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UNIVERSITY OF SAN DIEGO
Philip Y. Hahn School of Nursing
DOCTOR OF NURSING SCIENCE

BEING ALONE: THE EXPERIENCE OF ELDERLY
HOMEBOUND FEMALES

by

Sharon Davis Burt, MSN, RN

A dissertation proposal presented to the
FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING
UNIVERSITY OF SAN DIEGO

in partial fulfillment of the
requirements for the degree
DOCTOR OF NURSING SCIENCE

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Abstract

Being Alone: The Experience of Elderly Homebound Females

Elderly women comprise one of the fastest growing segments of the population in the United States. This growth is due in large part to increasing longevity, and a woman's life expectancy has now reached 79 years. However, along with those added years comes an increase in morbidity and a greater likelihood of living alone.

This study describes the life experience of a specific group of elderly women, those who are homebound and living alone. When elderly women are included in research, the same combination of descriptors used for the participants in this study has not been incorporated. Consequently, while much has been inferred about this specific group of women, little is actually known.

Using a phenomenological method, the lived experience of homebound elderly females living alone was explored. Interviews were conducted with fourteen women who were 65 years of age or older, lived alone, and were able to leave their homes only with great effort and/or the assistance of others. The phenomenological methodology of Giorgi was used to analyze the data from these interviews.

Five main themes emerged from the data: slipping away, balancing dependence and independence, making the most of it, connecting and looking inward. Portions of the women's lives were slipping away as they passed their life expectancy and

were living on borrowed time. Contacts with friends and relatives had been lost due to death and distance. In response to these changes, the women had to find a balance between dependence and independence. To maintain a degree of independence, it was necessary that they accept assistance in getting around and maintaining their home. However, the women were making the most of their lives, and living alone did not make them lonely. Those who were most positive about their lives all resided in senior complexes. These women stayed in contact with others and were likely to give assistance or gifts to others. They also looked inward to discuss where they found their strength, reflected on their past, and offered advice to younger women who would be following in their footsteps.

DEDICATION

This dissertation is dedicated to my grandmothers, Olive Elizabeth Babb and Elizabeth Oster. The time I shared with them was short. However, the lessons learned from them have stayed with me through the years.

ACKNOWLEDGMENTS

The completion of this dissertation was accomplished with the assistance and support of some very special people. I was extremely fortunate to have a very encouraging and helpful dissertation committee. I have had the pleasure of knowing two of the members, Dr. Roth and Dr. Anderson, from previous years when I was in USD's Masters program. These women are true role models as nurse educators. The time, patience, and support they have given me has been invaluable.

For a long time, "normal" home life has been suspended due to my work on this dissertation. A very special thanks goes to my son, Scott, and my husband, David. Their continued support and encouragement gave me the opportunity to complete this endeavor. I want to thank them for their patience and understanding of my commitment to this work.

Two friends also deserve recognition for the help given to me on this project. Dr. Jane Rapps, a colleague and fellow student, was a wonderful support who would give a push when it was needed and always offered encouragement when it seemed like this work would never come to an end. To Nancy Pettersson, I want to say thank you for continuing to remind me that "this too shall pass!"

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Chapter I

Focus of the Study

Do not deny getting older, many are
denied the privilege. (Source Unknown)

Today, elderly women comprise one of the fastest growing segments of the population in the United States. It is estimated that from 1988 to the year 2000, the number of elderly in the US will double and the number of individuals over 85 will triple (Dimond, 1989).

In 1994, the elderly comprised one in eight (33.2 million) Americans. The projection for 2050 is that the number of elderly will grow to 80 million. The greatest increase will be primarily between 2010 and 2030 when the "baby boomers" enter their senior years (US Census Bureau, 1995).

San Diego County experienced an overall growth rate of 3% between the years of 1980 and 1990. However, the senior population experienced a more phenomenal change. During those same years, the number of individuals in San Diego County who were 65 years of age and older went from 191,742 to 272,348 representing a 42% increase. The projection is that there

will be 331,466 seniors in San Diego County in the year 2000. Females represent 55.3% of those 65-74 and 62.3% of those over 75 (County of San Diego, 1995).

This population growth is due, in large part, to individuals living longer. Life expectancy has risen steadily since the founding of the United States when an individual could expect to live only 35 years. In 1950 the life expectancy reached 68 years. That number increased to 76 years in 1991. However, women continue to experience a greater longevity. A woman's life expectancy is 79 years compared to 72 years for her male counterpart (US Census Bureau, 1995).

Verbrugge (1985) says that "the quality of life is as important as its quantity: increasing a population's life expectancy is a fine achievement, but a compromised one if it means many years of symptoms and disability for older people" (p.48). While women do experience a longer life than men, they are also faced with greater morbidity which is defined here as "generalized poor health, a specific illness, or the sum of a number of illnesses. [Morbidity is reflected by] higher rates of restricted activity, disability, and physician visits,...and higher levels of prescription and nonprescription drug use" (Rodin & Ickovics, 1990, p.1021).

Elderly women are also more likely than their male counterparts to be living alone. This is primarily a result of widowhood, and widows tend to be the poorest of all the

elderly who live alone and are at risk of being dependent (Davis, Grant, & Rowland, 1990; Schank & Lough, 1989; Stone, 1989). In analyzing data from the Supplement on Aging of the 1984 National Health Interview, Wolf (1990) found that 68.6% of his sample of 4124 women 65 and older were living alone. In 1993, eight of every ten noninstitutionalized elderly living alone were women. The likelihood of women living alone was found to increase with age. The numbers grew from 32% in the 65 - 74 year olds to 57% in the 85 years or more group (US Census Bureau, 1995). In 1990, San Diego County had 52,373 households with a woman 65 years of age or older living alone (SANDAG, 1991). In the absence of adequate community based programs, the independence of the older female is severely compromised and the woman living alone is at risk for being institutionalized (Hess, 1990).

Additionally, Rowe (1996) reports that research has shown that older people who are isolated are less healthy and use more medical services than those who are socially engaged. This being the case, one could expect the elderly female living alone to be a candidate for increased medical care.

Roberts (1983) makes an even stronger statement about women and says that they should be identified as oppressed because of their control by outside forces having greater prestige, power, and status. It is this despairing image of elderly women that provides the impetus of this study.

While much can be inferred about the lives of elderly homebound women who live alone, information from the individuals actually living the experience is lacking. A true picture of what life is like for this aggregate needs to come from the women themselves. Consequently, this study was undertaken to identify how these women view their lives and to start filling the void in the literature pertaining to elderly homebound women living alone.

Purpose of Study

This study was initiated to discover what is it like for elderly females who live alone and have difficulty leaving their homes. Specifically, the research question was: What is the lived experience of the elderly female who is homebound and living alone? With women experiencing both greater longevity and morbidity, the number of women who are alone and confined to their homes is on the increase. The interest in studying these women has not kept pace with the growth of this segment of our population. As a result, little is known about this specific aggregate. Therefore, this study served as an initial step in gaining knowledge about elderly females who are both homebound and living alone from the women living the experience.

Philosophical Underpinnings

Phenomenology is a study of the lifeworld or of the world as we experience it pre-reflectively. Its development was a form of protest against reductionism and was meant to

give a deeper and broader understanding of phenomena than could be obtained from empiricism. The subjective experience of the informants is the primary concern of the inquiry (Spiegelberg, 1982; Swanson-Kauffman & Schonwald, 1988; Van Manen, 1990).

Phenomenology is not an homogenous philosophy. Instead, there are many different philosophical approaches to phenomenology. Two philosophers who have varied approaches and who are often cited in nursing are Edmund Husserl and Martin Heidegger (Walters, 1995).

Edmund Husserl is credited as being the central figure in the development of phenomenology. When comparing his work to traditional philosophies, phenomenology could be called a system in reverse. Rather than building upwards, Husserl kept digging deeper and deeper to lay a firm foundation for gaining insights (Husserl, 1913/1969). His philosophy was constantly in the making, but the guiding theme of phenomenology lies with Husserl's going back to the things themselves. He believed in posing a root question - or a question backwards - and going back to the source of the knowledge (Giorgi, 1985; Sinha, 1969).

Pure phenomenology as science is an investigation of essences and not one of being-there. "For the individual is not essence, it is true, but it 'has' an essence, which can be said of it with evident validity....Phenomenology can

recognize with objective validity only essences and essential relations..." (Husserl, 1965, p. 116).

For Husserl, phenomenology and science had a "positive, mutual reciprocal relationship with each other. Science provides the knowledge by which reality is revealed...phenomenology provides the foundational philosophical infrastructure and direction for science and its knowledge" (Omery & Mack, 1995, p.145).

Husserl's phenomenological method involves two attitudes: the natural attitude and philosophical attitude. The natural attitude includes the relationship consciousness has to everyday experiences including human relationships. The philosophical attitude is concerned with basic philosophical questions. Going from the natural to philosophical attitude is phenomenological reduction which involves reducing a complex problem into basic components by eliminating prejudices about the world. Husserl felt it was necessary to bracket or suspend the beliefs about the world to allow the phenomenon to speak for itself rather than through beliefs about it (Omery & Mack, 1995; Walters, 1995).

Heidegger was one of Husserl's students, but Heidegger disassociated himself from Husserl. Heidegger did not believe it was possible to bracket one's 'being-in the world'. Instead, Heidegger looked at human existence as *Dasein*, or being there. He believed that people are in and of the world rather than subjects in a world of objects, and that their

understanding of the world comes from their experience in the world (Molony, 1995; Walters, 1995).

Heidegger's method of interpretation is hermeneutics which is one of the processes people use to understand their everyday world. Heidegger argues that it is only through one's own lived experience that it is possible to interpret something. Hermeneutics then goes beyond the descriptive mode and uses reflection to uncover hidden meanings (Heidegger, 1972; Omery & Mack, 1995).

Method

Phenomenology, based on the philosophy of Husserl, was the research method used in this study. Because "the aim of phenomenology is to describe experience as it is lived by people" (Oiler, 1986, p. 70), the focus was on the experience of the subject rather than subjects or objects themselves (Munhall & Oiler, 1986). Since the objective of this study was to obtain insight into the lived experience of a specific aggregate of elderly, phenomenology was the appropriate method to use.

Like Husserl, Giorgi's phenomenological analysis incorporates the concern for essences. It is when searching for these essences that the researcher is directed toward the essentials. By trying to vary the phenomenon's description, the researcher is able to find its essential characteristics; if these characteristics are changed, so will the identity of

the phenomenon. Reliability is then perceived when this essential description can be used consistently (Beck, 1994).

"...The very worth of a phenomenological portrayal of reality must be judged in terms of how validly the researcher represents the experiences of those who live the reality" (Swanson-Kauffman & Schonwald, 1988, p. 98). Consequently, it is essential that the researcher suspend preconceptions when viewing the experience. One method of accomplishing this is bracketing.

Bracketing is a methodological attempt to set aside assumptions of the researcher before and during data collection. It attempts to bridge the gap between the researcher's experience and reality outside the researcher's world. "Bracketing allows a phenomenon to speak for itself rather than through concepts or beliefs about it" (Omery & Mack, 1995, p. 145).

There were specific assumptions regarding the aggregate under study that were bracketed. The first assumption that was set aside was that elderly females are an oppressed aggregate. Additional notions that were bracketed were: there are hidden power imbalances constraining the elderly female and elderly females experience social, political, and economic constraints that must be transcended. By setting aside preconceived ideas, the effort was made to confront the data in pure form (Polit & Hungler, 1995).

Significance of Study

With the increase in the numbers of elderly comes an increase in the number of dependents. In 1990, 1% of those aged 65 - 74 lived in a nursing home compared to the 25% aged 85 or older who were institutionalized. Among the noninstitutionalized in that same year, 9% of those 65 - 69 and 50% of those 85 and older needed assistance performing everyday activities such as bathing, meal preparation and getting around inside the home (US Census Bureau, 1995). In San Diego County in 1990, there were 150,848 noninstitutionalized female seniors 65 years and older. Of those, 12.7% had a mobility or a self-care limitation, and 7.6% had a mobility and a self-care limitation (SANDAG, 1992).

The task remains to determine how elderly females feel about their quality of life while in this late stage of life. If the elderly are to be maintained in their own home environments, identifying necessary services and finding resources to provide them will be essential.

Clinical Research and Curricula

As the elderly population increases, 18% of the males' and 27% of the females' added years will be spent living as impaired, disabled and frail individuals (Lookinland & Anson, 1995). Consequently, there will be need for more medical interface. The care given to both males and females should be equitable. However, this is not the case with the current system.

Malterud (1993), a female physician, points out two consequences of male dominance of medicine on care of women: medicalization and ignoring. Medicalization refers to defining the normal changes in the female life cycle, such as menopause, as a disease or abnormality in need of medical intervention. "In this way, female normality may be stolen and replaced by medical needs and dependency..." (p. 368). "Ignoring" is the result of insufficient knowledge of health problems specific to women. Medicalization and ignoring are double symptoms of the female voice not being heard in medicine.

In order to understand women's health problems, research which includes appropriate representations of women and research specific to health concerns unique to women must be generated. Because of changes that occur throughout individuals' life cycles, studies specific to elderly women are highly relevant.

There is a definite need for women to be included as research subjects. In the past, white males have been the norm in medical and pharmacological research. Even in research involving animals, it is male animals which almost always have been used. Unfortunately, the results of male based studies may not be reliably extended to women (Rodin & Ickovics, 1990). While it is understandable that women of childbearing years be protected, similar concerns are not applicable to elderly women.

Public law now requires that women cannot be excluded from clinical trials funded by the National Institute of Health (NIH) based on costs. However, the exclusion criteria are so rigid that it is often impossible to find elderly women who meet current criteria. In some studies, there are 50 volunteers for each individual who qualifies. The question then arises if the group being studied is genetically superior and not typical of this elderly population (Butler, Collins, Meier, Muller & Pinn, 1995).

The need for research that focuses on problems that uniquely or disproportionately affect women is another concern. The studies where women have been included have dealt with major disease categories such as cancer and cardiovascular concerns. However, areas that have not had adequate attention are those that affect women in unbalanced rates. These areas include: rheumatoid arthritis, lupus, and gastrointestinal disorders. Without an understanding of health specific problems related to women, females will continue to suffer from illnesses not regarded as diseases, have symptomatology that lacks a diagnostic label, and be seen as hypochondriacs (Malterud, 1993; Rodin & Ickovics, 1990).

Dr. Robert Butler, editor-in-chief of Geriatrics, reports that the gap caused by women's health being neglected in the medical curricula and research undoubtedly has had deleterious effects on the delivery of health care to women.

Another physician, Dr. Diane Meier, reports that while policy makers have begun to act on the lack of research and training in the chronic diseases of middle aged and older women, this insight has yet to be translated into clinically useful teaching experiences. She cites the example that most of the house staff on the in-patient facility at her organization, New York's Mount Sinai Medical Center, do not know the differential diagnosis and treatments for osteoporosis. At no point in their residencies, which are largely acute care oriented, do the future medical doctors receive exposure to chronically ill clients. Such examples succinctly demonstrate the gap between an awareness of the issues and their translation into practice in medical education. While it is recognized that curricula will vary among educational institutions, there remains a general neglect in this area. "Medical school curricula are hard to change, because focusing attention on women's health issues means taking time away from other important issues" (Butler et al, 1995, par. 8).

Theory Development

Health and person encompass two of the four basic concepts of the nursing profession. However, the body of knowledge related to elderly females in both of these areas is limited. In order for the nursing profession to be responsive to this aggregate, information needs to be obtained regarding this population.

While theory development was not the purpose of this study, the results provide insights for nursing theory. The findings of this study add to the knowledge base as it relates to this specific participant and to the concept of health.

Meaning of health. Health is one of the basic concepts of nursing. Each conceptual model provides a distinct perspective on four phenomena central to nursing: person, environment, health and nursing. While there is no single definition of health, each nursing theorist defines it according to personal philosophic beliefs. Florence Nightingale, considered the first nurse theorist, looked at health as "being well and using one's powers to the fullest extent" (Kozier, Erb, & Blais, 1997, p.31).

The concept of health falls into two major paradigms: the one used most often looks at health as the absence of disease. This paradigm puts health on a continuum with disease at one end and high level wellness at the other. Adaptation to disease and absence of disease are in between. The second paradigm sees health as a unitary evolving pattern of person-environment interaction with a spiraling progression to higher levels of development. Whichever paradigm is used, researchers must be clear as to the perspective of health guiding them (Newman, 1990).

