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Perspectives of Older Persons on Bathing and Bathing Disability: A Qualitative Study

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Abstract

Background—Bathing is an important and potentially challenging self-care activity, and disability in bathing is associated with several adverse consequences. Little is known about older persons' experiences with and perspectives on bathing.

Objectives—To understand the bathing experiences, attitudes, and preferences of older persons in order to inform the development of effective patient-centered interventions.

Design—Qualitative Study using the Grounded Theory framework.

Participants—Twenty-three community-living persons, age ≥ 78 years, identified from the Precipitating Events Project (PEP).

Approach—In-depth, semi-structured interviews were conducted in the participant's home.

Results—Three themes emerged: 1) the importance and personal significance of bathing to older persons, 2) variability in attitudes, preferences, and sources of bathing assistance, and 3) older persons' anticipation of and responses to bathing disability.

Discussion—The bathing experiences described by study participants underscore the personal significance of bathing and the need to account for attitudes and preferences when designing bathing interventions. Quantitative disability assessments may not capture the bathing modifications made by older persons in anticipation of disability and may result in missed opportunities for early intervention. Findings from this study can be used to inform the development of targeted, patient-centered interventions that can subsequently be tested in clinical trials.

Keywords

Baths; Disability; Qualitative; Preferences

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INTRODUCTION

As an important aspect of self-care among older persons, bathing serves the physiological purpose of cleaning away accumulated waste materials and dead skin that might otherwise lead to infection. It also serves the social purpose of maintaining an acceptable standard of cleanliness and provides individuals the opportunity to revive and refresh through the washing process. Bathing is a complex task involving multiple subtasks, such as undressing and drying one's whole body.¹ The incidence of bathing disability (defined as needing personal assistance with bathing) per 1000 person months is as high as 23.0 for persons aged 70 to 79 years and 43.6 for persons aged 80 years or older.² Bathing disability is independently associated with the risk of a long-term nursing home admission³ and is a primary indication for home aide services.⁴ Moreover, bathing disability is a strong predictor of disability² in other essential activities of daily living and mortality.⁵⁻⁷ Nonetheless, relatively little is known about how best to forestall bathing disability and maintain independent bathing function. Because bathing is a highly personalized and culturally-informed activity, interventions to enhance bathing may be more effective if they are tailored to the preferences and goals of older persons.^{8, 9} Incorporating patient preferences into the development of bathing interventions may increase their use and allow older persons to maintain their regular bathing routines, which is critical to forestalling future decline and disability.^{10, 11}

The paucity of data on the preferences and goals of older persons regarding bathing, coupled with the complex nature of the bathing task, support the need for a qualitative analysis of the bathing experience. Prior studies of bathing among older persons have primarily used quantitative methods to elucidate the epidemiology of bathing disability¹⁻³ and to assess the use and efficacy of bathing interventions^{12, 13} but have not described the bathing experiences of older persons or their attitudes toward bathing disability and preferences for intervention. The use of qualitative methods in disability research has been shown to lead to a more robust understanding of disability, by uncovering additional layers of complexity in individuals' responses to disability, than quantitative methods can alone.¹⁴ Thus, the purpose of this qualitative study was to explore and understand the bathing experience from the perspective of older persons, by describing their practices, preferences, and goals regarding the bathing task.

METHODS

Design

We applied the key concepts of Grounded Theory¹⁵ to examine and describe the bathing experiences, practices, and preferences of community-living older persons. Grounded Theory is an inductive qualitative research method that enables key themes regarding a specific phenomenon to emerge naturally from the raw data through a recursive process of data collection and data analysis. This approach is ideally suited to our purpose of describing a previously unexplored phenomenon.

