want to.”

Several years prior Margaret had convalesced in a nursing home for about a month. She had a roommate and did not like the lack of privacy. Nights were the worst she said. “I just wanted to be home.” Her daughter and son-in-law came one Sunday morning and had taken her for a ride. They asked her if she wanted to stop by at home to pick up anything, and she said she did. When she got into her kitchen she said, “I’m not going back.” She steadfastly refused to go back to where she said all she did was sit in one room.

During her stay at the nursing home, she needed to go to the bathroom at 6:30 one morning so she called for a nurse who assisted her into the bathroom. When she came out, her bed had been made. Margaret had not wanted to get up at that time, but now had to. Margaret felt certain that any senior housing scenario involved abandoning one’s free will and being at the mercy of others. “They tell you when to eat, when to take a bath, when to go to bed. That one lady, she was like me, she was a night owl, she liked to stay up until she could see the news, so they’d give her downer pills. So she’d go to sleep. Then they’d give her uppers in the morning. Because they want you up in the morning.”

I interviewed Margaret shortly after Thanksgiving, which she had spent at her son’s house just a few miles away. With her wheelchair lift in the garage, she was easily able to get to the car to be driven to his home, but the entrance to his home had a half dozen or more steps. Her relatives had picked her up in her wheelchair to get her into the front door, an incident that she reported as embarrassing.

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When I interviewed Margaret in early December I asked about her plans for Christmas. Several years before she had come up with a good idea for Christmas decorating. She had a small artificial tree which she kept decorated with ornaments. It was kept in the front closet and taken out every year by her son—already decorated—to sit just in front of the closet door in the corner. Thus she was able to enjoy her decorated tree every Christmas through manageable effort.



Image #26 The front closet which housed the decorated Christmas tree.

Participant #8: Pseudonym Peter, age 93. One resource I used to locate potential participants was the Northeast Iowa Area Agency on Aging (nei3a) (<http://www.nei3a.org>). Located in northeast Iowa, nei3a is a non-profit providing services to elders in 18 Iowa counties. Although a great number of their clients would have certainly met the qualifications for my study, recruiting participants through them proved difficult. I met with a few key individuals within their main office who said the best they could do would be to circulate information about my study to the individual case workers who had direct contact with clients. I had all but given up hope of recruiting when one case worker did contact me about a 95-year-old male who received Meals-on-Wheels five days a week, and—through **nei3a**—a home health aide who assisted with showering, checking vital signs and light housekeeping once a week.

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Peter lived in a dilapidated two-story home built in 1900 in a small town in east-central Iowa. A ramp had been built at one time to accommodate the wheelchair used by his wife before she had died. The outside of the home showed considerable deferred maintenance. It appeared to need painting and porch, window, sidewalk and roof repair.



Image #27 The exterior of Peter's house.

The first few minutes following my arrival for the first interview were frenzied. Peter opened the door after I rang the bell and when I opened the screen door to enter a cat appeared from nowhere and scurried inside, dismaying Peter, who clearly did not want the cat to come indoors. The subsequent chasing the cat around the living room to catch it and trying to put the cat into the basement without letting another cat out occupied the first several minutes of my visit. After accomplishing this, Peter looked at me and said, "Now, who are you???"

The two cats belonged to Peter's 60-year-old son, Terry, who was a truck driver. Terry regularly drove a route from New England states to Colorado and would stop in route at his father's house for a night or two about twice a month. When Terry's stops in Iowa were less frequent than normal, due to route changes or weather or wind conditions, the cats, who lived in the basement, were left there alone for the duration, but with an ample supply of food and water, as Peter would have no part in their care. He was unable to bend over to fill their water or food bowls or to clean up the litter box, so he ignored them until Terry returned.

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When in town, Terry would pick up groceries and other necessities for his father and would haul the garbage offsite for disposal, but did not appear to provide much other assistance in the way of house maintenance. Nor did Terry facilitate Peter getting out of the house in spite of the fact that being home-bound disturbed Peter. The two would sit in adjacent recliners and watch hours of television. Peter said he enjoyed the company when Terry was there, but did not like that Terry commandeered the TV remote and made all the programming choices.

Peter was a big baseball fan and liked to watch games on TV, therefore he relished baseball season as a favorite time of the year. He was virtually blind but, with the commentary, could make out what was happening in the game. He felt he could see baseball games on TV much better than football games – because there was less activity on the screen in baseball.



Image #28 Peter's living room with a stack of clothing items belonging to his son Terry who visited between cross-country truck hauls.

Terry slept in an upstairs bedroom when he visited and used Peter's home as a storage location for his own personal items. He kept many clothing items scattered about on the living room sofa and floor. "That's all his stuff piled up around there on that couch there. He's got more clothes than Walmart" Peter said. The cluttered living room was where Peter primarily spent his days sitting and watching TV, as did Terry when he visited. Peter had pinned his

draperies closed at some point in the past when the drapery traverse mechanism on the rod had ceased operating effectively, and they could no longer be closed by the standard means.

Peter also had two daughters who both lived out of state and visited very infrequently. One daughter phoned every evening at 8:00 and had visited from Pennsylvania a year prior. The other daughter phoned very infrequently.

Peter had grown up in Iowa with five brothers and sisters, all of whom had passed away years before, many from complications of alcoholism, as had several siblings and family members. His father had died when Peter was 16. His single mother managed to operate a farm and get the younger children raised, with the help of the older children. Peter commented, "A person's life gets filled with tragedy. Why I'm still alive I don't know. God knows, I guess."

At the age of 18, Peter joined the army. In 1943, he was assigned to a field artillery unit and stationed in several locations in the Pacific and Japan. He did payroll and accounting work at times, but his duty often included diggings graves for the dead Japanese. He described:

I never actually killed a Jap, but I may have helped. I never saw such a gruesome....

They were lying dead like flies. They'd been in the sun for at least three days. There was hundreds of them dead Japanese. They finally brought a bulldozer in.... They'd scoop out a big hole then they'd back up and scoop these dead Japanese in. I've seen a dead bloated Japanese get under a tread and pfooo. You can imagine the odor. The war changed my life and I never got over it entirely. I can talk about it now because it doesn't matter. The Japanese are our friends now.

He had been wounded when, in his barracks, he accidentally dropped his gun while trying to put in the holster and it fired as it hit the floor and shot him in the leg. "I was sitting on a cot so I was tilted up. How it missed my other leg or missed worse places beats me. The captain

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came around when I was in the hospital. He said, 'You didn't do that on purpose did you?' I said, "Captain, I wouldn't shoot that close to my privates."

After the war ended, he returned home to Iowa to help his mother with the farm. She died just three years later and Peter, at age 26, took over the home and the farm. Two years later he married. Peter was married 63 years before his wife died in 2013.

He had decided he did not like farming so he sold his share of the farm to his brothers and sisters and became a truck driver. In 1966, he and his wife bought their home in a small town in east-central Iowa. At some point, his wife became fed up with his being on the road so much, so he took a job with shorter routes, allowing him to spend more time at home with his wife and young children.

Peter spoke of having a happy marriage and the enjoyment of raising his three children. Before his wife passed away in 2013, she spent the last year or so (Peter could not recall the timing exactly) at a nursing home. He had previously given up driving, so he purchased a golf cart that he used to drive to see her every day except when the weather was bad. Apparently, this was allowed in the very small town where he lived. He visited her every day he could. He believed marriage involved all aspects of life. "After all, we'd gotten married for better or worse."

Although he could not recall the length of time his wife had remained in the nursing home, he recalled the exact date of her death: February 27, 2013. Peter had a myriad of health concerns. The gunshot wound he incurred during the war gave him leg pain. He had difficulty swallowing which he attributed to having a crooked neck and throat. He had no teeth, of which he admitted to being ashamed. He had gradually lost teeth and had bad teeth pulled over time, but because he never had dental insurance, he had never been fitted for dentures. He described

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his eyesight as being ‘virtually blind’. He did wear glasses which had treated lenses that darkened when in sun light but he did not like because he felt the lenses darkened even inside and he felt he could not see. His sight was blurred due to macular degeneration and cataracts, and had a hole in his field of vision. He said, “My eyes get worse almost day-to-day.” Getting an appointment with an eye doctor to get a new prescription and new glasses seemed beyond him. His small town did not have an eye doctor and he did not know how he could get to a neighboring town to see the eye doctor. Apparently, Terry never volunteered to facilitate this process.

Peter also had some difficulty hearing. Many times he asked me to repeat myself or to speak more slowly. He was uninterested in a hearing aid based on the experience of his brother who had one year earlier and had difficulty managing it. Peter had a pacemaker implanted seven years earlier and reflected that the useful life of the battery may be nearly exhausted, but he did not feel a replacement was worthwhile because “I might not live much longer.” He utilized a seated walker. In addition to use as a walker and a chair, the seat, he felt, presented a handy tool for bringing his plate from the living to dining room at meal times.



Image #29 Peter’s seated walker served him well.

At some point in the past few years—he could not recall precisely when—Peter had been hospitalized for a sodium imbalance. Two years prior to our interview, Peter had broken a hip when he fell while walking from the bedroom to the bathroom in the middle of the night. He

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was wedged half inside half out into the very narrow corner where the main floor shower had been retrofitted some years earlier. Luckily, his grandson had been visiting and called 911.

Medics arrived and had to drag him out of this this tight corner. He had surgery to repair the hip and had recovered, for a time, at a nursing home.



Image #30 A small shower had been retrofitted on the main floor some years earlier. Peter's walker just clears this corner to get past to the half bath beyond.

Through the local agency on aging—through which I was connected with Peter—he received weekly home care services. He received these services free of charge through Medicaid. To my knowledge, Peter was the only participant in this study who received Medicaid, which indicated a low income. The home care worker also did his laundry, light cleaning (dusting and vacuuming), the dishes, counted out his pills and got him in and out of the shower to make sure he did not slip and fall. He said, “I still can't get used to taking my clothes off in front of another woman. You lose that modesty eventually.” She checked his blood pressure, cut his toe nails and checked his swollen ankle. When I was visiting, Peter's physical appearance was disheveled with wrinkled and slightly soiled clothing and he had ample dandruff on his collar and shoulders.

The home care worker also made out his checks to pay utility bills, and he signed them – he could not see to write the checks. She picked up the mail from the post office and brought it inside. Peter put the garbage bags on the back porch. When his son Terry came to town, he put

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them on a trailer and drove them to the transfer station. The home care worker was not able to do it because garbage day was Monday and she came on Tuesday.

At some time (he could not recall exactly but estimated it might have been about 2007), Peter could no longer navigate the stairs up to the second floor where the bedrooms were located so he moved his bedroom to the front room of the house. He had not been to the second level since that time. The house, originally built in 1900, had been a rectory. The main-level pastor's office had become Peter's bedroom. There was no closet in this room, so clothes were stacked on several pieces of furniture. Like all other rooms, this room was cluttered and in disarray. He explained, "You do what you can. What you can't do, you gotta let go."



Image #31 Peter's bedroom. With no closet, clothes and personal items were stacked up.



Image #32 The "commode" besides the bed.

In spite of this attitude, Peter was a daily bed maker. Even though his son and the home health nurse were the only ones to enter the house, he explained that he took pride in this accomplishment. He utilized a bed-side commode rather than making frequent trips into the

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bathroom in the middle of the night. His morning routine was comprised of getting up, getting dressed, having breakfast, making the bed and then emptying the contents of the commode.

Peter received Meals on Wheels five days a week for the noon-time meal. For other meals, he was fond of making frozen pot pies in the microwave or baloney sandwiches. He was afraid to use the gas stove. It was old and sometimes did not properly light, so he feared that in lighting it, he might cause a fire due to his poor eyesight. He used the microwave often but, due to his poor vision, needed to use a flashlight in order to illuminate the buttons on the control pad.



Image #33 Peter's stove and microwave.

Through Medicaid sponsored services, he also receives free boxed meals which needed no refrigeration and had a three-year shelf life. He was unable to use a can opener due to lack of hand dexterity, but was able to use the flip tops that these containers had. His son, Terry, had bought a Keurig coffee machine for the kitchen – the only shiny item in his messy kitchen. He used it daily to makes coffee.



Image #34 Juice box, beef stew, crackers, canned peaches and cookies in the boxed meal. The Keurig machine was the only bright shiny and new item in the messy kitchen.

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After his wife had died in 2013, he had cashed in his life insurance to pay for the portion of his wife's medical bills which were not covered by Medicaid or Medicare, and he was still paying on those outstanding expenses. He reported that his furnace needed repairing, but that he could not afford it. He stated that his utility bills were very high, which was likely the case as this 100-year-old house was likely energy inefficient.

Although the home care worker did light cleaning when she came weekly, the house was dusty and the floors were unclean. All areas of the home were untidy, with the exception of Peter's daily made bed. Peter was a self-described shut in, he only left the house to be taken to the doctor. Sometimes during good weather, he went onto the front porch. He reported that a year ago he could watch traffic on the road, but now he could not see that far. My interviews with him were in November and he had left the house only twice in the past six months: the previous June when he had been taken to the doctor because he was having trouble swallowing and a month or two before when his daughter had come to visit and took him for a ride in the car. I interviewed him a week before Thanksgiving, I asked what he would do. "Probably just another day," he said. He was unsure if Meals on Wheels would deliver on Thanksgiving. If not, his plan was to have a pot pie. Peter reflected on living to the age of 93: "Well it's not so great when you get up to it.... I'm housebound.... I'm kind of a lonely person, you know." But he was an enjoyable individual to get to know and seemed to be a good-hearted person in spite of his gruff exterior. When discussing why he had consented to participate in this process, he stated, "That's one reason I agreed to this. I thought I needed to give something to somebody."

Participant #9: Pseudonym Tilda, age 98. My two female cousins from the east coast visited me at my home in Minnesota during the summer of 2015. After hearing about my

ongoing dissertation research, my cousin from New Jersey divulged that her 98-year-old mother-in-law, Tilda, may be an ideal candidate. A single story about this elderly woman convinced me that her particular adaptive nature may be relevant to my study. Since 1947 Tilda has lived, in a two-story, two-family, walk-up home. Widowed for 15 years, she has been determined to remain at home despite the fact that her home was the second story of a duplex, with one 3-bedroom home on the main level, and a duplicate home—hers—stacked above. Remarkably, Tilda still drove for shopping and doctor’s appointments. She managed the challenge of bringing groceries home and up the stairs with the distraction of prayer. Starting at ground level, with bags in hand, she would lift them and sets them on the first step, reciting the first stanza of the Catholic prayer recited when saying the rosary: “Hail Mary, full of Grace.” She stepped up to unite with the bags, lifted the bags again to the next step, “The Lord is with Thee,” and so on through the entire prayer until she made it to the top.

I knew then that Tilda was a woman I wanted to interview. My other cousin, a sister of the first and physician in Rhode Island said, “I have many elderly patients and I could ask about interest in participating in your study if you want to come to Rhode Island.” Thus, participants #9 and #10 were recruited, one in Clifton, New Jersey, and one in Cumberland, Rhode Island, and a trip to the east coast was planned.

Tilda’s referred to her home in New Jersey—a two-story duplex with identical 3-bedroom units on each level as a ‘two-flat’. She had bought the home in early 1947, as a joint purchase with her sister, a young widow with three children. The sister and her children were to live in the main level unit, and Tilda—a 29-year-old single woman at the time—would live in the upper unit with her parents. Feeling she may never get married, she thought that purchasing a home would be a good investment for the future. As luck would have it, a month after

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purchasing the home, she met her future husband who moved in after their wedding in early 1948. Two children followed in 1949 and 1951, so the 3-bedroom upper-unit home housed three generations (6 people) until her parents passed away in 1957 and 1958. The couple on the main level were in their 80s, but it seemed that Tilda was better able to offer assistance to them, in the way of companionship and managing the joint utility bills, then they were for her.

Shortly after having their first child in 1949, Tilda's husband, Jim—who only had an eighth grade education—lost his job. Tilda, very much an extrovert, went down to the local grocery store where she herself had worked as a teen-ager. “You got anything around that can help my husband?” she asked the store manager? It happened that the store owner had decided to open a meat counter and was looking for someone to run it. Thus, Jim obtained a job as a butcher.

Several years later, the store owner offered to sell Jim the butcher shop business located within the store so that he could both own and operate it. It became a family enterprise, with Tilda sometimes working there on busy Saturdays while her mother and father watched the young boys at home. And both sons, as they went through school, worked at the shop after school to help their father. Although proud of her husband's hard work, Tilda used this as a teaching point, telling her sons “Now this is what you'll do if you don't go through college.” Both sons did graduate from college and went on to have successful careers.

When her sons were both in high school, Tilda decided she wanted to fill her days with more activity. She got a full time job doing clerical work at the nearby Sterns and Foster factory, where she worked for over 25 years. She was in charge on managing the inventory of ‘wadding,’ the soft stuffing material used in the fabrication of mattresses.

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I interviewed Tilda on three consecutive days. Each time she was wearing an attractive sweater, nail polish, earrings, lipstick and two diamond rings. Her hair was colored a stylish auburn. She did her own nails and put on makeup if there were to be any visitors to the house. She owned many nice clothes and shoes, purchased decades earlier and thought she might just as well dress nicely on a day-to-day basis, rather than wearing the same thing daily or wearing very casual attire. Because she had arthritis in her hands, she used the magnet clasps which augment the original clasps making it much easier to put on her jewelry.

Although she admitted to having difficulty getting rid of things, Tilda kept her home very tidy. She proudly displayed a drawer where she kept old bank statements, taxes and such. She had kept all of the paycheck stubs from her working career at the mattress company, a job she had retired from more than thirty years previously. She also had her husband's ties and wallets in a drawer, neatly organized. She still had many of the clothes and shoes she had purchased as a much younger woman. The home had been retrofitted—many decades previously—with several additional closets including one in the dining room. She also had two standing wardrobe closets.



Image #35 Tilda described having liked nice clothes and shoes, all of which had been kept for decades, in closets and wardrobe cabinets like the one at right with a broken lock.



Image #36 Tilda's formal living room (left), and dining room (center), although they had been the location for family activities for decades, were hardly ever used any longer. Tilda and her guests always spent time sitting around the kitchen table (right).

In the cold months, Tilda closed off the front part of the house to reduce her heating costs. Even in the warmer months, she rarely used this part of the house which included a large living room and dining room, both with peach plush carpeting, but spoke fondly of times when these spaces were used for gathering of her large, Italian family. Tilda spent the majority of her time in the kitchen, a small porch off the kitchen and in her bedroom.

The main front entry and enclosed stairway had long ago been ignored as the home's entry point in favor of the rear entry and stairs which led directly from the driveway into the kitchen—the main room used by Tilda and her guests. The exterior rear door—now the main point of entry—was at the ground level. The enclosed stairway—with treads which are uneven, sloped, worn and very steep lead to a small back porch and the back door into the kitchen. A few years prior to my interview, somebody had replaced the lock on the back door at the ground level with one Tilda could lock and unlock using a remote device. This saved her having to go up and down the steps when any guest or delivery person entered and exited. She herself had to climb and descend these steps each time she left her house. These were the times when she recited prayers to distract from the strain involved with climbing these steps. It is possible that

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managing these stairs regularly have provided Tilda with healthful regular exercise which had contributed to her present physical health.



Image #37 The exterior door into Tilda's home (on the far right of the left photo), and the interior stair leading to her kitchen. The exterior door had been retrofitted with a remote lock.

She split the cost of a lawn care and snow removal services with the owners of the main level duplex unit. Mail was delivered daily to the mailbox at the ground level entrance of the duplex. The downstairs neighbors had hired a home care worker who came in for six hours a day, five days a week. It was also part of her duties to collect the mail daily and bring Tilda's mail up the front stairs and leave it outside of Tilda's front door. Tilda noted that often the only time she went into her front living room was to get the mail left outside her front door.

The couple on the main level paid their home care worker \$15 per hour, a low rate that indicated she may have been working for cash only. Even at this rate, Tilda noted that they were paying about \$1800 dollars per month for these services. Even though the charges for a health care aid accumulated quickly Tilda noted that she might want to hire someone for the night time hours which were the most difficult for her as she could not sleep and sometimes had difficulty getting to the bathroom. But Tilda feared that no one would want to provide those services merely during overnight hours: "Who would want to come and sit with you at those hours? Two o'clock in the morning?"

Tilda still drove and she had a handicapped permit for parking. She said that she reduced her range of travel several years ago at the age of 90. She had a 2002 car with less than 13,000

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miles on it, a testament to the short distances she drove. She made sure never to be out after dark. She lived in a very densely populated area of New Jersey, but could get to the pharmacy, grocery store, post office, bank and Burger King by taking back roads so that she did not need to drive on major roads. When she purchased large quantity of items, she would use the delivery service available through her pharmacy and grocery. The delivery man would carry items up the stairs directly to her back door. She felt the added expense for delivery was worthwhile. Her daughter-in-law provided transportation to doctors' and hairdresser appointments - destinations further away from Tilda's home. In her densely populated suburban area, there were several nearby restaurants with delivery service, including an Italian restaurant just two blocks down the street. Being a full blooded Italian, this suited Tilda very well.

Both of Tilda's adult sons called her most evenings. She joked their purpose was to "see that I'm still living." Occasionally, one of her daughters-in-law or an adult grand-child would call Tilda during the daytime hours and she would, perhaps, be at the grocery or drug store. When she did not answer the phone, a bit of panic would set in for her loved ones, until it was discovered that she was fine, just temporarily away from home. Each of her sons visited about twice monthly, and fixed small things or replaced light bulbs. Her sons, daughters-in-law, five adult grandchildren and three great grandchildren all lived within 40 miles, so holidays were never spent alone and visitors were frequent. She had started to watch mass on television every Sunday morning rather than drive to the church, simply because it was less taxing. She did not allow this to deter her from what she felt was her financial obligation to the church, however. She put aside five dollars every Sunday and would mail her money to the church every month or so. She remained part of a woman's group at church which she attended about once a month. Every spring she brought her low mileage car to her mechanic for an oil change and a checkup.

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This car maintenance business was owned by the grandchild of a woman Tilda knew from church, so she trusted that the maintenance is done properly. The state of New Jersey is one of only two states in the nation (the other being Oregon) where it is not legally permissible to pump your own gas, a benefit for older drivers such as Tilda, who may have difficulty pumping their own gas.

Tilda prided herself on her daily computer use. She emailed relatives and was on Facebook. She enjoyed following the photographs that her children and grandchildren posted on Facebook. She also utilized her computer, located handily in one corner of the kitchen, to read news, play games and play music. She even admitted to dancing around the kitchen to the music she played on her computer.



Image #38 Tilda's computer in the corner of her kitchen.

Tilda enjoyed watching television in the evening. She described her activities after dinner:

So, I love [my computer]. That's half my life really. Then I have the TV. I have a TV in my bedroom, which is the one I use mostly. I've got an easy chair in there. Like, comes eight o'clock at night, I figure, eh... I close up the kitchen and I go in the bedroom. I get ready for bed and I'll sit in the chair 'til eleven o'clock watching TV.

Physically, Tilda seemed very healthy for her age. She spoke of her means of managing daily back and leg pain from arthritis and her occasionally dizziness. Describing the arthritis, she said, “That can cripple you. Some days it’s so bad I don’t want to move.” She utilized a seated walker during times when it was painful to walk and also during the middle of the night. Rising suddenly after waking in the night often made her dizzy, disoriented and unstable, so she used the walker, what she called a carriage, for the trip to the bathroom and back. She wore incontinence pads at night for the event that she did not make it to the toilet in time.

Standing up from a lying position—either first thing in the morning, or when she had to use the bathroom in the middle of the night—presented her most physical challenge. She followed the advice she had received from the Dr. Oz show, to put your hands on your knees to help you stand. Once upright, she gained strength and stability.

She had several episodes with painful hemorrhoids. She described, “You can’t sit, you can’t stand, you can’t sleep, you can’t go to the.... Terrible. Terrible.” A year previous to my interviews and during a painful bout, Tilda had hired a live-in home health care worker to care for her for a few weeks. I learned from my New Jersey cousin, Tilda’s daughter-in-law, that in the area where Tilda lived, in the outer suburban area of New York City, it was commonplace to hire un-documented foreign workers as home health aides for cash payments. My cousin knew a family from Belarus who knew of a young woman who had recently emigrated. Tilda had hired this woman to live with her during her bout of hemorrhoids. She described:

So we got a girl. We found a girl. A woman. A nice woman. She couldn’t speak too much English, but she was learning and trying, but I loved her. She wiped my behind. Whatever I had to do. I mean, oh, my God! She helped me. I went to the doctor, and he didn’t do anything. He just said to me to soak it and this and that. After I soaked it must

have burst, because it was bleeding and the girl was here and she helped me a lot. with that.

During the daytime, she watched TV and worked on her computer. “The Price is Right” at ten o’clock, “Let’s Make a Deal” at noon, “Dr. Phil” at three o’clock, and “Jeopardy” at six o’clock pm were her regularly viewed programs. During nice weather, she would like to sit on her porch and watch cars and people passing by.

Tilda ate fruit and cereal for breakfast. For other meals, she cooked simple dishes, such as fried eggs or toast with peanut butter. She often cooked frozen prepackaged—what she called TV dinners—in her microwave. She often shopped for and kept dessert items in the house, because she loved to treat herself and her visitors: ice cream, cookies, apple pie. When her sons, daughters-in-law, or adult grandchildren visit, they assist her with making spaghetti, using frozen meatballs and sauce from a jar.

Tilda had a cleaning person who came once a month to give the house a “good cleaning.” She also changed the sheets, as putting the fitted sheet on the bed was difficult for Tilda. But between times, Tilda managed to keep up with things. She explained, “I mean, if I’m in the bathroom and I dirty it, I clean it now. If I’m in the kitchen, then I’ll clean it. I mean, if I let that go and this go, then I’ll be in trouble.”

When her husband had died in 2000, Tilda never considered moving to senior housing or down-sizing. When her daughter-in-law’s parents toured a brand new facility in the area, in anticipation of moving themselves, she had accompanied them on the tour. This facility had an exercise facility and pool, a large restaurant-style dining room with many varied meal options, a convenience store, a movie theater and other amenities. These offerings did not impress her. Rather, her lasting impression was of the very long hallways, which left her wondering how she

would escape in the event of a fire. She was also put off by the large down payment required for admittance to this facility. She thought a much better use of her money would be to remain in her home and pay for in-home services as needed. She said, “I don’t know. I’d rather have a girl come here. Spend the money I’ve got in the bank. That’s what it’s there for.”

Participant #10: Pseudonym Helen, age 92. My cousin, a physician in Providence, Rhode Island, convinced me that a visit to see her would be worth my while, as she had several older patients who might fit my criteria. In the end, I interviewed only one of her patients. Helen was a 92 years old who had lived in the same home for 63 years and was agreeable to being interviewed. She agreed to meet with me based on her positive assessment of my cousin as her physician. “Any relative of Dr. Henderson must be a good one” she told me when we met.

Helen’s parents had both emigrated as young adults from Portugal and met in Massachusetts. Her father got a good job at a steel plant. Shortly after their marriage, and while Helen’s mother was pregnant with her, she was called back to Portugal to become a care-taker for her own mother, Helen’s grandmother. The grandmother had taken a fall and gotten a pebble imbedded under her skin which became infected. In an eerie foreboding of her mother’s own fate, Helen’s grandmother had her leg amputated and needed full time care. Helen’s father did not want to leave his steel-working job, so the couple separated, though not due to any relationship issue. The two wrote letters to each other often and longed for the day they would be reunited. Helen was born in Portugal. With his wife across the globe, Helen’s father began drinking and was not taking good care of himself. When Helen was about three years old, he quit his job at the steel plant and boarded a ship back to Portugal to reunite with his wife and young daughter. He developed pneumonia on the journey, never recovered, and died shortly after arriving in Portugal, at the age twenty-eight.

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Having had no relationship with her father, three year-old Helen did not understand her mother's sorrow. Young Helen told her inconsolable mother "Don't cry, mama. We can get another daddy." When young Helen was six, she and her mother, now a young widow, travelled back from Portugal to Massachusetts. They moved in with Helen's mother's aunt and her houseful of older children. The year was 1930, so the economic times were very challenging. Helen's mother took on jobs in other people's homes: caring for children, doing cooking and housecleaning, whatever work she could get. She would give all the money she earned to her aunt to help feed the entire family, including little Helen. Helen learned the English language much more quickly than her mother, so Helen became her mother's translator and teacher. Years later, Helen's mother met her second husband, who became Helen's beloved step-father.

Helen met her future husband, Tony, while in high school. They married in 1950 and two years later Tony was drafted to serve in the Korean War. Before he left for Korea, plans were already underway to build a home in Cumberland, Rhode Island. With Tony away at war, Helen managed to oversee the move into their newly-built three bedroom ranch home. Part of the plan all along was that Helen's mother and step-father would live in the home along with the couple, an arrangement that continued until the end of both their lives. After returning from the war in late 1953, Tony remained in the army for a time.

Tony and Helen's first son, David, was born in 1955, their second son, Dean, in 1958, and their third son, Paul, in 1960. For many years, there were seven people living in the modest three-bedroom home. Tony finished the basement with a laundry room, a second small kitchen, a playroom for the boys, an additional bedroom for the two oldest sons and a second basement bathroom. With four adults living in the house, all of whom liked to cook, the second small kitchen was useful for family and holiday meals.

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Image #39 Rooms in Helen's basement, the boy's bedroom at left, and the combined second kitchen and laundry at right.

Several times over the years, Helen's mother and step-father considered moving out of the home. At one time, when Paul, the youngest was still small, the couple had considered moving to a newly-built senior housing facility in the area. Little Paul cried and pleaded, "Don't go Grandma!" The closeness of all the family members kept them together under the same roof. Helen explained that Tony was always welcoming and supportive of having them in the family home: "I used to say to my husband, 'I think I probably cheated you because of [having them here]. He said, "I love them too, so you don't have to worry about that.' He was so good." When Helen's mother became very ill with diabetes, and the disease progressed rapidly, she had one of her legs amputated. Helen recalled Tony's ongoing helpfulness. "Tony and I helped right away, the first time we borrowed a wheelchair from one of the pharmacies in order to bring her home and I remember him carrying her from the garage here."

Helen's mother was a great cook. Helen said, "So my mother could bake and she could cook like nobody's business." She taught all three of the boys to cook. She was also an accomplished seamstress who made many of Helen's clothes. The three boys admired their grandmother. Helen said this about how they reflected on her in the present time, "My boys always say about Mae, they called her Mae, 'Mother, if Mae was living now and if she had had an education, she would have been a CEO of any company.'" After the three sons grew up and

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moved away, the arrangement continued to work well, Helen and Tony along with Helen's parents all living under the same roof.

