



Living Alone In Community and Over 85 Years Old: A Case Study

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ABSTRACT

More than 10 million Americans over age 65 live alone in community rather than in independent retirement communities, assisted living, nursing facilities, or in the same household with younger family members. According to the 2005 census, 57% of those age 85 and older live alone. By 2020, the number of persons over age 85 who live alone is expected to double to 2.3 million. Little is known about how live-alone oldest old adults view daily challenges such as access to health care, social interaction, and assistance with meeting their daily needs. The purpose of this case study (face-to-face interview) was to understand what it is like to be a woman over age 85 and living alone in community. A timeline approach was used to capture the experience of living alone from the moment the decision was made, through the present time, and including speculation about what will be in the future. Themes that emerged from the interview data included (1) being self-reliant, (2) maintaining social support, (3) controlling emotions, (4) expecting disappointments and moving on, (5) planning for the future, and (6) choosing to be positive. During the interview process, the participant came to a new decision about her plans for the future as a result of speaking about, and thinking through her choices.

Keywords: oldest old, case study, live alone, older women

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According to the US Census Bureau, the older adult population (those over age 65) will experience a surge in growth during the period from 2000 to 2030, doubling from 35 million to 74 million.¹ The same census reported that those over age 85, termed oldest old adults (OOAs) are the fastest growing segment of the older adult population in the United States. In terms of life expectancy, in 2000, Arias² found that OOAs who were age 85 had a life-expectancy of approximately 6.3 years, and even centenarians could expect to live an average of 2.2 more years. These numbers are expected to continue to improve due to advances in medical technology. For reasons that are not yet clear, life expectancy varies by gender and race after age 90, with women and blacks outliving men and whites.¹ It is important to note that 80% of centenarians and 75% of those over 85 are women.¹

With advancing age and widowhood, an increasing proportion of older adults are living alone in the community.³ More than 10 million Americans over age 65 live alone in community including the oldest old.¹ Far more women aged 85 and over live alone than men. For instance, from 1980 to 2003 the number of oldest old women living alone increased from 508,000 to 1.3 million, representing a 12% increase, while the percentage increase for oldest old men was less than 3%.^{1,3} A review of the literature reveals that an accurate picture of the physical and mental health status of live-alone OOAs is unclear at this time and certainly needs attention, considering the demographic growth in this area.

Resnick found that those who live alone, are oldest, have fewer social connections, and have more than two chronic health problems may be at higher risk of not receiving proper health screening.⁴ Oldest adults who live alone are also more likely to live in poverty,^{1,5} are more prone to social isolation,⁶ and are less likely to receive help with their functional limitations than are persons who are married.¹ Additionally, studies show that women who live alone in community and are over 85 tend to have increased risk for poor health and worse functional status than men.^{4,7} These latest demographic data are cause for concern for nurse researchers, the home health care industry, and primary care clinicians who should be aware of the increased health risks for older women who live alone - whether they are healthy, safe, and coping well with daily life.

Living alone in community over age 85 can be challenging in the areas of access to health care, social interaction, and meeting one's daily needs. Some OOAs seem to thrive in this setting and most desire to live in community for as long as possible. The purpose of this case study was to understand what it is like to be an 86 year-old woman living alone in community. This pilot study, precedes further work aimed at examining a larger group of live-alone OOAs to explore the following questions: what are the daily stressors or worries that live-alone OOAs contend with? How do they deal with them? And, what factors allow some OOAs to stay in their communities longer than others? Answers to these questions will increase knowledge about this underserved population, allow health care providers to craft individual health care plans, and may uncover unknown health

care needs that can be addressed to improve quality of life, and extend independent living in community.

Literature Review

Few studies were found that examined the health status of OOAs who live in community. The majority of extant research on older adults living in community is on *all* older adults over age 65. Furthermore, previous studies of the elderly tended to focus on long-term care settings and more recently on assisted living and retirement community settings.^{4,9,10} The good news is that researchers are beginning to differentiate the unique psychosocial differences of nested age groups within the older adult population. Not all gerontologists agree, but one possible grouping is as follows: the young old (65-74), the old old (75-84), and the oldest old (85+)^{1,11}. New knowledge is essential to explicate the unique differences in biopsychosocial states, attitudes, and health behaviors of each old age subgroup so that nurses can better understand their needs.