Participants

Potential participants were identified from the Precipitating Events Project (PEP), an ongoing longitudinal study that initially included 754 community-living persons, aged 70 years or older, who were nondisabled in four essential activities of daily living (ADLs), including bathing. The initial exclusion criteria included significant cognitive impairment with no available proxy, inability to speak English, a life expectancy of 12 months or less, and a plan to move out of the New Haven area during the following 12 months. The assembly of the cohort has been described in detail elsewhere.^{13, 16}

PEP participants completed a home-based, comprehensive assessment at baseline and subsequently every 18 months for 9 years. The 431 PEP participants who were alive and available to undergo their 108-month assessments were sequentially evaluated by a trained research nurse for inclusion in the current study. Of the first 98 assessments that were conducted after the protocol for the current study was finalized, 50 participants were excluded for the following reasons: 1) the assessment was conducted in a nursing home or by telephone (n=11), 2) a proxy was required to conduct the assessment (n=23), 3) the nurse for the assessment or the interviewer for the qualitative study determined the participant to be a poor candidate for the study (n=11), or 4) the participant refused to be contacted about the study (n=11). Of the 42 participants who were eligible, 3 refused participation in the current study.

In an iterative process consistent with Grounded Theory sampling methods, we purposefully sampled the 42 eligible participants to obtain broad representation according to gender, race, mode of bathing, and self-reported bathing ability. In addition, we collected and analyzed the interview data as we enrolled participants into our study. New participants continued to be enrolled and interviewed until theoretical saturation was reached, whereby it was apparent that no new themes would emerge with the selection of additional participants. We reached theoretical saturation after conducting 23 interviews.

Data Collection

Data were collected through semi-structured in-depth interviews, lasting approximately 45 minutes, conducted in participants' homes by a research investigator (SCA). The discussion guide (provided in Appendix A) used open-ended questions covering relevant topic areas including childhood and current bathing habits, the meaning and purpose of bathing, difficulties and concerns about bathing, goals and preferences for independent bathing, and the use of and attitude towards different types of bathing assistance. After six interviews were completed and reviewed, the discussion guide was refined to capture more fully in subsequent interviews the primary concepts that emerged from these early interviews. Interviews were audiotaped by the research investigator.

Data Analysis

Interviews were transcribed verbatim by an experienced medical transcriptionist. The Grounded Theory methods of open and axial coding were employed to analyze the data. During open coding, short sections of text representing discrete concepts were identified from the transcripts and tagged with a code. Two investigators (SCA and TRF) independently read and coded three transcripts and then met to review the codes and draft the initial coding scheme. When disagreement existed about the presence, scope, or definition of a code, consensus was reached through a discussion about the coding rationale. The same investigators repeated this process with another three transcripts after which the revised coding scheme was reviewed and further refined by the full research team. New codes were also added to the coding structure during the data collection period, as the investigators identified new concepts not previously captured by the existing codes. During axial coding, we compared codes within and across transcripts to identify larger categories of data and the relationships between them to develop a set of themes that integrated the categories. We supplemented the Grounded Theory approach by triangulating the qualitative data with the quantitative data obtained during the 108-month PEP assessment. We also used the quantitative data to describe the participants. All coding and qualitative analysis was performed using NVivo qualitative data analysis software (QSR International Pty Ltd. Version 2, 2002).

RESULTS

Descriptive characteristics of the 23 participants are provided in Table 1. The mean age was 84 years. About a quarter of participants reported no difficulty with bathing, 35% reported having difficulty but not needing help from another person, while 39% reported needing personal assistance to bathe or being unable to bathe.

Three themes emerged from our analysis: 1) the importance and personal significance of bathing, 2) variability in attitudes, preferences, and sources of bathing assistance, and 3) older persons' anticipation of and responses to bathing disability.

Theme 1: The Importance and Personal Significance of Bathing

Bathing was described as an important and meaningful activity by all of our participants, who expressed several different reasons for its personal significance. For some, bathing was a means to cleanliness, the importance of which was instilled during youth and often related to notions of well-being and virtue.