Helen described her mother as a wonderful woman and very loving. She described, (after her amputation) "Then I brought her home and she was such a trooper. I can remember in her little wheelchair she'd say, 'I can still help you, honey. Just give me the stuff. I can do it here.'" Helen would give her clothes to fold and cooking chores she could do with a bowl on her lap, like peeling potatoes or carrots. Near the very end of her life, her mother developed dementia. Helen said that the last few years of her mother's life was difficult: "I went through hell for those few years." She would forget that she was without one leg and unable to walk. More than once, Helen would hear a thud and find her mother on the floor after attempting to get up and walk across the room.

Helen's mother and step-father were very appreciative. Her step father offered what he thought was a great blessing. He would say, "Helen, you've been so good to me. I hope you live to be one hundred." At 92, however, Helen did not think she wanted that for herself.

Helen's husband, Tony, died in 1990 at age of 63 of bone marrow cancer (multiple myeloma). As a widow, she was thankful to still have her parents in the home for company. Helen's mother died at the age of 95 in 1995 and her stepfather passed away at the age of 97 in 1997. Helen had been living alone in the home for about eighteen years, since her step-father's death.

Helen and Tony wanted to make sure their sons had good educations. They all went on to have successful careers: David as a professor of music at the University of Massachusetts and Boston University and as a clarinet player with the Boston Pops and Boston Symphony, Dean as an accountant, and Paul, first as a senior executive at UPS, and currently as the CEO of an

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International transportation and logistics company. David lived about an hour's drive from his mother, and Dean was only about a twenty-minute drive. Paul lived in Redondo Beach, California. David and Dean came regularly to see their mother. Paul, who traveled the world for his job, had visited for a week a few months before our interviews.

Dean and his wife, who lived nearest, would provide transportation to doctor's appointments and would pick up groceries for Helen. Helen also utilized a home care service. She had the same woman, Janet, come every other week for several years. Janet would also bring groceries, in addition to doing all of the housecleaning, take the trash to the street and would drive Helen to the pharmacy or store. Sometimes, Dean's wife would make casseroles or stir-fry and bring them to Helen or freeze them in single serving sized containers for Helen to keep in her freezer and microwave for meals.



Image #40 Helen demonstrating the difficulty and pain that accompanied using her built-in microwave.

Helen had given up driving several years earlier. It was pain in her in shoulders which prevented her from continuing to drive. Upper body pain plagued her, making it difficult to dress and to reach for things. Her son had bought her a countertop microwave, because reaching the one which was built-in over the stove had become difficult and painful. She took medicine for the pain and did daily exercises suggested by a physical therapist. Each day, she would do

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the 'pendulum' forty times on each side, which involves bending over and swaying side-to-side. She also took medication for high blood pressure and congestive heart failure.

Helen employed a lawn care service. Her neighbor did her snow removal with his snow blower. The neighbor had expressed a desire to help her voluntarily, but she insisted on paying him well for his services. She described, "I remember I said, 'How much?' He'd say, 'Oh I'm cheap,' so I always give him quite a bit." In addition, at Christmas, she had given him a box of chocolates and a gift card to the local pizzeria. However, this neighbor and his wife reciprocated as well, giving Helen a box of home-made cookies and Starbucks coffee beans as a Christmas gift.

Helen received Meals-on-Wheels five days a week for her noon-time meal. Sometimes the meal was delivered as early as 10:30 am, but she did not mind. She had difficulty opening bottles and jars – she would wait and ask the Meals on Wheels delivery driver to open the jars and bottles for her. She noted that mouthwash bottle caps were particularly challenging for her.

All three sons appeared to want to assist their mother and, through a combination of their efforts, much was taken care of around the house functionally and financially. Dean's wife found a local company which did bathtub retrofits and had the side of Helen's bathtub cut down so that she could step more easily into the shower. David had given her a Keurig coffee maker for her birthday. Dean had called a service who was going to repair water damage which had occurred behind the paneling in the lower level. Paul had purchased for his mother a Lay-Z-Boy reclining chair which also had a lift feature that helped her to stand. This had become her favorite place to sit when watching TV, but she remarked that Paul should have never spent so much money—\$1400, as indicated by the delivery receipt—on such an item for her.

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Image #41 Sons and daughters-in-law had arranged for a bathtub retrofit, a keurig machine, upcoming repairs to a water-damaged wall in the basement, and a special reclining lift chair.

Helen was quite organized, clipping coupons from the newspaper for future grocery visits and organizing them by category and store into separate bags. She shredded mail which had any account information on it. And, like most other participants of this study, she wore an alert device in case she needed to summon immediate assistance. She told me about instruction she received from her adult children, “They tell me, ‘Don’t do this, don’t do that,’ so I try to do everything.” She kept a ‘chamber pot’, a short plastic toilet stool under her bed which she could use rather than going to the bathroom at night. She did not use it regularly, only during periods when she was feeling under the weather for a few days. Helen had strong self-efficacy, feeling that she had the ability to manage, come what may.

Codes, Categories, Themes, and Assertions

The following model by Saldaña (2015) with the quantities found for the present study was discussed above (p. 69) with regard to Research Methods and is repeated here. A discussion of the codes, categories, themes and assertions follows.

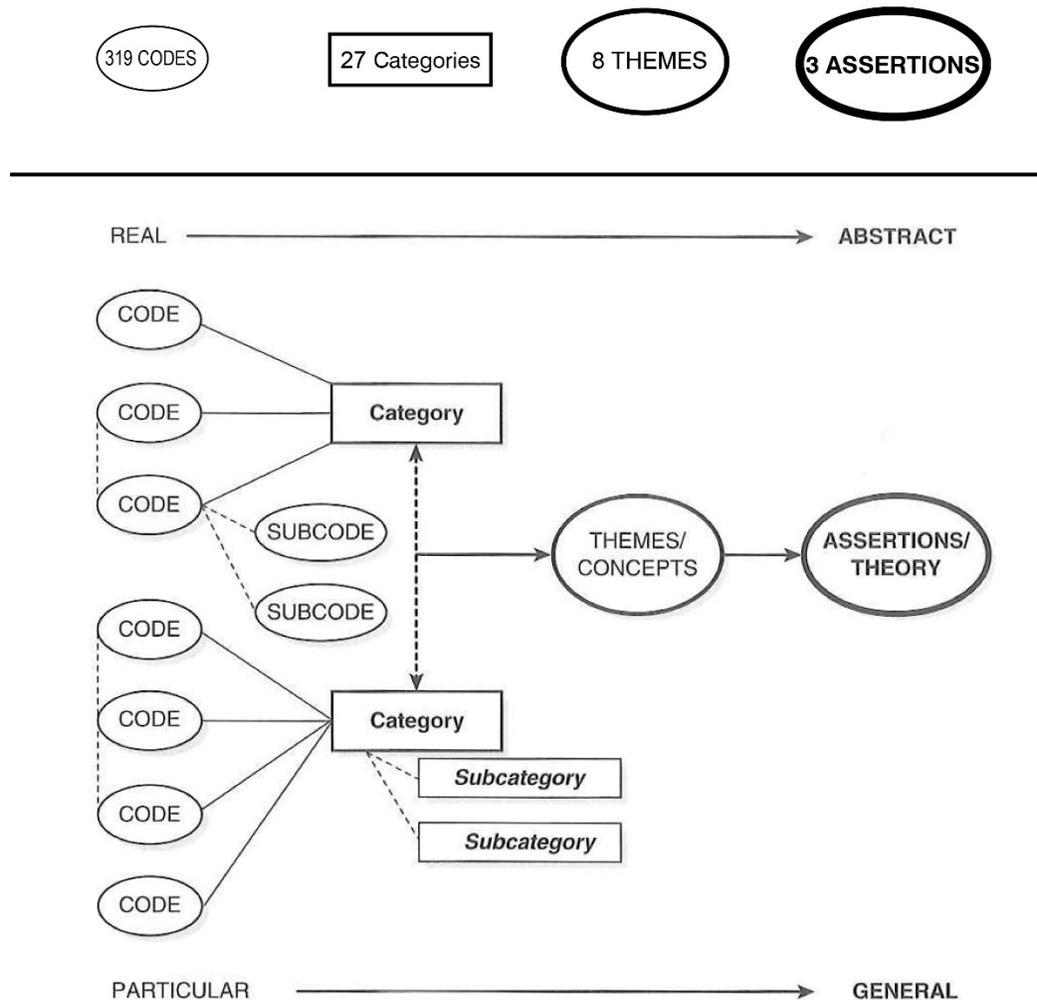
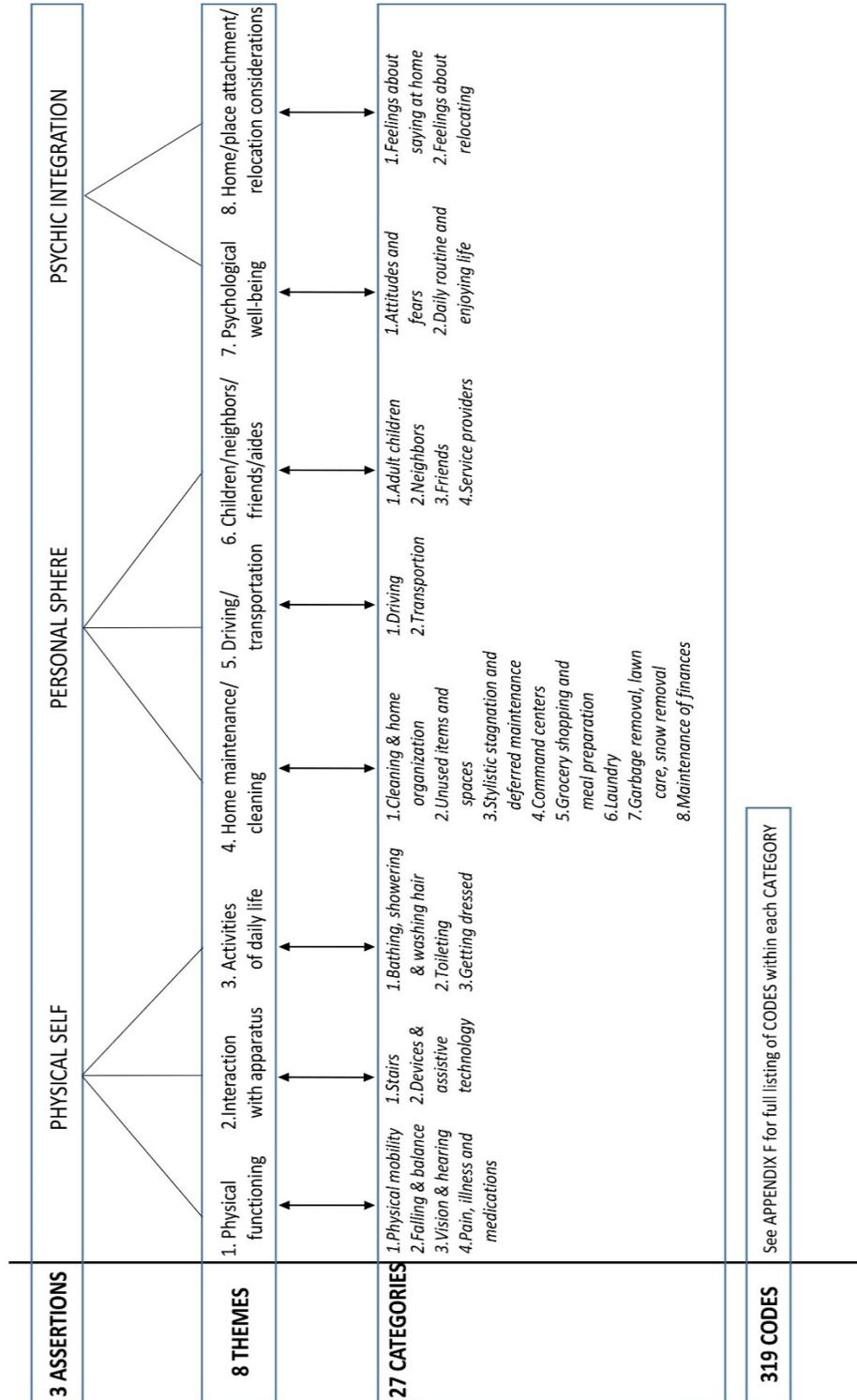


Figure #6. Saldaña’s Codes-to-Theory Model for Qualitative Inquiry shown with counts for the present study above. From Saldaña, 2013, p. 13. *The coding manual for qualitative researchers, 2nd ed.* Thousand Oaks, CA: Sage Publications.

Through the process of coding the data, 319 codes were derived. They were sorted into 27 categories, which were sorted into eight themes, and then separated into three assertions. A full listing of the 319 codes derived from the interviews, notes and photographs is included in

Appendix F. The illustration below lists the categories, themes and assertions. Following, each category within each theme is discussed.

Table #2. List of Codes, Categories, Themes, and Assertions derived from this study.



After the 319 codes were grouped into the 27 categories of behavioral/psychological findings, these categories were further grouped into like themes. It was felt, for instance, that the category findings pertaining to *physical mobility, falling and balance* and *vision and hearing* were highly related. These and other categories were grouped into the theme “Physical functioning.” Moreover, these themes were sequenced on a continuum relative to the more micro experiences to the most macro of experiences. The assertion is that the three themes: “Physical functioning,” “Interaction with apparatus” and “Activities of daily living” relate to the *physical self*—the most intimate of experiences, and have to do with abilities. Three themes: “Home maintenance/cleaning,” “Driving/transportation,” and “Children/neighbors/friends/aides” are more expansive and have to do with a person’s resources within their life-world, their *personal sphere*. Finally, at the most macro level, the themes “Psychological well-being” and “Home/place attachment/relocation considerations” pertain to psychological adjustments and attitudes, labelled here as *psychic integration*.

Following is a description of each category grouped by theme.

Physical Functioning. There were four categories within the theme of “Physical functioning”: *physical mobility; falling and balance; vision and hearing; pain, and illness and medications*.

Physical mobility. The inevitable loss of physical mobility plagued the participants in a variety of ways. Several had difficulty getting out of a chair and standing from a seated position. It took Loretta several seconds, and sometimes several tries, to stand from a seated position. She used an adjacent table or cane as leverage and a rocking motion to gain some momentum. Once standing, she needed several moments to establish balance before she could move forward. It was very difficult to respond to the telephone call or the doorbell in a timely manner, but she

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surmised that if the caller or visitor actually knew her, they would know that a response would follow a lengthy delay. Helen utilized a lift chair that assisted her in standing, which proved useful, but only when this was the chair being utilized.

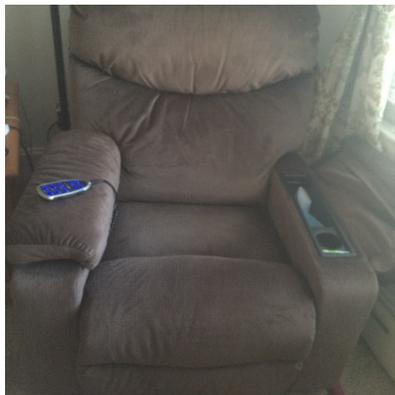


Image #42 A lift chair assisted Helen in standing.

Reaching overhead, as well as pain in shoulders, was an issue for several study participants. This translated into a few adaptations: not wearing shirts which were put on overhead, and keeping food supplies on the kitchen counter rather than in upper cabinets.



Image #43 When upper cabinets were difficult to reach overhead, necessary items were re-located to the counter or floor.

Several participants expressed frustration with increasing immobility. Leo noted: “I think the last year and a half or two years... I've always been pretty independent and did everything myself, and I've got to remember to ask for help now.” To stave off further physical deterioration, Leo walked daily in his basement as a means of exercise. He would descend the stairs, sit down on a chair at the bottom for a brief respite, then use the walker he kept in the

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basement to make the rounds. He set an egg timer on the chest freezer to time his exercise. His basement was accessed not via a stairway in the house, but rather a concrete stairway in the garage. It did have a toilet should the need arise during his walk. He said about this ritual during one interview: “It's a pretty good size basement. I've got kind of a path that I walk down there. I walked a half hour this morning and I was pretty tired.”

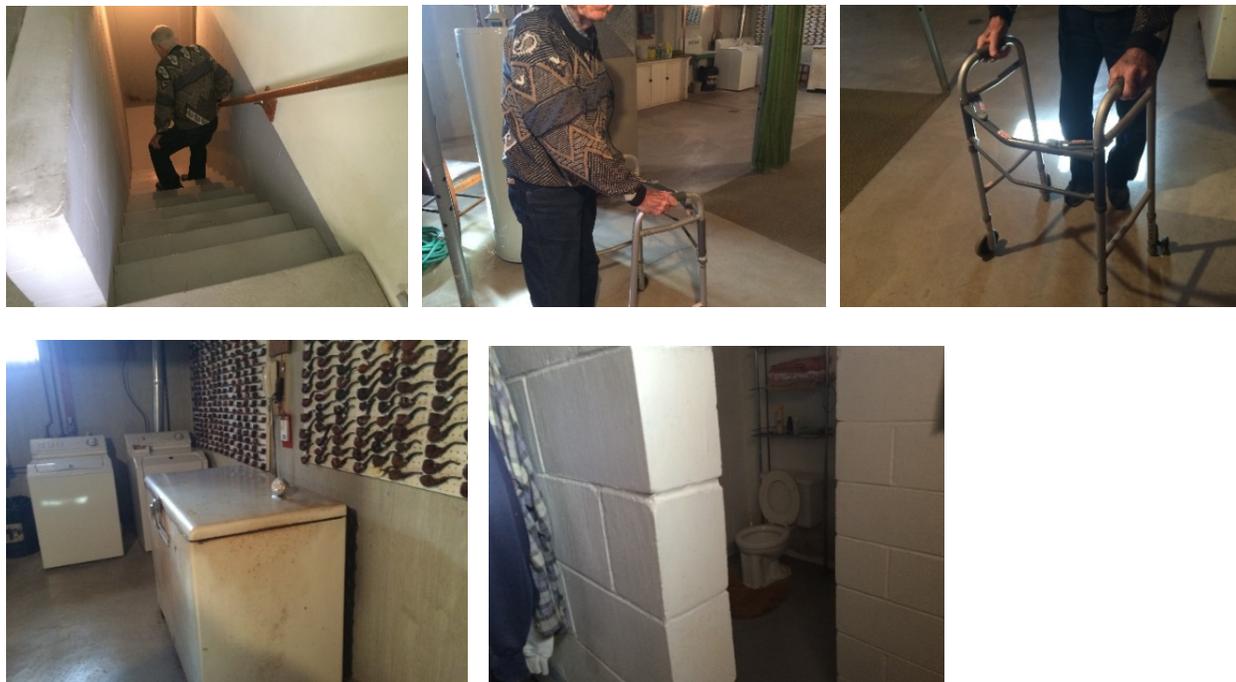


Image #44 Leo's daily ritual. In an effort to combat physical deterioration, and to exercise his bad knee, Leo walked for 30 minutes in circles in his basement. The egg timer sits on the chest freezer.

Reduced stamina plagued several participants as well. Ted described the continually depleting energy throughout his day, “you'll find when I go to bed and sleep good, by the time I get up and brush my teeth and shave and shower, it's all downhill from there.” Margaret described inactivity throughout her day, “I'll sit there. Some days I sit in here all day.”

Falling and balance. In addition to falls on steps, there were numerous mentions and incidents of falls related to balance. Gertrude had taken several falls over the last few years. Once she fell between the bed and the wall, a space was too tight to allow her to maneuver back

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to a standing position. She had also fallen outside on uneven ground and was unable to stand until she crawled—half on her back and half on her side—over to the fence at the side of the yard which she used to hold onto in order to stand. It took her 20 minutes to be able to grab ahold of the fence to pull herself upright to a standing position. This incident occurred before she had worn the Life Alert device or she would have used it then.

In order to reduce her risk of falling while dressing, Gertrude sat down on her elevated toilet seat. Amazingly, she had continued to pursue her much-loved sport of bowling up until the year before our interviews, but had given it up for fear of falling. She had taken a bad fall in her bedroom the morning of one of our interviews when she was walking around the bed to make it. The fall resulting in an arm injury. Soon after, her son installed a footboard on the bed to give her the needed support as she moved around her room.

About a year before my visit, Audrey had been walking around the bed to make it. Her toe had become caught in a small hole within the fringe and her forward momentum caused her to fall forward and to hit her forehead on the drawer pull of the dresser. Fortunately it was afternoon, so her daughter Jan was in the house. Jan gathered a wet washcloth and applied pressure to Audrey's head wound until the profuse bleeding stopped, then took her to her doctor, where, thankfully, stitches were not needed.

Ted had fallen on a scatter rug, before his daughter thought to remove them. Peter had taken a bad fall in the shower two years prior and had broken a hip. Fortunately, his grandson had been visiting at that time, but since then, Peter showered only when the home health aide visited so that she could monitor him. Fear of falling also affected Tilda. She made sure to take a few moments to ensure she was steady on her feet when she got up in the middle of the night to go to the bathroom. She described "The hardest part, I think, of my life is when I wake up 5

o'clock in the morning and I have to go to the bathroom, I gotta watch so I don't fall or anything.”

Vision and hearing. Participants had varying degrees of vision and hearing loss. Loretta had the most extreme loss of sight. Although she maintained a calendar, she had asked me to always phone her the morning of our appointments for fear she would not be able to read what she had written. In fact, she would typically write things on notepads or on her calendar in bold, black marker, and then ask her son, when he visited, to help her decipher her own jottings. She could make out some, but not all of the letters and digits, sometimes enough to be able to decipher the meaning, but usually not.



Image #45 If Loretta wrote using a thick black marker, she could sometimes read her own notes. Otherwise she would wait until her son came for his weekly visit, and she would ask him to read her jottings. Here she is writing a note about Gloria's (my) next visit.

Loretta utilized several items developed for blind individuals, including an audio watch, audio books on tape, and paste-on tactical markers to indicate often used settings for kitchen appliances. Little adhesive buttons applied to her appliance dials, these allowed her to feel, rather than to see the appropriate settings. Several times during interviews, she would put her cane down somewhere and then have difficulty seeing to find it again. “I spend all of my time looking for either my cane or my glasses.”

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Image#46 Adhesive buttons marked often used settings on appliances. On the oven control, red nail polish had also been used to indicate 350° the temperature for baking cookies.

In regards to her staying in her home, 100-year-old Loretta remarked that a move would mean she would have no idea where anything was. “Gloria, if I were to move into assisted living, I wouldn’t know where one cotton-picking thing was...I would have to sit in a chair, because I wouldn’t know what to do. I’d get into more trouble than I do now.”

Peter’s vision had also diminished significantly. He described himself as “virtually blind.” Peter was also challenged to see the buttons on his microwave, so he kept a flashlight beside it: “It lights up the buttons so I could see them.” He still enjoyed watching baseball on TV, and between the commentary and the movement he can make out on the screen, he knew what was happening. Football, he said was harder to discern visually due to more movement on the screen. A few participants had maintained good vision. Audrey and Gertrude regularly did jigsaw puzzles and Gertrude did crossword puzzles as well. Others struggled with reading small print and kept a magnifying glass close at hand near their favored sitting locations.

Although Gertrude still drove, her daughter Trish took her to many of her appointments to act as a second set of ears due to her poor hearing. Although Gertrude had worn a hearing aid for more than twenty years, there were many people's voices which she had difficulty hearing. To ensure that all the doctor said was heard, Trish would always be present. Also to compensate for her hearing loss, she utilized an amplifying device for the TV, and an alarm clock which had an auxiliary disc that vibrated which was she placed under her pillow at night.

Peter had some difficulty hearing and understanding my voice. After one question I posed, he paused and said, "Now..... you talk awful fast," after which I slowed the pace of my speech. Peter may have benefited from both new glasses with an updated prescription, and a hearing aide, but he was unable to locate, travel to, or purchase these devices, and his children had never facilitated such appointments. Several participants had maintained fairly good hearing. Only three of the ten participants wore hearing aids. Those who did not also occasionally asked me to speak louder or more slowly during interviews.

Pain, illness, and medications. Issues with pain, most often attributable to arthritis, were mentioned by all ten of the participants, sometimes during every interview. For Audrey, the issue was pain in her wrists which made it difficult to manage many things. Delores had breast pain for years following a double mastectomy. Both Helen and Gertrude were plagued with pain in their shoulders, and Gertrude additionally had severe headaches. Loretta suffered both pain and numbness in her knees and back, which made navigating the stairs in her home particularly difficult. Leo had pain and stiffness in both knees. Margaret had pain in her hip and also in her shoulder such that she could not reach overhead. Peter said he felt constant pain in his legs and knees and that throat pain made it difficult for him to swallow. Tilda had considerable back pain. And Ted had severe pain in his back, hips, legs and ankles.

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Having pain early in the morning was an issue for Margaret who could often not get out of bed and she would lie with a heating pad under her hip until the pain dissipated sufficiently to allow her to get up. Loretta needed to steady herself using a walker the first few minutes after getting out of bed until she could manage the pain: "I use it [the walker] to help me get up, and when I get up, I can't stand for a while. The pain in my legs is bad so I have to stand until it goes down a little bit and I get my balance. Then I trot off to the bathroom." She also had an acceleration of pain until bedtime: "There's pain in that arm. Of course with the arthritis, that's throughout my whole body. Let's face it, I hurt by nighttime. I manage all day, but by nighttime, I want to kick off my clothes and stretch out in bed and just let those muscles relax." She also experienced numbness by the end of the day: "And by 4:00 I'm tired and I tell you by even 7:00 my knees and my back are ... I have, I know there's a name for it, but I have no feelings. It's numb. It's this whole arm, like you had a shot of Novocain and it tingles."

Margaret expressed that she felt living with chronic pain was better than developing dementia. In response to the question of whether she would want to live to be 100 years old, she said, "Not especially. I have too much pain, that's why. If they could do something for the pain, yeah, then I would." Margaret was very thin, and she reported that in the last several years she had lost considerable weight because the constant pain diminished her appetite.

Tilda's son reported about his mother's outlook on dying, "She's not afraid of dying. She's afraid of pain. She says 'I just don't want pain.'" Tilda herself said this: "I don't feel bad. I have just this constant pain of arthritis that gets me down but it doesn't put me out. I push." I discussed with Loretta the fact that, if she moved from her home, she could eliminate the painful routine of climbing stairs to use the bathroom. She replied, "It's really reached a point where it is a painful thing going up and down the stairs. Then I say to myself, 'You can go do assisted

living where you won't have any stairs to climb, but I will still choose the pain in my knees for the privilege of living here.'"

Several participants spoke of getting relief from taking pain pills, but Margaret said she avoided them because they made her feel "slow." Ted too said he tried to avoid taking them, unless he was completely unable to sleep due to pain. Delores, Ted and Peter all spoke of having difficulty getting comfortable in bed and falling asleep due to pain.

Many of the participants of this study maintained fairly good health considering their ages. As health conditions were not a focus of this study nor my area of expertise, there was not extensive questioning within the interview sessions beyond a mere overview of major health concerns. However, there were a few extreme cases of note regarding illness. Gertrude's bone marrow cancer was unknown when she was interviewed, but was diagnosed shortly after the interview process ended and ultimately led to her death soon after. Ted's death was attributed to heart conditions with which he had lived for many decades. Issues such as high blood pressure and diabetes, when present, were controlled through medications. Arthritis pain, common to many participants, and common to the elder population in general, was dealt with by utilizing assistive devices, the use of analgesic medication, and adapting for reach ranges by relocating needed items.

Delores experienced Meniere's Disease, a disorder of the inner ear which causes severe dizziness, ringing in the ear, and potential hearing loss. The resulting episodes of vertigo can last twenty minute or more, affect balance and cause nausea. Delores had experienced several of these attacks in the middle of the night, so she kept a bucket, towels, and a water bottle near her bed in anticipation of another attack.

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Image #47 Delores kept supplies near her bed in the event of an attack of vertigo.

Participants took a variety of medications. Several spoke of the ritual of putting the week's allotment of pills in their daily pill boxes. Loretta, who was nearly blind, was very fearful of confusing the morning and nighttime eye drops, or misusing her other medications, so she used her big black marker to indicate, in a manner she could delineate, which was which. Getting prescriptions from the pharmacy was also a concern. For those who still drove, this was one of the few locations which was visited. For those who did not drive, either relatives or home health workers would pick up medications, or a pharmacy delivery service was utilized.



Image #48 Daily pill dividers were commonly used and conveniently located. Loretta needed to mark her medications in a way she could see. Tilda kept her medications neatly by the sink.

Interaction with Apparatus. There were two categories within the theme of “Interaction with Apparatus: *stairs and devices and assistive technology*. Going beyond the abilities of the body, this category had to do with utilizing several mechanisms.

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Stairs. The navigation of stairs was an issue, to varying degrees, for all participants. Margaret, who used a wheelchair, was fortunate in that when her ranch home had been built in 1966, a laundry room had been planned adjacent to the kitchen on the main level. This was not typical for homes built in the decades prior. She was able, with the assistance of her home care aide, to get her laundry done and put away. She had not been to her lower level for a number of years, even before her wheelchair use. She reported her children had “banned me from the basement.” Likewise, Helen reported that her children had offered similar strong advice, “Yeah, I got strict orders. I’m not supposed to go downstairs.”

Margaret had issues with getting in and out of her home, and getting in and out of her children’s homes and her church. About a year prior to my interviews, Margaret’s son had arranged for a chair lift to be installed in her garage, so that she could get down to car level, and he could drive her for appointments and shopping. He would drive her in her car—which she herself had not driven in about five years—since it was lower to the ground and easier for her to enter and exit. The lift installation had cost \$4100 but Margaret felt very fortunate that she had it. For several other participants, stair railing had been installed by sons or others to assist with stair navigation to and from the garage or the front or back doors.



Image #49 Chair lift in Margaret’s garage.

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Image #50 Stair railings outside Audrey's house and inside leading to Gertrude's back doors.

Steps from the garage into the back door of the house had proven disastrous in more than one instance. Ted had fallen about a year and a half prior to the interviews on the concrete step shown below and was unable to stand. Fortunately, he had a cell phone in his pocket, so he called his neighbor who came over and helped him. Ted's daughter felt this was an indication that he needed greater assistance from family members going forward.

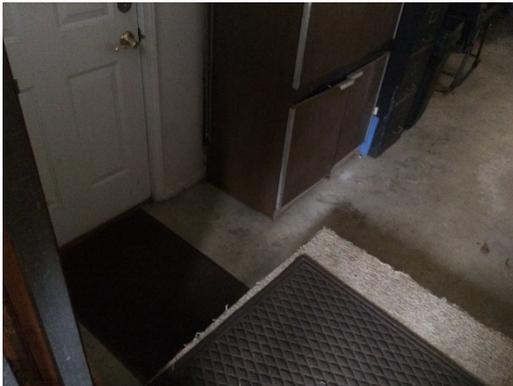


Image #51 Concrete step leading from garage to back door on which Ted had fallen. Leo had a bad fall on a similar step.

