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Perceptions of Living Alone Among Older Adult Women

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This exploratory study examines older women's perceptions of living alone. Older adult women ($N = 53$) living alone were interviewed. Findings show tremendous variability in the perceptions of this sample. Whereas some women showed significant levels of loneliness and depression, many did not. Thirteen percent of the participants ($n = 7$) negatively perceived living alone, 49.1% ($n = 26$) neutrally perceived living alone, and 37.7% ($n = 20$) positively perceived living alone. Participants' most enjoyed aspects of living alone were being one's own boss/being independent (51%) and keeping one's own schedule (49%). Common responses for least enjoyable aspects of living alone were lack of companionship (62%), no one to help with housework (36%), and fear of falling or getting hurt (30%). Nurses should be aware that although some have perceived older adult women living alone as a vulnerable population, one cannot make assumptions based on living arrangements.

In recent decades, there has been a significant increase in the number of people who live alone (Chandler, Williams, Maconachie, Collett, & Dodgeon, 2004). Living arrangements have shifted toward living alone for older adults in particular (Kramarow, 1995). At the turn of the century, only 12% of widows age 65 and older lived alone, whereas 70% resided alone in 1990 (Kramarow, 1995). Women, compared to men, are more likely to live alone (Davis, Moritz, Neuhaus, Barclay, & Gee, 1997). It is not surprising, that unmarried women ages 80 and older are more likely to live alone than men of the same age group (Zimmer, 2005). This difference is present mainly due to the increased life expectancy of women and the tendency for women to marry men older than themselves, as the death of a spouse is a primary reason people transition into living alone (Bureau of the Census and National Institute on Aging, 1993; Kinsella, 1995). In addition, a growing number of older women are experiencing divorce in later life (Nakonezny, Rodgers, &

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Nussbaum, 2003; Stroup & Pollock, 1999), an occurrence that in the past was considered rare.

Although maintaining a household with a spouse is typical for married older adults, the living arrangements of unmarried older women (e.g., widowed, divorced) are much more variable. Historically, older women moved in with adult children after the death of a spouse (Macunovich, Easterlin, Schaeffer, & Crimmins, 1995). According to some (e.g., Costa, 1999) this significant change in the living arrangements of older women has had a profound effect on the lives of aged women in both North America and Europe. This change has impacted elder women's lives in the areas of mental, physical, and financial health. Although the demographic changes in living arrangements in this population are substantial, it has been suggested that gerontologists have not adequately addressed the needs of older adult women who live alone (Jenkins, 2003).

Why has the proportion of older adults, particularly older adult women, living alone increased so substantially through the 20th century? Kramarow (1995) presents three possibilities. First, the decline in fertility has decreased the number of available adult children that older adults may choose with which to reside. Second, older adults in recent decades have had increased incomes and are able to support their own residences with less of a financial struggle than in the past. Third, it has been suggested that modern culture has changed to a more individual (vs. family) focus, and therefore living alone is more desirable for today's older adults than for older adults of the past who had a stronger desire to live with family. In other words, today's older adult values independence more than yesterday's older adult.

ELDERS LIVING ALONE: A VULNERABLE POPULATION?

Some research suggests that elders who live alone may be vulnerable to physical and mental health problems and therefore deserve special attention from social workers, community nurses, and other professionals. Typically, older adults who live alone have an increased risk of infections, falls, dehydration, and injuries (Campion, 1996). Unfortunately, it is not unusual for emergency medical services to find older adults living alone, particularly older women, helpless or even dead in their homes (Gurley, Lum, Sande, Lo, & Katz, 1996). This is referred to by Campion (1996) as being "found down" (p. 1738). Because older adults who live alone may not be able to summon help, this discovery often is a result of a neighbor noticing they have not seen an elder for several days. Data suggest that 3.2% of older adult men and women age 65 years and older who live alone will be found down each year (National Center for Health Statistics, Cohen, & Van Nostrand, 1995).

