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"Fiercely independent": Experiences of aging in the right place of older women living alone with physical limitations

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ABSTRACT

This study explores the experience of aging among older Canadian women with physical limitations who live by themselves. While aging in place has been a policy priority in rapidly greying Canada, a lack of complementary public supports poses challenges for many older adults and their family members. Employing a qualitative methodology, and drawing from the notion of *aging in the right place*, we collected personal narratives of 12 women (aged 65 to 92) in two geographic areas in Ontario, including residents of regular houses, apartments, condominiums, assisted living and community housing for seniors. Through thematic analysis, we identified four overarching themes: 1) striving to continue on "at home", 2) living as a "strong independent woman", 3) the help needed to support their "independence", and 4) social activities to maintain self. Our findings illustrate how, despite their mobility limitations, older women can change their residential environment and their behavior by deploying the coping strategies and resources they have developed over time. However, we also found that older women are largely silent about their needs, and that experiences varied depending on life histories, health conditions, and the availability of supports in their wider environment (home care, alternative housing options, accessible transportation, opportunities for social and physical activities). We hope these findings will incite further studies and discussion to help make aging in the right place a real choice for anyone who wishes to do so.

Introduction

Population aging in Canada will keep accelerating over the next decade. The ratio of "senior citizens" (aged 65 years and older) is expected to grow from 17.5% in 2019 to 22.7% by 2031 (Statistics Canada, 2019). "Old-old" Canadians in their late 90s and above are among the fastest growing age group (Hudon & Milan, 2016). Like many countries, Canada's policy response to this demographic change is the promotion of *aging in place*, generally understood as being able to remain in familiar homes or communities for as long as possible. The premise is to promote independent living in later life, while shifting care for the older adults from institutions to home and community (Dalmer, 2019; Lehning, Nicklett, Davitt, & Wiseman, 2017); a shift long criticized by social gerontologists for being part of the devolution of aging and long-term care policies. Policy makers have largely supported this strategy as a cost-effective long-term care alternative. More than anyone, however, it is older adults themselves who are in favor of the idea.

Aging in place has become common in Canada. Comparing the 2011 and 2016 censuses, the ratio of people aged 65 and older living in "collective dwellings" (e.g., assisted living, supportive housing, retirement residences, seniors' apartments, continuum care facilities, and nursing homes) has dropped from 7.9% to 6.9% (Garner, Tanuseputro, Manuel, & Sanmartin, 2018; Statistics Canada, 2012). Given the increasing numbers of older Canadians, one would expect this number to grow, not decline. The 2016 census found only 5.0% of seniors had moved in the past year, a much lower rate than the general population (13.0%). This should not, however, be assumed to reflect older adults' satisfaction with their housing. In fact, almost a quarter of seniors reported their housing as "below standard" in terms of either affordability, adequacy, or suitability (Federal/Provincial/Territorial Ministers Responsible for Seniors, 2019).

Although health status among older adults is heterogeneous, chronic diseases and physical limitations increase with advancing age. More than three-quarters of Canadians aged 65 and older reported having at least one chronic condition, and one quarter reported three or more. One out of four of those aged 85 and over reported a need for support in Instrumental Activities of Daily Living (IADL), while one in ten needed support in Activities of Daily Living (ADL). Like the rest of the world, older women are disproportionately represented in these

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groups (Canadian Institute for Health Information, 2011).

Older women in general are more likely to face challenges since women live longer and are more likely spend their later years with mobility problems and pain (Bushnik, Tjepkema, & Martel, 2018) and nearly twice as likely to live alone than their male counterparts. The 2016 census found 26.0% of seniors lived alone, 68.0% of who were women (Tang, Galbraith, & Truong, 2019). In addition, women living alone comprised 57.0% of seniors with "core housing needs" (Federal/Provincial/Territorial Ministers Responsible for Seniors, 2019). Given these demographic, health, and socio-economic trends, more research on the experience of aging in place among older women, especially those living alone with physical limitations, is needed (Gonyea & Melekis, 2018).

