"I Don't Want to Move": Older Women Deciding Where to Live

by

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B.S.W., University of Victoria, 1995

A Thesis Submitted in Partial Fulfillment of the
Requirements for the Degree of

MASTER OF SOCIAL WORK

In the Faculty of Human and Social Development

We accept this thesis as conforming
To the required standard

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ABSTRACT

This phenomenological study explored the process of deciding where to live for seven women over the age of 75. All the women were Caucasian, in failing health, lived alone and had minimal kin support. They all described themselves as being in the middle-class strata of society. The four themes identified and described are: *Practical Realities of Deciding Where to Live, Supports and Connectedness to Others, Ways of Understanding their Situation, and Responses to their Situation.*

The concepts developed in the findings: caring work; reciprocity in relationships; and the managing of need and being managed by others, are taken up to contextualize the experiences reported by the senior women in failing health as they face making decisions about where they wish to, or can, live. The most significant finding came in the resistance all the women showed to moving. They clearly articulated a need to remain independent, autonomous and in control of their lives. Yet they understood that failing health, minimal kin support, a change in previously experienced reciprocal support and not knowing how long their resources would need to last, was threatening their ability to remain independent. The paper concludes with a discussion on these findings, their implications for policy and practice and recommendations for further research.

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ACKNOWLEDGEMENTS

This thesis would not have been possible without the seven women who participated in the study and gave so freely of their time and their wisdom. My heartfelt thanks go to each of you for your generosity and willingness to share your experiences with me.

I would also like to thank the Senior Citizen's Counselors, Ministry of Health and Ministry Responsible for Seniors; staff from Victoria Silver Threads; and staff from Fairfield New Horizons for distributing the introductory letters.

The completion of this thesis is the end of a twelve-year journey of study at the University of Victoria. Along the way I have met countless numbers of people who have alternately encouraged and challenged me to complete an undergraduate and graduate degree whilst working full time. My thanks to them for being part of my journey.

These people are certainly reflected in the people who have helped with the writing of this thesis. First, there were the women who participated in the research and the organizations that helped me find them. Second, there was the support and encouragement by my employers: the Board of Directors at Cubbon Centre and latterly the Capital Health Region. There was my thesis committee who guided me through the process and were themselves challenged to help me finish within my timeframes. The friends and colleagues who taught me more about computers and computer operations than I ever thought I needed to know! They helped so much with the practical realities of completing this work.

My thanks also go to so many other people: My colleagues who allowed me to stay connected to both work and school at the same time and understanding that my priorities were not always with them; my family who has been there from the beginning of it all and who will be there long after it is finished; my thesis committee who helped me to understand the situation; and lastly the friends who have helped so much with my emotional response to the situation.

These are friends who helped in ways too numerous to mention. Their emotional, spiritual and practical support is something I cherish and will continue to cherish as a special memory of this time. Truly they give the real meaning to this work.

In conclusion, I would like to acknowledge two special Manitobans: Barry who persuaded me to start the journey and Mae who was so integral to my finishing.

My thanks to you all.

CHAPTER I

BACKGROUND

"This is where I live" can refer to two things. It can mean the physical location of a person's home, or in a colloquial sense it can refer to a person's core value or belief. Shelter is one of the fundamental needs of human existence; for most people in Canada it is referred to as "home" or a place to live. How a person chooses where to live is very individual and dependent on many things: work/school, location, cost, number of people to shelter, and their personal preferences. The decision of where to live is one which most people must make at least once, and likely more times, in their lives. It is rarely a simple decision and often a change in living situation involves grief at the loss of the old home, excitement at the new home, and fear of the transition.

In my work in health care with seniors, I have known many people who as they age have been forced to make these decisions and transitions in less than ideal circumstances. Because the decision is often driven by a change in health status, there are different considerations and often fewer available options open to seniors than younger people. Many senior women are making these significant decisions on their own perhaps for the first time; for some this exacerbates the feeling of loss.

As a health care provider, I have worried about the gradual erosion of available services to our older population, yet took comfort from the dominant thinking that families would be prepared and available to assist an aging

population. Over time this comfort level decreased. By reading current gerontological literature it was clear the reduction of government programs had two major outcomes. First, women assume the majority, but not all, of the care provided by families; second there is an inherent assumption by government that families and communities would provide the needed support. It was this last point that caught my attention.

This begged the question about expectations should a person have no family or other kin support. It also spoke to assumptions of other support available to people, either through affordable purchased service or by friends and neighbours. Yet networks formed when we were younger change over time. Retirement and a gradual withdrawal from volunteerism for example, narrows the range of opportunities to stay connected. Death and deteriorating health status change many previous relationships. My own history is that I am single, childless and family members living close to me are older. This makes it doubtful there will be a family member upon whom I can call for support and assistance should it become necessary when I am older and need to make decisions about where to live. My social network now is primarily my age peers; while many are close and supportive, there is no guarantee they will be able to continue providing support as we all age.

Unless government policy changes, I could have a problem. I questioned the prevailing attitude of the policy makers and those, like me, who implement the policies. Within that framework I wondered how women who are single, senior and have no family support manage now. Looking around my home and

considering how long I could manage to live there, led me to contemplate what may prevent me remaining there. But I do not have a crystal ball and so was projecting a list of possible reasons. To move away from this crystal ball gazing, I approached the issue from the service provider perspective. This was far more comfortable and comforting. It was easy to list the remaining services, which gave me some comfort. Yet health care services are being eroded. The British Columbia Strategic Directions for Continuing Care Renewal (2000) suggests new ways and options that need to be considered when providing continuing care services in the future.

In the Capital Health Region there are not enough long-term care beds to meet the demand. Recently, access to Continuing Care services has changed. For example, directions in the amendments to the British Columbia Continuing Care Policy Manual (2000) state, "housekeeping may only be provided as a stand-alone service on an exceptional basis (e.g. for caregiver respite, or high risk or frail clients)". This means only those people with a caregiver or those most in need of services for personal care have access. Housekeeping services used to be the mainstay of home support services, but are now only provided if personal care is required as well. Increasing emphasis is put on family members to either provide the services themselves, or assist by paying privately for these services. Again, what happens to people who have no family support or cannot afford to pay privately for help to stay in their own home? But is the question this simple?

In a pilot study on the lived experience of deciding where to live of single childless older women (McNulty, 1998), it became clear that we rarely hear the

voices of seniors themselves. This was also the finding in Aronson's larger study in 2000. Before becoming too critical at this absence, I reviewed one of my undergraduate papers, in which I stated that the wisdom of seniors is one of our greatest natural resources. I spoke of the knowledge they had gained from years of living, which many of us have yet to attain. Despite this knowledge, younger members of our society seem reluctant to accept that knowledge and learn from their experiences. Yet reflecting on my practice since then, I seem to have fallen into the societal norm of making old women invisible by ignoring them and consequently not valuing this resource in the discourse on aging. Neysmith (2000) addresses the dominant thinking of managing older women's needs. She speaks to how the language and culture of "being managed....is highly developed...and is communicated by and embedded in the policies and practices of powerful political, health, and welfare institutions, and is commonplace in media representations of governments' battles with deficits and calls for belt-tightening" (p.55). In her examples of how this practice manifests itself in the everyday lives of women, she argues that the experience of how these policies impact on women's lives is "quite lacking" in the discourse. When it appears at all it is in the form of "defeated statements" (p.55). This suggests a passive acceptance of policies that do not meet the needs of women; it also suggests providers and policy makers have not responded meaningfully to any input the women provided.

Looking at the issue of people staying in their own home from the perspective of a health care provider, there appeared little evidence of asking

people what *they* thought they needed to stay in their home. Nor is there evidence of seniors being asked why or if it is important for them to stay in their own home. I have made an assumption, based on my own beliefs that they do not want to move. Yet it is not uncommon to hear people say they moved to an apartment or condo from a house "because the house and/or garden got to be too much work". This led me to wonder what factors people do consider when they are thinking of moving. As a comparison to my own list of factors, I was particularly interested in what older single women without children had to say on this subject. Do I have a broad grasp of what other people want or am I drafting policy and designing programs based on my own set of values and beliefs? I know what I mean by "this is where I live", but is it the same for everyone? I doubt it. It was this that led to questioning what do senior single women without kin support grapple with when making the decision of how and where they are going to live in the latter part of their lives.

Focus and Research Questions

It is important to listen to senior women talk about their lives and discover more about the decision making process for women who are facing their late senior years with no kin support, as their experiences may be different from those seniors with families. This formed the basis of the research question. It would provide a greater understanding into what it is like when senior women have to decide if they can remain living independently in their current location. What brought them to the realization that a change in living arrangements may be necessary or desirable, be it a sudden realization or something they have been

thinking about for a while? What is relevant to the decision making process and what factors play a part in this process? Is the experience different for women who have suddenly become ill, compared to those who have lived with a chronic health problem for many years? Is there also a difference in the decision-making process when there is a sudden change in health status? Does a limited time available to make the decision result in a simpler and/or less stressful process or is it more stressful and more complex when decisions are made over an extended time? This small study could not possibly answer all these questions. Yet it was important to obtain a greater understanding of how senior women experience facing these decisions.

The focus of this phenomenological study was to explore and understand the lived experiences of senior (age 75+) single women who are in failing health and have minimal kin support. I was particularly interested to learn how they make decisions regarding a change of domicile. For the purposes of this research, failing health was considered as deterioration in health status. This could either be because of illness or deterioration because of the aging process.

Review of Related Literature

Aging as a Woman

> With few exceptions – usually our romanticizing of a grandmother or our fantasizing of a Wise Old Woman – our literature, our music, our visual images, our political analyses and organizing, tell us less about old women than about how thoroughly we younger women have absorbed male society's avoidance of our aging selves (Macdonald & Rich, 1987 p.54).

Although not entirely agreeing with this perspective, I found this quote brought forward the invisibility of senior women themselves. This invisibility was labeled as a form of ageism (Markson, 1983; Mullaly, 1993; Coyle, 1997). "To combat ageism, therefore, we need knowledge and understanding of the effective adjustments which so many very old people make in the face of radically changed situations, physical, social and emotional" (Stevenson, 1989, p.10). To understand these adjustments, however, we have to learn more about the experience of growing old from women's perspective(s), not from the practitioner's or the bureaucrat's perspective.

Twenty years ago Phillipson (1981) argued "we have yet to trace sex inequalities at early phases of the life cycle into the upper stages of later life. The reason for this, however, is not only because we have an undifferentiated category of older person; there is also the point that, up until recently, growing old and retiring was largely considered a male problem" (p.193). This is starting to change. Cohen (1984) in her interviews of two hundred and fifty women found "how intensely individual an experience aging is" (p.167). All the women were "angered by society's limited and stultifying definition of aging in women. They see themselves as having become increasingly individual as they age...although they differ in education, financial status, and social class" (p.167). In reading the interviews, it was clear that "the majority felt oppressed by the sense that society was organized solely to serve the interests and needs of couples" (p.29).

More recently Healey (1994) describes what it means for her to grow old:

> For me, first of all, to be old is to be myself. No matter how patriarchy may classify and categorize me as invisible and powerless, I exist. I am an ongoing person, a sexual being, a person who struggles for whom there are important issues to explore, new things to learn, challenges to meet, beginnings to make, risks to take, ending to ponder. Though some options are diminished, there are new paths ahead (cited in Garner, 1999, p.3).

It is important to address and understand the contextual differences that face many senior women. We need "to understand the processes through which people create and make sense of their own lives, yet do so within constraints which they have little or no power to alter" (Finch & Mason, 1993, p.173). Some of these have already been mentioned, such as the provision of care services, societal norms and perceptions of aging. There are more. There are the differences in income, health status, and most importantly, a person's value system; these differences play a part in any decision making process when an older woman faces a decision about moving.

As a community worker and social worker both in the U.K. and Canada for over thirty years, I have come into contact with many women who are seniors. As a front line worker, supervisor and now manager, the range of their experiences continually captivates and impresses me. To put these stories within the history of the twentieth century gives me a sense of awe, particularly the changes and challenges they have faced both as a generation and on an individual level. Women over eighty years of age have experienced two world wars, a depression,

the introduction of electricity and penicillin, the thriving economy of the fifties and for many the poverty associated with the Depression or more recently now as older women. They have gone from a world where it took a week to ten days to travel and get messages from Europe to North America, to a world where they can get messages over the "web" or by phone in two minutes and fly to Europe in a matter of hours. Yet now as a society we appear to be determined to make decisions for them – and help them adjust to change!

So how do we get to understand the experience of growing and being old? As May Sarton (1996) takes us through her life journey at eighty-two, she concludes that it will be good to talk about her old age, feeling that by doing so she will help herself sort her life out as well as teaching others about her old age. By using the "connected knowing" described by Belenky et al. (1997), we can "gain access to other people's knowledge.... since knowledge comes from experience, the only way they can hope to understand another person's ideas is to try and share the experience that has led the person to form the idea" (p.113). This notion of connected knowing was also addressed in Women's Growth in Connection: Writings from Stone Center (1991) where the "more appropriate study of women in women's own terms can not only lead to understanding of women,.. but also provide clues to a deeper grasp of the *necessities* for all human development" (p.26).

Because of these interests, it became clear that to fully understand the experience of being a senior woman, without kin support and at a time of deciding where to live, it was necessary for me to go to women who are currently living

this experience. To better understand the phenomena I needed to ask the women, talk with the women and listen to the women themselves, rather than continue to project my assumptions.

Women, Caregiving, and Aging

"In demographic terms alone, ageing is a substantially female phenomenon" (Russell, 1987, p.126). Twelve percent of the total population of Canada is over 65 years of age, with approximately six percent of those over 75 (Gee, 2000). Women outnumber men by "a ratio of 1.27:1 rising to a ratio of 2.65:1 at ages 90 and older" (as cited in Elliott, 1996, p.14). MacQuarrie and Keddy (1992) also point out that not only will these percentages and ratios change by 2011, there is already a societal change in a much larger population of senior women who are poor, single and consequently facing extreme difficulties. The Office for Seniors in British Columbia states that one in ten senior men and one in five senior women in British Columbia live below the poverty line (as cited in Northcott & Milliken, 1998 p.77). In the Capital Health Region (CHR), 19.1% of seniors over 75 years of age and 31.2% of those over 85 receive the Guaranteed Income Supplement (GIS), with the average income of senior women being significantly less that that of senior men (Seniors' Health Profile, CHR, 1998). Guaranteed Income Supplement is paid on an income-tested basis, which combined with the Old Age Security, pension is expected to provide sufficient income for seniors. However, these two pensions only provide $10,700 per year for a single person, which clearly does not completely alleviate their poverty (Northcott and Milliken, (1998).

Over the last ten years there has been a huge growth in the recognition and necessity of family caregivers in providing informal care to seniors. Kimball (1995) and Aronson (1998) argue that this caregiving is a continuation of societal norms of caring done predominantly by women. Others point to the diminishing resources and consequently diminishing service options (Hooyman & Kiyak, 1996), while Keating et. al. (1994) link care giving and diminishing resources to the long held belief that seniors are cared for best in their own homes.

Given the numbers and the trends, combined with the cuts in service, policy direction, and patterns of care, it can be assumed that the necessity for family caregiving will continue, primarily by women. Family members do 85% of caregiving for seniors, with most of the care provided to a senior in their own home (Chappell, Strain & Blanford, 1986; Kimball, 1995). I question if this is likely to change in the future. More than likely, we will perpetuate the belief that families should be the major caregivers for older people (Keating et. al, 1994).

A significant feature of the role of family caregivers, particularly in the health care system is as an advocate. This raises the questions of who advocates for those without family, should they be unable to advocate for themselves? With an emphasis on family caregiving there is a tendency to miss those who have no children and have never married. Rubenstein (1991) points out that more than 20 percent of older Americans have no children and almost 6% have never married. In British Columbia "relatively small percentages of seniors have never been married" (Northcott & Milliken, 1998, p.52). In 1996, 4.2% of women in each the three cohort groups between 70 and 84 were never married

(Northcott & Milliken, 1998 p.53). Statistics Canada (1994) indicates that 57.4% of Canadian women over 65 years of age, and 22.7% of Canadian men over 65 are either single, divorced or widowed (Elliott 1996). Of these, 7.7% women and 6.9% men are single. As the total number of seniors will grow as the baby boomers age, it is inevitable that the percentages of single, divorced, widowed and childless seniors will grow. Given these statistics, I believe it erroneous to concentrate on the role of caregivers in the care of seniors to the exclusion of single, childless seniors.

A review of current demographics in regard to marital status and children, showed an eclectic variety of meanings for the term "single". It can indicate never married or ever single; it can include those who were divorced or widowed; and it can include those openly gay or lesbian. For much research the numbers of those people who are single are considered not statistically significant and as such are often ignored, or put together with widowed, divorced or separated seniors. It is not clear at present how many seniors there are who have either lived common-law, or cohabited with a person of either sex during their lives. Given the lifestyles of today's baby boomers, this could be a significant factor as we move into the new millennium. These lifestyles include on one hand a greater number of divorces and remarriage; and more acceptance and openness of lesbian/gay relationships; on the other hand, a decrease of people choosing marriage and/or parenthood. Thus, the numbers who have an adult partner, or children to help care and advocate for them is uncertain. What is significant is that in British

Columbia 42.5% of senior women over 75 years of age live alone (Northcott & Milliken, 1998).

Another change over the last few decades is the role of the single, never married woman. Historically there was the expectation that she would be the person to stay at home and look after elderly parents. As Finch, (1989) states:

> even when women do remain unmarried we cannot expect necessarily that they will behave as single women did in the past. Many will have successful and high status careers... [and] very few will have remained in the parental home and dependent upon parental resources (p.103)

Interestingly little is written about these women when they become old and needing care.

These different interpretations of "single", and the lack of information about lives and kin support of single people brought up another interesting point. There is a tendency to forget that seniors are not created at age 65 or older. The reality of those previous years is frequently ignored. However, they are years of living a full life, with its inherent experiences, choices, challenges, barriers, successes, failures and disappointments. They are also the years that help to define the context of the latter or last years of life. It is only in the more current feminist literature (Aronson, 1998, 2000) that the combined effects of this lifetime are considered. Finch & Mason (1993) also pose the question "how can we understand the processes through which people create and make sense of their

own lives, yet do so within constraints which they have little or no power to alter?" (p.173).

Decision Making Processes

The process of decision-making is not simple. There are several definitions of decision-making. Harris (1998) describes the process as "the study of identifying and choosing alternatives based on the values and preferences of the decision maker " (p.1). There are theories on both decision-making as a choice and on the process of how a decision is made. For example, Low-Beer (1995) states that "chaos theory and fuzzy logic attempt to deal with the randomness of human decisions and the messy way we draw our inferences" (p.148). Prospect Theory "assumes that decision making is divided into two phases – editing and evaluation" (Maule & Svenson, 1993, p.11). There are also riskless and risky decisions. Riskless decisions are defined as those where the various outcomes are known, while risky decisions are those with probabilities of outcomes, but none of which are known (Maule & Svenson, 1993).

Work done by Bandura (1986) and McDonald-Miszcak (1995) found that emotions are an integral part of any decision making. They clearly showed that a person's emotional state impacts their confidence in themselves and consequently their abilities to make decisions. Deciding where and how to live is for most of us an emotional as well as a practical decision. For senior women the decision is perhaps more complex as physical frailty and an increased need for support is added to the usual factors of cost, preference and options.