Living alone may be related to declining health for older women with severe health impairments. Among a group of severely impaired elderly women in Baltimore, those who lived alone had a greater deterioration of functioning when compared to those living

with others (Sarwari, Freedman, Langenberg, & Magaziner, 1998). Research on the older adult population in Hong Kong has suggested that elders who live alone, compared to those who live with others, perceive their health more negatively (Chou & Chi, 2000). Elders who live alone are also more likely to enter a nursing home than elders who live with others (Steinbach, 1992; Wolinsky, Callahan, Fitzgerald, & Johnson, 1992).

There may also be psychological ramifications of living alone for this population. According to Dean, Kolody, Wood, and Matt (1992), living alone may play a role in the development of depression. Mui and Burnette (1994) also report higher rates of depressed mood among elders living alone. Furthermore, a recent study of community-dwelling individuals ages 75 years and older suggests a strong positive relationship between living alone and loneliness (Routasalo, Savikko, Tilvis, Strandberg, & Pitkala, 2006), a finding corroborated by other studies (e.g., Chou & Chi, 2000; Mui & Burnette, 1994). A study of community-dwelling Chinese elders (60 years and older) suggests that life satisfaction may be lower for older adults living alone when compared to older adults in other community living situations (Chou & Chi, 2000).

POSITIVE PERSPECTIVES ON LIVING ALONE

International, national, and local policy has recognized the need to decrease social isolation and loneliness among older adults to improve elders' quality of life (Cattan, White, Bond, & Learmouth, 2005). Although many of these policies target older adults living alone, living alone is not equal to being lonely (Yeh & Lo, 2004), and some have suggested that elders who live alone are not a group deserving of high-risk status (Iliffe et al., 1992). In fact, living alone is a highly valued way of life for older adults who desire to remain independent (Yeh & Lo, 2004). It is not surprising that older adults who value privacy also strongly prefer their own residence (Kim & Rhee, 1997). Although some may assume that these elders living alone are in need of special intervention services, a body of research suggests that they may not have greater physical and mental health needs when compared to older adults in other community living situations.

Some research on the mortality rates of those who live alone has suggested that living alone does not negatively impact survival (Davis et al., 1997; Davis, Neuhaus, Moritz, & Segal, 1992). In fact, some research (e.g., Zimmer, 2005) has indicated that older unmarried women living alone are less limited by health factors than older unmarried women who live with their adult children or others. In addition, a recent study of older adults living in New Mexico (both men and women) indicated that elders living alone did not have higher rates of health problems such as diabetes, hypertension, arthritis, emphysema, and asthma (Tomaka, Thompson, & Palacios, 2006). When subjective ratings are used to measure health, older adults living alone rate their health more positively than older adults living with others (Mui & Burnette, 1994). In sum, older adult women who live

alone seem to be no less healthy than other older adult women, and some studies even find that they are healthier than their counterparts who live with others.

Qualitative research has pointed to the strong meaning of *home* to older adult women living alone (Swenson, 1998). The sense of self appears to be connected to the home environment, and some women feel an attachment to the home that they are committed to maintaining for as long as possible. Homes give meaning to their lives, and maintaining a home is key to independence (Letvak, 1995). Women may also prefer the living arrangement of their own home to "keep the generations separate" (Porter, 1998, p. 401) and not burden adult children. This symbolism and importance of the home environment may be important for professionals working with older adult women because the home may play a somewhat intangible role in maintaining and improving women's physical and mental health.

PURPOSE

Although authors (e.g., Findlay, 2003) have suggested that the increase in older persons living alone should trigger concern of social isolation, there are older adult women who live alone and are resilient from social isolation and loneliness (Letvak, 1997). Some older adult women even see later life aloneness as an opportunity to establish creativity and new meaning in life. There is great variability in older women's perceptions of living alone and the perceived advantages and disadvantages of the living arrangement. However, little research has acknowledged elder women's perspectives on living alone (Porter, 1994). In this descriptive study, a strengths approach was taken to examine the subjective perceptions older adult women living alone have of their living arrangements. Older women were divided into three groups (negative, neutral, and positive) regarding their perception of living alone. In addition, older women's responses to questions about their likes and dislikes about living alone and their levels of loneliness and depression were explored.

METHOD

Sample

Participants were 53 older adult women (age 65 years and over) who lived alone in the local community. Women were recruited through flyers posted at senior centers, physical therapy clinics, doctors' offices, urgent care clinics, community libraries, bookstores, and quilting stores. Interested participants were asked to call the researcher to determine their eligibility and set up an appointment for an interview. Women ranged in age from 65 years to 93 years. All participants identified themselves as White/European-American.

