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OLDER ADULTS WHO REMAIN AT RISK: UNCERTAINTY IN DECISION-MAKING

by

Carolyn Eve Nichols

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STATEMENT BY AUTHOR

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DEDICATION

Limitless recognition is given to my fiancé, Martin, for his love, encouragement, assistance and endless patience for the past twenty-three months. Without his support, completion of this study would not have been possible.

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ABSTRACT

A qualitative study, using grounded theory methodology, was conducted to explore the decision-making process of at-risk older adults who chose to remain living in a situation which did not meet their functional needs. The six subjects participating in the study ranged in age from 72 to 91 years of age. Each of the subjects lived alone in a private residence.

The development of a framework began with subcategories and their properties derived from data bits which led to emerging categories, to core variables and finally to the resultant substantive theory of managing survival and its implications.

Insight into the decision making process of the older adult to remain at risk was identified. Implications suggest ways nurse case managers can help clients achieve their goals while containing cost and assisting the older adult to maintain their independence.

CHAPTER 1

INTRODUCTION

According to Healthy People 2000 (U.S. Dept. of Health and Human Services, 1990), the fastest growing segment of the United States population is the older adult, age 65 to 90. While overall life span is not increasing, the increase in the older adult population is due primarily to advances in medical technology, which directly influences the morbidity and mortality rates. Therefore, a larger number of older adults, who become frail*, are living longer. Basic functional elements, such as meal preparation, housekeeping, transportation and available emergency response systems are crucial in providing appropriate support to the individual. While the underlying concern is one of compassion in providing support to the older adult, accelerated health care costs are also a major issue.

Optimally, an older adult resides in a living situation that matches his or her support needs. A congregate living situation, for example, containing functional components enabling an older adult a modified level of independence, provides such a level of support.

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*In this study, frail or frailty is defined as a fragile state of health which results from a process of aging and/or in combination with a chronic physical condition or conditions.

This support level fosters an independent lifestyle in a semi-dependent milieu. The balance among independence, functional needs and available supports is necessary to maintain an older adult as a self-sufficient person in later life.

When an older adult's needs override the supports provided in an independent living situation, the person faces a decision involving a change from an independent to a semi-dependent living environment. This study focused on older adults who had overwhelming functional needs that were not being met, but who choose to remain in their inadequate living situation. Primarily, an understanding of the reasons for uncertainty in decision-making, which keeps elders from making decisions that match their functional status to their level of support, was needed.

Statement of the Problem

An at-risk older adult is one who exhibits a loss in functional status to the point that the person would benefit from support and assistance. A person who becomes vulnerable to a decline in health status is in a risky living situation. An at-risk older adult in a risky living situation signifies a chance of injury, danger or loss of health status resulting from decreased functional ability without appropriate supports. In addition, an at-risk older adult is viewed as an individual whose activities of daily

living needs are judged by an outside observer (e.g., physician, nurse case manager, social workers, or others) as not being met. At-risk older adults are individuals who delay making decisions about changing their living situation when the available options are presented. An older adult's perceptions of an at-risk living situation may not concur with an outside observer's views. Therefore, there is a need for research that explores the perceptions of at-risk elders concerning their living situation.

Many at-risk older adults choose to remain in unsafe environments despite prompting and advice from community professionals. This type of situation has been designated as self-neglect by a few professionals and has become a recognized concern affecting the elderly population. As long as the person is deemed competent to make his or her own decisions, a surrogate decision-maker cannot be called upon to enter into the decision-making process (Weiler, 1991; Hommel, Wang & Bergman, 1990).

For the older adult, a lifetime of influences and experiences explains the psychological basis that affects decision-making. For elders who value independence above dependence, experiencing changes associated with the aging process may create uncertainty (Munnichs & van den Heuvel, 1976). Fear of dependency is postulated as a negative influence in decision-making, creating conflict in

ascertaining or even recognizing the need for an appropriate level of support (as determined by a professional).

For such individuals the decision-making process contains elements of uncertainty in the shadow of overwhelming evidence of the need to relocate or acquire appropriate supports. This investigation was undertaken to determine reasons for the decisions elders make regarding their living situation.

The living situation of older adults is of concern to professionals because with the length of stay in acute care facilities dramatically shortened in response to prospective payment systems and managed health care, they are returned to the community but some may not receive proper care. In addition, for the older adult to qualify for temporary extended care under current Medicare guidelines, the person must meet the requirements needed for skilled care. A dilemma results when, after hospitalization, older adults choose to return to a living situation that is not sufficient to meet their needs, but does not qualify them for skilled care. Oftentimes, an impaired ability to perform activities of daily living (ADLS) is seen as a precipitating factor which leads to acute illness.

Acute care facilities (hospitals) provide a level of support that is suitable to the needs of ill older adults. However, problems may arise from a cycle of illness precipitated by unmet functional status requirements at home. Frequently, health care workers are faced with providing the needed care for an illness but then must return the older adult to a non-supportive, independent living situation. A choice to return to a former living situation may foster the reoccurrence of illness which creates an illness-wellness-illness cycle. In some cases, community outreach health providers, such as a nurse case manager or home health nurse, become an extension of the acute care facility to facilitate the transition of the client back into the community setting. A nurse case manager or home health nurse is the professional who frequently assesses the client and is confronted with the at-risk situation. These nurses assess the functional status of the older adult in relationship to their needs. Often, it is at this point that the older adult is discovered living in a risky situation. While a risky situation usually involves an older adult living alone, it may also include an older adult couple in need of functional supports.

Frustration on the part of helping professionals mounts as the vulnerable older adult becomes less

functional and inadequate provision for meeting needs prevails. A further decline in overall health status in which intervention could stop, modify or delay decline is observed but the decline cannot be readily alleviated unless the vulnerable older adult chooses to accept and or obtain the needed support. Knowledge of the older adult's perceived obstacles is paramount in providing assistance when the elder is faced with uncertainty while deciding about the acquisition of support.

This study focused on older adults living alone who were at-risk for a decline in health status due to a rejection of supports necessary to meet the functional needs of daily living activities. The risky situation, as identified by the community nurses, may have been a shared perception of the older adult. Even when the nurse's and the older adult's perceptions coincide; however, the at-risk older adult may have chosen to remain in the risky living situation without adding needed supports. Health problems increase when adequate needs are not met. The decision-making process has been well documented in sociological and psychological fields of inquiry, but little attention has been given to the reasons that produce decisions to remain in a risky living situation.

Significance

Living alone, lack of support and functional limitations are characteristics of many at-risk older adults who choose to live in a risky situation. Therefore, the presence of a support system, formal or informal, could provide a living situation that promotes a healthy lifestyle for the older adult. In contrast, research by Branch, et al. (1988) shows that living alone, lack of an informal support network, and cognitive and physical limitations are substantial factors that predict long-term care placement (nursing home). These findings are significant since they suggest that provision of appropriate supports matched to functional needs could substitute for or delay permanent placement into a highly skilled long-term care facility.

In addition, provisions for maintaining an appropriate level of support are likely to lessen the frequency of acute care admissions and to reduce health care costs. A variety of support and care options, which are affordable at different income levels, are presently available to the older adult. Cohen (1994) defines these options as a "geriatric landscape" (p. 585), a variety of settings where older people live and receive treatment that include congregate housing, assisted living, life-care or continuing care communities, senior hotels, foster care,

group homes, day care/treatment, respite care and the diversity of retirement homes and communities.

Gerety (1994) states from a geriatrician's point of view that a comprehensive medical plan and a spectrum of other nonmedical services provide good functional outcomes and establish usage of health care resources in a cost-effective manner. This perspective provides a focus on preservation and optimization of function and quality of life for the older adult rather than on cure or extension of life. Key to this view is the provision of the right amount of support at the right time.

According to Lazenby and Letsch (1990), the demographics herald an imperative to attend to the health care of the older adult since those age 65 and over comprise 12% of the 251.8 million people in the United States and account for 36% of all health care spending. Maintaining an appropriate level of support lessens the episodes of acute care admissions and reduces health care costs.

Purpose

The purpose of this study was to investigate and uncover older adults' perceptions of their living situations which had been defined as risky by a health professional. This perception may or may not have been shared by the older adult. In designing this study, a

grounded theory approach was utilized to form a theory about the decision-making process involved in at-risk elders remaining in risky situations. This study was devised to answer the following questions:

1. What are the at-risk older adults' perceptions of their present living situation?
2. What are the relevant factors (or alternatives) older adults consider in deciding to remain in a risky living situation?
3. What are their perceptions of their future plans?
4. What are their perceptions of their functional abilities? (Fig. 1). At-risk older adults' perceptions of their decision to reject support to meet their functional needs was explored in this study.

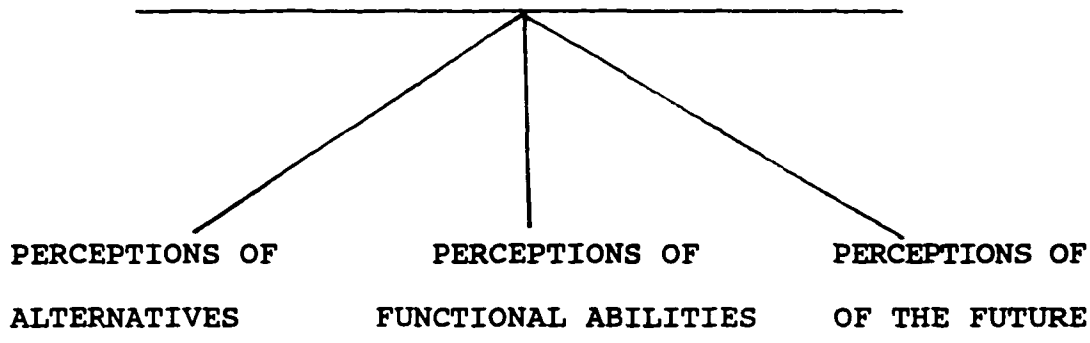

Fig. 1. Investigative conceptual model of important self-perceptions of older adults who chose to live in risky living situations

Summary

Acceptance of adequate support for declining functional status appears to be a link between living at home and entering a long-term care facility. For the aging population, an intermediate level of support may delay entrance into a long-term care facility. An assisted or congregate living arrangement or services provided in the home to supplement the functional status of the older adult can provide a bridge between semi-independent living and total dependent living, but some elders are reluctant to use this support. The issues of providing support for the older adult are being increasingly scrutinized since a growing segment of the population is reaching old age.

Health professionals are faced with the dilemma of providing adequate support and advice to the older adult who is facing the challenge of aging. Functional ability determines what level of support they need. Some older adults readily make the decision to accept the needed support while other at-risk older adults choose to remain in risky situations. This study focused on the latter group.

CHAPTER 2

REVIEW OF THE LITERATURE

While there is a great deal written about surrogate decision-makers, i.e., family members and the legal limitations of health professionals regarding older adults' choice of living situations (Feldman, Olberding, Shortridge, Toole & Zappin, 1993; McKenna, 1990; Bunting & Webb, 1988; Hanson & Thomas, 1968), there is little information regarding the perceptions of older adults themselves who choose to remain in risky living situations. Fortunately, there is literature available on factors that might affect decision-making among older adults, e.g., personality development, gender, race, health status, and other influencing factors in relation to making choices and commitments to decisions. Risk taking, a major component of this study, is described in studies of how American culture views this activity.

At-risk living situations are identified with contributing factors, such as functional status, gender, race and perceived health that affects needs and use of supplemental support care. Included are research studies that explore acceptance, successful and unsuccessful adjustment in choosing to live in continuing care retirement communities (CCRC), and older adult care

facilities, which provide an intermediate level of support to meet the needs of the older adult. Finally, the review of the literature points to explanations that provide a basis for understanding the process of older adults' decision-making.

Decision-Making

As far back as 1977, Janis and Mann described the decision-making process. They identified the stages and assumptions, as described below, which influence making a choice. Two specific influences, risk and uncertainty, can then be applied to the situation of the older adult in a risky living situation.

Janis and Mann (1977) delineated five stages of decision-making: "(a) appraising the challenge, (b) surveying alternatives, (c) weighing alternatives, (d) deliberating about commitment, [and] (e) adhering despite negative feedback" (p. 172). These stages are sequential and provide a way to understand the decision-making process, represented by an orderly progression from stage to stage. Therefore, a decision is built upon relationships among the stages of the process. In addition, the stages reflect an unpredictable of thought patterns (i.e., receptivity, recognition, evaluation, reflection and adherence) which designate progression of elements involved in making a final decision.

Janis' and Mann's (1977) stages form a connection among conflict, choice and commitment and are the basic parts of their decision theory. The theory includes influences of individual perception, stress, social status and self-esteem. However, stress is seen as the single most relevant factor influencing a complex or difficult decision-making process. Additionally, Janis and Mann delineated five assumptions regarding stress in decisional conflict. First, an opportunity for a new course of action, a decision, creates stress. The amount of stress depends on the commitment to the present course of action. Second, the greater the stress induced, the greater the effect on decisions which are dependent upon one's values, social influences and personal responses. Stress is not induced unless the decision-maker perceives a threat or a "loss or failure" to obtain one's decisions. Third, in a severe decisional conflict, each alternative is viewed as a threat. Loss of hope in finding a suitable solution accompanies the threat. Fourth, when threat cues are severe, the decision-maker perceives little time to find alternatives. This creates a state of hypervigilance in which thought processes are disrupted. Fifth, moderate threat produces a vigilant effort to scrutinize the alternative courses of action carefully and ascertain a satisfactory resolution to the dilemma.

At the same time, environmental influences and personality factors form an integrated system in which a decision is formulated. Environmental influences are defined as health status, finances, and living situation which impact on an individual. Personality factors are defined as coping mechanisms chosen by an individual in maintaining one's self in a decision-making process (Harvey, Hunt & Schroder, 1961). The environmental influences are components that may or may not be controllable by an individual. Harvey et al. viewed environmental influences and personality factors as jointly affecting a person's decision-making process.