Currently, the prevalence of diagnosed health problems for the oldest old must be extrapolated from US census data on persons over age 65. Common chronic health problems include hypertension, heart disease, and arthritis respectively, followed by cancer, diabetes and stroke¹². These demographics reveal that the typical OOA has an average of at least one or two chronic illnesses. There is also evidence that OOAs tend not to speak out to close relatives about their health care needs and that they become complacent in self-management of chronic illnesses.¹³ This lack of concern about their condition may extend to other areas such as dietary adequacy. Callen and Wells¹⁴ reported that declining overall health was a major reason given by OOAs for not consuming a healthier diet. However, other factors such as eating alone, also affect vitality and health.¹⁵ Evans¹⁶ reported that the nutritional risk of malnutrition increases in community-dwelling elderly who are sick, poor, homebound, or have limited access to medical care. While rates for malnutrition are well documented in hospital and nursing home settings, data on this important issue for live-alone oldest adults was not found. However, living alone may exacerbate multiple health problems and represents an area that has not been adequately explored.

Almost all OOAs must face the challenges of functional decline, which often leads to difficulties in completing their Instrumental Activities of Daily Living (IADLs), such as shopping for groceries, paying bills, and self-management of medications. Little is known about the functional status of community dwelling live-alone OOAs. According to Munson¹⁷ most OOAs depend on family, friends, and neighbors for IADL assistance. However, qualitative and descriptive studies aimed at providing more insight into how these systems operate for this age group are lacking. Although OOAs are less likely to be found in nursing homes today than twenty years ago,¹⁸ they still represent the highest users of support services and the highest expenditures in health care dollars.¹¹ For example, Hastings, George, Fillenbaum, Park, Burchett, and Schander (2008) completed a

large secondary analysis of the live-alone elderly (n = 1663) and found that they were 60% more likely to visit the emergency room than those living with a spouse or other relatives.¹⁹ This is a community health problem that has yet to be addressed by researchers and health care providers in geriatric community health care.

Lack of transportation represents a very significant barrier to maintaining health in the oldest-old, leading to a reduced number of health care visits and overall mobility.²⁰ Loss of driving privileges also limits access to social networks and social support, which has been shown to be a significant contributor to better health in OOAs.²⁰⁻²³ The percentage of live-alone oldest old who are currently driving was not found in the review of the literature, however it has been reported that dependence of the oldest old on driving or riding in cars rather than using public transportation, has increased from 3 out of 4 trips in 1983, to 9 out of 10 trips in 1995.²⁴ The oldest old who lose driving privileges must find ways to get out and shop for necessities to be able to stay in community, yet another area for further exploration.

Higher rates of depression and suicide in OOAs may be the result of an accumulation of losses, including close family and friends, as well as the cessation of driving privileges.^{25,26} In a longitudinal qualitative study, Dunkle, Roberts, and Haug²¹ explored the effects of stress on physical functioning. They followed 200 OOAs for nine years and found that worrying over daily stressors had a larger impact on the deterioration of health than responding to a major single-event stressor such as the loss of a spouse. You and Lee²⁷ found that older people who live alone had lower self-ratings for emotional health (happiness, well-being, contentment, and morale) than those who lived as a couple or with family. Thus, OOAs who live alone in community may be at higher risk for depression and the effects of daily stressors.

Cheng completed a comprehensive qualitative literature review of studies about older women (women over age 65) living alone.²⁸ Although these studies were not specific to oldest old women, and at least two were in rural settings, they form a background for comparison with this case study. Five major positive themes included (1) a sense of enjoying independence, (2) sharing life experiences with family and friends, (3) giving to others, (4) faith in God and religion, and (5) belief in self. Major negative themes experienced by older women living alone included coping with loneliness, fears for personal safety, and feelings of being vulnerable.²⁹⁻³⁴ Stanford⁷ completed a phenomenological study exploring how 13 women aged 75-91 thrived in community. By using multiple interviews, projective inventories, and focus groups, the researcher identified six group patterns of resilience: (1) vital involvement and service, (2) desire to learn, (3) appreciation of basic life components such as family, friends, health, home, and financial security, (4) valuing honesty and responsibility, (5) positive attitude, and (6) reliance on faith. Interestingly, the studies above found that live alone older women (in some cases, including the subgroup of those over age 85) were

relatively happy and that independence superceded the negative aspect of dealing with loneliness. By contrast, Porter and Lasiter studied six live-alone women aged 82-93, who “dreaded” the return of unwanted, unscrupulous persons, whom they knew, whom they viewed as being “troublesome”, and who made the women feel “vulnerable” living alone in community.³³