Four months following my interviews with Leo, as reported to me by his daughter, he had needed something from the grocery store and, rather than wait for his daughter's weekend visit, he made the trip himself. While trying to navigate the two concrete steps leading from the garage to the door into the kitchen while holding a cane in one hand and a grocery bag in the other, he fell. He chose not to trigger the "First Alert" device around his neck, but rather he crawled into the house, all the way to the living room where the phone was located and called his

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daughter. The resulting dislocated hip necessitated relocation to nursing facility for physical therapy and the additional care and supervision he now required. He never returned home after that incident. After his initial recovery, he moved to assisted living, and his children disposed of his belongings and sold his house.

In several cases, the bedroom, bathroom or laundry were not on the same level of the home as the living space. Ted had chosen to utilize—up until the last few days of his life—a basement bedroom because it was on the same level as the home’s only shower. Why the main level bath had never been retrofitted with a shower head, a fairly simple plumbing retrofit, was unclear. Thus Ted had to climb and descend the stairs, which were steeper than normal, at the beginning and end of every day. He had situated a chair at the top of the stairs to allow himself a brief respite when he had gotten to the top.



Image#52 The chair at the top of the stairs where Ted would sit briefly to catch his breath.

Loretta lived in a split level home with the kitchen and living room on the main level, three bedrooms and a bath up a half flight of steps, and the lower level family room and another full bath down a half flight of steps. She spent most of her time on the main level, but had to go up to use the bathroom during the day. She told me about climbing the stairs “It’s the most

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painful thing. Every step I take I can feel those bones grating against each other and it really hurts, so I try to make as few trips up [as possible]. This is why when I go to the bathroom, boy if I need it, I've got to go then because it takes me a long time to go up the stairs.” Climbing the six steps was, in fact, a lengthy process for her. She always wore incontinence pads in the event that she did not make the trip in time. Because of her blindness, Loretta put a brightly colored rug at the bottom of the lower level steps as a guide to recognize the bottom step when going downstairs.



Image #52 Loretta making the difficult trip up the half flight, and showing the rug which visually marks the bottom step on the lower level steps.

Gertrude still went to her lower level to do her laundry once a week. Trish pleaded with her to hand this duty over to her, but Gertrude insisted on doing it herself. She had difficulty and pain when she descended the steps, and had developed a system of walking down the stairs backwards which she felt was safer and easier. She noted that small children also often better able to manage stairs this way. Her son had installed a second railing so that she could grasp both sides while climbing up and down.

There was a laundry chute near the bathroom which emptied into the box shown at center. Gertrude used a grabber device to get the door open and the clothes down. To get the clean laundry upstairs again, she put them on the step to the right of this hanging dress, climbed the stairs to that point, picked the clothes up, and climbed the few remaining steps.

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Image #54 Gertrude demonstrating how she is better able to go down the stairs backwards to get to her washer/dryer.



Image #55 Gertrude's basement laundry, clothes chute, and steps where she would place the clothes before climbing up herself.

Peter had abandoned his second level bedroom years before when he became unable to navigate stairs, and had utilized a front living room as his bedroom ever since. Fortunately, there was a half bath already on the main level and a small shower had been added. For approximately eight years prior to my visits, Peter had not been to the upper level of his two-story home.

Tilda had the most creative method for dealing with stairs. She lived in an upper duplex, which was reached through a semi finished space on the side of the house. Whether managing the stairs on her own or with the additional burden of groceries and packages to carry, she coped with the challenge through the distraction of prayer. She described, "I say the 'Our Father,' and the 'Hail, Mary' all the way up and down. Every time."



Image #56 Outside her back door and attached to a covered back porch were the steps leading to Tilda's upper duplex.

Devices and assistive technology. Participants relied on devices and technology in a variety of ways. Nine of the ten participants utilized an alert system. The receiving device sat either on a bedside table or in the kitchen or living room. They varied on how they wore the activation device, some preferring to wear it as a wristwatch, and other preferring it on a cord around their necks. Tilda feared that if she were to wear it around her neck, she may toss and turn at night, and accidentally choke herself. All felt this monitoring service gave them piece of mind, although several had never triggered it. Gertrude paid an additional monthly fee for an upgraded device which could also detect sudden changes in velocity, which proved beneficial when she did fall, and the service was automatically notified. Tilda refused to pay an upcharge for a model which had an extended range, figuring she could save money by merely taking her cell phone with her when she did errands. Audrey was the only one of the participants who did not subscribe to such an alert service. Because her daughter Jan was present in her home throughout much of the waking hours, Audrey already felt that it was likely that assistance would be available if needed. And she also had a telephone landline if 911 needed to be called.



Image #57 Helen and Peter's alert receiver, one on a bedside table, and one on an end table in the living room.

Peter had an implanted pacemaker, Ted had an implanted defibrillator, and Leo had an implanted cardiac stent. Peter feared that his pacemaker, which had a useful life of about seven years and had been implanted just that long ago, needed replacement, but did not feel worthy of the effort and expense to do so at his age. Ted's defibrillator had fired several times shortly before and during our interview sessions. Gertrude had a shoulder replacement and a hip replacement. She felt the hip replacement had not resulted in an improvement. Other replacement surgeries, a hip for Margaret, a shoulder for Helen, and both knees for Leo, had been recommended by physicians, but they all felt they were too old for the procedure to be tolerable or worthwhile.

Margaret used a standard wheelchair, and had used a walker previous to that. Peter used a seated walker, which he felt had the added benefit of serving as a food tray to move plates of food from the kitchen to the living room chair where he liked to eat while watching TV. Leo used a walker and Ted regularly used a cane. Several used one device, but had the next, more supportive, device in their home should they need it. For instance, Peter used a seated walker, but had a wheelchair in storage in his bedroom. Loretta used a cane but had a walker available in her bedroom which, in the meantime, she utilized as a quilt stand to store an afghan. Audrey and Tilda kept seated walkers nearby but chose mostly not to use them.

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Image #58 Peter used a seated walker, but kept a wheelchair available.

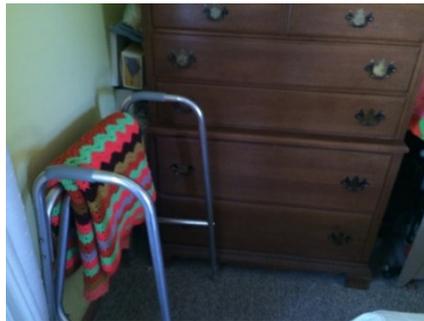


Image #59 Loretta used a cane, but kept a walker available, which she used as a quilt stand.

Grab bars and railings were utilized quite often and not only in the bathroom. Delores had grab bars installed to assist her in getting up two steps from the garage to the back door. Gertrude's son had installed a hand rail in the bedroom hallway and a footboard on the bed to assist in navigating through these spaces. Margaret utilized a bed rail to help her into and out of bed. Bathrooms were the most common location for grab bars and rails, both beside toilets and in bathtubs. Also, participants utilized shower seats and hand-held shower heads so that they could bathe sitting down.



Image #60 Bathrooms of Gertrude, Leo and Margaret

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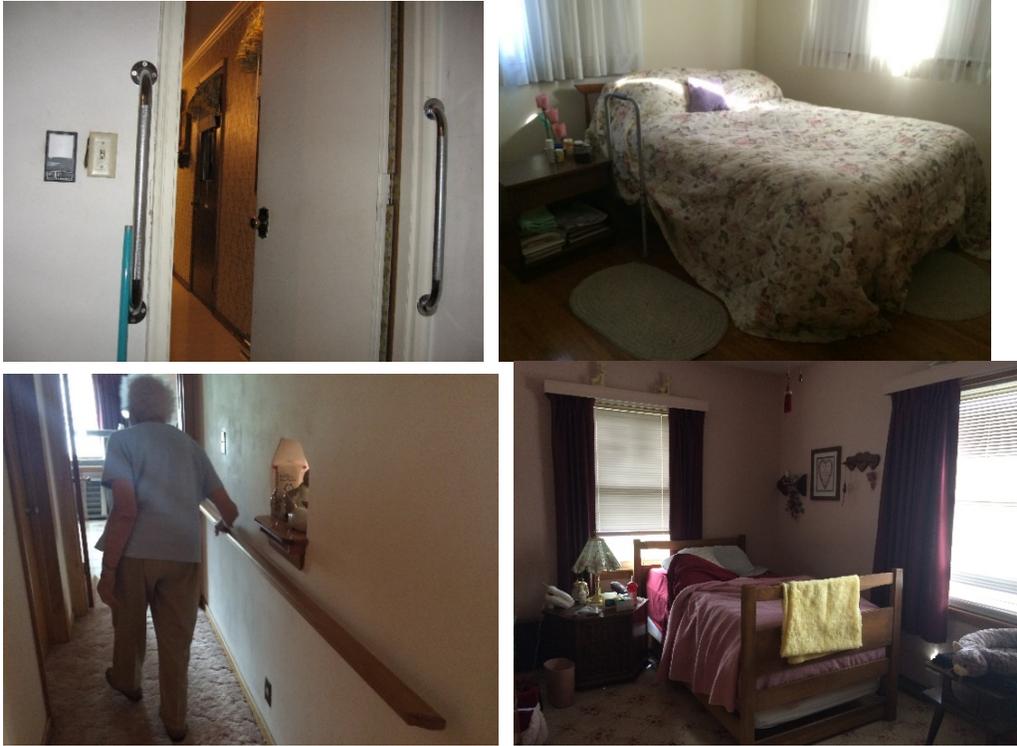


Image #61 Gertrude's grab bars in the garage, Margaret's bed rail, Gertrude's hallway railing and footboard.

Loretta, at 100 and with her bad knees, had much difficulty getting into and out of her bathtub which had a shower door. She was under the impression that it would be impossible to add grab bars due to the type of tile that was installed on the shower walls. She explained:

You asked about bathing. That was the one thing that the lady from Bloomington talked about, she said, "Do you have grab bars?" I don't. My son tried. He was going to put them, in fact, he went and bought them. But we discovered that my bath tub area, instead of tile that's permanent, it's little squares they're glued on. If you put the grab bars on that, and you pull on them, they're going to come right off and the tile too, so we gave up. This lady was very firm, she said, "That's one thing, if you insist that you can still take care of yourself, you do need grab bars." I have taken that up with my son, and he's just going to take it up with Cindy, and find someone.

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This was inaccurate information, because as long as wooden studs could be located behind the wallboard, grab bars could be securely installed through any type of tile. But Loretta was left thinking that she would either have to climb over the tub edge with nothing to hold onto, or go without bathing. She had taken to relying entirely on sponge bathing because she was unable to get into and out of her tub shower.

Helen, who lived near Providence, Rhode Island, had a bathtub retrofit which greatly improved her ability to get into and out of the tub. I had never seen this particular retrofit, perhaps because there is not a company in my area which does this bathtub work. The company she hired came into her home and cut her cast iron tub, then added a hard plastic step above the cut-out. She was very pleased with this change as she no longer had to step over the side of the tub, but realized subsequent owners may want to change it back to a standard tub. Several participants used reacher/grabber devices to reach items on high shelves, in upper cupboards and to pick up items on the floor. Helen did not own one, so that became my parting gift to her.

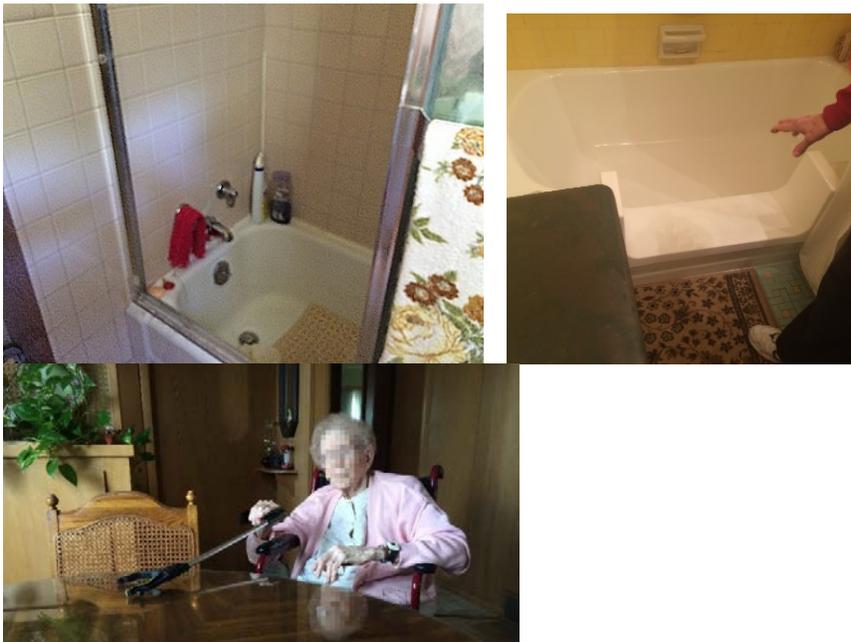


Image #62 Loretta's bathtub (left) was difficult to get into and out of, with the shower doors and her bad knees. Helen's bathtub retrofit (center), made it easier to get into and out of. Margaret showing me her grabber device.

Telephones were important devices. Six participants had both land lines and cell phones. Helen brought both phones, as well as her alert activation device, into the bathroom with her when she was toileting and showering for two reasons: so that anyone calling her would not be alarmed if they did not receive an answer or immediate callback, and also so that, if she fell or needed help, she could easily call for help.

Activities of Daily Living (ADLs). In the process of sorting codes into categories, and categories into themes, it was felt that the category of ADLs should include those strictly involving caring for the body, such as bathing, showering, washing hair, toileting, and getting dressed. It was felt that categories such as meal preparation and grocery shopping were better aligned with the theme of “Home Maintenance and Cleaning.” A similar distinction is often made in gerontological literature, where ADLs strictly refer to self-care: “the tasks that are required to get going in the morning...and then close out the day in the evening” and IADLs, or instrumental activities of daily living, involve “the activities that people do once they are up, dressed, put together” (Weston, 2009). Therefore, the three categories included in “Activities of daily living” included *bathing, showering and washing hair; toileting, and getting dressed.*

Bathing, showering, and washing hair. As noted above within the category of *Devices and assistive technology*, the addition of grab bars within a shower or bathtub significantly assisted with the ability to get in and out of the tub safely. Several participants also utilized shower seats, tub mats, and hand-held shower heads so that they could be more comfortable and lessen the risk of falling. All homes except Peter’s had showers which were in bathtubs. Peter had a stand-alone shower which had been added to a corner of a corridor near a half bathroom when he could no longer go to the upstairs bathroom. Because of the high edge, bathtub showers are particularly difficult to get into, necessitating raising one’s leg high in order to step over.

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Loretta had been told by her son that grab bars could not easily be installed in her bathtub shower, and with her bad knees and the installed by-pass shower doors, it was difficult for her to get in and out. She had been unable to take a bath for years, because it was too difficult to get into and up from a seated position in the bathtub. When it also became difficult to get in and out of the bathtub for a shower, she relied on sponge bathing (she called it her Dolly Parton), which she described:

Interviewer: You take a shower, right?

Loretta: Mm-hmm (affirmative). Getting in and out is a problem and I have to hold onto the framework to climb in and I have to hold onto the door then to make sure that I hold on with one hand. He tried to put those in, but it's plastic tile and it couldn't be done. You know to put grab bars in, it'll have to be a professional to do it and anchored.

Interviewer: So it doesn't come out.

Loretta: Yeah. This has been a problem and it's something that he says has got to go, but I have been able to do it. Sometimes I don't dare take showers. Then I take a Dolly Parton bath and you know what that is. That works too. I have a large basin there.

Interviewer: What were they called? A Dolly Parton bath?

Loretta: You don't know that?

Interviewer: No.

Loretta: Oh, that's a bath where first you wash down as far as possible and then you wash up as far as possible and then you wash possible. You've never heard that?

Interviewer: That's funny. Then if you do the Dolly Parton bath, do you just sit on the toilet and do that?

Loretta: No, I put a towel on the floor here and fill a large basin with water.

Interviewer: Oh, and then you just do it standing up.

Loretta: Mm-hmm (affirmative).

Interviewer: Well, I'm sure that hits all the important places.

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Loretta: Yeah, it does. When I get to the feet, then I do the feet.

Dolly Parton had in fact said this when interviewed about growing up in a tiny home with many siblings, explaining that she and her siblings bathed from a pan of water, using a washcloth to wash up and down as far as possible as long as brothers might barge in. Only after the boys were safely out of the room, would she and her sisters wash “possible.” (Parton, n.d.):

It was unclear how long it had been since Loretta actually showered within her bathtub/shower stall, but at the time of interviews, sponge bathing had become relied upon method. She described how difficult it was for her to enter the shower:

Because now climbing in and out of the tub, in fact my son has forbid it. He lets me do things my way, but once in a while, he lays down the law. That is when he said, when he found out how I got in and out of the tub. I have glass doors, so what I would have to do, I have to pull my walker up as close as I can to the tub, and then I have to reach up to the top of the [shower door] frame and put one leg and then put the other arm, and get the other leg in. Then I stand on a rubber mat and it’s the same process getting out. While I’m in the shower, I have to hold on to the handle of the door. I don’t dare let go of the handle of the door. He said, “Mother, it’s a miracle that you haven’t fallen and broken your neck so far.”

Audrey relied on daily sponge bathing, so that she only bathed and washed her hair once weekly, when Jan assisted her. Jan would help her get in and out of the tub, would help her wash and rinse using the handheld shower head, then help her get dried off. Audrey preferred to stand while in the shower, rather than sit on a shower chair. The shower had bi-pass doors, likely something that had been added much later than during the home’s 1950’s construction. But Jan had removed those several years earlier, so that it was easier for her to reach Audrey to assist her while in the tub. They made sure a rubber mat was always placed on the bathtub floor to

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eliminate slipping risk. The bathroom floor was carpeted, which prevented slip risk as she stepped out of the shower tub. Also once a week, Jan would wash her mother's hair while she sat in a chair, head leaning back over the bathroom sink. Every day, Audrey sponge bathed, a once-over using a wash cloth.



Image #63 Although not always considered sanitary, Audrey's bathroom carpeting reduce fall risk while getting out of the bathtub shower.

Several participants expressed that they had reduced the frequency of showers and baths at the onset of very old age. Tilda reasoned, "Oh, I don't take a shower every day any more. I used to until I was about 90, but after that I thought, 'You know what? I don't sleep with anybody. I don't wet the bed. And I don't sweat that much.'" Some participants relied on assistance from others for bathing to ensure safety. Peter showered once weekly when the home health aide came. She assisted him getting into and out of the shower, and getting dressed afterwards. He felt modest being naked in front of a woman, but felt it was a necessity. When I met with Peter, he had considerable dandruff on his shirt collar, and his hair appeared uncombed. The home health aide also gave him his haircuts. Peter shaved with an electric razor while sitting in his favorite living room chair watching TV. He also ate his meals in this chair, and confessed that the chair was probably quite dirty due to spills and whiskers.

Gertrude had her adult daughter, Trish, assist her with washing her hair. She would get into the shower naked, sit on the shower seat, and have Trish reach in to manage the shampooing and rinsing. Leo, who took baths rather than showers, said that his hair was thin enough that a swipe with a wash cloth cleaned it sufficiently between trips to the barber. Ted managed showers alone, but the fact that the home's only shower was in the basement convinced him that he should sleep in a basement bedroom, meaning he had to manage steps at least twice daily. His very well meaning adult children had never initiated the addition of a shower head into the main level bathroom, something that—even if wall demolition and tile re-setting were required—could have been fairly easily and inexpensively managed. He had some difficulty managing to step into and out of the bathtub/shower, but had developed a method of facing away from the tub, lifting his leg behind him to go over the tub. This was easier for him than lifting his leg up in front.

Helen also managed her showers independently, particularly after she had her bathtub retrofit done. She said that she had, for a time, had the home health aide come into the bathroom with her to assist her, but she felt it was not helpful: "I remember one time I had a girl and she was supposed to help me bathe. She practically just looked at me and I was doing it all." Helen had poor mobility in her shoulders, and difficulty raising her arms above her head but managed to get her hair washed and combed by lowering her head as much as possible. She was fearful of both falling in the shower and of someone phoning her while she was showering, and worrying if she did not answer. When she did shower, she would bring the land line phone and her cell phone into the shower, and put them on the back of the toilet along with her life line alert device – all within easy reach should she need to use them while showering. For all but Peter, who had the home health aide cut his hair, participants travelled to the salon or barber, either by driving

themselves, or by being driven by a son or daughter. Gertrude got regular permanent waves, and Loretta and Tilda had their hair dyed in the salon.

Toileting. Toileting presented a few issues to the participants. Loretta lived in a split-level home with no bathroom on the main living level. With her bad knees, it took her considerable time and caused significant pain to manage the stairs. For the times that she was not able to conquer the stairs in time, she wore incontinence pads. At one point in time, an aging-in-place advisor had made a visit to her home to advise her on changes she could make in her home to allow her to better manage staying at home. This advisor had suggested that, although adding plumbing for a toilet on the main level would be costly and difficult, Loretta should consider getting a portable chemical toilet, as campers use, to put in her kitchen. Loretta's kitchen was quite large, as she and her husband had built an addition on their home in the 1970's which made the kitchen much larger. The advisor suggested that if Loretta put the portable toilet in the corner of the kitchen as far as possible from the eating area, and put a folding screen around it, it would offer the privacy and isolation needed to make it seem appropriately discrete within a kitchen. Loretta found the idea distasteful, "Can't you see me putting a thing like that? Can't you even see me even using a thing like that?... I'm going to climb up those stairs if I crawl on my knees. I'm not going to go to the chemical thing." She told me that she wore what she referred to as a "panty liner" but I believe meant an incontinence pad, for the event that she did not make it to the toilet in quite enough time.

Peter did use a commode beside his bed for the instances when he had a need in the middle of the night. It was not a chemical toilet like the one suggested to Loretta, but rather a seat with a bed pan bucket. Part of his routine every morning was to take the bucket into the bathroom to empty. Previously he had fallen in the middle of the night and had been hurt, so he

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did not want to risk that happening again. The corridor leading to the main level powder room had been retrofitted with a corner shower when Peter had moved his bedroom down to the main level. The tight corner this created was difficult for Peter to navigate in the dark with his walker.

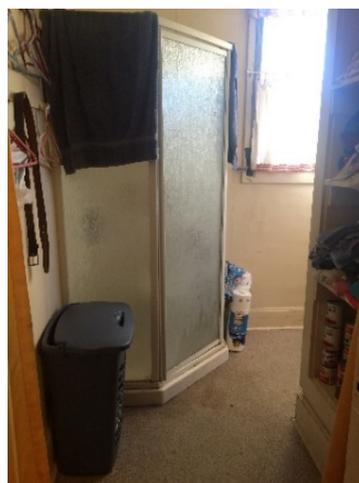


Image #64 To avoid having to squeeze past the shower to the powder room beyond during the night, Peter kept a commode beside his bed.



Image #65 Tilda stashed her raised toilet chair in the shower for my visits so that I would not see it.

Tilda also wore incontinence pads in the event of not making it to the bathroom in time. For her, she had difficulty when she awoke during the night needing to go. She would stand up feeling disoriented and off-balance, and it would take her some time to feel sufficiently level-headed in order to make the short walk. Needing to go to the bathroom also disrupted sleep for some participants. Audrey and Tilda both spoke of needing to take care to ensure stability after rising from a resting position before starting to walk towards the bathroom. Both Gertrude and

Tilda, who were small in stature, utilized a device to raise the level of the seat above the toilet. For my visits, Tilda, presumably wanting to be a gracious hostess, stored her raised toilet seat in the shower, out of my view.

Getting dressed. Most participants reported getting dressed following breakfast. Margaret reported being slow to dress, often not doing so until late morning. Margaret and Helen, who both had shoulder pain and limited arm movement, wore shirts which did not need to be pulled over head, or were easily pulled overhead. Tilda dressed very nicely for her interviews, and reported doing so very regularly, even if she did not expect company. Peter wore the same wrinkled shirt and pants for three of his interviews, and his shirt collar was very soiled with dandruff.

Home Maintenance and Cleaning. The condition of the home was a significant focus of inquiry and produced a large amount of data. There was a strong reliance on others for home cleaning, as well as a lessening of one's own standards for tolerable levels of cleanliness. Some recognized that their home was not in the condition they would prefer, but forced themselves to accept it. The eight categories within "Home maintenance and cleaning" included *cleaning and home organization; unused items and spaces; stylistic stagnation and deferred maintenance; command centers; grocery shopping and meal preparation; laundry, garbage removal, lawn care, and snow removal; and maintenances of finances.*

Cleaning and home organization. House cleaning was often done in large part by an adult daughter. Leo had an adult daughter and two adult granddaughters who would regularly come to do his house cleaning. He would take them out to dinner afterwards for their efforts, plus pay them a bit of additional money. Audrey had (in addition to two adult sons) her daughter, Janet, Gertrude had (in addition to one adult son) her daughter, Trish, and Ted had (in

addition to three adult sons and two additional adult daughters) his daughter, Anne. In all three of these cases, this one adult daughter provided most of the assistance to the aging parent in the way of housecleaning tasks. The daughters would come regularly to do dusting, floors, and kitchen and bath cleaning. In all four cases, however, Leo, Audrey, Gertrude and Ted largely managed to do their own laundry. In no instance among participants of this study did an adult son contribute significantly towards cleaning efforts as daughters did.

Loretta had only one son, and she felt that although her son and daughter-in-law supported her decision to remain at home, they secretly felt that the level of cleanliness was inadequate. She said, “They feel that it's too much work for me. They feel like I work too hard. I think, although they don't say it, that I don't keep my house clean enough.” However, neither her daughter-in-law nor her granddaughter-in-law appeared to help to perform any of the work themselves. And, because she was unable to get cleaning services covered by Medicare, she had never hired cleaning services. Her near blindness meant that it was very difficult for Loretta to do cleaning tasks. She said that when she tried to dust, she tended to knock things over and break them. Nonetheless, and in spite of her near-blindness, her home seemed tidy, if not altogether clean and uncluttered. She said, “I try to keep it up, but if you look in the corners you'll see cobwebs, and on the furniture you'll see the dust.” She also noted, “You can understand, I'm not able to keep it up the way that I want it to be.” Because she could not manage the vacuum cleaner which was hard on her back, she had developed a method to deal with the living room carpet. She explained, “I take my cane in one hand, and the broom in the other, and I sweep that living room floor. That's the way I do it.” It is doubtful that this actually removed any dirt from the floor, but for Loretta, it gave her the notion that the floor was clean. She demonstrated her method and further explained:

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The cane in one hand, and the other and I hold my cane like so, and the broom like so. When I get through it looks just as good as if it was vacuumed. In fact, it looks better because you don't see any tracks. I manage and I'm going to do that for a while. I can do it. It's not easy, but I can do it. That takes care of the living room.



Image#66 100 year-old Loretta sweeping her living room carpet.

Margaret had had the same female housekeeper, Pat, who was arranged through the *Home Instead* service, for several years. Margaret felt very comfortable with Pat and enjoyed her company, but at the time of my interviews, Pat had knee replacement surgery and was going to be away from work for a few months. Margaret fretted over having a new person, someone she did not know, come to replace Pat in the interim.

Both Tilda and Helen also had housekeepers who came regularly, plus they tried to do some cleaning up themselves between visits, especially in the kitchen and bathroom. Tilda had two adult sons in the area, and Helen had three adult sons, two of whom lived in the area. Sons assisted with yardwork and small repairs, but not with cleaning. Dolores had ample resources to pay for house cleaning and lawn care services. In the weeks before his death, her husband pleaded with her that she maintain all of these services after his death, so she would not need to worry about the work getting done. For her, having these services was not associated with age,

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she had utilized a cleaning service throughout her marriage.

Peter's home was the most unkempt of all. He had an adult son who visited regularly between trucking runs, and two adult daughters who lived further away and rarely visited. He had an aide who came weekly, and did many things in addition to light cleaning. She did the dishes, laundry, assisted him with showers, checked his blood pressure, cut his toe nails, cut his hair and checked his swollen ankle. A housekeeper is likely only able to maintain the standards which were followed by the client previously and Peter did admit that he had let the house go in the 2½ years since his wife's death. Having cats in the house also contributed to the issue—cat fur could be seen all around the floor. Peter's son, Terry, contributed to the clutter as he kept his clothing and personal belongings piled in the living room. Peter recognized that his poor vision and the vast accumulation of things within his house contributed to the disarray, but he noted that he had had to learn to not let it bother him.



Image #67 There was considerable clutter in Peter's home.

Adult sons were, in some cases, helpful for minor home repairs. Gertrude's son had done a number of projects for his mother: adding railings, adding a pantry cabinet in the kitchen to reduce the need to go to the basement, building a microwave cart and adding a footboard to her bed after her bedroom fall. Audrey's adult son did some minor roof repairs, and Delores's adult

son cleaned out her gutters and downspouts. In some cases, the adult son attempted to do a repair, but called in a professional to complete the job, as with Margaret and her leaky faucet.

All ten of the participants professed to be daily bed-makers. Loretta, who had such difficulty climbing stairs and lived in a split-level home, said “First thing I do in the morning is go to the bathroom, get dressed and then I make my bed, and I don't even go downstairs until that bed is made.” For many with back, leg, and shoulder problems, this task must not have been easy. From her wheelchair, Margaret used her grabber device to grasp the edge of the covers to maneuver them.

Audrey said about her bed, although it was very neatly made “I pull mine together, but it's nothing you could call made.” Gertrude said, “See, I don't put the spread on. Nobody's in here but me.” When I commented to Peter that I was impressed that he made his bed daily, as I myself did not, he commented, “Well you've got things to do. I ain't got nothing.”

Ted, who declined rapidly during my interview time with him, talked about making his bed during the first interview session. At my final interview with him several weeks later, and only a month before his death, he wanted to set the record straight. He said, in speech which had become quite halting, “One of the recent times you were here I told you I get up in the mornings and I make my bed. I've probably have made it twice since then.... Just so you get the record straight.” He wanted to be quite clear about what he had and had not been able to achieve. With that exception, bed making was one accomplishment that all of these participants were able to achieve on a daily basis, in contrast to other tasks which were beyond their ability and therefore were not even attempted.

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Image #68 The ten made beds of the ten participants.

Kitchens, as is the norm, were the location where much of the daily work took place. Of the ten participants, five had built-in dishwashers, five did not. Four of the homes without dishwashers were mid-century ranches with very small kitchens which would have been difficult to retrofit with dishwashers. In these same instances, the participants kept up regularly with their manual dishwashing. In Peter's case, the home health aide did the dishes twice weekly along with many other tasks.