[My parents] wanted me to be clean to go to church you know and so I used to expect to bathe, put on fresh underwear and get dressed for the weekend or to go to church. I just naturally like to be clean and I'm used to being clean and bathing that's why I like to do it.

I think [bathing] is important - get up every morning and shave and shower and get dressed properly. Even when you don't feel well, get up and get cleaned up and you'll feel better. Cleanliness is next to Godliness, they say.

Other participants discussed concerns about odor, and described a social expectation to bathe.

To me, it's important well social wise, if you get to be near people and you're dirty, people say oh wee, you smell.

Bathing is important; if you want to be out in public or if you want to have friends you'd better be clean or they're not going to hang around you too much.

Other participants described the pleasure and relaxation they derived from bathing.

I love to sit in the tub and soak. Oh you sit there you relax, your whole body is soft.... and sometime you may fall asleep for a little while, yeah relax.

I enjoy a shower, it stimulates me in the morning when I'm groggy and at night when I'm extremely tired I take a shower too because I think it relaxes me.

There were also some participants for whom the personal importance of bathing was based on the need to have a daily routine.

[Bathing] is just living, it's routine, it's like you eat 3 meals a day. You bathe, you get up....it's a project every day. That's the routine and that's how we live, is keep on schedule.

[Bathing] is routine with me anyway. Sometimes I come out 7:00, 6:30 put the coffee pot and go in and shower while the coffee's being made. It's a routine every morning.

Theme 2: Variability in Attitudes, Preferences, and Sources of Bathing Assistance

Participants expressed different attitudes regarding personal assistance with bathing, which reflected the value they placed on bathing on their own versus concerns about bathing safely. For example, these two participants felt strongly about bathing independently:

Oh golly no, I want to do it on my own. They can put bars all around me if they want to. I just have this deep feeling that it's something I should be doing myself, you know and please let me always do it. It's like if I have to accept help I'll have to, but I certainly would go to most lengths not to.

Well, I wouldn't want a caregiver, I think I would use anything that's available for me to use before I start hiring people to come in.

In contrast, the following two participants described a need to feel secure while bathing and preferred to have a person help them bathe:

I'd rather have somebody because I'm afraid I might fall. I mean I can get in the tub but sometimes I can't get one foot in, and I'm afraid if I don't have help getting in I'll fall and bang my head in there.

The help from another person...[that] has been very helpful I need a helper. It's not only safe for me, I feel secure when I have somebody here.

The desire to bathe independently or to bathe with security corresponded with the type of assistance participants were currently receiving, as recorded during the quantitative assessment from the parent PEP study. All of the participants who expressed a desire to stay independent in bathing were currently bathing without the help of another person, while participants whose goal was to be able to bathe securely were already receiving help from a caregiver.

Participants who were not currently utilizing caregiver services to help them bathe expressed considerable variability in their preferences for bath aids. As the three participants below describe, this variability was based on how useful these aids were to the individual in helping them perform the bathing task.

"The [hand held shower] helps me, I can do my back better, I can wash my bottom better. You know, all those things. I like it"

"...and I do use the handles. Oh yeah, they're nice, they're a help. I think it's hard getting out of the tub. Yeah, you have to lift yourself out and all. It helps a lot, yeah."

"I don't like those hand held [showers]. I get water all over everything, I'm clumsy. I'd rather stand there under it, move through it and stand still"

Participants cited a variety of sources of information about bathing assistance. Notably, these sources did not include a professional needs assessment or health care providers' advice on the use of bath aids. Instead, participants considered the use of a bath aid on their own, after receiving information about these aids from such sources as a catalog advertisement or a recommendation from a friend. Two participants commented, respectively:

I was just telling the girl that helps me I need [a grab bar] on the left side.... I saw some in a book that I was looking through and I was thinking about that. Doing it myself, getting one myself because.....I already got a chair from a catalog, so now I got a chair in the tub, a chair for bathing.