Methods

A phenomenological conceptual framework was utilized as the foundation for analyzing this case study. As Husserl noted in 1952, the phenomenologist must, “grasp what is momentarily perceived in faithful conceptual expressions, of which the meaning is prescribed purely by the object perceived or in some way transparently understood.”^{35p218} Hence, the goal for the interviewer is to seek a clear and honest picture of the ontological, emic (inner) essence of the participant’s experience of living alone in community. Munhall calls this essence a mystery that may never be answered by phenomenology, but nevertheless she asserts, as did Heidegger before her, that phenomenologists must still ask the question, “What is the meaning of being human?” The answer is to *understand* the meaning of being human.^{36,37}

Inclusion Criteria

Criteria for study participation included female gender, over age 85, and living in community. Living in community was defined as living by oneself in a house, condominium, or apartment, within an urban or suburban setting. Persons living in independent retirement communities were excluded from consideration because these facilities often closely resemble assisted living facilities: they are a closed, protected environment, often providing cooked meals, housekeeping and other amenities such as easily accessible social support and even an onsite nurse who promotes the health and well-being of the residents.⁶ Resnick found that older adults in retirement communities tended to be more interested in health promotion and had higher levels of health promotion activities (e.g., flu shots provided on-site) than those living in other settings.⁷ Thus, retirement communities represent a significantly different environment than urban or suburban communities. This case study participant also was selected because she was able to express herself verbally and had been living alone for a significant number of years (over 10).

Recruitment and Procedures

The local Institutional Review Board granted human subjects approval for the study before recruitment was initiated. Potential participants were recruited by “word of mouth” by an OOA who lived in a neighborhood in which several other OOAs resided. This woman was highly social and interacted with many of the older adults in the neighborhood. Of three individuals who indicated interest in the study, one met the inclusion criteria and agreed to be interviewed. She was

informed of the purpose of the interview and gave verbal consent (per project requirements).

The interview was conducted by the first author in the participant's home. See Table 1 for a time-line table of the interview questions. Originally, the interviewer planned to format the interview questions and data analysis according to major life events. However, the questions seemed to fall naturally into past, present, and future orientation. Data analysis and coding confirmed the appropriateness of this procedural design. The main interview was audiotaped and completed in approximately one hour. During the interview, observations of nonverbal behavior were also jotted in field notes. The interviewer considered nonverbal communication (field notes) an essential process in validating verbal communication.

At the conclusion of the interview, the participant (whom we shall call "Mary") asked if she did "ok". She was reassured that her responses were very helpful and provided the interviewer with insights about her experiences. Mary appeared pleased about having participated in the study and was thanked for her participation with a follow-up card. The interviewer completed a second shorter interview (lasting approximately 45 minutes) to share preliminary findings with Mary. She stated that the conclusions were accurate and that she would make no changes.

Data Analysis

The audiotape was transcribed verbatim by the interviewer. In accordance with Cohen, Kahn, & Steeves³⁸ process of phenomenological analysis, the transcript was reviewed multiple times to begin the process of data immersion. Next, key phrases, sentences, and ideas were identified by line-by-line coding. On the left-hand side of the transcript first level coding was completed and in the body of the transcript the main topics were underlined or circled in pencil. On the right hand side of the transcript non-verbal behaviors and the interviewer's impressions were noted. Like codes were combined and collapsed to create the six themes.

Tools to promote study trustworthiness included use of pre-understanding, participant review of the findings, and peer review. The primary author identified and reflected on her preconception that live-alone OOAs are a remarkably resilient group of individuals. This statement is based on over 20 years of home health care visits with hundreds of live-alone OOAs. To counteract this preconception, she worked to maintain an attitude of open-mindedness during the interview, reviewed the data repeatedly to get a sense for the essence of the participant's experiences, presented raw data and study findings to a group of nurse peers for feedback, and reviewed her findings with her participant.

The Participant

The participant (pseudonym Mary) was an 86 year-old woman who was a native Texan. She was interviewed in her home in a quiet mixed-age, well-kept, suburban neighborhood of Central Texas. No other persons were present at the time of the interview and the radio played softly in the kitchen. Mary stated she had been widowed for over 25 years and had two grown children who lived in another Texas city, at least three hours driving distance from her home. At one time she raised a great grandson from age four, until he was age 14, at which time he returned to live with his mother. Mary did not seem to have regular contact with him now that he had reached adulthood. At the time of interview, she had no other relatives living nearby, however, she had an extensive social network of friends and neighbors. She reported being very healthy for her age, with no reported chronic illnesses. She had lived in the same house for over 50 years.