Over time, there does seem to be a tendency among even the most capable of people to allow storage drawers and cabinets to become full, necessitating additional storage to occur outside those places. Culling things and re-organizing storage spaces can be a large job, and is undertaken rarely, even by the most organized and ambitious of homeowners. There was

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evidence of this among a few participants. Loretta had a large kitchen—it had been doubled in size with a home addition in the 1970s from its original small footprint. But all counter areas were teeming with items. Also, the interior of refrigerator was brimming with food items. With her extremely limited vision, it is doubtful whether Loretta could have kept up with food expiration dates or recalled the contents of items in the far reaches of her refrigerator or freezer.



Image #69 The kitchen and refrigerator of Loretta.

As a measure of the degree to which participants kept track of the locations of often needed items, I asked each of them whether they would easily be able to find a postage stamp should one be needed. In all cases, they answered affirmatively. Locations for stamps included kitchen drawers, a metal box within the linen closet, a wall-mounted mail holder, a desk drawer, the lingerie drawer within the bedroom dresser, a file cabinet and an envelope within an upper kitchen cabinet. When asked about postage stamp locations and knowing where things were kept, Peter replied, “I maybe can’t see it, but I know.”

Both Margaret and Loretta talked about how they had been trained by their mothers from a young age to put items away after using them, and that having this orderliness standard instilled in them served them well at their advanced age. Loretta explained that this was crucial to her because, due to her blindness, if things were not in their expected location, she may very

well never locate them again. She explained, “My mother taught me when I was a little kid, if you take something out, put it back. Fortunately, I do that because it’s a way I was raised.”

Unused items and spaces. A significant accumulation of no-longer-used belongings were seen with all ten participants. In many cases, participants spoke of their proliferation of belongings, and of not knowing what should be done with these items both during and after their lifetimes. An inability to manage the abundance of unused and unusable items within their homes was a concern for several participants. Loretta remembered where she had acquired many of the decorative items in her home, but fretted that she could no longer dust them. Peter wondered why his wife had collected so many things, and admitted that he no longer cared that house was cluttered. Gertrude spoke of an inability to get rid of things, even though she had not used them in decades. Loretta was capable of relegating cast-off items to the basement, garage, and unused rooms, but not of ridding her home of them entirely, and pondered why she had ever accumulated so many things.

Some participants had particular collections and others had collected a variety of things over decades. Leo was in the former category. Over his lifetime he had accumulated a collection of 1400 smoking pipes which were displayed very neatly in his unfinished basement along with WWII memorabilia. He had first acquired a few interesting pipes while in France following the war, and throughout the remainder of his life he and his wife had gone to estate sales in an effort to add to his every-growing, but interesting, collection. He liked to look at the pipes as well as to show them to others. He could remember many distinct stories about how they had been obtained. After Leo relocated to an assisted living facility, his daughter took the pipes and war memorabilia to an auction house to find a buyer. It is unknown whether any one buyer purchased the entire collection intact, or the collection was divided.

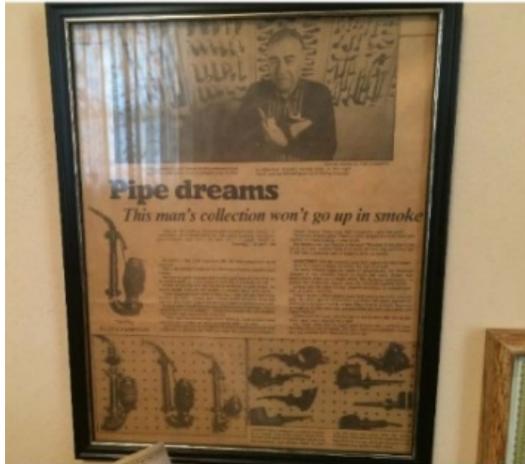


Image #70 Some of Leo's 1300 pipes and a newspaper article written about them.

Gertrude, who loved cats, had collections of both cat figurines and dolls. Peter had a collection of Santa Claus figurines his wife had accumulated. Helen had a collection of Precious Moments statuettes and Loretta had collected Lladro figurines. Both Loretta and Gertrude, who had been bowlers, had collections of bowling trophies. Many of these collections dated back decades and the way they were situated within cabinets and bookcases long predated my viewing of them. Some noted, but perhaps all had, abandoning any attempt to keep these collections dusted. Helen spoke of her things being from "all different places. Russia and Greece." and spoke of the things her mother had brought over from Portugal.

Collections of glassware and dishes were also very common. Loretta had three different china cabinets full of collected china plates, tea cups, and crystal glasses. Several spoke of wanting their daughters, daughters-in-law and grand-daughters to take these objects to their own

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homes. Tilda said, “I said take them, I’m not using them, take it. All these little goodies, all my Lenox, they’re beautiful. I said take what you want, you know.” It seemed that very few items from these amassed collections had been taken by relatives, perhaps due to generational differences in the appreciation for and the propensity to collect and display such things, but also because the true appreciation and meaning belonged only to the person who had collected them.



Image #71 Collections of figurines from various participants' homes

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Image #72 Collections of dishware and glassware.

The amassing of items and the tendency to not discard them was seen in a number of instances. In spite of the fact that Helen's husband had passed away in 1990, she still had his neckties hanging on the back of her bedroom door, and his baseball cap collection still hung in the basement family room. Tilda, too, had kept her husband's ties and wallets in a drawer. Philip had two old, unused cathode ray televisions (in addition to the new flat panel one which he watched) sitting in his living room and dining room, one beside an organ which had broken parts and had been un-playable for many years. He also had unused sofas in both his living room and his bedroom, served as a place to stack clothing items. The one in the bedroom blocked the way to two bookcases, also likely not accessed for years.

Many items had not been touched, much less used, for many decades. Other items had no useful purpose for anyone. Loretta had collected hanging linen calendars every year which

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she hung on a hook behind the door in the spare bedroom—all remained, the most current being 1990. Tilda’s stylish cabinet television had not worked for many years, but she kept it in her living room. In her dining room, Tilda had an old typewriter which she had used while on the job as a secretary for the Simmons Bed Company decades before and an old TV sitting in the guest bedroom. She felt that all would be taken care of after her death, when her children would shuttle all the old items into a garbage truck for disposal. She explained:

I have here an old typewriter from my office. I'm trying to get rid of it, nobody wants it. Electric typewriter. It works but who types anymore? I want to put it on the curb, I'm afraid they won't even take it. I figured, my children said no, don't worry. When the time comes we'll order one of those big trucks for everything. I said “good.” The same with this television here.

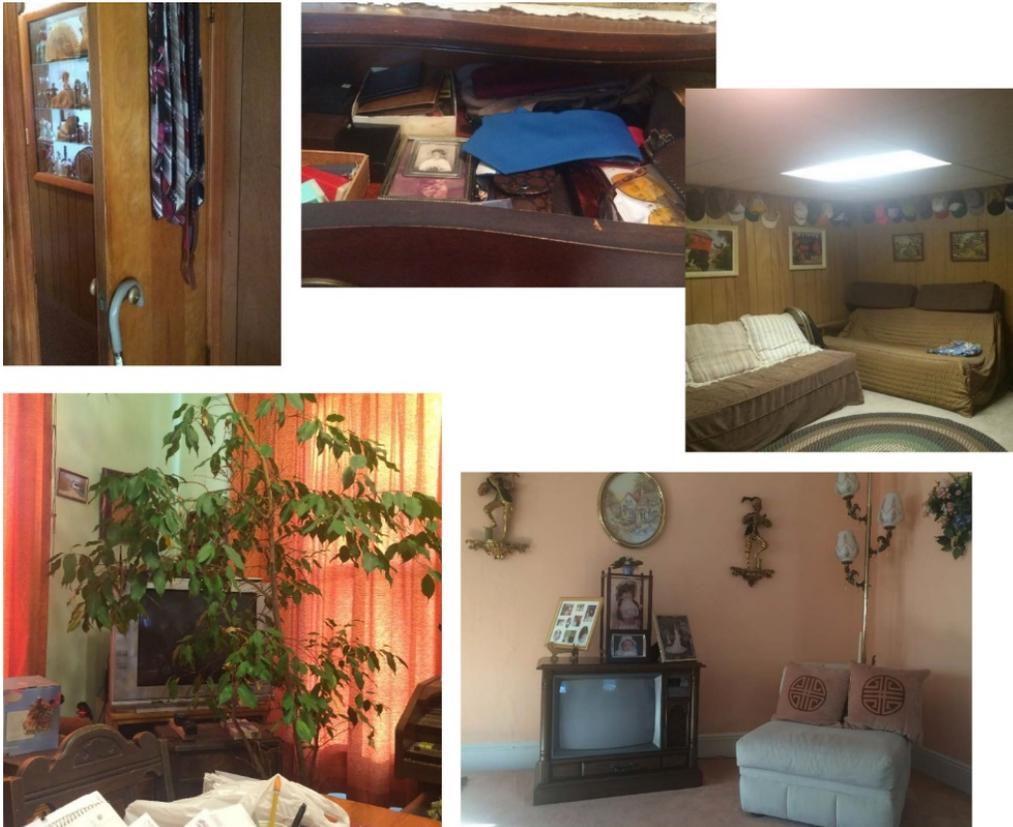


Image #73 Items which had were unused remained: neckties, wallets, and caps belonging to a long deceased husband, and TV’s which no longer functioned.

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Image #74 Additional unused items: an organ, books, calendars, a TV, and typewriter.

Six of the participants had unused bedrooms which had become rooms mainly for the purpose of storing unused items. As these homes had previously housed entire families, so an excess of bedrooms existed. Margaret's and Gertrude's both contained sewing machines which had not been used for many years because of their failing eyesight. Margaret's had piles of unused fabric with which she did not want to part. Although mostly a storage room, Tilda also continued to use her room for watching TV. For Loretta, this room also had file cabinets and served as a space to store old tax records and such.

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Image #75 Unused bedrooms used for storage.

Accumulations of unused items and furniture proliferated in basements and garages. There was old furniture, exercise equipment, children's toys and games, holiday decorations, unused small kitchen appliances, food storage containers, vacuum cleaners, cat carriers, old photographs and artwork, old TVs, lamps, and a host of other assorted cast-off but not discarded items.

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Image #76 Participant's basements and garages: many cast-off, but not discarded items.

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Image #77 Participants' basements and garages

Several of the basements—perhaps when the home was first occupied or shortly thereafter—had been decorated for the purpose of hosting gatherings and parties. In the 1950's and 1960's, when homes had limited main level square footage for get-togethers, basements, often called rec rooms at that time, were outfitted with swanky colors and furnishings and the obligatory “bar” for adult cocktail parties. Vestiges of these space remained in Loretta's, Gertrude's and Audrey's basements. One could almost imagine the swinging parties which took

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place there, with the record player blaring, and Manhattans being concocted at the bar. Loretta pointed out an unopened bottle of vodka which had been a gift to her husband on the last Christmas he lived, and it sat on her bar, and she had never opened it in the 32 years hence.



Image #78 Lower level rec rooms preserved for today. Cobwebs and dust covered the bottles of liquor

Several basements also included workbenches: areas where, during more productive years, home projects had been undertaken, Audrey's husband had been deceased fourteen years,

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but his workspace remained intact. Many of these tools and items may have not been touched for years. There had been no substantial changes made to these rooms in many decades.



Image #79 Basement workbenches in Audrey's and Leo's homes

Items which had lost their relevance for their owners years earlier, remained far after they had been useful. Books, encyclopedias, coffee makers, liquor bottles, all likely not used for decades remained markers of earlier times when the homes were used for entertaining family and friends.

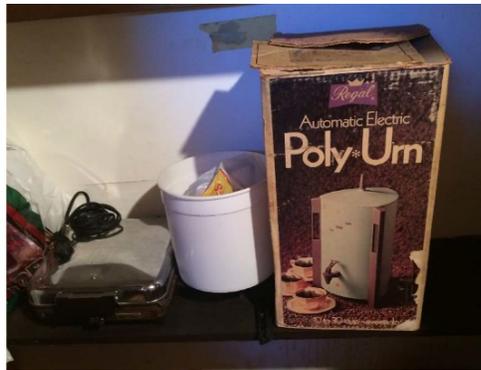


Image #80 Dusty items in basements not needed or used likely for decades. A gift of vodka had been given to Loretta's husband just before his death 32 years previously, and it remained in place, unopened.

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When a single older person remains the sole individual living within a home which was chosen to support an entire family, the quantity and usefulness of rooms can exceed their needs. Several participants had ceased traveling to the lower levels of their homes some time before, due to difficulty with stairs. Peter, who had a two level home, had moved his bedroom to the main level several years earlier, and had not ventured to the upstairs level since. Some participants had utilized unused bedrooms as space for storage. Others no longer used basement rec rooms, as the purpose for which they had been designed—parties and holiday get-togethers—were no longer pertinent in their lives. There were other instances of rooms no longer being utilized. Both Loretta's and Margaret's home included a screened-in porch. Both had remained unused for some time. Loretta's screened-in porch was in very poor condition. She explained that it had been added shortly after they moved into the house, and long before the home had air-conditioning. She explained, "We had that porch put on, I don't remember what year now. We used it a lot. It was fun because in the evening, we would sit out there. We'd like to sometimes take our supper out there. We'd have tables and chairs and what have you." It had become much less frequently used once air-conditioning had been added to the home, and not used at all in the 32 years since her husband had passed away. The city in which Loretta lived would haul away junk put on the curbside every year on the first of May. She used the porch now for storage of those items, until her son would take them to the curb for this annual garbage removal.

Margaret's screened in porch was in much better condition, it still had its original furnishings, and seemed quite pleasant, although had an accumulation of dead bugs around the windows. She used to go out to the porch to watch the birds and enjoy the breeze, but had been unable to since the time when she began using a wheelchair several years before, as there was a deep step down beyond the patio door to enter it. It had become a room she could see, but could

no longer use.



Image #81 Screened-in porches which had not been used in years.

Stylistic stagnation and deferred maintenance. In addition to the accumulation of items marking the passage of time, there were several homes which showed stylistic stagnation. When these homes had been initially occupied by the participants in the years from 1947 to 1972, they had likely been lovingly decorated. The exhilaration of being a new homeowner usually brings with it an enthusiasm for choosing favorite paint colors, buying new furniture, and embellishing the new home with thoughtfully chosen decorative accessories. Pictures are hung on the walls, furniture is arranged, drapes are hung, bedding is selected, and accumulated objects are displayed. As noted above, over these participants' lifetimes, they continue to amass cherished possessions to display in their home. But there were strong indications that much of the stylistic condition of these homes at the time of the interviews had remained largely unchanged since the time of original occupation or soon thereafter. These homeowners had not undergone major home remodels to update them to current trends. The participants fundamentally had not chosen to sell existing furniture to buy more current pieces, take down wall paneling or wall paper, install new carpeting, get new countertops, or purchase replacement lighting fixtures. They had not decided to take decorative accessories off the wall and replace them with brand new items for the benefit of a change of aesthetic, or if they had, that too occurred decades ago. If, and only if,

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a refrigerator or oven broke down was a new one was purchased. In many cases original, perhaps forty or more year old appliances still remained. In one case, an original oven had not been replaced, but because it no longer worked all meals were prepared on the cooktop or microwave. In other cases, ovens and cooktops were used only rarely, with the microwave becoming the main appliance used for meal preparation.



Image #82 Images of participants' living rooms

Birth years of these participants ranged from 1915 to 1927, meaning that they had largely come of age during the depression years. They were not raised to know the sense of disposable goods by which Baby Boomers or Millennials seem to live. Belongings and home finishes were purchased to be used for a lifetime. Home furnishings household items were intended to be used throughout one's life, then passed to children and grandchildren for their continued use.

The stylistic stagnation in these homes is interesting to contemplate when the length of residence is considered. To have the same piece of artwork hung on the wall, and to look at it daily for thirty, forty, fifty or more years represents an interesting life inertia, familiar and

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normal perhaps to member of the GI or Silent generations but at odds with how today's Baby Boomers have chosen to decorate and regularly update their homes.

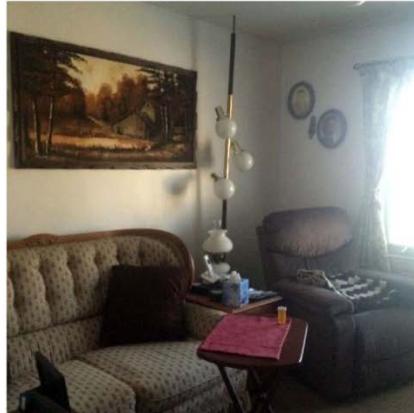


Image #83 Figurines as wall art



Image #84 Spoon collections, paint-by-number paintings, Hummel plaques, baskets, and needlepoints as wall art.

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Image #85 Kitchen and bathroom wallpaper, likely installed many decades before



Image #86 Appliances likely from about 1960, the year this home was built.

Adult sons and sons-in-law often did some of the house maintenance projects. Delores's son had recently cleaned out her gutters and downspouts. Peter's son-in-law had installed some ceiling fans, and put a storm door on the back door. A week before my first interview, Margaret had plumbing issues, which her son Mark attempted to fix, until he realized it was beyond him, and he called the plumber. Other participants were effective in contacting services to schedule home repairs. Delores's husband had left her with a list of local services he had utilized for the motel buildings he owned, so that when her front door jammed, she knew precisely whom to call. Audrey had recently contacted a roofing repair person when several roof shingles had blown off in a storm. Additionally, adult children were often depended upon to do minor tasks such as changing lightbulbs and furnace filters. Lightbulbs were also managed by housekeepers.

Margaret said of her housecleaner, upon whom she relied heavily for assistance and companionship: "Pat does what she can."

Leo spoke of frustration at no longer being able to take care of the maintenance of his home. When I asked him about changing light bulbs and cleaning gutters, he explained his reduced capacity and his daughter's concern:

Well, that's changed the last year and a half, too. Carol laid the law down. She says, "You're not using the ladder anymore." I used to get up, I got a seven foot ladder, and I'd clean.... My roof was gravel. Now it's shingles, but gravel would come down in the eaves so I'd have to get that out a couple times during the year. I could climb up on the deck and then the ladder would ... I was up on the roof ... I did all that stuff. Well, now I don't do that anymore. That's frustrating for me. Like I say, trimming the bushes and stuff. If I just can't do them.

Many of the homes were well maintained, but there were also several signs of deterioration within some of the structures. Loretta's home was in great need of painting and yard clean-up. The homes that appeared to have the greatest amount of deferred maintenance were the two which were the oldest buildings: Peter's home built around 1900, and Tilda's of which she occupied the upper level duplex, built in 1910. All other homes were built between 1951 and 1971. Peter spoke of having recently had his furnace repaired, which left him strapped financially: "Right now, I'm hard up." Tilda's upper level duplex appeared to have structural issues, evidenced by sizable wall cracks, and noticeably sloped floors. She had paid for many repairs over the years, but, after 68 years in the home, had adjusted to not maintaining everything as perhaps it should be: "Well, if it has to be done, you have to do it. If it bothers you, just close your eyes. What are you going to do?" Peter's home appeared to be the most in need of upkeep.

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This old Victorian, with lovely roof brackets was in serious need of repair. The exterior paint was badly cracked and peeling, the wood on the porch and front stairs was rotting, and the roof appeared to be in quite poor condition. Peter said about the condition of his home, inside and out: “You got to understand, at the tail end of your life, a lot of things aren’t important anymore.”

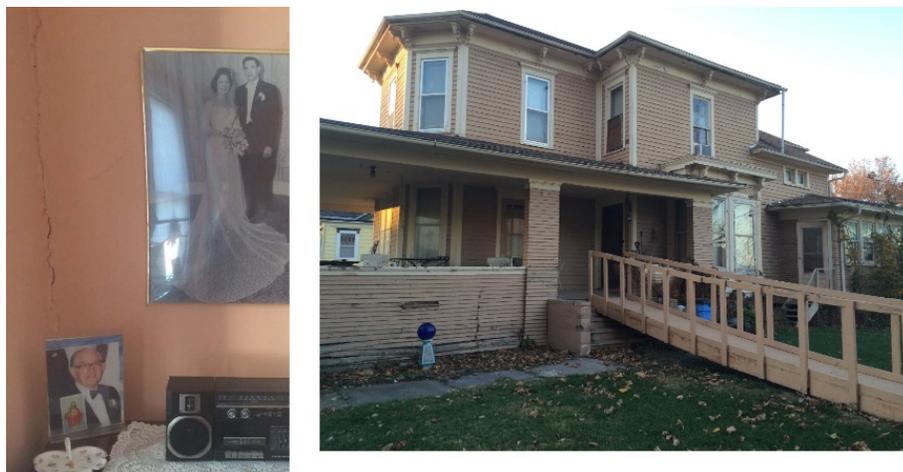


Image #88 Wall cracks in Tilda’s home, and peeling paint, rotting siding, and a broken window on Peter’s house.

Command centers. As noted earlier herein, environmental gerontologists have documented a pervasive age-related tendency to centralize actions within one chosen location of the home over time (Oswald & Wahl, 2005; Rowles, 1981; Rubenstein & Parmalee, 1992). Evidence of these chosen locations, or *command centers* were witnessed in many instances. Choosing to spend time in this spot, surrounded by these most used items, can provide older people with a feeling of control (Golant, 2015b).

Several participants spent a good portion of their day sitting at the kitchen table. This is where they would eat meals, take their medication, read the mail, take phone calls, and maintain their calendars. Audrey liked to watch the birds fly in and out of her back yard, and kept binoculars on the table. Margaret would watch cars drive by on the country road outside her front kitchen window. The corner of the kitchen counter adjacent to the kitchen table also

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housed needed items. All participants had a location, usually a comfortable chair or recliner where they would watch TV. Loretta, with her poor eyesight would keep the TV turned on to hear the news and weather report, but would often sit at the kitchen table rather than at a living room chair aimed towards the TV. In several cases, participants had end tables beside this favorite TV-viewing chair where they would keep an assortment of oft needed items. Several kept a similar assortment of items on bedside tables.

Items seen on kitchen tables or counters, end tables besides TV-viewing chairs, and bedside tables included: telephones (landlines), pads of paper, pens, a letter opener, mail, envelopes, a magnifying glass, the alert service receiving device, a cane, scissors, crossword puzzle books, an electric razor (male participant), a TV guide, TV remote control, address book, cough drops, eyeglasses, tissues, handkerchief, wash clothes, prescription pill bottles and dispensers, topical analgesics, eye drops, Vaseline, Chapstick, a nail file, a water bottle, coupons, a CD player, alarm clock, a prayer book, a rosary, the Bible, a flashlight, and a weather radio.



Image #88 Kitchen tables as command centers

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Image #89 Kitchen counters as secondary command centers



Image #90 End table beside favorite TV-viewing chair as command center



Image #91 Bedside tables as control center

Calendars, where the participants kept track of the dates of appointments, garbage pick-up, events, and visits were commonly seen, usually sitting on the kitchen table or counter.

Gertrude, who loved cats, had a cat calendar with a different cat picture for each day. Peter had a daily Garfield calendar, but could not read the small print in the captions. He needed to use a flashlight merely to discern the date. Loretta, who had even greater vision loss, wrote events on her calendar, but would then ask her son during his weekly visit to read them to her so that she

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was reminded of them for the short term. Tilda's calendar hung on the back of the door. She would cross out each day to keep track of time. Recently, she had mistakenly crossed out an extra day, and had called her son to wish him happy birthday one day early. Only two of the ten participants had and used a computer. Leo and Tilda both communicated via email to grandchildren, and Tilda additionally viewed her grandchildren's Facebook posts. The both had a grandchild who had enthusiastically trained them on the computer's use.



Image#92 Calendars kept near command centers.



Image #93 Two participants had and used computers

Grocery shopping and meal preparation. Groceries were both purchased by the participant and brought to the home by others. Tilda did her own grocery shopping, and carried her bags up the stairs to her second floor home. When the quantity of purchased items was large,

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she utilized the grocery delivery service, common in her more urban area near New York City. This service had a fee, but the delivery men would bring bags all the way up to her upper story door. At the time I interviewed Leo, he still drove to the grocery store. He would go early in the morning when there were not a lot of customers there, and he could be assured of getting a handicapped parking spot. At other times, when his daughter would come to help him with cleaning, she would take him to the grocery store. Shortly after the end of the interviews, his daughter reported to me that, because he had become increasingly dependent on his cane, she had taken to picking up all of his needed grocery items for him. However, in one instance he had decided to make the trip for a few items, and it was when he was trying to carry the grocery bag into the house that he fell on the concrete garage steps leading to the back door, the fall that caused injury necessitating his relocation to assisted living.

Every Tuesday, when Loretta would have her “special day” with her son, Jack, he would drive her to the grocery store. She would use her cane to get to his car, and use his arm to get from the car into the store. Then, she would use the electric cart available at the store to get around, while he reached the items on the shelf to put them into the cart’s basket. He would read the list that she had written. She would write the list throughout the week. Due to her poor eyesight she was unable to read her own list, but Jack could.

Ted and Gertrude, who both passed away shortly after my interviews, had been driving shortly before my interviews with them, so that they could pick up some of their own groceries and pharmacy items themselves. In addition, they both relied on their adult daughters, who visited very regularly, to bring food items and prepare meals. Tilda also drove herself to the nearby grocery store and pharmacy, and her sons and daughters-in-law would bring things over

when they visited. It was getting these items up the stairs to the door of her home that presented the greatest challenge, which she met through the use of prayer.

Margaret, Peter and Helen all relied, in part, on home health aides picking up and bringing grocery items. Margaret's son would regularly go to the grocery store for her. Peter's son did so sporadically, and mostly for the things he himself needed, such as Keurig cups and cat food. Helen sometimes made the trip to the grocery store with her son, and sometimes he went alone on her behalf. In addition, Margaret relied on both grocery and pharmacy delivery services. She would make sure to tell them to come through the garage, as she had difficulty opening the front door in her wheelchair. There was insufficient space between the pull side of the door and the adjacent wall—the condition prescribed in the Americans with Disabilities Accessibilities Guidelines requiring a minimum of 18 inches of clear space. She would instead wait on the chair lift for the delivery person to arrive.

Meal preparation involved several challenges. Some participants continued to actively cook and bake, even making food items from scratch while others had abandoned many meal preparation activities, especially involving the cook top. Several participants spoke of choosing meal items because they were very simple to prepare: canned vegetables and fruit, boiled or fried eggs, toast, oatmeal, cereal, and sandwiches. Both Helen and Peter received Meals-on-Wheels for their noontime meal five days a week. Additionally, Peter received free boxed meals through his Medicaid program, which included items such as canned goods, crackers, juice boxes, and packaged cookies. Tilda, who lived in a high density area of New Jersey, had an Italian restaurant within three blocks of her home which delivered throughout the day. Being 100 percent Italian, she enjoyed items from their menu, such as meatball sandwiches, pizza, and pasta, and would regularly order food delivery, particularly in the event that a friend or relative

was visiting. Audrey and Ted, who had daughters who came virtually every day, relied strongly on them to do much of the cooking. Margaret had a friend with whom she used to attend church who would occasionally bring a casserole over, which she could heat up in the microwave for several days following. Ted's daughter, who would come over to clean, would bring or prepare an item that could be frozen in individual-sized servings, which he could then microwave. Other relatives of both Gertrude and Ted would occasionally bring over a prepared item or casserole.

In several instances there was a fear of using a cooktop or oven, and therefore a strong preference for using the microwave for meal preparation. Margaret often used a slow cooker to cook dinner, as there was no fear of burning herself, which she feared might happen if using the gas cooktop. At several times during my interviews with her, Margaret mentioned this fear of using the cooktop. Loretta, who was very nearly blind, was also very fearful of burning herself using her gas cooktop. Her fingers had been burned before, and she also had difficulty with grip strength when trying to grasp pan and pot handles. She explained:

I'm so very careful because I wear a sweater so much because old people need warmth.

A sweater or some little something. Your blood is so thin. I'm so careful that I don't get that long sleeve into the flame. Really, I have to think. I have to think so that I don't do something stupid. I have a problem with the handle like on my cooking grip. Sometimes

I get too close to the hot part so my poor little fingers many times they are burned on the ends.

Gertrude had been fearful of using her cooktop, and had not used it for some time. This was quite clear, as she had now adopted it as the logical surface on which to leave notes, bills, appointment reminders, glasses cases, and her cell phone which would have been burn hazards had the cooktop ever been lit. Tilda had recently had a small incident while using her cooktop.

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She had accidentally moved a plastic trivet too close to the burner, and had not noticed until she smelt something burning. Luckily when she moved the trivet away from the burner, the burning ceased.



Image #94 Gertrude's cooktop (left) and Tilda's cooktop (right). Gertrude did not use her cooktop for cooking. Tilda did, but had burned her plastic trivet. Tilda's countertop microwave at right, clearly an old model.

Peter had also ceased using his stove sometime before our interviews. He prepared all of his cooked meals using his microwave. Pot pies were his favorite. He had to keep a flashlight handy to enable him to see the numbers on the microwave keypad. Loretta, with her very limited vision, also had difficulty with the dials and numbers on appliances, and utilized adhesive plastic dots to mark the most often used settings. It was the wall oven which Leo feared using, as it was very old and original to his home built in 1960. He too relied heavily on microwave cooking.

Microwaves were heavily relied on for meal preparation. Several participants spoke of eating pot pies and TV dinners. Many had fairly old microwaves, although the cost of a new one is very reasonable. Tilda said about her microwave, "It's still working. I don't throw anything out unless it's broken."

In spite of these compounding fears and hazards with cooking appliances, a few of the participants spoke of enjoying aspects of cooking and baking. Margaret said that she regularly made homemade noodles, which she liked much more than the store-bought ones. She would spread the dough out on her kitchen table to let dry out before she cut the noodles into narrow

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strips. She would put these with meats and vegetables in her slow cooker. Loretta still did baking, and the prior Christmas (nine months before our interviews) she had made 70 dozen Christmas cookies for family and friends. This was nothing, she explained, compared to the 300 dozen she had regularly made during each season throughout her lifetime. She was very nearly blind, so had mastered the necessary steps of measuring, mixing, kneading and forming without the benefit of sight.



Image #95 Loretta's appliances marked with adhesive rubber bumpers (left) and Leo's unused wall oven (right)

Laundry. Of the ten participants, seven managed to do their own laundry either independently or with some assistance. Three of those, Delores, Margaret and Tilda had the washer/dryer on the main living area level of their homes. Delores and Margaret both prided themselves that, when their homes were being built (in 1971 and 1966 respectively), the foresight was present to plan space for laundry on the main level by the kitchen. Tilda, who occupied an upper story duplex, had a stackable washer/dryer in a closet in the kitchen. This proximity aided in the ease with which laundry could be completed. From her wheelchair, Margaret could get the clothes into machines, but waited for her housekeeper to come to remove, fold, and put the clothes away.