...Not the regular bars but I wanted to get the bars that I saw in the AARP magazine and I called them up; it was almost \$900 or something for the one that has a lever that lets you down and a lever that lets you come up..... I was hoping I could get it because that would be so convenient.

Theme 3: Anticipation of and Response to Bathing Disability

Many of our participants expressed the belief that they would inevitably be faced with bathing disability as they aged, even if they were currently bathing without difficulty. For example, one participant who recounted having no bathing or other physical difficulties noted:

I'm sure that eventually I may have to get one of those chairs that you put in the tub because I will no longer be able to get up and down out of the tub. Sooner or later I'm going to have to go to getting one of those chairs because I just won't probably be able to get out. I might even have trouble getting in, I don't know.

In the anticipation of future problems, some of these participants also described modifying their bathing routine, prior to the onset of actual disability. For example, the following participants discussed changing their usual mode of bathing because of an anticipatory fear that they might fall while bathing or get stuck in the tub:

I never felt secure in a shower, I've never been that good on my feet and it was more secure for me to sit down in the tub. Although I never did slip in the shower, I always had a fear that I might....and as you get older it's worse.

I always liked sitting in the tub, but once I started getting in the shower I said I'm not even going to try to get in and out of the bath tub anymore. I'm too old..., something could go wrong you know. Now I like [the shower] because you're in and out ..., and you're not trying to get down. Especially at my age, you're not trying to get down.

Other participants, who were characterized on the quantitative assessment as not needing any help with bathing, discussed restricting their usual bathing because of functional difficulties. For example, one participant described limiting the frequency and way in which she bathed in the tub after a stroke:

I don't really take too many baths today because of my age and the stroke that I had. But what I do, I put just a little water in the shower of my tub and what I do is suds myself all over very, very good several times and then I take my hand shower and rinse myself off, if I don't want to do that I sponge bathe in my sink.

Another participant noted that the onset of arthritis prompted the switch from a tub bath to a shower.

I used to like to sit in the warm water; it was soothing. But, as it became a little more precarious I figured it would be safer to take a shower. Basically I don't sit in the hot water anymore. I go in there and shower, wet myself down and soap myself down and rinse, flush all the soap off me and that's it.

DISCUSSION

In this qualitative study of the bathing experiences of older persons, we identified three themes that illustrate both the importance of bathing and its complexity, in terms of the variability in older persons' bathing preferences and their responses to bathing disability. First, bathing is an important and personal activity for older persons, as reflected in the range of reasons given for bathing by our participants. Second, there is considerable variability in attitudes towards and preferences for bathing assistance, and in the sources of bathing aids. Finally, older persons respond to both current and anticipated bathing difficulty – the latter of which they appear to envision as inevitable – by modifying their usual bathing function.

Existing quantitative studies have described the burden of bathing disability among older persons and identified the ineffectiveness of certain bath aids at forestalling disability, but have not described the attitudes of older persons regarding bathing and bathing disability or their preferences for bathing interventions. One quantitative study that examined the subjective bathing experience among 58 older persons found, as we did, variability in preferences related to bathing practices, but did not elicit the attitudes of older persons toward disability or preferences for intervention.¹⁷ To the best of our knowledge, the current study is the first qualitative investigation of bathing disability and extends prior quantitative work by describing the individual experiences of older persons and their preferences and attitudes about bathing and bathing disability.

Our qualitative approach to studying bathing allowed us to draw out and highlight the personal relevance and significance of bathing among our participants. Our results suggest that bathing for older persons is an activity that may not only serve a functional purpose, but may also be a means of enabling social interactions, of maintaining an order and routine about daily life, and a way to relax and rejuvenate. This underscores the importance of helping older persons to maintain their bathing function and of identifying and addressing their bathing preferences and needs.