Literature review

From "Aging in place" to "Aging in the right place"

The conceptual development of aging in place began when American environmental gerontologists (Lawton & Nahemow, 1973) introduced the "ecological model of aging" to examine the relationship between people and their environments. In this model, an older person's functioning is determined by the "fit" between "personal competences" (e.g., physical, psychological, and social functions) and "environmental characteristics" (e.g., the immediate and wider environments). As changes happen in either or both, older adults can try to adapt their physical and social environments to find a comfort zone by deploying their resources (Greenfield, 2011; Lawton & Nahemow, 1973; Peace, Holland, & Kellaher, 2011; Stafford, 2016). This theoretical framework helps us to understand aging in place as a dynamic process of person-environment interactions.

Wahl, Iwarsson, and Oswald, and their collogues in Germany and Sweden have extended this framework to, "maintaining the highest autonomy, well-being, and preservation of one's self and identity as possible, even in the face of severe competence loss" (Wahl, Iwarsson, & Oswald, 2012, p.310). This process is influenced by two concepts: "belonging" and "agency". Belonging involves an older person's sense of connection with others and the environment and preserved identities over time. Agency refers to sufficient control of their environment to maintain autonomy. Belonging grows in importance as people get older, especially when they develop functional impairments (Oswald, Wahl, Schilling, & Iwarsson, 2007; Wahl et al., 2012). This model reminds us of the benefits of taking a life-course perspective to understand the experience of aging in place.

In the same vein, Golant (2011, 2015), an American environmental gerontologist, has put forward the notion of *aging in the right place*. Pointing to the unequal capabilities and resources among older adults, Golant (2008, 2015) criticizes how aging in place has been promoted as a cultural imperative in America, emphasizing an individual's self-reliance in sustaining a healthy active lifestyle. Even when older adults have chronic health problems, disabilities, or cognitive deficits, he argues, if they are offered "enabling residential and care opportunities that strengthen their coping skills to achieve their evolving needs and goals", they can still "age successfully" (Golant, 2015, p.353). Golant thus advocates shifting public discourse, and older adults' thinking, from aging in place to aging in the right place, which includes expanding the various alternative housing options being considered – such as group housing, active adult communities, senior apartments, assisted living residences, continuum care, and the like. In this model, regardless of residential type, older adults can achieve "residential normalcy" where they feel comfortable, competent, and in control. Older adults may use various coping strategies when their residential normalcy becomes incongruent. Moving to alternative housing such as assisted living, active adult communities, and nursing homes can be seen as adaptive responses to aging. Golant (2015) also noted that enriched coping strategies are products of the resilience of both older persons and their environments.

Unmet needs of aging in the right place and long-term home care in Canada

Despite this theoretical development, the public discourse surrounding aging in place in Canada seems to have stagnated. For example, in a public guide issued by the federal government, "aging in place" is defined as "having access to services and the health and social supports and services you need to live safely and independently in your home or your community for as long as you wish and are able" (Federal/Provincial/Territorial Ministers Responsible for Seniors, 2015, p.1). The guide also notes that an individual can achieve this goal through early planning in such areas as home, community, transportation, care and support services, social connection, healthy lifestyle, finance, and information. As Dalmer (2019) has noted, such neoliberal rhetoric frames aging in place as "a matter of choice" that can be responsibly managed by individuals. Given the lack of affordable housing alternatives and the unmet need for long-term home care services for many older Canadians, however, this so-called choice is often illusory.

As mentioned, according to the 2016 census, only 6.8% of Canadians aged 65 years and older lived in "collective dwellings," including nursing homes (the most common) and other alternative senior residences such as assisted living and retirement homes. This suggests that moving to alternative housing, as advocated by aging in the right place, is still uncommon in Canada. This is partly due to a lack of affordable senior residences. In Ontario, the average monthly rent for a standard space for a resident without high-level care needs was $3758 Canadian in 2018 (Canada Mortgage and Housing Corporation, 2019). Given seniors' average annual income – $48,800 for men and $34,900 for women (Statistics Canada, 2020) – alternative housing is unaffordable for most older Canadians, especially women.

As more and more older adults age in place, their homes and communities increasingly become locations for health and social care services (hereafter "home care"). Since long-term home care is not universally insured under the Canada Health Act, older adults who don't qualify need to resort to community agencies that often require a co-payment or privately hire help (Armstrong, Zhu, Hirdes, & Stolee, 2015; Gilmour, 2018; Government of Ontario, 2019; Johnson et al., 2018; Lee, Barken, & Gonzales, 2018). According to the 2015/2016 Canadian Community Health Survey, over one-third (35.4%) of people with home care needs did not have their needs met, especially among those with home support services for maintenance of daily living (Gilmour, 2018). The current policy of aging in place needs more complementary public supports to reduce the challenges facing many older adults and their families.