The perspective of health considered here is one of high level wellness. Smith's (1983) eudaimonistic model defines

this as the condition of complete development of one's potential and incorporates the entire physical, social, aesthetic and moral being. Nursing's goal is the promotion of health, but "a person who has not realized full potential does not have health" (Lyon, 1990, p. 268). The ideal would be for everyone to reach a high level of wellness. Interviews are one way of evaluating an individual's personal perception of his or her health.

Practice. When faced with the current trend of an increasing populace of elderly dependent females, questions arise as to who is going to care for these individuals. Geriatric nursing is not considered a dynamic field that attracts a large number of professional personnel. Oft times, nurses prefer to gravitate toward more stimulating arenas involving high technology and better pay. Finding an increasing number of staff to work with the elderly is an ever increasing problem. Concentrated efforts will need to be made to find ways to attract and retain innovative and qualified staff.

Health care workers are at risk of having negative attitudes toward the elderly (Lookinland & Anson, 1995). These attitudes are believed to be due, in part, to the nurses' exposure to the ill and infirm elderly and may have led to emotional rejection of the elderly. "Such feelings among the 'in group' of health care personnel may compound

problems related to recruitment and retention of geriatric care providers" (p. 53).

Robert Butler is generally credited with coining the term "ageism" which is described as "a societal pattern of attitudes and stereotypes that devalue aging and old people" (Cook, 1992, p. 292). However, the question needs to be asked: is ageism better described as a "... lack of knowledge about older people and the ways in which the elderly population is changing demographically?" (p. 292).

If the latter is more appropriate, a multifaceted approach to change is appropriate. Ageism, as well as sexism, should be addressed within the health care system. This would involve patient and professional education along with changes in policies and organizations (Sharpe, 1995). Because nursing is not immune to the prejudices of ageism and sexism, ways of instituting change within our own profession must be found. For a start, nursing education's transformation might involve curricula changes to put emphasis on the importance of care of the elderly and how they can be cared for in their own homes. Additional interchanges with healthy elderly women could be part of the clinical experiences so that more of the interface with this aggregate would be of a positive nature.

This study provided insight into the life experiences of a significant segment of our population. It is only by obtaining the personal stories of these women that one can

begin to understand the meaning of being an elderly homebound female living alone.

Chapter 2

Review of Literature

"It is said that the greatness of a nation is measured by how it treats its people" (Hanson, 1994, p.4). In many countries, including the United States, the elderly have not been treated with the respect due them. Their numbers are growing and the question is how will their needs for health care be met. In America, the future of health care for the elderly is described as a 'dangerous and delicate situation' (Hanson, 1994). This chapter looks at the majority population of this aggregate, the elderly female, in relation to her social constructs, economics, political concerns, and research arenas.

Social Constructs

Society impacts the lives of every individual, but the effects on the populace are not felt equally. Even the lives of women in general are affected differently than those of elderly females. The consequences of being an elderly woman in the American society can be seen in the way gender is defined, the consequences of a lifetime of economic inequities, and outdated policy decisions that are still in place.

Gender

To understand the status of the elderly female in the United States, one must look beyond the biological differences of the sexes to the social construct of gender. Gender is characterized as society's definition of what it means to be male or female (Hendricks, 1990). Based primarily on their gender, men and women are treated differently and have different socially created experiences.

Gender is not only the physical differences of the sexes but is the socially constructed, cultural interpretations of the sexes (Gailey, 1987). The prescribed roles assigned according to gender have been instrumental in the continuance of the "feminization of poverty".

Many American practices and policies are based on British common law. Historically, a married couple has been treated as a single person with the husband assuming all legal and economic responsibility for the dyad. These paternalistic attitudes have encouraged female dependency, discrimination in the labor market, and traditional divisions of household labor (Stone, 1989).

Over the past two decades, three distinct phases in the classification of male and female can be identified. First was the biological differentiation between the sexes. Then the emphasis moved to the role of socialization in shaping sex roles and personality traits. Now the relevance of gender has come to the forefront. However, social classifications

are determined by the specifics of time and place. As these specifics change, so will the meaning of gender (Hendricks, 1990).

Gender is beyond the control of individuals, but instead is a social category arising from cultural values and social structure. Hendricks (1990) refers to this as the politicization of one's chromosomes. As a result of life experiences within this social structure, men and women enter old age with vastly different personal and social resources.

Society affects the gender roles in both family and the work place. Glasse (1990) reports that even though women have more employment opportunities available to them, they are still "likely to confront age discrimination earlier than men, and wage discrimination is the norm" (p.73). To further exacerbate the situation, women can be expected to assume the caregiving responsibility in the family, and men can be expected to delegate it. Resulting financial repercussions are felt throughout the lifetime of the woman with vastly decreased resources being manifest in retirement years.

The concerns of the older woman have not been central in either the women's movement or the old-age movement. Women's groups typically have been addressing areas such as child care and pay equity that are concerns of younger women. Older groups more often deal with matters concerning both sexes (Marble, 1995). The "population diversity, range of concerns, and interests shared with other groups will continue to make the joining of old age and gender a difficult organization

feat" (Hudson and Gonyea, 1990, p.70). Pohl and Boyd (1993) report that, as women in this culture age, their powerlessness increases and other women are uncomfortable facing this inevitable condition. Elderly women would have benefited greatly from a political mobilization of these two groups: women and the aged (Hudson & Gonyea, 1990). That coalition did not occur.

Aging and ageism

The aging process consists of a series of complex changes that occur in all living organisms. Each individual varies as to the actual rate of occurrence of these changes over a lifetime. Consequently, aging is a gradual and individual process, and no specific age determination has been given to the terms of aged, elderly, or old. Instead, these terms have been used to describe persons of a certain chronological age in a given population.

In the United States, terms such as elderly, aged, and old have become synonymous with individuals who are 65 years of age and over. This age determination is a result of both social and legislative issues pertaining to retirement age and eligibility for Medicare (Clemen, Eigsti, & McGuire, 1991). Consequently, chronological age, which may be the least meaningful factor in determining if an individual is truly elderly, becomes the determinant of that classification.

The attitudes and beliefs about aging that are held by a society are culturally embedded and greatly affect how

individuals feel about themselves and others who are aging. Reaching retirement age was once a milestone to be celebrated. However, with the growing proportion of older individuals reaching that threshold, what was once an achievement is now considered a burden on society and met with personal anxiety due, in part, to ageism (Butler, 1993; Fighting the 'new ageism', 1995; Grant, 1996).

Ageism can be manifest in phenomena ranging from individual to institutional levels, from stereotyping to discrimination, from subtle to overt. Ageism can even be looked at as a disease that affects self-esteem. When negative attitudes and practices discriminate against the aged, self-esteem can be seriously compromised. Rather than being viewed in negative terms, aging should be addressed as another stage of development (Butler, 1993; Grant, 1996).

"The elderly female is said to have two strikes against her: her age and her sex" (McElmurry & LiBrizzi, 1986, p. 162). Unfortunately, both of these factors can affect the interpersonal aspects of health care and the type and quality of care that older women receive. Some examples of these include: physicians spending less time with older patients; patients receiving decreased numbers of pap tests and breast exams as they age; gender biases affecting clinical disease management, etc. (Sharpe, 1995).

The double stigmatization of ageism and sexism is felt by elderly females who are more likely to be denigrated than their male counterparts. Based on this disadvantaged state,

their sheer numbers, and their relative neglect in social gerontology, older women should be the focus of more attention in gerontological arenas (Markson, 1992).

Economic Concerns

Poverty among the elderly is not a random event. The individuals most likely to be affected are females. In part, this is really an exacerbation of occurrences from previous years. The aged poor are most likely to be the same who were the young and middle aged poor. They are the ones who had sporadic work histories and low income jobs. Primarily, they are women.

The assets available for use in old age tend to be a function of previous earnings. Since women traditionally have had low income employment with few to nonexistent benefits, income generated assets are often low to nil. Even the women who have worked outside the home often do not have private pensions (Leslie & Swider, 1986).

Provisions for loss of income upon retirement from a paid job vary by country but generally fall into two basic models of social protection. The first model is social insurance which provides benefits based on prior earnings. The second is universal pension which is generally financed from government revenues. Universal systems are designed to treat men and women equally. Unfortunately, the social insurance model is used in the United States. When this model was established, it was built on the assumptions that men were the primary breadwinners, women were homemakers, and

marriages would last until death. These assumptions no longer hold true. As a result, men and women are treated differently and women continue to be short changed when they retire (O'Grady-LeShane, 1993).

On a more positive note, there have been improvements in the Social Security benefits received by women. In December 1993, eighteen million women who were 65 or older received Social Security benefits. The average benefit was \$571 which was a major increase over the 1985 average of \$399. The beneficiary status of women has also changed from 1960 to 1993. In both of those years, three-fifths of women 62 or older were eligible for spousal benefits. However, in 1960, 57% were entitled solely as wives or widows and 5% were dually entitled as retired workers. Those figures showed a critical change by 1993 when 39% were entitled as wives or widows only, and 25% were dually entitled based on their own earnings. The average benefit for the dually entitled in 1993 was \$617 or \$46 over the average payment for women (Grau, 1987; Lingg, 1994).

The term "feminization of poverty" aptly describes the current state of affairs. While women constitute 58.7% of the elderly population, women compose 72.4% of the elderly poor (Sofer & Abel, 1990; Stone, 1989). Households headed by older women are twice as likely to have incomes below the poverty threshold as are households headed by males.

Living alone also correlates with the probability of a person being poor. Largely as a result of high rates of

widowhood, women are three times as likely as men to be living alone. This imbalance of elderly females living alone is expected to continue over the next thirty years (Davis, Grant, & Rowland, 1990). Glasse and Leonard (1988) report that by the year 2020, poverty among the elderly will be confined primarily to one group - the female living alone.

Poverty and chronic illness go hand in hand. The poor are more likely to suffer from ill health (Grau, 1987). A shortfall of financial resources directly affects the individual's ability to practice preventive health practices. Good nutrition and health care assessments at the early stages of illness or disease often are overlooked, frequently due to financial problems. Not surprisingly, chronic diseases are more common with people living below the poverty level than with those in the middle or upper income categories (Leslie & Swider, 1986).

In one longitudinal research study, 1,674 unmarried older women were evaluated to determine the causes of the postponement of essential health care. The findings indicated that "distress over finances tended to be more salient in determining postponement of care than health status" (Keith, 1987, p. 47).

There is a direct link between the income for seniors and their lifetime earnings. Hess (1990) talks about the gender stratification model which demonstrates why elderly females are struggling for economic survival. The United States has a dual economy with a split labor market. Men make

up the core of this economy and women remain on the periphery.

It could be argued that with an increasing number of women being employed outside the home, they should be better off financially in old age. However, women are still considered the primary caretakers for children and elderly. Of the elderly, 80% are cared for by family members. These caregivers are primarily women. The needs of the caregiver continue to require either reduced, intermittent or no outside employment. Even when outside employment is feasible, the gender gap in wages continues. Women can expect to be working for reduced wages. These factors combine to decrease not only their immediate financial status, but their economic self sufficiency at retirement as well since their pension and social security benefits are based on their lifetime wages (Leslie & Swider, 1986; Quadagno & Meyer, 1990). In addition, since women live longer than men, their fixed incomes are exposed to more inflationary erosion (Glasse & Leonard, 1988).

Some analysts argue that gender inequality in old age is merely a function of market derived inequalities accumulated during productive years. Quadagno and Meyer (1990) contend that political decisions have made the rules that determine benefit decisions. Glasse (1990) says that we learned from civil rights that while we may not be able to legislate values, laws can be enacted which require institutional

behavior changes which, in turn, encourage changes in values.

Political Concerns

"Politics is the process of influencing the allocation of scarce resources in the spheres of government, workplace, organizations, and community" (Kozier, Erb, & Blais, 1997, p. 438). The resources being used for Social Security and Medicare for the elderly are becoming more and more scarce. The programs are under attack to stop the resultant financial drains. The possible changes that could take place in these programs are of critical concern to the elderly female who will be the most affected by them.

"By the year 2010, average female life expectancy is projected to increase to 86.1 years, and the number of women over age 85 will more than double. Now and in the future, the cost and availability of long term care and the lack of public and private financing alternatives are a critical concern of women" (Older Women's League, 1988, p. 69).

Our current health care system underserves the majority of the individuals it was developed to assist. With the continuous emphasis on acute care, there has been minimum importance placed on the needs of health maintenance, preventive care, and long term care. When one looks at the American way of long term planning for health care, there is definite reason for concern. Political action is needed to enact the necessary legislative changes.

Social Security

Social Security was enacted in 1935 as part of the New Deal. The program was established to protect Americans against lost wages due to retirement, disability, or death. While the language used in the act was gender-neutral, the program was based on meeting the needs of the typical American family. However, that previously typical American family is no longer the model that should be used today. Until the basis of the program changes, women will continue to be discriminated against financially in their later years (Leonard, 1992).

Because Social Security is the most important source of income for elderly females, Social Security benefits receive a great deal of attention when poverty related to this aggregate is discussed. Current methods used to calculate the Social Security benefits penalize these women because the determination of the monthly payment is based on the male's work pattern. All Americans born after 1928 have their benefits calculated on average earnings over a 35 year period. Men generally work 35 years. However, women, because of their caregiving obligations, average 11.5 years less over that same period of work time (Leonard, 1992; Iams & Sandell, 1994).

Policy makers describe an adequate retirement income as being like a three-legged stool. The legs represent Social Security, a pension, and individual savings. However, because

of women's work patterns of job mobility, working in small businesses for lower pay, and more flexible job arrangements (shared jobs, part-time jobs, seasonal jobs, and homebased jobs) to accommodate family responsibilities, those legs may be short, uneven, or non-existent. Based on having a lifetime of lower paying jobs, the private savings may be very limited, the Social Security benefits small, and the pension plans minimal to nonexistent (Leonard, 1992).

Medicare

Medicare was established in 1965 to insure that older Americans would be covered by basic health insurance. Butler (1995) writes that women make up 19 million of the 32 million Medicare beneficiaries and have a vital stake in Medicare's future. Women also constitute more than a fifth of the elderly living below the poverty level and 80% of the elderly living alone which is a risk factor for poverty, hospitalization, and institutionalization.

Medicare is another example of a public program that "...was created for the medical circumstances of working men, not the health care needs of older women" (Butler, 1995, par. 4). Because of women's greater life expectancy, women are more likely to be burdened longer by chronic illness and disability - areas that Medicare has traditionally neglected.

Medicare has also turned a blind eye to outpatient prescriptions and long-term care. This absence of long-term care is principally a women's issue because most nursing home residents are women, spousal impoverishment is more likely to

affect women, and more than three-fourths of the family caregivers are women. If nursing home care is required, older women usually have to "spend down" their income and assets to pay for the care which in turn pauperizes them for their remaining years (Butler, 1995; Day, 1993; Glasse & Leonard, 1988).

An illustration of the years of medical neglect suffered by women under the Medicare system is the coverage of mammographies. It took Medicare 25 years before this basic screening test was a service covered by the plan in 1991. A report was cited from the New England Journal of Medicine that only 36.9% of elderly women had a mammogram in 1991 and 1992, the first two years there was coverage for mammogram screening. The number was even lower for women without supplemental Medicare coverage; only 14.4% of this group had the screening. Part of the reason for this low number is believed to be due to a co-payment that is required for this test. Under the Medicare system, there is a \$100 deductible for Part B coverage which includes medical and physician care. After that, most women pay 20 percent of the cost of the mammogram. Even though the out-of-pocket expenses should be less than \$25, low income women are less likely to obtain preventive services such as mammographies than their wealthier cohorts (Butler, 1995; Medicare and mammograms, 1995).

Public opinion and public meaning

Dr. Fernando Torres-Gil, the first Assistant Secretary for Aging in the Department of Health and Human Services, talked about emerging from the period of Modern Aging (1930 - 1990) into the period of New Aging. Between 1930 and 1990, there was a development of the politics of aging. For the first time in history, programs for the elderly were instituted due to the influence of older people. Lobbying and advocacy groups committed to enhancing programs and benefits for the elderly such as Social Security, Medicare, Medicaid, Older Americans Act, and the American Association of Retired Persons emerged. However, with the period of New Aging came another look at the wisdom of continuing these policies. The political influence of the elderly began to be questioned. We have now moved from the debate regarding the reform of Social Security and decrease of Medicare to questioning whether we can even afford to continue to have benefits solely on age (One on one, 1997).