Our findings suggest that quantitative assessments of bathing ability may not fully describe the spectrum of bathing disability among older persons. Some of the participants who had reported being able to bathe independently during the assessment from the parent PEP study commented during the qualitative interview that they had modified their usual bathing function by restricting their method or frequency of bathing. This change in bathing routine, which was not captured in the quantitative assessment, suggests that although they were independent with a restricted form of bathing, they may have needed help to continue their prior bathing routine. As such, modification of a usual bathing routine may be an important indicator of decline and future disability. Indeed, an earlier study of 231 older persons found that task modification among those who reported being independent in that task was actually indicative of functional decline, and in some cases denoted functional loss comparable to that of persons who reported being dependent.¹⁸ Bathing independence is usually defined as the absence of bathing disability, or being able to bathe without personal assistance. However, this operational definition may be too narrowly focused to help providers identify an important subgroup of older persons who may currently be bathing without personal assistance but have had to modify their previous bathing routine, and hence are at-risk for future dependence. Prior research has shown that expanding disability assessments from the dichotomous categories of independent versus dependent to include the category of task difficulty can help to identify individuals at risk for future dependence.¹⁹ Adding a category of task modification to bathing assessments may provide yet another mechanism for identifying individuals who are either at risk for future bathing disability, and who would benefit from interventions aimed at maintaining independence with their usual bathing function. In addition, we found that fear of falling was often described as a major reason for modifying one's bathing routine. This finding adds to existing evidence supporting the importance of fear of falling as a cause of bathing disability¹ and suggest that fear of falling should be a component of assessments of bathing function.

Findings from this study also suggest that disability assessments are not being regularly used in clinical practice to inform the provision of appropriate bathing interventions. Most of the participants in this study described considering the use of a bath aid based on a family member's suggestion or a television/catalog advertisement, rather than on a professional assessment of bathing disability. This description of an informal process for obtaining bath aids suggests that, in the absence of a professional assessment of bathing disability tied to the provision of a targeted bathing intervention, these individuals may be underutilizing bath

aids or using aids that are not appropriately aligned with their actual needs. These results complement those of an earlier quantitative study that documented underuse of bath aids among older persons who have difficulty or dependence with bathing.¹³ Incorporating standard assessments of disability into clinical practice could facilitate the formal prescription and use of bathing interventions that are targeted towards individual needs. The variability observed in the type of bath aids preferred by our participants suggests that the prescription of bathing interventions should include several possible approaches, so that individuals can determine the type of assistance best suited to their personal needs and desires.

The perception expressed by our participants that bathing disability is inevitable suggests that interventions to enhance bathing function and promote independence will need to address older persons' expectations regarding disability. Some of our participants restricted their mode or frequency of bathing in anticipation of future disability instead of seeking out and implementing strategies to maintain or enhance their full bathing ability. A similar relationship between older persons' expectation of disability and reduced physical functioning was observed in a prior quantitative study that found an association between negative expectations of aging and decreased levels of physical activity.²⁰ Interventions to promote independent bathing may first need to raise expectations around the inevitability of functional decline in old age. A recent pilot study of a behavioral intervention demonstrated that raising negative expectations about physical activity and old age resulted in an improvement in walking levels.²¹ In addition to raising expectations, interventions that engage older persons in setting specific goals for bathing may also prompt older persons to seek out and implement strategies to maintain and improve their bathing function. An earlier study in the home-care setting demonstrated that an intervention that involved patients in setting concrete goals for their care improved functional outcomes.²²

When designing interventions to enhance independent function, it may also be necessary to consider the preferences for bathing assistance held by older persons. We found that participants who were receiving personal assistance with bathing preferred this type of help, while those who were bathing without personal assistance preferred the use of bath aids to help them remain independent. Although cross-sectional, these findings suggest that some older persons may adapt to functional decline and disability by simply accepting the need for personal assistance and not considering the possibility of regaining independent function. While adaptation has been posited to be an important factor in successful aging,²³ adaptation to bathing disability may have the unintended consequence of engendering a reliance on costly hands-on care⁴. Whether this reliance on personal assistance is amenable to intervention is uncertain, but should be the focus of future research. The strong preferences expressed by independent bathers in the current study to continue bathing without personal assistance support an alternative strategy of intervening prior to the onset of disability or decline. An earlier clinical trial of a home-based physical therapy intervention demonstrated a significant reduction in the progression of functional decline among frail, but nondisabled older persons.²⁴ Such a program of "prehabilitation", focusing specifically on bathing, has the potential to maintain independent bathing and forestall the need for personal assistance.