Forty participants (75%) were widowed, nine participants (17%) were divorced, and 3 (6%) had never married. The remaining participant's husband was in a nursing home with end-stage Alzheimer's disease. Among the 40 widows, the mean number of years since being widowed was 12.1 (SD = 11.04, min = 0, max = 53). Of the 53 participants, 5 (9%) indicated that their highest level of education was "less than high school," 32 (60%) indicated "high school diploma/GED," and 16 (30%) indicated they had attended at least some college. All except for three participants (94%) had worked outside the home during their life, and five (9%) were currently working part-time (ranging from 5 to 20 hr per week). Seventy-nine percent (n = 42) of the participants owned their own home. Excluding the never-married participants, only four (10%) women had lived alone before their marriage. Only one of the four lived alone for longer than 6 months before marrying. The remainder moved directly from their parent(s)' home into a residence with their husband. Although the group overall was in good health, 29 participants (55%) indicated symptoms of arthritis and 7 (13%) indicated they had diabetes.

Procedure

Whereas one woman preferred to be interviewed at a local restaurant, the remainder of interviews were conducted in the participants' home. Interviews lasted approximately 1 hr and participants were compensated with a $15 gift certificate for their time. Data collection began in July of 2007 and ended in November of 2007. With the exception of measures of depression and loneliness, the questionnaire used in this study was constructed by the researcher.

Perceptions of living alone. Participants were asked the following open-ended question: "How do you feel about living alone?" All of the responses were coded as positive, negative, or neutral by the researcher. A graduate student then coded 100% of the responses to determine interrater reliability (94%). Although many participants responded with several advantages and disadvantages of their living arrangement, the first response given by the participant was decided to be most important for coding purposes.

Most and least enjoyable aspects of living alone. All participants were asked to list the three most enjoyable and three least enjoyable aspects of living alone. Most, but not all participants were able to provide three responses for both items.

Depression. The 10-item short-form Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977), a self-report measure designed for the general popu-

lation, was used to assess depressive symptoms in participants. Respondents indicate how many times per week they experienced each item, using a scale ranging from *rare or none of the time* to *most or all of the time*. The internal consistency for the 20-item measure has been shown to be .85 for the general population (Radloff, 1977). Higher scores indicate more symptoms of depression. It should be stressed that this scale measures depressive symptoms and does not determine a clinical depression diagnosis. However, a cut-off of greater than or equal to 8 has been used to indicate the presence of clinically relevant depressive symptoms. This measure has been validated for use with older adults (Irwin, Artin, & Oxman, 1999). Possible scores range from 0 to 30, and Cronbach's alpha in the present study was .80.

Loneliness. The UCLA Loneliness Scale, a 20-item measure, was used to measure loneliness (Russell, Peplau, & Cutrona, 1980). The scale assesses general, or global loneliness, and is one of the most widely used loneliness measures. The scale uses a 4-point system (1 = *I have never felt this way*, to 4 = *I have felt this way often)*. Possible scores range from 20 to 80, with higher scores indicating higher levels of loneliness. Perry (1990) indicated ranges of 20–34 for low levels of loneliness, 35–49 for moderate levels of loneliness, and 50 and higher for moderately high or high levels of loneliness. Cronbach's alpha in the present study was .84.

Other variables Participants were also asked to provide the following ratings and indications: their health on a scale of 1–10, their closeness to neighbors on a scale of 1–3, how many close friends lived within 50 miles of their home, how many hrs a week they spent volunteering, their fear of living alone and the difficulty of living alone on a scale of 1–10, their daily level of pain on a scale of 1–10, and how many days per week they typically drive. In addition, participants were asked questions about their family and marital history.