There is legitimate reason for worry about the uncertainty of the future of the aged in American society. While the health and economic status of the elderly is improving overall, there are still subgroups (such as elderly females living alone) who are living at poverty or near poverty levels, the cost of health care for the elderly continues to escalate, and the number of young people needed

to support the elderly in the decades ahead is decreasing (Callahan, 1990).

It was a shift in understanding of the meaning of old age that served as the impetus for the Social Security program and Medicare. It had been politically decided that old age required social and economic support beyond the private resources of the family and individual. The question is what will the moral and cultural meaning - or "public meaning"- of old age be in the future. The answer to that question is bound to have an enormous impact on future economic and politic policies (Callahan, 1990).

Some of the conflict that surrounds the allocation of resources is based on the assumption that the costly old-age benefits are going to middle-class and affluent older people and being diverted from poor children and other needy groups. The large-scale spending on today's elderly is believed to be depleting the funds for future generations. The picture of the elderly is being changed from one of compassion to one of greed. Resentment against the benefits for the elderly may spread as the fiscal crisis surrounding old age benefits worsens (Day, 1993).

Society has begun to blame the elderly and the poor populations for this financial strain put on the nation's budget. Additionally, the public is blaming the elderly for the costs of the solutions - Medicare, Medicaid and the increased Social Security benefits in the 1960s and 1970s. As a group, the elderly are seen as well off and reaping great

benefits from the state (Gonyea, 1994). Conveniently overlooked is the fact that those deriving the largest benefits of Social Security are those who have contributed the most to the Social Security account. When elderly females fall into the large homogenous group known as the elderly, their true economically oppressed status is easily overlooked.

Legislative practices

With the current emphasis on acute care, many services needed by elderly females are not covered by Medicare. To remedy this problem, a major refocussing of the health care system needs to occur. Political action is necessary to change the emphasis on covered services to those so badly needed by this aggregate - long term care, health maintenance, and home services. In particular, "the past record of policy regarding chronic care does not suggest that our political and policy processes are well equipped to meet the challenges that lie ahead" (Jennings, Callahan, & Caplan, 1988, p.5).

When one looks at the American way of health care planning, there is definite reason for concern. To better understand how changes are made with regard to health care policy, it is necessary to look at the legislative process. Prior to the 1980's, health policy was legislated one bill at a time. However, starting in the 80's all major changes in health policy have been handled in one fell swoop - the budget reconciliation process. This process essentially

adjusts politics and policy to the budget. Representative Brian Donnelly says that "if public policy decisions are driven by the budget decisions you end up with bad policy" (Rovner, 1989, p.966). The end product is compromise based on fiscal policy and not health care policy. Time pressures accompanying reconciliation bills often don't allow one to fully understand the ramifications of what is being proposed. When the here and now of budget reconciliation is being addressed, it doesn't meet with the required planning for the long term health needs.

Research Arenas

Research is being done on elderly women, on those living alone, and on those who are homebound. However, investigations are not being conducted that include all three parameters at the same time. Consequently, there is no knowledge base for the aggregate under study.

Use of the phenomenological method in research is evident in nursing literature. While this method is used across many spectrums of topics and ages, the number related specifically to elderly are still limited. Examples of research regarding the elderly include Trice (1990) who explored meaningful life experiences of elderly and found that an experience was considered meaningful if the individual felt the activity was worthwhile and perceived it as being helpful to another. Mitchell (1990) looked at the lived experience of taking life day-by-day in later years and interpreted this experience as "valuing the enabling-limiting

of transforming "(p. 32). Porter (1994) described the experience of older widows living alone and the strategies used to increase their comfort with being alone. Further phenomenological exploration to gain an understanding of the lived experiences of elderly - particularly elderly women - is needed.

When literature reviews were done regarding homebound elderly women living alone, none could be found identifying the lived experience of this specific aggregate. Additionally, if the participants in other studies included men, women who were not homebound, or women who were not living alone, the relevance of the findings to the participants in this study could not be determined. Women who are not living alone and confined to their homes have very different needs and concerns than their homebound counterparts. This void in the literature regarding elderly homebound women living alone indicates that this is an area needing exploration.

Elderly females live in a society where their socially constructed roles, economic status, and health care are compromised. Political policies that could greatly affect their health care and financial well being in the future are being decided by others who know little about the circumstances of these women. There is no current knowledge regarding the lives of this aggregate. It is only from women themselves that one can learn what the life experiences are

of being elderly women. That knowledge can provide insight to nurses and others to influence the needed policy changes.

Chapter Three

Methodology

A unique group of women were the subject of this study. These women were at least 65 years of age, lived alone, and were not able to leave their homes without great effort and/or the assistance of others.

This aggregate is growing appreciably, but their lives remain a mystery. Because the voices of this aggregate have not been heard, questions remain as to what women experience in these situations. Consequently, this inquiry utilized a phenomenological approach to explore the life experiences of these women. Included in this chapter are the techniques used for data collection and data analysis to maintain the credibility of the study.

Phenomenology

Phenomenology is both a philosophy and a research method. As a research method it is an inductive, descriptive approach developed out of phenomenological philosophy. The purpose of phenomenological research is to describe experiences as they are lived. In phenomenological terms, this is defined as capturing the "lived experiences" of the study participants (Burns & Grove, 1993).

A phenomenon for study may be described as any circumstance that can be investigated. Consequently, one is

able to explore the meaning and perceived structure of any event or experience affecting human beings. Because anything in one's consciousness is potentially of interest to phenomenologists, there is a vast range of possibilities for study. By using the phenomenological method, the researcher is guided toward discovery of the meaning of a phenomenon as humanly experienced (Omery, 1983; Parse, Coyne, & Smith, 1985; Van Manen, 1990). The phenomena to be explored in this study are homebound and living alone.

A variety of methodologies have been developed for implementation of the phenomenological method. Van Kaam was the first to develop such a methodology. He identified very specific steps to be followed for interpretation of data. Colaizzi developed a method that involved observing and analyzing human behavior within its own environment and allowed for the examination of experiences that could not be communicated. He emphasized matching the appropriate source of data with the appropriate method of collection of data (Burns & Grove, 1997; Omery, 1983).

For this study, the methodology of Amedeo Giorgi was the most appropriate as it strives to maintain a sense of wholeness. Giorgi's analysis relies entirely on the researcher. While individual elements are identified, the frequency of the occurrence of the elements is not considered as significant as the intuitive judgment of the researcher. Giorgi considers the relationships of the units to each other

and to the whole to be important (Beck, 1994; Burns & Grove, 1993) .

Participants

The participants in this study consisted of fourteen women who had experience with the phenomena being studied. Consequently, the participants were women 65 years of age or older who lived alone and were able to leave their homes only with great effort and/or the assistance of others.

The women ranged in age from 70 years to 94 years. With the exception of one lady who said she was divorced, the remaining women identified themselves as widows. However, one woman later admitted that she always identifies herself as a widow but is not certain that this is correct. However, she has had no contact with her husband for many years and believes he is probably dead by now. The women's ethnic backgrounds included one Hispanic, one African American, and twelve Caucasians. The study participants were all English speaking and cognitively aware.

These women had lived alone from three years to over 30 years. Their financial status ranged from being at poverty level to being financially secure, with the majority being at the poverty level. They had been homebound for a period of less than six months to over 19 years. Identifying the precise length of time and reason for being homebound proved difficult for many of the participants. Some reported that it had just been a gradual occurrence related to getting older. Consequently, the researcher concentrated primarily on

verifying that the participant met the homebound status requirement rather than the reason for being homebound.

The participants were from either southwestern California or western Florida. Their living arrangements varied a great deal. They were either living in a mobile home, a private home (either rented or owned), or a complex designed specifically for senior citizens. These senior complexes took on a variety of configurations and included high rise buildings with individual apartments, separate apartments on spacious grounds, apartments in a complex that had been converted to senior housing, and apartments in a senior complex that required one "buy into" the facility and pay a generous monthly maintenance fee.

Locating participants for this study was a complicating factor. Because of the criteria of being homebound and living alone, potential participants were not readily identifiable. Consequently, an Area Agency on Aging in southern California was contacted to gain access to individuals appropriate for this study. The Florida participants were accessed through personal contacts.

The Area Agency on Aging (AAA) was chosen as a resource for participants because of its program to assist homebound who are frail elderly, 65 years of age or older, and have limited financial resources. Each client in this program is assigned to a case manager who sees the client on a regular basis to assess the individual's circumstances and provide any necessary interventions to assist the client in remaining

at home. The case managers were the ones who identified potential participants who met the established criteria for taking part in this study. The majority of participants in this study came from the AAA.

After a potential participant was identified, the case manager contacted her to determine her interest in taking part in the study. If the client's response was positive, her phone number was given to the researcher to contact for follow-up. When the client was contacted, the purpose of the study was explained and an opportunity was given for her to ask questions about the study and/or her participation in it. The potential participant was advised that taking part in the study was entirely voluntary and could be terminated at any time. Additionally, the participant was advised that her confidentiality would be maintained and no identifying information would be used in any written or oral presentations. If the AAA client was still interested in being a participant, her address was obtained and an appointment was scheduled for an interview.

Interview Process

Data were collected during fourteen interviews with the participants. The interviews were conducted at the home of the participants. In one case, the visit was conducted on the participant's porch. All others took place inside the participant's home. The length of the interviews averaged an hour and a half each.

Informed consents were obtained from the participants before the interviews were initiated (Appendix A). The consent form was verbally reviewed with each participant and any questions the individual had were answered prior to signing. One copy of the consent form was left with the participant and the other was retained by the researcher. Included in the consent was a request to tape the interview. One woman, who felt she didn't know the researcher well enough to entrust her with a tape of the interview, declined to have the interview tape recorded; hand written notes were taken by the researcher in lieu of tape recording this interview. All other interviews were taped. The researcher personally transcribed all but three of the interviews which were done by a professional transcriptionist.

The interviews were arranged at the convenience of the participant. Most of the women requested that the interviews be held in the afternoon. The usual schedule for the women included having homemaker services in the morning. Therefore, the preference was that the interview be conducted when the women were alone and had more privacy.

Care has been taken to maintain confidentiality of all data. The identifying information, tapes and transcriptions are all kept separately and are in the possession of the researcher. The tapes and transcripts will be destroyed at the end of this or any follow-on studies.

Ethical Issues

Prior to the initiation of this study, approval was

obtained from the Committee on the Protection of Human Subjects of the University of San Diego (Appendix B). Included in this process was the concurrence of the committee that the participant's rights and welfare had been safeguarded and acceptable ethical practices for the study had been established.

Additionally, a meeting was held with the Area Agency on Aging to provide information regarding this study and qualifications for participants. After discussions regarding the method and methodology of the study, the Area Agency on Aging agreed to provide potential participants for the study.

Prospective participants were advised that there was minimal risk involved in taking part in this study. If a participant would have become upset during the interview, the interview would have been terminated and the case manager would have been made aware of the individual's status to provide any needed follow-up.

Data Analysis

Data analysis was done according to the methodology of Giorgi (1985) who sees the guiding theme of phenomenology lying with Husserl's idea of going back to the things themselves. That idea is interpreted here as going to the everyday world where people are actually living through the phenomenon. Data gathering using this method involves lengthy interviews where the subjects are given the opportunity to let their experiences unfold in an unbiased way. Due to the length of the interviews and the detailed accounts of the

experiences, the sample size is usually small (Omery, 1983). The interviews were conducted until data saturation was reached and no new themes emerged.

Once the interviews were conducted, the following steps of analysis were done according to Giorgi's (1985) methodology. First, all the transcribed interviews were read to get a sense of the whole. Next, the text was reread to obtain discrimination of "meaning units". These meaning units do not exist in text but in the attitude and set of the researcher. Then the meaning units were read and transformed into expressions of psychological language with emphasis placed on the phenomenon being investigated. Finally, all the transformed meanings were synthesized into a consistent statement regarding the subject's experience. Giorgi refers to this procedure as "...the practice of science within the 'context of discovery.'..." (p.14).

Methodological Rigor

Guba and Lincoln (1981) report that naturalistic inquiry must meet the requirements of rigor in order for there to be trust in the outcomes of the inquiry. The requirements of scientific inquiry are compatible with those of naturalistic inquiry and include: truth value, applicability, consistency, and neutrality.

Truth value is comparable to internal validity in the scientific arena. For the naturalistic inquirer the question is how one can test the credibility of the findings and interpretations with the sources from which the data were

drawn. The issues and questions come from the people and situations being studied rather than from the investigator's perceptions. Through persistent observation and extended contacts, the investigator is able to differentiate between the typical and atypical situations (Guba & Lincoln, 1981).

To maintain the truth value in this study, participants were interviewed in settings which were comfortable to them. Care was also taken to avoid time pressures so the women were able to have their stories unfold in a relaxed manner. When the researcher had questions regarding information obtained during the interviews, clarification was sought regarding the validity of the inferences. When completing the data analysis, there were frequent reimmersions in the data to ascertain the meaning from the perspective of the study participant.

Applicability refers to the possibility of using the findings of one investigation in another setting. Unless there is a reasonable level of internal validity no such generalization can be made. Guba and Lincoln (1981) question whether generalization in the traditional sense is possible and suggest one think instead of the idea of "fittingness". In this vein, a working hypothesis from an investigation would fit into a context other than the one in which it was derived.

Applicability was achieved in this study by providing comprehensive descriptions about not only the women being studied, but also the circumstances in their lives and the

environment in which they lived. It would then be the decision of the reader of this study to determine from the descriptions if there was applicability to his or her specific needs.

Consistency is the ability to replicate. In this area the concept of auditability is used to indicate that the work of one evaluator can be tested for consistency with another evaluator who would, after examining the work of the first investigator, concur with the conclusion (Guba & Lincoln, 1981; Miles & Huberman, 1984). In this study, transcriptions were done of the tape recordings from the interviews. Then selected transcripts were reviewed by the dissertation chair to ascertain the consistency of the researcher's interpretations.

Neutrality in naturalistic inquiry is similar to objectivity in the scientific paradigm. In any study, the objectivity of the data is critical. However, no person can ever be free of all subjectivity. Consequently, requiring that the data be confirmable shifts the burden of truth from the investigator to the information itself (Guba & Lincoln, 1981). To establish confirmability, assumptions held by the researcher were bracketed. The participants were then provided the opportunity to verbalize their experiences in their own words.

In any study, there is a need for methodological rigor for it to be credible. Consequently, acknowledged

methodologies of rigor were utilized in this study to maintain its integrity.

Chapter 4

Presentation of Findings

This study described the lived experience of elderly females who were homebound and living alone. Five major themes with some subthemes emerged from the interviews. These are presented in Figure 1.

Portions of the women's lives were slipping away. They were living on borrowed time and were no longer enjoying good health and had lost the youthful image of their previous self. As a result of death or distance, contact had been lost with many friends and relatives. These changes were not always sudden developments and often occurred in subtle ways over time.

In response to the changes that were occurring in their lives, the women needed to find a balance between dependence and independence. All of these women needed to accept help in order to maintain independent living. Due to physical limitations and/or not being able to drive, they faced constraints when leaving the house. Assistance was also needed to maintain their own homes. All of these participants used housekeeping services. However, the interaction between the participant and the housekeeper was not always positive. The type and amount of assistance accepted reflected the

Figure 1

BEING ALONE: THE EXPERIENCE OF ELDERLY HOMEBOUND FEMALES

SLIPPING AWAY

- Living on Borrowed Time
- Diminishing Relationships

BALANCING DEPENDENCE AND INDEPENDENCE

- Getting Around
- Maintaining a Home
- Making your own Life

MAKING THE MOST OF IT

- Feeling Secure
- Alone but not Lonely

CONNECTING

- Keeping in Touch
- Contributing to Others

LOOKING INWARD

- Finding Strength
- Reflections of the Past
- Advice to the Young

women's efforts toward making their own lives more comfortable.

The feelings the women had about their current lives ranged from very positive to very negative, and some were obviously trying to make the most of their lives. One of the influencing factors regarding those attitudes related to where they maintained their homes: the women who were positive about their lives all lived in senior complexes where they felt a sense of security. While all of these women lived alone, they did not consider themselves lonely.

Connecting was also a theme that emerged. If they chose, these women kept in touch with others. Some also made a point of giving to others. This giving sometimes took the place of offering assistance to others and, at times, it was in the form of gifts to special relatives.

