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Contours of “here”: Phenomenology of space for assisted living residents approaching end of life

Ann E. Vandenberg^a, Mary M. Ball^a, Candace L. Kemp^c, Patrick J. Doyle^{b,d}, Meredith Fritz^a, Sean Halpin^a, Lee Hundley^a, and Molly M. Perkins^{a,e,f}

^aDivision of General Medicine and Geriatrics, Emory University School of Medicine, Atlanta, GA, United States

^bCenter for Innovative Care in Aging, Johns Hopkins School of Nursing, Baltimore, MD, United States

^cThe Gerontology Institute, Georgia State University, Atlanta, GA, United States

^dBrightview Senior Living, Baltimore, MD, United States

^eDepartment of Sociology, Emory University, Atlanta GA, United States

^fAtlanta Site, Birmingham/Atlanta VA Geriatric, Research, Education and Clinical Center (GRECC), Atlanta, GA, United States

Abstract

Informed by theory from environmental gerontology, this study investigates how assisted living residents who are approaching end of life navigate and experience space. Since its development, environmental gerontology has moved beyond the concept of person-environment fit to encompass aspects of place attachment and place integration, processes by which inhabited impersonal space becomes a place of individual personal meaning and this person-place relationship evolves with changing needs. Our study is a secondary data analysis of in-depth interviews completed with the first 15 residents (mean age 88, range 65–103; 8 white and 7 black) recruited from four diverse assisted living communities in metropolitan Atlanta. Using interpretative phenomenological analysis, we identify five overarching themes within and across assisted living communities and their subthemes. Findings show that participants experience a neutral theme of shrinking space, negative themes of confinement and vulnerability, and positive themes of safety and intimacy. Results dovetail with other phenomenologically based environmental gerontology research from community-dwelling populations that indicate behavioral changes to accommodate aging and health decline. Findings have implications for interventions to improve place integration in AL and enhance residents' quality of life at end of life, including developing strategies to promote small meaningful journeys within context of shrinking life space.

Corresponding author: Ann Vandenberg, PhD, MPH, Assistant Professor, Division of General Medicine and Geriatrics, Wesley Woods Health Center of Emory University, 1841 Clifton Road NE, Rm 546, Atlanta, GA 30329. Phone: 404-728-6872. Fax: 404-728-6425.

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Introduction

Assisted living (AL) is an increasingly common setting for end-of-life services and supports for older adults (Ball, Kemp, Hollingsworth, & Perkins, 2014; Dougherty et al., 2015). This study uses a phenomenological approach to investigate how AL residents who are approaching end of life (EOL) navigate and experience space. In humanistic geography, space has been defined as the physical environment perceived and experienced by a body; space becomes place with emotional bonds and a sense of spatial identity and boundaries, and places can be seen and known from inside the person (Tuan, 1979). Achieving the comfortable feeling of being at home in a space such as AL, or place integration (Cutchin, 2013, 2001), is a goal of humanistic phenomenological geography that we embrace. Place integration moves beyond the seminal concept in environmental gerontology of person-environment fit (Lawton & Nahemow, 1973) to posit that person and place are a relational unity that is continuously negotiated through situational challenges and transactions (Cutchin, 2013). Drawing on Deweyan pragmatism, Cutchin argues that AL residents integrate with place by developing positive habits and that they can be helped to form these habits. This paper draws on this place integration and phenomenology within environmental gerontology to focus on the unique experiences of AL residents nearing EOL.

The current landscape of assisted living in the United States

AL is among the fastest growing sectors of the long-term care industry in the United States, with, in 2014, approximately 30,200 communities serving about one million residents (Harris-Kojetin et al., 2016; MetLife Mature Market Institute, 2013). These non-medical community-based settings, which typically do not provide skilled nursing care, vary in size, structure, ownership type, and levels and combinations of services, accommodations, and amenities and are referred to by a number of labels that often reflect differences in state regulations (Carder, O’Keeffe, & O’Keeffe, 2015). Here, we use the umbrella term “assisted living (AL)” to be consistent with general practice.

In recent years, partly owing to changing regulations and consumer demand, AL communities have been evolving into places with increasingly frail residents aging in place until death (Ball et al., 2014; Khatutsky et al., 2016). A 2010 national survey of AL communities with at least four beds finds that 54% of residents are aged 85 and older, 38% of residents need help with at least three activities of daily living (ADLs), 26% have from four to ten chronic conditions, and as many as 42% of residents have a diagnosis of dementia (Caffrey et al., 2012). Evidence indicates that dementia is underdiagnosed in AL and that as high as 90% of residents have some level of cognitive impairment (Zimmerman, Sloane, & Reed, 2014). Increasing frailty, morbidity, end-of-life (EOL) presence, and death in AL is creating challenges for the industry to retain its original philosophy of providing a homelike social environment distinct from nursing homes’ medical model of care and one that

emphasizes resident autonomy, privacy, and choice (Ball et al., 2014; Barmon, Burgess, Bender, & Moorhead Jr, 2016; Morgan et al., 2014). Within this context, there are national efforts to advance person-centered care, a holistic approach to care that is tailored to the needs, values, and preferences of the individual (Brummel-Smith et al., 2016; Fazio, Pace, Flinner, & Kallmyer, 2018; Love & Pinkowitz, 2013).

Theory development in environmental gerontology and insights from AL research

Since its development, environmental gerontology has moved beyond the concept of person-environment fit to encompass aspects of place attachment, the process by which inhabited impersonal space becomes a place of individual personal meaning (Rubinstein & Parmelee, 1992). Place attachment has roots in philosopher Gaston Bachelard (1958)'s and human geographer Yi-Fu Tuan (1974)'s phenomenological explorations of "topophilia," the affective bond and meanings people attach to place. One benefit of place attachment is the ability to live comfortably and unselfconsciously within the space. Other terms associated with this experience include "existential insidedness" (Relph, 1976), "place insidedness" (Rowles, 1983), "being in place" (Rowles, Oswald, & Hunter, 2004), and "at-homeness" (Seamon, 2012). Place attachment becomes especially important with age because it supports aspects of life less related to functioning and more related to one's identity (Rowles et al., 2004; Wahl, Iwarsson, & Oswald, 2012). With age and health decline, people typically spend more time at home, a site most accessible to such insidedness (Rowles, 1978; Rubinstein & Parmelee, 1992).