The predominate American culture values success and status as well as risk, but individuals must succeed in their ventures before risk is considered to be a favorable personality trait (Finney, 1978). Using analysis of variance, Finney compared the three values of success, status and risk and found status, success and degree of risk, in that order, reflect an unpredictable relationship existing between these values. These values were defined by the participant as desirable personality traits in decision-making. Finney suggested that a change in any of these values may account for delays in the progression of decision-making among hypothetical situations involving

risk-taking. If status and success are not achieved, then a degree of risk is considered last.

Calhoun and Hutchinson (1981) investigated rigidity and cautiousness in the older adult. The participants were mentally alert and in good health. The mean age was sixty-nine years and the mean educational level was 12.88 years. There were 45 female and 19 male subjects for a total of 64 participants. The Choice Dilemmas Questionnaire (CDQ), which required a crisis decision about fictitious individuals involving life situations, was utilized. For example, a scenario required a decision focused on a job opportunity with six options available to the participant. The participants made decisions based on alternatives that ranged from very risky to very certain. Each CDQ item had five options which were rated on a level of risk based on probability level ranging from 1/10, 3/10, 5/10, 7/10, 9/10, and the "no choice" option, which was considered the most cautious response. In general, the older adult more often chose the "no choice" option when given that opportunity with items requiring a risky decision. Also, the older adult was more cautious about making decisions for a younger individual and took less risk when making decisions for individuals their own age. ANOVA analysis among factors of rigidity, life situation and probability revealed that rigidity was the underlying component in the

group which chose 5/10 (lowest level of risk) when the option of "no choice" was eliminated. Despite a variety of options available, cautiousness and rigidity may explain why older adults choose to remain in a risky living situation.

Risky Decision-making

Early researchers based their investigation of risky decision making on two theories prevalent at the time. These theories describe an individual's choices among risky alternatives, utility theory and descriptive theory, as reviewed by Luce (1967). Utility theory states that a person's preferences form a logical sequence based on a numerical ordering which explain the resultant choice in risky decision-making situations (Bernoulli, cited in Kaplan, 1964; Luce). Descriptive theory states that individual differences in learning, discrimination, information processing and sequential behavior explain individual choice in a risky decision-making process. These two theories are utilized extensively in the literature to explain risky decision-making (Luce; Cohen, 1964). Intuitive psychology, as espoused by Kaplan (1964), describes more fully that individual differences impact upon the risky decision-making process.

Uncertainty in Decision-making

Uncertainty is another influence in decision-making. Cohen (1964) focuses on behavior in uncertainty such as when a person considers conflicting information in relation to decision-making. An individual's behavior is influenced by the perceived level of risk-taking involved. In risky decision-making, an individual must make a choice based upon the perceived level of risk taking involved. Luce (1967) further elaborates on elements involved in risky decision-making by stating that a "specific outcome...depends to some extent on his or her choice but also depends upon chance events that are quite beyond his or her control" (p. 334). A degree of uncertainty may affect the perception of an older adult, who continues living in a situation considered risky by health care advocates.

In a 1991 study, Mishel and Sorenson utilized the uncertainty illness theory that suggests the existence of a relationship between uncertainty and the appraisal of danger and opportunity. The study was composed of women (n=131), who were faced with uncertainty in gynecological cancer. A relationship existed between the severity of the illness and the type of coping strategy chosen by the subjects. As the options for wellness or healing became uncertain, coping strategies became less concrete and

converged upon an appraisal process. During appraisal, the individual exhibited openness in exploring options. This finding tends to support the actions of receptivity as previously reported in Janis' and Mann's appraisal stage of decision making.

Uncertainty in illness theory was investigated further by Mishel, Padilla, Grant and Sorenson (1991) who demonstrated how coping strategies are developed in responses of women (n=100) who were receiving treatment for gynecological cancer (age range 20-81 years, mean=53 years). The researchers investigated the appraisal categories of danger, opportunity and emotional distress which resulted in the identification of two coping strategies: wishful thinking and positive coping. The most severely ill participants relied upon a "faith in something specific that promotes optimism" (p. 240) rather than a behavioral skill.

In summary, the literature explains the decision-making process as individualistic but with a set of progressive decision-making stages that are dependent upon psychological factors and influenced by coping strategies. It is possible at-risk older adults with functional decline feel they must make decisions they perceive as risky and uncertain.

An At-Risk Older Adult

While the literature does not specifically provide a description of older adults' perceptions in a risky decision-making process, it does describe personality influences as they relate to complex decision-making. Harvey et al. (1961) state that the response of individuals is dependent on their perception of the present situation and their response to cues based on personality organization. Therefore, it is likely that decision-making is related to personality development.

Personality Development

Fishburn's (1972) personalistic decision theory states: "a decision is a deliberate act of selection, by mind, of an alternative from a set of competing alternatives in the hope, expectation, or belief that the actions envisioned in carrying out the selected alternative will accomplish certain goals" (p. 19). Personalistic theory includes the psychological considerations comprising the internal components of the individual which influence actions or inactions in decision-making.

Coping or defense mechanisms are factors that can influence an at-risk older adult's decision which may not be apparent to another individual (Kohurt, Kohurt & Fleishman, 1987). These coping processes are developed from early life experiences which provide coping patterns. These

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coping mechanisms can be viewed as cognitive and behavioral determinants. Kohurt, et al. define ten defense mechanisms summarized in Table 1.

Rimoldi (1969) describes "thinking ability" (p. 128) which denotes how an individual reaches a particular solution. He concluded that the individual's strategy throughout life depicts the thought processes of arriving at a conclusion influenced by personality development. Harvey et al. (1961) postulate four stages of personality development: (a) establishment of structure and avoidance of ambiguity, (b) emergence of internal control and resultant questioning control, oppositional tendencies, testing of limits, avoidance of dependence, (c) development of internal and informationally-based concepts that act as a reference for evaluating feedback from the environment including reactions of older people, and (d) ability to maintain an interdependent relationship with the environment while synthesizing thoughts in a process.

Self-abuse/Neglect

A choice to remain in an inadequate support milieu has been identified in the literature as self-abuse or neglect as judged by helping professionals. Since there is limited documentation and research on self-neglect and/or abuse by older adults regarding themselves, this aspect must be

Table 1

Cognitive and behavioral coping mechanisms (according to Kohurt, Kohurt & Fleishman, 1987, p. 9-12)

Mechanism	Determinant
Repression	Blocks out memories of stressful events exhibited by rejection, anger, sexuality, and dependency
Denial	Produces glaring distortions of threatening stimuli
Projection	Distortions associated with this defense produce obvious delusions with no connection to objective reality
Intellectualization	Development of a rigid, dispassionate, affectless (emotionless) way of responding to the world because of fear of own personal emotions
Rationalization	Handles conflict by changing memory of the circumstances that produced it, can be used as a form of therapy to provide more balanced views to cope with anxieties
Reaction formation	Behavior that is the opposite of what is felt

(Cont.)

Table 1-*Continued*

Mechanism	Determinant
Displacement	Directing one's anger toward another if unresolved in adolescence
Fantasy	Used to develop sensitivity and communication
Regression	Reverting to childlike mechanisms of handling stress, but in general the aged do not regress
Identification	Greater wisdom arises as a result of insight

approached cautiously. One reference to self-neglect explains that the individual is responsible for the results of his or her inaction regarding appropriate decision-making (Fulmer & O'Malley, 1987). Further, Fulmer and O'Malley point out that intervention for older adults is dependent on their permission, which requires their acceptance of intervention, to provide support for their needs. They conjecture that a definition of self-abuse or neglect should include the older adults' willingness to address acceptance of support.

Risktaker

The process of risk taking and its relationship to success or failure may include factors that older adults may consider in decision-making. Finney (1978) investigated the views of college students (n=120) who completed a questionnaire about risky and conservative traits in decision-making. In this study, Finney found a successful risk taker (a person willing to make a chancy decision) was equivalent to a conservative decision-maker. Participants viewed unsuccessful risk taking as a negative characteristic. Finney further found that success must be combined with risk before risk taking is considered a favorable trait.

Similarly, in a study by Harvey, et al. (1967) with college students (n=128), a questionnaire was used to elicit the opinions of risk taking and conservative decision-makers. It was found that successful risk takers and conservative

decision-makers were rated on the same level of favorability. The unsuccessful risk taker was viewed unfavorably. These two studies on college age participants negate generalizability to older adults except that learned behavior in the early years is likely to carry over into the later years of life.

Factors Predicting an At-Risk Living Situation

The ability to perform activities of daily living (ADLS), e.g., personal care and eating, and instrumental activities of daily living (IADLS), e.g., shopping, transportation, and paying bills are addressed in terms of the functional liabilities predicting the need for long-term care. Branch et al. (1988) report five predictors of long-term care: (a) receiving help with at least one activity of daily living, (b) being dependent in functional health areas, (c) being homebound, (d) having multiple errors on mental status items, and (e) having no involvement with social groups. Their study, conducted over a two year period, included both men and women (n=3,706), aged 65 or over. In this study women and men, aged 85 or older utilized home care services twelve times more than the 65 to 74 age group. Frailty and poor cognitive function were the dominant indicators leading to the need for long-term care. The difference between this study and others was the advanced age group (85+ years) and the extent of home care services utilized because of declining functions.

These findings support a significant relationship between functional assistance needs, acceptance of supports, and the aging process as predictors for long-term care usage. The absence of sufficient support, coupled with a decrease in functional ability, eventually leads to substantial care needs. Alternative solutions to meet the problem of decreasing functional ability of the older adult are usually available whether provided in the home or in an alternative living situation. An adult care home is an example of a alternative living situation that provides an intermediate level of support for the older adult's functional and social needs.

Gender, Race, and Health

Johnson and Wolinsky (1994) investigated the use of health care services based on the older adult's perception of health status and functional limitations. The sample (n=5,151) included black males (n=188), white males (n=1,632), black females (n=342), and white females (n=2,862). This sample was taken from a prior study (n=16,148), which examined relationships between disease, disability, functional limitation and perceived health for different races and or genders over a six year period with participants aged 70 or more. The study concluded that activities of daily living and instrumental activities of daily living were different between males and females but not

between races. In contrast to the males, females of both races were more likely to report functional disabilities and accept support. Females reported the need for assistance in dressing and household activities more frequently than males.

A ten year study conducted by Branch and Ku (1989), used the independent variables of age, gender, baseline ADL status, marital status, household composition, education, poverty, self-reported health status, length of stay in hospital or long term care settings, to predict transition from independence to dependence. The sample consisted of subjects (n=1,625) age 65 and older who were living in the community. The interviews and record reviews were conducted in 1976 and repeated in 1980 and 1985. The variables age, gender, ADL status and self-reported health status were selected as predictors of dependency, institutionalization or mortality. Functional status at baseline was a singular significant predictor of transition from independence to dependence. Those with the higher level of functional status at the beginning of the ten year study exhibited a higher functional outcome at the termination of the ten year study.

Acceptance of Living in a Supportive Care Environment

Evidence indicates satisfaction with a supportive care environment occurs when older adults' perceive that the services provided and friendships developed contributed to improving life in later years. Lemon, Bengtson and Peterson

(1972) examined life satisfaction of male (n=182) and female (n=229) in-movers to a retirement community. Eighty-one percent of the sample were married couples: The total sample (n=411) consisted of 39% age 52 to 64, 46% age 65 to 75 and 15% age over 75. The theoretical framework used in the study was the disengagement theory of aging which states a decrease in social interaction correlates with a decrease in life satisfaction. Data collection consisted of a 200-item structured interview. The dependent variable was life satisfaction and the independent variable was the frequency of formal, informal and solitary activities. The results substantiated the hypothesis that informal activity associated with friends produced a greater satisfaction with life.

Cohen, Tell, Batten and Larson (1988) queried older adults (n=1,498) for their reasons for entering continuing care retirement communities (CCRC). The sample contained an equal percentage of married, never married, widowed and a much smaller percentage of divorced participants. A 66-item questionnaire was conducted by mail. The usual reason given for entering was access to services (especially medical attention) and protection for spouse. Other significant reasons were available housekeeping, meal preparation, emergency assistance and transportation. The study concluded that the older adults viewed the "CCRC as an environment

which prolongs their ability to live independently in their own apartments even as they lose function and become more dependent" (p. 640). Also, the accessibility of meals, housekeeping services, laundry and a handyman enabled the joiners with functional limitations to avoid institutionalization and consequent dependence.

Beaver (1979) designed a study of the decision-making process among older adults (aged 66-95 years, average age 76). The majority of the participants who relocated to a retirement apartment setting were female (90%). The sample (n=108) of older adults consisted of those who successfully (n=56) and unsuccessfully (n=52) adjusted to the relocation. The decision-making process model attempted to identify and describe successful adjustment to relocation. The data collection was by personal interview, observation, staff records and a staff-rated adjustment scale. Good physical health, 'outgoingness' and number of choices available in relocating were dominant predictors of successful adjustment to the new living situation. Participants who experienced an unsuccessful adjustment exhibited passive participation and expressed fewer options available to them during the decision process. The most important factors in adjustment in the decision-making process were the value placed on personal involvement and the number of resources available. The respondents who made a successful adjustment had more

intimate resources, such as family and close friends to consult during the decision-making process. "Good physical health" (p. 571) was a significant factor in older adults who took responsibility and control of their lives (Beaver).