The women then looked inward to provide other insights into their lives. They discussed their sources of strength. They also related stories from their past and offered advice to the younger women who will be following in their footsteps.

Slipping Away

Throughout the interviews, the predominant theme that was expressed was that of loss. These losses took on many forms and were a result of events associated with aging. The women had outlived their spouses, were experiencing health

problems, were encountering decreased mobility and were now becoming increasingly dependent.

The sense was that these losses often were not sudden and abrupt changes. Instead, there frequently was a gradual, almost nebulous, disconnection that occurred. Their youthful selves had vanished, and along with them had gone the health and relationships that had accompanied those earlier years; things were slipping away.

Living on Borrowed Time

All through the interviews the women shared experiences important to them that represented who they had been in earlier days. Some common threads running through those stories were visions of having been youthful, active, healthy, creative women. The acceptance of their current selves was not always easy.

Of the fourteen women, ten had exceeded normal life expectancy. One 85 year old woman who was well aware of this fact reported that she was now living on borrowed time. Another participant indicated that "the last time I went to the doctor he said you've lived longer than you're supposed to because of [her respiratory problems]." An additional participant reported that "age doesn't mean much to me. It's attitude that counts...Maybe that's why I don't feel 94."

When one woman talked about getting old, she was asked what old was. She explained:

It's a state of mind, of course. I'm 91 and it surprises me. I'm 91. How on earth did this ever happen? But, uh,

I don't know, the trouble is just from day to day. I get mixed up sometimes and it embarrasses me terribly....if I don't stop this forgetfulness I don't know how I'm going to get along.

When I arrived for the interview, this lady had forgotten about it. She was in her nightgown and had said that she had decided to spend the day in bed. However, since I was already there, she did consent to continue with the interview. Periodically during our conversation she would forget the word she wanted or lose her train of thought. These episodes, coupled with forgetting our appointment, caused her much distress. This constant forgetfulness was not consistent with how she used to be.

Others had changes in their individual self image that, to an observer, might seem much less severe. However, to the women experiencing the changes, the impact on their lives was great. For instance, there was a very memorable woman in her 80's who took great pride in her physical appearance and her "beautiful body and legs." She still tried to maintain her "model" appearance by being well dressed and made up at all times. She had developed circulatory problems and had to have vascular surgery on her legs. She reported that she hated it when the doctors had to cut her "beautiful legs". She said if she won the lottery, she'd spend the money on a plastic surgeon. Her regret was that when she could afford to have plastic surgery, she didn't need it; now that she "needed it", she couldn't afford it.

Physical ailments often served as frequent and unwanted reminders of lost youth and healthier times. One participant reflected that "I have really enjoyed my life. It's now that I don't enjoy it. I wasn't sick before, and this is the part I don't enjoy." She went on to explain:

I always had two jobs or three. How the money was coming in. I always worked, and I love people and I like to be around them. Not to sit home like this and do nothing; I'd be out there with people doing something...

Everything they tell me to do I don't want to do. Sit down and keep your legs propped up. Sit down and stay in bed and I don't want to do that. I have exercises to do and walk.

This lady loved to dance and travel when she was younger. She was always planning her next trip and would put money away in a Christmas Club until she had enough to pay for it.

Sometimes she even had two accounts going at once. She was now able to maneuver around the house only when she had something nearby to hang on to so she didn't lose her balance. She no longer had the capacity to be the traveler and dancer that she so fondly remembered.

Other participants experienced different physical limitations that drastically changed their lives. A woman, who was diabetic, developed an ulceration of her heel. She experienced intense pain when it was touched and was unable to walk. As a result she was confined to her home for a year and said, "It was pretty hard. I got to the point where I

thought, should I give up?" Another female reported that she thought that she was in good health until recently. She reports:

I fell out in the street and broke my hip and I'm still recovering from that, supposedly. But they discovered that I had emphysema - I had been short breathed before. But it developed into the point where I needed the oxygen. When it got ahold of me I've been on oxygen ever since.

She saw her life divided into time frames of before needing oxygen and now requiring oxygen. Since being on oxygen, she is no longer the self-reliant individual she used to be.

One lady, restricted by respiratory problems, reported that when she goes out she must use a portable oxygen tank. She related that a trip to the doctor meant she had to:

...put [the portable tank] in the car, [drive] over there, and wait in the doctor's office and then go down and get the prescription or whatever he wanted me to get. By that time - by the time we drove back home that tank was just about ready to go out. So other than that I haven't gone anywhere except to the doctors.

For this woman, running out of oxygen was a constant worry every time she left her home. Possibly that was the reason her only excursions out were for medical care and those were as seldom as possible.

Another woman on oxygen, who was also wheelchair bound, would like to be more mobile. The time limitations do not

bother her as much as the restrictions she faces when trying to travel with the oxygen. She reported that she was:

...limited - you see the size of the portable. They're all right but you can't travel on an airplane. Even Southwestern won't have us - they won't even consider us. The railroad won't take you, some busses won't. I'm limited to riding the wheelchair [transport]... and a private car. I don't like to bother people my age - my peers - to carry my wheelchair.

Consequently, any traveling she was going to be able to do would be strictly limited to her local surroundings.

Someone else who was on continuous oxygen reported a different view of her circumstances:

There are an awful lot of people that are in the same boat that I am. [They] are ashamed to wear the cannula. They are amazed at me because I'm on 24 hour oxygen. It's what keeps me alive. They don't want people to know; they don't want to wear it; it's disfiguring.

She was able to adjust to her need for continuous oxygen and had given it a name: her "umbilical". Because the use of oxygen was not a matter of choice for her but a necessity, she either had to adjust to having people see her with it or become isolated. She chose the former.

Others reported generalized weaknesses related to strokes, circulatory problems, heart difficulties and osteoporosis. They were often unable to walk or balance without the use of a walker or a cane and three were reliant

on wheelchairs. Several felt that it was important for them to be as active as was possible for them. It was particularly disconcerting when physical limitations restricted those attempts.

One lady reported that she had osteoporosis and "just fell apart. I've had one of my hips replaced and my whole spine has spontaneous fractures." She was very frail and seldom left her apartment. Even maneuvering around her apartment was done with care and caution.

Another participant reported that she got a pain in her thigh and had had back trouble for years. She was using a cane to balance because she was "a little imbalanced". She was also losing weight. Her height was five feet four inches and her weight had dropped from 130 to 85 pounds and she admitted to tiring "now and then" when she was out.

A lady in her late 70's had different health limitations. When asked what caused her to be homebound, she reported that:

I had two strokes, and I had two heart attacks, and I had eight or nine heart failures, and I died twice. So that's why I have a monitor on me so that if anything happens....when I was young nothing ever happened to me. She remembered her youth as an active and exciting time in her life. She felt that her problems were related to losing that youth and her ability to exercise and be active.

One participant, who was realistically contemplating some possibilities for the future, reported:

If I'm meant to take and spend my last years in a wheelchair or something like that-nothing I can do about it is going to change it....it would be quite a blow to me. I think I could cope with it, but I probably would cry myself to sleep every night but I mean I would try to cope with it during the day because I have always looked at things from this standpoint.

She continued to have a very positive outlook on life and reported that "a day doesn't go by that I don't say how lucky I am and how fortunate I am."

Gastrointestinal problems had crept into the lives of two of the women. One woman had reached the point where she was afraid to leave her apartment because of periodic, uncontrollable diarrhea that hits without warning. Her last visit out had been a disaster that included her soiling all her clothes and making a hasty retreat back home. Even the use of protective devices did not help. The mere thought that this could occur again kept her a virtual prisoner in her own home.

Another woman reported that she was not able to eat anything with salt or milk. If she accidentally has a product that has milk in it "she gets gas and it is so embarrassing". Consequently, she found it easier to eat only at her home where she had control over the food that she ate, and questioned whether it was worth it to even try to go out.

Strokes were common causes of limitations experienced by this group of women. While the weaknesses that were left were

at times problematic, the mental ramifications had as much, if not more, of an impact. One woman, when talking about her stroke, said, "...it left me standing like I am, and it left me weak on the right side. It left me [sic] and I can't think the things that I used to know. If I think long enough I can think them up." Another woman explained her memory loss by saying, "I know but I just can't recall it. I hate this."

One woman who had had a stroke talked about the difficulty she now had expressing herself. When the comment was made that she seemed to be conversing easily at the time she explained:

No, I'm not conversing very easily and it makes me very mad. And when I stop and don't say anything it's because I'm seething at my inability to say what I want to say because the words aren't there.

Possibly the most poignant comment made regarding limitations following a stroke was:

It was during surgery they gave me a stroke. They didn't watch me so when I woke up my hand was shaking. I'm so deformed from the stroke in my left side and my clothes won't stay on me. And the hand is so short...So I discovered that I lost all my creativity and that's a bad loss for me. Money they can have. They can have everything, but I hated to lose that. That's worse than getting cancer by far. I'd rather be eaten up by cancer or whatever than lose my ability to create. Cause that really occupied my mind completely, I enjoyed my own

company.

She could easily speak for others when she relayed that "I did not appreciate my abilities until I lost [them] ... the cruelest part was that I was left with the ability to realize what I had lost. Now if I had just slipped a little farther ..." This lady had spent her life in creative pursuits. Before her stroke, she had been developing calendars that incorporated her talents in photography and drawing. When she had needed money, she would do free hand drawings of children and animals. Additionally, she talked about the pleasure she had received from writing. To have lost all this creative ability in her waning years was an unmerciful twist of fate for her.

Several women had experiences with their health care providers which left them with long-term, negative outcomes. One example was a lady who was definitely left in worse shape than when she entered the health care system. When she initially had surgery on her hip, she was anticipating a complete recovery and full use of her hip. However, a number of incidents occurred that precluded that as a possibility. She reported the following occurrences with physical therapists:

They were rehabilitating me and I was walking up a little ramp and I had to go to the bathroom. 'Well back down' [they said]. I said 'no, I'll fall, I'll fall.' They said 'oh, no we'll hold you.' And of course they didn't. There were three of them and they dropped me and

I had to have [my hip] pinned again. The third time a therapist came on a Sunday, a young man, and my doctor said I wasn't to put any weight on it. He [the physical therapist] took me out of the chair and walking down the stairs. The thing [her hip] fell apart and they couldn't do it over again so it's landed me in the wheelchair.

This woman was now confined to a wheelchair with no possibility of having future surgery to improve her hip or have the ability to walk. She required a great deal of assistance to be able to maintain her independent living.

Another woman related how she had been in a coma and had not been expected to live as a result of a medical misadventure. In her case, she felt she was given an overdose of medication by a doctor who she suspected was on drugs. After a week she came out of the coma and was transferred to a nursing home where she had to learn to walk again. She felt she could have sued over this, but didn't want to bother.

Another woman was experiencing a disheartening experience. In her case the participant had gotten progressively weaker to the point where she was now confined to a wheelchair. She had constant pain. Additionally, she had no diagnosis and got different opinions as to the cause of her problems depending on the doctor she was seeing. She asked: "Who to believe or who's telling me the truth or is he saying - I don't know who to believe. The thing is that I am very, very disappointed."

Diminishing Relationships

The gradual loss of family and friends was evident with each of the women who was interviewed. They had all experienced the loss of a spouse. With the longevity of women compared to men, this was not an unexpected occurrence. Most had also lost relatives and friends and accepted this as part of getting old. However, the loss of children was an enigma. Losing all contact with children appeared to be accepted by these women. By contrast, losing children to death was an unforgotten and unforgettable experience.

Losing a spouse was not always a distressing event. Two of the women interviewed reported having had married lives where they were greatly overshadowed by their husbands. In their cases, becoming widows led to newfound freedoms to explore their interests.

One woman started talking about the changes in her life as a result of her husband's death shortly after I entered her residence. She was quick to point out that when she was married her husband didn't like to share her so she had a great many restrictions as to what she could do independently. She stayed married because "I was a Roman Catholic, my parents were dedicated Roman Catholics. It would have broken their hearts if I had divorced. So as long as they lived, I would never have done it and they lived a long time." Consequently, it took the loss of her husband for her to gain her personal independence.

Another woman described her situation as follows:

When I was married I wasn't [independent]. I'd do whatever my husband [wanted]. He was a yeller when he got older, and he'd yell. So if he wanted to do something in particular, if I could, I'd agree to the whole thing. I wasn't so independent. I just felt that [it] was best for me and to comply with his wishes.

After she went through the mourning period she discovered her own independence.

I would speak out for myself and I would talk back to people. I could tell the doctors if I thought something wasn't just good enough. I wanted them to explain things to me more. Before that I was just a little mouse. I wouldn't say anything. It was very difficult for me to talk. You'd never know it now, but people always said I was very quiet. If we were someplace together, if I would talk to someone he'd come into the room talking. You just stopped and listened.

Some difficult times were experienced following her husband's death. She related how she had felt very guilty going to neighborhood parties where she enjoyed the singing and gaiety. She felt she should be grieving more and not having a good time. Consequently it took a lot of work on her part to be able to give herself permission to become the woman who had a voice of her own.

Two other women had each been married to their best friends for over 60 years. Their experiences with losing a

husband were very different from the previous women. Instead of gaining freedom, they encountered very intense losses. One fairly recent widow described her situation:

..the thing I think that upset the apple cart is losing my husband cause I was married to him for well over 60 years and it was a very pleasing marriage - very happy. And that's the thing I've had to adjust to. He was the one who did the talking and told the stories. I didn't. I was the youngest one. It's just like my family, my father does all the talking and my mother just keeps still. I said well what can you do, you can only have one person talking at a time.

She desperately missed their life together and felt he was the one who brought the interesting and exciting people into her life. With him gone, there was a definite void that was not likely to be filled in her remaining lifetime.

Another widow described being married to her best friend. The hardest thing she has had to adjust to with the death of her husband is:

Not being able to discuss things as they come. Because we talked to each other. We were the kind that in the morning he would go his way and I'd to my way. At 3 o'clock in the afternoon we'd get together, have a cocktail, play a game of gin or something, and go to the kitchen and cook together and have dinner. We did things together.

She had lost both a friend and a spouse when her husband

died. And while she had to accept this loss in her life, she continued to keep herself busy and tried not to dwell on her loss.

Another area of interest regarding the loss of relationships centered around children. The acceptance of the loss was greatly influenced by whether the loss was due to the death of the child or a disruption in the mother-child relationship. One woman had two children, a son and a daughter. When asked if she stayed in touch with them she said, "No. I don't have any touch with them. They don't know where I am and I don't know where they are." Another participant had two sons. She was very close to the younger one, but not the older. She said, "I have two sons, but one of them got mad at mother...like they do sometimes. And well, I'll tell you it's a very foolish thing. I haven't heard from him in over a year." When asked if she thought he would come back, she replied "never will." Neither of these women gave any indication that the severed relationships were disturbing to them. They related these stories factually and without emotion.

By comparison, another woman had had a recent encounter with her son that could well result in a severance in their relationship. This possibility was extremely distressing to her. She related that:

...I have never asked him or anyone else for any help
...when he was getting ready to leave - his wife was out
some place else - she never did come by to see me and

kind of hurt my feelings. He put his arms around me and said, "Mom I can't help you - if I did it would mess up my life." Boy that hit me just like a ton of bricks.

This exchange was so upsetting to this participant that she brought it up three different times during the interview. She reported that she had been very cool to him when he last called her and at one point said she was even considering writing him out of her will.

The most intense loss and the one that was most difficult to forget was the death of a child. This was described as "a sore that will never heal." One woman said you're:

...constantly bitter, you're quiet, you don't smile anymore, you talk if you have to talk. But it seems like you're always way out someplace. It's - I don't want you to go through it cause that's the only way you could understand. It's hard.

Even though this event had occurred over 20 years ago, the tears still flowed as if it had occurred recently. When talking about the death of her son, she said that "you learn to live with it - you don't forget it."

Another woman related the stories behind the deaths of her children. In her case she had lost two daughters and a granddaughter. When she was asked how many children she had, she said that she had had three girls, but never had three alive at once.

I didn't have all my three girls at one time. I had [my daughter] and she passed with ptomaine poisoning. I was young, that was my first baby. I was nursing her but I was giving Eagle Brand milk to her, and at the time we had iceboxes. I had it on the ice but it wasn't good and she died of ptomaine poisoning because I didn't know. Another of her daughters died of pneumonia when she was six years old. Additionally, her only grandchild was killed. She now has one remaining daughter who is her sole heir.