Findings/Themes

Self-Reliance and Social Interactivity

Several themes became apparent after reflection and review of the data (summarized in Table 2). Mary spoke repeatedly about being self-reliant, but at the same time she very much enjoyed the social ties she had built in her life. She seemed to have an excellent balance of aloneness and togetherness. The social ties that Mary had built for herself over the years were impressive. She had joined an AARP travel group, a local women's exercise group, and she interacted at regular local neighborhood events. She also drove by herself to visit her children. She stated, "I go see them when I want to see them... they don't come to see me very often." The relationship with family was not explored further because it was clear to the interviewer that Mary's main source of socialization was with her friends and neighbors. Mary traveled several times per year as well as weekly out into her neighborhood. She was alone, but by no means isolated or inactive. It is hypothesized by the authors that social connectedness with others was a very important contributor to Mary's overall wellbeing. She talked about her relationships with other neighbors and reported that she was literally surrounded by people who would help her if she needed help. She also revealed that more than one neighbor knew where her house key was – a sign of great trust for a single older woman.

Expecting Disappointments and Controlling Emotions

Mary talked about the two great losses (her spouse and her great grandson) in her life very candidly. Although she did not display visible outward emotion, the interviewer felt intuitively, the presence of inner pain and struggle with these previous life losses. They were not forgotten. She continued to deal with them, but for this interview she would not break down. For example, she stated that other women seemed to need to discuss their "woes", but she did not see any use in this practice and did not participate in it. She stated that she usually

became the listener to others who did. At one point, Mary related, in a very matter-of-fact way, an intense episode of driving herself to the emergency room with chest pain and having to park far from the entrance of the emergency room door to avoid having her car towed away. She looked at me almost defiantly about this feat. She reacted to disappointments and emergencies with the same stoic pragmatism. Yet, she seemed to balance this lack of emotional weakness with an emphatic display of her opinions and attitudes towards topics other women might have become emotional over.

Mary seemed to always be prepared for hardships and loss. Mary said that she “knew” her husband was not going to make it ahead of time. This attitude may help to form psychological resilience in recovering from great personal loss. Regarding presence of depressive symptoms Mary stated, “I’ve got my blue days and my feel-sorry-for-me days, but you have to carry on!” When asked if it was difficult to go on after these losses she exclaimed with determination, “I didn’t let it be!” At one point, Mary relayed that she avoided a certain restaurant. She became quieter and stated that she didn’t go there anymore because – “it’s different, you know, once you’ve been happy with a certain place and your situation...” she may have been referring to a time in the past when she and her husband had frequented this restaurant. The author did not ask Mary how many years they had been married, but she seemed not to have forgotten previous feelings of closeness.

Planning for the Future and Choosing to be Positive

When asked if she wished for anything more, Mary said, “If I ever can’t drive, I’ll be stuck!”, thus showing anticipation of possible future difficulties. Only once did she voice, “I do wish somebody would help me”. This one-time call for assistance, was not repeated and she returned to themes self-reliance and being thankful to be able to rely on neighbors and friends. The process of counterpoint thinking aloud seemed to help Mary come to self-formed conclusions and increased her confidence in the plans she had set for the future. For example, Mary had several photographs of a Chihuahua whom she was very happy with for many years. She shared that as soon as she stopped traveling, she would purchase another Chihuahua for the next part of her life (future planning).

Early in the interview Mary stated that she had been thinking about moving to a retirement community or assisted living facility. When questioned about continuing in her current living situation, she said emphatically, “Well, I have to! But I don’t worry about it... I think I’ll know when I need to move or get out.” Later, she concluded the interview by announcing that she had decided she would stay in her current living position instead of seeking the above alternative options. It was clear that the interview process had facilitated the decision making process. Whether or not this decision was permanent may depend on many variables such as a continuation of Mary’s current very good health status.