Study Limitations

Because this was a qualitative study, no conclusions can be drawn around the frequency of the experiences that were ascertained in the interviews. Although we used purposive sampling to capture a wide range of individuals and experiences, our final sample reflected the advanced age and limited ethnic and racial representation of participants in the parent study; hence, we may not have captured the entire range of bathing experiences within a younger population or among ethnic minority older adults. Given the very personal nature of the bathing task, it is possible that participants may have been reluctant to report on some

bathing experiences during the interview. However, the use of prompts, including those that were added after review of the initial transcripts, helped to enhance the collection of key ideas and reports of personal experiences. Finally, this form of inquiry is primarily exploratory and hypothesis-generating, and additional quantitative analysis is necessary to confirm the relationships among older persons' bathing experiences, attitudes, and preferences.

Conclusions

The bathing experiences described by older persons in this study suggest the need for improved assessment tools and interventions that consider the ways in which older persons adapt to changes in function as well as their individual preferences and goals for bathing. A significant challenge for providers will be to identify older persons at risk for dependence and provide appropriate interventions to help them remain independent before the onset of disability. Findings from this study can be used to inform the development of targeted, patient-centered interventions that can subsequently be tested in clinical trials.

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Appendix A –Discussion Guide

I want to thank you for agreeing to this visit today. We really appreciate your participation in our study. As we discussed, our group is trying to understand how older adults remain healthy and get the care they need in the ways that they prefer. Over the years, we have been asking you a lot of questions about bathing. These questions have been based on what we think are the most important issues related to bathing, and the questions, on the whole, only allowed you to give yes or no answers. Today, we want to give you the chance to tell us what you think are the most important issues related to bathing, and we want to do this by having a conversation with you, rather than asking for yes or no answers.

As we discussed, there are no “right or wrong” answers to these questions – we are just interested in hearing your opinions. Also, remember that we are doing this to gather information and not to change your care or routines.

As you recall, I am going to record our conversation so that I do not miss what you are saying. With the tape recorder on, we can go ahead and have a conversation without my having to try and write everything down.

Do you have any questions?

Turn on recorder (ONCE RECORDER IS TURNED ON, STATE PARTICIPANT ID# AND DATE SO THAT THIS INFORMATION IS RECORDED ON THE TAPE BEFORE INTERVIEW)

To begin our discussion I would like you to:

1. Think back in time to when you were a youngster and describe for me your personal bathing habits.
 - a. Probes:
 - i. Purpose: "Why did you bathe?"
 - ii. What type: "How did you bathe"?
 - iii. "How frequent"? "Why with this frequency"?
 - iv. What was your family's occupation?
 - v. Do you think your family's culture played a role in how you bathed?
2. How do these routines compare to when you became an adult?
 - a. Probe: relationship to occupation?
3. Have you made changes to your bathing routines since you were in your 40's and 50's?
 - a. If **YES**, what are these changes?
 - b. If **YES**, why did you make these changes?
 - i. Change in functional abilities (fear of falling, falls, getting stuck in tub, arthritis)
 - ii. Change in environment (bathroom on different floor)
 - iii. Gain or loss of help in the home
 - iv. A specific incident that happened while bathing?
 - c. How do you feel about these changes?
 - d. What effects have these changes had on you?
 - i. Probes:
 - a. Reduced social activities
 - b. Have more need for assistance
4. Based on all of your experiences as you have described them, what would you say you think is the major purpose of bathing? Has this purpose changed for you over time? Why? What are other purposes bathing has had for you either in the past or currently?
 - a. Probes:
 - i. Getting clean
 - ii. Relaxation
 - iii. Washing hair