As a group setting, AL presents challenges for place attachment. Moving into AL is usually a process of downsizing from long-familiar homes encompassing possessions that have become part of one's narrative of self (Rubinstein & de Medeiros, 2005). Finding a setting consistent with one's personal history and identity can ease this transition and contribute to a better person-environment or resident-facility fit (Ball et al., 2005; Perkins, Ball, Whittington, & Hollingsworth, 2012). Considerations of social and interpersonal dimensions of the environment are key to achieving a good fit, enhancing resident well-being, and reducing environmental press (Cutchin, Owen, & Chang, 2003; Leith, 2006; Morgan et al., 2014). The ability to bring furnishings and personal effects is another important way to retain and express valued aspects of one's self following relocation (Perkins et al., 2012). Although promoted as a non-institutional homelike environment, AL is fundamentally different from an individual's home. In contrast to home, it has been described as semi-public space (Milligan, 2006) with interpenetrating public and private spaces (Doyle, de Medeiros, & Saunders, 2012; Roth & Eckert, 2011), where "public" dining rooms can become the site of expeditious medication dispensing or treatment and "private" rooms can be entered by staff without warning. Within the context of this congregate care setting, the concept of "liminality," or threshold space between social structures that allows for redefinitions of identity (Turner, 1975), is useful in describing both the spatial transitions of care from home to institution (Leibing, Guberman, & Wiles, 2016; Shield, 1990) and also the biopsychosocial transitions of EOL as experienced through an increasingly frail body (Black, 2006; Nicholson, Meyer, Flatley, Holman, & Lowton, 2012). As noted by Black (2006), this experience of liminality can be either positively transformative or cause for anxiety and suffering and thus complicate place integration.

In this article, we report on a study that investigates the phenomenon of space as experienced by residents in the liminal world of AL at EOL. By looking at specific depictions of the phenomenon through in-depth resident interviews, we seek to describe patterns of experience that transcend individuals and settings. Phenomenology has been called a “radical empiricism” (Seamon, 2000) that triangulates analysis of data (e.g., interviews) with researcher involvement and empathic understanding. In contrast to positivist methods, phenomenology strives to understand a phenomenon rather than explain it (Seamon, 1982). Our phenomenological approach to space does not assume that an environment has external characteristics that constitute a shared and empirically measurable reality. As each body is empirically different, so are perceptions of space and movement through space. Each person brings different lifetime associations to spaces and objects, affecting perceptions and emotions, resulting in an experience of space on individual terms. By examining residents’ experiences and perceptions of space in depth, we seek to understand how they experience space, including what helps or hinders place integration and, in so doing, to provide insights that can inform person-centered care in AL.

Methods

Participants

Participants for the current study are part of a larger qualitative study that is using multiple data collection methods (in-depth and informal interviews, participant observation, social network mapping, and health and sociodemographic surveys) to identify best practices for end-of-life and palliative care in AL. Data are currently being collected in four diverse AL communities in metropolitan Atlanta chosen to reflect variation in ownership type (corporate, non-profit, family-owned), size, licensing, resident income level (high, moderate, low), resident/staff profile, and location (urban versus suburban). To protect anonymity, we refer to each community with a pseudonym (Parkside, Fairhaven, Summit Place, and Sunbrite) (Table 1). To be eligible for the larger study, residents have at least one of the following criteria: are 85 years of age or older, have multiple chronic conditions, are diagnosed with a life-limiting illness, and/or use hospice. Within these criteria, we are using purposive, maximum variation sampling (Patton, 2002) to select residents who vary in characteristics such as race, age, gender, socioeconomic status, clinical conditions, functional status, availability of informal and formal supports, and residence inside or outside of a dementia unit.

This paper represents a secondary data analysis of in-depth interviews completed with the first 15 residents enrolled in the larger study, representing all 4 study homes. The size of the resident sample is proportional to the size of each study home (5 at Parkside, 5 at Fairhaven, 4 at Summit Place, and 1 at Sunbrite). The study conforms to requirements of Emory University’s Institutional Review Board. We assign pseudonyms to each participant to preserve anonymity (Table 2).

Instruments

To reduce participant burden, the resident interview is designed to be completed in five-to-six parts and includes five semistructured interview guides, a health assessment, a brief

sociodemographic survey, and a social network map. Interview topics include: personal history and the move to AL; daily life; social support network; care needs, self-care, and formal healthcare; perceptions of care and care relationships; attitudes and knowledge regarding hospice and palliative care; perceptions and experiences related to death and EOL in AL; EOL decision-making; and views of the self within context of past, present, and future life. Interviews typically are conducted across five or six different days and therefore capture different time points, physical states, and moods. One question in the first interview directly related to perceptions regarding space: “Do you view (name of community) as home? (Probes: why/why not, resident’s definition of home).” Other questions that tap into residents’ perceptions and experiences related to space and place integration include, but were not limited to, queries regarding daily routines; attitudes about AL as a place to live and die; changes in daily life since moving to AL and over the course of living in AL; care routines and health behaviors; social relationships and interactions; and views of the self.

In addition to other health measures, the baseline health assessment includes measurements of grip strength, assessed with a hand-held dynamometer, and cognition, measured with the Montreal Cognitive Assessment (MoCA) (Nasreddine et al., 2005). We also collect information on prescribed medications and clinical diagnoses from resident records. Time to complete all six parts of the resident interview in the current study ranged from 2.06 to 8.17 h, with a mean of 4.95.

Data analysis

Our analytical approach is interpretative phenomenological analysis (IPA), following Smith, Flowers, and Larkin (2009). This approach has been used in environmental gerontology to describe the phenomenon of aging in place with visual impairment (Rooney et al., 2017) and the experience of being monitored by technology in one’s home (Pol et al., 2014), among other topics. IPA typically involves a small sample that permits idiographic detail to be revealed and focuses in depth on what matters most to participants, the meaning of those things, the language participants use, and the context of their concerns.