Mary's nonverbal behavior was rich in communicating a theme of determination and stoicism— especially notable was the absence of what might be thought of as “weak” emotions such as crying or self-pitying statements. Instead she often laughed and chuckled – especially when referring to friends and neighbors. When referring to the losses in her life she looked off to the side, staring, but without tears. At her most “emotional” time, when she talked about losing her great grandson, with whom she had traveled with and been close to for 10 years, she was quiet for a moment or two.

At the follow-up meeting, Mary mentioned one concern that she had not previously discussed with the interviewer. She was worried about dying alone and not being found “in time”. She admitted that she use to call a neighbor regularly, but had not continued this practice since that neighbor had passed away. She stated she would try to start this practice again with another friend and the interviewer supported her in this decision. She did not mention worries or concerns about her future again.

Discussion

As compared with other study findings, this case study of an oldest old woman who lives alone in community revealed both similarities and differences. Independence appears to be greatly valued by both the oldest old as well as the young old.²⁵ The importance of social interaction and a strong sense of self-reliance were previous themes confirmed by this case study. In comparing the outlook of the study participant with the findings from the Stanford study, one sees that vital involvement, appreciation for close contacts, and a positive attitude were shared themes. Both the Stanford study and Cheng's literature review list reliance on faith or religion as an important source of coping for older women. This participant did not discuss spirituality at all, but did state that she attended a local church where her exercise group met. She expressed appreciation for this contact. However, it was unclear whether this gathering provided the spiritual support found in other studies. Religious affiliation may have been something Mary simply chose not to share during this interview.

When Mary admitted she was worried about dying alone and not being found, this concern paralleled the findings of Dunkle et al.¹⁸ in their study of community dwelling oldest old adults and daily worries. However, in Mary's case, her very stable and secure neighborhood provided an elevated level of trust. The safety and security of “good neighbors” enabled her to enjoy freedom from certain fears that other women who live alone may not share.

Another important variable that was not found in the literature reviewed for this study was socioeconomic status. One can infer that Mary had adequate financial resources since she traveled regularly and was able to afford lawn service (she did her own mowing up until last year, and it is not a small lot!). Although financial

issues were not discussed during this short interview, the role of socioeconomic status could be investigated in future studies.

Finally, knowing the socio-cultural or life span growth and development of the oldest old is an important facet that was not explored in this interview but is useful for a better understanding of what the current cohort of OOAs are like. Many of America's OOAs experienced the hardships of the Great Depression during the 1930's era, which logically helped to shape their personality development. They often do not spend more-than-adequate savings for necessities, preferring to "go without". Emotionally they tend to be tough on the outside but have a big heart on the inside because they have lived through hard times and shared what little they had with others (M. Nichol, age 85, personal communication, August 11, 2008). It will be very interesting to see how the younger old generations who have never had to go without, handle the challenges of very old age.

Conclusion

This case study serves as a starting point for designing larger similarly designed explorations into the attitudes, behaviors, and health status of the oldest old living alone in community. Primary care physicians, gerontologists, and home health nurses can utilize the results of this study as an impetus to become better informed about the concerns and needs of their oldest old patients who live alone in community. An ideal time to assess these needs is at each point of care, such as during routine visits or the annual flu vaccination appointment. Assuming that persons who live alone in community are naturally resilient, regardless of age, is not conducive to providing holistic healthcare. Nurses should ask their oldest clients how they are getting along and what their daily concerns are. A comparison of persons from diverse cultures and socioeconomic levels, and urban versus rural settings are areas for further study. The aspect of the sufficiency of neighborhood social support in the absence of family involvement is another intriguing area. Future studies could also investigate the dietary adequacy and the effects of functional limitations on IADLs. The oldest old are a distinct subgroup of older adults that are worthy of focused studies aimed at improving the quality of their remaining years.

References

1. U.S. Census Bureau. (2005). *65+ in the United States: Current population reports, special studies*. retrieved on April 28, 2008, <http://www.census.gov/prod/2006pubs/p23-209.pdf>.
2. Arias, E. (2002). United States Life Tables, 2000. *National vital statistics report, 51(3)*, National Center for Health Statistics.
3. U.S. Census Bureau, (2003a). Current population survey. *Annual social and economic supplement*, (p.151). Retrieved on December 13, 2008, from, <http://www.census.gov/prod/2006pubs/p23-209.pdf>.