It is within this context that we explore the experiences of aging in place among older Canadian women with physical limitations who live alone. Our research questions include: 1) What is it like to live at "home" alone for older women with physical limitations? 2) What support do they receive and how? and 3) What are the enabling and disabling factors for their independent living?

Methodology

This study employed a qualitative research methodology (Merriam & Tisdell, 2016), more specifically, combining personal narrative analysis (Maynes, Pierce, & Laslett, 2008) with a narrative gerontology approach (de Medeiros, 2014). A qualitative approach lets us explore inductively how older women construct and make sense of their experience of aging in place (Merriam & Tisdell, 2016), connecting their individual experience and life trajectories with broader cultural and social forces (Maynes et al., 2008). This reinforces what narrative gerontology advocates: listening to older people's lives as stories to understand their social world – personal, interpersonal, structural and cultural (de Medeiros, 2014). This study is part of a larger study, and ethics clearances were obtained from the Research Ethics Boards of

both researchers' universities.

We recruited participants in two areas (a large metropolitan area and a medium sized city) in Southern Ontario. The criteria for inclusion were: women 65 years and older, who lived by themselves at home with chronic physical conditions, and who were using or had used home care services. Following the notion of aging in the right place, we included both regular house, condominium, and apartment, as well as alternative housing such as assisted living and community housing for seniors. We created a flyer, noting we were "looking for participants in a research study to learn their experience of and opinions about living with chronic physical conditions." Approximately 70 flyers were either posted in their residences or directly delivered to potential participants through personal support workers (PSWs) in collaboration with five different community organizations. Recruitment was harder than we had expected. Since only two participants voluntarily called back, we asked our participants, colleagues, and friends to deliver the flyer to whoever might meet the criteria. Eventually, we had 15 interviewees. Although every interview will be used in our larger study, 12 participants met all the criteria for this study.

The 12 participants ranged between 65 and 92 (the average age was 83), and lived in various residential types in varying states of health. All have been given pseudonyms (See participants' profiles in Table 1).

The data collection was conducted in the spring and summer of 2017. The first author and a student research assistant conducted all interviews together. Eleven interviews were conducted in participants' homes and one was in a public space. Visiting their residences let us observe their daily living and neighborhood environments. Each interview lasted from 90 to 120 min. We began by asking participants to tell us their life histories, followed by questions about their daily and weekly routines, current physical condition, strategies and challenges for managing their independent living, the support they receive, and their opinions about aging in place in general. Since one Chinese immigrant participant (Hong, 90) had difficulty speaking English, her daughter (Lin, 64) joined the interview as a translator, also providing some of her own insights as a family carer. Following each interview, we provided a gift card of $30 with a thank you note. Then the two interviewers debriefed each other, recording what they had noticed in the field notes. All interviews were audio recorded, transcribed verbatim, and sent to participants to check accuracy and to modify if requested.The twelve transcripts comprised 281 pages in total.

Following the steps of thematic analysis (Merriam & Tisdell, 2016), we started open coding by reading the first participant's data set (transcript and field notes), then underlined any segments that might be meaningful and attached labels (i.e., code and themes). Next, we moved to axial coding by sorting these codes and themes into more comprehensive groups (i.e., categories). Then, we created a matrix to display the categories, themes, and supporting quotations for the first participant transcript. We went through the same procedures for the second data set, and compared the two matrices to create a master list of cross-case categories and themes. This master list was used as a basis for analyzing the other participants' data. Comparing all 12 participants' matrices, we generated four overarching themes as findings. To increase trustworthiness, our design included data triangulation, member checking of interview transcripts, a reflexive journal, and peer debriefing with research team members (Creswell, 2013; Merriam & Tisdell, 2016).

Findings

We found the following four overarching themes: 1) striving to continue on "at home", 2) living as a "strong independent woman", 3) the help needed to support their "independence", and 4) social activities to sustain self. These overarching themes contain several subthemes.