5. In what ways is bathing important to you?
6. Thinking about all of your daily activities and routines, how much thought do you give to bathing? How much do you worry about bathing? Why?
7. What do you find to be the most difficult part(s) of bathing?
 - a. Probes:
 - i. In/out of tub
 - ii. Getting dressed/undressed
 - iii. Washing, drying
 - iv. Motivation-just getting around to it
 - v. Shampooing hair
8. Are there some innovations or creative ideas that you developed for your bathing routine?
 - a. If **YES**, what are they? What purpose do they serve? What made you decide to do this?
9. Has anyone had suggestions to help you with bathing?
 - a. Probes: changes to environment (e.g. grab bars), personal assistance
 - i. If **YES**, what are they?
 - ii. Have you decided to use these suggestions?
 - iii. If **NO**, why?
10. Describe for me any kind of help that you have received in the past or are receiving now to help with your bathing?
 - a. Probes:
 - i. Help from another person: What kind of help? Who? Paid or unpaid?
 - ii. Help from equipment: Changes in your bathroom or special equipment (grab bar, shower chair).
11. Of the changes you have made and the help you have received, what has been the most helpful in bathing? Why?
12. What has been the least helpful in bathing? Why?
13. Describe for me any times when your bathing was more restricted than it is now, such as when you were in the hospital or were too sick to bathe the way you do now)?
 - a. What was your reaction to the restrictions on your bathing?
 - b. What helped you to get back in your prior bathing routine? (i.e. facilitators)
 - c. What made it more difficult/not possible to return to your prior bathing routine (i.e. impediments)?
14. Describe any concerns, issues, problems, or dissatisfactions you have about the way you bathe now?

- a.** Probes:
 - i.** Not as frequent as desired
 - ii.** Fears about safety
 - iii.** Need for personal assistance
 - iv.** Not able to soak in warm water

15. Do you sometimes have difficulty making it to the toilet in time?

- a.** If yes, how does this affect your bathing?

16. What are your thoughts and/or concerns about bathing as you get older?

- a.** For people expressing more than one concern: Which of these is the most important to you? Why?
- b.** What do you think would be the best way to fix your concerns?
- c.** What ONE THING would you change about your bathing?

17. How important is it to you to be able to bathe independently, or, in other words, without the help of someone else? Why do you say that?

18. Thinking about the different kinds of help you can get for bathing, what are the differences to you between getting help from another person and making physical changes, such as changing where you bathe, getting equipment for the bathroom, or installing grab bars? Is one type of help better or worse? Why:

TABLE 1

Description of Participants (n=23)

Characteristic	Value
Age, years, median (IQR)*	82 (81–86)
Female, N (%)	14 (61)
Race/Ethnicity, N (%)	
Non-Hispanic White	18 (78)
Black	4 (17)
Hispanic	1 (4)
Education, years, median (IQR)	12 (9–14)
Number of chronic conditions, median (IQR)	2 (1–3)
Chronic Conditions, N (%)†	
Hypertension	14 (61)
Arthritis	12 (52)
Myocardial Infarction	6 (26)
Cancer	5 (22)
Diabetes	5 (22)
Chronic Lung Disease	5 (22)
Stroke	3 (13)
Congestive Heart Failure	2 (9)
Hip Fracture	2 (9)
Mini-Mental State Examination score, median (IQR)	27 (22–29)
Mode of Bathing, N (%)	
Shower	17 (74)
Tub	3 (13)
Sponge	3 (13)
Bathing Ability, N (%)	
No difficulty	6 (26)
Difficulty, but requires no help from another person	8 (35)
Requires help or unable to bathe	9 (39)

* Interquartile range.

† Presented in descending order according to prevalence.