4. Resnick, B. (2003). Health promotion practices of older adults: Model testing. *Public Health Nursing, 20*(1), 2-12.
5. Dalaker, J. (1999). Poverty in the United States: 1998. *Current population reports, U.S. Census Bureau*, Washington, DC: Government Printing Office. Retrieved on December 13, 2008, from <http://www.census.gov/prod/2006pubs/p23-209.pdf>.
6. Wilmoth, J. (2001). Living arrangements among older immigrants in the United States. *The Gerontologist, 41*(2), 228-238.
7. Standford, B. H. (2006). Through wise eyes: Thriving elder women's perspectives on thriving in elder adulthood. *Educational Gerontology, 32*, 881-905.
8. Walter-Ginzburg, A., Shmotkin, D., Blumstein, T., & Shorek, A. (2005). A gender-based dynamic multidimensional longitudinal analysis of resilience and mortality in the old-old in Israel: the cross-sectional and longitudinal aging study (CALAS). *Social Science & Medicine, 60*, 705-715.
9. Hansen-Kyle, L. L. (2006). *Older single women in transition: moving to a supportive retirement community*. (Doctoral dissertation, University of San Diego, 2006, UMI No. 3239311).
10. Resnick, B. (2001a). Continuing care retirement communities. In M. Mezey (Ed.) *Geriatric Nursing Research Digest*. New York: Springer.
11. McKenzie, J. F., Pinger, R. R., & Kotecki, J. E. (2005). *An Introduction to Community Health, 5th ed.*, Sudbury, MA: Jones & Bartlett. Retrieved on September 1, 2008, from <http://books.google.com/>.
12. United States Aging Demographics (2006). *UNC Institute on Aging*, retrieved on April 24, 2008 from www.aging.unc.edu/infocenter/slides/usaging.ppt.
13. Glasgow, R. E., Stryker, L. A., Toobert, D. J., & Eakin, E., (2000). A socio-ecological approach to assessing support for disease self-management: the Chronic Illness Resources Survey. *Journal of Behavioral Medicine, 23*(6), 559-583.
14. Callen, B. L. & Wells, T. J., (2003) Views of community-dwelling, old-old people on barriers and aids to nutritional health. *Journal of Nursing Scholarship 35* (3), 257-262.
15. Sharkey, J. R., & Schoenberg, N. E. (2002). Variations in nutritional risk among black and white women who receive home-delivered meals. *Journal of Women and Aging, 14*(3-4), 99-119.
16. Evans, C. (2005). Malnutrition in the elderly: A multi-factorial failure to thrive. *The Permanente Journal, 9*(3) 38-41 retrieved on August 30, 2008, from <http://xnet.kp.org/permanentejournal/sum05/elderly.pdf>.
17. Munson, M. L. (1999). Characteristics of elderly home health care users: Data from the 1996 National Home and Hospice Care Survey. *National Center for Health Statistics*. Retrieved on April 28, 2008, from <http://www.cdc.gov/nchs/data/ad/ad309.pdf>.
18. Alecxih, L. (2006). Nursing home use by "oldest old" sharply declines. *A report to the national press club, November 21, 2006, on the results of the 2004 National Nursing Home Survey*, National Center for Health Statistics,