Striving to continue on "at home"

The first theme involves our participants' efforts to live in their homes comfortably and safely. As shown in Table 1, many participants had lived in the same residence for decades, while a quarter had moved in the past four years due to changes in their mobility or marital status. In any event, all participants seemed comfortable in their residence, which they called "home". The first thing that we noticed was that these homes preserve their personal histories and identities. Their well-kept living rooms were stuffed with vintage furniture, family photos, art, crafts, books, instruments, souvenirs, plants, pets, etc. Participants

Table 1
Participants' profiles.

Participant No. Pseudonyms	Age	City size	Residential type	Tenure in current residence	Immigration history	Physical limitations The number of chronic illnesses (either treated or under treatment)
1. Tami	65	Large	Assisted living	1 year	Immigrated 25 years ago	Walking, balance, uses a walker One
2. Mei Lien	68	Large	Assisted living	12 years	Immigrated 44 years ago	Walking, uses a cane One
3. Luisa	78	Mid-size	House	30 years	Born in Canada	Balance Two
4. Dorothy	83	Mid-size	House	32 years	Immigrated65 years ago	vision, injured hands (temporary) One
5. Renelsa	84	Large city	Community housing for seniors	unknown	Immigrated 50 years ago	Walking, uses a wheelchair, frailty One
6. Margaret	84	Mid-size	Condominium	Less than1 year	Born in Canada	Walking, balance Two
7. Emily	85	Large	Assisted living	23 years	Born in Canada	Walking, balance, uses a walker Two
8. Katherine	88	Large	Assisted living	4 years	Born in Canada	Walking, balance, uses a walker One
9. Hannah	88	Mid-size	Assisted living	16 years	Immigrated70 years ago	Walking, balance, uses a walker Three
10. Hong	90	Large	Assisted living	20 years	Immigrated22 years ago	Walking, balance, hearing, uses a wheelchair, frailty Three
11. Elizabeth	92	Mid-size	Apartment	30 years	Immigrated 30 years ago	Walking, vision, pain, uses a walker Three
12. Valerie	92	Mid-size	House	65 years	Born in Canada	Walking, balance, pain, uses a walker Two

readily shared memories of some items: “This is the treasure box my father carved when I was a child. He was a great carver” (Louisa, 78); “This is a photo of our family reunion. Here I am with my son and two granddaughters” (Dorothy, 83).

Most participants expressed emotional attachment to their “homes”, wishing to stay there with familiar belongings as long as possible. For witty Elizabeth (92), who has vision and walking problems, her desktop computer is a “window to the world”:

> I've been here [in her apartment] for ONLY 30 years! (laughs) […] Somebody told me if I moved to an old folk's home, I couldn't take anything with me, including my computer. To me, it would be like a prison. Even if I became totally blind, I hope someone could still come and help me here. I would like to die here, dammit. I don't want to go anywhere.

Four participants mentioned they might have to move in the future when they could no longer take care of themselves. Yet their narratives suggested the difficulty of moving to alternative housing.

> Certainly, I couldn't afford one of these fancy private assisted retirement homes. I've been to one of them to visit a friend of mine. She pays about $3500 a month for one room. I cannot afford that on my pension (Dorothy, 83).

> My mom [Hong, 90] is on the waiting list. Well, it's been 10 years already since she registered. It's one of the Chinese long-term care homes. […] Oh, yes, it's common. They say it normally takes over 10 years! (Lin, 64).

These comments underline the lack of affordable alternative housing many older adults face.

During our visit, we were also impressed by their efforts to control their home environment to live safely. All participants had at least one chronic health condition. However, their biggest challenges were mobility issues – especially difficulty in walking, falls, and the fear of falling. Despite their use of mobility aids (e.g., cane, walker, wheelchair), many participants talked about their occasional falls. All had made some home adaptations by installing safety features (e.g., staircase railing, grab bar, special chair and non-slip mat for bathrooms). They were also using assistive devices. Ten of 12 participants carried an emergency alert pendant or had installed an alert system with pull cord for their bathrooms. This was a lifesaver for some. Valerie, 92, who has had multiple falls, related:

> I've used it twice. One time, they were able to get in through the kitchen window. The other time, I was doing Christmas decorations when my daughter phoned, and when I turned, I fell. My daughter phoned a friend's husband to come, but before he arrived, I phoned the emergency alert and asked them if there was a particular way he should pick me up. They immediately sent somebody and got me on the chair.