Numerous studies support the valued existence of community continuing care facilities as an intermediate level of support that provide independence within a supportive living situation (Mahoney, 1991; Ross, 1988; Turner, 1988; Williams, 1988). A study which examined the elderly (n=1,160) aged 75 or older, who lived alone, but had supports such as home help care, meals on wheels and a community-based professional contact, did not have significantly higher morbidity rates than elders living in retirement communities (Iliffe et al., 1992). In summary, research suggested community continuing care facilities, family and professional support as well as retirement communities have similar low morbidity rates as long as the older adult's functional needs are met.

Conceptual Orientation

In qualitative studies, theory emerges from the natural world. New elements are defined based on previously developed elements. The investigation is not objective as in quantitative research, but subjective. "The instrument in naturalistic inquiry is not an operational definition of anything, but a sensitive homing devise that sorts out

salient elements and targets in on them....Data analysis is open-ended and inductive" (Lincoln & Guba, 1985, p. 224). Hypotheses are then developed as inquiry proceeds. The issue is to "make sense" of data collected and provide an understanding of the subject being studied. S y m b o l i c interactionism theory was chosen to uncover the older adults' perceptions of their present living situation in an attempt to understand their decision-making processes which resulted in their choices.

Symbolic Interactionist Theory

Symbolic interactionists depicts human behavior as a result of a process based on a concept of self, which provides meaning to one's behavior (Mead, 1934). The development of human behavior is accomplished during childhood and through social interaction creating a concept of self (Chenitz & Swanson, 1986). The symbolic interactionism theory derives theory from concepts created by relationships among empirical data through abstraction, which begins to explain the phenomena under study.

Blumer (1969) further explained symbolic interaction theory as being developed from three suppositions. First, human beings create meanings which form the basis of how they react to objects, other human beings, institutions, guiding ideals, activities of others and situations. Second, the meanings are uncovered through social interactions that are

encountered with others. Third, the empirical data demonstrate conditions under which meaning is created. Blumer views self-concept as a mirror that reflects one's behavior arising out of social interaction with others. The concept of self is based on attributes of human beings who are able to express meaning from social interaction. According to Blumer, past experiences create the meanings which affect human response to a variety of situations encountered. Identifying the "underlying picture" (p. 25) begins the inductive analytic process in developing the theory of older adults who chose to remain at-risk. A depiction of the older adults' perception of their present living situation provides a framework for theory development. An exploratory study based on the symbolic interaction theory provides a milieu in which to attach meaning to the data collected.

In this study, a decision-making process lent itself to investigation by symbolic interactionism to "view human behavior as the result of process" (Chenitz & Swanson, 1986, p. 5). They stated:

> Nothing in the world, that is, objects, people, or events, has intrinsic meaning or inherent value in and of itself. Meaning is created by experience. Through interaction with the object and with self, the meaning the object has to the individual gives it a value. (p. 5).

The symbolic approach views action and behavior as a result of an individual's meaning and a value created by experience. A specific individual has many influences over a life span that contribute to his or her deliberations during decision-making.

Summary

There is insufficient knowledge related to older adults' perceptions of risky decision-making process when they choose to remain in a risky living situation. The decision-making process has not been fully explored from the elder's point of view. The reasons the older adult chooses to remain at risk despite prompting from community professionals has not been fully explored. With the age group from 85 years on up increasing in number, concern focuses on elders living at home alone with inadequate supports but who are competent to make their own decisions. A symbolic interactionist model provides a theoretical framework to interpret and create meaning from the at-risk elder's perceptions.

Some elders are resistant to accepting available supports. This qualitative study explored their perceptions which provided meaning to this risky behavior in order to develop a grounded theory. A conceptual orientation was used to define and describe the components of an at-risk older adult, an at-risk situation and risky decision-making. The investigative conceptual model (see Fig. 1, p. 18) contained

perceptions of older adults who chose to remain in risky living situations. As postulated, an outsider's perceptions of an at-risk situation may not necessarily coincide with the judgment of the older adult. An understanding of the older adults' perception of their situations was the focus of this study.

CHAPTER 3

METHODOLOGY

A qualitative approach utilizing grounded theory methodology was chosen to investigate the decision-making processes of older adults relative to their living situation. The sample, setting, human subject consent, data collection protocol, and theoretical sampling are described in this chapter. Elders' decision-making processes regarding living in a risky situation has not been explored thoroughly as can be ascertained by the scarcity of literature in the area.

A qualitative approach was chosen to uncover the decision-making processes as perceived by the elder living at-risk. The inherent attributes of qualitative research were used to capture the essence of the elders' perceptions. The characteristics of this approach are: (a) it is complex and broad, holistic and subjective; (b) it involves dialectic and inductive reasoning; (c) it utilizes knowing, meaning and discovery; (d) it involves shared interpretations, communication and observation; and (e) it utilizes words as the basic element of analysis (Chenitz & Swanson, 1986). Qualitative research "gives us the direction and full-bodied knowing about something that has implications for further research or direct practice implications" (Munhall, 1992, p. 261).

Grounded Theory

Grounded theory is founded on symbolic interactionism as a means to uncover and describe social phenomena and to formulate theory. Symbolic interactionism identifies human behavior and focuses on the meaning of events to people in natural, everyday settings through identifying the involved social processes (Kaplan, 1964). The elements of elders' decisions to remain in risky situations must be sufficiently explored by identification and integration of discovered behavior patterns to establish generalizability and power of the research findings (Chenitz & Swanson, 1985).

According to Newman (1994), one's behavior pattern continues to unfold from birth to death independent of aging changes. The pattern reflects the complexity of influences that affect an individual's decision-making processes. A pattern can be transformed into an explanation of decision-making behavior. The concept of patterning as explored in this study was used to investigate the complex relationship which influences decision-making.

Grounded theory, an inductive theory-generating methodology, was chosen to link symbolic interactionism, patterning of human behavior and social experience to provide meaning to the elders' perceptions. This method offered a distinctive approach to the study of human life and the social experience which generated rationale for decision-

making. Human life does not exist without making decisions. According to Clarke (1995), the grounded theory methodology is a strategy for discovering the prevailing process within the context of social interaction rather than just a description of what is observed. The research sought to generate theory taken from interviews with older subjects which was then translated into data bits derived from words, phrases or sentences.

Theoretical Sampling

Theoretical sampling and constant comparative analysis guided data collection until no further information about the phenomenon were discovered (Clarke, 1995). The related data bits formed categories which were compared to understand how they related to each other to formulate and generate the theory (Stern, 1985). Concepts were derived from related categories during analysis. A model or conceptual framework was formulated to illustrate how the concepts related to each other and to depict the process which resulted in the derived theory. According to Stern, the derived theory is formed from the emerging concepts which explain social process.

Theoretical sampling guided the selection of subjects and was the process of data collection which controlled the emerging concepts (Glaser & Strauss, 1967). The researcher examined data as they were retrieved and began coding, categorizing, conceptualizing and writing the research report

(Stern, 1980). Theoretical sampling was a reoccurring process of data collection, coding and analysis that led to decisions about what data to collect next. This process was complete when no new data were derived from the subjects and categories were filled.

Setting

The setting for the interviews was the subjects' private residence in a southwestern city. The subjects were chosen from the caseloads of community-based nurse case managers who monitor at-risk older adults. The community-based nurse case managers were employed by a non-profit health care system. The nurse case managers referred subjects who met the criteria of an at-risk older adult in need of support who opted to remain living in their present situation and the concerns each nurse case manager had for the subject's assessed risk.

Characteristics of the Sample

The sample included six subjects, age 72 to 91 years. The subjects, who were considered high risk, were referred by nurses, who assessed them as requiring support in activities of daily living and/or instrumental activities of daily living, but lacked the benefits of additional support in their living situation. The typical at-risk person lived alone with a partial or inadequate support system to

supplement needs whether informal or formal. The study participants included males and females who were over 72 years of age, (a) English speaking and reading, (b) living alone for at least six months or more, and (c) able to tell a story about their living situation.

The selected individuals were those who had adamantly refused sufficient support to match their functional needs to prevent a decline in health status. Prior to the study, the nurse case managers had informed the subjects of assistance that was available.

Survey Questionnaire

The following interview guide questions were asked of the participants to determine their perception of their living situation:

1. What is it like for you to be living alone at this time?
2. Tell me about any problems you may have with daily life, i.e., shopping, cooking, transportation, paying bills, bathing, dressing, etc.
3. What alternatives do you have to living here?
4. What do you see as disadvantages to living here?
5. What would you do if you became ill?
6. Tell me what you think about your health.
7. What would you do if you couldn't take care of yourself?
8. What are your plans for the future?

9. What would your ideal living situation be if you could live any way you wanted?
10. What do you see as the advantages to staying here?

Data Collection Protocol

Data collection began with the selection of the first subject randomly chosen from a list of subjects meeting the sample criteria. An informal interview session convenient to the subject was arranged. Data were collected from taped interviews and observations by the researcher. The following demographic information was collected: (a) age of subject, (b) length of time living alone, (c) marital status, (d) educational level, (e) closest living relative, and (f) presence of chronic illness (Appendix A).

An open-ended, unstructured interview was utilized to provide rich descriptions and perceptions of the informants (Glaser & Strauss, 1967; Treece & Treece, 1977; May, 1989; Streubert & Carpenter, 1995). The question, "What is it like for you to be living alone at this time?" was used to open the interview. An informal storytelling format was utilized to collect the data in a naturalistic setting (Brandriet, 1994). The use of unstructured questions allowed for content and flow that was uncontaminated by the preconceived thoughts of the investigator (May, 1989). The interviewer established rapport to obtain salient information. A second interview was not needed.

The interview lasted an hour, depending on the interest of the interviewee and the coverage of the topic. Permission to tape record was elicited at the beginning of the interview. Field notes and recorded observations were included in the data collection for holistic and substantive formulation of emerging theory (Strauss & Corbin, 1990).

Trustworthiness

A researcher must be aware of the threats to theoretical sensitivity when committed to a preconceived theory which limits and skews the generation of the theory (Glaser & Strauss, 1967). Bracketing is a qualitative research technique of laying aside what was previously known about the social process under study by the researcher. The researcher became part of the research process by reporting the reality as described by the older adult (Streubert & Carpenter, 1995). During the interview process, any preconceived ideas formed by the researcher were bracketed (Oiler, 1982). The subject's own description of his or her present living situation assisted the investigator to capture the respondent's perception of the living situation. The creation of an audit trail, which could explain the derivation of the emerging theory by an external auditor, verified the responses and how the emerging theory was obtained (Lincoln & Guba, 1985). The first interview was reviewed and approved. All additional interviews were then reviewed with the thesis

faculty advisor to verify the categories that reflected the research under investigation.

A concurrent comparative analysis facilitated and identified potential areas for further exploration. A decision to continue sampling depended upon a saturation of the emerging categories, accomplished by examining the properties for each category (Glaser & Strauss, 1967). Sampling continued until the categories were saturated and no further data produced any additional categories. The emerging theory was obtained by comparative analysis.

Data Analysis

Theoretically, it was important to discover similar characteristics among the descriptive properties, subcategories and categories of the data arising from the interviews (Glaser & Strauss, 1967). A reconstruction of the participants' perceptions of reality laid the foundation for the emerging theory (Streubert & Carpenter, 1995). The reconstruction of the interviews formed the data bits. The data bits, which began the taxonomic process of descriptive properties that evolved into categories, were obtained from the transcribed interviews. Coded data bits were labeled as descriptive properties generally ending with ing which denoted an action word such as managing, deciding, and recruiting support (Thomas, 1990). Similarities and underlying uniformity surfaced, which resulted in inductively

derived theory. The properties and subcategories reflected the categories from which core variables or concepts were developed, leading to a resultant substantive theory. Memoing was a process that derived from the coded data the importance of certain variables or in which relationships between categories began to emerge. This process created core variables and/or theoretical links that merged into concepts leading to identification of the emerging process which formed the substantiated theory.

A concurrent review of the literature revealed no information about a known framework which emerged as a result of the discovery of the relationships or linkages in the core variables. The theoretical framework was self-correcting in that the framework was generated and grounded in the data (Thomas, 1990).

Analytic Induction

This phrase, analytic induction, coined by Wilson (1985), described the process used in grounded theory. The researcher searched for concepts and linkages between the categories that applied to all subjects in the study. This led to an exhaustive analysis of individual interviews and a comparison of the interviews to each other. Examination of the emerging data assured that the formulated core variables reflected the relationships between the categories (Wilson, 1985). Comparative analysis continued until universal

patterns of relationships or set of core variables or concepts were identified, explained, and supported with data (Denzin, 1970). When the existing literature did not provide the explanation for the emerging theory, original concepts were formed by scrutinizing the data thus validity was developed from the interviews (Wilson).

Protection of Human Rights

This study was approved by the Human Subjects Committee of the University of Arizona (Appendix B). Permission to interview the at-risk older adults was obtained from the research committee of the participating nurse case managers' community based institution.

Voluntary participation, confidentiality and anonymity were guaranteed by verbal explanation and a written disclaimer (Appendix C) as presented to the participants. The interviews were coded; no names were used; and the data were reported in a way that cannot be linked to any particular participant.

Summary

Qualitative research utilized a grounded theory approach to uncover the components of the decision-making process of older adults who chose to reside in a living situation that did not meet their functional needs as determined by a professional health care worker. The grounded theory

methodology and the analysis process delineated by Glaser and Strauss (1967) was used to identify the data collected from the perceptions of the older adult.

CHAPTER 4

ANALYSIS OF DATA AND PRESENTATION OF FINDINGS

The analysis of data and resultant theory inductively derived from the description of properties, subcategories, categories and core variables or concepts which emerged from the subjects' interviews based on grounded theory process are described in this chapter. The inquiry questioned why adults living alone decided to remain living alone despite the risks. The at-risk older adult was identified by an assessment of a nurse case manager which prefaces each interview. The focus of the interview itself was older adults' perception of their living situation.