What is clear however is that human decision making is usually unique to an individual, follows different paths and can have different results. It is difficult to generalize or isolate the process from its environment or the important elements to the decision. For instance the decision of what to eat for breakfast is unlikely to be as important as whether to have recommended surgery. Regardless of approach, many factors have to be taken into consideration, such as risk, choice, stress, time-constraints and age or previous experience of the decision maker.

"A person has a choice to make, only when he has options to choose from" (Schick, 1997 p.8) appears an obvious concept, yet one that is frequently ignored. From the research by Evans (1998), Aronson (1998) and others it is apparent that several factors such as poverty, health and social support affect the decision making process, by limiting or negating the range of available options. Another is that of other "kin support", where family responsibilities and non-decisions have evolved over time. Finch and Mason (1993) describe these non-decisions as part of "the process of reaching an understanding about family responsibilities without either open discussion or any party having formed a clear intention, in so far as we can tell" (p.74).

In studies on friendship and support, Coyle (1997) found friendships of older women, particularly those who have never married, to be a significant factor in being able to remain independent yet connected to their communities. She described these friendships as encompassing both emotional support (talking and recreational activities) and instrumental support, such as transportation and shopping, particularly during illness.

Health of Senior Women and Health Care Provision

While most people suffer health problems requiring medical attention as they age, aging is not a health issue, but a time of life with many complex issues. Yet health is important. The Canadian Institute for Health broadly defines health (as cited in CHR Seniors Health Profile, 1998) as including: environmental context, individual capacity and coping skills, personal health practices, and health services. Despite this broad definition, the government, through the *Canada Health Act*, (1984) is only obliged to provide certain health services.

There are hints in B.C. policy documents that home and health need to be linked. For example: the British Columbia, "Closer to Home", (1991) policy framework and the Capital Health Region's "Home is where the Health Is" (1998) report, and the B.C. Continuing Care Service Provider Handbook (1992), which outlines to providers that long term care facilities should have as "home-like environment" as possible. These are names of reports or terms used frequently in the delivery of British Columbia health care. There is a blurring of the lines between recognized health care delivery as laid out in the *Canada Health Act* (1984) and the expectations we have of the Long Term Care delivery system in B.C. But the *Canada Health Act* is silent on the issue of home. It addresses only medical care as provided by a physician or within a hospital environment. It does not take into consideration any other services that may be required or preferred, particularly as people become older and frailer, such as primary services like home support or adult day centres, both of which support people to remain living in their own homes. It also does not include residential long-term care facilities.

In British Columbia continuing care "means the provision of health care services, designated by the Minister, to a person with an acute or chronic illness or disability that does not require admission to a hospital as defined in section 1 of the *Hospital Act*, or to a person with a frailty" (B.C. *Continuing Care Act*, 1989). It should be noted that unlike universal health care, "the minister shall determine the persons who will receive continuing care for which a payment will be made under this Act" (B.C. *Continuing Care Act*, 1989, Sec.3 (1)). This means there is no automatic or universal entitlement to continuing care services. Rather the Minister delegates professionals to assess eligibility and determine if, and how much, care will be provided by the state.

The combination of diminished resources and tightening of eligibility requirements for continuing care, along with increases in the senior population, has resulted in a rapid growth in private agencies, facilities and congregate housing options. Only those services authorized by Government receive any subsidy. Consumers pay the full costs of private care and housing. Those who are unable to afford the private care option may receive subsidized help from government-funded services. There are many services provided by the B.C. government: home support, adult day centres, facility care and respite care. However, they are all subject to the limitations of continuing care and strict eligibility requirements.

Besides restrictions on eligibility for subsidies, the range of continuing care services and the assessment to this service are based on a medical model of care. This model uses a person's disease as a basis for service, rather than how they

themselves manage the disease and the support they need to manage to a level acceptable to them. This medical approach to health and housing permeates all aspects of working with senior women. For example, the "Continuing Care Division will identify the designated continuing care services which it wishes to purchase from the Homemaker Agency on behalf of each client and will identify the involvement of other agencies" (B.C. Service Provider Handbook (1992), Sec. 5.A p.1). The philosophy of the Continuing Care Division is "to supplement and complement (but not replace) care provided by individuals, families and communities" (B.C. Service Provider Handbook, 1992, Number 1A p.3). Therefore service is often provided first for the physical care of a person, which is clearly articulated in the mission statement of health care services. Other services are negotiated by the client and their families, and often paid for privately or on a sliding scale.

Although the voices of seniors are muted in much of the policy discourse, the effects of the policy and practices on seniors are starting to be known. Diamond (1986) in his early critique of nursing home care in the U.S. speaks clearly of the medically oriented impersonal care provided to seniors:

> This creation of the impersonal mode of patienthood is accelerating (and) will be derived in a purely mechanical fashion, based on what is called activities of daily living, the components of which are the time it takes to feed, transport, and toilet any given patient. The patient as a subject in this process is further

> obliterated, becoming the acted upon, encased in a discourse of crude behaviorism (p.1289).

This impersonal approach to senior care is also prevalent in community health care services in Canada. Neysmith (2000) shows that community care restructuring is embedded in contemporary policy. The result of this is a focus on the "management of low cost, standardized services [which] eclipses elder care recipients and, in so doing, assigns them very passive and powerless identities" (p.54). In contrast, when Aronson (2000) described the success of one paid caregiving encounter, the senior's "success hinged on the fact that she had the capacity (cognitively, socially) to establish a positive relationship with her care provider who, simultaneously, had the capacity to personalize her work and was willing to go beyond the call of duty". This speaks of something beyond what the health care system provides, which is care to the total person. A person does not just have a physical presence, but a spiritual, cognitive, emotional and historical presence, all of which must be respected

Limitations of the Existing Research

In reviewing the literature there was information on decision making, on the services available to support seniors in their own homes and the burgeoning senior population. Little spoke to what the seniors themselves feel they needed in the way of support. More significantly there was little from the perspective of senior women themselves on deciding where to live in later years, especially older women without partners or children.

This meant there was a limited range of literature I could use as a reference for my personal planning. On a professional level, there were very few sources to draw on in order to confirm or challenge the delivery of community support service options for senior women without kin. It is my intent in this study to address some of these gaps in knowledge.

CHAPTER II

METHODOLOGY

The purpose of the study was to explore and understand the lived experiences of senior (age 75+) single women as they decide where to live in the later part of their lives. In particular the study focused on those who are in failing health and have no kin support.

Design and Rationale

A phenomenological approach was used in this research. Phenomenology is based in part on the work of the German philosopher, Edmund H. Husserl who defined it as the study of how people describe things and experience them through their senses (as cited in Patton, 1990, p.69). For this study I used the approach taken by Heidegger whose view was that "humans are constituted by the world (set of relationships, culture, practices, customs) and situated within different possibilities for creating meaning" (as cited in Haylor, 1996, p.84). By exploring the structures of consciousness (Polkinghorne, 1989) of the experience with the women in the study, I was looking to hear from them what they considered as meaningful in their decision-making regarding "home".

Inherent in a phenomenological study are two major components: 1) the description of the experience, and 2) the interpretation of that experience. As Van Manen (1997) states: "Phenomenological research is the study of lived experience" (p.9) and it uses a systematic approach to uncover and describe the internal meaning structures of lived experience.

Reflexivity

As a researcher it was important to listen to women's stories and understand them. Yet I was an integral part of the research process.

The research question was chosen to assist me in my work as a community health provider. The questions were developed to help me understand more about the elderly women's experience of deciding where to live. This understanding was important as I am in a position to influence policy and practice within local health care service provision particularly in the area of providing support programs which assist people to remain living in their own homes. I wanted to be sure that policy and practice decisions reflected what senior women themselves needed in order to remain living in their own homes.

Throughout the research process I was aware that I was drawn more to the stories the women had to tell and the implications for service delivery than any other part of the process. In reflecting on this, I realized that what was important to me through the process of the research, was to learn more from the women and how this learning may influence my practice. For example, my assumption prior to the research was that all seniors wanted to remain living in their current location; yet I had not looked at why I was making that assumption. By unpacking that assumption, I started to see how my desire to stay where I was, influenced what I was doing at work and what I was looking for in the stories. As I listened to the women I heard different voices from my own, and was able to reflect on what they were struggling with in their decision -making.

A part of phenomenological research is for the researcher to set aside his or her own preconceived assumptions, as much as is humanly possible, in order to more clearly understand the phenomena as experienced by the participants in the study (Cresswell, 1998). Yet as I was drawn to the women's stories, in particular as they related to health care provision, I found that I was comparing their stories to current health care services in the region. By keeping a reflexive journal throughout the research, I was able to honour my own experiences and reactions, and at the same time determine the similarities and differences of such experiences with that of the participants (Banister, 1999). The significance of the variations also needed examination (van Manen, 1997).

Participant Selection Criteria

There were six basic criteria for participants to meet in order to participate in the study:

1. They were 75 years or older
2. They were women living alone, single now, never married, widowed or divorced
3. They had no available kin support
4. They were in failing health
5. They were currently experiencing making the decision of where to live for the later part of their lives
6. They were able to articulate this experience through a working knowledge of spoken English.

Finding enough women for the study proved difficult. Nine women came forward in a five-month period. One woman chose not to participate. Of the

remaining eight, three of the women did not meet all the criteria. One was living with her daughter, was under 75 years of age, and was in good health. Therefore she did not participate, as she did not meet four of the six criteria. Of the eight remaining, two had children but in both cases the children lived in another province and were not able to provide support on a day-to-day basis. Because of the difficulties in finding women for the study, the two women who did have children were included in the study as they met the other criteria.

Fortunately, in the analysis of the seven interviews, no new information on the phenomena under study emerged after seven interviews (Cresswell, 1998). That is saturation of concepts and themes was reached with the volunteer sample.

I wanted to find participants from a range of socio-economic backgrounds and women with different health statuses. From an earlier study (McNulty, 1998), I learned that the experiences were different for senior women, and for different reasons. For this thesis I wanted to select participants who reflected different perspectives and backgrounds from the women in the pilot study. By doing so, I was looking to obtain a deeper understanding of the phenomenon under question. This current research was also an attempt to document the diversity and understand the variation between women's stories (Patton, 1990).

The seven participants chosen for the study had various health challenges. For example, one woman had chronic Rheumatoid Arthritis, one was hearing impaired, one had a heart condition, one was recovering from a recent hospitalization and two stated they were reasonably healthy. All the women classified themselves as being in the middle class/middle income strata of society;

none classed themselves as either wealthy or poor. The town where the participants were drawn from is a predominantly white middle class community, with a reported percentage of 80.5% of women and 94.7% of men over 75 years of age living above the poverty line (Reitsma-Street et.al., 2000). Although I had hoped to find participants from different socio-economic backgrounds, those who volunteered to participate were women in the middle class/middle income strata of society. No interviews with women from poor or rich backgrounds meant the study cannot examine the diversity of constraints with options that women below the poverty line face, or the expectations with options encountered by wealthy ones.

Recruitment Procedures

Participants were accessed through two seniors' organizations in a local western Canadian community. I met with representatives from each of these organizations to explain my research and asked for their assistance in finding participants to the study. All the organizations agreed to distribute a letter from me that described the research to their members (Appendix A).

Participants were asked to contact me direct as none of the organizations felt it appropriate for them to know of a person's participation. The organizations did agree to vouch for me should any of their members express concerns to them about either the research or myself.

Eight women came forward from these recruitment procedures; and six participated. Three of the women asked for a preliminary meeting, the other five made the decision on participation after a telephone conversation in which I

described the research and their participation more fully. Thus of the nine coming forward from recruitment initiatives through the organizations, six women volunteered to be part of the study. Another woman, the seventh, was recruited in a different manner. I met this woman while completing an earlier study (McNulty, 1998). She met the criteria of the thesis so I asked her to participate, and she agreed.

In the proposal for the research I used terms such as "having no kin support" or "in the process of deciding where to live". In discussions with the two senior's organizations, I was advised that their members might not understand some of the terms. Therefore I changed "no kin support" to "having no children" which was felt to be more understandable. In the information letter I used the term "considering a move from their current home", rather than "in the process of deciding where to live". For me, in a letter asking people for their assistance, I felt that considering a move was a more descriptive and less definitive term than deciding where to live.

The women in the study ranged in age from 75 to 97. They all classed themselves in the middle-income strata of society, lived alone and were all able to speak English well. There was some diversity in health status, from reasonably healthy to quite debilitated.

Ethical Issues

Approval for the study was obtained through the University of Victoria Human Research Ethics Committee in September 1999. All seven women who participated in the study signed a consent form (Appendix B). This consent form

was presented to them soon after we first met and was signed prior to the interview beginning. This consent form included a section on confidentiality of the participants and who would have access to the data. Access to the data would be restricted to the thesis supervisor and myself. All seven women asked that I give them a different name for the research.

Few risk factors were anticipated. Yet because deciding where to live could be an emotional time, I invited the participants to call me should they feel any discomfort after the interview was over and I had left. When I returned the transcripts I again invited them to call if they were experiencing any discomfort. Once the research is completed I intend to provide each participant with a copy of the final document. When I contact them I shall again offer support should they have any lingering discomfort.

Interviewing the Women

I used one major data collection tool - individual interviews. The interview was a qualitative one exploring how people understand their world, their life, and about making the decision on where to live (Kvale, 1996). I drew up a set of questions to structure and give focus to the interview (Patton, 1990). I initially tested these questions with two colleagues who recommended changes. I then gave the questions to two senior women; one of whom is still married, the other single. While both women provided further recommendations on the questions, it was interesting that the woman who is still married was unable to answer some of the questions. She stated that the questions were better asked of someone who is widowed rather than someone who had to consider a husband in any decisions

about living arrangements. I accepted this as a further indication that the questions were suitable for single senior women. The single woman who assisted with this final check of the questions had been a participant in the pilot study two years previously. She was most helpful in answering the questions in their final form, and was able to assist me to practice the probing questions in the seven major interviews. The four major questions were:

1. Describe your current living situation and what is prompting you to consider a change?
2. Where do you see yourself living in the future?
3. Talk about how you are making the decision about future living arrangements.
4. What is it like to live through deciding these changes? (Appendix C).

As anticipated, I found the participants' stories also structured the interview (Sorrell & Redmond, 1995). I started with a set of questions and probes and soon became immersed in the women's stories. Consequently I asked many other questions as the interviews progressed. Some were for clarification; others asked the women to expand on topics they talked about. For example when one woman was discussing the feasibility of various options open to her, I asked "What sort of things affect your sense of what's possible or not possible?"

For this study, five of the interviews were conducted in the women's homes; the other two at different senior's centres. All interviews were audiotape recorded and lasted between 1 and 1½ hours. These interviews were then transcribed and returned to the participants for further comments and input. This was done for

two reasons. 1) to ensure that the transcription was correct and no errors had been made and 2) to ensure that the participants were comfortable in what they said. When I returned the transcripts to the participants I confirmed they remained agreeable to the content being used for the analysis (Kvale, 1996). Only one participant provided more information by correcting three of her responses to questions. These corrections were to change the length of time she received Home Care, a place name, and the name of an organization.

My own observations during the interview were written down immediately following the interview. These included observations on the women's home, in particular the care of the home, the memorabilia and the comfort level of each woman as she moved around her home and answered my questions. In my professional life I used to spend a great deal of time going into people's homes and interviewing them for various services. I found during the interviews that I instinctively continued to do this. Rather than having my observations cloud the interview and consequently my understanding of the women's stories, I wrote them down in memo form in my journal for use during the data analysis.

For example, moving at any age is often accompanied by decisions of what to take, leave or change to fit the new abode. While not necessarily an integral part of the key decision of where to live, it certainly has a significant role in the actual move. In many of the interviews I found myself wondering about the physical act of moving for these women. The following quote helped to contextualize the difficulties of moving and the possible importance of attachment to material things collected during their lives.

Example from Personal Observation Memo:

> As I sat in her apartment, I couldn't help but think of the incredible amount of work it would take for her to move out. It was just full of beautiful mementos of her travels around the world. Much of the furniture was big and likely heavy. Although I was fascinated by everything, feeling I was almost on a mini world tour, it was so much of a part of her and her story as she was telling it. Almost as if it gave a visual history as well as the verbal she was telling me. But with that came attachment. Those articles were reminders of times past and I wondered how she would feel if she had to give them up. From what she was telling me she was looking to move to something smaller, which by definition meant she would have to downsize. She had spoken of giving things to her daughter and then being distressed at how they had been spoiled...I wonder how easy it would be to give things up, and how she would feel if they weren't kept as beautifully as she had done.

Data Analysis

There are several steps used in the analysis stage of phenomenological research. Most follow similar basic steps, such as bracketing, transcription and theming. For this research I chose a combination of the methods laid out by Hycner (1985) and Colaizzi (1978).

Prior to reading the transcribed interviews I listed as many of my preconceptions as I was aware of. For example, I didn't think there were many options open to the women. This led me to further acknowledge other assumptions and beliefs were driving this process. To ensure these beliefs and assumptions were openly acknowledged I kept a personal journal. This allowed me to record my reactions to the interviews and my reflections on the process. As Banister (1999) described, this provided me with a way to honour my responses, while at the same time "provide a venue by which I could explore and critically reflect on my responses" (p.10). As I was engaged in the analysis process it was

crucial that I acknowledge the ways in which such written reflections influenced my analysis process and final interpretation. One example of an assumption that was evident at the start of the research was my expectation that choosing to live somewhere different is a difficult and emotional decision. For me to make this decision right now would be traumatic given my attachment to my present home. Yet I had to acknowledge that not everyone would experience that trauma. In fact, one woman openly acknowledged she would be glad when the decision was made and she just wanted to get the whole thing over with. To capture my journey, while staying focused on the women's stories I wrote this entry:

Excerpt from my Reflexive Journal:

> The more I get into this the more I realize how much of my value system and personal choice is that people shouldn't have to move if they don't want to. I have worked hard to create the home I have now, despite many personal setbacks and difficulties to do so. I can't envisage moving, and if I have to move because my health fails, then wow. Not only will I have the adapting/adjusting stuff of illness/loss whatever, I'll have my nest taken away.
> Not only that, at work the programs I'm involved with have as a primary purpose/mission "to support people in their own home" some add "for as long as is practically possible" however that is described in the different programs. So it is almost as if my personal stuff and my work stuff are joined at the hip in some way.
> I need to keep that in mind and not let this colour or cloud the research on other women's stories – I have to keep reminding myself that it isn't my story but theirs.

When I started the analysis, the journal was also the place where I started to really look at the process of the analysis and how much I was looking for my own story in the women's. As shown in the following excerpt, I also used the journal as a way to document my own journey, to help in the process of discovering the

meaning of the data. By clearly and openly acknowledging my journey I was able to provide clarity for myself and examine how my own experiences actually did influence the data analysis. I also found it a way to ensure that my thoughts were not clouding the women's stories (Banister, 1999; McKenzie, 1999). So for example, in this excerpt from my journal I comment on how quickly I jumped through the analysis, and how that speed created problems in staying close to the women's interviews.