Valerie's story suggested how unexpectedly and easily falls can happen at home, and how the assistive device helps in those instances.

Many participants were also using other technologies to help increase their sense of control and autonomy. Half used a tablet or a computer for frequent communication with their families, reading news, and searching information. A participant with vision problems showed us a sight enhancement reading machine. One had a mobile chair lift for the staircase. The most advanced case of impairment was Renelsa, who at 84 spent most of her day in bed due to her frailty, but she could still live alone in her one-bedroom apartment in community housing. Her building had a security camera to screen visitors, and her apartment door could be opened with a remote control beside her bed. We had no idea about how limited her mobility was until she greeted us in her bedroom.

Participants in assisted living appreciated similar safety features in their units, and the railings in the hallways and elevators. In addition, Mei Lien, 68, explained how her residence gave her “peace of mind”: “Last year, in the middle of night, I had to call somebody, and they [staff] came up. I don't have family in Canada, so at least you know somebody is there if you call”. Margaret, 84, who was recently widowed, reflected on her decision to move from her house to a senior-friendly condo:

> The very last thing I wanted to do was move into this building… Do I want to live here? No! But should I live here? Absolutely! … If you think your health is going to be the same tomorrow as it is today, you are wrong. We all progress to some extent from day to day … I did not know the presence of a garbage disposal in the hallway was so convenient. So in the big picture, it was a very wise thing.

In this way, each participant was negotiating their own physical and social conditions, and actively managing to control their home environment as best they could.

Living as a “strong independent woman”

The second theme involves our participants' distinctive shared character. Although their life histories and current conditions varied, we were struck by their positive, spirited, and persevering attitudes. Contrary to our expectation, participants rarely brought up their needs. We thus had to ask if there was anything to complain about. Dorothy, 83, who had just recovered from a fall on ice, laughed and said:

> Well, I think, oh, god, I ache, I ache, I ache, but I shouldn't complain, especially when I see other people… At least, I can still walk around, I can still look after myself, and do my own thing in my own house. So you know, I would say I'm fortunate. […] Well, you have to make the choices yourself, don't you? You either sit there and wither away, or you get involved and do something.

Luisa, 78, mentioned that she had learned it from her role model:

> I am a contented person. I am not always looking for what I don't have. I learned that from my mother. She independently lived in her own apartment until 93, climbed stairs to the fourth floor, and always baked and cooked for visitors. You know, she never complained about her situation. She was fiercely independent.

As these comments imply, many of our participants held to a similar principle in their lives.

In fact, participants commonly described themselves as brave, independent women. Their life stories were full of personal and historical events: The Great Depression, World War II, immigration, marriage, divorce, separation, accident, the deaths of spouses, children, and friends, and their own health problems. Every participant had an occupation at some point, and many repeatedly used the word “independent” to describe themselves. As Hannah, 88, who had immigrated from Germany with her husband after World War II, put it:

> I was always this independent (laughter). I was married, AND I was independent. I became a widow at the age of 42, and raised three children. When my husband got sick, I had a job [a lab aid in a hospital] and I took a year of absence to take care of him at home. But I needed the money, so I cleaned houses, took in other people's clothes. I wanted my children to have a better education. I never went on welfare, I worked and all my children went to university. If you came from a different country, you help yourself, you don't rely too much on the country. It's my job to look after the family.

A former university professor, Margaret, who was mourning her husband's death and managing her own health problems, described her efforts to be a strong role model for others at 84 years old:

> I am very strong-willed person. I was always a determined youngster. Even as a girl, I was an independent child (laughter). Even now, I just have to get really strong to be a good role model for women. I always try to be, because who is going to be the one to make me look and feel strong? Me! You will only be strong if you work to be that

way. […] I just live today, that's exactly how I think. I believe you stay the strongest person you can be each day you are alive.

As these comments suggested, our participants' self-identity as strong independent women developed through various life experiences, sustains them in the face of the challenges of later life.

The help needed to support their "independence"

Nevertheless, we also learned that participants' "independent" lifestyles were supported by many other people in a mix of formal and informal care. Due to our recruitment criteria, all participants had had an experience of publicly funded "formal" home care. However, at the time of our interview, only four were eligible for long-term home care, receiving 30 min to 1.5 h a day. For the other eight participants, publicly funded home care ended two to three months after a hospitalization. Once this post-acute care was over, they were back on their own. The four participants who could afford it hired a paid housekeeper a few hours a week. Two more, thanks to their retirement benefits, continued regular physiotherapist visits at home or attended weekly exercise classes through community agencies.