Definition of the Sample

Six caucasian subjects in this sample, age 72 to 91 years, had been living alone in their own residences from three to twenty years. They were all legally blind. Four of the subjects were widowed, one was divorced and one was currently married to a spouse living in an extended care facility. All subjects were referred by nurse case managers from their current caseload. The subjects met all the selection criteria of an at-risk older adult living alone. Additionally, four other subjects were identified, but

because of recent hospitalization or placement in an extended care facility could not be included in the sample.

Description of Subject Interviews

Data analysis began with subject #1 and continued through to subject #6. Data analysis consisted of categorization and clustering of data bits. Through constant comparison, a description of the initial taxonomic process was developed. The intent of the research was to identify the processes of at-risk older adults living alone and the decision-making processes they employed to continue living alone. For the reader's benefit, a synopsis of all interviews is presented *first* to illustrate the similarities of the subjects' responses.

Subject #1

Subject #1 was an 85 year old widow. She was referred by the nurse case manager who had expressed concern regarding the frailty of the subject and the multiplicity of chronic health conditions that could alter her current status. The present living situation was viewed as unsafe and insufficient to adequately meet her needs, e.g., lack of consistent informal supports, improper diet, diminished eyesight and worsened chronic obstructive lung disease (COPD). The perceptions of the nurse case manager were influenced by the subject's increasing age, high risk for

falls, nutritional deficits, impaired eyesight, impaired hearing, limited funds and non-acceptance of customary supports available to her. The subject demonstrated increased anxiety which decreased her ability to problem solve and she became less realistic in her assessment of her ability to maintain herself.

The subject had lived alone for 20 years, ever since her husband died. She had two years of college. Her closest living relative, a cousin who lived about 15 miles from her, would make decisions for her only if she were unable to do so herself.

After the tape recorder was turned off, the subject made the following remarks about her personal feelings on the subject of moving to an assisted living situation. She stated, "Don't let them do it to you."

In the question of self-reported health problems, her responses showed her awareness of her health problems and how they affected her daily living activities. She had survived three strokes, including her current health problems: COPD, arthritis and glaucoma. She used a cane because of arthritis and childhood polio.

She attributed the ability to maintain her lifestyle as being organized. "Well, for one thing, I'm very organized. I've always been very well organized." She described her daily routine as one of paced activities. Her

acceptance of a lost function was followed by compensating for the disability. She believed that being alone forced her to find a way to maintain her activities of daily living. Her ability to cope was dependent on past life experiences with advice from significant family members. She was advised to "...clean up, never leave dirty dishes, always wear clean underwear, etc."

She explained how her past social skills influenced the formation of formal and informal support systems to supplement her needs. Her informal support system was composed of her closest living relative, church members, the manager of the mobile home park and neighbors. She was reluctant to accept support while she was still able to manage by herself.

Since she could no longer read the newspaper, she used the television to keep current on world affairs and through this avenue of communication, she attracted others and broadened her circle of acquaintances who, in turn, supported her needs. Her formal support system consisted of Lifeline (emergency contact line), a primary care physician and a professional nurse case manager.

From her self-report, it appeared her closest relative and her primary care physician provided reinforcement for remaining in her own home. Their reinforcement focused on her personal qualities. She reported these as being

independent and adaptable, taking things as they come, and possessing a sense of humor. The final decision about living in an alternative situation was to be made by her closest relative or by the primary care physician if she were unable to make the decision herself. Her closest relative stated that if she moved somewhere else, "... [she'd] just sit there and wouldn't say a word and probably would just die." As for planning for the future, her comments centered upon maintaining her present living situation and her funeral arrangements. She had knowledge about assisted living situations, but had not seen or experienced an intermediate level of support with services available to her such as her own independent apartment.

Subject #2

Subject #2 was a 91 year old married male. He was referred by the nurse case manager, who, in addition to the selection criteria, expressed concern about his frailty and high risk for falls due to extensive osteoarthritis, impaired memory, almost total blindness and frequent episodes of congestive heart failure. The nurse case manager's perception of the subject's living situation placed him in a tenuous position as related to a major decline in health status. Health promotion and preservation were concerns of the nurse case manager.

The subject had been living alone for four years. His spouse was living in an extended care facility within walking distance. He visited her frequently. He had completed high school. His closest living relative, his wife's 78 year old brother, had power of attorney. He lived in another state, visited about twice a year and also had health problems.

When asked about what is it was like to be living alone at this time he responded, "Well, it don't, it don't really bother me to be alone." He compared himself with a friend who also lived alone and who called him at least three times a day. The subject stated his personal qualities as not demanding attention, not needing to be noticed, and being introverted.

He attributed loss of function to a health problem but did not identify the problem as a chronic health concern, except when he felt it interfered with activities of daily living. The loss of eyesight was reported as, "Well, my biggest problem is, is my, uh, eyesight." Being able to drive was perceived as maintaining his ability to be independent. He voluntarily ceased driving at age 88 after he almost sideswiped another car. As he perceived the loss, "that was harder then, then, most anything else, not being able to go when I wanted to, and where I wanted to. And

having to depend on somebody else to take me. That's quite a change."

Recruiting support was not an activity for him. His wife continued signing checks for the bills although she was in an extended care facility, a permanent placement for her. He stated that being satisfied with less was his view of maintaining his present situation.

He ate one meal a day which was prepared for him at a dining area within walking distance of his apartment. He minimized the effects of weight loss saying he only really needed one meal per day. When he could arrange transportation, he shopped and bought microwave meals to supplement his diet. He did not actively recruit support, but he did accept support to maintain an independent lifestyle.

His informal support included his wife in the extended care facility, a neighbor and his wife's brother. His formal support consisted of his primary care physician and the professional nurse case manager. Of the two relationships, the relationship formed with the nurse case manager was more influential for him in decision making. She assisted him with decisions about his lifestyle and visited him on a regular basis although he was not sure how she had come to visit him in the first place. She helped with the decision-making process regarding his ability to

take care of his wife. The subject described the nurse case manager's help with the process of his wife's admission into the nursing home, "She knew just what to do."

Since he perceived his status as sufficient to meet his needs, when deciding to make a decision about an alternative living situation, he would rely upon the nurse case manager but only if he was unable to manage himself. In an emergency, he would utilize 911. He perceived the loss of his eyesight as the basis of his current situation. He stated, "If that was better, everything would be better." He had no plans for the future except, "Only if I can't take care of myself, I'd probably go next door, in the rest home." The subject stated, "No, I've not really planned anything." "Cremation" was the only definitive answer regarding the future.

He perceived his health to be "pretty good," despite his heart problem, diminished eyesight, and COPD. He also reported, "I, I never thought this was gonna happen to me....twenty years ago, I had no idea I'd be living like I am." He managed despite his physical limitation which he minimized. He also compensated with supports to supplement his deficiencies with, for example, a microwave oven, medication box (set-up by the nurse case manager), purchased house cleaning services once every two weeks and transportation provided by a van when available. In spite

of his physical limitations, the subject's perception was, "I think I'm getting along pretty good." He stated he had problems with his memory which decreased his socializing. "It's hard to get acquainted when you can't remember names," but he was satisfied with living alone.

Subject #3

Subject #3 was a 72 year old female. She was referred by the nurse case manager, who, in addition to the selection criteria, expressed safety as the main concern because of the subject's total blindness, depression, isolation and impaired mobility. Her daily living activity needs were met sporadically as the availability of informal supports varied. Since she lived alone, the probability of accidents and the need for appropriate responses substantiated the presence of a risky living situation as perceived by the nurse case manager.

The subject had been divorced several times in the past. She had been living alone for four years. Her educational background was limited to the seventh grade because of a childhood illness. Her closest living relatives were two married daughters who lived in the same city. She enjoyed her family and her grandchildren. The subject enumerated many health problems such as: sinusitis, described as "pretty bad"; degenerative arthritis, "in my spine"; nervous stomach, "I should be on a bland diet";

degenerative heart trouble, "that I don't have it anymore"; and a stroke last year. Blindness was reported later in the interview.

She stated that she preferred to live alone. "I like living alone,...and I cry every time I think about anybody helping me." The overall emphasis of her coping strategy was the ability to survive the negative happenings in her life which involved poor health and difficult relationships. She used the telephone as her means of recruiting support whenever she was lonely. She attributed her ability to be satisfied with being alone from her experience with a childhood illness. She also acquired aids from the Blind Association, such as talking books. "There are so many things I want to do, and, of course, if I couldn't talk to my girls on the phone, I would be, I would get lonesome." She defined past experiences with poor health and difficult relationships as helping her to cope with her living situation. "... [I] had a very hard time for a long time." It was difficult for her to relay the past negative experience, "I'm sorry. I can't. I shouldn't go over these things. It's hard for me to do so."

Uncertainty and denial characterized her perception of her heart problem, "that I don't have it any more....I suppose this is a thing that's rather dormant and can probably occur again. I don't know exactly." In regard to

her eyesight, "I was losing my eyesight more than I realized, I guess." She also expressed no control over her health problems. She was aware of her numerous health problems but chose to manage despite the difficulties encountered. Her life review revealed coping strategies which helped her to survive in a variety of difficult situations.

She managed with aids, such as a microwave oven and placing medication boxes in different places of her home for specified times. She had developed a network of informal supports in the trailer court where she lived, e.g., someone to get the mail, someone to check on her if she didn't open her blinds in the morning, and similar activities. As it became more difficult for her to manage, she recruited other informal and formal supports.

Her prior work history included cooking and organizing recreational activities in an extended care facility. She was adamant about refusing residence in an extended care facility because of past negative experiences. She felt she could rely upon herself in making decisions regarding her living situation.

She accepted assistance from a social worker who visited every six months to evaluate her needs. Her energies focused on self-maintenance in her own home. Her overall perception was "I manage quite well." In regards to

future planning, "I know I'll have to someday, but I'm not ready to go yet, and I'm not going to go until I have to." She was aware of losing function but she felt she was able to adequately compensate for her disabilities by being satisfied with less. She focused on past activities that she was able to do but could no longer accomplish because of her health problems. She accepted support for only what she could no longer do, "...I don't want anybody to help me take a bath. I don't need anybody to give me a bath." In regards to the ultimate decision to care for herself, she stated, "I'd have to give up and, and go some place where they can take care of me."

She expressed negative feelings about change. Change was defined as "making radically different"; for instance, the Blind Center had initiated new programs and she felt uneasy participating in them. She had not been there for three years because of chronic low back pain which limited her ability to function. Her current assessment of her ability to function in the Blind Center was "I think I'm past that. I don't think that would do me any good any more." She also reported that being satisfied and being quiet were qualities which she enjoyed alone in her own residence.

Subject #4

Subject #4 was an 81 year old widow. She was referred by the nurse case manager, who, in addition to the selection criteria, expressed fears about the subject's vulnerability as a result of impaired eyesight and trusting attitude. She also lived alone and did not have a sufficient support system to meet her everyday activity needs, such as cooking, shopping, paying bills and transportation. She had informal supports which were not consistently available to meet her needs.

The subject had been living alone for 10 years. Her loss of vision had occurred only six months before the interview. She had completed high school and had been a full-time wife and mother. Her closest living relative was an adult daughter who lived about 125 miles away. The subject remained in contact with her daughter by telephone and was visited once a month or more. She maintained close ties to her church which also provided an informal support mechanism.

Even though hypertension of five year's duration and macular degeneration for the past six months were health concerns, she perceived her health as, "I seem to be in pretty good shape, except with my eyes." Although she reported that the loss of eyesight was the most significant event which affected her living situation, she felt, "very

comfortable....I can manage around my place and take care of myself....I've been trained at the blind school....Right now I feel very competent." She utilized formal and informal supports to remain independent. She also exhibited a positive attitude which helped her to remain in her living situation. She reminisced about things she was previously able to accomplish for herself and the impact that she felt from the loss, particularly about her eyesight. She said for example, "... [it's] quite a blow, you know. We get used to things, you know." Even though tearful, she quickly dismissed negative thoughts of past functioning and focused on the things that she was still able to do. "I can hear, not too good, but good enough." Further minimalization of function loss was reported as "I've got bad eyesight, but there's a lot of other people got a lot of worse things than I've got." The subject also minimized her loss of function such as using the telephone, "I have a little problem there. I apologize when I get the wrong numbers, but I'm managing."

She saw herself as self-reliant, "I do manage to clean the house. I don't know how good I do it, but I do do it, you know." She did not always rely on others to shop or clean for her, stating, "But many times, I'll catch the bus myself...get my groceries....I really can't read the price of stuff, if there's somebody close by, I'll ask them." But

she was also aware of shortcomings and she did recruit informal support for what she could no longer do, such as paying her bills, driving, etc.

Her deciding not to decide was evident in, "Well, right now I, I really don't...I don't have any thought of doing anything different." She based her decision on information about her eyesight, "that you will never go completely blind....so maybe I'll just be able to keep on....that's what I'm hoping for." She relied upon her physician to decide when she needed the hospital and to notify her daughters if she became ill. She had no direct answer for what she would do if she was unable to take care of herself. "I don't know what I would do...I haven't given that a thought...It's foolish to think about it." No planning for the future was in keeping with the decision not to decide even about a change in her functional status. Deciding not to decide was further demonstrated by remarks such as "Well, just live on here 'till I die, I guess....I figure, if I can do it, I will, you know....I figure it's really home." The subject also reported that if she was unable to make a decision about taking care of herself, she would leave it up to her children.

The subject chose to actively maintain the status quo. She viewed several activities as being essential, "you know, it's better for you...to keep active....it's better

for you all the way around, your mind is everything....Even if I have to push myself, I'm gonna do it."