Digitally-recorded interviews were professionally transcribed verbatim and each transcript was read multiple times before coding began. Next, each transcript was analyzed individually through two stages of coding. In a first round of analysis, transcripts were coded for noteworthy descriptions (e.g., objects of importance to the speaker), linguistic constructions (e.g., repeated phrases used by the speaker), and concepts (e.g., getting lost). This stage expanded the data under examination. In the second round of analysis, each transcript was analyzed with emergent theme labels, reducing the data into manageable slices. The process was repeated for each of the transcripts. Once all 15 transcripts were coded, a third round of analysis was initiated to label emergent themes within and across cases. In a fourth stage, a master table of themes was produced, showing relationships between themes and subthemes. The method thus moved from the specific and individual towards more abstract concepts useful in describing the full study sample. Each stage of the process was iterative, requiring adjustment of terminology and scope of emergent themes as the coding process compared data within and across transcripts.

The primary author coded all manuscripts through stages 1–4. The master table of themes and subthemes with textual data by home and resident was then presented to the full author team at a series of analysis meetings where findings were discussed, questioned, reexamined, and revised as needed to achieve consensus. In addition, the first author prepared an additional biographical profile of each study participant, putting coded material into the chronology and context of the resident's life, and sent this narrative to each community site lead, with queries regarding interpretation of the data. The site leads responded to questions, edited the narratives, and offered additional comments. Any interpretive grey areas were discussed by the full author team until consensus was reached. These biographical profiles served as the basis for the two illustrative cases selected for presentation in the Findings section to show how the themes interact in the context of the resident's life. The primary author collaborated with the senior author in revising and refining the final narrative, which, consistent with IPA (Smith et al., 2009), involved additional analysis throughout this and earlier writing stages.

Findings

Sociodemographic and health characteristics

Tables 2 and 3 summarize participants' sociodemographic and health characteristics for this study. Participants range in age from 65 to 103 years (mean age 88), most (12) are female, and they are racially diverse (8 white and 7 black). Only five (May, James, Maria, Ruby, and Lucy) regard their AL community as "home." Most (13/15) use assistive devices to ambulate and 3 need help propelling their wheelchairs outside of their rooms (e.g., to meals and activities); 7 need help with 3 or more ADLs. Participants have an average of 4 chronic conditions, with a range from 2 to 6. Seven have a dementia diagnosis; 6 have mild cognitive impairment, and 8 have moderate to severe cognitive impairment. Ten out of 14 who completed a grip strength test are physically frail. One could not complete the grip strength assessment because of severe arthritis. Nine participants report moderate to severe pain and 5 report severe to very severe pain; 4 use hospice.

Themes

We identify five primary themes within and across the homes, each with overlapping subthemes. The first theme, shrinking space, describes residents' experience of their world inside AL growing smaller. As connections to the outside world fade and residents' movements and activities are reduced, spaces and interactions inside AL assume more macro-level qualities (e.g., halls are described as "streets" and groups of residents are described as "crowds"). Whereas five participants regard AL as "home," 10 do not, indicating a lack of place integration among two-thirds of our participants. While the theme of shrinking space is generally described in neutral terms, the themes of confinement (feeling trapped by the environment) and vulnerability (feeling threatened by the environment) are depicted with negative feeling. In contrast, the themes of safety (feeling safe in the environment) and intimacy (have relationships in the environment) are depicted positively. Table 4 defines and provides an example of each theme by subtheme.

Illustrative cases

Two contrasting cases below demonstrate how the themes operate and interact in the lives of participants. While both experience shrinking space in AL, May's narrative expresses the predominance of security and intimacy, indicating successful place integration, whereas Michelle's focuses more on the negative themes of confinement and vulnerability, indicating incomplete place integration.

May—May, a 91-year-old Caucasian resident of Parkside, spent most of her life in one Southern state, had a career as an elementary school teacher, and moved to be close to her caregiver daughter in Atlanta when her husband became sick. She has two daughters, one of whom is intellectually disabled. After her husband died and she had an accident with a mechanical garage gate that had crushed her arm and hand, May went to live in an AL. She later moved to Parkside to be closer to her able daughter's home.

May navigates distance through space in a pushed wheelchair, has mild cognitive impairment, and is legally blind, incontinent, and in constant pain from arthritis. May is on hospice for a serious heart condition and needs help with 6 ADLs. Despite these considerable impairments, May states, "I am never really sad." When reflecting back over her life, May stated, "I have had a wonderful life. I've done almost everything I wanted to do." Her lifelong nickname "Ms. Fabulous" was adopted with enthusiasm by the staff. May has lived at Parkside for 20 months and regards it as "home." Her words reflect a bonding with place facilitated by a number of spatial strategies used by herself, her family, and the staff.

May describes a progressively shrinking world. She now needs assistance getting in and out of her wheelchair and misses her independence. Fearful of going out since her accident, she remains inside, preferring being visited to visiting: "I don't really enjoy that [going out.... My daughter] calls me two or three times a week—comes over once or twice a week to bring me my clothes from the dry cleaners, brings her husband. We visit and laugh and talk." May frequently describes visits by other people, including prospective residents, and enjoys playing hostess. When we visit for interviews, she often says that she's put the (fictive) kettle on for tea or that she's put on lipstick in case the President showed up to visit.

May also acknowledges the salience of body parts. Her first action each morning is "opening my eyes," a gratifying action. May faces the pain in her hand with upbeat, good humor: "My hand that's never healed, this is sore, but hey, that's just life. I'll live with it. I just say, 'Hello, hand.'" May takes pride in the small activities that she can do: "I can brush my own teeth, I put my own lipstick on" and "I can pick up that fork and find my mouth." These actions are not taken for granted and seem to number as accomplishments of independence. May talks about the importance of independence: "I try to help myself as much as I can. I like to be as independent as I can."