Compared to those living in regular houses or apartments, participants in assisted living had an advantage in the availability of and accessibility to long-term home support services right in their own buildings. However, some expressed hesitation to use additional support services due to their worry about the additional cost: "If you need the extra service, you have to pay. It depends if you or your family can afford it. So you just hope and pray you won't need more services" (Mei Lien, 68). Like Mei Lien, many participants saw cost as a barrier to longer-term formal home care. As mentioned before, however, none explicitly advocated a more affordable publicly supported long-term home care system.

In contrast, participants talked much more openly about informal care and support – their reliance on their family members, friends, and neighbors for regular help for transportation and household chores. Ten out of 12 participants, regardless of residential type, had at least one close family member nearby. While most participants still managed to clean their homes, do laundry, and cook simple meals, carrying groceries and to taking public transportation were getting harder. Family members were the primary source for a wide range of household chores. Luisa, 78, described the support from her son's family:

> It helps me a lot that my son and daughter-in-law live here [in the same city]. I've been calling them to do things. He installed the railing on the basement stairs, because I've had three falls since last December. It just makes me feel more secure. And my daughter-in-law takes me to a rheumatologist in another city, because I don't drive highways anymore.

For participants whose family members lived far away, friends and neighbors were crucial sources of social support: "I have a good friend who takes me grocery shopping and to doctors' appointments" (Hannah, 88); "When I had the cancer, I had radiation 28 times in December. Every morning I told my friends, I cannot do it one more day, but I did thanks to them" (Elizabeth, 92). As these comments suggest, most participants were grateful for the informal support and care provided by family members, friends and neighbors. Clearly, these provided crucial instrumental and emotional support to all participants.

Overall, participants' narratives suggested an imbalance between formal and informal home care and support. Even for participants receiving publicly funded long-term home care, that was not enough to live alone at home with disability and frailty, due to the limited time and tasks performed by the personal support workers (PSWs). For example, although PSWs help Renelsa three times a day for a total of 1.5 h, it is her brother who brings over meals twice a week to store in her freezer. For Hong (90), who speaks limited English, communication with the PSW is challenging. As her daughter said, "The agency working in this building has no PSW who speaks Chinese. For showering, communication is very important. That's why I need to translate. Otherwise, I could be preparing breakfast during that time" (Lin, 64). Participants in assisted living also reported regular informal support from their family members. Katharine, 88, who no longer cooks for herself, mentioned: "I can have dinner at the dining hall downstairs, but my niece and nephew do weekly shopping for my breakfast and lunch." Compared with participants living in houses, however, those in assisted living did not have to rely family and friends for daily personal care. Overall, regardless of residential type, our participants' narratives suggest their independent life was unattainable without support from many others.

Social participation to sustain self

The fourth theme involves the benefits of opportunities for continued social participation. Despite noticeable physical discomfort, most participants kept trying to maintain the activities and the relationships that they valued, which were clearly an important part of their social identity. Three participants living in houses were still earning a small income. Many participants also kept volunteering in their communities. In particular, participants in assisted living had many opportunities within their own buildings. For example, Tami, 65, a master of 3D origami, taught it to her fellow residents while volunteering at a nursing home once a week. As she explained:

> In 2010, when I got this problem [a rare and progressive degenerative disease], I started volunteering. The volunteer work makes me happy. Sometimes, it's just sitting and talking to them [the residents in a nursing home]. But if I talk to them, they smile. They are losing their smile all day, so I want to make them smile. Smile … like cheeks up. Their smiles make me happy.

Like Tami, many participants mentioned their joy at making themselves useful to others, despite, or possibly because of, their own mobility and health challenges. Tami also appreciated the Wheel-Trans system that made her volunteering possible. Most participants also stayed active in the groups to which they belong. Elizabeth, 92, a former entrepreneur, described her monthly routine: "I go to church on Sundays, Probus Club and Torch Club once a month…I also go to all sorts of classes". Although Elizabeth had no family members in Canada, her long-term involvement in her local community had helped her develop a circle of good friends who she could rely on. Renelsa, 84, a former nurse and devoted Christian once nicknamed "the Sister in the operating room", could no longer attend church, so three fellow congregants visited her twice a month: "On Sunday, we have church right here in my apartment! I really look forward to when they come".