Although the subject recognized her inability to maintain her previous level of physical activity, which was walking, she had not been able to compensate for that loss as yet. In other instances, she invited church friends to conduct Bible sessions at her home to maintain her activity. In fact, she had to consider her schedule to be available for the research interview.

Subject #5

Subject #5 was an 84 year old widower. He was referred by the nurse case manager, who, in addition to the selection criteria, expressed concern about his fluctuating mood swings which interfered with his daily life functioning and his ability to make decisions. The subject had been told by the social work case manager that to qualify or be accepted into an adult care home setting he would have to give up chewing tobacco and his dog. He was unwilling to part with these two attachments. The instability of his current health problems, e.g., atrial fibrillation, transient ischemic attacks (mini-strokes), angina, osteoarthritis, depression and living alone placed him in an unsafe living situation.

The subject had lived alone for three years. His educational experience consisted of four years of college

and two years of engineering. Although he had four adult children, they were not actively involved with his every day life because they lived great distances from him.

The subject's perception of living alone at the time of the interview was described as "a lifetime of livin'. It's just been a lifetime." He was referring to the loss of his wife three years ago. The subject was married for 61 years. He was well known to his neighbors as "Cowboy Bill." During the interview, he was visited by a volunteer social worker, interested neighbors and a delivery person for home delivered meals.

His description of chronic illness was "sometimes pretty bad on my heart, sometimes it don't work right, sometimes it gives me quite a bit of trouble....Loss of memory, I've had quite a bit of trouble with that lately." He perceived his health problems as due to stress, depression and "everything like that" as health professionals had explained it to him. He related his present living situation as, "I never thought about it, never gave it no thought, no consideration, not anything, 'til this happened, then you know it."

He described his coping in the past as seldom talking about the losses he encountered. Beside losing his wife, he also lost two sons. He accepted situations that occurred as, "it's just somethin' that just goes on in life." The

experience of past losses did not prepare him for the effects of his living situation. He perceived loneliness as one of the worst things in the world.

He was able to recruit assistance for the things he was no longer able to do for himself. "I can pretty well get that done." He described his level of functioning as varying from "It's just at times, which you're regular and everything goes along pretty good, then at times, it don't." He attributed that variance to getting old and "things", "no controlling over it, it's just, it's gotta come and go." He compensated for his inability to use the stove safely by, "I try not to do any more cookin' then I can, because I'm, I'm just scared of it." He was aware of his limitations in this area and used the microwave to avoid fires because of forgetfulness. The subject was realistic about his abilities and inabilities. One coping strategy he used was, "they say if you give in to depression, you're in an awful stress...and that's no good....it just takes it all away from you, and you don't have it."

In planning for the future, he said, "I cain't see any future to anything now that's just it. I live in the past too much. Now, I have friends, lots of friends, Oh, I got those, but just, you cain't see any -- I cain't see any

future to anything." He added that he was too old to look forward.

He reported his health as dwindling to a "certain amount" because of his functional impairments. He minimized his disabilities and felt he was satisfied with what he had. He had been approached by health professionals about relocating to a supportive environment but he stated he didn't have sufficient first-hand knowledge about an intermediate level of support. Because of the experiences both he and his wife had as volunteers with extended care facilities, he was adamantly opposed to living in a nursing home. He recounted that he would rather be dead than live in an extended care facility. His negative experience in the nursing homes was reflected in his desire to continue in his living situation, "so I guess I'll just continue like I am, till I find out the whole story....Time will come and then we'll know all about it."

In planning for the future, he said there was no benefit to it and he never gave it any consideration. He thought he would go before his wife and she was the stronger person, "the woman has more resistance than a man does." His reasoning for not planning for the future focused on "if you knew you had no future, didn't have anything to live for, you wouldn't want to live, would you?"

His disabilities of sight and hearing limited his interaction with other people because he was embarrassed to show his disabilities and oftentimes did not understand what was required to seek assistance. Telephone use was impaired by his hearing loss and ability to remember what was said. He compared present and past ability to function in everyday life as deteriorating but sufficient to meet his needs. He was satisfied with the way things were. His coping strategy was "As long as I can live in the past, with my memories, I can get along pretty good."

His decision-making process was one of deciding not to decide about an alternative living situation. He had no close family on which to rely and would call 911 if he was able to do so. He would not be the ultimate decision-maker in the event of further disability. The process would be conducted by a health professional or the "Lord would just take me home."

Subject #6

The subject was a 91 year old widower. He was referred by the nurse case manager, who, in addition to the selection criteria, expressed concern about safety issues related to declining health, e.g., impaired eyesight, impaired hearing, COPD, and impaired mobility. He expressed strong views reflecting racial prejudice which might evoke conflict in social situations and provoke personal injury.

The subject had lived alone for 15 years. His closest living relative was a daughter, a retired nurse, who lived 25 miles away. He described his marital status as, "I'm quite single," and he stated he dated when the opportunity arose. His educational background consisted of several years of college. He reported having several chronic illness such as bronchitis, emphysema, asthma, heart trouble and the "side effects is the pain in my legs."

He described his living situation as a pleasure, because he did not need to be concerned about anyone else; he enjoyed the benefits of living alone, i.e., eating and sleeping when he wanted and he could do as he pleased, going where he wanted to go. But all these benefits were based on what his health would allow him to do. He further explained that because of the weakness in his legs, he could no longer do the work he wanted to do. His daughter told him, "It's the dirtiest house in town and I don't agree with her, but it could be." He minimized the risks in his living situation, i.e., although he was concerned about falling which had happened in the past, he was able to manage the situation and eventually got up to a standing position. He also recruited friends and neighbors in a crisis situation but only when he was unable to manage the situation himself. He had used 911 in the past, but was dissatisfied with the assistance and the ensuing charges

for service rendered. If he could find alternative emergency assistance, he would utilize it.

Impaired eyesight had forced him to use a golf cart for transportation, but despite advice from his physician, he continued to drive on occasion. He did his own shopping, cooking and some housekeeping. He had sufficient finances to acquire household help but it had been difficult for him to find the right person. He had specific criteria for all aspects of his everyday activities. This was the personal coping strategy he displayed during his lifetime. He also had strong feelings about persons taking advantage of older people living alone.

He had negative past experiences with extended care facilities and assisted care settings, which directly influenced his decision not to live in either. If he was unable to make a decision regarding his personal needs and his family placed him in a setting other than his own home, he said he would give their inheritance away. His decision-making process was well defined regarding his wishes. He felt in control of the situation as long as his health status allowed, but he had made provisions for his wishes if he were unable to decide for himself.

He believed he had managed adequately and was satisfied with what he had and his ability to maintain himself in his own surroundings. He demonstrated insight

about his health status but was determined to remain in his own home. He had the finances to support his wishes and the mental ability to decide upon remaining in his own home. His son, who lived in another state, had power of attorney to manage his affairs in the event that he was unable.

He summarized his major objections to an alternative living situation as the restrictions and dress codes imposed, the arrangement of the activities area and the cost, particularly a significant entrance fee. His decision to remain in his living situation was based upon limited exposure to alternative living situations. While he reported deficiencies in his ability to provide for his daily life activities, he made allowances, "I manage." He was determined to make his own decisions. Despite a precarious health situation, he was satisfied with his living situation and made the comment, "I'm such a wonderful person (laughing) and I don't know of anybody that would be better company than myself."

Coding, Analyzing, and Categorization

To reiterate how the inductive process was developed see Table 2. The descriptive properties and subcategories shown in Table 3 and Appendix D were obtained from data bits which led to the development of initial emerging categories. Finally, core variables or concepts (Table 4) and the resultant substantive theory were formulated. The

analyses were derived from the previously described interviews which provided the data for creating these properties and subcategories. The emerging similarity among characteristics was identified as data analysis continued.

Subject #1 provided a rich description of her present living situation. She felt she had adequately provided for any risky situation that might arise. Processing the data bits resulted in categories which described her process of choosing to remain in her own home.

Subcategories were retrieved during the analysis of the data from this first subject. ***Aloneness**** reflected a perception of just being by oneself. The subject did not

Table 2.

Taxonomy of inductive derived theory

- Constant comparative analysis of data bits
  - Comparing similar subjects
    - Descriptive properties
      - Subcategories
        - Emerging categories
          - Core variables and/or concepts
            - Resultant substantive theory

*Bolded words represent initial subcategories and their definitions. See Appendix D for their descriptive properties.

Table 3

Taxonomy of subcategories/properties and initial emerging categories

Subcategories/properties	Emerging Categories
Aloneness	1. Factors Influencing Decision not to Relocate
Being Alone	
Informal Supports	
Staying in Home	
Recruiting Support	2. Impact of Health on Present Living Situation
Managing	
Reciprocity	
Attracting Others	
Functional Ability	3. Personality
Influences	
Perceiving Daily Life Situation	4. Survival Strategies
Losing Function	
Losing Independence	
Compensation	
Inaction	
No Planning for the Future	
Unknowns	
Deciding	
Past Influences	
Negative Experience with Nursing Homes	
Self-awareness	
Perceiving Daily Life Situation	
Personal Strengths	
Past Coping	
Unknowns	
Uncertainty	
Health Perception	
Decision	
Making do with Less	
No Planning for the Future	
Control	
Comparison of Past and Present Functions	
Change	
Independence	
Victim	
Negative Past Experiences	

Table 4

Core variables (concepts) from emerging categories

1. Deciding not to decide
2. Managing on a daily basis
3. Preservation of autonomy
4. Satisfycing
5. Minimization of disabilities
6. Acceptance of support as a necessity

feel alone. She disclosed that she recruited ***informal support*** and used ***reciprocity*** as a means of attracting others to help her to maintain herself in her environment. Informal supports provided by a cousin, friends and church members helped in getting things done, i.e., grocery shopping, transportation, doctors' visits, housekeeping, and church activities. ***Functional ability*** was defined as her perception of how well she performed the activities of daily living despite her physical limitations. ***Compensation*** was defined as devising supplemental support to sustain herself in managing the status quo, such as use of a microwave oven for cooking. ***Inaction*** was defined as her decision-making strategy about the inability to care for herself. The decision would be made by the closest involved

relative if she were unable to make the decision herself. ***Past influences*** was defined as past life experiences which established a reasoning process to remain in her own home. ***Self-awareness*** was defined as a self-report about personality qualities which she believed would make it impossible for her to live in another situation. "I would just sit and not to talk to anyone." ***Personal strengths*** were defined as the qualities necessary for her to maintain her current living style, i.e., "I handle that very well." ***Unknowns*** were defined as the lack of information in depicting what an alternative living situation would be. The prevailing issue was maintaining self in the present living situation despite diminished ability.

Subject #2 also focused on the perception of the present living situation and influences on decision-making. An at-risk situation was not perceived by him nor did he have any plans for the future except cremation. Being alone was not perceived as a negative but as a personal preference compared to his friend who called him frequently and whom he felt did not like living alone. ***Health perception*** was defined as a self-report of impaired physical conditions but was perceived as a separate entity which did not impact functional ability. He rated his health as good and as always having been good, even though in addition to being legally blind, he suffered congestive

heart failure, shortness of breath, and bronchial problems. A ***decision***, defined as maintaining the status quo of the present living situation, was apparent in spite of his disability. He reported that the singular functional impairment was his lack of eyesight which impacted on activities of daily living. He viewed the deficiencies in his living situation, such as weight loss from lack of food as not very important. He felt he was able to manage with one meal per day even though he had lost 8 pounds in the last month. The availability of support was his main reason for staying in his present living situation.

Subject #3, in response to questions about decreased ability to take care of herself, said the ultimate decision was being left to her children. This response was similar to the ones from subject #1 regarding further loss of ability to manage and maintain oneself in the present situation despite limitations and deficiencies. Managing with available supports was a key determinant in remaining in the present circumstances. An emerging subcategory of ***no planning for the future*** was defined in regards to losing the ability to maintain her present lifestyle. Everyday decisions were centered on the present and maintaining in the current situation. If she lacked the ability to function in some area, she adapted. But, the subject expressed concern about change in her present living

situation. *Change* was defined as negative feelings elicited by relocating to another living situation.

She viewed alternative living as an option with no benefits. Although she was unfamiliar with an intermediate level of support such as an assisted care apartment, which promoted independence and provided supports as needs arose, her past work experiences influenced her decision not to live in a more supportive environment.

Being alone was perceived as positive as long as she maintained contact with her children and had other available supports. Her remarks regarding present circumstances focused on the ability to control her environment and make it work for her. *Control* was defined as being in charge of her living situation. Her perception of the persons who provided support, "just didn't understand" her requests in arranging her present environment so she could function and be self-reliant when she was alone. She was better able to function when her environment was arranged to allow for independence in functional ability despite her impaired eyesight. But she also accepted what she could no longer do and was satisfied with less. *Comparison of past and present function* was defined as a significant link to justify her current ability to maintain her living situation. She relied upon

her ability to survive negative experiences despite the functional disabilities she currently demonstrated.

Subject #4 who was maintaining her present living situation believed a decision to live in another environment would be made by her children when she was unable to make the decision. She did not view her present circumstances as risky. Not recognizing the facts was the main strategy that helped her to be satisfied with her current surroundings. She accepted supports as she needed them, but relied heavily on her own ability to acquire and arrange supports. She had lived alone with disabling blindness for the past three years. The onset of blindness occurred suddenly over a period of several days at that time.

Constant comparative analysis revealed an emerging core variable as being able to manage despite the loss of ability to function as in the past. Managing then exposed the element in the emerging process identified as personal qualities channelled to maintain the living situation. One such quality, self-determination, was a result of the driving force of managing. Managing supported her perception of *independence* which was defined as an acceptance of support only when she decided that it was necessary.