May has imaginatively constructed Parkside as a miniaturized world. She often tells the story of going on journeys downstairs with the staff, who recognize her love of music, as though they were major excursions. The living room is considered an important space

because her late husband's organ has been placed there on loan for use in weekly church services or other occasions. She describes being roused from her bed in the afternoon:

They know I love music, so they'll say, "Get up, we're going." I'll say, "Where?"
She'll say, "I hear that they're having somebody play the piano," or "Some group of singers are here." I'll say, "Sure." I swing my feet over the edge of the bed, get my slippers on, my shoes on, and away we go.

Once arriving, she will be recognized and will dance: "I'll go down. They recognize me. They'll nod and they'll smile. They know I'm dancing in my chair. *[Laughter]*." May repeats the scenario frequently, with slight revisions. Here she describes it as "traveling":

I get down there, 'cause it's just a minute—put on my lipstick whenever I'm traveling—and I go down there.

May's narratives suggest expansion of her small world, magnifying the possibilities and importance of space and enhancing its pleasure.

May and her caregiver daughter have established spaces and objects within her room that serve as destinations to enhance movement and agency. May's daughter organized her closet to provide easy access, doors replaced by a sliding curtain and daily outfits boldly labeled on successive hangers reachable from her wheelchair. May's daughter collects, launders, and replenishes these outfits in different combinations weekly. May explains, "I can wheel myself in there, I can count and get it (an outfit) down. I want to do as much for myself as I can." The towering grandfather clock given to May by her late husband on their wedding anniversary stands facing her bed. She proudly recounts her daily routine of wheeling to the clock to wind it: "Every night I can wind my clock. I don't have them do that. I do as much as I can for myself as I can."

Rather than negative themes of confinement and vulnerability, May expresses positive themes of safety and intimacy. Upon waking, she summons caregiver help with her call button on the lanyard around her neck. She is proud of this ability, despite acknowledging that help will come without calling because of protective oversight. May also experiences intimacy with people in another dimension. For example, while being interviewed about her many health problems, May recounts that her caregivers will ask, "Ms. May, why are you always smiling, why do you feel so good?" and she will reply, "Because when I wake up and I find out I'm alive I say, 'thank you dear Lord.'" In addition to conversation with God from her bed, May also engages in conversation with her husband through her grandfather clock, which chimes every quarter hour. During our interviews May would often stop talking to listen to the clock chime or even talk back to it, seeing it symbolically as a connection with her late husband, although quite aware he is dead. She once paused and said to the chimes, "I love you, too, darling," explaining, "My clock is talking to me. . . . He [my husband] spoils me rotten." Along with the closet, the clock connects May to family in intimate relationships represented in spaces inside her room.

May often repeats two refrains, or similar patterns of sentences, to express her consciousness of and emphasis on ongoing life and agency in space despite physical limitations at EOL. Such refrains, which were common among residents across the homes, would be repeated

over and over again with slight changes in sentence structure in the context of her declining condition. The first was her gratitude at simply being alive:

They [caregivers] always say, “Ms. Fabulous, we know you’re legally blind but why are you always smiling?” I said, “Because I have a good appetite, the food is good and I don’t have to do the dishes, and I can get my lipstick on without hitting my nose.”

In this refrain May acknowledges one of her limitations (blindness) but turns her attention to what she can still do – eat and put on makeup. In the small symbolic action of putting on lipstick, Ms. Fabulous calls attention to the ongoing skill of her hand in reaching the important destination of her mouth. The other refrain is her being woken up while sleeping in the afternoon in her room, told that there are musicians downstairs, and making the journey downstairs to hear them. Here too she puts on lipstick because she is “traveling” downstairs to the concert hall in the living room in this miniaturized world. The importance of having journeys and preparing for them, however small the world, characterizes this woman’s existence at the end of her life:

Well, I’ve just gotten older and have lost a lot of my vision through macular degeneration, but I still want to get dressed up. I still want to get dressed up. I still love music. I still attend the services.

In our discussions of death May is aware that she is on hospice and that she has signed a do-not-resuscitate order. She would like to die in AL, describing a good death as, “I’m in bed. I close my eyes and I’ve said my prayers then I don’t wake up in the morning. Just go to Heaven. Just like that. I’m not worried about death.” A person of faith, she states that if she has a significant health crisis “I’d like for nature to take its course. It’s up to God.” May wants to be cremated and her ashes mixed with her late husband’s ashes: “Take us outside, our ashes, sprinkle them on the ground and let the birds come and eat.” May envisions a comfortable death space as her bed at AL and future existence for both body and soul after death in sacred spaces on earth and in Heaven.

May’s narrative illustrates the potential pleasures of safety and intimacy within shrinking space. With family support to organize her closet and bring two prized family possessions into the environment (clock and organ), May’s AL is a rich miniaturized world in present AL space moving towards an unknown but comfortable and unthreatening future space in burial and afterlife.

Michelle—Michelle, an 85-year-old African-American resident, has lived at Fairhaven about as long as May has lived at Parkside, 21 months at the time of interview. Michelle grew up in rural Georgia and enjoys remembering the fresh air, fruit and apple trees, and woods that she would walk through in her youth. She worked at a beer tavern, and she and her husband had one son. Now a widow, Michelle came to Fairhaven after her son found her passed out at home, having forgotten to take her hypertension medicine.

Michelle is more physically functional than May but more cognitively challenged (with a diagnosis of dementia and a MoCA score of 10). She is visually impaired, has hypertension, and a diagnosis of depression, but has no reported ADL needs or physical pain. Unlike May,

Michelle does not consider Fairhaven “home,” describes her stay as “temporary,” and longs to return to her former home. Her definition of quality of life, “a comfortable home,” is lacking, as are privacy and connection with the outer world, both keenly valued. Although Michelle does not feel at home in AL, she acknowledges her current need for care. She says, “I’m trying to make the best of it. I appreciate this place, because there’s no telling what would have happened to me if we didn’t have a place like this to come to.”

In discussing her transition to AL, Michelle acknowledges that her world has grown smaller but indicates she has adapted to these changes: “I like to window shop. I like to go to the bakery. What else do I like to do? I like to go where you play games (the arcade). But I have adjusted.” Yet, when asked if there is anything she would change in her life if she could, Michelle stated: “I wouldn’t be here.”