RESULTS

Perceptions of Living Alone

Thirteen percent of the participants ($n = 7$) had responses coded as negative, 49.1% ($n = 26$) had responses coded as neutral, and 37.7% ($n = 20$) had responses coded as positive. Examples of negative, neutral, and positive responses are displayed in Table 1. Table 2 displays means of study variables by group (negative, neutral, and positive) and for the sample as a whole. Because of the small sample size (and the particularly small number of participants in the negative group), no inferential statistics were performed on this

TABLE 1
Examples of Negative, Neutral, and Positive Responses

Negative (n = 7)	*Neutral (n = 26)*	*Positive (n = 20)*
"I don't like it but there's nothing I can do."	"I don't mind it."	"I enjoy it. I do what I want. I love being so blinkin' independent."
"I hate it."	"I get along okay."	"I'm perfectly content here."
"It's really lonely."	"I'm used to it now."	"I love it."
"I can't stand the quiet."	"It's better than a nursing home."	"I could never live with someone else ever again."
"It surely wouldn't be my choice."	"It's alright. I can handle it okay."	"I didn't think I'd like it as much as I do."
"It's the hardest adjustment I've had to make in my life."	"It's not easy, but being here is my choice."	"It certainly has its advantages."

TABLE 2
Differences by Response Type

	Negative (n = 7)	*Neutral (n = 26)*	*Positive (n = 20)*	*Total (N = 53)*
Age	82.71 (5.31)	78.50 (8.18)	72.45 (7.63)	76.77 (8.37)
Length of time (yrs.) lived alone	6.71 (3.63)	14.39 (15.76)	12.60 (9.58)	12.71 (12.68)
Number of living children	5.14 (1.46)	2.19 (1.74)	4.20 (1.47)	3.33 (1.97)
Children living within 50 miles	2.85 (.89)	1.04 (1.40)	2.35 (1.87)	1.77 (1.69)
Health (1–10)	6.57 (1.90)	7.19 (2.17)	8.20 (2.04)	7.49 (2.14)
Neighbor closeness (1–3)	2.71 (.49)	2.15 (.88)	2.40 (.68)	2.32 (.78)
Friends w/in 50 miles	1.86 (2.34)	2.27 (3.82)	2.45 (2.16)	2.28 (3.07)
Volunteer hours	1.43 (2.93)	2.92 (4.68)	2.40 (4.59)	2.52 (4.41)
Fear (1–10)	2.14 (2.19)	2.08 (1.85)	2.50 (2.14)	2.25 (1.98)
Difficulty (1–10)	7.71 (2.28)	3.88 (2.76)	2.30 (1.45)	3.79 (2.82)
Pain (1–10)	4.28 (1.98)	3.38 (1.96)	3.35 (2.56)	3.49 (1.69)
Days drive	2.57 (1.51)	4.88 (2.80)	4.20 (2.42)	4.32 (2.60)
Loneliness	29.14 (3.53)	30.12 (8.54)	26.90 (6.31)	28.77 (7.30)
Depression	9.71 (2.87)	8.65 (5.84)	4.35 (2.80)	7.17 (5.02)

data. Although caution should be applied when making conclusions based on group comparisons, it may be useful to look at trends in the descriptive data. The positive group was the youngest group ($M = 72.45$ years; $SD = 7.63$), and the negative group was the oldest ($M = 82.71$ years; $SD = 5.31$). In addition, self-rated health appeared to differ between the three groups; the positive group's self-rated health mean was 8.20 ($SD = 2.04$), whereas the neutral ($M = 7.19$; $SD = 2.17$) and negative ($M = 6.57$; $SD = 1.90$) groups perceived their health more negatively. Interestingly, the negative group had lived alone ($M = 6.71$ years; $SD = 3.63$) for about half of the length of time of the neutral group (14.39 years; $SD = 15.76$) and the positive group (12.60 years; $SD = 9.58$). The negative group ($M = 7.71$; $SD = 2.28$) also perceived the difficulty of living alone as greater than the neutral ($M = 3.88$; $SD = 2.28$) and positive ($M = 2.30$; $SD = 1.45$) groups. The negative group ($M = 9.71$; $SD = 2.87$) appeared more depressed than the neutral ($M = 8.65$; $SD = 5.84$) and positive ($M = 4.35$; $SD = 4.35$) groups.