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Leo, Audrey, Gertrude and Ted also did their laundry, but had their washer/dryer located on the lower level of the home. Leo made the trip downstairs daily anyway, for his regular walk around the basement for exercise. He could make the trip up and down the stairs without the use of his cane, by hanging on to the stair rail. That left one hand free to hold a bundle of clothes. Audrey managed stairs very well. Since her daughter Janet came almost daily, they would sometimes split the job: one would put clothes in, one would take them out. Ted also made the trip downstairs daily as his bedroom was on the lower level. In this case, having the washer dryer on the lower level was convenient, as it was on the same level as his bedroom and bathroom where dirty clothes were accumulated. Gertrude had the most difficulty with having her washer and dryer on the lower level. She had a clothes chute so dirty clothes were readily at their needed location. She would go downstairs, walking backwards down the stairs as was her habit, to get the laundry completed. Often, if the quantity of items was small she would just hand wash them in the laundry tub and put them in the dryer. To get the clothes back upstairs, she would put them on an upper step through the open basement wall without gypsum board, climb up to that step, pick them up off the step and continue up the few remaining steps. Although Gertrude's daughter visited often, and regularly volunteered to do the laundry for her, Gertrude insisted on completing this task mostly on her own.

Peter and Helen had their home health aides do their laundry during their regular visits. So the task of getting the dirty clothes down to the lower level of the home where the washer/dryer were situated, and getting the clean clothes back up and put away, was completely taken care of for them by others.

Loretta relied on a friend, the mother of Loretta's grand daughter-in-law, who voluntarily came over every other week to help her with her laundry. This friend would come, put a load of

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laundry in the washer, sit and talk with Loretta over a cup of coffee, put the load in the dryer, chat some more, then fold the completed laundry and go home. Or sometimes, because this friend lived near-by, she would make the trip to Loretta's house to put a load in, return to her own home, then stop by again later when the load was finished. Loretta's washer and dryer were two half flights down, which was exceedingly difficult to manage, so she greatly appreciated this assistance. Previous to this friend's assistance with laundry, Loretta had gone down to the unfinished basement herself to use the washer and dryer and would sit there for the duration of the cycles rather than ascending and descending steps additional times. But at some point several months before my visits, the washing machine had broken down. Loretta's son arranged for the purchase and installation of a new one, but Loretta could not see the new dials and had difficulty learning to operate it. She was very thankful for this friend's help, but this woman's husband had recently had a stroke. Loretta feared that needing to provide constant care would prevent this friend from being able to make her visits to do laundry in the near future. At one of my visits, Loretta informed me that this friend had taken a fall, so was unable to come on the planned day to help with the laundry and she did not know when she would be able to come again.

Garbage removal, lawn care, and snow removal. For most participants, trash services required that garbage be put in large plastic garbage bins with wheels, and rolled down to the street end of the driveway. Delores, who was quite capable, was able to do this herself, or she had her housecleaner do it for her during regular visits. Having been widowed only eighteen months when I interviewed her, she described how her late husband had always taken care of the smallest of house maintenance issues, and until his death, she had never had to do this task even once:

Mitchell was such a leader and I was such a follower in my life, this is one of the things we talked about at grief support, what would you wish you could do differently in your relationship. I was just a follower, that's all there was to it. I don't think I even ever pushed the garbage cans down there.

Several participants relied on the housecleaner, or adult children, when they visited, to take the trash to the street. Ted still did it himself, but commented on how it had gotten to be a more difficult chore, and that he only did it every several weeks in the winter. Loretta paid her garbage service extra to come up to the front of the garage to pick it up. Somehow, with her cane, she was able to get the trash bags to the garage and into the bin, and to get the bin to the outside of the garage. She commented that it was inconvenient that Tuesdays were the days her son always visited, but garbage day was Friday.

Peter also had an issue with the misalignment of the trash pick-up day and the day that the house cleaner arrived. Instead, and to evade the cost of garbage pick-up, he utilized his back porch as a temporary garbage storage space. On one of his son Terry's stops between trucking runs, Terry would put all of the accumulation of bags on a flat-bed trailer and haul them away. "It goes onto the back porch and then out to this trailer sitting out here. Then when the trailer gets full my son pulls it up to the transfer station and empties it and which is quite a job. There's nobody here to take it out to the street."

Leo had developed an effective means of getting his garbage and recycling to the street. He would put the recycling bin and his bags of garbage in the trunk of his car, back the car up to the end of the 30 foot drive, and leave the them. Out his window, he would watch until his recycling bin had been emptied and left, and the garbage had been picked up, and he would again back the car up to retrieve the empty recycling bin in his trunk.

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Where Tilda lived, plastic bins were not used. She was only required to leave bags on the boulevard the day of trash pick-up. This was more manageable for her as it did not require maneuvering a large bin. It just meant a trip down her steps with the bags, which she tried to align with another purpose such as going to the grocery store, and back up again, made more manageable, as always, through the diversion of prayer. If however, the ground was covered in snow, she would keep her garbage bags on her back porch for a week or two until the snow dissipated, for fear of slipping and falling on slick pavement.



Image #96 Tilda had only to bring loose bags, not an entire bin to the curbside.

The degree to which the exterior yard area was maintained was directly attributable to adult children's efforts. Audrey's daughter Janet mowed, weeded, and planted flower gardens in her mother's yard. Tom's daughter Anne put hanging baskets of annuals on his front porch, and his son mowed. Gertrude's daughter Trish also enjoyed gardening, and neatly maintained the perennials and shrubberies. In these three cases, the home's yards were quite well groomed. In contrast, Loretta's and Peter's yards were full of weeds, and the shrubberies were very overgrown. Loretta had a large tree in her front yard, with a sizable dead branch hanging dangerously over the roof. As with other areas of the home, Loretta's and Peter's adult sons (in their 70's and 60's respectively) were frequently present but did not largely contribute to or

facilitate maintenance. The condition of the other participants' yards was somewhere between these conditions: mowed, but not groomed.

I interviewed Leo in the winter months, and he had been able to maintain his own yard the previous summer. In July of the following summer, a bad fall precipitated his moving into an assisted living facility. Regarding the previous summer, he had still enjoyed using the riding lawn mower that he had purchased about five years previously. He like to keep his yard neat, so he would sometimes sit on his lawn and picked up sticks and put them into a bucket. A neighbor who saw him sitting there came over to see if he was okay. After that, he was reticent to do this activity to avoid alarming any more neighbors.

Loretta lived near a family with two grade school aged boys. Their mother had come over to ask Loretta if she would like to have her young sons mow for her, expecting that they would do it as an unpaid service for her. Loretta was happy with this offer, but insisted paying them nearly as much as she had previously paid a lawn care service. She enjoyed watching these young boys working in her yard, felt that they did an excellent job, and was happy to pay them, particularly because their mother insisted they put half their pay in a savings account.

The remaining participants either hired a service, or had their adult sons or daughter do the mowing. Snow shoveling was also either hired out, or, in some instances, done by a volunteer neighbor. Delores had a neighbor who always did her driveway snow removal, and refused to be paid. She explained what he had said about his generosity: "He says I'm getting exercise outside. I've got a good snow blower and he says instead, I feel good to get out in the fresh air instead of just going out and standing or walking. He said furthermore, I feel like I'm doing something for somebody else." Leo also had a neighbor who voluntarily did his snow removal. Helen had a neighbor whom she asked whether he could help her find a snow removal

service, and he replied that he himself would be happy to do it. When she asked how much he would charge he responded “Oh, I’m cheap.” She always made sure to give him what she thought was appropriate, plus gave him a box of chocolates at Christmas, and a gift certificate for a local restaurant at the end of the season.

Maintenance of Finances. Getting utility and other bills paid was a challenge for those with limited vision, particularly Loretta and Peter. Neither could adequately see to discern the amount due nor to write out the check. Loretta paid most utility charges through auto-pay arrangements with her bank. But for other bills, she would have her son Jack review them at his weekly visit, make out the checks, and she would sign them. He would have to point to where the signature line on the check was. She noted that her signature was no longer legible “but they accept them, so I guess it’s all right.” Peter had a similar arrangement where his nurse’s aide would make out the checks, then show him where to sign. This would seem to be an arrangement with a bit of risk should the aide be less than scrupulous.

Bills and notices which came in the mail daily were often kept near the phone, at the kitchen table, or at the *command center* near their favorite chair. Audrey and Delores spoke about having kept financial records from decades previously, of virtually not having thrown any tax or investment records away. In both cases, these records were kept in metal file cabinets in the basement. Three participants, Helen, Leo and Loretta, spoke of shredding mail and old documents. Although they did not specifically address their purpose for doing so, it was likely driven from fear of some form of identity theft or pilfering. All three kept paper shredders plugged into wall outlets for handy use. Leo stated, “Anything with my name on it, I shred it.” Helen spoke of stress regarding pulling together records to give her tax accountant for her annual income tax filing. She said that she tried to keep track all year of statements and records, but that

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each year when her son took her for her tax appointment, there seemed to always be one needed paper that could not be found, necessitating phone calls and reprints. Income tax season seemed to be a stress for her.

Peter, who received Medicaid assistance was required to keep the balance of his checking account balance (countable resources) under \$2000. He said this was difficult for him to continually ensure, as his Social Security payments were directly deposited into his bank account. He explained “that’s hard because I got big bills to pay and so I never know what I got really.” When he received his bank statement each month, he used both a flashlight and a magnifying glass to decipher the balance information, sometimes needing to also experiment with glasses on and glasses off, to get precisely the correct acuity.

For Margaret, financial interests had caused a significant rift with her daughter and son-in-law. The son-in-law had expressed a strong opinion on a number of occasions about what he felt she should do with some of her financial resources. She seemed to feel significant pressure about his promptings, but she had held her ground in refusing to do as he wanted. This had caused there to be greatly reduced ongoing communication with he and her daughter at the time of the interviews.

Helen did not speak of having major financial concerns, and her three sons were quite successful in their careers and found a variety of ways of helping her out. Even though one son paid her cable and phone bill, she expressed outrage at a recent charge. She called the company herself. She described:

My son Paul said Ma, let me pay for it now. He does, he pays for it. I said I can’t see them doing what they’re doing every time you turn around. They’re raising it. You know what they did? They charged me five dollars for a call to [directory] assistance. I

called yesterday I was so angry and I told... I told them, I said that's not right, highway robbery, I was so mad. The thing that gets me is that when I worry about it then I don't sleep the night before [I am going to call]. It's like in my head. That's not right what they're doing to me.

She expressed that she feared she might be taken advantage of because of her age, "I thought it was me because I'm getting old and you know. I've always been very... whatever I spend or whatever I do, there has to be a reason and I don't like being fleeced, you know."

Driving and transportation. Driving and other means of transportation—most commonly being driven—emerged as a theme impacting lifestyle relative to emerging, or not emerging from the home. The two specific categories were *driving* and *transportation*.

Driving. Of the ten participants, five still drove at the time of their interviews, and all five had handicapped parking hangtags for their car. All five who drive talked about not driving after dark, and all five drove only very locally, in a small circumference around their residence. When asked if she went out after dark, Tilda replied, "I don't go out at night unless it's with my kids and I have to go. By myself, never, not anymore." Additionally, several spoke of avoiding driving if there was any snow or ice on the roads. Several participants expressed thankfulness at still having the ability to drive. Delores said, "I feel blessed that I have my driver's license and I'm not restricted. I don't drive at night because I don't feel comfortable going out in the dark. I just don't do it but there are no restrictions on my driver's license."

Leo, who lived in a small town, drove almost daily to pick up his mail at the post office, as he did not have a mailbox at his house. He would also drive to the local grocery store weekly and to get his haircuts. When he had doctor's appointments however, which were known about in advance, his daughter would provide transportation. He occasionally would meet a friend for

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dinner at the local Embers restaurant, but had to schedule it to make sure it was still light when he drove home. Delores also drove, but also strictly avoided ever driving after dark. For church, she accepted invitations from others to pick her up and drive her, as she rationalized that the fewer times she got behind the wheel herself, the less her risk of an accident.

When I interviewed Ted and Gertrude, they were both still driving themselves to the grocery store and to appointments, again, only during daylight hours. Ted drove to the grocery store, the pharmacy, and the mall. He said, "I don't want to quit driving, but I know that when the time comes, I'll hang it up." Gertrude drove to the grocery store, the pharmacy, and to church. She had her adult daughter, Trish, drive her to doctor appointments, because she could not hear the doctor well and wanted Trish there to hear all that the doctor said. Gertrude had purchased a new Chevrolet, of which she was very proud, just about a year prior. She said, "I hate to think when I can't drive, because you're independent this way. I drive to church and I can drive to get my hair done and I get groceries. I don't go on the big highways though." My interviews with Ted preceded his death by only about a month and a half, and my interviews with Gertrude were about two and a half months before the beginning of her nine week stay in hospice prior to her death. So, their responses about driving during interviews likely aligned with some of their very last thoughts about and experiences with driving.

Tilda drove, and lived in a very high density area. She had routes to get to all the needed locations, grocery store, pharmacy, bank, post office, doctor's office, and hair salon all within several blocks and all without needing to go onto busy four-lane roads. She had a minor accident just a few weeks before our interviews. While driving down a narrow residential street, a man in a parked car with his hands full opened his driver's door, rather forcefully, with a push of his foot, and the door swinging open just happened to hit Tilda's side mirror as she drove by,

knocking it completely off. She pulled over and the man asked to write down her name and license number. She drove home and called her son, asking what she should do. He instructed her to call the police, which she did. Shortly after, an officer came to her house and told her the man in the other car had already reported the accident but said, "He is not going to press charges." As Tilda recognized the incident to be entirely this man's fault, this rattled her and left her wondering if she had misinterpreted the sequence of events. She described "It was a minor thing, but it was major to me because I didn't know what happened." However, she was determined not to let the incident deter her from continuing to drive. Her son duct-taped the mirror back on to her car, and promised he would take care of getting the car to the auto shop for her in the near future.

Helen had given up driving several years before our interviews, not because of poor eyesight, but rather because of the arthritis in her shoulders which left her with much pain and very little range of motion for managing the steering wheel. Audrey had forfeited driving at age 96, about three years prior to the interviews. She had the advantage of her daughter Janet, who was available and willing to provide any needed transportation. Loretta could not recall precisely when she had stopped driving, but it had been many years previously when her issues with vision became quite limiting. She spoke of weighing a desire to drive against the possible risk she knew she would pose to others:

After Gary died, I was able to drive myself of a long time, but as my eyes got worse because my eyes were the beginning of my bad problems, as my eyes got bad I recognized that as much as I wanted to drive, I couldn't drive. I could go down the back roads maybe and hope I don't hit something, but I would not do that, because if I would

hit a child, I'd never forgive myself. Just my selfishness because I had to be able to go places, it's not worth it to me.

Peter had also given up driving some years earlier due to his poor vision. His wife had gone to a nursing home, and for a time he drove daily to see her. When he no longer felt safe driving his car, he found another means to visit her, permissible in his small town. I asked how long his wife had been in the nursing home, and he replied:

Oh, a year or two. I don't know. I got to where I couldn't drive, then I bought the golf cart so I could drive it out and see her. Then winter came. She may not have been there as long as I think. I guess that's pretty weird. The nursing home thought a lot about me because I was always there to see her every day. I knew she needed me. After all, we'd gotten married for better or for worse.

Margaret spoke of deep regret at having to give up driving. She had stopped driving about five years prior to our interviews. It was fear of the license renewal procedure which prevented her from attempting a renewal. "I just knew I couldn't do it. If they would question me, then I would have had to take the test, I mean the driving test.... I just didn't want to do it, bad as I wanted to drive." About giving up driving, she said "That's the worst. For me it was. I don't know about other people. I miss that terrible. I can't stand it.... You just can't imagine. You can't do it anymore." She had chosen not to sell her car, so it remained parked in her garage: "I should sell my car but I just can't yet." Often when her son came over to take her places, they would use her car as it was easier for her to transfer into from her wheelchair than his SUV.

Transportation. Those participants who did not drive relied heavily on others to transport them or they simply stayed home. Those who did drive had a reduced range of travel, so did not partake of activities that they had in their earlier life. None spoke of ever having taken

a taxi to needed locations, although this may have been a logical solution. For instance, people could have taken taxis to church, but seemed not to be inclined to utilize this type of service.

Leo spoke of missing the experience of attending live sporting events. Loretta could depend on her son, in his 70's at the time of our interviews, to take her wherever she needed to go, which worked for all but trips to church. He had converted when he was married so he no longer attended the denomination of service that Loretta did. For many years, a friend and fellow parishioner had taken Loretta to church, but she had since died of cancer. So Loretta developed a similar arrangement with another friend from the church who not only took her to church weekly, but also took her to get her hair done. This was clearly an arrangement that satisfied Loretta by being able to compensate her for her time and effort:

She stepped in and took over taking me to church, just the way Doris had. Once every six weeks she takes me to the beauty parlor and I get my hair cut. Then we go out to lunch together. That's just understood. That's one time she lets me take her to lunch. When we go out to lunch after church with a group, she insists on paying her own, but that's one time she will let me do it. I have that to look forward to. I know that every six weeks, in fact she's the one that makes the appointments and tells me when it's going to be.

Margaret's son, Mark, was agreeable to taking her where she needed to go—to the grocery store, to the pharmacy, to get her hair cut, to doctor's appointments—but she felt that asking him to take her to church would be too much of an imposition, as he did not regularly go himself. The necessity of having to navigate the wheelchair ramp once she got there was also a deterrent to going to church. But she spoke of an event, a local annual bible study event that she had really wanted to attend. It took place for a few days in town every summer, and she spoke of regret at not having been able to attend it the previous year, and remorse that she could not

foresee getting there at any date in the future. It had been a highlight for her when she had attended it in the past. She spoke of the beautiful music and the inspirational readings and discussion, but she felt it was just too much to ask her son, or anyone else to facilitate her attendance ever again, as that would involve much time and vigilance on their part

When I interviewed Loretta, she had recently been invited to a wedding. The groom was the son of the couple who had been her neighbors for thirty years. She said, “This Saturday, their only son is being married. I feel like I'm part of that family. No. I can't go. The only transportation I have is my son..... That's my only transportation. Of course, I can't go to the wedding. They understood. They invited me anyway.” She clearly did not feel that she could ask her primary provider of transportation—her son Jack—to take her, as he had not been invited himself, but she felt it was a kind gesture that they had invited her.

Peter was a self-described shut-in. Because his son did much of the grocery shopping when he visited his father between trucking runs, and the nurse's aide brought the mail from the post office, Peter said he left the home only to go to the doctor. While speaking of having enjoyed taking family vacations earlier in his life, Peter expressed, “Boy, I miss a lot of stuff.” When asked what he missed specifically he explained, “Everything, just seeing scenery.” It is notable that at no point during Terry's (Peter's son) visits did Terry make an effort to transport Peter out of the house simply for recreation, or to take him to see things or places of interest. This would seem to have been an easily achievable respite from his isolation. Peter's daughter had visited a few months before my interviews, and had taken him out to dinner during her visit.

Children/ neighbors/ friends/ service providers. As with driving assistance, participants had reliance on individuals within their personal sphere for support in many areas. In many cases, assistance was offered willingly and enthusiastically by others. In other cases,

assistance would have been greatly appreciated by the participants, but was not offered by those who could have provided it. As Loretta explained: “If I can do it myself, I’m going to do it myself. If I can’t do it myself, I welcome help. I’m grateful for all the help I can get.” In some cases, these arrangements were very precarious: there was a willing participant, usually an older person who provided assistance, but if that person succumbed to sickness or injury, a chain reaction meant that the assistance ceased. The categories within this theme were *adult children*, *neighbors*, *friends*, *service providers*, and *community members*.

Adult children. All participants had adult children who played significant roles in their lives. All also had grandchildren, and many had great grandchildren, but in all cases the adult children played more significant roles in the lives of their elderly parent than did the adult grandchildren. The range in ages of the adult children at the time I interviewed their elderly parents was from 52 years old to 79 years old. Loretta had only one son (age 79), and Ted had six children (ranging in age from 52 to 63 years). All of the other participants had either two or three children. Notably, all participants with the exception of Peter had at least one adult child who lived within an hour’s drive, or in many cases much less, of their parent’s home. This would certainly not be the case for many elderly people currently living alone. Many elders may have no adult children in the vicinity, so participants of this study were thus advantaged. Peter’s three children all lived several states away, but his son Terry, who lived in New York, made regular visits during his cross-country trucking runs between New England and Colorado, often staying overnight for one or several days. Peter’s oldest daughter, who lived in Pennsylvania, called him in Iowa every evening, seven days a week, at 8:00 pm to have a brief chat about the day’s events.

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For the participants who had adult children living in the same city or within an hour's drive of their homes, there were varying levels of regular involvement. Audrey and Gertrude's adult daughters visited almost daily. Margaret's son, who lived very close, also come almost daily to bring in the mail and the newspaper. In the last few months of his life, Ted's daughter moved into his home to assist him. For other participants, such as Tilda and Helen, visits from children were on weekends or holidays. Leo's daughter came every few weeks to clean his house, then afterwards, they would go out to dinner together.

Adult children provided assistance in a myriad of ways. When Tilda's husband, Jim, was seriously ill, and just months before his death fifteen years previously, her son Jerry and his wife had rearranged their home so that Tilda and her husband could stay for two months. Jim was undergoing daily dialysis for kidney failure. Jerry's home was very near the hospital, so Jerry moved their furniture out of the living room, brought in a hospital bed and an additional twin bed, and that became Tilda and Jim's bedroom. When, after two months, it was clear that the therapy was ineffective, they decided to go home so that Jim could die at home. He passed away very shortly after returning home.

For the most part, relationships with adult children were enjoyed, but not always. In Loretta's case, her relationship with her only son brought great joy. Loretta's 79 year-old son Jack always visited his mother on Tuesdays. She called Tuesdays her 'happy day,' and would not schedule any other activity for that day. She clearly looked forward to it each week. With Jack providing transportation, she would get her grocery shopping done, as well as other necessary appointments. She explained:

My son will take me any place every Tuesday. That's my happy day, Tuesday. Every Tuesday, Jack picks me up and we go grocery shopping. We either go out to lunch just

the two of us or we come back here and I make his favorite food. We have lunch together... so I don't make any plans for anything else on Tuesday, and neither does he , which is nice.

Gertrude had her daughter Trish, who was in her early 60's and no longer worked. She was able to spend as much time helping Gertrude as she wanted, and it is likely that the assistance she provided to her mother gave her a sense of fulfillment. Trish and her mother had bowled together until very soon before my interviews. After Gertrude was no longer able to bowl, Trish would still pick her up and take her to the bowling alley so that she could watch the others on the league play. Trish would go to her mother's house very regularly to help with cleaning and yardwork, and to provide companionship. They would sit together and complete jigsaw puzzles, watch TV, or chat. To assist with Gertrude's other favored pastime—crossword puzzles—Trish had under-taken the lengthy task of compiling a hand-written glossary of words. When Gertrude came across an unknown word, she would jot it down, and Trish would put these unfamiliar words and their definitions alphabetically into a notebook as a reference for the next time her mother might come upon the same word in a new puzzle.

In other cases, relationships with adult children were fractured. Although Loretta's relationship with her son was cherished, she had a much different relationship with his wife, Diane, her daughter-in-law. She had felt from the start, when they were married over forty years earlier, that this woman was not kind or generous, but that feeling had intensified as Loretta grew older and offers of any form of assistance from Diane were never forthcoming. Certainly, at age 100 and almost completely blind, Loretta could have used assistance from another woman in the family who lived less than a twenty minute drive away, as she had no daughters. Loretta explained this relationship:

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Just between us, and I wouldn't want it to go any farther, I have a daughter-in-law, I dearly love her, but she is different..... I'll be frank about it.... Jack and I are the only two... who really knew how difficult it was, and he has thanked me for being the way I was, because we have kept a good relationship, but I have walked on ice for forty some years now..... Normally a daughter-in-law would be willing to come in and run the vacuum, or do a few little things, but she has never offered. Not even once.

At some point in the few months before my visit, Margaret had a conflict with her daughter and son-in-law. She felt they was interfering in her life and finances by telling her what she should do with her money. Over the course of my interviews, the daughter did come to visit once and Margaret described, "We've been having a few problems but Sunday she was real good to me. That made me feel better." Peter had one daughter who called him every evening, but the other daughter very rarely called or visited.

Tilda had a very good relationship with both of her sons, and particularly with one of their wives, her daughter-in-law, Julie. She was conscientious about making arrangements so that Tilda would see her grandchildren often, and she made sure that family occasions were planned around Tilda's presence. Julie had a designation within her Catholic Church that meant she could take a Holy Communion wafer to Tilda each week, since she no longer attended mass. Altogether, Tilda's relationship with her sons and daughters-in-law seemed very good, but that did not extend to the possibility of her forfeiting her home to go live with them. As Julie and her husband Jerry, Tilda's son, worried about her living alone, they had extended an invitation, but Tilda was not interested. She explained, "Jerry says, 'Come live with me.' I don't want to go live with them. What would I do in their house? They're gone all day. I'll be with the dog. I hate dogs." She further explained that she felt that the better arrangement would be to continue

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to hire help for the things she needed assistance with, feeling that that would be a logical use for the money she had saved in the bank.

One of Helen's sons, who had a successful career and a large home about an hour's distance from hers, had offered to build an apartment for her above his garage. She declined, and explained her reasoning, "You're comfortable in your own place. I've been comfortable all these years.... They wanted to build a little apartment for me. They have this beautiful home in Westford with a big garage where they could do it. I started thinking, it's a lot of money and everything else, and I was happy in my house."

Loretta was an example of being at the mercy of her adult child and grandchildren to make arrangements for her, and when their abilities or interest were faltering, Loretta was left to patiently wait. Her son Jack mistakenly believed that grab bars could not be installed in her bathtub/shower due to having plastic wall tile, so Loretta went without. Her adult granddaughter was looking into having the bathtub taken out and retrofitting a shower with a low curb which would have been easier for her to access. The grand-daughter had even contacted a contractor to provide an estimate. Loretta said, "I'm hoping that in the near future, I'll have this." This was a small project that any competent residential contractor could have done. Because Loretta had been referred to me by a relative of mine, I had occasion about nine months later to have that relative check, during a visit to her home, whether this change had been made, and it had not. Also curious during my time with Loretta was the fact that she wanted to try to hire someone to come and do housecleaning tasks for her, but no service provider had ever been obtained, although a simple on-line search and phone call would be all that would have been needed to make this happen. Reliance on family members for assistance with this had not proven effective.

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Loretta described an additional device that would have helped her that she was waiting for her grand daughter-in-law to purchase: a telephone with programmable memory buttons. Loretta had such limited vision that she was unable to see a written listing of telephone numbers. She had to memorize the telephone numbers she most frequently used, and could only recall about five. Otherwise, she either waited for people to call her, or she did not talk by phone. She described:

What Cindy is going to work on, she says there is a new type of something or other that is on the market and she's going to look into it, which is similar to one that's on the market now, only so much better where she will program in as many as... I think she said as many as 30 or more numbers so that anybody that I would call, she can program that in so that I would just push the, to turn the machine on and then push number 1, 2, 3, 4 whichever number. The only thing I would have to learn would be the sequence.

What Loretta was describing is a programmable telephone which have been available for decades and can be purchased fairly inexpensively at stores like Target. It would seem to be have been a fairly easy thing to facilitate to assist Loretta in being able to telephone more people in her circle.

As noted relative to home maintenance and cleaning, many of the adult children were very involved and helpful. There were several instances where adult daughters contributed significantly to housework, as was the case for Leo, Audrey, Gertrude, and Ted. In no case did an adult son contribute as significantly to household cleaning chores as did these daughters. Having had daughters proved a very helpful situation in later life. However, some of the adult sons were involved in lawn care and household repairs. Gertrude's son was particularly helpful in getting small construction projects completed, such as installing extra hand rails in the home.

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Other sons were not as helpful, as with Loretta's son who could have had neither installed nor hired anyone to install grab bars in her shower, even though these would have been very helpful for her. Other sons did what they could, but when it was beyond their capabilities, would call professionals in to assist, as did Margaret's son when she had a leaky kitchen faucet.

Neighbors. In a few cases, neighbors provided both oversight and assistance to the participants. Both Delores and Leo had next-door neighbors who watched daily to make sure that living room drapes were opened in the mornings and pulled closed in the evening. In both cases, these close neighbors possessed duplicate house keys which would be used to enter the house in the event that the regular drapery movement failed to occur.

For Delores, Loretta, and Lloyd, neighbors also helped by doing snow shoveling. Loretta had a neighbor, Lisa, who was in her mid-50's and had lived next door for over 30 years. She would check on Loretta regularly, and would administer her B-12 shot once a month, in addition to occasionally doing some light cleaning. Loretta described:

I feel I could call [her] for anything. Lisa, bless her heart. She gives me my B12 shot. She comes over. She knows it gets lonely. She knows that, and she'll come over and just spend time with me. I don't know. I just feel like she's such a close friend. I could tell her anything. She's a wonderful friend.

Another of Loretta's neighbors had young sons who did her mowing and yard work for a nominal price.

Others spoke of not knowing their neighbors as well as they had during earlier times. Tilda, who lived in a dense neighborhood with small lot sizes and many multi-unit homes commented that as a younger person, particularly as a mother of young children, she had known everyone in the neighborhood. Over the decades, familiar neighbors had moved away, or even

passed away, and those old relationships were never replaced, as new acquaintances were more rarely made. She said, “You don’t know too many neighbors when you get older.”

Friends. Several participants spoke of having had all of their siblings and life-long friends pass away. Lloyd noted that the VFW organization had been his source for social interaction throughout his life, as he was the only World War II veteran still alive within his area, he had ceased participating in events some time before. Hazel, after she had attended a funeral, kept the funeral cards, and taped them up in her china cabinet as a reminder of who her friends had been. Audrey observed:

You know, I’m so old, and I have lost all of my brothers and sisters, and everything, they’re all gone. It seemed like it was one funeral after another. Two of them were dying, one in a week, and another week, you know. Seemed like all you were doing was going to funerals.

When asked how that experience felt, she responded, “You feel like you’re on a banana peel, and it’s pulling out from under you.” Later she also noted, “Then that leaves you thinking, all the time, about, ‘Why did this have to happen? Why am I the one that’s still here?’” Ted commented that he was even past the point of going to funerals regularly, as there was simply no one remaining in his circle of friends yet to die. He said:

Almost all my friends are dead, or have recently died. In the last year I think, at least seven people I know well that died. I couldn't even go to the wake and funeral and I always used to go to a couple of funerals a week, a couple of wakes for years and not anymore.

As with the relationship that Loretta forged with her 54 year old neighbor, participants had developed friendships with younger people who could provide assistance and

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companionship. Audrey had joined a bowling league where she was the oldest member by far. Delores played bridge with a group of women in their 50s and 60s.