Subject #5 contributed another aspect of the living situation. ***Victim*** emerged as a subcategory that was defined as a precarious health situation over which he had no control. This subcategory had not been defined by previous subjects. The intensity of health concerns filled his day. The instability of present health status created an environment of potential changes over which he had no control. Although he stated he was satisfied with what he was able to do and accepted what he was unable to do, the uncertainty of his health problems, mainly angina, transient ischemic attacks and memory loss were of concern to him.

The decision to live in another setting was once again left to someone else. In this case, it would be made by a professional if the subject were unable to make a decision himself. His decision regarding changes in his ability to care for himself would be initiated by a call to 911. Although he had adult children, they were not closely involved with his everyday happenings.

He made a decision to remain in his living situation despite the explanation of options available to him. Like subject #3, he, too, had negative past experiences with extended care facilities in which he and his deceased spouse had volunteered in their retirement years. He expressed uncertainty about intermediate levels of support

which he might consider since he had no actual first hand knowledge of the living situations being proposed. No further planning was customary for this person. He emphasized, "I just never made no plans whatsoever, of what, what I would do or what I won't do." As was consistent with previous subjects, he accepted supports to maintain his present living situation. He was satisfied with less and dwelled in past experiences with previous functioning ability. He knew the extent of his disabilities and compensated for them, i.e., he purchased a microwave to prevent fires when cooking.

Subject #6 contributed to the subcategories already established. His perception of self-sufficiency was evident throughout his interview despite his loss of functional abilities in various areas. The subject had a memorable seven days of living in a nursing home and visiting a friend who resided in an assisted living setting and this ended any further discussion about assisted-type living facilities. Thus, another subcategory emerged from the data, ***negative past experiences***, defined as a result of actually living in nursing and assisted living homes. The subject expressed strong feelings about these environments. He reported that a loss of freedom, restrictions and personality conflicts were major deterrents as he perceived them. He also had no further plans and the final decisions,

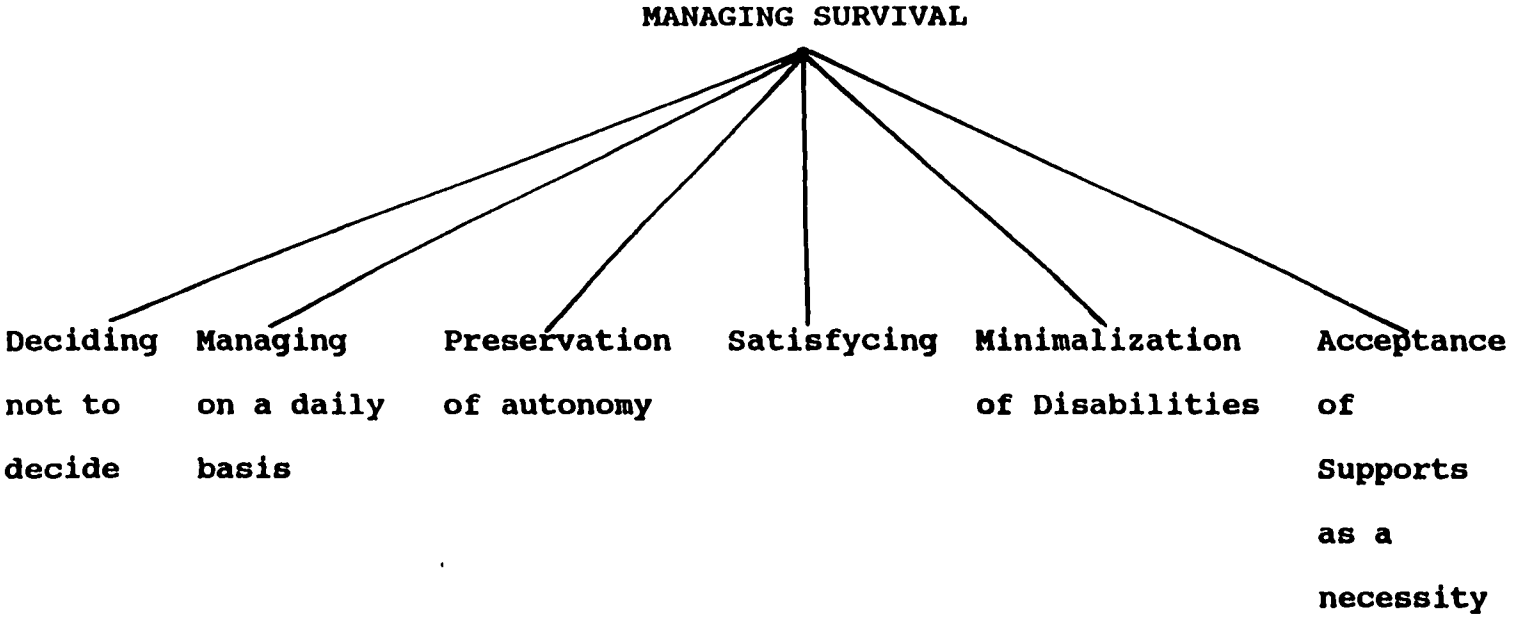
if he were unable to make them, would be left to his children who had power of attorney. The precariousness of his health problems were not a concern to him. He felt he managed on an everyday basis despite his disabilities, such as a long-standing COPD, Diabetes Mellitus Type II and osteoarthritis. Although his ability to function, which he accepted, varied from day to day, he remained active, i.e., he continued to drive his Cadillac to the casino daily.

Results of Comparative Analysis

Four initial categories emerged from the data: 1) factors influencing decision not to relocate; 2) impact of health on present living situation; 3) personality influences; 4) survival strategies. These initial emerging categories were derived from the descriptive properties and subcategories referred to in Table 3. Appendix D contains the initial listing of descriptive properties, subcategories and emerging categories arranged in a progression of concepts as derived from the interviews. Table 5 summarizes the derivation of the theory Managing Survival in which core variables linked the relationship among categories:

Table 5

Resultant substantive theory



1) deciding not to decide; 2) managing on a daily basis; 3) preservation of autonomy; 4) satisfycing; 5) minimalization of disabilities; 6) acceptance of supports as a necessity.

Managing Survival as a Process

Managing survival provided the driving force for maintaining and utilizing supports when it was necessary. Throughout all interviews, the comparative analysis of the data bits supported aspects of self-reliance as responsible for the ability to manage on a daily basis. This, in turn, strengthened the perception of autonomy. Self-sufficiency was substantiated in the presence of managing survival which was aimed at deciding not to decide about an alternative living situation while exhibiting satisfaction with the current situation.

Summary

The components of emerging theory in this study were directed toward conceptual categories and their properties and relationships among the categories and their properties which were derived from the original data bits of the interviews. As the categories were identified and developed, their inter-relationships made it possible to identify the core analytic framework of the emerging theory. The initial categories guided further collection and analysis of data. In its final stage, the framework

integrated subcategories and properties to provide categories which were linked to form core variables or concepts. In this study an attempt was made to discover multiple and varied relationships between and among concepts or core variables. Frequency of recurrence pointed to the variable(s) which formed the basis for the resultant substantive theory. When a central condition which linked all variables was developed from the process, the framework was considered established.

CHAPTER 5

CONCLUSION

The results of this study were presented as a substantive theory derived from the taxonomic process which produced "Managing Survival" as the older adults' perception of their living situation. The symbolic interactionist theory framed the discovered process which identified the components of the social process. The social process in this study was identified by the symbolic interactionist framework and the implication that this theory holds for the existing body of knowledge and newly discovered relationships explored as to cost containment, priority setting, and non-cognitive behavior. The study's limitations, recommendations for future research, and implications for nursing are complete in this chapter.

This exploratory study, a process for discovering decision-making elements and a description of the ability to survive and maintain despite declining function, began with an investigation into the perception of older adults who had been identified as living in a tenuous situation with inadequate supports to meet their daily care activity needs. These older adults chose to continue living in their present living situation despite promptings from professionals to consider moving to a more supportive

environment. The results indicate that the subjects did not perceive their lifestyle as risky; they did not refer to that term to describe their living situation. Their energies were focused on maintaining themselves in their present situation and deciding not to decide about an alternative living arrangement. Informal supports were readily accepted but only if deemed necessary. A conscious decision was made to remain in their familiar surroundings no matter what the consequences. Collectively, the participants did not mention any interest in improving their health status but accepted the deterioration or loss of function.

The decision-making process was driven by the desire to maintain and not to decide or plan for the future except for funeral arrangements. The perception of their current living situation was to maintain despite changes in their level of function. An intermediate level of support was not perceived as providing a level of independence within a supportive environment. If involved family members were available, a decision to leave their present environment would be made by the families -- but only if the subjects were unable to make decisions for themselves. The two subjects who did not have family closely involved would leave it to a professional or call 911, but once again -- only if they were unable to make a decision

themselves. Their preference for living alone was a conscious choice even though other options were available to them. An analyses of the subcategories and their properties resulted in substantive theory based on four initial emerging categories: 1) factors influencing decision not to relocate; 2) impact of health on present living situation; 3) personality influences; and 4) survival strategies. These preliminary categories were defined in the descriptive properties, subcategoires and emerging categories referred to in Table 3 and Appendix D. Several of the subjects were unfamiliar with an intermediate level of support but were not interested in accessing knowledge regarding an alternative living situation.

The process of maintaining the subjects' current living situation was identified by the properties, subcategories and emerging categories which resulted in six core variables or concepts linking the categories together: 1) deciding not to decide; 2) managing on a daily basis; 3) preservation of autonomy; 4) satisfycing; 5) minimalization of disabilities; and 6) acceptance of support as a necessity. The resultant core variables (Table 5) described the subjects' decision-making process to remain in their own residences despite the riskiness as deemed by health

professionals. These six core variables formed the theory derived from the subjects' perspective.

Relationship of Findings to Review of Literature and Conceptual Orientation

Deciding Not to Decide

The first core variable, deciding not to decide, precedes the first stage of Janis' and Mann's decision-making model (1977). The concept of *inaction*, which is expressed in their theory, denotes a conscious effort not to decide, yet this too is a decision. The decision not to decide blocked the first stage requiring the subject's openness to new information gathering of appraising the challenge in Janis' and Mann's four sequential stages in a decision-making process. Oftentimes, the health professional's perceptions are in direct conflict with the subject's perceptions. The health professional views added support as providing quality and preserving function to optimize lifestyle in the later years. At the same time, the subject was able to accept support if it helped in maintaining his or her familiar surroundings. Some subjects reported that a change in their living situation would be detrimental to their psychological well-being.

Managing on a Daily Basis

The second core variable, managing on a daily basis, coincided with Rimoldi's (1969) description of individual strategies which were dependent upon ones' thought processes derived from personality development. The data bits confirmed that managing patterns derived from their personal attributes. Accounts of past experiences provided examples of surviving losses, not depending upon others, feeling comfortable, competent and secure in their own ability. Several subjects reported distrust of others, and vulnerability as an older adult was a concern of theirs which stemmed from past experiences. They valued an ability to make choices on their own behalf. The subjects who had an interested significant person involved in their current status were more open to suggestions regarding their current living situation. Several properties reinforced the managing situation, i.e., being satisfied with less and minimizing disabilities.

Preservation of Autonomy

The third core variable, preservation of autonomy, was described by Harvey et al (1961) as a part of personality development which relied upon internal control, questioning control, oppositional tendencies, testing of limits and avoidance of dependence which could be found in the initial properties obtained from the study subjects.

Such traits reinforced the autonomy exhibited by choosing to remain in their living situation as an attempt to be an independent person despite the effects of health and the aging process.

Satisfycing

The fourth core variable, satisfycing, is a sociological term derived from two words, satisfy and suffice (Levin, 1970). In other words, it denotes a symbiotic relationship between being satisfied and having enough to meet one's needs. This term aptly describes the perceptions of older adults who accept the loss of function and are satisfied with "getting by" or being able to manage and maintain in their present situation.

Minimalization of Disabilities

The fifth core variable was developed from the properties which demonstrated the older adult's perception of the aging process and chronic illness as it relates to a slow decline in functional ability. The older adult denied the degree of severity of the functional disability accepting the limitations as a reduced but acceptable situation as long as he or she could maintain a degree of independence.

Acceptance of Supports as a Necessity

This sixth core variable denoted the importance of maintaining control over one's choices. In Mishel's and Sorenson's (1991) exploration of uncertainty with women who had gynecological cancer, an openness resulted when less options became available to them. In this study, subjects became more open to acceptance of support when they realized their declining function might become a factor that would not allow them to remain in their present living situation. In contrast to Mishel's and Sorenson's uncertainty study, the older adults at-risk were not concerned with uncertainty but energies were aimed at maintaining in their own home. A threat to their living situations created an openness to explore available options. Similarly, coping mechanisms developed earlier in life (Kohurt, et al, 1987), such as *identification* were defined as a wisdom which arises out of insight. If the subjects' insight coincided with losing function, the acceptance of support became a positive option to them if it resulted in remaining in their present living situation. This was a plausible explanation in supporting their choice to remain where they resided.

Limitations of the Study

Generalization of the present study to other at-risk older population has several limitations. While a

larger sample may have included other risk factors that were in common or significantly different, all the subjects in this study had significantly impaired eyesight as well as other major health problems. The very small number of subjects suggests caution in generalizing this information to other similar populations. The blind are a very unique population and the inability to see greatly influences the activities of daily living. Furthermore, had an objective assessment of the functional status of the individuals been undertaken, it may have helped in a comparison and analysis of differing perceptions between nurse case managers' and the subjects' perceptions of managing survival.