Most and Least Enjoyable Aspects of Living Alone

Participants were also asked about the three most and least enjoyable aspects of living alone. Ten of the 53 participants (19%) were unable to come up with three enjoyable aspects, and two participants (4%) said there were no enjoyable aspects. Common responses were being one's own boss/being independent ($n = 27$; 51%), keeping one's own schedule ($n = 26$; 49%/), being able to eat what one wants ($n = 22$; 42%), having control of the TV/remote control ($n = 20$; 38%), having quiet around the home ($n = 9$; 17%), not having to cook ($n = 7$; 13%), not having to take care of anyone ($n = 6$; 11%), not feeling obligated to keep the home clean ($n = 5$; 9%), and having the bed to one's self ($n = 3$; 6%). Nine of the 53 participants (17%) were unable to come up with three aspects of living alone that they did not find enjoyable, and three participants (6%) responded that there were no aspects of living along that they did not enjoy. Common responses for least enjoyable aspects were lack of companionship/no one to share things with/loneliness ($n = 33$; 62%), no one to help with housework ($n = 19$; 36%), fear of getting hurt/falling ($n = 16$; 30%), no one to help make decisions ($n = 9$; 17%), home is too quiet ($n = 9$; 17%), and home maintenance (plumbing, electrical, yard work; $n = 8$; 15%).

Depression and Loneliness

Actual CES-D scores ranged from 1 to 19 (possible range 0 to 40). Overall, 41.5% ($n = 22$) of participants had a score equal to or greater than 8 on the CES-D short form, indicating depressive symptoms of clinical significance. Within the negative group, 71.4% ($n = 5$) of the participants had depressive symptoms of significance. This percentage was 53.8% ($n = 14$) for the neutral group and 5% ($n = 3$) for the positive group. Actual loneliness scores ranged from 20 to 45 (possible range 20 to 80). Examination of the entire sample revealed that no participants reached moderately high levels of loneliness, and 22.6% ($n = 12$) indicated moderate levels of loneliness. Whereas no women in the negative group reached moderate levels of loneliness, 38.5% ($n = 10$) of the women in the neutral group and 10% ($n = 4$) of the participants in the positive group indicated moderate levels of loneliness.

DISCUSSION

This data points to the tremendous heterogeneity in older adult women's perceptions of living alone. Although participants lived in the same area and identified with the same ethnic background, women's perceptions of living alone ranged from extremely negative to extremely positive. In addition, most women viewed living alone as neither all positive

nor all negative. Most (64%) were able to identify both positives and negatives to their living arrangement.

Only seven of the 53 participants perceived living alone negatively. The vast majority of women in this study (87%) viewed living alone either positively or neutrally. This is not to imply that this 87% did not see negative aspects of living alone. However, when asked how they felt about living alone, their first response was not negative. The majority of the women in this study were living alone for the first time in their lives; most did not live alone before marriage. The findings imply that although many women must adjust to living alone for the first time late in life, they are able to successfully adapt to their new living arrangement. Professionals should be encouraged by this, particularly when one considers that several women who perceived living alone positively lost their husband to death when they were 75 years old or older.

Which women appear to be likely to perceive living alone negatively? Although the sample size was too small to perform inferential statistics, future researchers may want to explore some of the trends seen in this sample. For instance, women who negatively perceived living alone appeared to be older; however they also had lived alone for a shorter period of time. It would be useful to determine whether these trends are evident in larger data sets. Participants who negatively perceived living alone were also likely to be in poorer self-reported health than other participants. Only longitudinal datasets with larger samples could determine whether a person's perception of living alone changes as their health, age, and time living alone change.

What do older adult women enjoy about living alone? Although many mention the value of independence, many participants also mention what could be considered small pleasures: having control of the remote and TV, being able to eat when one wants, having the bed to one's self, and not having to cook. In fact, several women confided that widowhood brought the revelation that after 40 years of cooking, they really didn't like to cook at all! Of course, other women may miss having loved ones for which to cook. What do older adult women dislike about living alone? More than half of the participants cited having no one to share day-to-day experiences with, or lack of companionship. Although most were not significantly lonely overall, this implies that they do sometimes experience aspects of loneliness. Women also mentioned having no one to help with housework and home maintenance as well as fear of falling as disadvantages of living alone. Perhaps these responses reflect the participants' fear of having to leave their home because they cannot keep up with home tasks or are unable to maintain physical safety. Previous research (e.g., Letvak, 1997; Swenson, 1998) has suggested the importance and value of maintaining one's home environment for similar women.