On rare occasions Michelle’s son brings her home to visit him but more often he visits her, although not as frequently as she would like. Michelle laments, “He does not like to be around all these sick people.” Michelle passes time by participating in activities such as bingo and exercise class. She sometimes offsets reduced mobility in the form of stiffness by exercising in her room. This condition too she accepts: “Once you get old, ain’t nothing you can do. Can you see me out on the floor, jumping?”

Michelle expresses the salience of the parts of her body that still function, such as her eyes and vocal chords in praying for their preservation:

I always pray that I won't ever be where I can't speak. I understand what a person is saying, talking to me, what they're meaning. Every time I ask the good Lord to help me or show me, I always get an answer. It's been that way all my life. Please don't let me be blind! Don't let me lose my vocal chords!

In contrast to May, Michelle’s miniaturized world is limited and impersonal, with a distance between her and others. Although both women report having small social support networks, Michelle reports a lack of support compared to May. Michelle describes herself as “antisocial.” She reports that her closest relationships are with family members who are deceased, saying “I have never found another person that would replace some of them.” When asked who she can rely on for comfort and support, Michelle replies, “Nobody but God, honey.”

Unlike May, Michelle expresses the themes of confinement and vulnerability with regard to space, in addition to safety and intimacy. She describes herself as “confined” and elaborates on being cut off from the world:

Maybe Roy Rogers I heard sing “Don’t fence me in.” I’m fenced in. It took me a long time to get used to being fenced in. You come to this world [AL], you don’t see nothing. You go out here [out her door]. All you see is them same people every day. They might be happy. They might be sad. You don’t say anything to ’em in the hall. I know I gotta stay my distance, because they’ll make you nervous, being around people. You don’t know what to say to them. I guess they don’t know what to talk about. That includes the staff. They don’t know. Nobody discusses weather, what the headlines were in the paper, just general things.

Here Michelle refers to the common spaces “out here” as “this world” but they are monotonous and cut off from activities and events outside. She longs for conversations over common reference points to the broader world, such as weather or news headlines.

Michelle also feels vulnerable. She values privacy and regards her room as her sanctuary. She enjoys doing puzzles in her room, especially when she wants to avoid residents she does not like or who “get on [her] nerves.” She portrays interactions with staff in her room as disrespectful, even rude:

Somebody come in the door and ask you a question before they say, 'Good morning.' That pisses me off. Say, 'Good morning,' or 'Good evening,' whatever time you come in the door. Don't come in the door asking me something. When I first came here, it used to be, 'Have you had a BM (bowel movement) today?' Come in the door asking that before they say, 'How are you?' Call my name: "How are you, Ms. Michelle?"

The caregiver's behavior seems to belittle the autonomous realm that a room door normally signifies. Michelle feels similarly about visits by her son early in the morning or by caregivers summoning her for exercise when she prefers not to go. She copes with these intrusions by feigning sleep, retreating into her body. Michelle also fears loss of possessions, stating that “I don't keep nothing personal here (in the room) 'cause it might walk.”

Despite feeling confined and vulnerable, Michelle experiences intimacy in another dimension. She speaks to God daily about personal matters and also engages in reminiscence. Here, Michelle recalls the enjoyable act of lying in bed and reflecting on her “wild” youth:

You lay down, relax by yourself, and think about way back when you was, I'm gonna say in the streets. You think about some of the things you did. Some of them was good. Some of 'em was bad. You wouldn't try it again, but [it was] fun. Like I told you one time, I was in here laughing to myself, because I talk to myself.

Through her imagination and memories, Michelle finds deep meaning and also effectively extends space, thus countering the theme of confinement in sometimes successful ways.

Michelle's views on death are in some ways similar and in striking ways different from May's. Like May, Michelle views a good death as dying in her sleep but she expresses it in more negative terms as avoiding a bad death (i.e., not being murdered, not committing suicide, not having an accident such as drowning, and not having a long lingering illness). Like May Michelle sees dying as a movement from one space to another, as “leaving this world one of these days” to “cross that river,” with some curiosity about it (“I don't know what's on the other side”). She does not talk about Heaven, however. Instead she talks about rejecting cremation in order to avoid burning (“I might go to Hell after I die. I don't wanna burn two times!”) and about already owning a burial plot where her body will go. Michelle states matter-of-factly, “It's almost the end of my life.” Yet unlike May, Michelle is “not ready yet” for death. In fact, she wishes to beat her mother's age of death at 96 to reach 100, which would mean that she would live 15 more years. If she has a significant health crisis, Michelle, in contrast to May, wants to live as long as she can and “I want them to do

everything they can, because I don't think you going until God get rid of ya." She does not have a DNR because "I want everything I can get." Michelle describes an uncomfortable atmosphere of secrecy surrounding death at Fairhaven which seems to puzzle her. She understands that "They don't wanna upset anyone. But we are old people. We are used to death, you know?" According to Michelle, deaths at Fairhaven are not announced and residents find out about them because they notice relatives visiting uncharacteristically, flowers bouquets appearing, and residents and staff whispering about newspaper obituaries. At times, a resident's room is turned into a funeral home where "they take dimensions of the body" and residents are asked if they would like to "go view the body."

In addition to reporting some discomfort related to deaths she has experienced at Fairhaven, Michelle expresses some anxiety about her own death. When asked how she would compare herself as a younger person to the person she is now, Michelle admits some past sins (e.g., "getting tipsy" to the point of falling) that she worries she may have to "pay for" (i.e., by going to hell). When asked at the end of the resident interview if she had any final thoughts related to EOL in AL, Michelle said, "I wish someone could tell me how it feels (to die). I want to know what kind of feeling do you have. . . . I wanna know how a person feels when they have a heart attack. . . . I wanna know how to brace. No one's ever been able to tell me that." As Michelle discusses the experience of death at Fairhaven she stops talking to listen, and says "That's my nerves. I thought somebody was knocking on the door" – as though the subject of death increases her sense of vulnerability in space.