Implications for Future Research

Lack of other factors not considered for the present study became apparent and suggest a need for further research for the future. Since most older adults had little or no first hand knowledge of alternative living situations until suggested by the professional at a time of escalating need for support, a study should be undertaken to determine the outcome of providing first-hand knowledge of alternative living situations which address the uncertainty or unknowns for future planning prior to a crisis. Along similar lines, a risky living situation was not perceived by an older adult as long as subjects managed the situation to their satisfaction. Because the first

stage of Janis' and Mann's (1977) decision-making theory, appraising the challenge, is the key to starting the process of decision-making, the investigation of the possibility of benefits to be attained by alternative living arrangements might provide an important clue to their decision making process.

Further identification of personality characteristics may provide useful information about a subject's perceptions because specific individualistic patterns of coping are already established in the older adult. According to Munnichs and van den Heuvel (1976), past influences and experiences form the basis of decision making, especially when independence is valued more than dependence in spite of declining function as was revealed in the subjects' interviews. In this study the characteristic of independence was a stronger influence than dependence or uncertainty on decision-making and should be investigated further.

Nursing Implications

This study indicated a need for nurse case managers to rethink their recommendations when dealing with the at-risk and frail older adult. At times, the nurse case manager and the patient have very different perceptions concerning the older adults' functional ability and ability to maintain their independent living situation.

According to Maslow's hierarchy (1970), self-actualization is necessary in preserving of oneself and fulfilling personal needs. With the older adult, a slower paced decline of function must be recognized as normal by the nurse case manager who may suggest supports as they become necessary.

According to Branch, et al's (1988) study, no higher morbidity rate is predicted for a group of older adults living alone than for other older adults residing in extended care facilities as long as the elders have access to and use the supports available to them in their homes. The loss of function, especially over an extended period of time, seems to enable the older adult to become accustomed to losing function and subsequently to become satisfied with less. Since the nurse case manager is in a position to provide necessary supports to the at-risk older adult when needed, she must learn to recognize at what stage the subject can no longer manage with less.

An important finding of this study was that when an event arose for which the older adult was forced to make a decision, a surrogate decision-maker may be necessary to help them make wise choices. The one subject who had a trusted relationship with a nurse case manager relied upon the nurse case manager's ability to facilitate and manage situations as they arose. The subject was open to the

health professional becoming a facilitator in the decision-making process. For other subjects, the findings indicate a readiness to explore options for support as long as they could remain in their present living situation.

Summary

According to Janis and Mann (1977), a person will avoid making a decision in order to preserve oneself and avoid disorder or confusion. The results of this study should create an awareness in the health professional about the at-risk older adults' perception in avoiding a decision to relocate because their energies were focused on managing survival without a change of status quo. The older adults in this study showed an increased willingness to accept assistance as long as it supported their decision to maintain in their situation. They viewed relocation as detrimental to their well-being.

Having information regarding an independent living area which meets the needs of the older adult would help resolve relocation issues if that were deemed agreeable to the older adult. First-hand knowledge and assistance in making the actual move would facilitate the decision-making process before it becomes a crisis situation. The information regarding living options should be presented when the subject can appreciate the benefits of relocation. In addition, the more experience the nurse case managers

have with the older adult at-risk, the better able they are to recognize the moment to provide or suggest adequate support to maintain the living situation.

As for cost containment, the nurse case manager is charged with the dubious responsibility of reducing cost for care for the older population. The longer older adults are able to remain in their own home with supplemental support, the more cost effective it will be. Permanent placement in an extended care facility is considerably more costly.

The effectiveness of the health professional depends upon recognizing and facilitating the readiness of the older adult to be open to the options available. To be effective, a trust relationship must be established to begin the information gathering process as described in Janis' and Mann's decision-making theory. A partnership relationship between the health professional and the older adult can be helpful in exploring available options for support to meet declining function.

When the client and the professional work together, more appropriate decisions about living arrangements may be made which can satisfy and provide the client with the incentive to follow the eventual plan, when necessary, as suggested by the professional. Ideally, this will improve the quality of life for the older adult, contain cost for

the system, and provide professional satisfaction for the nurse case manager.

APPENDIX A

DEMOGRAPHICS

Subject # _____

Age:_____

Length of Time Living Alone:_____

_____

Marital Status:_____

Educational Level:_____

Closest Living Relative:_____

_____

Presence of Chronic Illness:_____

_____

Consent Obtained:_____

Notes:_____

_____

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APPENDIX B

HUMAN SUBJECTS APPROVAL

Human Subjects Committee

THE UNIVERSITY OF
ARIZONA.
HEALTH SCIENCES CENTER

1622 E. Mabel St.
Tucson, Arizona 85724
(602) 626-6721

22 November 1995

Carolyn E. Nichols, BSN, RN
c/o Linda Phillips, Ph.D.
College of Nursing
PO BOX 210203

RE: OLDER ADULTS WHO REMAIN AT-RISK: UNCERTAINTY IN DECISION-MAKING

Dear Ms. Nichols:

We have received documents concerning your above cited project. Regulations published by the U.S. Department of Health and Human Services [45 CFR Part 46.101(b) (2)] exempt this type of research from review by our Committee.

Thank you for informing us of your work. If you have any questions concerning the above, please contact this office.

Sincerely yours,

William F Denny, M.D.
Chairman
Human Subjects Committee

WFD:js
cc: Departmental/College Review Committee

APPENDIX C

UNIVERSITY OF ARIZONA HEALTH SCIENCE CENTER

SUBJECT CONSENT TO PARTICIPATE IN A RESEARCH PROJECT

Older Adults Who Remain at Risk:

Uncertainty in Decision-making

Subject's Consent Form

I AM BEING ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT I AM INFORMED OF THE NATURE OF THIS RESEARCH STUDY AND OF HOW I WILL PARTICIPATE IN IT, IF I CONSENT TO DO SO. SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY CONSENT. FEDERAL REGULATIONS REQUIRE WRITTEN INFORMED CONSENT PRIOR TO PARTICIPATION IN THIS RESEARCH STUDY SO THAT I CAN KNOW THE NATURE OF THE RISKS OF MY PARTICIPATION AND CAN DECIDE TO PARTICIPATE OR NOT PARTICIPATE IN A FREE AND INFORMED MANNER.

PURPOSE
I am being invited to participate voluntarily in the above-title research project. The purpose of this project is to express my thoughts about living alone at this present time

and any dangers that are of concern to me.

SELECTION CRITERIA
I am being invited to participate because I am between ages of 65-95, live alone and choose to do so. I have difficulty with some aspects of daily living but choose to remain independent without available support. Approximately four to six subjects will be enrolled in this study.

STANDARD TREATMENT
I will be able to withdraw from the research study at any time during the interview process.

PROCEDURE
If I agree to participate, I will be asked to consent to the following: an informal interview, presence of a tape-recorder, list of eight questions, conducted in my private residence and at a convenient time, involving about an hour. A second interview may be requested to verify my thoughts as previously recorded.

RISKS
If I become uncomfortable with or wish not to respond to any of the questions or express my thoughts about my present living situation, I am not obligated to further participate in answering questions that I'm uncomfortable with. I will tell the researcher not to continue with that

question or questions.

BENEFITS
There are no direct benefits to me personally. The benefits from this research will be useful in understanding the older adult's thoughts in choosing to live alone. This information will benefit society as a whole in knowing the thoughts and feelings of an older generation.

CONFIDENTIALITY
Confidentiality will be insured by coding the information obtained from me and without any reference to the source of the information. No names will be used as a reference. The initial information will be destroyed after coding is completed. The coded material cannot be linked to any one person. All information associated with this study will be held in confidence and only Linda Phillips, Ph.D. and the researcher will have access to the information.

PARTICIPATION COSTS AND SUBJECT COMPENSATION
There are no costs of approximately to the participate except personal time one hour.

AUTHORIZATION
BEFORE GIVING MY CONSENT BY SIGNING THIS FORM, THE METHODS, INCONVENIENCES, RISKS, AND BENEFITS HAVE BEEN EXPLAINED TO ME AND MY QUESTIONS HAVE BEEN ANSWERED. I UNDERSTAND THAT I MAY ASK QUESTIONS AT ANY TIME AND THAT I AM FREE TO WITHDRAW FROM THE PROJECT AT ANY TIME WITHOUT CAUSING BAD FEELINGS OR AFFECTING MY MEDICAL CARE. MY PARTICIPATION IN THIS PROJECT MAY BE ENDED BY THE INVESTIGATOR OR BY THE SPONSOR FOR REASONS THAT WOULD BE EXPLAINED. NEW INFORMATION DEVELOPED DURING THE COURSE OF THIS STUDY WHICH MAY AFFECT MY WILLINGNESS TO CONTINUE IN THIS RESEARCH PROJECT WILL BE GIVEN TO ME AS IT BECOMES AVAILABLE. I UNDERSTAND THAT THIS CONSENT FORM WILL BE FILED IN AN AREA DESIGNATED BY THE HUMAN SUBJECTS COMMITTEE WITH ACCESS RESTRICTED TO THE PRINCIPAL INVESTIGATOR, CAROLYN E. NICHOLS, OR AUTHORIZED REPRESENTATIVE OF THE NURSING DEPARTMENT. I UNDERSTAND THAT I DO NOT GIVE UP ANY OF MY LEGAL RIGHTS BY SIGNING THIS FORM. A COPY OF THIS SIGNED CONSENT FORM WILL BE GIVEN TO ME.

_____ _____

Subject's Signature Date

Parent/Legal Guardian (if necessary) Date

Witness (if necessary) Date

INVESTIGATOR'S AFFIDAVIT
I have carefully explained to the subject the nature of the above project. I hereby certify that to the best of my knowledge the person who is signing this consent form understands clearly the nature, demands, benefits, and risks involved in his/her participation and his/her signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding.

Signature of Investigator Date

APPENDIX D

LABELED SUBCATEGORIES AND THEIR PROPERTIES

Category: Factors Influencing Decision Not to Relocate

Subcategory: Inaction

Property: Deciding

S1- Thank God, I haven't got that far yet.

S1- She wanted you to stand on your own two feet as long as you can.

S2- ...different ones advise me not to, so uh, I haven't done anything about that.

S2- And they (911) take it from there, I guess.

S2- ...don't do it until you have to.

S2- I hopes to go, go next door and uh, I guess, when I can't take care of myself.

S2- I was thinking I'd like to move over in the rest home, but I guess that's pretty expensive.

S2- ...if it gets so I can't take care of myself, I'd probably go to next door in there... (nursing home).

S4- But naturally, I'd call my children. I'd call my daughter in Phoenix. She's closer.

S4- But, we'll have to see.

S4- Well, if I wasn't able to, yes, I guess I would, uh huh, yes (children to decide).

S5- This lady asked me, what am I gonna do tomorrow? I said, well I guess I'll do just what I'm doin' right now.

S5- Just wait here is my thing, I cain't change it.

S5- And that's the only way I can see it now.

S5- I just don't, I, I cain't, I cain't say, because I don't know.

S5- I'm just living because I cain't do nothin' else about it.

S5- So, I guess I'll just continue like I am, till I find out the whole story.

S5- Sometime I get a hold a 911 and get help, because there's nothin' else I can do with it.

S5- I never have really put anything in, into consideration or thought of what what it would be, or what, I, I, I just never made no plans whatsoever, of what, what I would do or what I won't do.

S6- Don't do it until you have to.

S6- I have a Living Trust and they have Power of Attorney to take, do what they want with me, if I can't take care of myself.

S6- My daughter wants me to move in to one of the facilities in Tucson, that's nearer to her, but I don't want to.

S6- Well, if it gets to that point, I'll probably have to hire somebody.

S6- I haven't even made funeral arrangements, but I have a, a grave paid for.

S6- There's an organization here, it's right here at the center, that will help.

S6- Call my daughter. I'd call my daughter if I couldn't take care of myself.

S6- As long as I can help myself.

Category: Factors Influencing Decision Not to Relocate

Subcategory: No Planning for the Future

S2- I've not really planned anything.

S2- Un, cremation, I guess.

S4- Well, just live on here till I die, I guess.

S4- I haven't given that a thought. It's foolish to think about it.

S5- So like I said, un, un, as far as I'm concerned, my future is, I just cain't see it.

S5- I just don't feel, because I don't live for the future.

S5- It's like I told you a while ago as far as I'm concerned, there is no future.

S5- I've wondered, but what, what could I do about it. Nothin', I guess.

S5- Because if it is, just like tomorrow is goin' to be just like today, so, there's not much future.

S5- that's the way it is. I cain't do anything about it lady.

S5- So I just take one day at a time, because I couldn't, I cain't look forward to see any future of what I would do, because I don't know, I just don't know.

S5- So like I said, un, un, as far as I'm concerned, my future is, I just cain't see it.

S5- And as far as that goes, it just, uh, there's just nothing.

S5- I'm just waitin' now.

S6- No, no plans. I want to continue living here as I am.

Category: Factors Influencing the Decision Not to Relocate

Subcategory: Past Influences

Property: Negative Experiences with Nursing Homes

S5- It changed. It changed the experience as first and very quickly.

S5- It;s the latter part of their lives go to waste.

S5- I don't, uh, I'm nowhere near in the shape some of them was in, no way.

S5- I had me signed up for this Handmaker outfit over here. I was over there one time, and I had to git those T.B. shots, you know, we do that now, and I haven't really gone since then.

S6- And they had the cheapest poker player that they could possibly buy.

S6- ...then they have dress codes.

S6- We used to go over there and play poker, and they had so many restrictions, that it was, it was miserable.

S6- But I would never, never go back to La Posada or Santa Ruta nut house.

S6- ...if they put me in another home and my 2 boys, if they put me in another home like that, I would disinherit them and give everything I have to charity. And that stopped them.

S6- They're, they're, they're like sadists, they torture people instead of helpin' them.

S6- The last time they, the person yelled at me for half way to the hospital, because he said, we're tryin' to help you.

S6- That's a bad part of being old, because, the, many professionals try to take advantage of you.

S6- This is unprofessional.