Each of the women had relatives and friends who were lost to them. For many, the loss was through death. For others, it was due to distance and the inability of one or both to travel. However, the problems with distance were not restricted to physical limitations but also included time and money constraints. One lady, when asked how frequently she was in contact with her relatives, said: "Since they don't live here it's like not having them...I feel that to come and visit me ... takes money and money is scarce right now." For women who had financial constraints, even the expense of phone calls had to be carefully considered. They also recognized that many of their friends and relatives have similar limitations and, as a result, did not expect frequent contact with them.

One participant reported that when she first experienced being homebound she lost the companionship of her female friends. This was a particularly difficult adjustment for her. She related that:

I was so depressed that [I thought] it would be much better if I'd just go ahead and kill myself. That's the way I felt. I was so lonely and I didn't have company, because the ladies that I know don't have cars, and the ones who do have cars, they work.

This woman is also very concerned about not interfering in the lives of friends who are married; she was reluctant to invite them to her home because she didn't want to interfere with the time the women could be spending with their husbands. All of these issues had greatly restricted the number of guests to her home. Consequently, she was actively looking for someone to rent a spare bedroom in her home and be some company for her.

One of the participants reported that she gave up her relatives when she moved to this area with her husband. She had since lost contact with them and did not know of any way to reestablish contact, assuming they were still alive. Another woman reported that when her husband died "it's like I died too" since she has heard nothing from his family after his death.

Balancing Dependence and Independence

While emotions were a natural response to loss, the strongest display of feelings was elicited when the loss of independence was discussed. Some women were restricted from leaving the house because of physical barriers. Others lost mobility due to their inability to drive. The result of these

restrictions was the need for the participants to adapt to a variety of new stresses and limitations.

It was crucial that the elderly woman maintain her health. Because she was alone and homebound, assistance was needed to get to medical appointments and transportation had to be arranged. Additional help was also needed around the home, and all participants had a housekeeper to help with personal care and to maintain a healthy environment. Additionally, many of the women also used assistive devices to aid in safety. It was by recognizing that she was dependent and accepting assistance, that the elderly woman was able to live in an independent state.

Not all of the interactions with the medical system have been positive ones for the women in the study. Consequently, they had to deal with the results of those misadventures. Learning to work with the medical system was necessary if they were to achieve the maximum rewards due them.

Getting Around

Three of the women interviewed were restricted from leaving their homes due to environmental barriers. One of them lived at the top of some very steep steps that had to be maneuvered in order to leave her home. She related that the steps not only restricted her from getting out, but were also a barrier to others coming to see her. She identified one person in particular who seldom comes by anymore: her Avon lady who is 88 years old.

Another lady had only two steps that she had to negotiate to leave the house. However, she had taken a fall on them before and was now unable to leave her house or even go to the garage unless she had someone there to help her. Visually, this woman's barrier was not as significant as the one previously mentioned. However, the resulting confinement to her home was the same.

An additional participant in the study lived at the bottom of a little hill. Her problem was getting up the grade to get to her transportation. She reported she could get back home going down one step at a time, but leaving was a real problem for her. Consequently, she only left for medical appointments.

When issues surrounding their current lives were discussed, the loss of a car and/or the ability to drive were two areas that consistently evoked strong reactions. For several of the women, the car had been the ultimate symbol of emancipation. From the time they were teenagers, they had cherished the freedom it provided. Now the loss of that freedom had to be accepted.

For one woman, this topic was so significant that she had to bring it into an unrelated discussion. As issues surrounding her health were recounted, she shared the following, "And the very next day after the operation I was driving. Oh, don't talk about driving. I'm still upset. I had to sell my car....I feel that a part of my independence has been taken away."

Another woman talked about getting a car from her dad when she graduated from high school in 1927. When she reflected on selling her car this past year she said:

I mean it has been an adjustment. I mean I **hated** to give up my car. Oh, I hated that with a passion because I had had a license and a car since I was 16 years old. And so I mean I just felt that when I first got rid of it that I was on a raft on the middle of the ocean or something.

Both of the above women pointed out that they had good driving records so safety had not influenced their decisions to give up their cars. They each decided to quit driving because they felt at their age, if anything happened, they would automatically be assumed to be at fault because of their advanced years. For one of the women, a son had had a strong influence in getting this message across to his mother. Neither mentioned any problem, such as decreased eyesight or reaction time, that was responsible for her decision to quit driving.

One other participant who was in her 70's reported that she had been driving since she was 16. Four years ago she gave up driving on the freeways and quit driving altogether two years ago. "By driving I could go sit at the park or sit out there and read or I used to invite one of my friends to go out to coffee with me. Things like that I just can't do without driving."

Three of the ladies have kept their vehicles. One woman had a truck parked in her driveway. The truck had been

sitting there for the last year and it was unlikely that the owner would ever drive it again. Another woman, who was wheelchair bound with little to no possibility of ever resuming driving, related:

I was active all right. I drove a car and my car is sitting out there. I did everything. I was very seldom home. I went to Canada, and I went back and forth four times to New Jersey and Florida to see my son. I did all those things. Now I can't do anything. I'm stuck.

For her, keeping the car was important as a symbol of possibly regaining her long lost freedom.

One of the women with a car reported that she did drive occasionally. However, as this possibility was discussed in more detail, the likelihood of this woman driving seemed remote. In the house, she was unsteady on her feet and needed to balance herself on furniture, the wall, or a cane when walking. She admitted to tiring easily when she went out and could not do so unaided. Initially in our discussion, she reported that she did drive, but only in the daytime and only in good weather. "I don't go far now. I have a good driving record. I have nothing on my record." She later added that she only drove when she felt like it. She related that "I know when to stop" and indicated that when that time came, she would no longer drive at all. She was very elusive when attempts were made to pin her down as to her actual driving. It was suspected that the car was kept more for symbolism than utility.

Another participant reported that:

I feel that part of my independence has been taken away. Because it's very easy [when you have a car] when you want to go somewhere to just do it. Now if I want to go somewhere either I have to call a cab or I have to sign the book in the big office to tell them where I have to go and wait until they pick me up.

While this woman was very upset about no longer driving, she was determined to make the most out of her current situation. She was going to learn to live with inconveniences such as signing up for a ride two days in advance.

For several of the women who were interviewed, a trip to the doctor was the primary, or sometimes only, excursion they regularly had away from home. Surprisingly, few of the women reported any difficulty coordinating their medical appointments with transportation to get there and back.

Transportation was generally provided either by the housekeeper, taxis or transportation services. The only complaints about obtaining transportation dealt with the latter. The problems were generally related to long waits for pickups after a doctor visit or having to get to their appointments too early due to scheduling of other transportation clients. A couple of people reported that they had been "forgotten" and waited outside for a couple of hours for a pick-up to return home. One woman was eager to share her experience and related:

Last night I stayed out there until after 6 o'clock waiting for them. How in the world do you think I'm going to University Hospital and cancel the ride coming back, and it's going to be at night? But I had to wait until after 6 o'clock for them to pick me up. I called and I was standing out there and my knees got so cold, I was standing up so they could see me with the cane and nobody came.

Another participant was also having trouble with the transportation services. Her problems were of a different nature. She reported:

I've got that wheel transport thing but it's no good. Because you call up and then they tell you that there's no transport that day; that it's all filled up. If you call ahead of time they tell you when they can come. And then they tell you when they can take you back. That does no good because when I go to the doctor's office I have no idea how long he will take with me. Or if he's going to have time with me right away because normally I go there on the spur of the moment.

Because of her difficulty arranging transportation, she made as few visits to the doctor as possible. Fortunately, her doctor made house calls, thereby reducing her transportation needs.

The people who experienced the least difficulty arranging appointments were the ones who went by taxi. They reported easy access getting to their needed appointments and

were very grateful for the free vouchers to pay for this service. However, the individuals who were wheelchair bound did not have this option, and they were restricted to transportation services which were not always as efficient.

Maintaining a Home

All of the women in this study were receiving housekeeping services. The amount of help received varied according to the senior's physical needs or, at one senior complex, the amount paid for these services. While the women were grateful for the services, the accordance between the women and their housekeepers affected all areas of the women's lives. When the fit was not good, much time was spent venting about it.

Of the women who commented on their housekeeping services, eight were negative about their help and four were positive. When the women were happy with their housekeeping services they just made a comment regarding that fact and moved on to other areas. Two did not address the area of housekeeping.

Most of the women scheduled these interviews at times when the housekeeper was not going to be present. They commented that they did not have privacy when the housekeeper was there. At times they reported that the housekeeper even pulled up a chair and joined in on their private conversations.

One problem area that was discussed by several of the participants was the housekeeper either not arriving on time

or not at all. "Here I am sitting waiting and waiting and the day ends and she never did show up or call." There were great implications for the woman reporting this as she had difficulty standing long enough to cook. On days when the housekeeper didn't come to help, the woman often stayed in bed and reported that her meals might consist of cookies.

This lady had an additional problem because her housekeeper often brought her four year old when she came to work. The child jumped on the furniture and got into her things. The woman wanted to get a new housekeeper who would be better suited for her. Another woman was very dissatisfied with her housekeeper. However, she was reluctant to do anything about the problems until after a doctor's appointment because she was dependent on the housekeeper for transportation. When asked what the key was to finding a good housekeeper, one lady gave the following reply: "Lord knows. Someone with heart. Somebody that has a conscience that might think, 'well I'll be in her shoes one of these days and who's going to help me'."

Another woman who was having housekeeper problems talked about a day when her helper hadn't shown up for work. "The fact she didn't call me irritates me because I was expecting her and I needed her." For another, a major irritant was the housekeeper eating her cookies. The lady now made a point of hiding her cookies in an old Pringles container so the housekeeper wouldn't know where they were.

One lady was especially distressed when her homemaker hadn't shown up on time to clean her house before our scheduled interview. She had wanted her house to be clean and because it wasn't, we sat out on her stoop to talk. When the housekeeper finally did arrive, the participant said "if she'd come at one the house would have been ready for you and we could have been inside rather than out here." She reported that the housekeeper was always about 20 minutes late. During the interview, she was distracted at times trying to keep an eye on the housekeeper and giving the housekeeper directions which weren't being taken. There was obvious tension between the two of them.

Many of the issues that presented conflict between the women and their housekeepers were over small concerns rather than major ones. For instance, one woman who lived in a private residence could not take out the garbage cans each week. Her homemaker would bring them back in but would not be responsible for taking them out to the curb. The woman reported that these were the rules all over town. This was a necessary service that needed to be performed. Luckily, the woman had a neighbor who helped her with this task.

One participant was asked if there were changes she would like to see in her life. She replied: "No, no I don't see any changes. I'm satisfied with what I have here. Except that I'm not satisfied with this girl. That's the only thing that I'm not satisfied with." This woman's housekeeper was not staying her allotted time and the woman reported she was

"not the one to speak out". This caused her enough stress that it was brought up several times during the interview.

Making Your Own Life

It was interesting to discover the attitudes that the women who were interviewed had regarding devices that were available to them to help with their mobility. In some cases, rejection of these devices seemed to represent their last vestige of independence. For others, these devices offered an opportunity to be more mobile and to experience a fuller life. Regardless of which outlook was taken, there were very strong arguments supporting each decision.

It was easier to understand the rationale of the opposing opinions when listening to the words of one woman who required a lot of assistance to maintain her life in a noninstitutionalized setting. She reported that:

You make your own life. I really believe that a lot of times people die because they want to die, they give up. But you'll find that a lot of people don't, will keep on going and keep on going. And that's my point; as long as I can keep on doing something I'll stay alive if I can. As a result of these feelings, this woman was grateful for all the help she received. She did not allow the fact that she had to use a wheelchair and oxygen deter her from making the most of her life.

One of the women who was adamant about not using her walker took great pride in the fact that she would leave her apartment without any assistance. She continued to refuse to

let anyone see her using a walker. This she did in spite of having severe circulatory problems that had affected her legs and compromised her stability when walking. It was unlikely that either of the two walkers she had in her apartment would be utilized outside the privacy of her own apartment.

Other women resisted making moves that, to them, indicated an increase in frailty. If they had a cane and a walker, the walker would be stored in the corner or used, as one woman did, only for balance to get out of her chair. Making the progression to a walker was, at times, a psychological block for them.

At the other end of the spectrum were the women who had breached that emotional barrier. In these cases, the women looked at the various devices as a means of getting around outside of their homes. One woman was especially proud of her new therapeutic shoes that provided support for her to be on her feet. The new shoes, coupled with a new walker that had a basket and a seat that allowed her to sit when she tired, were providing an incentive to get out and get more exercise.

Another lady said she used her walker all the time. She said:

A couple of times I turned around to get my walker and it would be over there but I can't walk without it. It's a matter of balance. As long as I have something to kind of touch I'm okay.

She, like several of the other women, had experienced

previous falls. For them the fear of an injury from a fall far outweighed the stigma of using a walker.

In order to obtain desired services and supplies, the women needed to utilize the health care system. This often entailed frustration when trying to understand the logic behind the decisions that were made regarding their respective cases.

One woman who was wheelchair bound was trying to achieve a degree of independence. She only had the use of one hand and it was difficult to maneuver a wheelchair manually. Consequently, she had been authorized a motorized wheelchair to assist her. She received the \$1800 chair but was not able to work the controls and additionally felt the chair was too heavy for her. She immediately asked that the chair be taken back and requested that it be replaced with a motorized scooter. She had the following to say about the potential use of a scooter:

... I can use it. I can drive it and I can be sort of independent and like a human being. You know not depending on anybody. I would be awfully frightened because you get awfully frightened after being so crippled and wondering if you go out in the street if someone will mow you down or something, but I think you could overcome that - go out a few times, a short time and go longer and longer. Or get yourself a cell phone. If you get stuck without a battery you could call and say, 'hey here I am'.

Unfortunately for her, the motorized wheelchair remains unused at her home and has still not been taken back by the vendor. Because of red tape and the way the system works, it could be five years before her request for the scooter she wants is considered.

Another woman who was wheelchair bound and on continuous oxygen would like a motorized wheelchair like the previous woman had. However, this lady couldn't get one authorized because, as she reported, someone apparently believed she still needed exercise and should operate one manually.

Another participant had been having difficulty with her vision. She couldn't read very long because her eyes tired so easily. Her doctor said her eyes were fine and she didn't need glasses. She told him that while her eyes may be fine "they don't last me....I'd like to take my money and get some glasses. I should be able to see." Because she couldn't get an authorization for a prescription for glasses, she had been contemplating buying some glasses with her own money. For her, purchasing glasses would be a financial hardship on an already strained budget.

One of the ladies who has had little success with traditional medicine had sought help through alternative methods. In her case she had had blood work analyzed and recommendations were made that she be on four different vitamin and mineral supplements. These supplements were not prescription medications and were not covered by Medi-Cal or Medicare. They were also too costly for her to continue on if

she had to pay for them on her limited income. Her case served as an example of how financially comprised elderly are restricted to the more conventional methods of health care.

Making the Most of It

All of the women interviewed had experienced loss. The question remained as to how they were adjusting to those losses and the aging process. To gain a better understanding of their status, the women were asked to describe their current lives. What followed was a wide range of responses that showed the diversity of how these women were making the most of their lives.

The study participants identified a number of descriptors ranging from "love it" to "shitty" to identify their lives. Five women expressed either a degree of contentment or a positive reflection regarding their current life. By contrast, nine had more negative reactions to their present life.

The most enthusiastic reply was from a woman who said: Love it... I'd have been a politician if I could have afforded to be. But not the kind of politician that's saving for this, that and the other thing. I would have been the kind that would look out for people. So that's why I'm happy with doing these things for people. This lady had really found her niche in life. She enjoyed being an activist involved in making positive changes for seniors. Whether involved in committee work or board work, she found her life very rewarding.

Another's response was, "I'm very happy. I have all the love that anybody could ask for". This woman counted her friends and family as blessings. She had regular contact with them and felt very fortunate. Another woman reported that she enjoyed her life and explained:

I've always been able to adjust to circumstances ...This is the present, this is what you've got to learn to expect now. So I mean you might just as well accept it, make the most of it. Well, when I look around I see people a lot worse off than I am. And that's always been my attitude... I've always managed to sort of keep my chin up and look around and say, well there but for the grace of God go I.

This woman had experienced some hardships in her life. However, she was a very upbeat person who maintained a very positive outlook.

The women who were "satisfied" and "content" often did not expand on their responses. They just said they felt that these adjectives described their situation. However, one woman gave the following reply:

I don't like it at all. I'm satisfied with it in this respect, when I was young I did all the things I wanted to do when I was working. I took all the trips... I have nothing to regret.