Discussion

Our interpretative phenomenological analysis of the experience of space by residents of four diverse AL communities indicates most broadly that space shrinks as these older adults decline and cope with challenges associated with advanced age, frailty, multimorbidity, and physical pain at EOL. Residents report that their range of motion decreases; they travel less frequently to places and people offsite, and increasingly are the focal point of visits from those outside; body parts acquire new salience; and the miniaturized life-world inside the home takes on aspects of the larger world outside.

The theme of shrinking space within AL is not surprising, given the abundance of research showing age-related spatial reduction among community-dwelling elders. Rowles's seminal phenomenological study (Rowles, 1978) found a tendency towards geographical and activity constriction, as well as a change in orientation that selectively intensifies around certain zones, such as home, and spaces within those zones, such as a central chair. Older adults with health decrements spend increasing amounts of time closer to home (Rowles et al., 2004; Rubinstein & Parmelee, 1992). Other behavioral research has focused on age- and disease-related processes that gradually reduce "life-space," the physical area of functioning in one's life (Baker, Bodner, & Allman, 2003). The current research indicates that these age- and disease-related processes similarly reduce space for older adults who are aging and dying in place in AL.

As subthemes, reduced mobility and salience of body parts are closely related and may be explained by what Lindenberger, Marsiske, and Baltes (2000) theorize as "age-associated

permeation of behavior with cognition,” which may accelerate at EOL. As Viv states (Table 4), as one’s range of movement and stability decrease, one’s mental effort to physically accomplish an activity and keep from falling increases. Close-at-hand spaces such as those on the body become sites of both agency and destination, as in bringing one’s hand to one’s mouth, which is also an example of a small journey in a miniaturized world. At this level the theme of shrinking space suggests a radical shift in scale and perspective near EOL, one that we think caregivers should understand in order to deliver person-centered care.

Findings show that many AL residents in the current study generally accept and have developed strategies to cope with age- and disease-related functional decline and the associated reduction in life-space. However, attitudes towards the AL environment evoke different emotive characterizations. The fact that two-thirds of our 15 participants do *not* regard AL as “home” may be explained in part by our two emergent negative themes of confinement and vulnerability. Those who feel confined to an institution reference rules, staff surveillance, and furnishings designed for visitors rather than for the comfort of residents. Others who view AL as “home” express experiences associated with more positive themes, such as safety and intimacy.

Previous research shows that how residents characterize their initial move into AL often shapes their subsequent adjustment (Perkins et al., 2012). Michelle views her move as temporary and hangs onto the fantasy of one day moving back to her former home whereas May has embraced AL as “home.” Michelle’s fantasy provides her with some hope regarding the future but limits her ability to adapt to AL and achieve place integration. Findings suggest that May, who has the lifelong nickname, “Ms. Fabulous,” has personal strengths she has developed over her life course that perhaps make her better equipped to adapt to loss and other difficult life transitions, such as the move to AL and EOL, compared with Michelle. Whereas May is at peace with her past life, her current life in AL, and also with dying, Michelle is conflicted and expresses some anxiety related to EOL, living in AL, and her life in general. While she enjoys reminiscing about her “wild” youth, she also expresses some guilt regarding some aspects of her earlier life she perceives as “bad” and fears she might have to “pay for” once she dies. Although Michelle says she has adjusted to moving to AL, her narrative indicates an inability to adjust to this space she does not perceive as “home.”

May’s comfort in AL is bolstered by her daughter’s thoughtful organization of the space inside her room that facilitates actions symbolic of independence, such as wheeling to the closet to get down a hanger with the day’s outfit or reaching up to her grandfather clock to wind it. Such thoughtful arrangement of space gives it the contours of personal place as opposed to just space. It also facilitates the establishment of meaningful habits that are the hallmark of place integration. Few residents have this type of support which likely is an unrecognized need. In contrast to May, Michelle expressed a lack of meaningful destinations and journeys within AL and has the perception that she cannot keep any personal possessions in her room; she experiences a contour-less liminality that contributes to her inability to feel at home in AL (Black, 2006; Cutchin, 2013).

May's spatial support is a benefit of her social support network, which Michelle lacks. Michelle's relationship with God gives her some strength but she reports a lack of connection with other people. Our previous research (Perkins et al., 2012; Perkins, Ball, Kemp, & Hollingsworth, 2013) shows that residents who lack meaningful ties to others are less well equipped to cope with life's challenges compared to those who have stronger social support networks; this lack of support also can negatively affect overall well-being. Michelle is socially isolated and experiences what Charmaz refers to in her study of the chronically ill and dying as a "restricted existence" (Charmaz, 1983). Although May's life space is restricted, she has relational and spatial supports in place that provide her with meaningful connections to people and place that promote feelings of intimacy and comfort as opposed to the sense of confinement and vulnerability that May experiences. Michelle also exhibits some anxiety regarding approaching death compared with May who says she is not worried about death. Unlike May and ten other residents in the current study, Michelle reports no physical pain. Yet, she is clearly suffering. Psychological pain as well as physical, social and spiritual pain are all forms of suffering that limit the ability to cope with the liminality of living in AL at EOL and have been identified as an important public health problem (Bern-Klug, 2010; Morrissey, 2011) that have not received much attention in the AL literature.

Several of our participants in AL indicate feeling cut off from the world. Many hunger for connection to shared cultural life beyond AL. Michelle, for example, cannot find valued reference points of weather or news headlines in interactions with co-residents or staff. We were surprised by the number of participants across all homes who, like Lucy (Table 4), take pleasure in reading, including many residents with substantial cognitive impairment. In keeping with Cutchin's concept of place integration, residents can be helped by administrators and care managers to form habits and routines that make reference to the outer world, possibly thereby promoting a sense of spatial continuity and lessening the sense of loss and confinement within the AL setting. Consistent with earlier research (Kemp, Ball, Hollingsworth, & Perkins, 2012), we find that expanding space by creating visual and imaginative opportunities can counteract residents' sense of confinement and promote meaningful social interaction. Unfortunately, in some residential care settings caregivers underestimate the importance of enrichment and personal growth activities, such as keeping up with the news, learning, or engaging in religious services and therefore do not expressly encourage them (Heid, Bangerter, Abbott, & Van Haitsma, 2017).