Excerpt from Reflexive Journal

> So I took the first interview, marked everything out that I thought relevant, did the same with the next two, then started to try and find themes... and the whole thing took about an hour/hour and a half. And – surprise – I found exactly what I was looking for.. finance and lack of options being the two major difficulties encountered by these women. Couldn't understand why everyone thought the analysis so tough – until I remembered Pat's work.
>
> So – back I went again and started to try looking at the data differently.
>
> Yet I wonder how often when trying to look at something, particularly at work, I do this "immediacy" type of analysis? There often isn't the time in large organizations to really analyse information received. Deadlines are an inevitable part of doing business – most are tight and often have to be met within competing priorities. In particular I'm thinking of those in which we try and hear the voices or respond to client needs.
>
> Do I, as a practitioner, respond/hear best to that which I'm looking for? Or do I/can I take the time to dig a little further and maybe try and find the responses I'm not wanting to hear or not looking for?? Maybe my irritation at the length of this process is because it runs counter to the processes I am involved with on a daily basis?

After all the interviews were completed and transcribed, I read through them in their entirety to obtain a sense of what the participants said. Once this was completed, I returned to the list where I had written down my reactions. These had been done either during the interviews or upon reflection afterwards and were

primarily overall concepts of what I thought I heard, rather than verbatim transcription.

After the transcriptions were complete, I listened to each tape and read each transcription in its entirety. This gave me a "sense of the whole" (Hycner, 1985, p. 281) and I acquired "a feeling for [the data], a making sense out of them" (Colaizzi, 1978, p. 59). I continued to read the data and listen to the tapes to start delineating units of meaning; I developed a three-column approach to making notes, illustrated in Table 1 on the next page. Column One is an excerpt from a transcription with the meaning units underlined. I went through each transcript and underlined significant words, phrases or non-verbal communication. Hycner (1985) defines a unit of meaning to be "that which expresses a unique and coherent meaning, (irrespective of the research question) clearly differentiated from that which precedes and follows" (p.284). Column Two includes my codes, or words of meaning. To ensure I continued to capture my own comments and assumptions, I wrote reactions in the third column on the same page. The three columns as illustrated in Table 1 captures a lengthy process that I had to repeat several times before I was comfortable that I had extrapolated all possible meaning units from the data.

Table One: Starting to Find Meaning Units

Column 1	Column 2	Column 3
Interview Transcripts with meaning Units underlined	My names of Meaning Units	My Reactions
And my place is comfortable[1], but it's large[2]. And I like it. I love it. But I can't do[3] everything I want to. I have solved[4] this a little by having help[5], but it's expensive[6]. But that in part is a help[7]. But um, my health isn't that great[8], and when I can't do something[9], I have my neighbour; she's just a godsend[10]. When I fell in January, I told you[11], she brought me soup, she came in and she still checks on me every day, but she has a home overseas[13]. And I can't live my whole life thinking she's going to be here for me[14]. She's almost as old as I am. Not quite[15]. And she's very active. And she will pick up things for[16] me. But when she goes away[17], then I'm lost again. And I'm worried[18] about things I can't do[20]. And also, now I need new windows[21], and that's a big expense because I have a lot of windows. And um, its' going to take money[22] to make the new windows, but I should put it in[23], but its' expensive and it's a hassle[24].	1. description 2. preference 3. restrictions 4. success 5. paid help 6. cost/finance 7. health 8. restriction 9. neighbours 10. accident 11. practical support 12. comfort 13. restrictions 14. description 15. comparison 16. help 17. helplessness 18. worry 19. restrictions 20. maintenance 21. cost/finance 22. money 23. cost 24. effort	Doesn't want to move. Regret at changes Used to be able to afford help/do it herself, lived a lifestyle where help came with her husband's job overseas – lifestyle change How did she feel about help from neighbour? Grateful/resentful or a combination? Resentful neighbour about same age and able to do more – regrets? Never thought about home maintenance – I know it's a worry I live with. Cost ability, importance, relevance

I then reviewed the general meaning units with the research questions. Those meaning units that were not relevant to the research question were ignored. For example, one of the women I interviewed, Geraldine described her beliefs of the cultural similarities of countries on the same continent. While this information told me a little more about her belief system, it did not add to the research question of deciding where to live.

The next step was to cluster the remaining general meaning units into relevant meaning. Both Colaizzi (1978) and Hycner (1985) described this process as being involved in that ineffable thing known as creative insight. When this was completed I was ready to determine themes from the clusters of meaning. I did this by writing all my names of meaning units onto post-it notes. I then started to group the ones I felt belonged together on flip chart paper. For several days I moved the post-it notes around until I was comfortable that the themes I started to see became clearer and more certain in my mind. I then used the same process to group the themes into major themes. Table 2 illustrates the result of this two-step process.

In the left hand column the words of the women transcribed from the interviews are placed, while the second column clusters my words of these meaning units together, using my codes words like worry, money, helplessness etc. The last two columns illustrate themes that transform the cluster of meaning unit codes into large ideas. In Table 2 the themes of fear and change are all aspects of a major theme I call "emotional responses to situation".

Table 2: Example of meaning units clustered into relevant meaning.

ORIGINAL UNIT OF MEANING IN THE DATA	CLUSTER OF MEANING UNITS	THEMES	MAJOR THEMES
Worried about things can't do	Worry		
That's how I live, but then I get scared, what if I can't	Scared	Fear	EMOTIONAL
Uncertainty makes me fearful, the not knowing what is going to happen	Uncertain Not knowing Afraid	Change	RESPONSE TO SITUATION
I'm afraid of moving What if I lose control of my mind	Fear of future change/losing control		

The final step of the analysis was to write an exhaustive description (Colaizzi, 1978) on each of the central themes of the research topic. The four central themes that will be described in the next chapter were:

1. **Practical Realities**
2. **Supports and Connectedness to Others**
3. **Ways of Understanding their Situation**
4. **Responses to their Situation**

Credibility and Study Limitations

Throughout the research process I used several methods to ensure accuracy of the findings. First I sent the transcriptions back to the participants for verification of content. Only one person made comments or changes. Second, I was able to check with one participant, who volunteered to comment on my tentative interpretation of her story. She was a woman I came into contact with frequently and as part of one conversation she asked how the thesis was coming along. When I told her I was in the process of doing the analysis, she showed interest in seeing what I had "said about her". So, although not in my original plan or ethics review, I took the opportunity to check if I was at least on track. She did agree with what I had done and said she found it very interesting.

Once all the interviews were analyzed and I started to find common themes in the data, I asked two colleagues who work with seniors to comment on the findings. Based on their experience they concurred with what I had found, which made the meanings congruent with their experience (Lincoln and Guba 1998).

To add further credibility to the findings I looked through my journal and the observations I had made through the interviews. The journal was used as a check that I had not concentrated on what I was hoping to find. By identifying and clarifying my own thoughts in the journal, I was able to ensure that I had not transferred anything to the findings, unless it was clearly evident in the data. For example, the excerpt from the observation memo (p. 27) spoke to my thoughts on the amount of work it would take to move and the emotional upheaval of getting rid of some of their possessions. In the data several women talked about the huge

task of getting rid of their possessions to move to somewhere smaller. They described the physical necessity of arranging for the move as well as the emotional ties they have to some of their possessions.

It should be noted that given the small sample size and the similarities of the women, that to generalize these findings (Lincoln and Guba 1998), is not possible. The stories of these women and the findings of the research can only be said to be representative of these seven women and cannot be transferred to the general population of senior women over 75 deciding where to live for the later part of their lives.

CHAPTER III

FINDINGS

At the start of this research based on my own experience, moving and deciding where to live is rarely simple at any stage of life. From my experience working with seniors for many years I learned that as we age, different issues arise; many of which are new experiences, with decisions to be made alone, possibly for the first time. The decision making process is complex, particularly when the person involved is cognitively intact and retains some control in her own life. Yet many relocation issues remain the same throughout the life span, such as location, cost, preference etc. None of these can be taken in isolation of the others. Although I was trying to understand the experience of deciding, I could not do this in isolation of these issues. But it was apparent there was something more influencing the process. The most striking aspect was that each of the women was resisting moving.

The Women Who Participated in the Study

The seven women I interviewed ranged in age from 75 to 92. They lived in either their own condominiums or rental apartments. Apart from one woman, all had lived in houses prior to this. They spoke of when they downsized from a house and of wanting to leave behind the work of a house and garden. However, they all wanted to continue looking after themselves preferably in their present homes. Each woman took pride in her independence and resisted any attempt to jeopardize her individual choice. The women wanted to stay living as they were

now, but because of age related deterioration in health, and concerns about inadequate support in their homes, they were contemplating other options. The seven women had various health challenges, including Rheumatoid Arthritis, hearing loss, a heart condition or recovering from a recent hospitalization.

Their resistance to moving affected how these women made or were making the decision on where to live in the later part of their lives. How they were resisting varied between the women, although there were similarities. These variations were based on their differences as people, their personal histories and individual responses to changed circumstances. The individuality of the women was apparent in each interview through preferences, values and most importantly, each woman's personal stories.

Margaret for example, was a woman in her mid eighties from the Prairies. She was very proud of both her British and Prairie heritage; taking pleasure from family contacts still in the "old country". She described the hardship of life on the prairies through the Depression and the impact of losing friends and loved ones in the Second World War. Shortly after, she chose to make a new life for herself and on her own moved out to Victoria. She talked of her career, both her early training in Manitoba and then her career in Victoria and the expectations that "in those days" women could have either a career or marriage and a family. Although she had opportunities for marriage, she talked of how she never regretted her choice of a career and the opportunities it provided her.

Josephine in contrast, was born and raised in Europe and did not come to Canada until her forties. She talked lovingly of the happy relationship she had

with her husband. She described how her life centered around their home, but how she also found time to volunteer to help other people, particularly children.

From analyzing the data four major themes emerged: (1) Practical Realities of Deciding Where to Live, (2) Supports and Connectedness to Others, (3) Ways of Understanding their Situation, and (4) Responses to their Situation. Each theme contained sub-themes. For example under the theme of Practical Realities of Deciding Where to live there were six sub-themes: Change in Health Status, Experience with the Health Care System, Affordable Options, Taking Care of Finances, Known Options and Limitations.

At the core of the decision-making, it was the women themselves who influenced the process: their histories, their values, their preferences and their response to the issues. In talking with the women it was usually the practical realities, and supports and connectedness they discussed first. Then as the interviews continued they emerged as individual people with rich histories and preferences that influenced their understanding of options and possible decisions. Yet there were themes common to each of the women. Hence the themes "Ways of Understanding their Situation" and "Responses to their Situation" emerged from exploring the individuality of the women. The themes of understanding and response were common to all the women. How they understood and responded illustrated the differences between the women as people. At the end of the chapter I will return to the striking point: their resistance to moving.

1. Practical Realities of Deciding Where to Live

Although not unique to the women in this study, moving requires looking at different options. What became clear was that there was a difference between the stories these women were telling, and experiences I have with moving. When I move I look at size of accommodation, cost, location, but do not look for other services. In all instances the women described looking for living accommodations that provided services to support them remaining independent, as well as meeting size, cost and location. These services varied from simple daily checks, to someone to call on when needed and finally, full personal care services. They were looking for supportive services because of a change in health status that was compromising or creating a change in their abilities to remain independent in their own home.

1.1 Change in health status:

Each of the seven women I interviewed described how it was a change in health status that was prompting them to consider moving. This was the main reason given in all cases for them experiencing the phenomena. Although it was not necessarily an imminent move, it was the driving factor in their planning for the future "when they could no longer manage". When asking each of them what they meant by manage, all referred to a change in abilities because of deteriorating health status. An inevitable part of the aging process is a change in how the body functions. This varies for everyone and these women were no exception. Their experiences and therefore the descriptions were different but the phenomena was the same.

As Mary described it: "I hate to say this, but as you get older, just the main fact of what happens to your body, you don't do what you used to. You know, if my body could keep up to my brain, it would be doing very well. But it can't". Florence who suffers with arthritis describes the changes:

> I feel like I just can't do what I used to do. I used to do all the things that I want done now.... But I can't do it all. I hurt. It's too much, but you have to pay for everything. The housekeeping and the shopping. But every little thing.

Elizabeth described "part of the aging process is to have the ailments...I'm tiring and I've got diabetes...when I was sent home from the hospital about a year ago, I went to pieces, because I was supposed to learn everything in one day and I couldn't, and I just fell apart".

Margaret talked about her experience of being healthy until she fell and broke her hip. She took some time to heal and so became quite isolated from her usual social contacts. "I just felt like my world had come to an end..and was very depressed – I had to learn to walk again, and to be with people again. You know dear, it's harder at my age" (85).

1.2 Experience with the health care system

As a result of their changing health status, each of the women had accessed the health care system. In addition, two had husband's whom they had looked after prior and after placement in a long-term care facility. Each of the women spoke of their experiences and related it to their decision-making process to remain at home. Part of their search was looking for support; at some point they

had looked to the health care system. One thing that struck me in talking with the women was the different experiences they had with the health care system. Those who had a good experience were more confident the health care system would be able to support them. "They were so good to me, so kind – you know [the nurse] really made me feel important and special – she told me they [adult day centre] were relying on me to attend to help them out. I realized that it was more for my good than theirs really, but she did make me feel special". (Margaret)

Jane talked about her positive experience of coming home after a hospital stay.

> This very nice lady came in and I told her, I don't know what I'm going to do when I get home. I said I have nobody there. So she said well you're obviously not going to be able to feed yourself at home. I'm going to call and have somebody come in for your supper tonight. A supervisor will come and you can tell her how much you think you need her. So that was fine. But that was only temporary. They would have come longer but by then I was strong enough that I could get out of my bed and I thought I don't want anybody, I was fine.

The women who did mention their doctors, did so very positively. One mentioned taking her family doctor little gifts, like cookies occasionally "just so he remembers me".

One woman, who is a retired nurse, spoke about the health care system she had worked in for so long. Her expectations were much different from the other

women. She seems to be starting to look at some of the choices governments are making in what care they can afford or *should* provide in the context of her own expectations of whether or not the health care system *should* support her at home. Certainly with the current health care constraints she raises points that are becoming part of the health care debate.

> I have a little difficulty with the health care system. You know, people are so spoiled. And I don't think there is a country in the world that can afford to finance the health care system as it is today. I don't think its' possible. And yet, you know, when it was first introduced in Saskatchewan, they couldn't possibly perceive the costs that would escalate. And the amazing advances in medical science. And the cost of heart transplants and all those amazing things that are wonderful. But they cost the earth. And there is no health care system that can finance it. Mr. Romanow... is working on a system of sort of changing the whole concept of the health system there. And I think it's the only solution. But you can't make changes without causing a lot of unrest.

Geraldine talked about her experiences with a home support worker who was sent to help her in her apartment.

> Well she obviously didn't even know how to make a bed.. I know that from being taught as a child and then I have St. John's Ambulance papers.. we learned it at school on how to look after a sick person. Well, I asked her to make my bed and I could teach

> her and oh, that's such a pain. At last I could not get in or out of my bed, it was all wrinkled with a bed that was just made. Five minutes it took her. And one day I got up at 6:00 and took that walk. And I walked around the bed and it took me 2.5 hours to make my bed. But I did it, you know. So now I tell them my friend does the laundry and I do my bed and my cooking.

Another woman talked about coming home from hospital with home support services and the number of different workers who came to help. This she found difficult but appreciated the help they could give her. The experience has left her wanting to find "someone to call on when I need her – someone who can just take over when I'm sick, but who knows my ways and I don't have to explain".

As the women talked of their different experiences with the health care system it was clear that all of them had only minimal expectations that the health care system would be able to provide the help they may need. They had no expectations of subsidized support except when nursing home care was necessary. Interestingly it was only when all other resources, options and financial resources were used up that nursing home placement was considered and then as a last resort.

1.3 Affordable and Known Options:

For most people the cost of shelter/accommodation is the most expensive purchase or monthly expenditure they are likely to make. These women were no different. Interestingly all the women asked if I knew of any living

accommodations they had not heard of. It was apparent they had all been looking at options and were continuing their quest to look at everything that is available.

Although all the women had some knowledge of different housing options, all except one asked me if I knew of other options they hadn't thought about. In the end, the options they knew of fell into four categories: subsidized help or private care in their own homes, living with family, congregate seniors housing or full nursing home placement options.

The extent of their knowledge about housing options varied between the women. Some had spent time visiting the different congregate care homes in the area. One talked about visiting a place with her son, or with others visiting a different congregate care home. She spoke of "visiting a lady there to have tea. And I was most distressed to find that we had tea, that a lot of the people, and I mean a lot of the people, were what I could term certainly intermediate care". Another talked about congregate care, which " has no facilities there if you get sick. I had an acquaintance, whose mother was there, and she broke her wrist and she had to leave. She could still keep her place if she paid for it but she couldn't be looked after there". This woman had visited several of the congregate care homes in the area and was doing her own comparisons: "And so, I think to myself if I was in a retirement home, and I know that I would have to go in one of the, like the ..... or the ....., I don't like ..... because it's too far away from everything. ..... House I like because it's right on the bus line. The bus stops at the corner and takes you downtown and stops to let you off there I thought that would have been handy". Another talked of one,

> where you can get a room, but you have to go down the hall to the bathroom, and I don't approve of that. But they are very nice, and you know, their living, I don't know if you've seen their living rooms, very very nice. And the dining room is nice. It would probably be all right if you didn't have to go down the hall to the bathroom.

Three of the women had experiences with long-term care facilities, two because their husbands were in placed there, one because of volunteering at a facility. All the women touched on facilities as an option, but only as a last resort and only when they felt they would need total care. One spoke of the waiting lists "And there is waiting lists, you see, for veterans or non-veterans". She was concerned that if she needed to go to a government subsidized facility she knew as a non-veteran she would be placed on the longer waiting list.

One woman talked of her mother being in care in another province and how wonderful it was. She described the home as a big old house with caring staff to took care of her mother. "It was a mansion, it wasn't just a building, you see. It was beautiful. The stair rails that went up the balconies that stretched and the rails came right off the balcony. The beautiful railing, it was lovely. But it wasn't efficient". She spoke of the care: "They had a nurse all the time, but to cook they had several maids. Of course they had to have maids for that house because they couldn't do it. They just sat outside and talked and crocheted. And then they used to have a lot of things provided for them, like we do here at some of the homes".

She then went on to contrast this experience with that of her husband who was placed in Extended Care. She spoke of her husband as a very gentle man who:

> Never raised a hand to anyone... But when he had Alzheimer's he bit one of the women nurse's aid over there, and punched another one. You know, and they told me that. I just looked and thought you're making it up. And I thought, no, you're not. What did they do, he didn't understand? I know one thing, he wouldn't swallow his food. Mother always told me to chew it 100 times and I haven't chewed it 100 times yet. But the nurse, you see, had worried that he would choke or something and she put her finger in his mouth... I thought they never should have told me about that. The nurse that he punched, I don't know why he did that. But I never asked. But he wasn't himself then anyway.

Another talked of her volunteer experiences; assisting residents get to their church services and helping with the choirs. All the women who knew of the facilities spoke of the esthetics of the place, rarely did I hear mention of the staff.

One obvious difference between the women who had children and those who did not was the choice of going to live with their children. The women I interviewed with children reflected on this option. Two were not prepared to move to be closer to their children.

Although Jane came from Ontario over twenty years ago, she felt she had grown apart from her friends, and she "can't see herself" moving back to be

nearer her son and friends. She commented, "my son still lives there and works for the Government there. He wants me there. But I can't see myself, we've lived apart these 25 years I'd say and he's lived on his own in his own place". Florence, who also had considered moving to her daughter's, spoke of a neighbour's experience:

> There was a widow up on the 5th floor, and when her husband died, she said, oh, I'm not staying here. I'm going to move back east and live with my daughter. So, everybody talked to her and said go for a visit, for a three-month visit. She was back within two months, and never mentioned it again. She said she couldn't live with her and it would never work out. So most of us go through the same thing. We can't rely on the children. And we can't get them into our lives. And they don't have room in their lives. And we accept it, I think, but it's hard. But it's hard. But we're so set in our ways and it would be very difficult to accept their priorities, because they are not the same as ours.