For this lady, the memories that she had from her earlier days were carrying her through some more difficult times in her later years.

By contrast, the women who were dissatisfied with their current existence were more vocal about their situations. For instance, one woman said her current life was:

Miserable. What else can it be. You can't be happy if you're just in the house crippled...You can't do anything, you don't feel like doing anything, and then I'm so weak constantly.

Another indicated that her life was:

Lousy, I guess. It's all right as long as I have the dogs. I can look back and say what a downfall to enjoy dogs. I've always had pets but they were something extra. Now they are everything.

The interview with this woman was most memorable. Her life had truly taken some traumatic turns. One minute she would be relating a sensitive and sorrowful tale and the next she would be talking about how she coped. When she was talking about the significance of her pets currently, it was clearly with disappointment that the dogs had attained such importance in her life.

Three ladies indicated that life was dull. One spent the majority of her time in a chair in front of the television and reported there were only a couple of programs she liked. Another was more descriptive in this area calling her life "Dull as dishwater" because her husband and those close to her were gone. The dullness was described by another as "very, very - how do I say it - smooth. Nothing happens." A more graphic negative depiction was that life was:

Shitty. Shitty because I can't get out and do the things I want to do. And I'm not enormously depressed about it. I'm unhappy about it. I don't like being forced to do nothing. That's one way to get to me.

Someone else questioned what she "was here for" and felt her life was "hell". An additional noteworthy response was:

I ...hate to say that the only thing I am waiting for is to die.. . that doesn't mean that I'm going to sit and do nothing about it. [I plan to remain as active as possible until my health won't allow it.] And then after that if it gets to the point that my doctor says that this is the end, it'll be the end. I'll take care of it, I'm all ready for it. My doctors have my living will and know that I don't want to be resuscitated if something should happen.

This was the only woman who talked about dying. She was very clear that she would never go to a nursing home. If the time came that she would need that level of care, she would see to it that she did not make that move. She was very determined and sure of this decision.

While all of these ladies were living alone and homebound, their feelings about their current lives were diverse. Half of them were less than satisfied with their lives. However, the women who were satisfied or content were adamant about the enjoyment they currently had in their lives.

To gain more understanding about these responses, some of the predominant subthemes evident in the interviews about making the most of it are now addressed. By exploring the important facets in their lives, a better awareness may be obtained regarding what factors were influential in determining life satisfaction levels in this group.

Feeling Secure

The women who were interviewed lived in a variety of settings ranging from a trailer park to senior high-rises. From the interviews it was evident that the type of housing where the senior lived contributed to the senior's sense of security and, at times, camaraderie.

Not all of the women living in the senior complexes were content or positive about their current life. However, all of the women who expressed at least a degree of satisfaction with their lives lived in one of the housing compounds designated for senior citizens.

The primary difference expressed between living in a residence for seniors and independent living was concern about safety. One woman who lived independently, and had had her home broken into twice, reported that:

It's not a very nice neighborhood. ..[They stole] all that was in the back bedroom. They crashed through the bedroom the one time I went out to the doctor. They climbed through the window and stole everything that was in the room.

Her losses didn't stop there. Another break-in occurred and

drawings and other creative projects were gone. She reported that she "was heartbroken because it was three years of work" that disappeared. She related that she continues to hear strangers around the house at night and was trying to get into the habit of locking her house.

Another senior felt that her safety was compromised because there were so many new people in the neighborhood whom she didn't know. A direct approach to these safety concerns was taken when she related:

I mentioned the fact to someone if anyone tried to break in that I have a rifle and I wouldn't hesitate to use it. A lawyer told me a long time ago that if you shoot somebody, be sure you drag them in because if they are in your home you can shoot them. This worries people to death that I have a rifle.

When asked if she had ever used it, she reported no, "they're not looking for some poor thing." However, she didn't know if she'd have the nerve to use it or not, but thinks she would.

By contrast, the residents in senior complexes related more positive aspects of their dwellings. One reported, "We are so blessed to be in this building and have the security and the comfort." Her prior abode had been a "little dinky small apartment" in the alley. She felt life had really turned around for her when she moved into the present residence. At another senior complex, a woman reported that "They look out for you...they watch over you."

One woman moved into a senior complex specifically for security. She had been a crime victim and wanted to be somewhere where she felt more protected. She reported:

I was waiting for a friend of mine to pick me up to go to bridge. I saw this car coming. The car stopped to ask a question and before I knew what was going on, grabbed my arm and pulled my pocket book. Then on the curb, the back of the car knocked me over and left me there for dead. And I couldn't move...they took me to the hospital. I had 10 stitches and a broken shoulder and a cracked pelvic bone which didn't show till about three days after and a very sore mental attitude because I didn't expect any of that.

The idea of being victimized remained very much with her. She related that:

It's very different. Today you have to be so careful when you're dealing with people because the majority around you are out to take advantage of you. Not in a place like this, but outside.

One resident said she had seen a lot of places for seniors and felt hers "was very near about tops". She particularly liked the idea that if "you don't feel well you don't have to feel bad by yourself." All she had to do was pick up the phone and someone was there to help.

Another senior described her place as follows:

We have three floors here and they come down and sit right there and sit by the mail till the mail comes.

They all gather there. It's like a big family really. At least this particular place. I don't know how the others are.

While all the residents of the senior complexes expressed the feeling of security in some way, there were mixed reactions as to their involvement with other seniors living there. One lady reported that she didn't associate with anyone from the complex. She felt they were jealous of her looks and she didn't want everyone to know about her personal business.

Another reported that she didn't participate in the activities and preferred to keep by herself. However, she did have a couple of friends who came to see her now and then. Additionally, one resident reported that she didn't attend too many of the complex's activities because she was not interested in "old folks' stuff" like crocheting, knitting and mending. She had other things that were of much more interest to her. The only function she did try to go to on a regular basis was the monthly birthday party for the people living in the complex.

At the other end of the spectrum were the individuals who enjoyed frequent encounters with their neighbors. One lady reported that in her complex people would often stop by during the day, knock on the door and just ask if all is O.K. and say hello. She felt this contact was very important and encouraged others to continue it. Another lady felt particularly blessed when a friend of 30 years was able to

move into the same building where she lived. While they continue to remain close, she also reported an open door policy with people coming by on a daily basis to see her.

Women residing in the senior complexes reported that "If you don't want to be by yourself, you can always go out that door and you won't be out that door five minutes before you'll run into someone." A treatment for cabin fever was described as a trip to the front office because there were "always people sitting down there." One woman who liked involvement with others was busy in card and game groups, exercise classes and chairing the flea market.

While living in senior complexes was no guarantee of satisfaction, all of the women who expressed a contentment with their lives resided in these facilities. The factors that contributed most to these feelings were a sense of security and the availability of contact with others.

Alone but Not Lonely

The media portrays elderly women as being poor, sick, and alone. However, that was not the case with all the women in this study. Instead of the perception of the participants being old, lonely, dejected women, there was a sense that most were able to adapt to their current life situations. So, while they were alone, they were not necessarily lonely and had found ways to pass the time they had alone.

One of the descriptors that is used regarding the elderly female is "alone". While the women who were interviewed had lived alone anywhere from three to 30 years,

there was no general sense that this was necessarily a negative experience. Living alone did not always mean being lonely. One woman who had lived alone for more than 20 years said:

I get lonesome, everybody does. I don't think there is a person who doesn't. But somehow we have a way of dealing with it. I perhaps will call somebody if I get too upset or I'll call [for transportation] and I'll go traveling someplace. Just around the block is enough. Or I'll read.

One spirited woman talked about being alone for 26 years and asked "what do I want with another man - unless he's got a million tucked away some place?" She reported that she had considered having her spare room fixed up so she could rent it out and have somebody in the house. But she liked living alone so did not go through with the idea.

A woman living in a senior complex with a variety of activities had the following to say:

They only have one meal [a day] and I don't know anybody there. I keep to myself. I'm not a loner you know. And they have a lot of things going. They have movies, they have bingo, they have talks, and exercise classes and all. But I don't participate, I keep by myself.

This lady made the choice of not participating in activities at her senior complex. She did interact with others from another social group, but preferred to stay in her apartment at the complex.

A woman in her nineties who had become a widow only three years ago reported that "I don't mind being alone. Somehow I'd rather be alone than have people around I don't want to talk to." This statement was from a woman who had been happily married for over 60 years and had now been alone for only three years.

Another had previously lived with her adult son. He was less than happy when she told him that she was going to leave and get a place of her own. She had now been living alone for 12 years and said she "absolutely loves it".

Connecting

The amount of contact the women had with others varied, but most were able to stay connected with individuals who were significant to them. Some of the women also went further and made a point of giving to others in ways ranging from providing assistance to new residents to leaving significant gifts.

Keeping in Touch

Twelve of the women interviewed had children. However, only five women had regular contact with their offspring: two daughters and three sons. None of these children lived in the same city, so the phone was the essential method to stay in touch. Three of the children called their mother on a daily basis and the other two called weekly. One was making his weekly call from overseas.

The remaining mothers who chose to stay in touch with their children heard from them sporadically and usually by

phone. These women recognized that their children, who ranged in age from 40 to 60 years, were very busy with their own lives and families and had little time for their mothers.

It was interesting to note that these women were predominantly on the receiving end of the phone calls. One participant reported that she gets calls "once in a while." However, when they ask how she is she responds, "well I'm here, that's all I say." There was only one woman who reported that she was as likely to make phone calls as receive them and commented that the "telephone works both ways".

Very few talked about friends. While two women reported long-term friends of 30 years or more, one woman had lost her friend's phone number and hadn't heard from him for over a year. The other woman lived in the same senior complex as her long time friend so was able to have regular contact with her. In fact this friend dropped in during the interview and it was evident that they had a deep bond.

One of the seniors who was truly enjoying her present life got together with "a bunch of females - old bags like me" on a regular basis. Every Friday night they met at one of the local restaurants for dinner. She reported that they were very much like her and they enjoyed each other. It was obvious that this weekly ritual was a very important part of her life. It did not bother her that she had to make the trip in transportation for handicapped so her wheelchair and oxygen could be accommodated. The inconveniences were well

worth the enjoyment she received for the socialization.

Contributing to Others

Even though the majority of the women in this study had very limited finances, half of them made a point of giving to others. Because of their limited funds, some of the giving was in non-monetary ways. Others provided gifts that ranged from tokens to significant legacies. Regardless of the nature of their gifts, the women showed genuine pleasure in being able to contribute.

There were numerous ways that assistance was given by these women. Two of them who lived in senior complexes reported that they made a point of helping new residents find their way around the compounds. If any new residents wanted to go to church, either of these women would be available to accompany him or her. If assistance was needed carrying trays in the cafeteria, help was given without asking. Another woman who had been a social worker for 30 years reported that "people around here tell me that I look after them which is true".

Another woman took a more proactive approach to giving. When she was able to be more active and maintain a garden, she regularly gave fresh vegetables and fruits to all her neighbors. All new residents in the neighborhood were welcomed with a freshly baked cake. When she heard of a request for blankets from the Salvation Army, she went through her cupboards to pull the ones she wasn't using to

donate to others. She said "why should I just have them laying back there [when] somebody can use them."

During one of the interviews, neighborhood children were coming over one by one to thank the participant for their Christmas gifts. She had bought small gifts for each of the children who had moved in next door. This woman was very modest when her generosity was mentioned and indicated that what she did wasn't much and she just wanted them to know she was there. This particular participant was probably the most financially needy of the group and the money she spent on others represented a substantial gift from her monthly allowance. She related that she didn't have any grand ambitions regarding money, but there were ways of improving things in the interest of others.

Two of the women had decided to give substantial gifts to loved ones while they were around to enjoy the giving. One woman commented that no one would see any diamonds on her anymore. She gave them to her granddaughters. She said that she "wanted to be absolutely sure that they had what I wanted them to have". She had also given a beautiful necklace to her granddaughter for a graduation present. It had cost her \$1200 but she related that "I never got such a thrill as when she opened that box and saw it"

Another woman was anticipating her daughter's 60th birthday. The lady reported that her engagement and wedding rings were too tight on her so she took them to the jeweler and had the diamonds reset for a ring for her daughter. She

was eagerly anticipating the surprise her daughter would have when she opened the gift.

Looking Inward

These women had lived long lives and had been through many different life experiences. They shared some of those events including where they found their strength, glimpses into their past, and advice they had for young women.

Finding Strength

All of the women who were interviewed had experienced hardships of some sort. But more importantly, they had also been able to deal with what had beset them. Trying to discover what constituted their capacity to deal with adversity proved more difficult.

The question was asked as to where they found their strength during difficult times. Not all could answer that question and simply replied that they didn't know. One woman who gave that reply was sitting in the chair where she spends the majority of her time. Above her on the wall was a crucifix. Next to her chair was a table with her phone and reading material that included religious pamphlets. She could not identify the source of her strength.

Three of the women did indicate that they got their strength from religious beliefs. One said that she "talks to God". She was born in Italy and brought up with many traditions based on the Catholic religion. Another reported that she was:

...a Catholic but I'm not a Catholic that every time you turn around you say 'Oh, after all we belong to the Catholic church'....If I feel like missing mass, I'll miss mass. I'm the one that's going to have to account for it, nobody else.

The other lady described the Lord as her daily strength. When she prayed, it picked her up. It was evident that church and religious beliefs had been an important part of her life for many years and she had passed this on to her children. She related that her grandchildren still call her and ask her to pray for and with them.

Three ladies identified an inner strength. One commented that her belief was "I can do it, I'm going to do it."

Another expanded by saying:

I had all my life a strong will. I was a person that said I'm going to do this and I would. Nothing would keep me from doing it. I would find my way no matter how. So I call that will power. And that's what kept me going.

One of the participants felt she got her strength from her father who "was the meanest old devil that God ever let live." Later she confessed that she wasn't as mean as he was though. Another indicated that she kept going by being "...pretty chipper. I'm griping to you [but] I usually don't get mad." And yet another responded that "I'm not sure I have any. I don't know. I guess stubbornness is strength."

Reflections of the Past

One of the recurring themes in the interviews was the reflecting that was done by the women regarding their younger years. At some time during each of the interviews, stories from the past that had significance to the storyteller were introduced. These narratives detailed a variety of different events such as childhood memories, the early marriage years, raising children, and times with friends. As a result of these reflections, a wide range of emotions surfaced.

By far, the number of stories related were ones that recalled happy times and events from the past. Two women, in particular, had family chronicles that were rich with California history. One of the women had grown up on the property which is now Old Town in San Diego. She described how her father had farmed the area. He had owned a lot of acreage, so when they needed money, he would sell part of the property. She had a picture on her wall of the house where she was raised. That house is now an historical monument.

Another woman spent her early years in Northern California. She related: "My mother and father both came from Northern California. They were born and raised there. California wasn't what it is now: most everyone comes from somewhere else." Her father had been in the first graduating class at Stanford University, and her family maintained contact with individuals such as Leland Stanford and the Varian brothers. Her mother had been a member of the

Daughters of the American Revolution and loved talking to her about the past history of their family.

Hearing the narratives from those who had experienced the actual events was an unforgettable experience. When one of the women was asked if these stories had been shared with her children and grandchildren, the response was that she questioned whether anyone in her family was even interested. Consequently, the stories had not been saved in a retrievable context and would likely be lost with her death.

Another lady chronicled her life as an activist. She had been influential in affecting change for others and took obvious pride in this accomplishment. Detailed accounts of these milestones were scattered throughout the conversation. She described one instance where she helped the handicapped:

One time I had to go to a meeting and they wanted me to attend the city council. So I went from the meeting at which I was attending to the city council. Meanwhile I had to go to the john. I used their so-called handicap facilities. I got jammed in and I couldn't move, the wheelchair wouldn't fit. Anyhow, it's been straightened out since then because I hounded them.

She was a very lively and animated raconteur who took great pleasure in relating her past accomplishments. She was also delighted to report that she was still working for seniors.

One of the women had a previous modeling career. She was particularly vital as she recalled those days. In her case she held court from an oversized recliner. She was

beautifully dressed and well coifed for the interview. Her conversation was given emphasis with dramatic gestures. One could almost visualize her on that runway years ago. One of the remnants from her past profession was her love of clothes. She said she couldn't show me her bedroom because she had run out of closet space and was now storing her clothes on top of the bed. Since she slept on her oversized chair in front of the television, she did not have a problem with this arrangement.