Image #97 Funeral cards decorating Helen's china cabinet.

A few participants relied on friends to provide transportation. Delores accepted a ride to bible study in the winters when the sun set early, so that she did not have to drive after dark. Loretta relied on one fellow church-goer to pick her up every Sunday and take her to church service. When that person died of cancer, Loretta found another member of her church to step in. She relied on another friend to visit and do her laundry for her. When this friend took a fall, and her husband had a stroke, she was out of commission for the laundry assistance. Loretta relied on yet another friend to drive her to the beauty parlor every six weeks. The friend would drop Loretta off for her appointment, then go on to the grocery store to get her shopping done, and come back to pick Loretta up after the appointment. In exchange for the transportation, Loretta would take her friend out to lunch. At the time of my interviews, Loretta was three weeks overdue for her hair appointment, as this friend had been hospitalized for a blocked intestine. Relying on others left the participants at the mercy of these people and the alignment of many external factors. If any piece of the puzzle was out of place, the participant was left with no one to provide the needed care and assistance.

Service providers. Delores in particular utilized service providers to get repairs and maintenance completed around her house. Her husband had left her with a valuable list of people to call for various needs. On the contrary, Loretta had experienced difficulty connecting with service providers who could provide assistance with cleaning and laundry. She was unable, due to limited vision and mobility, to do many house-cleaning tasks, but had not yet found—at the time I interviewed her—a provider, although there must have been many people providing such services in her area. She had just, at age 99 at the time I began interviewing her and with the help of her adult grand-daughter, been connected with a local agency on aging which she hoped would help to connect her with a service providing house cleaning and services.

A few participants reported having fear about being taken advantage of, or of being intimidated by service providers. Margaret was fearful of having a new house cleaning woman come into her home when her regular person was recovering from knee surgery. Peter had had to overcome his modesty about having a home care worker assist him with showering. Loretta told a story of having located a yard service to trim her shrubberies and hedges by calling the local community center for a referral. When two men arrived at her door, she instructed them about what she wanted done. When she looked outside after a period of time had elapsed, she had found that one man had spent the time working on the taillight of his truck, and that the other man had begun chopping down a birch tree. She hollered, “What are you doing?!” and he replied, “Well, I thought this tree looked pretty sad, so I thought I’d take it down.” She said, “You’re supposed to be trimming the hedges.” And he said, “Well, I’ll get to that later.” Then she saw that the parts of the birch tree which had been already chopped down had been cut in pieces and loaded into their truck, she presumed, to be sold by them as firewood. She further described:

I was furious, and I was scared to death. I didn't know what to do. I went in the house, and got my checkbook, and went out on the porch. I made a point to be way out where people could see me, and I just said, "You're done, how much do you want?" and I had to pay them.

She called the community center through which she had located these landscape service providers, and related the story, but felt "They really weren't all that interested."

For Tilda, who lived in the outer suburbs of New York City, it was common practice to hire under-employed foreign workers as home health aides or for cleaning services for cash payments. It seemed that it was fairly easy to find such workers, and as long as they had been referred through an acquaintance, Tilda felt this was safe. The cost was much less than procuring such services through a provider, and she felt that these foreigners were very well-intentioned and happy to get the work. She felt comforted knowing that, if needed, she could hire such a woman to move in temporarily and provide around-the-clock assistance.

Psychological Well-Being. A true exploration of the psychological well-being of the participants is well outside the parameters of this study, but in several instances, attitudes regarding contentment and apprehensions arose and are of note. In particular, some statements made by participants related to their will-to-live, independence, adaptiveness, and self-efficacy. The two categories within this theme were: *attitudes about aging*, and *daily routine and enjoying life*.

Attitudes and fears. In several instances, participants expressed frustration and annoyance about their diminished capabilities over time. Audrey succinctly stated, "When you get old, you're "pufftt" Tilda said, "The only thing is, like I say, as I am getting older, I notice that I don't do things as good as I did before. I notice it." Helen's response to the question, what

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is the most challenging thing about getting older, was, “Not being able to do the things I used to do.” Ted, who was experiencing considerable pain when I interviewed home, and happened to be near his life’s end, commented about his age-related suffering, “I had no notion it would turn into this.”

Participants spoke of their quality of life. Peter, who rarely left his house any longer and had several health concerns noted that, with getting older, “everything gets worse.” Tilda said the worst thing about living alone was “Being lonesome. Not so much during the day maybe, but at night. It’s such a long night.” In spite of the fact that both of her sons called nightly and visited regularly, and that she communicated with her grandchildren via email, she said, “The hardest part about living alone is the lonesomeness. You know, sometimes you like to talk to someone.” She said her sons’ nightly calls were “what keeps me going.”

Some participants expressed amazement that they had lived as long as they had. Ted had had a heart a heart attack in 1976 and a defibrillator implanted in 2001. He noted that “I’ve had heart failure for 40 years. I’m a living miracle.” Tilda expressed her astonishment and fortitude about aging:

I used to say gee, when I’m 80... I wonder what I’ll be doing when I’m 80! Now I’m in the 90s... Sometimes I say, gee, am I really 98? I can’t believe myself sometimes. I don’t feel bad. I just have this constant pain of arthritis that gets me down, but it doesn’t put me out. I push. I have to go down, go to the car... I find the more I move, the better it is.

Similarly, Audrey expressed that long life may be related to continued action and engagement. She related that when people became aware that she was 99 years old, they would often asked her about her secret to aging well. She said her response to this question was “Do the same thing

you always did” and “Keep mobile, or keep active. Keep moving.” She also noted, “You know when you decide to take it easy you doomed yourself.”

In some cases, participants expressed some thoughts about their end-of-life. In no case did any participant express any fear of impending death. Many were or had been church-goers, so likely had faith regarding the existence of an after-life. I asked Margaret, who was 95, whether she thought she would live to be 100. She said she doubted it. When asked if she would want to, she replied, “Not especially. I have too much pain, that's why. If they could do something for the pain, yeah, then I would.”

Loretta, who already at 100 was the oldest participant in this study, expressed her thoughts about her own death and heaven. She was clearly resigned to impending death. She said:

I always feel like I got a good place waiting for me. It's a lot better than this. Why am I sitting here with all this pain in my knees and back, and arthritis and practically blind...? There has to be a reason. I have this silly notion, I guess, but my idea is that the day that you're born, God has a plan for your life. He puts you on earth to do something, and he's not going to come and get you until you've done it. I keep saying, “Well, what is it you want me to do?”

On another occasion I commended Loretta for having reached one-hundred years of age, and she replied, “I had nothing to do with it. It's God's will. He did it and I've had a little talk with him and I told him, ‘I'm getting awful tired of this. I think there's a better place waiting for me.

Why am I struggling to crawl up those steps and stuff when I can fly?’”

Daily routine and enjoying life. In spite of the suffering, loneliness, and pain experienced regularly, several participants articulated a remarkably positive attitude. Loretta, at

100 and with considerable pain said, "I've been okay, considering everything. I will not complain already because I just feel that I've been so blessed. It could be much worse. I get along." Responding to a question about her level of life satisfaction, Tilda said: "Oh, I'm very happy with all that. I thank the good Lord many, many, many times each night and Mary. I say my prayers morning, noon, and night. No, I am very lucky that I don't have no major problems." Helen noted that she felt fortunate to be as capable as she was:

At least so far I know who I am and what I'm doing. Once in a while I get a little dizzy. I'm not a perfect person, don't think I am. I might get a little [confused] and I just calm down and then I push through and fight it. Nobody's perfect. I do have a lot to be thankful that I'm not confined to a bed or worse. And my kids are great. Great kids, that's a big help."

Audrey, Ted, and Grace also noted feeling fortunate to have had a long life and a loving family.

In no instance did any of the participants speak of pervasive depression, although it should be noted that a participant's mental state was not a key area of questioning. Loneliness and boredom were discussed in several instances. Peter noted that he appreciated when his son stopped by between trucking runs, which broke up the monotony of his days. Margaret also noted the sameness and of each passing day. Ted felt that by the time he got up every day, the remainder of the day seemed to go downhill. Those who did not have very regular or lengthy visits from family members most noted a tedium to the rhythm of their days.

Margaret noted that she would enjoy having her grandchildren visit far more often, but understood their reluctance to come because "I can't do much so it's not a very exciting place to come." Peter also noted that he wished that his daughters and grandchildren would make more effort to visit him, as it would have meant so much to him.

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All participants found ways to fill their days with activities in which they were interested. Leo and Peter both enjoyed watching sports on TV. Audrey and Gertrude both did jigsaw puzzles with the help of the daughters when they visited. Gertrude additionally did crossword puzzles. Margaret and Helen enjoyed watching daytime TV, such as “Let’s Make a Deal” and “Judge Judy.” Tilda and Leo had computers and could email their grandchildren, Tilda even utilized Facebook to keep track of grandchildren’s activities. And Audrey, who enjoyed a daily shot of scotch every afternoon, her *happy hour*, certainly had discovered a daily activity that brought enjoyment.

Holidays were either opportunities for gratifying time with family, or days just like any other, depending on the level of involvement from family members. Just before his death, Delores’s husband asked his children to make sure she was never alone on a holiday or birthday. Ted, Audrey, Tilda, and Helen also had children who ensured that holidays included time with extended family. For them, holidays were enjoyed and anticipated.

Leo noted that, in the past, holidays had often been celebrated at his home, and he had enjoyed the activity of having his young grandchildren present, but that now, family members often had other places to go. He sometimes felt it was an imposition to have one of his daughter’s pick him up to take him to their in-law’s homes to celebrate with them.

I interviewed both Margaret and Peter in the fall, as they were anticipating both Thanksgiving and Christmas. For Margaret, both holidays were to be at her son’s nearby home, but she dreaded the experience of having to be lifted up the steps leading to her son’s front door in her wheelchair by three male relatives. She found this embarrassing. Peter anticipated nothing out of the ordinary for either Thanksgiving or Christmas Day, except perhaps a phone call from the one daughter to whom he rarely spoke. And as he did not know whether Meals-on-

Wheels would deliver on those days, he assumed he would just make a pot pie in the microwave. He was holding out hope that his son Terry might be passing through on a trucking run, so perhaps could spend a few days near Christmas time. He figured that, as had happened in the past, he would receive a Walmart gift card in the mail as his Christmas gift, and would need to wait to be driven there by his son in order to redeem it.

Home / Place Attachment / Relocation Considerations. Attachment to home was a key focus of this research. With the exception of the first participant, Delores, who chose to relocate shortly after she was interviewed, all participants remained in their family homes well into their 90's. The very act of remaining at home demonstrated firm commitment to the home as the preferred place of residence, and indicated their desire for continued independence and autonomy. Participants were questioned regarding their decision to remain. In their responses, they did not use language pertaining to place attachment, nor did they articulate the meaning their home held for them, but home was clearly identified as their desired place to live. Participants communicated their decision to remain at home in terms associated with their aversion to living in senior housing and the loss of independence this would bring, rather than in terms related to their desire to remain. The two categories within this theme were *feelings about staying at home* and *feelings about relocating*.

Feelings about staying at home. When asked about their desire to remain at home, responses most often concerned their negative perceptions of senior housing, rather than fondness for their current home. A few participants did reveal some thoughts about home. When Margaret was asked "Why would you prefer to stay here? Can you put it into words?" her concise response was "Because it's home. Not that it's anything special. It's not a great house or anything, it's just home. I can practically do [things] in the dark." Loretta also spoke of a

growing affection for her home and the memories it held: “I have a lot of happy memories and spend a lot of time looking back. I think your home grows on you. I think when you move in you like it, but I think as you live and become accustomed to it, it becomes something special.”

Loretta also spoke of her willingness to endure hardship in exchange for the ability to remain. She said, “It’s really reached a point where it is a painful thing going up and down stairs. Then I say to myself, ‘You can go do assisted living where you won’t have any stairs to climb,’ but I will still choose the pain in my knees for the privilege to live here.”

Loretta, Margaret, Delores, Tilda and Helen spoke of receiving pressure from adult children and care-givers to relocate to senior housing. Phillip once said to his doctor, “Don't put me in a nursing home, Doc. It must be a lot like prison.” At one time, when Margaret was in a nursing home during a month long recuperation, she tricked her daughter into getting back home. Margaret told her daughter that she needed to stop at home just pick up a few things, then when they arrived there, she refused to be taken back to the nursing home. She felt that her adult children’s arguments were motivated by their desire to reduce the amount of worry they had about her well-being, rather than concern for her wishes. She said that “It relieves them of the responsibility.” Loretta described the pressures she had received to relocate, except from the one person whom she held most dear in this world: “I’m going to live here as long as I possibly can, and I’m fighting the whole world to do it except my son, bless his heart. He says, “Mother, you can make the decision. Whatever you want, you’ll get, but you make the decision.”

Feelings about relocating. Several years before our interviews, Tilda had toured a nearby, newly constructed continuing care retirement facility with some relative who were themselves considering moving there. This was a very large complex with a host of recreational

and service amenities. She was not at all tempted to make such a transition, in spite of all that was offered there. She described:

I have everything here, what do I need? If I need help, I'll pay for it. That's all there is to it. While I can take care of myself I figure... What would I do in the building by myself over there, tell me. I'd be in the apartment I can't be out messing around in the pool or whatever, who the heck knows. I'd feel alone. What would you do? You'd stay more in the apartment. I'd rather be here and it costs me less to be here.

Several participants felt a relocation to a facility would only occur if and when they had declined significantly and could no longer resist their children's pleas. Tilda said, "I told them I want to stay here and if I'm not in my right mind I don't care then, where you put me. I won't know. I don't care." Helen took care not to tell her adult children the times that she felt under the weather, for fear a conversation suggesting relocation would arise.

A few participants expressed that going to a nursing home would only occur by someone else's doing, that it would never be a choice they themselves would willingly make. Loretta described her anticipated feelings were this to happen: "It would be like putting me in a prison.... That would be my feeling. I would feel like they were putting me in the loony bin. I would resent it. I would hate every minute of it. I would resent those who did it to me. I would just never be happy if they did it."

Audrey shared her feelings about potential relocation to senior housing, "I'd die in a month." She felt that the quality of care in such facilities had declined over time, "Things aren't like they used to be. They took really nice care of you [before]. Not anymore. You're just a number now." Tilda described someone who had tried to persuade her that life could be good: "He said, 'If you go to a nursing home then they have Bingo and crafts.' I've been there, done

that, I don't want to do it anymore. I don't know if I ... I try not to be negative but I just don't want to.”

Ted felt that being around other elders would not be beneficial. He said, “There's being around other sick people that I wouldn't think would be very recuperative.” Peter also did not want to be around elders who may be more frail than he. He described:

They make you come to the table and sit down. You may wait an hour and half before you get your food. That's terrible. You're sitting at the table with three other dingbats, and then they're all dingbats out there, the patients. Not of all of them I suppose but some of them's had strokes.

Participants further described their perceptions of life within a senior living facility or nursing home. Margaret felt that convenience would be compromised: “I went to a rest home and looked. Not near as handy as what I have here. You have to bundle up all of your clothes and take them heaven knows where to wash them.” Leo provided his perception: “That's no good out there, not my style. It's kind of like I imagine a prison might be. You can't leave. In the summertime you can go out and sit by the bench by the door, and they'll even help you out there if you need it, but you don't leave.”

Although all participants were tenacious in their resolve to remain, sadly, only six of the ten participants remain in their homes as of this writing. Despite decades of tenure in their homes, the end of their residence came unexpectedly and suddenly for four people. Sadly, Ted and Gertrude passed away within months following their interviews. Both clearly enjoyed and were proud of their homes, and neither had a sense of imminent end-of-life at the time I spoke with them. Although Delores had been committed to remain in her home because of the memories of her late husband, pervasive loneliness convinced her to relocate where she could

more easily connect with peers. When an attractive unit became available at a near-by facility, she quickly sold her home and moved. A debilitating fall prompted Leo and his family to decide that he must move in order to have greater support, and his home was quickly sold and his possessions disposed of.

This dichotomy—long residential tenure on the one hand contrasted with the precariousness of existence on their own terms on the other—is of interest as a finding from this study.

Analysis of Findings: Summing Up and Adding On.

What follows is the result of ongoing analysis of the data from this study. The first portion: “Summing up” was my first attempt at finding themes and assertions within the data at the conclusion of writing the first entire draft. It provides a basic framework and conceptual language for the types of personal adaptations found. The subsequent section: “Adding on” was a result of further analysis initiated by critique from outside reviewers, which prompted a much more comprehensive review and resulting discussion of the findings, which I had not initially anticipated. This section provides a deeper dissection of a critical theme within the data, a second guiding framework and conceptual language for the sorting of personal adaptations found in this study, and a theoretical proposal for a continuum with adaptive changes.

Summing up: The organizing framework for the enumeration of findings - the three assertions: *physical self, personal sphere, and psychic integration.* The categorization of three assertions proved useful in framing the diverse nature of adaptations participants utilized to accommodate for diminished capacities within this text. Similar challenges and behavioral adaptations were grouped together into categories, and then ranked from more micro themes to more macro themes. Thus, findings related to bathing were grouped together with findings

related to dressing, assistance from adult children was grouped with assistance from neighbors, and findings related to driving were described along with findings related to other means of transportation. Those adaptations which were the most intimate and related to abilities were discussed first, within the assertion of *physical self*. Then, within a wider lens, those adaptations which occurred within participants' *personal spheres* were examined. These had to do with resources. Finally at the most macro level, adaptations and attitudes surrounding participants' reflections of their place within this world—their *psychic integration*—were described. As illustrated in Table 2 on page 160 herein, this was a useful way to recount the myriad of adaptations found within the data. Looking at adaptations through the lens of this guiding framework took the findings of this study beyond a mere cataloging of behaviors to a conceptual language of the nature of the adaptive behaviors witnessed.

Adaptations within the category of *physical self* were most often specifically related to a reduction or diminishment in personal abilities. These adaptations had to do with physical functioning, interacting with apparatus within the home, and completing activities of daily living (ADLs), literally with what one's body was able to do. Participants pushed through pain and made additional provisions for their inabilities. They strategized about how to avoid potential problems and committed such accommodations to memory, making sure they always performed these needed extra steps. These were new ways of accomplishing common tasks within reduced capacities.

There were widely varied adaptations relating to one's *personal sphere*. Adaptations within this category related to one's environment, and the resources and players within. The identified themes were: home maintenance/cleaning, driving and transportation, and children/neighbors/friends/aides. Adaptions within the *personal sphere* can be envisioned as falling

within an imaginary circle drawn around the tight geographic area in which the participant acted. This encompassed the home environment, all the players who entered it, and the means to go out of the home into the surrounding areas which were part of one's lifeworld. For all of the participants in this study, this geographic circle had become very small, encompassing only the immediate neighborhood.

One's interaction with the home environment, and attempts to maintain it, were an important part of this grouping. Many adaptation strategies involved action. As with adaptations related to the *physical self*, many of these involved eliminating, changing, or modifying activities, for instance, circumventing the need to use the oven—which caused fear of fire—by using the microwave instead. But far more strategies involved in-action, the choice to not act, such as the cessation of cleaning tasks which had become too challenging, or the decision to stop attending church because it was just too difficult to get there. In many cases, satisfaction was achieved because of the lowering of expectations and standards to conform to the new reality of what was achievable. The adaptations were achieved not only by terminating an activity, but also by loosening a grip on attainable goals. In many cases, manageable tasks, such as making the bed were still performed, while un-manageable tasks—such as culling through, organizing, and disposing of cast-off items—were not attempted.

Also within the category of *personal sphere* were any adaptations which were dependent on the assistance of others. Several study participants relied heavily on others in order to maintain an agreeable lifestyle. Some solutions utilizing the assistance of others within one's *personal sphere* were precarious, depending on a myriad of factors to align in order that the goal be reached.

The composition of helpful people within one's *personal sphere* was critical to the kinds

and quantities of assistance of which participants were the beneficiary. The ability to maintain an agreeable lifestyle was observed to be dependent on the assistance of others. Participants who had adult daughters received far more housekeeping assistance than those participants who had only adult sons. And those who had established better connections to care-giving services had greater assistance than those who struggled with finding appropriate service providers.

Adaptations within the realm of *psychic integration* concerned the continuation or adoption of certain attitudes which facilitated ongoing well-being. Included here were facets of emotional adjustment rooted in one's personality, which had emerged in youth and solidified with age. It is likely that one who has developed strong personality attributes, such as an optimistic, positive life outlook, could remain more happily independent throughout life. Key also is one's self-efficacy, the sense that one can muster the ability to persevere, come what may.

Also falling within *psychic integration* are the perceptions of the family home as the most viable alternative in which to live and assessments of other housing arrangements as being far inferior. One who possesses this view, as participants in this study did, is strongly motivated to pursue adaptive behaviors in order to maintain existence within this preferred home environment. There is an aligning of ideals with where one is situated, and an adaptation of the situation to meet one's values.

Adding on: Going beyond the findings - the classifications of coping repertoires into a continuum of strategies. Although the recounting of findings within this text was logically presented within the assertions of *physical self*, *personal sphere*, and *psychic integration*—a straight-forward and systematic way to compile and describe the data—a further classification of these adaptive behaviors is worth contemplation as well to deepen and extend this analysis. A *second* framework is presented here for the cataloging of the coping behaviors exhibited within

the data. The behaviors are here re-categorized into correlated categories relating to the nature of the adaptive change made by the participant. The quantity of instances participants exhibited each change category are also noted below, as this appears to have meaning relative to how elders choose to adapt, and which types of changes are easiest or most challenging to achieve.

Each participant of this study exhibited strong resolve and determination in establishing a repertoire of coping strategies, which together created environmental conditions which facilitated their remaining at home. These coping strategies were in some cases common to all participants, but far more often were highly individualistic means that participants contrived to maintain self-reliance. Each participant essentially formulated their own unique brand of behavioral nuances for staying independent. When considering some of the behaviors exhibited, it is not difficult to find some wit and absurdity in the some of their exertions. So difficult was it for Tilda to grapple with her stairs daily that she yielded to her own means for putting the painful effort out-of-mind: reciting prayer verses out loud. Leo's grit was exhibited in his daily walks around his basement to maintain health. He shuffled slowly in circles around the room, leaning on his walker for support, until the buzz of his egg timer marked his completion and gave him respite from this physical exertion for another day. And Loretta was likely mistaken in believing that pulling a broom across her carpet was effective in preserving cleanliness, but tasks such as these likely offered her some insulation from feelings of uselessness.

These adaptations underscore the resilience that is inherently human. Growing old is essentially surviving, and in one's latter years, the need to adapt to accommodate for diminished capabilities is inescapable. Golant (2015) noted that older people essentially become "agents of change" in response to environmental discord as they proactively alleviate unpleasant or maladaptive aspects of their residential arrangements. It is an individual's "constructive

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response to adversity” which is the hallmark of aging successfully (p.ix). Table #3 below itemizes the behavior and attitude adaptations that the participants of this study exhibited, and provides the quantity of instances for each change category. These category instances are arranged according to instance quantities, from high to low on the following three pages.

Table #3 - Coping behaviors correlated by category. Noted at right are the quantities of individual instances listed within each change category.

| How to cope in order to stay in one's own home: Coping behaviors exhibited by study participants | | | |
|--|---|---|--|
| Change of Technology Use | Utilize alert technology, such as "Life Alert" wearing wrist watch or necklace activation device | all participants except Audrey | 41 individual instances of change of technology use |
| | Use canes, walkers, and wheelchairs in progressive order as capabilities decline | Leo, Loretta, Margaret, Peter | |
| | Use chairs with mechanical lift devices to assist with standing | Gertrude, Helen | |
| | Use magnifying glass to be able to see things | Loretta, Ted, Margaret, Peter, Tilda | |
| | After giving up driving, use a golf cart to visit wife in nursing home | Peter | |
| | Use heating pad to relax muscles before being able to get out of bed every morning | Margaret | |
| | Carry cordless phone and cell phone everywhere, in case a call for assistance is needed | Helen | |
| | Use cell phone to call for help when needed | Delores, Leo, Ted | |
| | Have a chair lift installed at back door in garage to be able to descend in wheel chair | Margaret | |
| | Use microwave and slow cooker for cooking which is less risky than cooktop or oven use | Gertrude, Margaret, Peter, Tilda, Helen | |
| | Use grabber device to assist to make bed, get things from cabinets, get things from the floor, get clothes from closet | Audrey, Margaret, Tilda, Helen | |
| | Use a flashlight to see buttons on microwave | Peter | |
| | Use a Keurig one-cup coffee maker instead of standard coffee maker | Peter, Helen | |
| | Put trash bags in car to drive them to the street, rather than carrying them | Leo | |
| Use binoculars to watch birds or snoop on activity in the neighborhood | Audrey | | |
| Changing Behavior | Walk in circles daily in basement to get exercise, reduce additional physical deterioration | Leo | 40 individual instances of changing behavior |
| | Neatly arranging bucket and towels by bedside for vomiting/drinking/elimination | Delores | |
| | Borrow wheelchair from pharmacy when needed | Helen | |
| | Allow to be carried from garage and into son's home | Margaret | |
| | Signal daily survival to neighbors through opening and closing of window shades | Leo and Delores | |
| | Trade service of storing a car in the garage for a neighbor who can provide occasional care | Delores | |
| | Comply with adult children who demand not to drive, not to go downstairs, not to use ladder, not to change light bulbs | Leo, Gertrude, Margaret, Tilda | |
| | Revise trash removal method when the trash pickup is not on the best day | Peter | |
| | Move elevated toilet seat into shower so it will not be seen by visitor | Tilda | |
| | Close off part of the house to reduce heating costs | Tilda | |
| | Cook and eat pre-packaged food because they are easier to prepare | Leo, Ted, Margaret, Peter, Helen | |
| | Keep food and cooking items on the counter where they are easier to reach, rather than putting them away in cabinets | Peter, Tilda, Helen | |
| | Use magnetic jewelry clasps to make it easier to put on necklaces and bracelets | Tilda | |
| | Wear clothing which does not need to be pulled overhead | Margaret, Helen | |
| | Do not drive after dark, do not shop when parking lots are full, do not go to stores further away although prices are lower | Delores, Leo, Gertrude, Ted, Tilda | |
| | Memorize phone numbers because writing cannot be read | Loretta | |
| | Warn self continually with self-talk - don't fall now, be careful, walk slowly | Audrey, Tilda | |
| | Stop going to church, watch on TV or forfeit altogether | Margaret, Tilda, Helen | |
| | Do not take on too many things in short span of days - interview needed to be postponed when plumbing repair was being dealt with | Margaret | |
| | Wear incontinence pads in the event that the toilet cannot be reached in time | Loretta, Tilda | |
| Lie in a recliner in the living room, for comfort during a visit from interviewer and in order to remain sufficiently sociable | Ted | | |

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Table #3 continued

| How to cope in order to stay in one's own home: Coping behaviors exhibited by study participants | | | |
|--|--|---|--|
| No Change / Maintaining Lifestyle | Dress up with makeup, nail polish, jewelry at home | Tilda, Delores | 37 individual instances of maintaining lifestyle |
| | Continue activities and participation in clubs and activities (greeter at church, bridge club, bible study, Red Hat Society, VFW) | Audrey, Delores, Gertrude, Leo | |
| | Have a nip of Scotch whisky in careful measured amount in afternoon | Audrey | |
| | Use computer for Facebook to stay in contact and for music to dance in the kitchen | Leo, Tilda | |
| | Keep busy with and taking pride in domestic tasks of making bed every morning, washing dishes, doing laundry, putting things away | all 10 participants | |
| | Continue to make Christmas cookies each year, although much reduced quantity | Loretta | |
| | Continue to make home-cooked meals, although with decreased use of stove, increased use of microwave and slow cooker | all 10 participants | |
| | Keep Christmas tree decorated all year long to avoid extra effort of decorating and storing items | Margaret | |
| | Work regularly on jigsaw puzzles, crossword puzzles, recording travels and family history to fill the time | Audrey, Gertrude | |
| | Watch long-enjoyed TV shows: Let's Make a Deal, Lawrence Welk, Judge Judy, etc. Pet a beloved cat | Margaret, Tilda, Helen Gertrude | |
| Change of Outsourcing | Hire out services such as house cleaning, lawn care, snow shoveling, minor household repairs | Delores, Loretta, Margaret, Peter, Tilda, Helen | 34 individual instances of changing of outsourcing |
| | Hire home care workers to assist with personal care, such as grooming, showering, cutting toe nails, administering medicine, assist with hemorrhoid treatment | Margaret, Peter, Tilda | |
| | Hire undocumented foreigner and pay with cash for extended and overnight care | Tilda | |
| | Utilize delivery people to get groceries, meals, and prescriptions to home | Margaret, Peter, Helen | |
| | Utilize Meals on Wheels service | Peter, Helen | |
| | Ask Meals on Wheels driver to assist with opening jars | Helen | |
| | Have others write out checks for bills and utilities, and then sign | Peter | |
| | Rely on others to provide transportation and give assistance | everyone | |
| | Leave copies of house keys with neighbors in case of emergency | Leo, Tilda, Helen | |
| | Be willing to spend money to hire outside help to prevent the need to consider moving to a nursing home | Delores, Leo, Peter, Tilda, Helen | |
| Changing Relationships | Rely on adult children to do things one can no longer do: interpret written notes, get the mail, clean the house, do laundry, manage personal finances | all 10 participants | 27 individual instances of changing relationships |
| | Paying adult daughter to do the cleaning and occasional meal prep | Leo | |
| | Teasing with an adult child - who is helping whom (both feel as though they are helping the other person) | Audrey | |
| | Obeying adult children's requests: being 'banned' from the basement, told not to drive in cold weather, not to change light bulbs or use ladder | Leo, Gertrude, Ted, Margaret, Helen | |
| | Enjoy chatting with delivery people because they are the few people seen | Margaret, Tilda, Helen | |
| | Avoid expressing needs to family for fear they will respond by pressuring to move | Margaret | |
| | Get over the embarrassment of showering in front of home care worker | Peter | |
| | Despite strong needs to get new glasses, a hearing aid, and dental work, put up with things as is because no one will help you connect with services, and you cannot manage yourself | Peter | |
| | Rely on three men who are relatives to lift up the stairs and into son's home for holiday | Margaret | |
| | Rely on others to provide transportation, assist with laundry, give monthly shots | Delores, Loretta, Tilda | |
| Changing Environment | Convert rooms and closets for better proximity to things/spaces needed | Peter, Tilda | 23 individual instances of changing environment |
| | Use a different bedroom to be closer to the shower | Ted | |
| | Put a chair at the top of the stairs to sit on and rest | Ted | |
| | Use a recliner to lie down while visiting with others, as had become too weak to sit up | Ted | |
| | Have son reconfigure bed so headboard is at the foot, to provide support while maneuvering in room | Gertrude | |
| | Pin draperies together to close them when drapery mechanism breaks | Peter | |
| | Use second microwave on counter instead of higher built-in microwave | Margaret, Helen | |
| | Keep food items and cooking items on the counter so as to be easier to reach | Peter, Tilda, Helen | |
| | Use a special reclining chair with lift mechanism | Gertrude, Helen | |
| | Use commode in bedroom | Peter | |
| | Have bathtub retro-fitted, grab bars and rails added | Delores, Audrey, Gertrude, Margaret, Helen | |
| | Add tactile messages on stove, microwave and dishwasher because of visual impairments | Loretta | |
| | Use stove top as storage for better proximity to needed items | Gertrude | |

Table #3 continued

| How to cope in order to stay in one's own home: Coping behaviors exhibited by study participants | | | |
|--|---|---------------------|---|
| Changing Attitude | Lower standards of housecleaning and maintenance, personal hygiene, and meal quality | all 10 participants | 18 individual instances of changing attitudes |
| | Put up with son's stacks of clothing everywhere and cats because you appreciate having your son with you | Peter | |
| | Give up control of the TV remote to son because you appreciate his visit | Peter | |
| | Refer to a wheelchair as a "carriage" and a bedside potty as a "chamber pot" to be more acceptable, and to diminish extent of neediness | Tilda, Helen | |
| | Say prayers while climbing/descending stairs to make them more manageable | Tilda | |
| | When hospitalized, treat a stuffed animal like the cat left at home | Gertrude | |
| | Downgrade expectations about the enjoyability of holiday celebrations | Margaret, Peter | |

The participants of this study exhibited a multiplicity of behaviors. A categorization looking at these idiosyncratic adaptations is worth contemplating within this analysis, as it points to the very innovative and sometimes unpredictable adaptation inherent in participants' accumulated experience. Table #3 on the preceding three pages lists some of the study findings correlated by the very impetus driving their coping strategies, with each individual instance counted one time.