She went on to reflect how she'd talked to her daughter and had come to the realization that this was not an option for her either, so "we decided to just let it be". Another talked about moving in with her brother but acknowledged that "we get older and we get set in many ways. I know I am and so they probably would be too".

1.4 Taking care of Finances:

All the women spoke of the need to look after their finances. This fell into two categories: the lifetime experiences of taking care of finances, and then the acknowledgement that their current income and savings were a finite resource.

Margaret described how her father took her down to the bank with her very first pay packet. He insisted she open two bank accounts: one for daily use, the other for savings. She had to save five percent of her pay, from that first pay packet onwards. This became a life long habit, and resulted in seventy years of saving "for a rainy day". Interestingly she had recently accessed this account to purchase much-needed health care aides to enable her to remain in her own apartment with greater ease. Her comment was that "the rainy day is finally here"!

Florence and Geraldine looked at the finite realities of their savings in context of how long they would live and consequently need the money. As Florence described "well, number one, I could see myself in something smaller because financially I'll have to get something smaller to be able to pay for all the things that I can't do". She described the reality of having to take care of her finances: " I've got to protect it, I've got to take care of it because that's all there is. And if I don't, who will? I could be living on the street if I don't take care".

Geraldine is able to provide for herself. Her condo is paid for, leaving only daily living expenses to be found from what she terms "a basic pension". She talked about purchasing prepared food and how much she enjoys doing so. Yet she described, "how it is only $6 a meal, but it is only for the dinner – there is also

breakfast and lunch. Then I have other expenses that are far over my budget I have.. and I said I don't know how long I will live".

As a widow, Jane highlighted a challenge that many women of this generation face, that of having to learn late in life how to look after money. As she said:

> I can afford to pay for help. I can afford it. My husband had a good job and knew how to look after money. I don't. It's one of my real worries. I just try to follow what he did. But money is an awful problem. When you don't have it, it's worse I guess, because at least I know I can afford to go (to a congregate care facility).

Two participants in the study mentioned wanting to leave something to their children:

> But again, back to the financial part of it though, I do think that the security of you know, making sure I have enough, but then on the other hand I really want to leave my kids something. The house or something....and so do you worry about material things, or do you just say, well, what's important, but on the other hand they are the only value, they're the only estate I have. Not that they're that great or anything, but that's all you have.

Both women in the study who had children mentioned leaving something to their children. Another woman spoke of leaving something to her nephews who had been so good to her.

1.5 Limitations:

None of the women could be categorized as poor, or living below the poverty line. All were middle income, either because of their own private pensions, or because of their husband's pension benefits. Regardless, none had unlimited income and as a result some of the choices open to them were limited by finances. As Elizabeth described:

> I don't know what I'm going to do because I don't have the money to go into paid places. And I can't get into subsidized rental because I have too much money. And some people say, all right, sell your apartment and you have that income, but the income tax I'd be paying on that income deducts what I can pay for rent. It doesn't mean you've got that much income. You've got income minus all the tax, and you see it will be putting me in a much higher bracket. This [the condo] is probably worth $150,000. And people without thinking, I would say, oh, that's $150,000 interest. But it's not, it's $150,000 minus income tax, on you know, the interest, which brings it down automatically. So I'm one of the people who are in a real gap. So, no options are open to me.

This was particularly distressing to her, as she and her husband had moved here on their retirement for the cheaper real estate prices. They were no longer able to afford prices in the city, so believed the move would provide financial security for them. She felt they "were forced here. It's not as though we had a choice". Florence also mentioned the cost of real estate but in reverse. She had considered

moving closer to family but "it would cost a fortune. Their real estate is so high" in those cities.

Another option two of the women considered was moving to a congregate care facility "if I can afford it when that day comes". In both cases the women knew they could afford to live there now, but were concerned that they would not be able to manage the on-going costs over too many years "because of everything you have to pay for". It is common practice to charge for all the "extras" in a congregate care home. An example of an extra is if food needs to be cut up prior to serving, there is an additional cost to the person. Both the women looked at what extra services they may require. For example, one has bad arthritis in her hands and back. She knows some days she is unable to cut her food and so requires help. They were both uncertain of how long their money would last once these extra services became necessary. One did say that should their money run out "then the government would have to put me in a home".

Margaret talked about the amount of help she requires now to stay in her own home. She had been receiving extensive home support hours, but was recently told her hours were to be cut. She described how she had become reliant on the help, but now it was suggested her family do more to help her. With a close relationship with her nephew and his wife, she knew she could ask, but was reluctant to ask them to do more than they already did, "after all they also have their own parents to look after". She had recently started paying for additional private help so she would not burden her family.

but I just got the first month's bill and it was nearly $800... with my rent and groceries and everything else I need I just can't afford to live like this for long.... I'm going to have to go into a home. I'd really like to go to ....., but they charge extra for all the care I'd need, so it is out of the question. It'll have to be a home.

Another woman priced private home support and decided "I'm not going to get them through an agency because I can't afford it. I'll get somebody out in the community. Because a couple of the agency's cut is too big. I don't know why it's so big; I've got no idea. I've never run an agency. A lot of it is regulation".

It became clear in talking with the women that there were few options open to them. Even when they had taken prudent care of finances, most felt they could not afford the private congregate care homes on an on-going basis, two knew they couldn't afford them now. All felt that ultimately a long-term care subsidized nursing home would be their last, but only option. As one person said "well, would it be cheaper if they built, like the [congregate care home], but at a price range for ordinary people?"

2. Supports and Connectedness to Others:

All the women talked about times when their lives were different to what they are now. They spoke of the positive changes and the negative changes, particularly a deterioration of health status. As they spoke of the changes, their need and their history of friendships and connectedness to their community, it was clear that they were looking for support as one aspect of the decision of where to

live. This support was different from that provided by the formal systems. It was support from friends and the community.

All the women I interviewed spoke of their contact with other people. They all talked about old friends and the contrast to their current relationships. They all talked about their need for some support, be it emotional or practical assistance. And they all spoke of what it means to them now to live alone.

2.1 Ties to Old Friends:

All the women I spoke to had moved to this city from somewhere else in Canada. They are settled here and over the years made friends. Yet they all spoke of friends or relatives who knew them as they were growing up or in their earlier years. I was surprised at how many still kept in touch: some on a regular basis.

Jane described "a very dear friend that's been my lifelong friend, she lives over on the mainland. And I used to drive over to see her. But that Highway 99 now, frightens me to death. So I don't drive over anymore". She went on to talk about how they speak regularly on the $20 a month long distance calls. Three of the women spoke of the importance of having cheap rate long distance rates, particularly the $20 a month calls.

There appeared to be a comfort of keeping in touch with old friends and relatives "who knew me from my childhood" that was different to the local contacts they had now. There was a sense of full understanding of each other as people, built up over the years as they had grown up, moved away and aged.

"It's the history. And I can go there and say anything or do anything. We know what we've been through. And we went through the depression together". One woman described keeping in touch with her Prairie roots and visiting as "interesting and you know when I go back to the Prairies, which isn't very often, there's a nostalgia about it and even the air is different. And I just love that. It's just the whole atmosphere that I grew up with". One woman talked about the daily telephone contact she had with her sister; another about the weekly telephone calls to her brother in Ontario.

Two of the women had immigrated to Canada in their twenties. They both talked about the challenges of life in a new country. Because of my own experiences as an immigrant I was interested to hear how they still related to the "old country" as well as Canada. Elizabeth talked about her experience in these terms: "Well, what I find is that in Canada I'm English, and in England I'm Canadian. And you end up nowhere really".

Reflecting on her story along with the other women's stories, there was a connectedness with long-time friends with whom they were still in touch, that was different than the connectedness of friends of the last twenty or thirty years. It was evident in how they spoke of a long and shared history. I realized that these friendships had often been built from childhood, so this could be eighty years of friendship. They had experienced a depression, a world war, marriages, children, and deaths of spouses, families and in some cases children. These friends had literally grown up, matured and grown old together and as a result were a mirror image of each other's lives.

2.2 Shrinking Regular Social Supports:

Friends of the recent past were as important as long time friends but in a different way. It was here where I heard specifically of the losses in friendship brought about by death or aging and the impact it has on the women I interviewed. In all cases it described a shrinking social network that had been in place for most of their adult lives. They also spoke of the difficulties of replacing friendships because of lack of opportunities to socialize, some because of transportation difficulties, some because of a decrease in health status.

All of the women talked about the social supports they had in their own buildings. Those who had lived in the buildings for many years spoke of the differences between when they moved in and now. One talked of how the neighbours all used to be able to support each other but aging has changed their ability to now when:

> There are three deaf people right around me. There is a lot of... and we don't have the stamina. At the time we got the apartment there was, now we've all aged by 20 years. So I mean some of us have nursed sick husbands for months on end. We're tired. I would say aging weariness. Not lack of wanting to help.. So when you talk of neighbourly support, it depends on your age group. Now the gentleman across the hall brought my groceries for 18 years. Well, his license was taken, he can't drive because he can't see.

She also talked about her social network shrinking as old friends moved away to be nearer their families., and pointed out that as people stopped driving, it changed the group dynamics. She described as "the groups at the Seniors Centre are not there, if you lose one driver with three people, you lose four people".

Ruth described the environment in her apartment building as that of reciprocal support. "One thing about this building, it's not everyone is his brother's keeper, but each one of us has some kind of a support system. And we reciprocate". It was obvious this provided a comfort to her, both as a recipient of help and an opportunity to assist others that maintained her feelings of independence and control.

2.3 Working to Stay Connected:

Despite some obvious difficulties, staying connected in some way to the world outside was important for these women. Many used the telephone as a contact, most continued to get out as often as possible, sometimes daily and often just around their buildings. They described how walking around the neighbourhood made them feel connected. One talked about the location of her apartment, close to downtown and the government offices. From her second floor window "I can sit up in bed and watch people going to work, and the tourists wandering around. Even on bad days I have something to watch". Two continued to volunteer in the community. Three of the women spoke of clubs or societies they belong to or to speakers they had recently gone to hear. As Ruth described it "I involve myself in a lot of things, I never get lonely".

2.4 Being Alone:

At the same time as being connected, the women talked about their time of being alone. They clearly identified this as being very different from being lonely. What was significant is that either through a lifetime of living on their own, or having adjusted to living on their own, they seemed to value the time for contemplation or reading. I was reminded of an old gentleman I met in the community. For health reasons he was practically housebound. When I asked him if he was ever lonely, he replied by taking me to his bedroom and showing me a bookcase full of books that covered an entire wall of his room. His question to me was "How can I be lonely with all these old friends?"

Each of the women had books, newspapers and magazines in her home. Most spoke about the enjoyment they get from reading. "I do a lot of reading and I love reading about strong women. I get a lot of pleasure out of that. And I admire these women." Florence, who suffers from arthritis, is often in too much pain to go out. After recognizing she "was fighting with myself", she started to get in touch with her spiritual self. She talked openly about the books she read and how they are leading her to look more closely at how "when you were studying spirituality and the rest of it, so many of the things say that you control your body. It's all connected to your mind. And you bring on these diseases like arthritis". She is learning of the mind/body connection and "a lot of conflict between my body and mind and so much of it is spiritual. But I'm at peace with myself now, I don't worry about too much like I used to because I figure things happen for a reason".

Ruth said about her time alone, "I'm quite content to be alone. And I always have me, that's just the way I am. I don't get lonely". Two of the women talked about the times they did get lonely. They told me they went for a walk, read a book or telephoned an old friend to chat.

3. Ways of Understanding their Current Situation:

It seems obvious to state that each woman was different. Their stories were different and their experiences different. Yet they were all considering their changing health and wondering about whether to move and where. They were going through a similar process of things to consider in order to arrive at some decision. All the women were making decisions within the same context of failing health, financial considerations and support systems. Yet there was something else. After going through the transcripts over and over again, what came through with absolute clarity was that the individual decision was being made based on the woman's own values. This value system which most of us have developed over our lives is often the core of any decision we arrive at. These women were no different. It was these values or core of "where they live" as people that illustrate the differences between the women. It was this core value system that drove the differences in attitudes and responses to their situation.

Life is often complex and difficult to understand. As these women struggled to understand what was happening to them, the change in health status and how it was forcing them to look at moving when they really didn't want to, brought to the fore their personal histories. I started to see that the decision making process of where to live was making them look back, almost as a reference point to

decisions and events they had previously experienced. It was as if they were looking for answers within their own history and story. So their personal histories, life events, successes and regrets were an integral part of the decision-making process of where to live.

3.1 Personal History:

One of the most interesting aspects to me of talking with seniors is to hear their personal stories. The stories illustrate in a very unique way how much "ordinary people" have done in their lives: their achievements, their challenges, their regrets and their memories. As a health care provider I am often lulled into forgetting that seniors are not "clients/patients/residents" who become frail, or burdened with caregiver responsibilities. They are in fact people who are experiencing the latter part of life, with experiences of life that have made them who they are today. I got the sense of a lifetime's history talking to the women in this study. I could not fully understand their experiences of today without knowing something of their personal stories.

To find the similarities in these women's lives, without acknowledging the differences in their individual stories, would not honour and respect each of the women who participated in this study. Therefore, I have chosen to use five sub-themes in an attempt to capture a rich and full history of seven women's lives, who between them have lived over 600 years.

3.1a Life Events:

Every one of the women recalled something significant in her life. For Elizabeth it was the wonderful experiences she had in the Navy and how "the

Navy's played an enormous part in my life. I went into the Navy during the war and then I came out, then I came to Canada, and when I was in Toronto and a new immigrant, just out of the Navy I joined the Canadian Naval Association – and one of the ex-officers, a Canadian, had gotten me a good job, I'd have never got on my own. Without the Navy I wouldn't have met my husband. So the biggest influence in my life has been the navy".

Margaret talked of the fear of moving out to Victoria from Winnipeg on her own. She had been offered a good job in the telegraph office here and didn't feel she could pass on the opportunity, although it meant leaving everyone she knew behind.

Florence talked of her experiences in the depression and then the incredible opportunities she had to live overseas. Her apartment was full of wonderful things from the different countries she had lived in with her husband. She talked of the markets and bartering she did to purchase the items that now surround her. I could just see her "having seven horses one time in Europe. I used to ride and gallop along the ocean because they all had to be exercised, and, you know, it was wonderful".

Geraldine also talked of travel, but for her it was as an immigrant to Canada just after the war. She described coming from war torn Europe in her early forties. After the deprivations of living in an occupied country, she found it hard to adjust to the abundance of North America. What struck her most was Canadians' lack of appreciation for their wealth.

Mary experienced her husband's sudden death and how she dealt with it. "My husband dropped dead, you know. It's a terrible shock when it happens, but in the long run, he's lucky and I was lucky. No long illness and all that. He just dropped dead one day at work, he was just on his way home".

Ruth talked about the depression. She "was living with my family in Saskatchewan through the depression and the drought, which was very, very difficult. You have to live through it to know how hard it was. But my family moved to Alberta and they left me behind to finish high school. I stayed with my grandmother. And I finished high school. And then I worked on a farm as a mother's helper for a while and then went to train as a nurse". She also described her life as a clergyman's wife, in particular: the moving from parish to parish, the expectations of her as the minister's wife, both from the church and the congregation. One of her children was born with a disability that required extensive medical intervention. Sadly this child died when only a young adult.

Jane spoke of her early history. She talked of how her parents had left Canada and gone to England during the first world. She herself was born in England during the war, and recalls stories her mother told her of the Zeppelin's going over their home, dropping bombs close by. She described her life in Ontario raising two sons and moving here when her husband retired. She also talked of her experiences in taking care of her mother, then her husband. As she said, "I've lived through all kinds of things. We all build something up behind us".

3.1b Achievements:

In addition to the life events the women described, they all spoke of some special achievement they had either been recognized for, or felt pride in themselves. What I noticed was the change in body language and tone as they recounted these stories. They sat a bit straighter, they spoke glowingly when remembering happy times. I was also very struck that none of the women were bragging – just acknowledging for themselves, and maybe for me, a job well done. It was as if the uncertainties of the present were being grounded by a time when they felt they were successful and in control. That by doing so they felt more secure in their own abilities which could be transposed to the current decision-making time of where to live.

These achievements were different for each woman. One described being mentioned in a book written by a Professor on setting up home in the 1950's. Two took great pride in the care they had taken of their families, particularly through very troubled times. All of the women discussed community organizations they had belonged to, or still belong to. They described the work they did in these organizations and in two cases the very public recognition of their work. I felt very privileged to hear these women's stories. It helped me to know them better.

3.1c Regrets:

I have heard from many seniors over the years that it is far harder to live with regrets than memories. In talking with the women in this study, I found the same

thing. On the few occasions I did hear of regrets, I had the sense they were harder to talk about.

Elizabeth felt she and her husband made poor choices moving:

> Because of the housing. We made that mistake. He was, I didn't realize he was aging so fast, and we should have made a decision three years before we did. At least a financial decision. But we didn't, so we got landed in this high-rise, this high estate. And we got caught in the jam, we didn't see it coming and we weren't quick enough to do something while we could.

Geraldine regretted going into a "care place" four years ago. Many people felt it was time, but she just "hated it". However, in her nineties, she made the decision to move out again on her own – and feels she has been very successful! So she turned a regret into an achievement.

One of my favourite stories was from Mary. She is a very positive up-beat person who does not seem to let much get her down. She talked about adjusting to life living alone and the things she had done to help herself. "But you do miss having a roast. I love to have ham and potatoes, but to buy a ham would do me for 50 years! You know, you don't get roasts or hams or things like that".

Florence talked about learning to forgive herself. "I try not to have guilt about anything because the things I did back then, I forgive myself because I was a different person. And I'm a different person now. And why I have the guilt I don't know".

3.1d Contrast to Present:

As I was hearing and reading the stories, I could not help but compare their earlier lives with their current living situations. The adjustments life had forced them to make were incredible. We hear of the changes and the speed of change and advances in knowledge of the last hundred years. Yet talking to people who actually lived through these advances remains remarkable.

Margaret was a telegraph/telephone operator most of her working life. She went on to describe being at the senior's centre and experimenting with a computer. She put it in context by likening it to the excitement of electricity being installed in the telegraph office, the excitement of putting through a transatlantic telephone call for the first time and then her excitement of being shown "how to access the Internet". Her very dry comment to me was "I feel sorry for you girls having to learn all these new things and then keeping up!"

I listened to Florence describe her active life overseas, the travel, the frequent moves, exercising the horses along the ocean and "being able to do anything". I watched her now in, quite debilitated with arthritis, being terrified of managing to organize a move and thinking that eventually she would have to buy a motorized wheelchair to even get out of her condo. The two huge contrasts: married to a man who worked for the government and therefore had all the overseas moved arranged for them, to being on her own contemplating a move which she would have to complete alone; exercising her horses along a beach, to getting around in a wheelchair.

I listened to Elizabeth describe the very prestigious environment in which she worked and the people she had met through her work. She talked about "all his [husband] love and devotion". Then I see her now, a widow who is experiencing the loss of many close friends.