Past careers were often discussed. Those ranged from being a scientist to being in the entertainment field. All of the women were proud of their past activities in their chosen fields. One woman reported that she: "danced and sang for a living. I danced with Kathryn Dunham and then Billy Holiday. I was in the ballet with her at the Ebony Club."

It was also interesting to hear the scientist talk about her past. She graduated from college in the 1930s and was:

...valedictorian in my school and I was always smart in math. Now my grandson, who is the doctor's son, is undoubtedly very good in math. He just started college and he started with an A all the way through. He's taking after me with my ability to remember things and to build.

She gave no indication that being a college graduate in that era was anything special and said that girls were doctors and nuclear physicists then. Instead, she talked about her mother who "had all the brains in the family" and tested her with

the crossword puzzles of the Sunday edition of the New York Times.

There were many stories of early married life and the childbearing years. One woman was actually smiling as she was recalling her past. When this was commented on she replied, "I don't care if I don't go anywhere or do anything else, I can sit here and enjoy what I've done." She later added, "I have really, really, really enjoyed my life and I wish that everybody else could enjoy theirs the way I've enjoyed mine."

Not all past remembrances were happy. As previously discussed, the stories of losses brought back many poignant recollections. When these life events were recalled, the tone of the conversations definitely took on a more subdued tone.

A very insightful woman who was comparing her past with the present summarized the feelings of many of the women with the following story:

They say the trees when [they have leaves and are so] beautiful, everyone goes under for the shade. They sit there and enjoy the shade of the tree. Come time when the tree loses the leaves and the tree looks sad because the leaves are going away, no one is going to go there. She continued to relate how, when she was active, if someone needed a ride or needed a translator her reply was "what time, I'll be there". Now that times had changed and she needed help, no one was there for her.

Advice to the Young

The women who were interviewed were asked if they had any advice for young women who might want to plan ahead so they could enjoy their later years. A couple of the women did not feel they had anything to offer. However, others came up with some ideas for the women who will someday be in their situations.

Two areas that were mentioned by more than half of the women were to maintain financial security and maintain good health. This was a common response by both the women who were financially secure and those who weren't. Some of the ladies expanded on their health responses. For instance, one reported, "don't worry about the age. The age doesn't mean nothing. Keep on doing what you're doing and your body will tell you when to slow down." Another passed on the following dietary guidelines, "We were raised on hominy grits and greens. And even today I don't think I have a dinner unless I have some Southern greens like turnip greens, mustard greens, collard greens and they keep your bowels open." And yet another summed it up as follows:

First of all I would say be very careful in life, and mainly once you get over 50. You never know when you're going to slip on a rock, a piece of banana or something. And from there, there are going to be a lot of changes in your life....So I would advise to be real careful in

the way [you walk] and the way of life too - especially now. And get good insurance.

There were additional areas of advice that the women wanted to pass on to younger generations. One woman said that age didn't mean much to her, it was the attitude that counted. Another lady would give the following advice to a young girl:

I would tell her not to judge a person until you really get to know them. Then when you really get to know them, you will be so fond of them that you won't judge them anyway. That's the way I look at it.

Other suggestions for a good life were: don't dwell on unhappy things and be yourself, try to be independent, and "...be satisfied with what you've got. Don't hope for anything more that you can't get." These words came from women who were practicing what they preached.

Another woman's advice was: "To live and let live....if you're going to be part of the human race, you have to act like a human sometime. Otherwise you can be kissed off just like you can kiss somebody off."

One of the participants also shared some personal advice for the researcher. The interview was over and we were walking toward the door talking about getting older. The researcher commented that she sometimes forgot she was getting older until she looked in the mirror. The astute participant put her hand on the researcher's arm and responded, "Well, honey, just get rid of all your mirrors!"

Composite of the Study Participants

The typical representation of the participants in this study was a woman who was 82 years old and a widow. She was living in a senior complex and had been alone for 14 years but did not consider herself lonely. Due to chronic ailments, she had been homebound for six years and had very limited financial resources. She stayed in contact with friends, neighbors, and/or relatives, but most of her contact with relatives was by telephone.

Half of the participants expressed a degree of satisfaction in their lives. They had a positive outlook. While they had experienced loss and gone through distressing times in their lives, they made it a point not to dwell on those times. Instead, they related a contentedness with their present lives and focused on the happiness they were able to experience. The participants who were not contented found life dull and miserable and were often dissatisfied with their homemaker.

The fourteen women who were interviewed had experienced long and eventful lives. They had had their share of losses and were facing life alone and with increasing dependence. Adjustments had to be made to live with those changes that came as a result of loss and aging. Among the issues they were dealing with were maintaining a home for themselves and maintaining their health.

While these participants shared numerous commonalties, many of the life events they experienced resulted in their

taking very different paths to reach the final years. They even were willing to give some advice to younger women to help guide them toward their own waning years. This was a group of interesting, entertaining, and unforgettable women who were willing to share their life experiences as a legacy to those still waiting in the wings.

Chapter Five

Discussion

This chapter discusses the findings of the study in relation to other information available in the literature. The research question that was asked was: What is the lived experience of the elderly female who is homebound and living alone? The answer to that question is important in order to understand the life experiences of an integral part of our population.

There has been an increase in the number of women experiencing the phenomena of being homebound and living alone. Projections are that those numbers will continue to grow. This study was undertaken to discover the essence of the women who are currently experiencing this life event.

In an effort to identify past research regarding this unique population, a literature review was initiated. An exhaustive search regarding the homebound elderly woman living alone revealed that this specific populace has been neglected in published research. While studies may encompass one or two of the descriptors, the combination of being an elderly female who is both homebound and living alone was not present in the literature. Unless all three elements were being included in one study, the nature of the subject is very different from the participants in this study. For

instance, issues concerning a homebound elderly woman with a husband or family at home are very different from those of a homebound elderly woman who lives alone. Additionally, the life of an elderly, homebound female living alone varies a great deal from an elderly woman who lives alone but is not homebound. Consequently, the studies referred to in the present chapter have information related to the themes of this study but were done with participants who did not meet the same criteria as used for the current research.

Slipping Away

The women in this study had seen aspects of their lives slowly slipping away. When stories of those earlier years were shared by the participants, a glimpse of those young girls was often revealed. However, the young girl of those earlier years was gone. A new and older version had taken its place. Contrast the mental picture of that young girl to the image of the current self.

Freedman and Golub (1985) refer to the stereotype of elderly women as poor, dumb and ugly. Obviously, these are not exemplars for which younger women aspire. Because we tend to see ourselves as others see us, this view of elderly women can affect self esteem. According to the authors, with the diversity of older women, more role models need to be identified who show how to grow old gracefully.

The women in this study had some insightful and interesting stories to relate about their lives. Certain tales of great satisfaction with their lives now and in the

past were recounted. Some of the study participants could be considered the role models of older women that Freedman and Golub discuss. However, to find these role models, the voices of the women must be heard. This study is a step in having those voices be heard.

Some of the women in the current study were resistant to having others see them with assistive devices. Walkers and canes would be visible around the residence, but when asked if they were used, the reply was "no". For example, one woman even made a point of saying that she would not leave her apartment with a cane, a walker, or anything else that appeared to compromise her independence. A self-sufficient image was very important to many of these women.

In a study of living with chronic illness, similar findings were reported. According to Belgrave (1990), women with chronic illness were concerned about stigmatization related to their condition and the attention being paid to the visibility of their physical problems. The perception and fear of this stigmatization varied according to the visibility of the condition, the length of time they had the condition, and the past medical crises that had been experienced. Some examples of the visibility of the chronic conditions were the need for oxygen by emphysema patients, the use of hearing aids for the hearing impaired, and use of canes by the physically unstable. However, a positive similarity of both studies was that some women were able to

overcome their concerns about stigmatization as they became more accustomed to their specific physical problems.

When research was done to examine the relationships between the self, physical health, and depression, physical health was not found to have a global effect on the self-concept of elderly women. Instead, the alteration in self-concept was felt to be more related to advancing age. A multidimensional understanding of the self-concept of elderly women, not just their physical health and functioning, was felt necessary to assess overall psychological well being (Heidrich, 1994).

The lived experience of health in the oldest old was researched by Wondolowski and Davis (1991). This group of seniors had all exceeded their longevity expectations. For the 100 of the oldest of the old who described personal health, this phenomenon of health was "an abiding vitality emanating through moments of rhapsodic reverie in generating fulfillment....Nursing practice could be guided by the practice proposition: *sharing moments of remembering clarifies meaning and prompts changing ways of becoming*" (p. 115). In working with this proposition, more creative ways of dealing with people should be adopted. An example would be the nurse exploring the meaning of the lived health experience with the older population. By uncovering the past, new disclosures regarding actions in the present could be identified.

Balancing Dependence and Independence

The women in the current study were trying to maintain their independence while experiencing dependency. In order to continue living alone, they had to accept help. The assistance needed varied from the use of mechanical devices to housekeeping services in the home. Their acceptance of this help varied from refusing to use assistive devices to being grateful for all the help they could get.

All of the women in this study received housekeeping or homemaker services. While the services were necessary to help each participant maintain her independence, the interaction between the housekeeper and participant was often either a very negative or a very positive experience.

A possible explanation for the women's reactions may be found in Belgrave's (1990) discussion of how women with chronic illness used homemaker services to perform tasks they were no longer able to accomplish. While the women with chronic illness needed the services, they had little control over how and when the services would be done. A general finding was that the fewer the duties that needed to be transferred to others, the less likely the individual was to describe herself as restricted by limitations. This being the case, the presence of the homemaker could be a constant reminder to the women in the current study of their waning independence. Feelings such as these could easily account for some of the tension between the woman and her homemaker.

Some of the issues surrounding the non-professional home care workers were presented by Chichin (1988). The homemaker can be viewed anywhere from a member of the family to a maid. The workers may, at times, be verbally abused or asked to do things outside of their job description. They receive low pay and poor benefits. However, their work is important and more needs to be done to determine how to attract and retain motivated workers, find the factors that contribute to a good match between the worker and client, and determine how to evaluate the quality of care provided by these workers.

Making the Most of It

All of the women in this study had experienced loss and hardships in their lives. The majority of the women were also financially constrained and had serious health problems. Even with these difficulties, the participants were actively trying to make the most of their lives. In spite of all their tribulations, some of the women were finding a degree of satisfaction in their current lives.

A literature review conducted by Benson (1997) examined research that pertained to fear of crime among older adults. The findings suggested that fear of crime was a serious concern for certain groups of seniors including women, those living in high crime areas, and those residing in housing not limited to seniors. One of the effects of the fear of crime is reluctance to leave the home, even for health seeking reasons. Nurses were encouraged to screen for fear of crime as part of the client assessment.

The findings in this report were consistent with the current study for those not living in a senior complex. Two of the women who were interviewed had been crime victims. Both were residing in non-senior complexes at the time of the crimes. For one woman, moving into a senior complex was her way of handling the fear. However, she still made reference to not being able to trust those outside the complex. The other woman still lives in an area with a high crime rate. The last time she had her house broken into was when she had gone to a doctor's appointment. She is now trying to become more safety conscious and lock her doors. However, she still hears unfamiliar noises outside at night and has developed a fatalistic attitude about the possibility of additional crimes. Another woman in a private residence has had safety screens installed on her doors and has a rifle as back-up.

In contrast, the women living in the senior compounds expressed no concerns about safety. Instead they talked about being watched over and about the security of the building.

All of the women in this study had lost their mates and were now living alone. While the image of these women might be expected to be that of a lonely old woman, just the opposite was the case. With one exception, the women had adjusted to living alone and some were even reveling in the experience.

Donaldson and Watson (1996) reviewed the relationship between aging and loneliness. An analysis of four theories of loneliness (psychodynamic theory, the existential theory, the

cognitive theory, and the interactional theory) along with their application for research were reviewed. The conclusion was that loneliness is not a severe problem for every senior and loneliness did not always have to be an accompaniment to old age. On the other hand, there are many elderly who do experience loneliness and there is evidence of a correlation between loneliness and a number of physical and psychological problems.

By contrast, Porcino (1985) suggested that the major mental health concern for older women is loneliness. Additionally, both divorcees and widows were felt to have experienced at least a temporary state of loneliness. In the analyses of this current study, loneliness following the loss of a spouse was found initially, but on-going loneliness was not a common theme. While the current participants indicated that they sometimes felt lonely, they had developed ways of managing those feelings. For the women currently being studied, being alone did not make them lonely.

In Wagnild and Young's (1990) study of the characteristics of successfully adjusted older women, experiencing a major loss did not provide an opportunity for growth, but the adjustment to the loss did. For example, the women in that study who were identified as living alone for the first time in years had a positive outlook about that experience. Even though these women may not have lived alone for a long while, many found it to be a time for self examination and reflection.

Two recent studies were done looking at elderly women in Appalachia. The functional health, social support and morale of the older women in Appalachia were looked at by Collins (1992). All of the women in this study had been living alone two years or more. The findings suggested that the levels of functional health and perceived social support were relevant to the morale of the participants in that study. The higher the levels of functioning and the perception of social support, the more positive the feelings were about themselves, their aging, and their satisfaction with life.

The other investigation from Appalachia also studied elderly women who had been widowed for at least one year. The widows in that study did not follow the stereotypical passive and emotionally dependent women of the Appalachia area. Instead the widows emerged as women who had an inner strength to survive and the ability to manage their lives, their families and their finances (Hardin, 1990). Although the women in the current study were getting assistance, they, too, were able to manage their lives well enough to be able to continue living in a non-institutional setting.

The participants in the current study reported that they were able to access health care. Some even had services provided in their homes. Others had to go to various offices or laboratories for care. When they had to rely on others for transportation, many chose to use taxis to get to their appointments. This was a preferred method because they did not have to get worked into the schedule for pick-up. When

vouchers for this service were provided, it was definitely the preferred method of transportation. Others, particularly those with wheelchairs, had to rely on handicapped van services, housekeepers, or friends for their rides. However, there were very few difficulties mentioned regarding obtaining desired health services.

These findings are contradictory to a report on the health of poor women by Thomas (1994). Thomas' analysis of health care for poor women showed a limited access to such care because of poorly located sites for health care delivery and inadequate transportation. Thomas' report was not confined to elderly women but dealt with poor women of all ages.

The women who participated in the current study had different experiences accessing health care from those of Thomas' subjects. Possibly elderly women have an easier time obtaining care than younger women because the elderly poor have both Medicare and Medicaid. Additionally, the areas where the participants resided, California and Florida, could have been a factor since both locations have a substantial number of health care providers servicing a large population of elderly.

Connecting

The type and amount of contact the participants had with others varied from participant to participant. Each, in her own way, did stay connected either by keeping in touch or contributing to others. Heidrich (1994) found that positive

relations with others was a most important dimension of the ideal self for elderly women, and those relationships support the women's psychological well-being and mental health.

The women in this current study received a great deal of pleasure giving to others. The type and size of the gift did not appear to matter. The joy was in the giving.

Findings similar to these were identified by Trice (1990). Eleven elderly, nine women and two men, were asked to describe any experience in their lives during which they felt that life was meaningful and had purpose. In each of the descriptions, the experience involved a concern for others, a perception that the study participant was helpful or useful to that other person, and the perception by the participant that they had taken action or were going to take action in an activity that was helpful to that other individual. A sense of positiveness then pervaded the experience in feelings about both the self and the activity. The act of doing for others, or even the perception of helping others, was a meaningful experience to these seniors.

Looking Inward

In each of the interviews that was conducted, the participants shared stories from their past. Some of the stories were sad and even brought tears to the storyteller's eyes. Other women related events with happier memories. In each instance it seemed important for the participants to share their past.

Trice (1990), whose study included both men and women, described reactions similar to those of the current study's participants. Tears in the eyes of the participants were often observed when they were asked to describe what it felt like to find their life meaningful. Broad smiles and grins were then seen when responding to the question. It was suggested that the tears represented a depth of emotion in those reflections and not sorrow.

In the study by Wagnild and Young (1990), characteristics of elderly women who had adjusted to major losses in their lives were explored. Resilience was found to be an important element of successful psychosocial adjustment in later years. Participants used both internal and external sources of strength to get through difficult times. Among those inner strengths were: a positive comparison with others, faith in God, a sense of humor, a belief in themselves, and determination. External sources included meaningful work and activities and friends and family.

The women in the current study identified similar sources of strength. Faith in God and belief in themselves were two, in particular, that were cited. The women who described a belief in themselves were specifically emphatic when discussing this.