Atchley's (1999) Continuity Theory hypothesizes that people will adapt in order to maintain their continuation of lifestyle. In some instances, participants strove to maintain portions of the lifestyle to which they were accustomed. In many cases, they were able to cope effectively by changing certain behaviors, certain attitudes, or adjusting the nature of the relationships they had with others. The change to elements within their immediate environments, or the adaptation of new technology was often utilized as a means of coping, whether performed consciously or not. And in many cases, participants negotiated terms with others who could do for them what they could no longer do themselves. This compilation provides a window into the very personal experience of aging-in-place as uncovered in the findings from this study.

A theory for a continuity of adaptive changes. Although this list pertains only specifically to the participants of this study, and is by no means an exhaustive compilation of

copied strategies employed by elders at-large, it is highly noteworthy that there are differences in the quantities of instances within the identified categories. The largest quantities of coping instances were seen in the categories of *Change of Technology use* and *Changing of Behavior*, 41 and 40 instances respectively. Perhaps these instance categories represent the low-hanging fruit for elders, that is, the easiest of adaptations to realize, and therefore became the most often utilized adaptive coping strategies. Capable older adults are well able to increase their use of devices and technology, such as alert devices, walkers, microwaves, grabber devices, and magnifying glasses. This presents no need for extensive behavioral re-adjustment. Likewise, they need not encounter major re-negotiations in their lifestyle to merely add or revise their own daily behavior. Although not all of these instances of changing behavior were easily achieved, such as with Leo's daily walks around the basement, they were neither costly nor relationship intensive and could be achieved simply by reliance on oneself.

The next most often observed instances of coping strategies were *No Change/Maintaining Lifestyle* with 37 individual instances, and *Change of Outsourcing* with 34 instances. Atchley's Continuity Theory would perhaps suggest that *No Change/Maintaining Lifestyle* would perhaps be the most desired of behaviors. One may prefer to live exactly as one always has, with no diminishment in activity or ability whatsoever. However, the reality of aging means this is not entirely possible. Elders do appear to maintain their lifestyle without significant change, to the extent that their capabilities and living conditions allow.

The next highest instance category, *Change of Outsourcing*, allowed elders to rely on individuals other than family members for assistance. Many relied on others who were willing to lend assistance with transportation. Most study participants had the monetary resources to hire out yard work, personal care, and housekeeping chores, and Peter, who did not have the

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monetary resources, was able to procure the needed services through Medicaid. There were several comments made about preferring to use monetary resources to hire assistance, rather than to receive assistance in a nursing home. Notably, one participant, Loretta, had encountered considerable difficulty in locating services in her area, so she relied more heavily on personal behavioral changes. And there were instances where participants were resourceful in their use of others in their immediate circle to do for them what they could not do for themselves.

Continuing on in diminishing quantity order, the next instance categories were *Changing Relationships* and *Changing Environment*, with 27 and 23 instances respectively. In many cases, there was increased reliance on others to do for them what they could no longer manage themselves. There were several instances of having to assume a more obedient or deferential role to others, as with participants who complied with their adult children's requests to relinquish behaviors such as climbing ladders and stairs. And there were other instances of elders having to endure assistance from others which made them feel ill at ease, as for Margaret being lifted in her wheelchair up the steps to her son's home, and Peter being assisted by a female care worker when showering. Both spoke of having to learn to tolerate such indignities.

Changing the Environment had the second to fewest instances of coping behaviors in this study, at 23 instances. This finding strongly supports the previous discussion of the concept of *residential inertia* discussed herein on pages 268 to 270, as well as Atchley's Continuity Theory. Elders who have long resided in the same residence, do not seem to have the impetus to make changes to their home. There appears to be a strong desire to keep the spaces as they have been previously, and to continue routines and rituals that have long transpired within the walls of the home. Even in cases where the home or its contents are in disrepair and do not well support current needs, there seems to be a desire to keep the home in its present condition. It is not clear

whether this inertia is due to lack of resources, energy, motivation, competence, or a combination of these forces.

The fewest of instances were seen in the category of *Changing Attitude*, and by a significant quantity. There were only 18 individual instances of changing of attitudes as a coping behavior. When considered along a continuum, this is the least often, and perhaps therefore, the most difficult type of adaptation to achieve for elders. And this category is distinctly different from all the others, as it involves emotion-focused coping (Golant, 2015b). The first six categories have to do with actively maintaining or changing behaviors, technology use, outsourcing, relationships or environment, or simply making no changes. Only this last category has to do with coping by adjusting one's personal outlook.

The theoretical work of Golant is particularly relevant to a discussion of the types of adaptations made by elders within their homes. Golant (2011, 2015a, 2015b) proposed that elders retain residential normalcy by effectively coping and adapting with discordant features and experiences in the home environments, and that these coping strategies can be divided into two categories (discussed herein on pages 15-16). First, *assimilative coping* involve active action, such as behavioral, affiliation, or environmental strategies. The first six of these categorizations would align with this definition by Golant. Elders eliminate discord by changing or modifying their activities, lifestyles, capabilities, relationships, or surroundings to make them better align with needs and goals (Golant, 2015b, Schulz & Heckhausen, 1996).

Golant's second category, *accommodative coping*, is distinctly more passive, and involves mind and attitude adaptations to deal with obstacles by putting a more "positive spin on their difficulties and de-emphasize their salience" (Golant, 2015b, p.103). This was observed in some instances as a lowering of standards and as a reduction in attainable goals. Only the last of

the categories presented here, and the one seen with the least incidence, *Changing Attitude*, aligns wholly with this categorization from Golant, although some of the *Changing Relationships* strategies may also have aspects of mental adjustments.

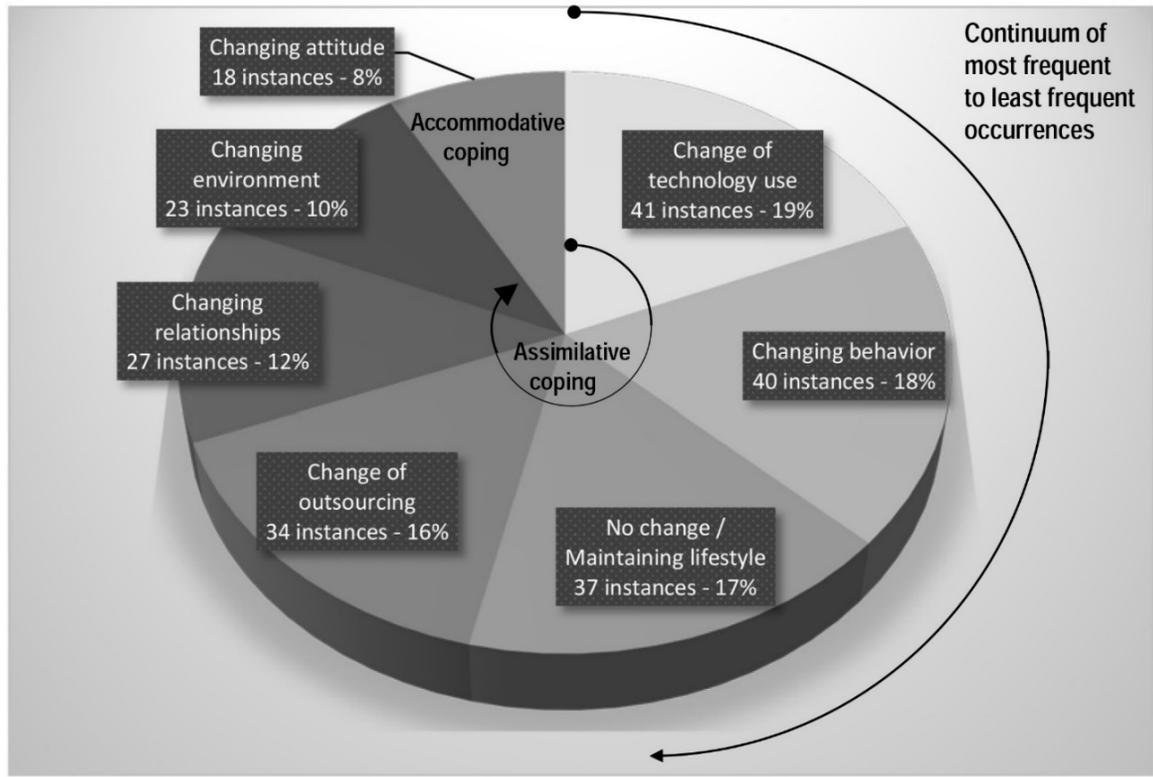


Figure #7. Chart showing the continuum of coping occurrences discussed here, as well as alignment with Golant’s *Assimilative* and *Accommodative* coping strategies.

Even in his 2015 writings, Golant made no strong assertions about relative frequency and of action (*assimilative*) versus mind (*accommodative*) coping strategies among elders aging-in-place, although he did note a stronger reliance on assimilative strategies. On this issue, he noted: “Human development theorists do not offer any clear-cut guidance about when older people are more likely to initiate accommodative as opposed to assimilative coping strategies. However, most believe that aging successfully requires older people to initiate action rather than mind-coping strategies” (2015b, p.105). This assertion would appear to be consistent with the findings

of this study, where action strategies were found in a far greater preponderance than mind strategies for coping with challenge.

Additionally, Golant (2015b, p. 105) noted some support within the literature for the notion of a continuum of coping strategies, where mind-coping strategies are employed only after all efforts to successfully utilize action strategies have been exhausted as unsuccessful. Only after an “accumulation of irreversible events” and “unsuccessful attempts to alter the situation” (Brandtstadter & Greve, 1994, p.72-74) do elders become so overwhelmed that they abandon active strategies as hopeless and excessively exhaustive, and they adopt a new mindset to accept and tolerate what cannot be changed. Are active strategies, such as increased reliance on technology and the adaption of behavioral changes, easier to embrace and execute than the change of one’s attitudes to better align with a harsh reality of incompetence? Therefore, is there a clear continuum of adaptations from the easiest to adopt strategies, through the more difficult to adopt strategies, then finally to the most exhaustive of strategies to adopt – those that require a shift in thinking? It seems logical that this may be the case, especially for people in their later years who have a long-established set of attitudes. One’s sense of self-efficacy, the belief that one can manage come-what-may, developed over a lifetime, becomes strongly eroded when one must come to terms with an inability to actively adapt, and face the need then to passively resign their way of thinking. Only additional residential-focused research among elderly participants will further illuminate this question. But the results from this study do support a theory of a continuum of adaptations, as illustrated in Figure 7.

CHAPTER FIVE: DISCUSSION

“Aging-in-place has a price.”

Dr. Benyamin Schwarz

This research project was undertaken for the purpose of better understanding the central core of existence among those people who have persisted in residing in their home into old age, or, as became the case for two study participants, until the time of their death. Who among us—when imaging the last years of our lives—would not similarly prefer to remain in the most familiar and comforting of surroundings, in the location of our choosing, and with our life’s accumulations of most cherished objects close at hand where they have always been? It is difficult to imagine that the inverse—to undergo the burden of relocation, precipitated by poor health, and necessitating a culling of precious possessions, enduring the tiresome task of being packed and unpacked, and then attempting to cultivate an attachment to new surroundings and neighbors—would be the preferred path for many. This is not to say that, for a wide variety of reasons, many older people do voluntarily relocate to new homes to enjoy during their later years. However, when that new home choice is not freely selected and aligned with a vision towards a pleasurable future occupancy, but is rather driven by declining health, a need for greater support, and a glimpse towards impending mortality, it certainly does not embody anyone’s nirvana.

Aging-in-place has a price. And there is no panacea for the myriad of issues facing the oldest-old who are aging-in-place today. The participants of this study exhibited fierce grit, determination, purposeful resolve, and prayer merely to accomplish the multiple challenges present in everyday life. They endured physical pain, loneliness, isolation, and feelings of purposelessness. They had suffered tumultuous events such as retirement, widowhood, declining health and mobility, and a lessening of financial status. They compromised standards of hygiene

and orderliness as they lost their ability to perform the tasks of basic subsistence or homemaking (Golant, 2015b). They became incapacitated in ever increasing ways as years went by. For some, those around them unabashedly denounced trust that they could continue to exist within their lifestyle. Yet these people endured and persevered within their treasured homes, so strong was their desire to remain. By developing unique, strategic and constructive responses to all the adversities they faced, they were able to push through the hardships they confronted.

Participant's dwellings were in several cases frustratingly inadequate; either too large, designed for earlier life, poorly retrofitted, incompatible with current needs, out-of-date, or with considerable deferred maintenance. There were unmet needs for services, social isolation, unsafe conditions within the home, and limited or perilous transportation options. These homes were clearly not residential utopias. But so strong was their link to their dwelling-related biographies, that they could scarcely fathom living in any other place. Facing physical limitations precipitated by old age, participants viewed their residential environments as something to overcome or conquer (Golant, 2015b). Each participant uniquely formulated revised ways of living in order to cope with declines and losses.

This strong desire to remain at home was certainly evident through their actions. But far more than expressing attachment to home, participants of this study expressed an intense resentment to the notion that relocation to some type of senior housing could, or should be, part of their future. Indeed, such a relocation was dreaded far more than even the contemplation of death. Participants spoke without emotion about not necessarily wanting to reach 100, or not wanting to remain alive for a great extension of time. Such was their acceptance of impending end-of-life. But when they envisioned a future within institutional housing, they expressed dread and revulsion. They foresaw a prison-like environment, and the loss of free will and

independence. They pictured life among the frailest and most maladjusted of other elders. They imagined loss of pleasurable and chosen activities. They presumed a daily life of regimentation and control.

In sharp contrast, the participants of this study discussed their home environments in terms of familiarity, comfort and mastery. To ensure their continued tenure there—as opposed to succumbing to the ills envisioned within other housing arrangements—these people succumbed to a number of adaptations and concessions. They had lowered their standards to conform to less-than-ideal living conditions. Their will to remain in their home shaped their lives, their days, and even passing hours. This was the price to be paid for aging-in-place.

Residential Inertia.

For all of the participants, and likely many of the oldest old aging-in-place today, a halting of environmental changes decades earlier was evident. Golant (2015b) utilized the term *residential inertia* to describe this permanence in both address and surroundings. Data from this study further elucidates and expands upon this conceptual term, used by Golant, as evidence of such inertia was demonstrated in several ways by participants. Not only did these people not want to change their residence over a period of many decades, they seemingly had a much reduced desire for changes within that interior environment as well. They did not want to change the home, the look of the home, nor the contents of the home. This is not to suggest that economic and functional limitations did not play a role in inertia, as some of these elders had limited incomes and many felt that making changes would be exhausting and beyond their capacity. Both the enduring tenure in their homes and the stagnation of style and content—that is, contents remaining in place, neither new items brought in nor old items discarded—was an inertia that was pervasive across all participants.

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When considering the lives of these participants and this inertia, with regards to a life course perspective, it is interesting to contemplate the juncture at which major residential changes reverse from highly anticipated to dreaded and avoided. Young people certainly look forward to moving away from their parents' home, perhaps into a college dormitory or into a first apartment, no matter how austere or how compactly arranged. Purchasing one's first home, whether as a single or newly married person, is usually a significant life highlight. Perhaps a larger home is in the cards, due to the birth of children or increased affluence. Thanks to the late 20th century building boom and low mortgage interest, many middle-class Americans have been able to realize the home of their dreams. Some empty-nesters look forward to downsizing to a home more suited to the needs of a couple, where they can enjoy life focused on their own, rather than their children's interests. Acquiring new furniture pieces, artwork, and décor items are all very pleasurable activities for many homeowners throughout all of these life stages. Today, the proliferation of retailers offering trendy decorative home accessories in stores and on-line supports this notion that Americans love to update their homes. Many home items and possessions are lovingly selected and placed within the home and enjoyed for years. For much of one's life, these updates characterize a loving interplay between one's increasing affluence, one's interests, one's preferences, and one's home environment.

But somewhere in middle to later age or after retirement, this anticipatory momentum reverses, and the move to one's next home often represent declines in income or health. Changes to the conditions of home are likewise no longer pleasing updates, but rather marks of increased needs for support. The desire to acquire new items and to rid one's home of older items becomes beyond one's ambition. Perhaps due to a desire to remain linked to one's environmental biography, or because change would seem to be a deterioration of one's sense of self, or because

the effort of culling out becomes beyond one's capacity, or because of a recognition that housing changes and the disbandment of possessions are precipitated by the steady march towards death, there was evidence of a distinct lessening of changes within one's home environment. For participants of this study, there was acknowledgement that home changes would occur only following their death, when adult children would take care of sifting through clutter, take care of deferred maintenance issues, and update home features to get the home ready for sale. They had become firmly entrenched in residential inertia and had no further aspirations towards residential renewal or rejuvenation. Their mere continued existence within the home became the extent of their residential aspirations.

The lived experiences of the oldest-old aging-in-place today should be regarded as unique among humanity. Never before in the history of mankind has their experience been precisely duplicated. The aligning of several late 20th/early 21st century socio-economic phenomena—increased life expectancy, deterioration of an agricultural-based culture encouraging multi-generational living arrangements, and decades of sustained material affluence—have cultivated the potential for such a long-lived experience (from 43 to 68 years for the participants of this study) within the home of one's choosing, living alone surrounded by one's cherished personal possessions. Participants of this study considered themselves fortunate to have remained in their family home throughout the last half of life, in spite of the reality that this environment presented a wide variety of challenges which were difficult to overcome. That was the price which they paid for their long tenure: emotional fulfillment, autonomy, and emotional comfort in exchange for a continued need to overcome obstacles presented by the environment. They held on in spite of losses and declines and exhibited a residential inertia which was manifested in both length of time in residence and length of time without aesthetic or functional change to homes.

Linking to the Dimensions of Adjustment Model.

A model for the dimensions of adjustment, those phenomena which drove both the desire and the ability to remain at home, were discussed previously herein (see pages 9-18). Those dimensions of adjustment were: *competence, autonomy, security, continuity, normalcy, and self-efficacy*. Drawn from the literature in the realm of environmental gerontology, these six concepts were chosen as the most salient linkages to aging declines and the pursuit of constancy throughout life. Viewed in relation to a life-course perspective, aging becomes a quest to continually adapt and adjust to remain solidly entrenched in one's chosen life path. As for a high-wire artist, one who finds himself in a high risk environment continually strives to achieve balance in order to remain on course and to avoid teetering into downfall. Constancy, not change, is the hallmark of an existence where one feels most in control and is most gratified (Golant, 2015b). Through the lens of these six dimensions, a deepening understanding of both the interplay between psyche and environment and of the nature of personal adaptiveness among the oldest-old aging-in-place can be explored.

Competence. Lawton posited that as personal competence is reduced, an increased influence is exerted by one's environment. It was certainly seen in the lives of this study's participants that housing features become increasingly challenging over time. A staircase presents little challenge throughout most of one's life, until one encounters the unrelenting pain and stiffness associated with arthritis. Home maintenance and organization involve merely pesky chores, until they exceed one's ability to manage. How does an elder deal not only with the grim acceptance of irreversible declines in functioning near life's end, but also the inability to accomplish what needs to be done on a day-to-day basis? In this study, participants were seen to both increase their resolve and perseverance as well as to decrease their active coping in

response to losses in competence. In many cases, they just tried harder, took more time, or contrived some type of accommodation. In other instances, they abandoned efforts altogether, accepting defeat from their struggles and acknowledging the powerlessness in their inabilities.

Autonomy. Autonomy was proclaimed as paramount to contentment, and strongly associated with the ability to remain at home. Participants of this study likened congregate senior housing to prison, and imagined being told when to rise, when to eat, and when to be allowed to go outdoors. For them, remaining at home was regarded as the only way to maintain personal autonomy, sense of self, and freedom of choice. In reality, participants were experiencing a vast reduction in their range of choices. In sharp contrast to the choice-rich experience one enjoys throughout one's adult life, these participants—due to diminishment in vision, hearing, mobility, and dexterity—became at times severely limited in choices, such as how and when to go out, what to eat at mealtime, what to wear, what to pursue as entertainment, and even when and how to bathe. Their hold on to a sense of autonomy had become for them less about having a control over one's personal affairs—because aging had diminished that control—as it had become about avoiding the need to succumb to the directives of outside players.

Security. The concept of security was multifaceted in regards to findings from this study. Although envisioned as the counterpart to autonomy by Parmalee and Lawton (1990), and typified in housing conditions where oversight and control exist to maximize safety, participants regarded security in a number of ways. They felt especially secure in their dwellings due to their long tenure there and being so accustomed with every inch of their surroundings. There was a fluency to their daily existence which was rooted in a deep familiarity with their home—and this equated to a sense of security. The increased reliance on technology, the vigilance of altruistic

neighbors, and the loving concern of adult children also lent a sense of safekeeping and peace of mind within their four walls. But one might conceive that they were living in a fool's paradise. When calamities, particularly falls, did occur participants found themselves helplessly awaiting the arrival or intervention of a person who might be able to help. Participants experienced continual anxiety about potential catastrophe in their daily lives. With their rising age, the risk for mishap became increasingly likely, which they could combat only with the tenuous hope for good fortune. For the oldest-old, aging-in-place is in fact a high risk condition, and the rapid decline into death for two of the participants accentuates the precariousness of this existence.

Continuity. The desire for continuity, that is, constancy in the way one has lived and the continuation of long-established patterns was seen as paramount to continued residential adjustment. Atchley (1999) described a lifelong quest for continuation of lifestyle, realized through persistent adaptation. But within a life-long perspective, there is an arc to the anticipation of life's events, from the quest for new experiences in earlier life to the very strong appeal of the familiar and routine in later life. As discussed above, this manifested in residential inertia—a desire to neither change the location nor the features of the existing residence—among these elderly residents. After a lifetime of formulating the life that one desires—the routines, the pastimes, and the habits—it is logical that in old age, one would not aspire to deviate from those chosen patterns. The mere construction of each day becomes a confirmation of one's self within the world, an affirmation critical to subsistence when facing the impending inescapable decline into death. One might imagine that, in very old age, every daily, even hourly effort, is expended in an effort towards biographical continuity.

Normalcy. Normalcy, or the sense that one's lifestyle is consistent with one's personal objectives, was likewise seen as essential to residential well-being among elders. Within their

dwellings, people want to feel as comfortable, competent and in control as possible (Golant, 2011). Participants of this study expressed being unable to fathom living in any other place that would be as emotionally fulfilling. Only one participant deviated from this sentiment in choosing to relocate due to pervasive loneliness following her husband's death. For all others, their evaluation of senior housing as prison-like was the most extreme deviation from normalcy that could be imagined. When they had difficulty performing even the simplest of household tasks and activities of daily life, their home provided psychological and physical comfort, and a sense of normalcy.

To continue to achieve residential normalcy, participants of this study tackled unfavorable challenges and adversity through a variety of action and mind strategies. Action strategies—called *assimilative* coping efforts by Golant (2011, 2015a)—were numerous and varied. Greater reliance on supportive technologies, modification in daily behaviors, dependence on others within their personal sphere, and actions such as eliminating, changing, or modifying home elements or activities were seen in abundance. Where they were able, participants maintained actions they had always performed, or found simpler ways to achieve the same end. To a far lesser degree, participants exhibited the use of mind strategies—what Golant referred to as *accommodative* strategies—when they reduced their standards of cleanliness and closed doors of unused bedrooms to diminish concern about the proliferation of unused items. By vanquishing such concerns from their active thoughts, they managed to cope.

Self-Efficacy. It was perhaps due to feelings of strong self-efficacy that participants of this study felt secure within their homes. They had managed to get along for decades and had established extensive coping repertoires. Often one successful adaptation begot another, such as the progression from the use of a cane to the use of a walker to the use of wheelchair, and

reinforced a person's sense of efficacy. They were buoyed by the sense that, because they had managed up until the current time, they had the capacity to continue on. And they had become effective in seeking help from others within their close community when even their own exhaustive efforts fell short.

But slowly, bit by bit, an erosion in the confidence in one's abilities was seen among participants. They expressed considerable distress about having to come to terms with the tangible diminishment of skills, such as when one could no longer drive, had difficulty with dressing or bathing, or could no longer participate in beloved activities. A difficulty in internalizing newfound shortcomings is perhaps human nature, as it necessitates the acceptance of a revised self-concept. When one has always been able to rely on one's own skills for decades, there is anguish in the acceptance of no longer having that skill. There seemed to be a tug-of-war in play with regards to self-efficacy among participants: an inner strength sustained by a lifetime of self-reliance struggling against the grim acceptance of a divergence away from lifelong patterns of effective action.

Implications and Recommendations for Future Research.

We do research and attempt to better understand a phenomena in order to put ourselves on a path towards creating better solutions. However, regarding the study of the experiences of the oldest-old aging-in-place today, we, as an academic community, are only in the very early stages of grappling with implications for environmental design (Rowles & Bernard, 2013). A far greater quantity of research within the field of environmental gerontology has focused on improving the residential quality in senior congregate housing, and certainly there have been vast advancements in the informed design of such spaces. But, as with the participants of this study who yearned to remain at home, many people today who have not yet reached old age will likely

fiercely avoid a move to group housing in their later years as well. Many people simply want to stay in their own homes – a notion so basic that it paradoxically brings in to question the inherent focus of environmental research for decades. Have we perhaps been missing the mark in environmental gerontology research? The pivotal guiding question within home-based research for the elderly should perhaps not be how to make supportive environments more home-like, but rather, how to make home environments more supportive.

Within the field of environmental gerontology, we are still far from being able to transform knowledge into action with regards to the residential settings of choice – the long-occupied home. There is a great need for refinement in our conceptual and theoretical understandings of the lived experience within the close confines of elders' homes (Bernard & Rowles, 2013). The environments in which older people live out their lives are crucially important. They provide the context for maintaining personal identity and sustaining meaning in the face of debilitating declines in health and functioning. Bernard & Rowles (2013) noted “the importance of uncovering the complex and multi-faceted nature of person-environment interactions if we are able to reconcile an objective analysis of housing issues with subjective constructs such as meaning, belonging, and agency” (p.286). A deepening understanding of the “complex relationship between people and their environment and the manner in which this relationship evolves over the life course, and especially into old age” (Bernard & Rowles, 2013, p. 290) is called for before this knowledge can be harnessed into ideologies to inform residential design practice.

There has been a scarcity of investigation and discourse on the aging-in-place phenomenon from the perspective of those who are doing it. Many people simply want to remain in their home until life's end and the ravages of aging do not make this an easy journey.

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There is a distinct need to understand the lived experience of old people within their long-occupied homes in order to better support the pervasive desire of elders to age-in-place. By advancing knowledge, the ultimate goal in environmental gerontology is to optimize congruence between the lives of elders and the places in which they live. This study hoped to lend insights into this discourse by telling the story of ten people who were individually fighting their own battle to survive at home. By investigating individual experiences, this study articulated what it is to age at home while combating the progressive and inevitable declines one must endure when approaching life's end.

This research study took into account several related questions which require far greater and continued exploration: how and in what ways do elders adapt as they struggle against the diminishments of aging in order to age-in-place, and how do they regard their housing alternatives relative to these efforts? It considered the creative adaptations that particular elders utilized in order to compensate for the wide variety of biological changes related to aging, in order to realize continuing competence at home. There appeared to be a continuum along which adaptive changes were undertaken, with instances of active action strategies strongly leading beyond the need to adopt attitudinal change, which were seen with far less frequency. At the far reaching edges of this exploration exists the larger questions of whether such knowledge about these individual approaches can somehow inform the design of homes in the future.

Today, single-family homes are often designed solely with able-bodied adults in mind, with virtually no regard for the changing abilities that inevitably come with age. Collective aging may not have had a resounding effect on house design up to the current time, but the changing demographic in this country—due to the aging of the baby boom generation—will create a more urgent need for thoughtful residential design to accommodate an onslaught of older

people striving to age productively. How can the design of residential environments advance the goals and aspirations of people who choose to age at home? Transforming knowledge into action will not be realized quickly, as there is much to ponder and understand about the older person's evolving relationship with their home environment.

There is good reason to expect that the continued use of assistive devices and technology—those currently existing and those yet-to-be designed and realized—will continue to improve the home lives of elders (Golant, 2015b). The implementation of home modifications will reach greater audiences who can benefit from proven effective home alterations and improvements. Service programs and providers will continue to explore the delivery of their services to optimize access, effectiveness, and affordability. Care providers continue to improve best practices for in-home care. Policy makers will decide how to best advance age-friendly public policy. And the medical community will persist in realizing cures and treatments for the huge array of aging-related maladies. Somewhere within this trajectory is a pivotal place for the design researcher to continue to understand the life experience of the aging population in their residential environments, and to shape future developments in order to reduce the price that must be paid in order to age-in-place.