Many residents in assisted living had an even busier schedule of social, cultural, and physical activities. Emily, 85, showed us her monthly calendar on which she had circled her activities. On some weekdays, her schedule is packed from 7:30 am to 3 pm! We also noticed a notable difference in the accessibility for exercise between those living in their own house and apartment and those in assisted living. Most participants in assisted living continued to attend using their canes and walkers, while those living in their own houses stopped going to exercise classes in their communities due to a lack of transportation and coverage for long-term physiotherapy. Participants' narratives make it clear that these opportunities for civic engagement and social and physical activities give them a routine to leave their "homes" to socialize, and enable them to keep playing a social role in their communities. Moreover, older women mutually support each other in various ways by giving rides, bringing soups, etc. They not only receive support from others, they kept providing support to each other.

Discussion

Overall, our study's findings illustrate how older women living alone with physical limitations can, with support from others, manage to

maintain their independence in places where they feel “at home”. All were achieving “residential normalcy” (Golant, 2015) in “homes” that were “uniquely their individual domain” (Kontos, 1998, p.286), where they could feel comfort, autonomy, security, self-identity, and continuity of self (Golant, 2015; Stones & Gullifer, 2016; Wiles, Leibing, Guberman, Reeve, & Allen, 2012a). Their familiar belongings–what Coleman and Wiles's (2020) termed their “objects of meaning”–symbolically connected their past, present, and perhaps future selves. This also overlaps with the concept of “belonging”. As Wahl et al. (2012) noted, familiarity, routines, and emotional attachment developed over time help preserve identity and enable aging well in the right place.

Despite their physical discomfort, all were “fiercely independent”, a phrase used by two participants (Elizabeth, 92; Louisa, 78). As prescribed by aging in place policy, they strove to alter their home environment to live as independently and safely as possible, deploying the strategies and resources available and affordable in their contexts. They practiced problem-focused “assimilative coping”, but many also used emotion-focused “accommodative coping” by accepting and being content with what they have (Golant, 2015, p.102). These conscious behaviors exhibit our participants' “competences” (Lawton & Nahemow, 1973) and “agency” (Wahl et al., 2012), another enabler in person-environment interactions.

One unexpected finding is their emphasis on being strong-willed “independent women”. This self-image, developed over their life course, provides a psychological resource to cope with challenges in later life. Clearly, they are “resilient” people (Golant, 2015, p.118) who are motivated and confident, with the physical capabilities, mental stamina, and flexibility to find appropriate solutions to the environmental obstacles they face. Yet, based on their life stories, we suspect that their resilience is not an innate personality trait so much as an ability to “adapt well” learned and developed over time in relation to others and to their environments (van Kessel, 2013; Wiles, Wild, Kerse, & Allen, 2012b). We found this learning process to be resilient operating even among very old and frail participants. This supports Peace et al.'s (2011) finding that, while frailty and decline of personal competence are related, they are not synonymous. Older adults can confront challenges by bringing their life experiences to their person-environmental interactions.

Despite their limited mobility, many stayed involved in social and volunteer activities, using their skills and sustaining and developing relationships. Importantly, our participants did not passively receive care. They also actively provided it to others. This finding overlaps with the concepts of “vitality and agency in frailty” for preserving self-identity and continued self-development in later life (Bjornsdottir, 2018; Latimer, 2012). It also highlights the crucial role of opportunities for social participation, meaningful and reciprocal contribution, and relationship building to aging in place. A recent increase in innovative community-based participatory approaches to aging in place, such as the Naturally Occurred Retirement Community (NORC), for example, includes this reciprocal exchange of support and care by creating resourceful community environments (Greenfield, Scharlach, Lehning, & Davitt, 2012; Sixsmith et al., 2017).