Interviews with 42 women were conducted by Heidrich and Ryff (1992) in order to study how elderly women see themselves coping with the problems of aging. One of the observations was that, at the end of their interviews, many

of the women commented that being asked how they would handle hypothetical questions gave them time to reflect on their actions and capabilities. Even though some of the insights were not necessarily pleasant, they liked spending time thinking about themselves. Consequently, it was questioned if there could be positive outcomes in just allowing elderly women the opportunity to talk about their everyday concerns.

Mitchell (1994) reviewed over 600 narratives, written by both men and women, that were submitted about the meaning of being a senior. One of the seven common elements identified was "retrospective pondering amidst everydayness." This referred to pondering and thinking about past times. "This element also reflected the process of 'taking stock,' of recalling life's decisions, the good and the bad of choices made long ago. Retrospective pondering was portrayed as a cherished activity that centered on the present joys of recalling the fabric of one's past" (p. 74).

The women in this study were a very distinct aggregate whose make-up has not been replicated in other research. Because other studies have not used the same descriptors for study participants, it is not known if those findings would pertain to this aggregate.

These study participants had experienced losses of health, relationships and independence. However, they were also balancing the dependence and independence in their lives to remain living in noninstitutionalized settings. The study participants were making the most out of their life

situation. Many took advantage of senior housing opportunities and were adapting to living alone. They were staying connected with others. While some were not able to identify where they got their strength, all the women had a sense of determination and were able to adapt to their present life situation.

Chapter Six

Conclusions and Recommendations

This study explored the lived experiences of fourteen elderly women who were homebound and living alone. A critique was done to examine the strengths and weaknesses of the study. Implications of the findings for nursing practice, nursing education, health care services, and social and political change were identified. Recommendations were given for directions that future research should take in relation to this aggregate.

Critique of the Study

A major strength of this study was the subject chosen for investigation. The combination of being an elderly female, living alone, and being homebound is one that will become increasingly common, but has been neglected in research. This study was a beginning step in learning more about a significant and neglected population.

Another strength of the study was the use of a qualitative methodology. By employing phenomenology, personal interactions with the participants were required. The open dialogue conducted with the participants provided an opportunity to gain insight into important events from their lives. This combination of having both personal interaction and an active listener was well received by the individual

participants. This proved to be a positive aspect of the process.

Prior to initiating this study, there had been concern that reliving old memories of the participants could be depressing. However, this did not occur. Instead, the overall feeling during the interview was upbeat and the discussions were sprinkled with periodic laughter. The common response by the participants at the close of the visit was to invite the researcher back. The participants made a point of saying that the invitation was extended even when the research was completed.

Tape recording the interviews also proved to be an asset when reviewing and reflecting on the interviews. This became very obvious when comparing the dialogue and insights obtained from the tapes versus that from the notes taken in the one interview where the participant declined to be tape recorded. While the major thrusts of the interview could be obtained from the notes, some of the nuances were undoubtedly lost.

All except three of the tapes were transcribed by the researcher. While this was very time consuming, it also proved to be very beneficial and analogous to reliving the actual interview experience. When the tapes were difficult to understand, knowing what was discussed made these areas more decipherable and gave a better reiteration of the interview.

The majority of the participants were served by the Area Agency on Aging. Consequently, the participants were already

linked with supportive services. It would have been insightful to have interviewed women who met the established criteria but who were not yet involved in this system to see how they were managing on their own. However, the problem inherent in such an approach is the inability to locate appropriate participants. Women who are not part of the support system may be in need of additional services to safely maintain their independent living. However, if they remain secluded, they are difficult to identify.

Accessing the majority of participants from one source also presented restrictions in writing the findings. By maintaining the confidentiality of the participants, some of the richness of the write-up may have been lost. For instance, even if fictitious names had been used, the descriptions of the individuals would have made the study participants identifiable to the agency personnel. Consequently, it was not possible to give a "picture" of the individual women and a composite was used instead.

This study did not introduce additional variants for the women being studied. For instance, the ethnic mix of one Hispanic, one African American, and twelve Caucasians is not representative of the population where the participants live. A study more representative of that population may have resulted in somewhat different findings. However, because of the need to have English speaking participants and the difficulty accessing women who met the study criteria, additional variants, such as ethnicity, were not included.

Implications

Nursing is concerned with the health and well being of all populations. Consequently, determining how the members of this aggregate could be assisted in having more fulfilling and healthy lives is consistent with nursing's mission. This was a descriptive study that provided insight into the lives and needs of a significant aggregate receiving nursing services.

Nursing Practice

A large segment of nursing practice relates to care of the elderly. To understand the needs and concerns of this elderly aggregate, it is essential to have dialogue with them. While having extended interviews in the home may be the preferred method of learning about these women, other opportunities are also available and should be accessed. For instance, one of the women talked about her concern about running out of oxygen when going to the doctor. This concern was a worry for her from the time she left her house until she returned home again. If women on continuous oxygen feel this anxiety, nurses working in clinic and office settings need to be aware of these concerns so ways of alleviating added stress may be instituted. In this example, if the health care providers know of this anxiety about running out of oxygen, being attentive to time constraints when the individual has an appointment and having oxygen available for use while at the appointment, could alleviate this identified concern.

Apprehensions and concerns that this aggregate have will not be identified without communicating with them. Any interface with these women provides opportunity for that communication. The health care provider has the obligation to pursue those opportunities to initiate a dialogue with these women.

All of the women in this study were elderly and experiencing a variety of health care problems. As a result, they required more interface with health care providers. Five incidences were identified where the elderly client was at a disadvantage when interacting with the health care system. Two dealt with acquiring the desired assistive devices and three were in reference to having received questionable health care. The advocate role of the nurse has an essential function in all of these cases. That role could take the form of helping the client maneuver through the bureaucratic maze that has become an integral part of health care in the United States. It could also involve working with the client to be sure she is both fully aware of her options regarding health care and receiving the quality care she deserves. At times, it could require the assertiveness of the nurse to make sure these things happen.

Nursing, like health care in general, is moving from the hospital setting to a community setting. In this milieu the needs of the client are different. Services taken for granted in the institutional setting such as food service, housekeeping, personal care, transportation to other clinical

areas, etc. are not always available to the homebound client. Consequently, assessing how the client is managing in the home setting is essential. The nurse must also be familiar with community resources so that needed referrals can be made. The goal of nursing should be to provide necessary home support so that individuals can safely remain in their residence of choice and enjoy as healthy and fulfilling a life in their final years as is realistically feasible.

Nursing Education

To help nursing students gain an understanding of the elderly homebound woman who is living alone, interaction with this aggregate should be introduced into the curriculum. Ways of interfacing should not be limited to clinical sites but should incorporate visits in the home environment of the women.

In both this study and others, the women appeared to benefit from the opportunity to be able to reflect on their past experiences. Finding ways to interact with others would provide the opportunity to continue that process.

The possibility of incorporating such interactions into the educational process should be explored. Schools of nursing and social work could investigate adding visits to homebound elderly into the curriculum. This would allow students the opportunity to interface with this population and do a needs assessment at the same time. Because the majority of elderly women are living in noninstitutionalized settings, the population living in the community should be

the ones accessed to better understand the health and health related needs of senior women.

Health Care Services

Finding a way of maintaining independence was an ever-present concern. The study participants had physical limitations but were continuing to manage on their own. However, assistance was needed for that independence to be a reality.

All of the women in this study used homemaker services. The homemaker was a vital link if the homebound client was to maintain independent living. For some, the homemaker was also the most constant and relevant contact they had with others. However, the relationship between the elderly woman and the homemaker varied from being a very positive to very negative experience. Research needs to address how to find the right "fit" between the two so that the outcome is more positive.

Staying connected with others is essential in maintaining health. While the women in this study did have contact with others, they also experienced barriers in this area due to physical and financial restrictions. Identifying ways of overcoming those barriers need to be accomplished. Nurses need to determine if the woman is utilizing all available services, such as homemaker services, transportation assistance, nutritional services, etc. that are available. If there are voids, then new methods of remaining connected with others need to be found.

For women who are unable to leave home and have few opportunities to interact with others, obtaining a computer may be the answer. Programs to provide the hardware, internet access, and education on how to use the equipment may need to be developed. However, if the result is entry into an expanded and rewarding world for the senior, the undertaking would be worth the efforts required.

Social and Political Change

One of the findings of this study was that the women who expressed a level of satisfaction in their lives all lived in senior complexes. More investigation needs to be done to see if this is a consistent finding for senior women. If so, social action may be needed to provide adequate and secure housing for this group of women.

In order for elderly homebound women living alone to attain a realistic quality of life, an array of services will need to be available. Continuation of transportation and homemaker services are two of those critical necessities. In a time of restricted resources to pay for such services, providing this assistance may become more and more difficult without tremendous social support. With the backlash against programs for seniors that are seen as taking away from services to children, finding support and funds for programs essential to elderly women may become even more difficult.

Since nursing is a predominantly female profession, nurses should have a very special interest in improving the fate of elderly women. Support of programs that assist the

elderly female in maintaining her independence need to upheld. Because these services will require funding, it may even be necessary to accept financial ramifications in the form of increased taxation to provide the needed care.

To help in this effort, nurses need to develop a consciousness of their surrounding social, political, and economic structures. Chopoorian (1986) suggests that nurses have been negligent in this area. However, nurses have a duty to understand the structures that influence policy and services. Learning how to work for the betterment of the health of this aggregate may include forming alliances with consumer groups like the elderly in an effort to rectify such problems through social and political endeavors.

Research related to health issues of elderly women has been identified as an essential need. The increased longevity of women only emphasizes how critical that need is. The chronic nature of the health concerns of elderly women imposes physical limitations that compromise independence. Identifying ways of preventing and/or alleviating these conditions and resulting circumstances needs to be a priority on the health care agenda.

Directions for Future Research

The methodology used in this research proved to be advantageous in working with this aggregate. The interface allowed the researcher to obtain insight into not only the lived experience, but also emotional reactions, environment, and interactions with others who happened to be present. The

women also responded well to meeting with the researcher and the opportunity to have an individual actively listen to them. While other methodologies should not be excluded, the use of phenomenological methods should be continued to explore the lived experience of this group of women.

When data were collected during one interview, the picture obtained was for that one period in time. Future studies should incorporate the use of longitudinal studies to obtain a more complete picture of how life events affect the lived experience. For instance, in this study, two of the participants were scheduled for surgeries within the month. An additional area of study could determine how periods of health crisis impact life. In light of the positive response to the interviews that were conducted, the women would undoubtedly be receptive to the possibility of developing a long term relationship for study.

With relationships diminishing as one grows older, ways of staying connected should be explored. With the loss of loved ones and friends, connections such as pets, spiritual beliefs, support groups, and other individuals may need to be found. Research related to the relevance of these connections is needed.

Two of the women interlaced stories rich in California history. If these stories are not captured before the women's deaths, this heritage will be lost. Consequently, ways of capturing personal narratives need to be developed. Possible research in this area could include the personal value of

leaving this legacy, the benefits of the process of sharing this past history, and methods that work best to accomplish this endeavor.

An area of concern with this elderly population is how middle income women are functioning. The poor elderly qualify for many services, such as homemaker services and transportation vouchers, that make their life easier. The financially secure can purchase the services needed. The group that needs study is the one falling between these two: the middle income older woman. Research should explore how this aggregate is coping with the aging process, what services they have access to, what ones are still needed, and what their life experience is. It would also be of interest to investigate the lives of elderly women who are homebound and live alone and are not yet connected with any service agency. Research could explore how these elders are managing on their own, what level of satisfaction they have in their lives, and what would enhance their life experiences.

Another component of elderly homebound females living alone that merits study would include the cultural aspect. This study included primarily Caucasian participants. It is not known if there are cultural variations that need to be addressed in future research. Areas of study would involve exploring the cultural nuances related to being homebound and living alone and the impact on this group of women. Specifically, how difficult is it to ask for assistance, how

is the family viewed if they do not provide care for the elderly woman, and is there a difference in the life experiences of elderly women related to cultural variances?

One of the interesting insights found in this study was the significance that the type of housing played in the lives of this group of women. All of the women who expressed a degree of satisfaction or contentment with their lives lived in senior housing. More research needs to be done to determine if this is a significant finding for the senior population. Also, what are the specifics that seniors would like to see in senior housing?

All of the seniors in this study had housekeeper services. The interface between the two could either enhance or detract from life experiences. Research is essential to determine what can be done to enhance the housekeeper/senior relationship, attract caring individuals into the housekeeper field, and determine ways of finding good matches between the senior and housekeeper.

A remaining question that needs to be answered is: Are there ways to predict whether an elderly female will be able to experience life satisfaction in her waning years? If so, what are the factors that would positively influence her life? If such determinants could be found, planning could be done in the earlier stages of life to incorporate ways of enhancing those later years.

Because of the void in research related to this aggregate, the areas needing additional study are only

limited by the imagination. Consequently, researchers with special interests and preferred methodologies have an uninvestigated area for exploration and should not neglect the homebound elderly female who lives alone.

Concluding Thoughts

The fourteen women who were interviewed for this study each provided interesting and unique perspectives to the understanding of the lived experience of the homebound elderly female living alone. They were receptive to the interviews, open in their discussion, and willing to share their insights to help women younger than themselves. This study was a beginning, but much more needs to be done so this very significant group can have their voices heard.

Time is endless when it is adequate. For in one sense time exists only in relation to what is willed and done; and the act of completing something is like closing a circle in nature (Grudin, 1982, p. 126).

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APPENDICES

APPENDIX A
CONSENT FORM

Consent Form

Project: A study that examines the lives of women 65 years of age and older who live alone and are able to leave home only with great effort and/or the assistance of others.

Researcher: Sharon Burt, RN, MN

Ms. Burt is a doctoral student conducting research for a doctoral dissertation at the University of San Diego.

The purpose of this research project is to gain an increased understanding of the life experiences of women who are homebound and living alone. Each interview on this topic is expected to last an estimated hour to hour and a half. Unless I notify the researcher otherwise, the interview will be audiotaped. Taping of the interview is requested to provide an accurate account of the interview.

The tapes and transcripts of the interviews will be in the possession of the researcher and kept in locked cabinets. Identifying information will be stored separately from the tapes and transcripts to protect my identity. At the conclusion of this study and any follow-on studies, the tapes and transcripts will be destroyed.

During the interview, I will be asked to describe experiences occurring in my life as a result of being homebound and living alone. I will be free to telephone the researcher with any additional information that I wish to add to the interview. Information provided in the interview will be treated in a confidential manner. However, if any evidence of abuse arises during the interview, I understand that the researcher will be obligated to report it as required by professional licensure.

This study will not provide any direct benefits to me, but the results of the study may influence the quality of life of other women in the future. I understand there is no health risk to me due to my participation in this study. However, if an area of discussion should become emotionally sensitive, I can terminate the interview and the interview tape will be destroyed immediately. I understand that neither my willingness to participate in the study nor my request to terminate my participation in the study jeopardizes my care or service from the Area Agency on Aging.

I hereby give permission to be interviewed and for these interviews to be tape recorded. I understand that I may be quoted and that the information I provide may be included in presentations and/or published reports, but that my name will not be associated with the research in any way.

I understand that I am free to choose not to participate in the study, or to withdraw my consent at any time. I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction. There is no agreement, written or verbal, beyond that expressed in the consent form.

Signature of Participant

Date

Location

Signature of Researcher

Date

Phone number of Researcher: 760-436-5822.

APPENDIX B
DEMOGRAPHIC DATA

Client # _____

Demographic Data

A Phenomenological Study of Homebound Elderly Women Living Alone

Age: _____

Marital Status: Divorced: _____ Widowed: _____ Never Married: _____

Homebound:

Length of Time: _____

Reason: _____

Living Alone:

Length of Time: _____

APPENDIX C
INTERVIEW GUIDE

Interview Guide

Medicare defines someone as homebound who is able to leave his/her home only with great effort and/or the assistance of others. Does this definition describe your current situation?

In the last month, how many times have you been out of your house? What were the reasons for leaving?

Quality of Life:

How would you describe your current life?

How has your life been affected by being homebound?

Are there changes you would like to make in your life?

How do you stay in touch with those outside your home?

Where do you find your strength?

Health:

What health limitations do you have that have contributed to your being homebound?

What have your experiences been when obtaining health care?

Is there anything more about your experience that you believe is important that we haven't touched on?