3.1e Preparation for Aging:

All the women described the necessity of planning for successful aging. And they all gave me specific information on things to consider in this preparation.

Elizabeth described how people think she's lucky in her condo and its' location. "And they don't understand. Luck's got nothing to do with it. It was a choice, it was a decision – and we planned for it".

Ruth talked about the different plans she has made should her health deteriorate any further. My daughter "always said I could go and live with her in Ontario if I wanted to. You know, but I hope I don't have to do that. But I know I can if I have to". After describing a lifetime of helping others she learned, "and pardon me, I think that living alone, we have to reach a point where you have to become almost selfish. Because you are, you have to look after yourself and you have no one else to do it for you. So you don't reach out, do things that are going to make it more hazardous to your ability [to look after yourself]".

All the women talked about one of two ways of preparing. One was the importance of getting affairs in order; the other was to get rid of as many possessions as possible before they became a burden. As I re-read how they described this, it was always presented as a learning opportunity for myself.

Knowing I too was single, Margaret kept stressing the importance of being "self sufficient".

> You know Vicki, you must get a lawyer and an accountant. It's important to have a doctor who knows you, but just as important to have a lawyer and an accountant who know exactly how you want your affairs handled. Look at me now – I've looked after myself all my life. Now I can't do it. So all I had to do was phone the lawyer and the accountant and they arranged everything so I don't have to worry. Now have you got a lawyer and an accountant – because you know, just because you do it all now, you have to have a will, you have to plan for the future. No one else is going to do it for you.

Mary also talked about the need for preparation.

> I've had a power of attorney and a lawyer draw up a consent for physical care in case my brain is gone, then somebody who knows what I want will see that this happens. And I've got a will and an executor, my funeral is all planned. Well, you might as well, its so much easier. We signed up with the BC Memorial when we first came to here. And we laughed and kidded about it and when my husband died, and they told me – the ambulance people – I said BC Memorial. And the next day, the man came and got me to sign something. And that was it. It really makes it easier for the person left, whoever it is.

Florence talked about all her beautiful things stored away and in drawers and how important they were to her at one time. "Do you know I sit here now and I think, oh, that will have to go. I'll start cleaning out those drawers. Yes, I'll get a box. And I'll do it all thoroughly in my head. But physically, I don't. But you know, I really have to start getting rid of some of the excess, it's becoming a burden".

3.2 Their Words about being Women, Aging and Society:

As I listened to the women talk, I started to wonder. They were all between 75 and 92 years of age. I wondered if they had been younger or another generation, whether any of their comments would have been different. Reading the transcripts it became more apparent that these women had internalized some of the societal norms of their generation. There were also indications of how seniors are sometimes regarded in present day society.

Because these women have lived such a rich and full life, there was a wealth of experience contained in their stories. To fully capture the variety there are five sub-themes to cover the women's words about being women, aging and society.

3.2a Product of their time:

The most transparent comment I heard was from Geraldine. She talked of reading a newspaper article describing how there are more women working than men. "And I said there should be a man. But the women take the place everywhere and they want equality with the men. It's not right".

Two of the women worried about their children's inheritance and were reluctant to use all their savings on themselves. One woman's children had

assured her they didn't want anything, but would rather she spend her money on herself. It was clear that she remained uncomfortable doing so.

All of the women had owned or continued to own their own homes. Three talked about the importance of this in their lives. All three talked of the struggle to own their own homes, particularly during the depression. It was interesting that they spoke of either their children or nieces and nephews who could not afford their own home. Elizabeth felt "she was very fortunate in owning the roof over my head. In our world today, the greatest security a woman has is owning the roof over her head". She then went on to say, "It's not a good thing when your young people can't afford housing. It's not a good thing socially or politically or any of it. It's the destabilizing of society".

Another described how "my father was Russian. When he came from the old country, the first thing was the mortgage. You have to have a house. Why would you pay rent? And then of course the depression. But first came the mortgage. And after that you worked from there. But that was instilled in me, you know, that you have to have real estate. But the kids don't see it, they'll never be able to have some".

Two women had never handled any of the family finances until after they were alone - one after her husband's death, one after divorce. It was through their comments that I realized that they did not go out of the home to work after their marriages. Florence told me "all the perks came with the [husband's] job. And I was never in control of my money or that. But everything was supplied for me. But now, when I'm having to take care of my own finances and you have to

pay for this and you have to pay for that and it seems so excessive. I guess inside me I'm still that little girl that didn't have anything [in the depression]". Another said, "I didn't know about taxes and bills and cheques and anything because I had never done it".

Hearing these statements as we spoke and reading them afterwards I felt some discomfort. It was only when I realized they illustrated thinking that was different from mine, and my generation, did it become clear that these women were of a different generation and as such lived through a time of different norms.

3.2b Gender Attitudes:

All the women spoke of a lifetime of providing care and support to others, particularly their families. Jane talked about having to look after her mother when her father died.

> As the girl I was expected to. And oddly enough I used to think how unfair it was of my brother not to even offer to pay anything to help look after mother. You know, when she needed a new winter coat and that. My husband was expected to pay.

I was fascinated to hear Florence talk about her brother. She had been thinking of moving back to Ontario to live with him:

> It's one of my options. Now my brother is much younger and we get on well. But then again I'd like to see him make a life for himself with a female, with a woman. But it's not happening now, but it could. He's a nice person. I mean I wouldn't want a man, but I think he should have somebody.

It was interesting to hear Elizabeth describe a recent lunch she'd been to and how it reminded her of good times past.

> Anyway, we had a lovely lunch down at the dockyard on Wednesday, with white cloths and a big roast of beef. And wives were invited. And for each one of the wives, and us too, the men brought a red rose. I mean to count us in. Wasn't that nice? That's the world I used to live in.

In contrast she talked about her experiences as a caregiver. "I'm talking about my age group – it's a man's world. As long as a man has a wife to look after him, they won't give him a bed [in a care facility], they wait until their wife has a breakdown. But a single man aged 80, whose wife is dead has a bout of pneumonia and goes ahead [into the facility] ahead of the rest". She was obviously angry that based on her experience women are expected to look after their husbands to the detriment of their own health.

In reading the interviews together, I realized that all the women had been very active in their communities. They had volunteered or were continuing to volunteer their time helping others. Two expressed regret they were unable to volunteer now and appeared to feel guilty about it. "I feel there is so much more for me to do. I'm sure I could do something to help somebody. But I'm good with people, so I feel I should be helping somebody. But I do have a little guilt that I'm not".

Evident in all the stories was a lifetime of a caring for others. Each of the women described a situation or a time when she had looked after others, either as a volunteer in the community or within her own family.

3.2c Generational Differences:

The day I met Florence there had been an article in the newspaper about young people harassing seniors. She mentioned this was really bothering her. She went on to say that if this had been her experience she "wouldn't know how to talk back you know, or cajole them into being nice. I don't have that talent any more". She was putting herself down because of her age, which is another way of internalizing the marginalization of aging people.

This exchange led me think about the contact the other interviewees had with younger people and if that would play any part in their decision of where to live. Ruth talked of her friendships with younger people. "I have a lot of young people and communication with my family and I've had more young friends that I've had friends my own age really. And it's interesting and it keeps you younger I think". She went on to talk of what we could learn from the Native communities where "their older people are their teachers. And they have tremendous respect for them. And they use them to get their grandchildren to learn about the past and what everything means".

Margaret volunteers at a place where there are "tons of them". It was great to hear of her talk of young people with such understanding. She described an accident she was involved in when a young girl knocked into her and didn't stop to see how she was: "Kids don't think of these things, you know. And I probably

wouldn't have. If I had hit somebody, I would have stopped. Well, maybe I wouldn't have at her age either". I asked her if she ever shared any of this wisdom with the kids. Her response was "I don't think they'd accept it because they are immortal. I feel that it never occurs to them that they are not immortal".

I did notice that all of the women talked about living in predominantly seniors' buildings. Two spoke of younger couples moving in, one of whom had a baby. But all the women said they preferred the quieter buildings with no children. It seemed that although they liked to live in quieter places, they wanted contact with other generations. As Elizabeth said "I didn't realize at the time that we bought in this area, there is young people. There are schools and the university. You go to some other places, and I mean I never see anybody younger than me in [another part of town]. So at least I feel I'm in a real world when I walk".

3.2d Invisibility:

There were three examples of the invisibility that old people often experience. Margaret felt the only way she could have her wishes respected was to have them all written down by the lawyer. This was in regard to her finances, will and power of attorney documentation. She wanted to be remembered by someone who knew what she was doing and able to look after herself.

Another example was when Jane had a teenage girl on a skateboard bump into her. "She saw I wasn't a teenager and I was carrying a cane. She didn't see if I needed help, just sorry and she was gone".

Another talked of going on a cruise to try and meet people. She described being put at a table with three sisters and their husbands. "And of course, with all these old ladies, they put us back in a corner where we couldn't see or hear a thing".

Elizabeth talked about dealing with "the pension people". "You're just a number in this game. Not that you're a living, breathing human being that needs food on the table and somewhere to live and all the other things that make life take over". Through her own story, she described other occasions in her life when she had challenged government bureaucracy; she obviously was proud of continuing her own tradition.

3.2e Ageism:

Several of the women felt they had experienced ageism. Most said it was very subtle and ranged from being ignored in a checkout line to being rushed when they didn't want to be and couldn't handle it. The most blatant example I heard was the description one person gave me of driving to the Interior of B.C. She was surprised when a younger woman, who knew her well, said she couldn't possibly be driving. Her response was "yes I can. I said to keep everybody quiet, I'll do it in two days, but I'm going to do it. And she said, I'm paying your way up there. I told her I didn't want to be up there for two weeks without a car". What irked her most was that the implication was "at 85 you shouldn't be driving. Not because I'm incompetent but because I'm 85".

Listening to the women talk about themselves in this way brought home to me how society regards older women. All the women in the study, although at

times obviously annoyed by it, all seemed to accept the expectations and responses from society as being a facet of being older.

4. Responses to Their Situation:

The last theme was the women's responses to their situation. There were four types of responses evident in all the women's stories: (4.1) emotional responses to change; (4.2) attitudes to change; (4.3) values of autonomy and sense of control that affects their approach to making decisions about change; and (4.4) resistance to wanting to move and resiliency in living with changes in health status. Articulating strategies, such as maintaining reciprocity are some of the aspects of the resistant, resilient responses described by the women. Some of the responses were stronger in some women than others, but the four responses were there in all the women's stories.

4.1 Emotions:

On a very personal level, I enjoyed meeting all these women. I loved hearing their stories and I felt honoured to be allowed to share them. What I particularly enjoyed was the range of emotions displayed in the telling of the stories. There was clearly fear of what the future may hold: yet there were so many other emotions as they told their stories.

Each of the women displayed a range of emotions, yet as I listened to them, one emotion stood out for me as each of the women spoke. To acknowledge the range of emotions the women conveyed, while honouring them as individual people, I have listed the emotion which stood out strongest for me during the time I spent with each woman. As you read this list, I trust it gives a collective sense

of the women I met, while providing you with a picture of the women as individuals. I hope it conveys a picture of the women as having led and continue to lead rich and fulfilling lives.

1. The feistiness of challenges conquered. Elizabeth described how she took on government agencies and politicians to make them aware of issues close to her heart. I liked her certainty and solidness as she described the importance of home to her and the affection in which she held her husband. The longing in her voice as she talked about his love and devotion and how bereft she felt after he had gone.
2. The excitement of describing her life of travel and adventure was very evident in Florence's story, and her humour when acknowledging the difference in her current living situation.
3. Mary's humility in talking of so many things but rarely mentioning all she had done to better this community we all live in.
4. Geraldine's struggle to understand the modern world and the myriad of different values and beliefs to those she has held for over 90 years.
5. Jane's confusion in her struggle of contemplating why a move may be necessary, at the same time as rationalizing why and how it was so important to her to stay where she is.
6. Margaret who had known me for many years, cared enough to struggle out when she wasn't well, to participate in her interview. Then when she admitted to me she didn't want me to worry, but wanted me to learn from her experience.

7. And the quiet gentle way Ruth described the love and caring she had poured into her family, her friends, her husband's congregation and all the countless of others she had cared for over her life.

The most amazing thing was the surprise these women all showed, that I was even interested enough in them to want to hear their stories. The last comment of every interview was that they hoped they had helped. Their surprise and their last question stand apart in describing the extent to which senior women are undervalued and their contributions to society not acknowledged.

4.1a Fear

I became aware in speaking with these women, that many of them had an underlying fear of the future. The predominant articulated fear was of "being put in a home". Interestingly most identified cognitive deterioration as the major reason for placement.

> The only thing that really worries me, and I get scared, and I don't get scared very much, but if the body goes completely to my mind? What is going to happen to me because I am my mind"? "And I feel that need for security and some stability. But I get past that because I know my body is going, but then I get to something of a doorway, and I don't know where it's going, but that's where the fear starts. What's going to happen to me?

One woman described how when she borrowed something from a neighbour she returned it as soon as possible, so she wouldn't forget. She did not want people to think she was getting "old and forgetful". Another talked about how "it

depends on the condition I'm in. "If I get a sudden, terrible illness, or if I'm just sort of slowing down gradually. It makes a different. And also it's hard to tell. I mean at this stage, its' totally, the whole thing is in my control. But who knows what's going to happen?"

Three of the women said very clearly that they couldn't see themselves in a long-term care facility. Two actually identified they would prefer to die than "go into one of those places". I got a sense from all the women, that should facility placement be a necessity, it would be a stepping-stone to their death. Through it all, the fear of placement came through loudly: "and I keep having visions of these places, and it scares me to death. It really does".

And:

> I think having had considerable exposure to the nursing home situation where I see the lounges and everything that is so nice. And they have televisions in there, and people sitting all around with their heads down and they are all asleep. And it, it just turns me I just find it hard. And I just hope I don't have to go that route.

Two of the women had husbands or other family members in facility placement before they died. This experience left a lasting impression in many ways. First they all said they couldn't imagine themselves living there. Secondly there was some guilt they hadn't been able to continue the care of their family members at home. Despite this and quite contradictory to it, all were left with a lingering sense of not wanting to be a burden to their own remaining family

members. In contrast when I mentioned being a burden to Elizabeth her response was, "Well, I have nobody to be a burden with".

There were other fears articulated by the women. All spoke of taking fewer risks in their lives. A fear of falling was predominant. They described learning from experience not to try and over extend their aging bodies – not to reach too far, not to try and walk along uneven ground with assistance, either from others or with mechanical aids.

In contemplating whether to move to be nearer family, one woman decided against it saying, "I went to there and oh, you hear about the crime over there, and it scares me. And I have visions of me going to the hockey games and going to the theatre, even alone, you know. But I wouldn't do that. I'd be too scared to be on my own now". One mentioned her fear of going downtown and being scared of the kids she saw.

> And my granddaughter has told me this, she said, grandma, don't go by the looks. They are really very nice people. I said honey I can't help it. It's a fear in me. I don't know how to handle it. So it makes me scared. Because when you don't know, you get frightened. So it's different.

It was this prevailing sense of fear of an unknown future that struck me most. The fear of not knowing what the future held, how long the future was going to be and whether they were going to have the capacity to cope with the future. There was a significant difference in how they described coping with life's earlier changes.

4.1b Anticipation of Change:

These women had all experienced many changes over their lives. What struck me was how they all seemed to anticipate more changes ahead. One story in particular captured how much these women's lives had changed and yet remains interested in new possibilities.

> And when my friend came from Toronto, I said, oh, I have to take you out to Superstore, because she lives right in the middle of downtown. No grocery stores, no nothing. And we both laughed and laughed and we said, isn't this funny? Whenever we used to get together we used to say, well, you have to go to this nightclub or this designer shop, or go there. And we'd go to this nightclub or something and have a ball. Now it's a grocery store. You have to come out and see this grocery store. What a change our life is. And she was so excited because she saw these new products... how life changes and what's exciting? My day at the Superstore!

Another woman talked of the changes in this way: "I have the family complaint of heart problems, but I can still lawn bowl. I haven't lawn bowled or golfed for the last two years, I'm waiting for the weather to get better to see if I can".

Several of the women talked about their anticipation of future changes. All described how they felt it was going to be because of a triggering health reason. Margaret talked of how if her health deteriorates any further she would have to go to a home. Mary said, "I don't know now, but I probably have a clue whatever

triggers it [the change], its' something I haven't thought of yet. Some strange thing will happen, like I never thought [my accident] could do so much damage to my bad leg. And it's been catastrophic".

4.1c Need for Security:

It was through the conversations about loneliness versus being alone that I started to identify a common thread that ran through their responses: that of security. I noticed as they spoke that they were looking for a sense of security. This evidenced itself in many ways.

Margaret talked about the security of having her sister to talk with each day: "At least that way she knows I'm alive and I know she's alive – its very reassuring!" Another spoke of having the security of a nurse coming to visit her each day while she learned how to live with diabetes. "It gave me a sense of security that I could manage. You need to know someone competent is around". Florence talked about "feeling that need for security and some stability" in relation to the many changes she has had to contend with in her life.

Yet it was the changes these women were experiencing that threatened their previous security. The most common change described was that of their neighbours. Most had come to have a relationship of knowing their neighbours and knowing they could call on them when needed. Three things happened to threaten those relationships; the neighbours became less able to help as they aged, or they died, or they moved away. This was happening as these women learned that there were more things they required to feel secure, and they were less willing to ask for help.

Elizabeth talked of security in relation of owning her own condo. "We're back to security. Yes, more control and things like that of your own. Your money isn't going out of your hands". She was in the process of setting up some private help to call on "when she feels he needs it". She was hoping that the security of knowing she could just call up the Home Support Agency and they'd know her, would enable her to continue living in her condo.

4.2 Attitude

The interviews gave insights into the experience of being a senior and the factors that go into making the decision of where to live. Yet they were not based just on personal preferences or practical realities, but on something more. The decisions were being made in the context of the women's histories and experiences. At the end though, it was their individual attitudes that gave the defining component of how the decision was made. It was their response or attitude to change, their attitude to themselves, the response to the often mentioned fears for the future, their experiences of the emotional upheavals the decision was causing and finally their acceptance of the both the phenomena and its place in their lives.

4.2a Acceptance:

Through all the confusion and questioning, I had a wonderful sense that these women were more accepting of themselves and their circumstances than I had initially thought. In reading their words, I saw the comments that spoke of a wisdom that came with age.

I heard the humorous remarks on moving:

> And when I moved where I am, and I've been where I am now for 17 years. And I was going up in the elevator a couple of days after I moved in and I said, that's it, never again. I'm moving out feet first next time. So then they said, well then you'll be in a green plastic bag. I said that's fine I don't care. And you know what – I still don't!

Then there is the acceptance of things impossible to change: Florence who said: "Because I'm, you know, I pretty much do what I want to do now, and I feel I'm in control and if I didn't do it, it's because I didn't do it". Another woman said: "Every time something happens to you, it makes you think, what if it doesn't get better, what if it gets worse of whatever. And you think what would you do about it? And I don't know. I just have to hope that I'll feel better soon. And not have to worry about it".

Or learning to live with a debilitating disease: "But there are some days that I can't get out of bed. And I say, that's okay. I can't do it today and I know the arthritis is connected. They did tell me, reserve your good feelings for the things you like doing. Not for vacuuming or things like that. The things you like doing". This woman had learned to separate her lifestyles into what she used to do and what she is able to do now. "Not disassociating, but separating the lifestyles and learning to enjoy both – but it's hard".