The theme of vulnerability is another indication of inability to achieve the comfort level of place integration in AL. The semi-public status of resident rooms (Milligan, 2006; Roth & Eckert, 2011) is a new experience for most residents and can be unsettling to their sense of privacy. The issue of theft in long-term care has rarely been examined (Harris & Benson, 1998), although industry and community news stories suggest that it is an ongoing problem. Loss of possessions is also a common perception or misperception among residents, especially those with cognitive impairment (Alzheimer's Association, 2017). Some interview passages suggest that residents are often unsure whether possessions are being taken by staff or being lost by themselves; the disorientation or uncertainty over what is happening in spaces around them may contribute to vulnerability. Furthermore, professional caregivers operate under conditions of suspicion and within relationships with flexible parameters of gift and social exchange (Buch, 2014), whereby residents expect or ask for extra favors and

may repay them with gifts or money, against home policy. Without clear parameters to distinguish resident disorientation from gift giving from stealing, a sense of vulnerability can pervade AL communities.

Despite these negative themes, five of the study participants *do* regard their AL community as home, suggesting that place integration may be achievable rather than an unrealistic expectation. We were heartened that residents across the homes experience protective oversight within AL. They feel safe and empowered through the use of their call buttons, phones, and other methods to summon help. Comments about safety allude to an underlying sense of danger that is being handled well. Two months before dying, James (Table 4) states, “you can get lost in this building.” Although with his considerable dementia he doesn’t understand how his call button works, James views it as an ever-present lifeline between himself and the staff. Again, such small spaces as hand and button can be sites of empowerment for even the most impaired of residents.

In addition, residents across homes indicate higher levels of comfort and place insidedness through narratives of intimacy (with people inside and outside AL, with nature, with people in another dimension). May communes with her late husband through her grandfather clock, whereas Michelle travels back in time and memory to places of former activity; each experiences pleasure in these imagined actions. This finding supports Rowles’s (1978) observation that vicarious forms of geographical experience increase with age, involving both reminiscence and projection. Evidence indicates that reminiscence or life review can be an effective intervention at EOL and increase older adults’ ability to cope with suffering and accept death (Bern-Klug, 2010) and may be one creative method Michelle uses to expand her space beyond the perceived confines of AL. Our theme of intimacy interacted in interesting ways with our theme of constriction, suggesting that AL communities that offer what we might call “windows on the world” can lessen the theme of constriction. These narratives offer useful ideas for supporting residents whose spatial area is shrinking but whose space in other dimensions, including spiritual space, is without limit. Cutchin suggests that the use of “imagined possibilities” could help residents with place integration in AL (Cutchin, 2013).

The example of May, who expresses active and ongoing place integration within AL, suggests that shrinking space might be effectively mapped into zones to support person-centered care. Instead of Rowles’s general schema of home, surveillance zone, neighborhood, city, and “beyond spaces” (Rowles, 1978) and the University of Alabama Life-space Assessment tool’s concentric geographical zones of bedroom, home, outside house, neighborhood, town, and “unlimited” (Baker et al., 2003), zones in AL might include body, room, building, outdoors, and community. This schema could be used by caregivers to map specific resident actions and small journeys in those spaces that give residents pride and joy. An understanding of these activities could offer opportunities for support, such as articulating and announcing occasions for favorite journeys (e.g., music in the living room), supporting preparation for the journey (e.g., putting on lipstick), and recognizing arrival (e.g., greeting at living room destination). It might also become an assessment tool for identifying functional changes in a resident. Finally, a life-space assessment tool for AL could be the foundation for larger-scale research aimed at testing the hypothesis that life-

space continues to shrink within AL and is a marker of increasing debility until a threshold of impending mortality.

At the same time that a life-space tool could map opportunities for agency within a shrinking world, such as micro-behaviors in body space that constitute independence (e.g., brushing teeth), it could also ensure that spaces are anchored with objects symbolic of residents' identity that can become destinations for journeys in room, building, or outdoor space. From Rowles we know that as space constricts and orientation intensifies, feeling intensifies also around certain objects or spaces that have been meaningful in one's life (Rowles, 1978). AL administrators and others involved in the transition to AL might consider recommending to residents and families that they move cherished objects into AL that promote meaningful journey-making (e.g., May's grandfather clock). We know that the transference of belongings in place-making is important in later life well being because of their symbolic expression of identity (Perkins et al., 2012; Rowles & Ravdal, 2002). Lack of a cherished object has been identified as a source of disease within long-term care settings (Sherman & Dacher, 2005). By facilitating the import of cherished objects, AL communities may support experiences of intimacy in space that transcend confinement.

Lucy's relationships with characters in books, residents' relationships with late spouses, relatives, or pets, and intensifying conversations with God suggest that vicarious, alternative spaces could also be mapped to reduce confinement in physical space and promote a quality of intimacy in space. Television is a ubiquitous and passive medium in AL, commonly on in each resident room and in shared living areas as we ll. Administrators and caregivers should consider promoting other more interactive forms of media. These could include radio, newspapers (e.g., newspaper coffee klatch), books (e.g., resident book clubs), atlases (to share geographical trajectories by residents and staff), video chat with residents' family and friends or, collectively, with residents in another AL, and participation in a community's Facebook page. Many of these ideas would no doubt come from clues or outright suggestions by the residents themselves.