Category: Factors Influencing the Decision Not to Relocate

Subcategory: Unknowns

S4- Gee I don't know what I'd do if I couldn't take care of myself.

S4- I don't know what I would do.

S4- Maybe later on I won't be so.

S5- I don't know where I'd be happy in anything like that or not. I don't know.

S5- Time will come and they we'll know all about it.

S5- My future is not, as far as ever entered my mind, because to tell you the truth I don't know. I don't want to see the future.

S5- I cain't see to, if I could just figure tomorrow, what, what's tomorrow?

S5- It's just hard to, cause, I, I don't like to, ask me something' and I don't know, but I cain't, un, I cain't put it in perspective of what I want to say, or how to do it.

S5- I don't know to be honest about it.

S5- It's just at times, which you're regularity and everything goes along pretty good, then at times, it don't.

Category: Impact of Health to Present Living Situation

Subcategory: Functional Ability

Property: Loosing Function

S1- That's why I'm in the shape I'm in.

S2- I think the last time I, I was a hundred and seventy-five, which is down a little bit, not too much.

S2- Well, I got a heart problem, but it isn't all that bad.

S2- Once in a rare while, I have, I have a chest pain, but it doens't amount to anything.

S2- I don't know if there's any disadvantages, only my eyesight.

S2- If that was better, everything would be better.

S2- So, uh, if I could read, it would sure help.

S2- ...almost side-swiped somebody and I thought that I, I gotta put a stop to this, so I, uh, went home and parked the car...

S4- I've kind a walk cripple like, but I'm able to get along and go and it don't bother me much.

S4- But then when I got so I couldn't see, uh, I didn't do it no more, you know.

S4- I wouldn't. I wouldn't get out every in the morning or in the evening, to walk any more.

S4- Got in that car and started down the street, and I realized I couldn't see the cars, you know. So I turn around and come back, parked it, and that was it.

S4- You know, that, that's one of the things, I hate the worse, you know. And not being able to drive, that was kind of a blow, when I, all of a sudden, I couldn't drive, you know.

S5- ...my eyesight's just about gone.

S5- Oh, sometime pretty bad on my heart. Sometimes it gives me quite a bit of trouble.

S5- I don't, my memory, at times, it'll be pretty good.

S5- My legs are just about gone.

S5- The things you want to do, you cain't do that anymore.

S5- cause I cain't walk much any more.

S5- And there's nothin' I can do about it, I know that.

S5- Sometimes you cain't, uh, you cain't regulate it, and I forget.

S5- I don't know if it's just my memory and everything just don't coordinate, just like it used to.

S5- Then other times, you just cain't, because it's not that you, your mind don't work.

S5- I cain't, couldn't a more hardly walk from here to that gate, and that's a fact, because my legs are gone.

S5- I went there, when I could get up, I went over there, for services and everything but I just cain't do it anymore.

S5- I forget dates. I lose days.

S5- Without my eyesight, I cain't, I cain't see it.

S5- It's about all I can do, because I, like, I dais, I cain't stop none of it, I cain't do much about it.

S5- I cain't help it, there ain't nothin' you can do about it.

S5- ...I just cain't think of things like, like I used to could.

S5- But now, I'm not able to, and I cain't do anything like that any more.

S5- I cain't even, even call anybody.

S5- I'm awful forgetful.

S5- Then other times, you just cain't because it's not that you, your mind don't work.

S5- I cain't keep everything in coordination in my mind, of

when this is, when that is, or circle when or what.

S5- I never thought about it, never give it no thought, no consideration, not anything, 'till this happened, then you know it.

S5- Sometimes you cain't, uh, you cain't regulate it, and I forget.

S5- 'Cause I cain't walk much any more.

S5- I know I;m, I know I'm a gonna dwindling to a certain amount.

S5- I haven't been goin' to when, when I'm supposed to go or what.

S5- I use to have to think of things, many things, but anymore, I cain't think of things like, like I used to could.

S6- Now, I, I can read, but very, very short times.

S6- ...I'm comfortable moving around because it's, I can, as you saw, I can walk without a cane, part of the time.

S6- That's the bad part of, of when you're you're legs are giving in.

S6- I over done it and I became very, very tired, and I couldn't stop my legs from aching that night.

S6- No, you can, you know, I, uh, one thing though I'm not watching television like I used to.

S6- You see, I have difficulty hearing a high pitched voice. When you have hering aid problems, a higher voice is a no no.

S6- And I can't go out and do, outdoors and do the things I want to, because If I fall outdoors, the rocks are hard, and I did fall once.

Category: Impact of Health on Present Living Situation

Subcategory: Functional Ability

Property: Perceiving Daily Life Situation

S1- Well, somedays, I just wonder if I'm gonna make it, you know.

S1- Say Doc, I'm gettin' tired a bein' sick and I don't like it a bit.

S2- I had no idea I'd be doin' living like I am.

S2- I, I never thought this was gonna happen to me, you know.

S5- It, I don't see nothin' that's benefit me now.

S5- Well if you cain't hear things, and you cain't see things, the you, you cain't understand anything that a way, it's just better not to be around that a way.

S5- ...your existing, and that's just the way it is.

S5- And there's nothing I can do about it, I know that.

S5- If you knew you had no future, did have anything to live for, you wouldn't want to live, would you?

S5- I just might near give up my rights and everything, but just existing, that's about all there is to it.

S5- But when you cain't, you're handicapped in a certain way, well, it's like the old boy said, well open a window and let the sunshine come in.

S5- Things, no controlling over it and it's just, it's gotta come and go.

S5- I don't know, they say that if you give in to depression, you're in awful stress.

S5- Well, my health, it well, it just ain't no good.

S5- Loss of memory. I've had quite a bit of trouble with that lately.

S6- The one thing I'm afraid of, is falling.

S6- It's lousy. My health is very, very lousy.

S6- And the side effects, is the pain in my legs.

S6- Because, because I'm so weak, that I can't do the work I want to so.

Category: Personality Influences

Subcategory: Aloneness

Property: Being Alone

S1- I say, I'm never alone.

S2- But uh, I've always been kind of, kind of a loner, and, uh, satisfied by myself.

S2- Well it don't, it don't really bother me much.

S3- But I do like to live alone.

S3- I like living alone.

S3- I'm very nervous, and I, but I do like to be alone.

S4- No, I've lived here so long that, uh, it seems very comfortable, you know.

S5- A life time, yeah, that's what it's been.

S5- A lifetime of livin', lady.

S5- In all, it just seems like a lifetime.

S5- It's a lonely old world to live in now.

S5- ...because loneliness is one of the worst things in the world.

S6- This is my place.

S6- But, I prefer living here, I prefer living alone.

S6- But it's a, the advantage of living alone, you can do as you please.

Category: Personality Influences

Subcategory: Self-awareness

S1- I never feel alone.

S1- With bein' 20 years alone, you become a little self-centered.

S2- I've uh, always been a, kind of a loner and it don't bother me to be alone.

S4- Well right now I, I, uh, I feel confident and I feel still very comfortable.

S4- And, uh, right now I feel competent, you know.

S4- Anything with paper work, reading or anything like that, is a lotta trouble for me.

S5- Then things can get jumbled up and, only thing you can do, is just close your eyes and wait 'ill you get over it, something' like that, because you don't understand.

S5- 'Cause I get them dizzy spells, and this room is goin' whirlin', and when it does, then, all at once, I just, I just pass out.

S6- So it makes you, people livin' alone, they put up with that crap, and I don't.

S6- I'm such a wonderful person (laughing) and I don't know of anybody that would be better company then myself.

S6- I did too much in one day.

Category: Survival Strategies

Subcategory: Decision

Property: Making Do with Less

S1- But I still use 'em.

S2- And, uh get one meal at 5 o'clock over in the dining room and uh, that's sufficient.

S2- That one meal a day is practically all I need, uh, and it's having 3 meals a day is far less of a habit now days...

S2- So, uh, we get by that way all right.

S2- Well, I don't cook much.

S3- My youngest daughter---they come often and help me when then can.

S4- I don't know how good I do it, but I do it, you know.

S4- Well, you know, about the only shopping I do is, is grocery shopping.

S4- I am usin' the phone, but, uh, it's really a problem sometimes to get the right numbers, and sometimes, I get the wrong people too, and I apologize.

S5- Uh, that's the reason I said, I just, I make the best of what I can, of what I got to make of it.

S5- My medicine's right here, and it's not, I don't well how, sometimes, I forget.

S5- I'll just, I'll just have to make the best of what it is, and, and nothin' else I can do about it.

S5- I have to call information, get the number, and then I try to write it down...

S5- Well, if I can git to a phone, I could try that.

S6- ...but this is good enough for one, an old men to live in.

S6- My house is a mess, my daughter says it's the dirtiest house in Green Valley, and I don't agree with her, but it could be.

Category: Survival Strategies

Subcategory: Informal Supports

Property: Managing

S1- Well for one thing, I'm very organized.

S1- And now that I'm alone and I'm older, I have, I have a little path, one day I do this, the next day I do that.

S1- And I have a parking card that we put in her car. We can park in a parking area, so I wouldn't have to walk so far.

S1- I just take my time doin' it.

S1- And I always get my groceries.

S1- No matter what I do, I'll do, I, I an very organized.

S1- I got up, this is funny, my mother-in-law used to say when we went to bed, clean up bef - cause somebody might get sick and the doctor will come.

S2- ...I get enough to eat.

S4- And that's, you know, then other people isn't in there, the crowd, so it's easy to get around.

S4- I have some trouble that way, but I'm managing.

S4- But I feel like I can do it now, you know.

S4- I feel like I can manage now, you know.

S4- Well, uh, I'm comfortable here in my own home, and I know where everything's at, and, uh, I got my area here, you know, where the, I got my shopping area close by over here, and a grocery close by and, my doctor.

S4- And I do manage to clean the house. I don't know how good I do it, but I do it, you know.

S5- That's the reason why I keep a little calendar book there.

S5- ...which I try not to do any more cookin' then I can, because I'm I'm just scared of it.

S5- I just, microwave...I use it more then I do anything, because it's, it don't have that danger.

S6- When I, when I played poker for 6 hours, I come home and do what I, I have to, to get, make my meals and so on and so forth.

S6- I think I can do it, I think I can do it.

S6- ...when I get through makin' dinner, I eat, and then I go sit down because I'm breathing very heavily.

S6- I manage.

Category: Survival Strategies

Subcategory: Informal Supports

Property: Recruiting Support

S2- Well, my wife can, uh, write checks yet, and she's able to do that.

S2- Three's a nurse over next door that, that comes over in uh, emergencies.

S3- And I do have other help.

S3- ...she's trying now to find me a lady to come and help with paper work.

S3- ...my daughter is supposed to come tomorrow, and help me.

S4- But then I gotta put it in my checkbook, and I have one heck of a time, uh, puttin' it in there, it looks terrible, if somebody comes, they'll do it for me, you know.

S4- Well, when I go to the doctor, he gives me my medication, so that's great.

S4- I really can't see the price of stuff, if there's somebody close by, I'll ask them.

S4- Yeah, I can's see, a friend comes in and will help me with that, you know.

S5- I've got a lady that's across the street over there, Sylvia, she pays my bills, and everything.

S5- Well, If I could live like I did in the past, it would be wonderful, it'd be wonderful. But I know I cain't do it, cain't do it.

S6- I finally called Joe, no, it was Sal, a friend of mine, and he came over and he broke into the window, and between the both of us, we got in, I got into bed.

S6- But, uh, she'd find somebody.

S6- then Joe called, uh, 9-11...

S6- I have, well I, I have recently called 9-1-1, and they take me to the hospital.

Categories: Survival Strategies

Subcategory: Personal Strengths

Property: Past Coping

S1- I've always been very well organized, I had to be.

S1- It's old time teaching that keeps you goin' like this, the way you're brought up.

S1- It's pleasant memories.

S1- I have had so, so many happy things happen in my life, and I've got such pleasant memories, that I'm never alone.

S1- I've had so many things wrong with me.

S3- I was alone a lot when I was young, and I, I really like to be alone.

S5- that's what I'm doing. I'm just living in the past.

S5- As long as I can live in the past, with my memories, I can get along pretty good.

S6- What would be, if a person could just turn time back 50 years, wouldn't that be something'?

S5- If I could live like I did in the past, it would be wonderful, it'd be wonderful. But I know I cain't do it, cain't do it.

S5- I don't know it's just my memory and everything just don't coordinate just like it used to.

S6- I used to read for hours and hours.

Categories: Survival Strategies

Subcategory: Personal Strengths

Property: Past Coping

S1- I've always been very well organized, I had to be.

S1- It's old time teaching that keeps you goin' like this, the way you're brought up.

S1- It's pleasant memories.

S1- I have had so, so many happy things happen in my life, and I've got such pleasant memories, that I'm never alone.

S1- I've had so many things wrong with me.

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S6- I used to read for hours and hours.

Category: Survival Strategies

Subcategory: Reciprocity

Property: Attracting Others

S3- But they come and visit me, and I enjoy them a great deal.

S3- People ask me, don't you get lonesome, and I say, no. I have so many things I want to do, and of course, if I couldn't talk to my girls on the phone, I would be, I would get lonesome.

S4- ...the group meets here and we study.

S4- And then, uh, some of my friends picks me up and takes me to a, our meeting place, you know, a couple times during the week.

S5- Nobody comes in, only maybe a few neighbors and friends, and m'm happy to come in, sure.

S5- Now, I have friends, lots of friends, oh, I got those, but just, you cain't see any, I cain't see any future to anything. Now that's just it.

S5- And then maybe we'll talk on a little while.

S5- But there's a lotta people comes in, different times and everything.

S5- No, uh, I really, if I could get up and go around, mingle with people, or something' like that, I know it would be better in a way.

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