Most of these women were searching for fresh information and the chance to look at options they hadn't thought of when we first met. All of them realized that I had little, if anything, to offer them than they already knew. I had felt badly

while doing the interviews that I could not help more. But in reading the transcripts I saw comments I hadn't really heard at the time. Florence captured in perfectly when she said:

> I guess maybe I was hoping to get a lot of answers. But it's like everything else when you're analyzing. It can only come when you, and if I knew what I wanted. If I knew what I'd be capable of, wouldn't it be wonderful. So you just have to plan and keep working on it.

4.3 Personhood:

I saw clear evidence of how these women continued to struggle to retain their personhood in the world they live in. All the women were individuals and so their descriptions of how they were working to stay true to themselves as individuals were different. Yet they shared the same intent of individuality of personhood.

Jane strongly stated, " I don't want to end up sitting in a chair sleeping. Having a frozen dinner and putting it in my microwave oven and sitting waiting for it to heat up. I don't want to do that". And her irritation at her doctor who "just laughed at me when I said to him I was thinking of going into a retirement home? He started laughing, oh Mrs. X, you're not ready for that. But I was worrying about it". She was clear in saying "I don't want to give up any of my independence yet. Yet how do you know when you should do that, give it up?" Yet was unable to identify what was making her say she "should" give it up.

Mary felt she could retain her identity if she could retain the control of her life. Florence had the same irritation in her voice when she described an interchange with her daughter who had expended a lot of money and time to buy a gift for her mother from overseas.

> You know, they don't think about what our needs are or what we need. I tell my kids, don't get me anything. I have no room. Don't buy me anything if I can't eat it or drink it, forget it. Yet they buy this huge gift and pay a lot of customs and I can't use it. They don't see how we're really living alone. You know? And we don't want a lot of knick-knacks.

This was the same person who described the woman she still thinks she is and then being ignored in a way she had never before experienced. "I mean I guess I think I'm still slim and pretty, you know. But then you know, things happen and you realize you're not. It was, it was devastating. You know, you put yourself to meet people and then.... Well"

It was when the women started talking about the time that is left to them and the opportunities which perhaps will be denied, that I got the sense of time passing in a different way for women in their eighties and nineties than for young or middle aged women. As they age, the years go by quicker and the number of years left to live gets shorter.

> Yeah, But I think I'm okay for a while, but the years are whizzing by and I don't know. I mean maybe I'm good for another couple of years, but if I live for another 10, I can't stand the thought of

what will I be able to do or not do? But what do older people do to make new friends? Where do they go and who will understand them?

4.3aValues:

Inherent in the decision making process are the values of the person making the decision. While each of these women had differences, two values were very apparent in all the women's stories: control and autonomy.

4.3a (i) Control:

In each of the interviews and in looking at different options open to them, the issue of control was paramount to every woman. Keeping control of their lives was important to all the women. None of the women I interviewed intended to give up control of their lives; for all of them it was a concern that circumstances or deterioration in health status would force them into doing so.

All spoke directly or indirectly of control as being a vital component of their lives: "I mean to say at this stage, it's totally, the whole thing is in my control. But who knows what's going to happen?" and "I can control my mind but if not my body then what am I going to do? Where am I going to go? Because I pretty much do what I want to now, and I feel I'm in control and if I didn't do it, it's because I chose not to do it."

One spoke of moving in with her daughter as losing control of her life. Another spoke of moving to a retirement home where "I'd have no control of what I ate and whom I had to sit with. She described visiting one home where "they have a care part, but they don't eat at the same time that you do. You know

it might sound very cruel, but I just don't think I could sit there and eat with people, who you know, I would term intermediate care, [requiring assistance to eat] it would be just too much. Someday it might be me, but I would hope that I would be put someplace then where I am not going to distress other people". This quote was a theme I heard often. While they all spoke of making the decision of moving themselves versus "being put" somewhere, they all indicated they did not want to distress or be a burden to others.

They all said it would be preferable to be able to make their own decisions than to have someone else taking control and deciding where the women would live. The comment was often linked to retaining the cognitive ability to choose.

All were clear that they "don't want to be sent. I want to be able to go myself". Some had visited several other places and had made the decision of where to move "when the day came and if they could afford it". Most described the experiences of other seniors of being forced by family to move to a retirement home, a care facility or in with the family members. They felt that "when you go in yourself, then you'll enjoy it. The people who were unhappy are the people who are sent here".

One participant clearly said, "I'd prefer to die before going into one of those homes. If I had to go there I'd lose control of my life. It doesn't matter how nice it looks and how good the staff is, I'd have to do what they said". She commented on how "they" would tell her which bed was hers, "they" would decorate and furnish it, "they" would tell her when and what to eat, and "they"

would organize her life. Another was concerned that she'd be forced to live with people she 'couldn't stand'.

4.3a (ii) Autonomy:

It was clear that all these women took pride in their own homes. They wanted to be able to look after their own homes and look after themselves.

Jane, after falling sick had a person come in to help her, but on recovery quickly chose to continue with her own work: "And that's why I don't have housekeeping. I can afford it, but I don't want to. I think I can do it myself, I do it on my own time, and I don't entertain a lot".

Geraldine spoke of doing most of her own cooking: "I'm a senior, I can only live so long. See, One day I cook for two days and two different recipes. I make soup, I have soup every day, sometimes three days the same soup. I put it in the freezer and the little oven. And there are the pots and pans to wash. And I don't care. It gives me something to do".

One woman wondered what she would do with her time if she moved to a retirement type home. Speaking of the present she asked, "what would I do with my time? I have to shop, I have to get my meals ready, keep the place half decent. Supposing I was sitting there, having my, being waited on all the time, what would I do with my time?"

Another spoke of keeping busy in terms of the location of her present home:

> It's a good location. And I think that as I walk around to do things. The druggist is near, the doctor; the two dentists are both within walking distance. I have a car, but I don't need it. Well, I must

> say it's handy to go and get a pile of groceries, but I can't even take it uptown anymore, it's too hard to be bothered. Too much bother parking it. So I take the bus out front and it drops me back off out front again.

4.4 Articulating Strategies:

As we talked I started to get a sense of actions and decisions the women had taken to avoid moving. More specifically they had looked at ways in which they could remain in their own homes in comfort. For some it was acceptance of change of abilities to keep the home how they would have preferred. For others it was having minor renovations made in the home. Two women made changes in their expectations of lifestyle, another made certain she could afford the long distance phone calls to stay connected. While each woman talked of different strategies, one strategy was evident in all the stories: that of reciprocity. They learned or were learning to ask for help as well as giving it to others.

4.4a Reciprocity:

All the women clearly spoke of a time when they required help and their level of comfort or discomfort of asking for help. Equally apparent were the times when they were able to provide help and support to others.

Mary described how she has "a friend who comes in every day to see if I want something. And she's older than I am, but she's still got her car. She picks up things at the store and takes me places. She'll do anything for me. And I have gone through a period of supporting her".

This sense of reciprocity came through in many of the women's stories. There appeared to be a greater comfort in asking for help when the help could be returned. When it couldn't there was some discomfort. Florence talked about the changes brought about when the people in the building changed.

> And new people move in the building now. We have a terrific couple up in the penthouse and then another, and they live in Florida. And they're couples. Now that makes a difference too. They say come on over and we'll cook. We need you to join us. And I say no. And one reason is, I can't reciprocate. When they go out for dinner, they want me to go along, the neighbour next door, she cooks. She has a husband. And she makes lovely dinners. Well, I can't make lovely dinners and they don't want lean cuisine. And so I can't reciprocate. My hands just ache thinking about it and I can't possible carry the dishes all the way out to the dining room – I'd fall.

The women had different experiences of asking for help, both inside their buildings and outside help coming into the building. But all of them experienced some discomfort asking for help. One person clearly articulated, "you can't call on strangers"; others talked about the type of help they needed to ask for. While the women accepted help with shopping, or had made other arrangements through a local grocery store to have groceries delivered, they were reluctant to ask for other types of help.

One woman described having to ask neighbours for help when she was sick and needed an ambulance called to go to the hospital. She was nauseous and was mortified that her neighbour had to clear up feeling "that it was just too much". I did not get a clear general sense of where they drew the line between asking for help and feeling a burden. For each woman it was different, but it was evident in how they talked that the line existed and drew on energy and emotions to negotiate.

4.4b Personal Choices:

When I first analyzed the data to understand the phenomena of deciding where to live I had concentrated on finding something different to experiences earlier in the life span. Yet I found I could not ignore the similarities to other decisions we make when choosing where to live, in particular that of personal preferences. I found these preferences, like many decisions of where to live, limited by choice and financial considerations, yet there remained other preferences these women chose to include in their decision making process.

All the women were looking for a home that was easy to maintain themselves, but all were becoming increasingly aware of their limitations compared to when they were younger. Elizabeth was looking for "someone competent around for when I need a little bit of help". She was also looking for a place to live "where I'm not just someone to be looked after, but a real person". Margaret also wanted a place where she could call on someone, but for her it was someone who would respect Margaret's wishes "and not try and run my life". Another talked of her fear of "being put somewhere that would segregate me from

others.... just leaving me with a lot of old people for company". Mary wanted an en suite bathroom and a room "to call her own". She also wanted to be sure that wherever she went, her cat would also be welcome. Jane wanted a bathroom that was equipped with a shower she could use easily "so I wouldn't be a bother to anyone".

The most often heard preference was for a place where the women could live independently but when needed there would be someone to call on.

Summary: Resistance to Moving and Deciding to Stay

The purpose of the research was to find out how senior women make decisions on where to live. From these findings it became obvious that decision-making is neither a static nor linear process. Rather, it moves back and forward, it is eagerly approached and reluctantly approached. Where to live is a complex decision making process with no one part able to be considered in isolation of another. Some aspects are closely linked; others only touch each other briefly and then move off again.

Aspects of the decision are different for senior women without kin or kin who live far away than from those taken earlier in life, and are based on a deteriorating change in health status. The options are limited by affordable choices and a higher uncertainty of the future. The change in health status made the women feel they are powerless to alter the inevitability of aging, and the perceived necessity of requiring help. In different ways the women were all resisting a change in where to live. The women all talked about how difficult it was to make the decisions. They talked about the difficulty of making a decision

within the context of not really knowing what the future would bring. They all talked about the decision-making within this context of uncertainty. They talked of several uncertainties, but two stood out. The first focused on their health status and further changes; the second was around their finances and whether their money would last through the rest of their lives.

What struck me in speaking to the women was that none of them really wanted to move. This came out in different ways. Two actually said they were definitely not going to move, but instead were looking for ways to remain supported in their own home. Two openly acknowledged that it was going to be very difficult to move, yet this was in the context of the physical act of moving. They talked about how hard it would be to sort all their possessions, indicating they would likely be moving somewhere smaller. Two spoke of needing to do more sorting but it was more in connection to just having too much stuff. "When I moved in here ten years ago, I brought too much stuff with me – well now it's becoming a pain. So I am going through things one box at a time and just getting rid of it". In none of their comments did I hear eager anticipation of a move. Rather I heard them arguing against moving, in comments like, "they'll have to carry me out of here". Geraldine, who returned to her own space after having lived in a facility said "she wasn't going back there".

There is an overall sense that the women really liked where they lived. This was described in several ways such as: "I live by myself here. I've lived here for 24 or 23 years - one or the other. And I don't want to move. It's a very nice condominium. It has everything I want, we had the balcony closed in so I sit out

there and eat my breakfast, do everything out there I want to. So that means that I don't want to move".

Ruth decided for both financial and practical reasons to move to a one-bedroom apartment in the same building after her husband's death. She talked of creating her present space as:

> doing some of my own creation so that I could have a desk and a sewing machine and a bed and all of what is necessary in the bedroom in one room. And so that was good therapy as well as fun to do. And I was talking about the tree, its' sort of like a canopy over the balcony. I had always had a dining room window so I put the mirror up in the dining room so I could see the tree and of course the movement of the tree, I could delude myself into believing there was a window at both ends.

Others spoke of finding comfort from the familiarity of their present home, in particular being surrounded by their own things and the predictability of their routines. Or Mary who "liked it here and I'm happy – and I have my cat". Florence, whose condo faces west, finds comfort from watching the sunsets each evening. She movingly described her condo as "my home. This is part of me".

Each of them women was connected to their own home. They could identify with their home; they had worked to ensure that the homes worked for them and it was apparent that they were all resisting the need to look at other options.

It was this resistance and lack of real interest in moving which struck me most as I went through the interviews. I had anticipated hearing about things to be considered when contemplating a move, particularly for those without kin support. What I found was that in considering these things, the women had also started to strategize ways in which they could continue to remain in their current location.

I had a sense that although something, usually a change in health status, had forced or was forcing them to consider a move, there was no real intent to move. Rather they were sifting and sorting their new realities and choosing to stay in their current homes, despite the new challenges they were having to face. It was this ambivalence that intrigued me. Some part of the women was telling them that they would maybe have an easier life if they chose to move; yet another part was resisting this option completely.

The resistance was clear; the reasons for it were not easily apparent. Yet by reading and re-reading the data, and going through the analysis process I started to see the reasons. In every woman's story, thinking about a possible decision to move was being forced on her, for two major reasons. One was a change in health status, and therefore a change in her ability to manage the home. The other was concern over finances and not being able to afford the help needed to manage in their current home. They were also concerned they would not be able to afford other supportive housing options that gave them the autonomy and help they desired.

The resistance to moving fed an ambivalence and an unwillingness to decide to move. The resistance also sparked and was accompanied by strategies to remain. The strategies included: minor modifications to the home, accepting their changing health status, and finding new ways to maintain reciprocal relationships with others.

CHAPTER IV

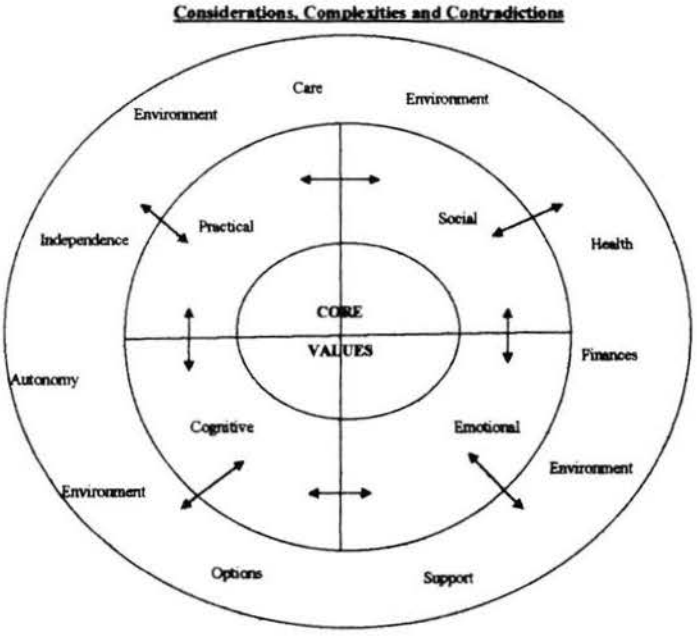
DISCUSSION AND IMPLICATIONS

The preceding chapter described the meanings found in the description of deciding where to live given by seven senior women with little or no kin support. These were grouped into four central themes: i) Practical Realities of Deciding Where to live ii) Supports and Connectedness to Others and iii) Ways of Understanding their Situation and iv) Responses to Their Situation. Each of the four central themes contained a number of sub-themes. Some of these themes were closely linked and aligned with each other. Many impacted on each other and many created tensions for the women in deciding where to live. Therefore it is impossible to look at one theme in isolation of another. Individually they give a part of the women's stories; together they provide the core meanings of the experience.

At the start of the research I had wanted to understand the experience of deciding where to live for senior women age 75+ in failing health and with no available kin support. What brought me to ask this question was my experience as a social worker in health care settings. As the study progressed it became more evident that I had started with a desire to confirm my own view of the world. Yet the women I met all had different experiences than my own; in addition their attitude to those experiences was uniquely personal, and the complexity of the decision was located within their own lives.

In listening to the women's stories and journaling my observations and thoughts, I started to see the connections between the four major themes in a circular way. As diagram one shows, each of the four themes represented a quadrant of the women's lives: emotional, social, practical and cognitive, held together by the core values and beliefs of the women. In the findings these four themes were evident: the practical considerations of where to live, the social support and connectedness, their ways of understanding their worlds and lastly their emotional responses to their situation. The interaction between the four quadrants and the core values also provided some insight into the women as individuals and how they gave meaning to their lives, in particular the process of deciding where to live. However, the decisions were not being made in isolation. They were being made within a context and environment that is in itself very problematic and contradictory.

Diagram One:



It was this interaction with the environment that best described the contradictions and problems and provided clarity to the resistance all the women displayed. For example, the women were all very clear they wanted to stay in control of their lives and retain their autonomy and independence. This is hardly surprising as we live in a society that values independence and autonomy. Because of failing health and/or in combination with the aging process, it was not always possible to retain the measure of independence these women had when they were younger. This change in health status and concern for being able to continue "managing" was what was driving them to consider making the decision to move.

They looked at various means of obtaining support, at a time when previous supports were changing. As women either without children or with no children locally, they were also unable to depend on their children to provide day-to-day support. They were still able to ask for help from others, but were only truly comfortable when they felt they could reciprocate that help. One woman described being invited out to dinner and not feeling like she could accept because she would be unable to invite them to her home in return.

Each of the women was at a different place in the struggle to understand their changing or changed world, but they were all searching to understand their new reality. Finally it was the women's response to the changes that showed clearly the resistance, with an underlying fear, that became so evident as the research process unfolded.

Discussion of Findings

The focus of the research was to listen to senior women describe how they were making the decision of where to live in the later part of their lives. For all of them it was a change in health status that was driving the decision making process. Significantly, each of the women was resisting the option of moving from their current home. Four themes were identified through the research: practical realities, support and connectedness to others, ways of understanding their situation and responses to their situation. These themes described different parts of the decision making process which ultimately led to them deciding not to move now.

Only one of the women was adamant that she would never move from her current home. The rest all had a sense that continuing to live there may be compromised if their health deteriorates further, which was driving them to search for ways to avoid moving. Many of the things they looked at were very contradictory. For example, they wanted to look after themselves, but recognized they needed help on occasion. Through all the various aspects of the decision-making process, they were clearly ambivalent to the option of moving from their current home.

Four concepts are developed that put the experiences of women in a broader context as they go through making decisions about where to live for the later part of their lives: (1) caring work; (2) reciprocity in relationships; (3) the managing of need and being managed by others; and (4) ambivalence in decision making.

The women in this research all gave clear examples of how they provided care for others at various stages of their lives. They described the form of that caring in different ways. Some raised children; some supported siblings; some cared for spouses; and most of them talked of a time when they volunteered to provide care of some sort in the community. Yet "women who have been caring for others all their lives are expected to be independent and self-sufficient and to make few demands on the state and familial resources in their old age" (Neysmith, 1998, p. 233). All these women lived through a time when this caring by women in the community was expected and taken for granted. The systems presently in place are built on these same concepts. It is not surprising these women are reluctant to ask for help. However, the aging of our population was a major impetus in placing caregiving on the policy agenda (Neysmith 1998).