About 40% of the participants showed clinically significant symptoms of depression. However, this should be interpreted with caution because the measure used (CES-D) does not diagnose depression. Although a significant majority reported clinically significant depressive symptoms, the range of scores (1 to 19) was large. In fact, 17% of the sample scored a 1 on the measure. In summary, some older adult women have significant

depressive symptoms, but many do not. This heterogeneity emphasizes the importance of assessing depression rather than making assumptions based on an older adult woman's living situation. Although participants showed varying levels of loneliness, none of the participants indicated levels of significant loneliness reaching more than moderate. This finding is encouraging, as this group of women seems to have maintained satisfying social networks despite living alone. Although this may not be true for all older adult women living alone, this sample suggests that for women elders, living alone does not necessarily equate to loneliness.

Although this exploratory study has yielded interesting and useful findings, conclusions must be limited for several reasons. The small, homogeneous, convenience sample included 53 European-American older adult women living alone. Obviously, this study may lack generalizability. On a scale of 1 to 10, women's responses regarding their self-perceived health ranged from 3 to 10. However, the mean (7.49) indicated that this was a sample in good health. This is not surprising, because women in poorer health might be unlikely to initiate involvement in the study. Older adult women living alone who perceive their health as very poor are certainly a population deserving of more attention. Women in our sample also averaged 2.5 hrs per week of community service work (mostly through church). This indicates that perhaps women who wished to be involved in the study were more active and community-minded than other women living alone. Older adult women who live alone and are quite isolated from the community may have not been included in our sample. In addition, this study was cross-sectional rather than longitudinal. Data yielded a snapshot of older adult women living alone, whereas a longitudinal study might tell a story that it is not possible to uncover with this methodology. It is impossible to determine how perceptions of living alone may change across time with cross-sectional data collection. It would be reasonable to assume that feelings about living arrangements are dynamic rather than static, but this study cannot address this assumption. For instance, some longitudinal research using small samples (e.g, Morrissey, 1998) suggests that women who live alone tend to see a change in the nature of interaction (from independent to dependent) as time progresses.

IMPLICATIONS

How would this information be used by community nurses? Nurses should be aware that although some have perceived older adult women living alone as a vulnerable population, these women vary tremendously and one cannot make assumptions based on living arrangements. Whereas some older adult women living alone may be in need of services that provide social connection, many are not. Some women may be at-risk for depression, but others are very satisfied with their lives and living situations. The only way to distinguish these women is to thoroughly assess them as individuals. Furthermore, similar features of living alone may be perceived differently by different women. For instance,

many women mentioned that their house was "quiet." However, some indicated this was a positive and others indicated this was a negative. Participants also mentioned a change in eating and cooking habits when transitioning to living alone. Yet, several women saw being able to eat when they wanted and to only cook when they felt like it as a perk of living alone. Others missed sitting down to a meal with a loved one. When a woman indicates to community nurses that her home is quiet or that she doesn't cook anymore, the nurses should take the time to determine whether the woman views that as an advantage or disadvantage of her living arrangement. This understanding will help to ensure clients' voices are heard when suggesting programs and interventions.

Nurses should also be aware of the enjoyment that older adult women may obtain from living alone, even if it requires an adjustment late in life. This enjoyment may make older adult women more resistant to suggestions of a change in living arrangement, whether that suggestion is to move in with family or to a facility (e.g, assisted living, nursing home). A change in living situation may require giving up control of the remote and the flexibility to eat when one wants, both of which were appreciated by the participants in the study. Also, when providing information about resources, nurses should be aware than many women's dislikes about living alone pertain to not having help with housework and home maintenance. Perhaps providing suggestions about obtaining assistance in these areas, particularly at a low-cost, would help women to increase their enjoyment of living alone. Many women also indicated a fear of falling in the home. Nurses can provide information about services that alert loved ones and emergency services to a problem with the elder. Perhaps by helping women obtain resources to minimize these dislikes, nurses can assist elder women, particularly those who perceive living alone positively, in remaining in their homes. As a nurse, one should recognize that even older adult women who have never lived alone before can successfully adapt to their new living arrangement and learn to appreciate the small pleasures of living alone.

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