- National Press Club. Retrieved on January 9, 2009, from <http://www.lewin.com/content/publications/NursingHomeUseTrendsPaperRev.pdf>.
19. Hastings, S. N., George, L. K., Fillenbaum, G. G., Park, R. S., Burchett, B. M., & Schander K. E., (2008). Does lack of social support lead to more ED visits for older adults? *American Journal of Emergency Medicine*, 26(4), 454-461.
 20. Bailey, L. & Zyla, K., (2004). Aging Americans: Stranded without options. Surface transportation project. Federal Highway Administration. Retrieved online on April 27, 2008 from http://www.transact.org/library/reports_html/seniors/aging.pdf.
 21. Dunkle, R., Roberts, B., & Haug, M., (2001). *The oldest old in everyday life: Self perception, coping with change, and stress*. New York: Springer Publishing Company.
 22. Surtees, P. G., Wainwright, N. W. J., & Khaw, K. T., (2006). Resilience, misfortune, and mortality: Evidence that sense of coherence is a marker of social stress adaptive capacity. *Journal of Psychosomatic Research*, 61, 221-227.
 23. Ryan, E. B, Meredith, S. D., MacLean, M. I., & Orange J. B. (1995). Changing the way we talk with elders: Promoting health using the communication enhancement model. *International Journal of Aging and Human Development*, 4(2), 89-107.
 24. Rosenbloom, S. (1999). Mobility of the elderly, good news and bad news. In *Transportation in an Aging Society: A Decade of Experience*. Technical Papers and Reports from a conference held November 7-9 by the US National Highway Traffic Safety Administration. Retrieved on August 31, 2008, from <http://books.google.com/books>.
 25. Grabbe, L., Demi, A., Camann, M. A. and Potter, L., (1997). The health status of elderly persons in the last year of life: A comparison of deaths by suicide, injury, and natural causes. *American Journal of Public Health*, 87(3), 434-437. Retrieved on April 28, 2008, from <http://www.census.gov/prod/2006pubs/p23-209.pdf>.
 26. Hays, J. C., Landerman, L. R., George, L. K., Flint, E. P., Koenig, H., Land, K. C., & Blaxer, D. G., (1998). Social correlates of the dimensions of late life depression in the elderly. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 53B(1), P31-P39. Retrieved on April 28, 2008, from <http://www.census.gov/prod/2006pubs/p23-209.pdf>.
 27. You, K. S. & Lee, H. (2006). The physical, mental, and emotional health of older people who are living alone or with relatives. *Archives of Psychiatric Nursing*, 20(4), 193-201.
 28. Cheng, C. Y. (2006). Living alone: The choice and health of older women. *Journal of Gerontological Nursing*, 32(9), 16-25.
 29. Morrissey, S. (1998). Resources and characteristics of elderly women who live alone. *Health Care for Women International*, 19, 411-421.

30. Bellin, C. L. (2000). *An exploration of women's experience of growing older while living alone in a rural community*. (Doctoral dissertation, University of Washington, Seattle, UMI No. 9975953).
31. Letvak, S. (1997). Relational experiences of elderly women living alone in rural communities: A phenomenological inquiry. *The Journal of the New York State Nurses' Association*, 28(2), 20-25.
32. Brunell, M. (2001). *Doing for others: It gives me something to do. An ethnographic study of older, urban women living alone in poverty*. (Doctoral dissertation, Columbia University Teachers College, New York, ATT No. 3007528).
33. Porter, E. J. & Lasiter, S. (2007). Handling the "People who are trying to get to you": Incidents with troublesome visitors reported by older women living alone. *Advances in Nursing Science*, 30(2), 108-122.
34. Petry, H. (2003). Aging happens: Experiences of Swiss women living alone. *Journal of Women and Aging*, 15(4), 51-68.
35. Husserl, E. (1952). As cited in Chapter 7 of Munhall, P. L. *Nursing research: A qualitative perspective* (4th ed.), Sudbury: MA, Jones and Bartlett Publishers.
36. Munhall, P. L. (2007). *Nursing research: A qualitative perspective* (4th ed.), Sudbury, MA: Jones and Bartlett Publishers.
37. Heidegger, M. (1962). *Being and time*. San Francisco: Harper & Row (original work published in 1927).
38. Cohen, M. Z., Kahn, D. L., & Steeves, R. H. (2000). *Hermeneutic phenomenological research: A practical guide for nurse researchers*. Thousand Oaks, CA: Sage.

Table 1. Interview questions divided into past, present, and future focus.

<i>Past</i>	<i>Present</i>	<i>Future</i>
<ol style="list-style-type: none"> 1. How long have you lived here in this area? 2. How many years have you lived alone? 3. Can you describe what it was like when you first had to decide to live alone? 4. Have you ever had a very difficult challenge that 	<ol style="list-style-type: none"> 5. What is it like to be 86 years old and living alone in the neighborhood? 6. What is currently the most challenging part of living alone in community at your age? 7. Do you have any concerns about managing your health or 	<ol style="list-style-type: none"> 11. Do you ever wonder if you will be able to continue like this? 12. Any doubts or worries about the future (living here alone)? 13. What would happen if you needed help in a pinch? Or you can no longer drive?

<p>made you wonder if you would come out ok?</p>	<p>illness?</p> <p>8. What do you like the most about your living arrangement? What is your quality of life like?</p> <p>9. What are your best resources (people or other)?</p> <p>10. Are you very satisfied with your current life?</p>	<p>14. Is there anything else you would like to share?</p>
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Table 2. Six major themes of an oldest old woman living alone in community

1. Being self-reliant
2. Controlling emotions
3. Expecting disappointments & moving on from them
4. Maintaining high social interactivity
5. Planning for the future
6. Choosing to be positive