Caring for others changes over the life span of women but is a constant throughout. (Neysmith, 1998) It is only in the last twenty years that this expected caring is being challenged by feminist authors such as Neysmith, (1998) Aronson, (1998, 2000) Reitsma-Street, et. al. (2000) and others. The role of women to provide the care is expected and apparent throughout the discourse, be it at the policy, practice or societal level. Questions remain as to the continued validity of those expectations. However, most of these questions are being asked by people, particularly women, who are younger than the women in this research.

Through research much has been learned of the types of caregiving and the "burden" caregiving places on the caregivers, comparatively little is know about the phenomena of receiving care. The women gave me a sense that not only did

they not like to ask for help, but they also did not appreciate having to receive any help when needed. When they spoke of the help, it was within the framework of being able to choose who provided the help. If a friend or acquaintance provided it they wanted to be able to reciprocate. If provided by a professional, they wanted to keep the control of what help was provided and by whom.

The women in this study were able to pay for some help privately, but they remained concerned as to how long they could afford to keep paying and they also were reluctant to accept a person into their home with whom they did not feel a rapport. Simply put, caring work is made up of practical assistance and personal attention, warmth, involvement, and empathic understanding" (Neysmith, 1998). In this study the women considered the practicalities of their living arrangements, along with their ability to pay for additional help, or have help provided by the state or familial/social support, such as housing, grocery shopping etc. As they talked of the decision making process, they spoke of finding somewhere that could provide help when needed. Yet they were also resisting needing any help. They spoke in terms of "perhaps" and "if or when" rather than definite need at the present time.

Another aspect of the decision making process was that of support. Not only support with the practical aspects of living, but social support, friendship and connections. A key feature of that support was that of reciprocity. They wanted to be able to provide both practical and emotional support to others, while also desired to be recipients of that support when it was needed.

In all the stories this element of reciprocal support was very evident. Each of the women clearly articulated a time when they were able to help someone either living close to them or in their apartment building. This help was often practical, such as shopping. Several of them also described a time when they needed the same sort of help, usually because of a change in health. They described the comfort of having a neighbour to call on and knowing that when they could, they would be able to return that help. Two of the women spoke to the fact that their neighbours were aging and not always able to help, just as the women themselves were aging and not always able to help.

As the women were making the decision of where to live in later life, this sense of reciprocity remained. Yet reciprocal relationships built up over time were changing. Not only that, the women's ability to provide reciprocal support was being compromised by their changing health status. They all spoke of changes in their social life; death of friends or spouse; friends moving to be nearer their own families; and a change in attendance at social functions. These changes were also a part of the decision making process. At a time when they needed more practical, social or emotional support, there was less available than before. This too seemed to be a key factor for them considering where they were going to live. Perhaps they could move to somewhere that would provide the practical service, albeit at a price? Yet in contemplating a move, four of the women worried about compatibility with new neighbours or others living in a congregate care setting.

Thinking about the notion of reciprocity and looking for a greater understanding in the literature, I became aware that this notion of "give and take" (Roberto, 1989, p.147) is evident through the life span of most women. As young girls give and take is often one of sharing of problems, ideas and time together (Roberto, 1989 p.148). As young mothers shared child minding is common – where one mother looks after both her own and other children, with the expectation that this help will be returned. With more women in the workforce mentoring has become a norm, where more experienced women support and assist less experienced women. In return the less experienced women bring new and fresh ideas to the interaction. This leads to a giving of the wisdom of experience and the taking of newly discovered ideas.

Finch and Mason (1993) have done a great deal of research in the area of negotiating responsibilities within families. Throughout their work the notion of give and take or reciprocity is evident. What they found is that much of the give and take within families is desired but not expected, and must be negotiated carefully. This was true of the women in this study. Although they did not have family locally, they did talk about their neighbours and the support they provide for each other. They also talked about this support being negotiated and maintained through reciprocity.

One aspect of this intrigued me. Those without children had little expectation of support from other family members out of a sense of duty. They seemed to be more self-sufficient, perhaps because it was more usual to them. Those with children clearly indicated that if needed they could call on them for

support. Given that all the children lived on the other side of the county, this support was obviously not day- to-day support. Both the women with children told me their children had said that, if necessary, they could go and live with them. Yet the women were equally clear that support from their families would be as a last resort – and only when all other options had failed, because they didn't want to be a burden. This spoke clearly to the discourse of "caregiver burden" as though it is something bad. From this data and my experience working with families, caregiving is not considered a burden in and of itself. However, the amount of time needed to care in already busy lives can be burdensome. Not only did they not want to be a burden; they also did not want to move to a different province where they didn't know anyone except their children. They felt that by doing so, they would experience further changes to their already compromised social network.

Those women without any kin support seemed in some ways the most vulnerable. Although they appeared more reliant, it was perhaps because they did not have kin people with whom to even ask for support let alone negotiate. They spoke more of friends and neighbours as their support system. Roberto (1989) showed in later life friendships tended to be a combination of practical and emotional exchanges. From this research the combination was evident. What was clear was that the emotional exchanges were more often found in long-standing friendships, while the practical exchanges were more often found in their interaction with neighbours. Sometimes these neighbours were long-standing, but

still there were richer descriptions of emotional ties with friends outside the building and often some distance from where these women are now living.

Yet as we age the need for support often becomes greater. It is likely that our health will deteriorate to some degree. Whether we are able to negotiate sufficient reciprocity from neighbours for the support needed to care for ourselves, will enter our thinking about whether to move or not, and what decisions are possible. It is at this point that the formal health care system may also become involved. Five of the seven women had experiences with the health care system, either personally or with a family member. Pensions provide some financial support for older people; some require additional financial assistance from the state such as housing allowances. It is rare that seniors do not require either financial support or health care resources. The women in this research all spoke of receiving some sort of state assistance. None stated that they were poor; most seemed to have additional pensions either their own or their husband's. So, while their resources were not limitless they were in a position to pay for additional and occasional practical help when needed.

Although some form of formal support was possible and available to these women, they were all resisting accepting it. Initially I thought it was just that they wanted to retain some autonomy and control in their lives. Then I wondered if it was a personal form of the cultural denial of the aging process. (Aronson, 2000). But intuitively I felt there was more here than the words the women were using. It was to understand this phenomenon more fully that I went to the some of the work by Aronson.

Aronson, (2000) described the combination of practical and emotional support for frail elderly people within a changing context of community support from the state. From my own experience in the system I am aware of what she calls the "narrow interpretations of needs and services" (Aronson, p.53). Within my own health region much of what is available is that which can be counted. These are all task oriented and include: personal care tasks, nursing tasks, home management tasks. Emotional support is difficult to quantify and therefore not made evident in service or policy provisions. From this it would appear emotional support is not a requirement of the formal care systems.

What I had not considered is how the older women may feel about receiving any care, as they consider decisions to move given changes in health and capacity to negotiate reciprocal support. The three images of receiving care described by Aronson (2000) include, "being managed, managing and making demands" (p.54). Being managed is a term she uses as a result of government restructuring which focuses on providing low cost standardized services. Managing gives an image of older women striving to remain in charge of their daily lives. Making demands broadens the image of seniors to those "demanding resources to overcome collectively experienced obstacles (p.54). All three were present in my research. When I met these women most of them were "managing", but they spoke of their experiences of both being managed and making demands. Like the women Aronson (1998) interviewed, the women in my study displayed incredible resourcefulness and determination to manage their everyday lives. When they were unable to do so, their different experiences of receiving care became evident.

One woman spoke of the caring and support she received from a home care nurse on being discharged from hospital and how it helped her "get back on her feet". Another spoke of the poor support she received from a home support worker whom she felt was useless and upset her more by being there than managing herself. She talked about the subsequent visit from the Case Manager/Nurse, who explained that things couldn't always be done her (the senior's) way and she would have to adjust. At that point the woman decided to "manage" on her own rather than submit to "being managed". Likely the interpretation would be that she was "making demands".

But the ambivalence about any form of support, be it from friends, family, neighbours or the state was clear in all the women's stories. This ambivalence was the key feature of the decision-making process. It was this ambivalence that actually made the decision for them all. They all decided to stay where they were living now – at least for a while longer! This was also the finding of Gnaedinger (1990) in her study of widows. They too chose to remain in their own homes and remain independent and autonomous in a known environment. She also found the women felt that although quality of life was compromised, the support they needed could be found in their own environment to help them stay.

Making a decision implies change, yet these women did not want further change. This was the first contradiction I found; the contradictions continued. They thought they may need help, but didn't really want it. They wanted their support system to stay the same, but knew that it really wasn't. Some knew

family were there for them, but didn't want to be a burden. Even those without family showed contradiction in their decisions.

A dramatic example was Florence, who went to live in a facility where a great deal of care was provided for her. Yet she chose to move out again and back to a new apartment on her own. She struggled to make her own bed so it was done "right". She found ways to continue with her own meal preparation and took comfort from the letters she wrote and received from old friends and acquaintances. Her comment was that "it gave her something to do". It seemed that living in a facility made her feel and burden and that her life had no meaning. There was more purpose to her living when she looked after herself. So, for her, although help was provided by the state, she declined it!

This was further proof that decision-making is neither a static nor linear process – it is often not even permanent, as Florence's experience shows. All the women seemed to have made the decision not to move, but were still contemplating how best to live now. This forced them to look at how they could support themselves, or be supported where they lived now. It forced them to look at what was important to them at this stage of their life, and contemplate what may be important in the future. It also forced them to look at alternatives if the support wasn't sufficient.

Key to the exploration of whether support was sufficient or alternatives had to be considered was if the women could participate in reciprocity: The reciprocal form of support from friends was the most acceptable to all the women, so long as they could maintain the reciprocity. Family was a form of support, so

long as the senior didn't feel as though they were a burden. The support and assistance from the state was accepted for short periods particularly if they had control of the type of assistance. It was most accepted when the help was provided in a manner that was not offensive to the recipient. Most of the women spoke of obtaining private help to maintain them in their own homes. Although it gave them a greater feeling of control, they did not continue it over a prolonged period of time, as they preferred to remain independent and autonomous.

Although they had all made the decision to stay where they were - hence the title "I Don't Want to Move", there was a sense they knew this may not be for the rest of their lives. The biggest fear was that poor health and limited financial resources would mean they would be "taken" from their home and "managed by others". What then became important to them was a plan for the future. This was the main contradiction in what I was hearing, and as such was so difficult for me to grasp. They were all very clear they didn't want to move but they had agreed to participate in the research to talk about deciding to move. Perhaps the title could have been "I don't want to move, yet" as the women were continuing to look at options for the future in case they become necessary.

It was as if they knew, either intuitively or from their own experiences of the aging process or change in health status, that change, in this case of where they live, was inevitable. There was also a sense that they were not supposed to be dependent, but to remain independent and "not be a burden", so they were looking for ways to retain that independence. Yet they knew from their own experiences this might not be possible – although they were striving hard to remain

independent. Their fear came from the inevitable knowing that change was likely. They seemed to accept the change, but were fearful they would not be able to control it. They did not know what would trigger the inevitable change, but were planning as much as possible to be in control of it.

Implications for Policy, Practice and Research

The purpose of this research was to explore and understand the lived experience of senior single women as they make the decision about where to live in the later part of their lives. In particular I was looking for the experience of those who are in failing health and have no kin support. The impetus to complete this research was driven by my experience of working in many of the existing support systems available to senior women as they age. It was also my intent to learn more about the experiences from the women's stories, to incorporate that learning into my professional life as manager of community support programs. On a personal level I was also looking for some insights on how I could plan for my own future aging.

What became clear was the ambivalence of the women in their decision-making process. They were looking for options for change, but only when it was necessary. They were looking to keep control of any necessary change, but were doing so in a very contradictory and complex environment. It included changes in health status, adequate but finite financial resources, a changing support system, limited options open to the women and finally an environment which gave two messages: remain independent– but negotiate with friends, family and as a last resort the formal systems when independence becomes compromised.

Implications for Policy

There is much debate at the present time on the future of health care delivery, in particular the cost of providing care for seniors (Northcott & Milliken, 1998; Carriere, 2000). Aligned with this is the blurring of the lines between health care delivery and delivery of social supports and housing for seniors. Current initiatives within the health care system are looking at combining the housing needs of seniors with basic care options. The findings in this research provide some input into the requirements of the seniors themselves. While all the participants were resisting the option of moving, they were all looking for external support that was not only at an affordable and sustainable cost but also emotionally satisfying. The findings support the need for assisted living or congregate housing options that are affordable and responsive to senior women. Although government housing grants provide some financial relief, by extrapolation, there is as great a need for affordable housing and responsive supportive options for women of limited income with small or no public pensions. As 19% of women over 75 years of age live below the poverty line in the Capital Regional District (compared to 5% of men of similar age) the needs of limited income women need careful attention (Reitsma-Street, et. al. 2000).

As a taxpayer and a health care provider we are told that resources are scarce. Yet I believe we need to continue to strive to establish, at the very least, a strong social network of care for the seniors in our society. This network would include a combination of formal care options and informal care options. To more adequately address the needs and diversity of our seniors, it would have to

encompass a range of services, health care, housing and social supports. Stevenson (1989) questions if this is possible because of the huge resource implications for government.

However, in developing policies that set the framework for care to seniors, we must be mindful of the findings of this study and the work done by Jane Aronson (2000). By developing policies to perpetuate the notion that care for seniors is "managed care" (Aronson, 2000) we marginalize and make silent the voices of the women themselves. In silencing the voices, the contributions and value seniors provide to our society are also silenced.

It is clear from this study and many larger studies (Neysmith, 1998; Aronson 2000; Carriere, 2000) that seniors continue to want to be valued. They do not want to be a "burden" but want to be included in a meaningful way within their aging capacity. Finding a way to include seniors in policy and practice will have to be done within the contradictions discussed in this research. Neysmith (1998) argues: "it is the responsibility of the state, not of families, to ensure that Canadians have the resources they need in their old age" (p.281). It is the discretionary nature of many of the current policies that leads to the power imbalance between the "provider" and the "consumer". Evans (as cited in Neysmith, 1998) suggests that this power imbalance is the major factor preventing those using the services from being free negotiators. As Aronson (2000) suggests, this conflict from elderly women's perspective is highly significant in their desire to remain autonomous and in control of their own lives.

There is some support for seniors in British Columbia provided through the Continuing Care Policies. Inherent in these policies are two major components: first, that the continuing care services supplement but not replace the support of the family and the community, and second access to these services are not universal but at the discretion of the Minister of Health and Minister Responsible for Seniors.

The implications of this policy assumes two major factors: (a) there are family and/or community members available and (b) family or community friends want and can provide help when needed, both intermittently and/or continuously. It makes little accommodation for differences between those women (and men) who have no kin or community support.

All the women were resistant to moving, yet they were continuing to look at options should a move become necessary or desirable later on. Most were looking for living accommodations that provided services as well as meeting preferences in size, cost and location. Several issues arose from their stories that need to be considered in future policy discussions: Affordable supportive housing options; affordable services to assist the women, but only when needed by them to retain their independence; an environment that supports the women's autonomy and independence; a culture that ensures the women have an equal voice in their own care and support needs and a living space that ensures privacy. Providing this type of options in a supportive and collaborative fashion for senior women, may address the fears so evident in this research; that of losing control over the

decision-making process of where to live and there being no other affordable option but placement into a facility.

Implications for Social Work Practice

The findings of this study illustrate the importance of a person's home and where they live. It describes the preference these women have to stay in the home they have made for themselves. It also illustrates their desire to remain independent and in control of their living space and their lives, while acknowledging that because of deteriorating health status they require support to remain in their community. The implications for social workers and others who work in the health and human services field, are to be cognizant of the strong feelings of wanting to remain independent and autonomous. The work of Aronson (2000) in her descriptions of systems which try to manage seniors, along with the findings of this research strongly suggest that seniors do not like being "managed", but rather need to be acknowledged as major partners in any support provided. Social Workers also need to be mindful of the fears of seniors, in particular the fears of the future changes that are an inevitable part of life. This could be a forced moved to a long-term care facility, or other changes that seniors have no control over. The final change is that of death. For seniors, the likelihood of this happening sooner rather than later, is inevitable. This is certainly a contrast from social workers who may not yet have acknowledged the inevitability of death.

Social Workers employed by the state to provide services to seniors are often expected to provide minimal services with decreasing available options. The

B.C. Association of Social Workers (1984) ethics declares that social workers "regard the well-being of the persons they serve as their primary obligation". The philosophy behind this is that social workers "believe in the intrinsic worth and dignity of every human being and are committed to the values of acceptance, self-determination and respect of individuality" (p.3). The stories and experiences of the women in this study helps us understand how senior women wish to determine their life and gives meaning to the philosophy of social work. For social workers working within government systems that are rapidly becoming based on market economy and resource allocation models of care, adhering to the professional ethic of self-determination can present challenges. The challenge comes when the social worker, employed by the state, has to make a choice, or decision, between following the policies of the organization, or negotiating around them to provide the services the seniors determine they require. At the same time, social workers have to remain cognizant that often this service is accepted because of need rather than want.

Social Workers need to advocate on behalf of their clients. As this study has shown, remaining autonomous and in control of their lives while negotiating reciprocal support arrangements can be a struggle, especially without kin or few financial resources. But even if one has kin and financial resources, maintaining autonomy and reciprocity is difficult. As social workers we can continue to learn from senior women themselves what they need and as importantly how they need that support to be provided. Often seniors, especially those experiencing health

challenges do not have the energy left over to become political in ensuring that needed care is available to them

The final aspect of this research social workers need to consider in their practice is the resistance and ambivalence so evident in these women's stories. It was clear that all the women wanted to stay where they were living now. They wanted to remain in control of their lives, retain their independence, autonomy and desired to maintain reciprocal relationships. In working with seniors we cannot forget that aspect of becoming older. Yet for some seniors remaining autonomous is not an option because of failing health or other losses such as support systems or financial status. It is imperative that the seniors who do require assistance are not seen as "failing" in their goal of remaining autonomous. Rather we need to acknowledge that most seniors were not able to remain autonomous because of deterioration in health status, which prevented independence, and at no time attach blame or criticism for not being able to "cope".

We need to learn from "some of the strategies and insights developed among younger women with disabilities that articulates the power imbalance between those needing care and those providing it, and to the injustices and diminishment that, subtly and out of public view, unfold in the lives of women who are sick and disabled" (Aronson, 2000. p.54). In my mind these younger women with disabilities are the seniors of tomorrow. Their struggle to be identified as equal partners in the caregiver/recipient relationship sets a standard social workers would do well to emulate. By borrowing from these insights, older women and

the social workers providing support and assistance to them would keep the potential power differentials to a minimum. In so doing social workers will avoid treating the older women as people to be managed. Rather senior women will be equal partners in their own care.

Implications for Research

Phenomenological studies describe the meaning of the lived experience of a person or group of people. Analyzing the meaning of the experiences of the seven women in the study, suggests concepts and themes that help to uncover aspects of the ambivalence that pervades the decision-making processes that senior women encounter, as they face failing health and limited financial and social support. Further research is needed to deepen the understanding of more aspects of the experiences of different senior women in failing health as they think about where to live. For example, a criteria of the study participants were that they be cognitively intact. If it had been possible, both practically and without burdening those whose cognition was deteriorating, it would have added greater insight to the issues of control and autonomy than those identified by the participants in this study.

The findings in this study add to the discourse about decision-making and connections between health, housing and support of senior women. More needs to be done to hear from senior women themselves, and to understand more about their lives. The original intent was to ask women who were single now and without known kin to participate in the study. Because of difficulties obtaining the numbers needed for the study, I accepted two women with children who live

in Eastern Canada. Their responses were slightly different than the women without children. This difference could be better understood with further research to investigate the differences between women with and those without children.