Nonetheless, our findings also suggest some disabling factors. The constant “balancing act” (Golant, 2015, p.355) person-environment interactions in later life demands was difficult for some, especially for those with severe mobility limitations, multiple comorbidities, few close family members and friends, and low income. Also, the quality of our participants' aging in place was influenced by local environments, including the availability of affordable home care services, physical activities, and safe and reliable public transportation (e.g., Wheel-Trans). Most notably, our participants were facing the challenges of pain and balance: falling posed a real threat, as found in previous studies (e.g., Bushnik et al., 2018). Nevertheless, for many participants – especially those living in houses and apartments without transportation and private home care insurance – regular exercise classes, physiotherapy, and fall prevention programs were neither affordable nor accessible. Given the proven benefits of interventions for falls and fear of falling (e.g., Whipple, Hamel, & Talley, 2018), it is essential to develop strategies to make those programs more available. Policies in aging, health, and social services should support greater collaboration between community-based formal and informal care (Ryser & Halseth, 2011).

In the current discourse surrounding aging in place, independent living tends to refer to an autonomous lifestyle achieved through the personal efforts of individuals. In reality, however, as our findings show, aging in place for older women with physical limitations inevitably requires a view of “independent living” which promotes reciprocity and interdependence between individuals and their communities, including both formal and informal supports. In other words, as Golant (2015, p.356) advocated, we need to adopt an “it takes a village” perspective. Nevertheless, consistent with previous studies (Johnson et al., 2018; Kadowaki, Wister, & Chappell, 2015), publicly supported long-term home care – especially for maintenance and prevention purposes, such as home support services and physiotherapy – was still unavailable for many of our participants. Our study adds further contextual evidence to Canada's need for the publicly supported long-term home care system many have advocated over the past decade (Canadian Home Care Association, 2016; Gilmour, 2018; Kadowaki et al., 2015; Special Senate Committee on Aging, 2009; Turcotte, 2014).

Overall, the findings of our study support the notion of aging in the right place proposed by Golant (2015). They suggest that, despite their tireless individual efforts to be independent in a place of their own, older women can reach a point where the changing balance between personal competence and environmental pressure requires a new strategy to maintain self-identity, what Peace et al. (2011) term “option recognition” (p.751). Participants who could afford it or were eligible for public subsidy often moved into assisted living to regain control. Given the lack of a universal long-term home care system in Canada, moving to assisted living helps reduce the heavy burden placed on some older adults and their family members (Ryser & Halseth, 2011). At the same time, our participants' narratives reaffirm that alternative senior residences – such as active adult communities, assisted living, and continuum care retirement communities – are not a readily available or affordable option for many middle-income older Canadians (Dalmer, 2019).

Finally, the most unexpected finding in our study is the collective silence of older women, the so-called “shadow story” (de Medeiros & Rubinstein, 2015), about their unmet need for more formal and structural support reported in previous studies (e.g., Canadian Home Care Association, 2016; Gilmour, 2018; Turcotte, 2014). This may be partly because the interviewers were “others” (Dorothy, 83), making it hard for participants to reveal their true feelings, and partly because respondents wanted to present themselves as role models for their interviewers, who were of their daughter's and granddaughter's generation. Complaining and demanding that their needs be met contradicted their core principle of “being independent”. Finally, adopting the neoliberal rhetoric of being self-reliant and autonomous model citizens, older women may see their growing care need for daily activities as an individual matter that they should take care of themselves, rather than a structural issue connected to the long struggle over public policy. Further study is required to clarify these points and investigate how a “sociological imagination,” as coined by C. Wright Mills (1959), might be used to collectively empower older women and inform public policies alike.

This study has several limitations. Due to our small number of self-selected participants who are resilient and have positive outlooks, our findings reflect more the experiences of older women who are successfully aging in the right place, despite their physical conditions. The voices of older adults who live with cognitive impairment, depression, and social isolation, or whose lack of resources make them more vulnerable, are missing. Furthermore, the data was collected before the COVID-19 pandemic, which has likely altered older women's

perceptions and experiences. All these areas are important, and deserve further study.

Conclusion

Despite these limitations, our research provides a valuable window into experiences of aging in the right place of an understudied group – older women living on their own with physical challenges in Canada. No matter how fiercely and successfully independent older women try to be, framing aging in place as a matter of individual efforts alone is misguided. It is crucial that more structural supports and improved community-based care that is informed by recipients themselves become an integrated part of public policy. The shifting of public perceptions from aging in place to aging in the right place has the potential to foster subjectively-defined aging well among older adults with different needs and resources. We hope these findings will encourage further studies and the political will to make aging in the right place a real option for older adults in Canada and far beyond.

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Declaration of Competing Interest

None.

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