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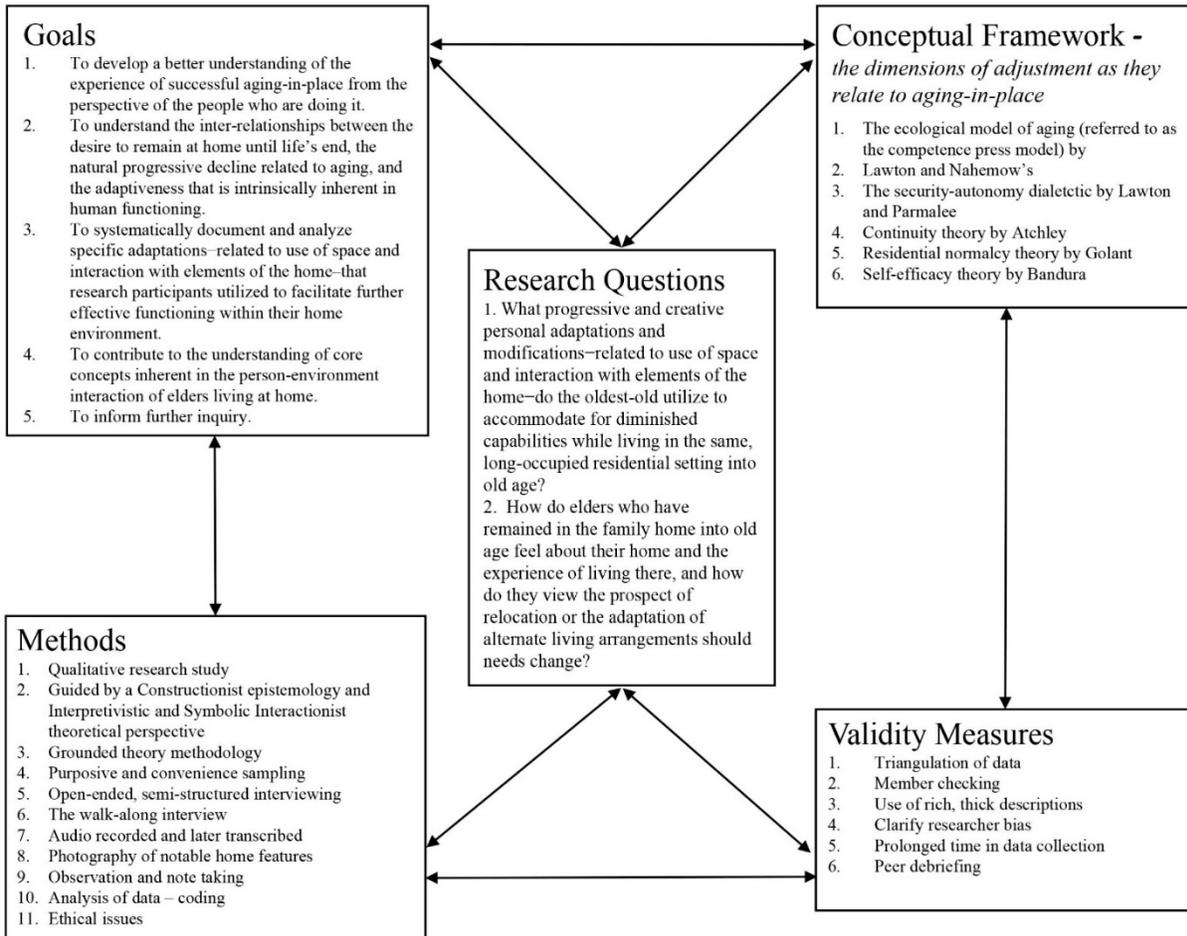
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Appendix A – Design of Study using Maxwell’s Model for Research Design



Maxwell interactive model of research design completed for the current study. Reproduced from Maxwell, 2005, p.5. *Qualitative Research Design: An interactive approach*. Thousand Oaks, CA: Sage Publications.

Appendix B – Interview and Observation Protocol

STUDY TITLE: Aging Alone in the Family Home: Exploring Place Attachment and Personal Adaptation

INTERVIEW AND OBSERVATION PROTOCOL

Research question: What progressive and creative adaptation and modifications – related to use of space and interaction with elements in the home – do elders utilize to accommodate for diminished capabilities while living in the same, long-occupied residential setting into old age?

Data Collection Methods: I will meet with each subject about six times in their home. I am looking for adaptations – either behavioral or changes to features within the home – that subjects have made due to diminishment of capabilities. As part of the Informed Consent Form, each subject will be informed about the intended methods described below.

Sampling

My participants will be found by asking my colleagues and acquaintances if they know of anyone who is over the age of 85, and is currently living in the same home where they have raised a family (Purposive and Convenience sampling). If a colleague/acquaintance of mine indicates knowing such a person, I will ask that colleague to first approach the potential participant to introduce the scenario. I will ask my colleague/acquaintance to explain that they know me and that I am a doctoral student in Architectural Studies working on research regarding aging-in-place, am looking to interview people such as themselves, and ask if it would be all right if I contacted them by phone to speak directly to them about my research, and perhaps ultimately interview them about their experiences. I will call their phone number to further the recruitment effort, and utilize the Recruitment Script (attached) phone conversation.

I will ask for an initial face-to-face meeting time with them in their home, at which time I will review the Informed Consent Form with them. If they are agreeable to continue, I will schedule one or all of the additional six meeting times. I will pick up the Informed Consent Form at the beginning of the first of these. I will also leave them an additional copy.

- **Interviewing**

I will utilize semi-structured approach, meaning that I have a rough script of interview questions to initiate discussion, but that I may change the manner in which I ask the questions – changing the wording or sentence structure – to better fit the respondent or the situation.

Please see the attached – Interview Questions – document for a full list of interview questions.

All interviews will be audio recorded, then will be transcribed for analysis.

- **Observation**

Over the course of the sessions, I will ask the subjects to show me through their home. I will note features that indicate adaptive behaviors, how certain items are arranged within the

home, take account of which spaces and elements the subject uses the most and the least, and not how those elements are being used. I will note the subject's use of items, interaction with features, and movement within the space of the home.

Documentation of observations will happen in two ways:

1. Note taking and Behavior mapping. I will carry a notebook and make written notes of noteworthy behaviors or home features. Quick drawings may be used to map behavior - to show how subjects utilize and interact with the features within their home, as well as their tasks, activities, how they navigate the space, and paths that they travel.
2. Photographs. I will take digital photos of noteworthy features of the home, and possessions which are meaningful to the participant in a relevant way, or are being utilized in a way that indicates particular adaptive behavior.

Participants: Participants will be men or women over the age of 85 who are aging alone in their family home (it is anticipated to gender differences in life expectancy that most are all the participants may be women). They have become empty-nesters, then widows or widowers, but are continuing to reside in the same home where they previously have raised a family.

Sample size: I will interview about 10 subjects for the full dissertation study. One subject will be interviewed as part of a pilot project during October/November of 2014, and the remaining subjects will be interviewed later.

Ethical Issues: The Informed Consent Form fully explains the nature and methods of the study. Participants will sign the form before interview sessions begin. I will maintain possession of the audiotapes, notes, and photographs, until the study is complete, after which these materials will be stored on-site at the College of Human Environmental Sciences at the University of Missouri, as is required by U of Missouri policy. There will be no name identifiers associated with these records, only dates that the interview took place. Only I, as the investigator, will have the cross references list of dates with subject names. Within the written dissertation, subjects will be identified as "one of the participants interviewed" or "participant #1". A typist will be hired to transcribe the audio tapes. He/she will not be given any identifying information, although the subject may be verbally called by her first name within the conversational nature of the interviews.

I will ask to see all portions of the home throughout the series of interviews, but will establish a strong rapport before asking to see the more private areas and contents of the homes such as bedrooms and bathrooms.

Documentation: Documentation will include: audio tapes, transcription of audio tapes, investigator's notes and maps, and photographs. Direct quotes from interviews, descriptions of verbal and observed content, investigator notes, and photographs will all be used within the written dissertation and any subsequent academic written material.

Appendix C – Recruitment Script

STUDY TITLE: Aging Alone in the Family Home: Exploring Place Attachment and Personal Adaptation

RECRUITMENT SCRIPT

My participants will be found by asking my colleagues and acquaintances if they know of anyone who is over the age of 85, and is currently living in the same home where they have raised a family (Purposive and Convenience sampling). If a colleague/acquaintance of mine indicates knowing such a person, I will ask that colleague to first approach the potential participant to introduce the scenario. I will ask my colleague/acquaintance to explain that they know me and that I am a doctoral student in Architectural Studies working on research regarding aging-in-place, am looking to interview people such as themselves, and ask if it would be all right if I contacted them by phone to speak directly to them about my research, and perhaps ultimately interview them about their experiences. I will call their phone number to further the recruitment effort, and utilize the following script in a phone conversation.

Hello Mrs. _____. My name is Gloria Stafford. I work with/know so-and-so whom you also know as a neighbor/friend/relative/acquaintance. I believe so-and-so mentioned me to you. I am working on a dissertation study as part of the requirements for a doctoral degree. I am very interested in knowing more about the experiences of people like you who are successfully aging-in-place.

At this point, I will try to be conversational to break the ice.

Mrs. _____, if I may ask, how long have you lived in your home? Oh that's wonderful. And so-and-so tells me that you have known him/her for _____ years, and that you are neighbors/friends/relatives/acquaintances, is that right? So-and-so tells me that you are about _____ years old, is that right??? Oh my, that's great.

Well you are precisely the type of person that I am interested in knowing about, because you are aging-in-place, that is, you have remained in the same home up until now. You may have heard the term "aging-in-place". There has been very little research done that has asked the people like yourself about your personal experiences. I imagine in the _____ years that you have lived in your same home, and now that you are _____ years old, you have had to make some changes to manage everything. Those are precisely the things that I am interested in knowing.

I am looking for people such as yourself to interview for this research. This would involve meeting for several hours over the course of about four to six meeting times. There are many things I would like to ask you about, so I would be asking for several hours of your time. What I would like to do initially, is perhaps set up a time for me to meet with you at your home so that I could go into a bit more detail about myself and my research process. Also, if you agree to participate in this research project, there is a consent form that you will sign. I will bring that along and we can discuss it further.

AGING ALONE IN THE FAMILY HOME

This last paragraph may elicit either additional questions from the potential participant, or an agreement to arrange a meeting time. I will answer questions, set a meeting time, review the home address and location, and then conclude the phone conversation.

Allow me to give you my phone number in case there is any reason you would need to reach me before our arranged meeting date. Can you write this down? It is 952-715-0880. And again, my name is Gloria.

Mrs. _____, it has been so nice talking with you! I am really looking forward to meeting with you on _____ (day/date). I will see you at _____ (time) at your home.

Thank you so much! Bye now.

Appendix D – Informed Consent Form to Participate

CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

Investigator: Gloria Stafford,
▪ Doctoral student at the University of Missouri-Columbia in Human Environmental Sciences with an emphasis in Architectural Studies
▪ Assistant Professor of Interior Design, School of Applied Human Sciences, University of Northern Iowa

Study Title: Aging Alone in the Family Home: Exploring Place Attachment and Personal Adaptation

INTRODUCTION

This is a research study. Research studies include only people who choose to participate. You have the right to know about the procedures that will be used in this research study so that you can make the decision whether or not to participate. The information presented here is simply an effort to provide you with all the information you will need in order to facilitate your decision *to give* or *to withhold* your consent to participate in this research study.

Please take your time to make your decision and discuss it with your family and friends.

In order to participate in this study, it will be necessary for you to give your consent in written form.

WHY IS THIS STUDY BEING DONE?

The results of this study will be the basis of a written dissertation, the completion of which fulfills a requirement for the degree of Doctor of Philosophy degree (PhD) in Architectural Studies for Gloria Stafford. This dissertation will initially be available to Gloria’s professors at the University of Missouri, may later be available to the academic community within the field, and perhaps may be the basis of a published article within an academic journal.

WILL PEOPLE KNOW ABOUT MY PARTICIPATION?

For all above described uses of the data you provide, your identity will remain confidential. Your actual name will never be used. Your name will be substituted with a pseudonym such as “Participant #1” or “Participant #2”. Therefore, any readers of the material will have no indication of your actual identity.

Page 1 of Consent Letter: Participant initials_____

WHY SHOULD I PARTICIPATE?

If you choose to be a study participant, please be aware that the information that is gathered during the interview/observation period will contribute to knowledge within the field of design for those interested in creating environments for older people to successfully age-in-place at home, rather than relocating to other housing arrangements. Your experiences as someone who has remained at home will provide very valuable knowledge within this field of study.

HOW MANY PEOPLE WILL TAKE PART IN THE STUDY?

The goal of this dissertation effort is to include 10 participants, such as yourself, all of whom are currently living along in the home in which they have previously raised a family. The target age for participants is 85 years of age or older.

WHAT IS INVOLVED IN THE STUDY?

If you take part in this study, Gloria Stafford will meet with you four to six times at your home. First, you will become better acquainted so that you feel comfortable with conveying information about yourself.

Then Gloria will ask you questions about your daily routines and the challenges you have faced in performing the activities of daily life as you have gotten older, such as meal preparation, personal hygiene and grooming, general housework, and forms of communication. You will also be asked to describe your feelings about your present home, and why you have chosen to reside there at this point in your life. Gloria will also observe how you have arranged things within your home, and take account of which spaces and elements you use most and least, and how you use them.

The investigator - Gloria - will carry a hand-held tape recorder throughout the sessions. Everything said will be recorded, and later transcribed (written down). Gloria will also use a pencil and paper to record additional observations and notes. She will take photographs of areas of the home that are noteworthy – with your permission. No one but Gloria will ever make use of the voice recordings, the typed transcriptions of the interviews, the hand written interview notes, or the photographs, although she will use them to produce written documentation.

As this information gathering involves many questions and interactions within your home, between four and six meeting times will be arranged. Each session may last two hours or more. All meeting times will be scheduled at your convenience (and the convenience of an acquaintance or family member if you would like to have another person present).

Page 2 of Consent Letter: Participant initials _____

WILL ANYONE ELSE BE AT THE INTERVIEWS?

Typically, just you and the researcher (Gloria) will be involved in the interview sessions, but, if you would feel more comfortable having a friend or member of your family present during these sessions, that would be absolutely fine. Please invite them to join by coming to your home during the scheduled meeting times. This is highly encouraged if it would make you more at ease.

WHAT ARE THE RISKS OF THIS STUDY?

The risks in this study are minimal. Some individuals may encounter frustration or boredom in discussing their personal living situation at great length. However, others may enjoy the sharing of information and experiences with the investigator. You are encouraged to share your feelings about being part of the study - positive or negative - with the investigator, Gloria Stafford.

ARE THERE BENEFITS TO TAKING PART IN THIS STUDY?

Because you are actually living the phenomenon under investigation - that is, aging in place in your long-occupied home - you will be able to provide much information that is valuable to this study. The field of Environmental Gerontology and designers who design housing for older residents can benefit significantly from the information and descriptions of experience that you can provide.

WHAT ABOUT CONFIDENTIALITY?

As noted earlier, your actual name will not be used in any discussion of the study, in the written dissertation, nor in any subsequent publication regarding this research. A pseudonym will be used in place of your real name so that your identity will remain anonymous. No one will know of your participation in this study except for those whom you share information with. You are encouraged to let your family and friends know about your participation, if you wish to.

All research materials, including audio recordings, typed interview transcriptions, and interviewer notes will be maintained at the University of Missouri for 7 years following the completion of the study.

WILL I BE PAID FOR PARTICIPATING IN THE STUDY?

There will be no monetary compensation for participation.

WHAT ARE MY RIGHTS AS A PARTICIPANT?

Participation in the study is voluntary. You do not have to participate in this study. If you wish to discontinue at any time, you can let Gloria know, and your involvement will end.

WHAT WILL BE DONE WITH THE DATA COLLECTED FROM ME?

The initial use of the information collected (data) will be for a doctoral dissertation. Following that, data may be used to an article to be published in an academic journal. Both descriptions of what you may have said, as well as direct quotes, as well as photographs taken in your home may be included in both the dissertation and subsequent article or articles. As noted, there will be no identifiers attached to this data. Instead, descriptors such as “Participant #1 described...” or “Participant #2 said’ ...” or this photograph was taken in the living room of the home of Participant #3 will be used.

WHOM DO I CALL IF I HAVE ANY QUESTIONS OR PROBLEMS?

You, or your friends or relatives, may ask more questions about the study at any time. Please contact Gloria Stafford at 952-715-0880 or email her at geskwd@mail.missouri.edu .

If you are uncomfortable about any aspect of the study, you feel coerced, or pressured to continue, you may contact the University of Missouri-Columbia Institutional Review Board (which is a group of people who review the research studies to protect participants’ rights) at 573-882-9585 or email at umcresearchcirb@missouri.edu.

A copy of this consent form will be given to you to keep.

Appendix E – List of Interview Questions

STUDY TITLE: Aging Alone in the Family Home: Exploring Place Attachment and Personal Adaptation

INTERVIEW QUESTIONS

During my face-to-face interviewing (which will be audiotaped) in the participant's home, I will be looking for both Manifest content (direct answers) and Latent content (unspoken content, such as hesitations or nervousness), which may indicate that certain things present psychological challenges. Particular artifacts (contents of the homes and possessions) may be noteworthy during interviews, and I will take written notes about them, or will ask if I can take photographs of them. I will use a semi-structured approach, meaning that I have a rough script to initiate discussion, but that I may change the manner in which I ask the questions – changing the wording or sentence structure – to better fit the respondent or the situation. Particular participant responses may lead to the need for additional probing. It is anticipated that some questioning will be open-ended, that is, responses to questions will lead to further inquiry along the same lines. The breadth of potential follow-up questions cannot be fully anticipated, but will involve adaptive behaviors related to diminishment of capabilities and changes over time.

Topic #1: Meaning of Home/Place Attachment

1. When did you move here? What was your family situation? Did you raise children here? Tell me about that. When did your spouse pass away?
2. What changes have you made to this house over time?
3. How do you feel about this home? How would you feel about moving? How do you feel about staying? Why have you decided to stay?
4. What would be the hardest thing to deal with if you decided to move?

Topic#2: Behavioral and Physical Adaptation over Time

1. Describe how you have had to adapt to the way you live within this home as you have aged? Are there certain rooms or household features that you use more or less now than you did before?
2. What particular things are challenging to you at home, now that you are older?
3. What tasks are frustrating or difficult to do? Are there things that take much more time or effort that they used to?
4. What things do you no longer do because they have become too difficult? And do you miss doing them?
5. Are there things that you fear might happen in your home that you may not be able to easily handle?

Topic#3: Activities of Daily Living

1. How do you manage personal hygiene, such as dressing, bathing, brushing your teeth or shampooing your hair?
2. How do you go about washing and putting away clothes?
3. How do you do your shopping for food, and how do you prepare meals? Where do you eat your meals? How do you clean up the kitchen after a meal?

AGING ALONE IN THE FAMILY HOME

4. What activities – such as going up and down stairs - do you have trouble with around the house?
5. Do you have to get your garbage to the curb? How do you go about doing that?
6. How do you manage to keep the house clean? Do you have hired help? If so, what does that person do, and what do you do? Are there certain housework chores that you just choose to ignore? Does that bother you?

Topic#4: Communication, Transportation and Household Management

1. Do you rely on relatives to assist you with things? Do they live in the area?
2. Do you have neighbors that help you with things? How do they assist you?
3. Does keeping track of things present a challenge? Right now, if you wanted to find – say a stamp, or someone’s phone number – would you be able to?
4. Do you watch TV or read the paper? What do you watch/read?
5. Do you talk on the phone a lot? To whom? Do you have trouble talking on the phone – either hearing or being heard?
6. If there doorbell rings, can you hear it? Do you always answer the door?
7. What hobbies do you have? What activities do you participate in?
8. How often do you leave home in an average week? Where do you go and how do you get there?
9. What do you do to celebrate holidays?

Topic#5: Home Features

1. In looking around this room, I see many lovely things. Could you tell me about some of them? Do you use this _____ (i.e.: piano, table, lamp, bookcase)?
2. Where did you get this _____ (i.e.: chair, table, rug)? Have you had it a long time?
3. I see you have _____ bedrooms in this house? Do you have company that stays with you? Have you always used the same bedroom that you use now? Do you use the other rooms for storage?
4. I see that you have a _____ (i.e.: dining room table, microwave, stereo). Do you use that often?
5. I see you have a lot of _____ (i.e.: framed pictures, photo albums, books)? Have you always had those?
6. In which room do you spend most of your time? What space do you use the least?
7. Where do you spend your mornings? Afternoons? Evenings?
8. Are there things in your house that you have not used or touched for a long time? What are they?
9. Are there things in your house that you come into contact with every day? What are they?
10. What are your most cherished possessions?

Appendix F – Themes, Categories, and Codes – Full Listing

THEME: PHYSICAL FUNCTIONING – 4 categories, 36 codes

PHYSICAL MOBILITY – 9 codes

Trouble getting out of chair, trouble standing, trouble reaching, can't reach above head, wears shirts that don't necessitate reaching above head, walking in the basement to keep up mobility, frustration at being immobile, bad balance, reduced stamina, reduced response time,

FALLING and BALANCE – 4 codes

Falling, fear of falling, past falls, grab bars and railings installed, bed rails

VISION AND HEARING – 8 codes

Using magnifying glass, poor vision, can't see, adaptations for not being able to see, can't hear, hearing aides, hearing loss, uses stick-ons on appliances, uses audio books,

PAIN, ILLNESS, and MEDICATIONS – 15 codes

Pain from arthritis, managing pain, unable to get out of bed due to pain, unable to sleep due to pain, stiff neck, stiff joints, trouble swallowing, pain medication, pain getting out of bed, aches and pain, handling pain and dizziness, management of pain, medications, getting to pharmacy, pharmacy delivery, organizing meds

THEME: INTERACTION WITH APPARATUS – 2 categories, 24 codes

STAIRS – 12 codes

Pain with climbing stairs, slowness with climbing stairs, has to climb/descend stairs for either bathroom, going up and down steps, going downstairs facing backwards is easier, getting to the basement, being told by children not to go to the basement, saying prayers while climbing stairs, hasn't gone downstairs/upstairs for years, moved bedroom to main level, maintains bedroom on lower level, rug at bottom of stairs to visually mark last step

DEVICES/ASSISTIVE TECHNOLOGY – 12 codes

Grabber, wheelchair, walker, pacemaker, defibrillator, bedrails, grab bars, handrails, LIFE ALERT, hand held shower head, shower seat, bathtub retrofit

THEME: ACTIVITIES OF DAILY LIFE – 3 categories, 24 codes

BATHING, SHOWERING, WASHING HAIR – 11 codes

Showering, bathing, washing hair, getting into tub, adapting the shower, grab bars in shower, being told no grab bars could be put in shower, managing the step to get into the shower, bringing phone into the bathroom when she showers, hygiene, shower seat,

TOILETING – 5 codes

incontinence pads, up at night, toileting, porta potty (commode) beside bed, considering porta potty in kitchen, having trouble getting to the toilet in time

AGING ALONE IN THE FAMILY HOME

GETTING DRESSED – 8 codes

Putting on jewelry and make-up, staying in pajamas part of the day, getting dressed first thing, clothing, putting away laundry, dressing, pairing socks (pinning) before laundering, state of personal grooming, outward appearance

THEME: HOME MAINTENANCE – CLEANING – 8 categories, 106 codes

CLEANING AND HOME ORGANIZATION – 20 codes

Cleaning, home organization, can't reach upper cabinets so keeps things on counter, cleaning up after cats, changing lightbulbs, knowing where stamps are, outsiders doing housework, doing housework themselves, doing things that don't really clean, dishwasher/no dishwasher, refrigerators – either sparse or full, can't keep up on housework, arranging cabinets and closets, keeping things tidy, putting things away, making the bed, adult children helping to keep things clean, housework even though it doesn't help much, not using rooms, accumulation of dead bugs

UNUSED ITEMS AND SPACES – 22 codes

Collections, dispersing (parting with) of belongings, rooms not used, basement with items, old fabric, stuff, junk rooms, unused things, not getting rid of things, how to dispose of things, extra furniture, unused sewing machines, unused organ, china and dishes, unused walkers, things not used for decades, spare bedrooms as collections of things, husband's ties still has, stuff from a long time ago, not getting rid of stuff, vestiges of time gone by, stockpiling supplies

STYLISTIC STAGNATION and DEFERRED MAINTENANCE – 8 codes

Wall art, pictures, furniture, maintenance issues (furnace filters, light bulbs), needing to fix up house, home repairs, things that can't be handled, deterioration

COMMAND CENTER – 14 CODES

Command center, phone by chair, calendar, newspaper, computer, kitchen table, stacks of bills and letters, collection of meds, phone and pencils, key locations, comfy chair, notes on refrigerator/stove, kitchen table, collection of meds,

GROCERY SHOPPING and MEAL PREPARATION – 17 codes

Meal preparation, cooking, family bringing food, home health aide doing grocery shopping and picking up food, stocking refrigerator, grocery shopping with son, grocery delivery, getting groceries, stockpiling supplies, meals on wheels, making coffee, not eating, using crock pot and microwave, pre-packaged meals, using stove/microwave, eating in chair while watching TV, buttons on appliances

LAUNDRY – 5 codes

Doing laundry, getting clothes to the laundry area, getting clothes out of washer/dryer, putting clothes away, dirty clothes

GARBAGE REMOVAL, LAWN CARE, SNOW REMOVAL – 11 codes

Hiring a lawn service, doing yardwork themselves, children doing yardwork, garbage removal, driving to end of driveway with garbage, getting garbage to where it needs to go, not needing to put garbage in bin, yardwork, gardening, snow removal, yardwork and mowing

AGING ALONE IN THE FAMILY HOME

MAINTENANCE OF FINANCES – 9 CODES

Paying the bills, financial issues, financial security, Medicare, Medicaid, children interfering in financial issues, financial issues, economic security/insecurity, home office/desk

THEME: TRANSPORTATION / DRIVING – 2 categories, 24 codes

DRIVING – 12 codes

Driving, doesn't want to sell car, was sad to give up driving, misses driving, car accident and driving, avoids driving at night, putting gas in car, driving a golf cart, getting to church, errands, car maintenance, shouldn't be driving anymore

TRANSPORTATION – 12 codes

Rely on others to take her places, wheelchair lift, leaving the house, being a shut-in, going outside, getting to church/children's home in wheelchair, going to the doctor, no longer going to sporting events, being picked up for church, watching service on TV rather than getting to church, errands, eating out, venturing out of the home

THEME: CHILDREN, NEIGHBORS, FRIENDS, AIDES – 4 categories, 38 codes

ADULT CHILDREN – 17 codes

Help/no help from children and daughters/sons in-law, support/no support from children, visits from children, phone calls from children, daughter who never calls, husband took care of things now he's gone, grandchildren visiting/not visiting, children supporting choice to stay at home, children pressuring to move, children's fears about finding them dead, disagreement with son-in-law/daughter, children meddling in financial affairs, children's attachment to the home, dispersing things to children, who to call for help, responsibility to children, pride in grandchildren,

NEIGHBORS – 7 codes

Neighbors, neighbors check to see if blinds open/close, neighborhood feels secure, help/non-help from neighbors, extra key outside, neighbors checking in, willingness to accept/ask for help from neighbors

FRIENDS – 8 codes

Friends, friends have all died, keeping funeral cards displayed, loss of networks of friends, doing things for others, pastor visiting, house guests, having company

SERVICE PROVIDERS – 6 codes

Home health aides, visiting nurse, having to have someone new as an aide, declaring dnr, Home Instead service, housecleaning service

THEME: PSYCHOLOGICAL WELL-BEING – 2 categories, 45 codes

ATTITUDES AND FEARS – 25 codes

Health concerns, feeling one's age, feelings about aging, recognizing limitations, misses being able to do things, feelings about inadequacy at not being able to manage ADLs, could do things a year ago that can't do now, not wanting to live to be a certain age, living to be 100, surprised one has lived this long, going downhill physically, the cruelty of aging, fear of using cooktop/fire, not liking having a stranger in the house, not afraid of being alone, locking doors, fear about what might happen, fear of

AGING ALONE IN THE FAMILY HOME

crime/burglary, fear of falling/getting sick/hurt, fear of being alone/not afraid of being alone, self-sufficiency, loneliness, isolation, anxiety, feeling lonely,

DAILY ROUTINE and ENJOYING LIFE – 20 codes

Enjoying television/sports/music, daily routine, jigsaw puzzles, crossword puzzles, reading, playing bridge, computer use, phone use, activities, looking forward to visits from children/grandchildren, doing things for others, holiday memories, going to children's home for the holidays, the good life, blessings/feeling blessed, faith, remembrances, happiness/contentment, thoughts of the future, enjoying afternoon cocktail

THEME: HOME, PLACE ATTACHMENT, RELOCATION CONSIDERATIONS – 2

categories, 22 codes

FEELINGS ABOUT STAYING AT HOME – 11 codes

Staying in the house, security at home, familiarity with home/neighborhood, here too long to leave, home memories, not changing things in house, not wanting to leave the house, feelings about selling house, what will happen with the house after I'm gone

FEELINGS ABOUT RELOCATING – 11 codes

Thoughts about nursing home, relatives in nursing home, moving to assisted living, life in nursing home, negative attributes of nursing home, feelings about leaving home, relocating/moving out, giving up home, cost of living in nh versus living at home, on Western Home waiting list, not wanting to live with children

VITA

Gloria Stafford was born Gloria Eaton on July 13, 1957, in Mankato, Minnesota. She grew up in Bloomington, Minnesota, a suburb of Minneapolis. She attended the University of Minnesota, and received a BA degree in Psychology and Theater Arts in 1980. She continued her education by earning a Diploma from Dakota County Technical College in Interior Design in 1995. She again returned to school to earn a MA in Interior Design in 2011 from Savannah College of Art and Design. In 2013, Gloria completed a graduate certificate in Gerontology from the University of Missouri in conjunction with the Great Plains IDEA (Interactive Distance Education Alliance). She has attended the University of Missouri's Architectural Studies program, within the College of Human Environmental Sciences, since 2011.

In the course of her interior design career, she worked as a Senior Store Planner for Target Corporation for 13 years, as a Senior Project Designer at RSP Architects in Minneapolis for three years, and later owned and operated her own her own design firm for a number of years. She continues to work with residential clients on various projects in the Minneapolis area.

Gloria earned her NCIDQ certification in 1999 and the LEED-AP certification in 2009. She is a professional member of ASID and IIDA, and also a member of NKBA, EDRA and IDEC.

Gloria held the position of Assistant Professor of Practice at North Dakota State University, within the Interior Design Program from 2011 to 2013. Since 2013, she has held the position of Assistant Professor within the Interior Design program at the University of Northern Iowa in Cedar Falls, Iowa, which received its inaugural accreditation by CIDA in 2016. She divides her time between living in Cedar Falls and the Minneapolis area.