Similarly, the experience of women who were widowed was different than that of women who were never married. Little is known about the lives of ever-single senior women compared to that of widowed, separated or divorced women. Although they are a small cohort group, it is a group that is likely to increase in number as the baby boomers age. Further research is needed to ensure that their voices are not lost in the bigger cohort group of married, widowed and divorced women.

More exploration of the impact of receiving care and the resistance of the women to moving is crucial. Only then will a fuller understanding of why these women, while considering a move, all clearly stated that they did not want to move until circumstances forced them to. Connected to this was the fear the women had of circumstances making the decision made for them. Yet again, the need to be in control was evident. More needs to be done to explore the connections and contradictions between these issues.

Also further exploration is needed to better understand the decision of where to live for women who live below the poverty line and those women of great wealth. The women in this study all classed themselves as middle income, which narrowed the findings. As well, all the women were Caucasian, five from Canada and two immigrants. Had women of colour or new immigrants participated in the

study, their experiences may have been different from the seven women interviewed.

I chose to concentrate on the experiences of women in this study. It would be important to do a similar study for men without kin and in failing health on how they go about making decisions. To combine the experiences of all these groups would provide a comprehensive basis for policy decisions and service options.

From the start of the research I wanted to learn more from seniors. In this study I concentrated on the experiences of senior women in failing health as they were making the decision of where to live. Yet my interest and pleasure at meeting and learning from seniors was peaked several times throughout the study, but not always around the issue of making the decision of where to live. Had there been the opportunity, I would have liked to explore several issues further with the women.

There were two in particular that intrigued me. One was the aspect of wanting to leave something tangible for their children or other relatives, contrasted by the guilt when they felt they might not be able to. This was particularly troubling for them when there was a sense that the ability to leave something would be compromised if the women chose to use the resources to support themselves remaining in control of their lives. The other was around ageism. Here the range of experiences varied. Some were clearly able to identify ageism others never mentioned it. Yet for me hints were clearly evident in the stories as I heard them or later as I read the transcriptions. More research would

help broaden the understanding of ageism and how it manifests itself. This would help society, young and old alike recognize it and its impact on the value of seniors as integral beings in the society we are all creating.

Finally more research would help deepen our understanding of the decision making process itself. This study showed how it is not a linear or static process. It also showed that it is often emotional as well as practical. It showed that decisions are resisted, but acknowledged as a part of life. What I became more aware of is that decision-making is intensely personal. More importantly I had a clear sense that decision making for people over 75 years of age is different from my own decision-making process in my fifties. Further research on the decision-making process at different stages of life would provide a deeper knowledge of the process. The result of a deeper knowledge of the differences age makes to the process, may address some of the contradictions so evident in this research. In particular, it is important to examine the disjuncture between policy decisions made by those in their middle years and how they are not always relevant to those in their senior years.

Conclusion

In summary this study showed the complexity and contradictions in the decision-making process of where to live in the later part of their lives for women over 75 years of age and in failing health. It described the importance of remaining independent and autonomous to these older women. They all evidenced the desire to remain in their own homes and retain control and autonomy over their lives. Although at times they required support and assistance

to do so, they strongly believed this should be a reciprocated arrangement when provided informally.

When provided formally they wanted to retain the control over the type and manner that service was delivered. Most of the women had received formal care or support at one time, and all spoke of the nature of the care. The occasions when care was provided in a context of warmth, caring and respect for them as individuals it was appreciated. The occasions when they were devalued as people were seen as a burden they would rather do without.

Finally the study illustrated the complexity of the decision-making process of deciding where to live for women over 75 years of age who were not in good health. It showed the women's ambivalence to making the decision; it also showed the contradictions in the environment in which the decisions were being made. But in the end what it showed most was the way in which these seven women were choosing to live their lives. They provided rich insights into what it means to be growing older, the challenges, the successes and the compromises they had to make. They provided us with a wisdom that comes from experiencing a phenomenon, and offered it to me as an opportunity to learn.

> *This "Golden Age" is just a load of rubbish. You see, you need two things for your retirement. An adequate income, and good health. Without those two things together, everything else is secondary. But if you've got good health and an adequate income*

where you don't have to make ends meet, you can take care of everything else.

Elizabeth.

REFERENCES

Aronson, J. (2000). Restructuring Older Women's Needs: Care Receiving as a Site of Struggle and Resistance. In Neysmith, S.M. (Ed.), Restructuring Caring Labour (p.52-72). Oxford University Press, Don Mills, Ontario.

Aronson, J. (1998). Dutiful daughters and undemanding mothers: constraining images of giving and receiving care in middle and later life. In Baines, C.; Evans, P.; & Neysmith, S.; (Eds.), Women's Caring (2nd ed.) (p.114-138) Oxford University Press, Don Mills, Ontario

Aronson, J. (1990). Old Women's Experiences of Needing Care: Choice or Compulsion? In Canadian Journal on Aging Vol. 9 no. 3. (pp. 234 – 247)

Banister, E. M. (1999). Evolving Reflexivity: Negotiating Meaning of Women's Midlife Experience. In Qualitative Inquiry *Vol.5 (1)* pp. 3 – 23. Sage Publications.

Bandura, A. (1986). Social Foundations of Thought and Action: A social cognitive theory. Prentice-Hall, Englewood Cliffs, N.J.

Belenky, M.F., Clinchy, B.M., Goldberger, N.R., Tarule, J.M., (1997) Women's Ways of Knowing. (2nd ed.) Basic Books, New York.

British Columbia, (1991). Closer to Home: The Report of the B.C. Royal Commission on Health Care and Costs. Crown Publications Inc. Victoria, B.C.

British Columbia. (1989) Continuing Care Act, Bill 15.

British Columbia. (2000) Ministry of Health and Ministry Responsible for Seniors. Strategic Directions For Continuing Care Renewal.

British Columbia, Ministry of Health. (1992) Service Provider Handbook. Continuing Care Division.

British Columbia, Ministry of Health and Ministry Responsible for Seniors. (2000) Amendments to the Continuing Care Policy Manual.

British Columbia Association of Social Workers (1984). Code of Ethics. Vancouver, B.C.

Capital Health Region. Victoria, B.C. (1998) Seniors Health Profile. Prepared by the Population Health and Clinical Evaluation Unit.

Capital Health Region. Victoria, B.C. (1998) Home is Where Our Health Is. Primary/Community Care.

Carriere, Y. (2000). Population Aging and Hospital Days: Will there be a problem? In Gee, E.M.; & Gutman, G.; (Eds.) The Overselling of Population Aging. (pp. 26 – 44) Oxford University Press, Don Mills Ontario.

Chappell, H., Strain, L., & Blandford, A. (1986) Aging and Health Care: A Social Perspective. Holt, Rinehart and Winston, Toronto, Canada.

Cohen, L. (1984) Small Expectations: Society's Betrayal of Older Women. McClelland & Stewart, Toronto, Ont.

Colaizzi, P. F. (1978) Psychological Research as the Phenomenologist Views It. In Valle, R.S.; & King, M.; (Eds.), Existential-Phenomenological Alternatives for Psychology. (pp. 48-71) Oxford University Press, Toronto.

Coyle, J. M. (1997). Handbook on Women and Aging. Greenwood Press, Westport, Connecticut.

Cresswell, J. W. (1998) Qualitative Inquiry and Research Design: Choosing Among *Five* Traditions. Sage Publications, Thousand Oaks, California.

Diamond, T. (1986) Social Policy and Everyday Life in Nursing Homes: A Critical Ethnography in Social Science and Medicine, *23(12)*, pp. 1287-1295.

Domarad, B. and Buschmann, M. Interviewing Older Adults, Increasing the Credibility of Interview Data in Journal of Gerontological Nursing. 1995 Vol. 21 (No.9) September. (pp.14 - 20)

Elliot, G., Hunt, M.; Hutchison, K . (1996) Facts on Aging in Canada. Office of Gerontological Studies, McMaster University, Hamilton, Ontario, Canada.

Evans, P. M. (1998). Gender, Poverty, and Women's Caring. In Bains, P.; Evans , P.; & Neysmith, S. (Eds.) Women's Caring. (pp. 47 – 68. Oxford University Press, Don Mills Ontario.

Finch, J. (1989). Family Obligations and Social Change. Polity Press, Cambridge UK.

Finch, J. & Mason, J. (1993) Negotiating Family Responsibilities. Tavistock/Routledge, London.

Garner, J. D., (1999), Feminism and Feminist Gerontology. In Women and Aging, Vol. 11 2/3 (pp. 3 – 12)

Gee, E. M. (2000) Population and Politics. In Gee, E.M.; & Gutman, G.; (Eds.) The Overselling of Population Aging. (pp. 5 - 25) Oxford University Press, Don Mills Ontario.

Gnaedinger, N. (1990) "It's Everything to Me Right Now": The Meaning of Home to Elderly Widows. In Canadian Housing, Vol.7 No.3. pp. 10 – 12.

Harris, R. (1998). Introduction to Decision Making. Vanguard University, Costa Mesa, California.

Haylor, M. (1996). Interpretive Research: Designs that Sensitize us to People's Lived Experience of Health and Illness. University of Victoria, Victoria, B.C.

Hycner, R.H. (1985). Some Guidelines for the Phenomenological Analysis of Interview Data. Marinus Nijhoff Publishers, Dordrecht, Netherlands.

Hooyman, N.; & Kiyak, H. A. (1996) Social Gerontology: A Multidisciplinary Perspective. (4th ed.) Simon & Schuster Company. Needham Heights, MA.

Keating, N., Kerr, K., Warren, S., Grace, M., & Wertenberger, D., (1994) Who's the Family in Family Caregiving? in Canadian Journal on Aging Vol.13 (2) pp. 268-287.

Kimball, M. M. (1995). Feminist Visions of Gender Similarities and Differences. Harrington Park Press, Binghamton, NY.

Kvale, S.(1996). Inter Views: An introduction to qualitative research interviewing. Sage Publications, Thousand Oaks, California.

Lincoln, Y. S. & Guba, E. G. (1998) Fourth Generation Evaluation. Sage Publications, Newbury Park California.

Low-Beer, F.H. (1995) Questions of Judgment: Determining What's Right. Prometheus books, Amherst, New York.

Macdonald, B. with Rich, C. (1979) Look me in the Eye: Old Women, Aging and Ageism. Spinsters, Inc., San Francisco.

MacKenzie, P.A. (1999) Aging in Place in Ageing Communities: Elderly Women's Accounts of Growing Older in Rural Saskatchewan. Doctoral Dissertation: University of Edinburgh, Edinburgh, Scotland.

Macquarrie, M.A., & Keddy, B., (1992) Women and Aging: Directions for Research. Journal of Women and Aging, Vol. 4 (2) 21-32.

Markson, E. W. (1983) Older Women: Issues and Prospects. Lexington Books, Lexington, Mass.

Maule, A. J. & Svenson, O. (1993). Theoretical and Empirical Approaches to Behavioural Decision Making and Their Relation to Time Constraints. In Svenson, O. and Maule, A. J. (Ed.) Time Pressure and Stress in Human Judgement and Decision Making (pp 3-22). Plenum Press, New York.

McDonald-Miszczak, L.C. (1995) Self-efficacy, Self-regulation, and complex Decision Making in Younger and Older Adults. Unpublished doctoral dissertation. University of Victoria, Victoria.

McNulty, V. (1998) Unpublished paper. Course work paper in Human and Social Development Multi-Disciplinary Masters Program in Policy and Practice. University of Victoria, B.C. Canada.

Miller, J.B. (1991) The Development of Women's Sense of Self, in Jordan, J.V., Kaplan, A.G., Miller, J.B., Stiver, I.P., Surrey, J.L. (eds) Women's Growth in Connection: Writings from the Stone Center (pp. 11 – 26) Guildford Press, New York.

Mulally, R. (1993). Structural Social Work: Ideology, Theory, and Practice. McClelland and Stewart Inc. Toronto, Ontario.

Neysmith, S. M. (2000). Networking Across Differences: Connecting Restructuring and Caring Labour. In Neysmith, S. M. (Ed.) Restructuring Caring Labour. (pp. 1. 28) Oxford University Press, Don Mills, Ontario.

Neysmith, S. M. (1998). From Home Care to Social Care: The Value of a Vision. In Baines C.; Evans, P.; & Neysmith, S. (Eds.), Women's Caring (2nd ed.) (pp.233 - 249) Oxford University Press, Don Mills, Ontario

Northcott, H. C., Milliken, P. J. (1998). Aging in British Columbia: Burden or Benefit? Detselig Enterprises Ltd., Calgary Alberta, Canada.

Patton, M.Q.. (1990) Qualitative Evaluation and Research Methods. (2nd Ed.) Sage Publications, Newbury Park, California.

Phillipson, C. (1981) Women in Later Life: Patterns of Control and Subordination in Hutter, B. & Williams, G. (eds) Controlling Women: The Normal and the Deviant. Croom Helm, London pp. 185 - 202.

Polkinghorne, D.E. (1989). Changing Conversations about human science. In S. Kvale (Ed.) Issues of validity in qualitative research (pp. 13-45). Luhc, Sweden: Student literature.

Reitsma-Street, M. et al. (2000) Poverty and Inequality in the Capital Region of British Columbia. University of Victoria, Victoria, B.C., Canada.

Roberto, K. A. (1989). Exchange and Equity in Friendships. In Adams, R.G., Bleiszner, R. (Eds.) Older Adult Friendship: Structure and Process. (pp. 147 – 165) Sage Publications, Newbury Park, California.

Rubenstein, R.L., Alexander, B.C., Goodman, M. & Luborsky, M., Key Relationships of Never Married, Childless Older Women: A Cultural Analysis. (1991) Journal of Gerontology Vol. 46 (5) 270-277.

Russell, C., (1987) Ageing as a Feminist Issue. Women's Studies Int. Forum, Vol. 10 (2) 125-132.

Sarton, M. (1988). After the Stroke W.W. Norton & Co. New York.

Sarton, M. (1996) At Eighty-Two: A Journal. W.W. Norton & Co. New York.

Schick, F. (1997) Making Choices: A Recasting of Decision Theory. Cambridge University Press, Cambridge, UK.

Sorrell, J.M. & Redmond, G. M. (1995) Interviews in qualitative nursing research: differing approaches for ethnographic and phenomenological studies. Journal of Advanced Nursing, 1995 Vol 21, 1117-1122.

Stevenson, O. (1989) Age and Vulnerability: A Guide to Better Care. Hodder & Stoughton, London.

Treas, J. (1981) The great American fertility debate: Generational balance and support of the aged. Gerontologist Vol. 21 98-103.

van Manen, M. (1997) Researching Lived Experience (2nd. Ed.) The Althouse Press, London, Ontario, Canada.

Appendix A

Information letter for potential participants

January 2000

Dear Potential Member of This Study:

Re: Women Without Kin Deciding Where to Live in Later Life.

This letter is to introduce myself to you and to ask if you are willing to participate in a research project on senior women who are considering a move from their current home for a variety of reasons. I am calling this study "Women without kin deciding where to live in later life".

My name is Vicki McNulty and I am completing thesis research as part of the requirements towards a Masters in Social Work degree at the University of Victoria. This work is under the supervision of Dr. Marge Reitsma-Street and a thesis committee made up of social work and nursing faculty.

I have had almost thirty years experience as a social worker in both Britain and Canada, primarily working as a manager in health care services for seniors. I am taking the opportunity provided by the thesis to learn more about what it is like to be a senior woman today by listening to you. In particular I wish to spend time interviewing older women who are now single and have no children.

To give focus to our time together, I will be asking questions about the experiences and factors which go into the decision making process for older senior women when they realize they may be unable to continue living as they are now. In this way I will be exploring issues, questions and processes that senior single women experience as they make decisions about new living arrangements.

I anticipate that there will be one or two interviews which will take between one and one and a half hours each. You will also be asked to sign a consent form prior to your participation.

Additionally, at the end of the research you have the option of participating in a recognition event at my expense as a way of showing my appreciation for your help and an opportunity to provide feedback on the research.

Participation is entirely voluntary. The Senior Citizen Counsellors and staff at Fairfield New Horizons Activity Centre, and staff at Silver Threads agreed to support the research by distributing this letter to women who may meet the criteria. However, no one will be aware of your participation.

If you are willing to participate or would like more information, please call me at 382-4888 preferably in the evening or on the weekend. Other times you can leave a message on the machine and I will return your call. Dr. Reitsma-Street can be reached through the Human and Social Development department at the University of Victoria at 721-6468.

Thank you for considering this request.

Yours Sincerely,

Vicki McNulty.

Appendix B

Informed Consent – One Page

CONSENT FORM

Consent to Participate in the Interview for the Lived experiences of senior women with no family as they decide where and how they will live for the later part of their lives.

The following information is provided for you to decide whether you wish to participate in the study, conducted by Vicki McNulty, a graduate student under the supervision of Doctors Reitsma-Street, MacKenzie and Banister. You are free to decide not to participate or to withdraw at any time. Your participation or withdrawal will not affect any services you currently receive or may receive in the future.

The purpose of this study is to understand the process and the thinking that single senior women without children go through when they are deciding whether they can continue to live as they are now. The procedure will one or two audio taped interviews with myself each lasting about one to two hours each. There will also be the opportunity of going through the findings of the research and providing feedback to the researcher.

Your interview will be audiotaped and the tape erased immediately after the thesis is approved. There will be no information used in the interview transcripts or data summaries which could identify you. You will also be provided with a copy of the typed transcript of our interview(s), for information and reflection. Your interview, with those of several other women, will be analyzed to understand your current situation, decision-making process and resources available to senior women. They will form the basis of a greater understanding of the experiences and their essential meanings.

Any data collected in the study will remain confidential; interview results will be kept in a locked filing cabinet in a locked office. Only the researcher, Vicki McNulty and her supervisor, Dr. Marge Reitsma-Street will have access to the data. Your name will not be attached to any published results, and using a code name to identify results obtained from individual subjects will protect your confidentiality. The master list linking your name with the code name will be kept in a different locked cupboard to the other research data.

All data will be destroyed upon successful completion of the Master's degree. Papers will be shredded; computer discs destroyed and the computer hard drive will be cleared of any of this research data.

If you agree to participate in this interview, please sign in the space indicated.

I have had the opportunity to discuss the project and agree to participate in the interviews to research the experiences of senior childless women facing a change in residence.

Signature of Participant:

Date: Phone:

Witness:

Appendix C

Interview Questions

1. Describe your current living situation and what it is that is prompting
   you to consider a change.

2. Where do you see yourself living in the future?
   - What options do you have/don't you have?
   - What affects your sense of what is possible and not possible in your future?
   - How come you see some futures and not others?

3. Talk about how you are making the decision about future living arrangements.
   - How do you know what matters to you?
   - What doesn't matter to you?
   - How do you know your decisions are being respected?
   - How does this need to be recognized?

4. What is it like to live through deciding these changes?
   - Describe your feelings as you go through this process of deciding to change
   - What do you fell is in your control?
   - Describe your reactions to the choices you feel you have.

VITA

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Educational Institutions Attended:

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Salford College of Technology	1967 to 1970

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Title of Thesis:

"I Don't Want to Move": Older Women Deciding Where to Live

Author 

Vicki Elizabeth McNulty

April 1, 2001