We believe that creating supportive spaces and small journeys within the context of shrinking space would constitute a form of person-centered care. Our findings and their implications are corroborated by a study of frail community-dwelling older adults characterized the dying trajectory as persistent liminality between living and dying and identified attempts to "retain anchorage" through connections to the physical environment as well as through routines and social connections (Nicholson 2012). Our findings are further supported by the landmark SOC theory of successful aging, which posits a process of Selection (reducing activities to the most valued), Optimization (specializing in them), and Compensation (making use of available supports to accomplish them) (Baltes & Baltes, 1990). As the world within AL continues to shrink, caregiver mindfulness of body spaces as salient places of meaning and action can bring added sensitivity to the palliative and hospice care experience through the last days of life. Addressing the secrecy and discomfort surrounding death and AL spaces where death and dying occur can contribute to easing some of the anxiety we have identified related to living and dying in this environment. An intensified presence inside of "here" by residents (encompassing "there" of past, imagined,

and anticipated e.g., Heaven) supported by caregivers could lead to greater comfort in AL at EOL.

Despite important strengths, we acknowledge some limitations in our study. Our findings are limited to a sample size of 15, a relatively large sample size within phenomenological research but not representative of all AL situations. Furthermore, we limited ourselves to data from interview transcripts. Additional analysis of data from observations and interviews with formal and informal caregivers could offer additional insight and reflections on care delivery within AL spaces and allow us to triangulate data from multiple data sources. Finally, this study is a secondary analysis of data collected as part of a larger study that did not directly investigate residents' experiences with space. Collecting such data directly would undoubtedly lead to additional insights. Regardless, by focusing on residents' experiences navigating space at EOL, this paper makes an important contribution to the environmental gerontology literature as well as to the growing body of research in AL that has drawn on this perspective. Findings also have important practical implications that can inform interventions to improve place integration in AL and increase residents' quality of life at EOL.

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Abbreviations

AL	assisted living
EOL	end of life

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Table 1

Characteristics of study homes

Characteristic	PARKSIDE	FAIRHAVEN	SUMMIT PLACE	SUNBRITE
<i>Licensing category</i>	Assisted Living Community ¹	Assisted Living Community	Personal Care Home ²	Personal Care Home
<i>Ownership</i>	Corporate	Private	Nonprofit	Private
<i>Location</i>	Urban	Urban	Suburban	Suburban
<i>Resident Socioeconomic status</i>	Upper income	Moderate income	Moderate-to-upper-income	Low income ³
<i>Resident racial mix</i>	Majority white	Majority black	Majority white	Black and white residents
<i>Licensed beds</i>	100+	100+	36	6
<i>Occupancy at start of study</i>	106	80	27	6
<i>Dementia unit</i>	Yes	Yes	No	No

^{1,2}In 2011, Georgia added Assisted Living Communities (ALCs) to its existing licensing category, Personal Care Homes (PCHs), to accommodate rising acuity levels among residents and to facilitate aging in place

³This home participates in two state Medicaid waiver programs

Table 2

Sociodemographic characteristics of study participants (n=15)

Name	Sex	Age	Race	Education	Community names	Tenure at community (in months)
<i>May</i>	Female	91	White	Master's degree	Parkside	20
<i>James</i>	Male	85	Black	Some college		18
<i>Harold</i>	Male	93	Black	Degree beyond master's		15
<i>Peter</i>	Male	76	White	Degree beyond master's		5
<i>Viv</i>	Female	94	White	College degree		29
<i>Betty</i>	Female	88	White	High School degree	Summit Place	3
<i>Jean</i>	Female	87	White	High School degree		17
<i>Lil</i>	Female	94	White	Some college		3
<i>Maria</i>	Female	89	White	High School degree		40
<i>Ruby</i>	Female	103	Black	Some college	Fairhaven	67
<i>Bev</i>	Female	100	Black	Master's degree		49
<i>Alice</i>	Female	96	Black	Less than high school degree		22
<i>Michelle</i>	Female	85	Black	Some college		20
<i>Sal</i>	Female	100	Black	College degree		29
<i>Lucy</i>	Female	65	White	College degree	Sunbrite	45

Table 3

Baseline health characteristics of study participants (n=15)

Name	Assistive devices needed to ambulate	Chronic conditions ¹	Number of ADLs ² requiring assistance	On hospice	MoCA ³ score	Grip strength ⁴ (maximum strength in kg.)	Pain score ⁵
<i>May</i>	Wheelchair ⁶	Arthritis Dementia Heart disease Hypertension Osteoporosis	6	Yes	18	8	4
<i>James</i>	Wheelchair	Diabetes Dementia Heart disease Hypertension Stroke	6	Yes	6	24	4
<i>Harold</i>	Wheelchair ⁶	Arthritis Depression Heart disease Hypertension Stroke	6	No	15	26	0
<i>Peter</i>	Walker	Arthritis Depression Hypertension Stroke	2	No	28	28	6
<i>Viv</i>	Wheelchair	Arthritis Hypertension Osteoporosis	2	No	24	18	7
<i>Betty</i>	None	Arthritis Dementia Heart disease Hypertension	0	No	13	8	0
<i>Jean</i>	Walker	Arthritis Diabetes Depression Hypertension	2	No	19	26	3
<i>Lil</i>	Walker	Diabetes Hypertension Stroke	3	No	19	16	4
<i>Maria</i>	Walker Wheelchair	Heart disease Hypertension	2	No	23	14.5	2
<i>Ruby</i>	Cane Walker	Dementia Heart disease Hypertension Osteoporosis	1	No	10	12	6

Name	Assistive devices needed to ambulate	Chronic conditions ¹	Number of ADLs ² requiring assistance	On hospice	MoCA ³ score	Grip strength ⁴ (maximum strength in kg.)	Pain score ⁵
<i>Bev</i>	Wheelchair	Dementia Hypertension	1	No	7	12	0
<i>Alice</i>	Wheelchair ⁶	Arthritis Heart disease Hypertension	5	No	14	NA ⁷	8
<i>Michelle</i>	None	Dementia Depression Hypertension	0	No	10	22	0
<i>Sal</i>	Walker	Diabetes Dementia Heart disease Hypertension Stroke	3	Yes	12	14	4
<i>Lucy</i>	Wheelchair	Arthritis COPD Depression Heart disease Hypertension Osteoporosis	3	Yes	24	18	8

¹Based on a range of 1–10 chronic conditions common in AL (Khatutsky et al., 2016, p. 23).

²Activities of Daily Living (ADLs) based on measure of 7 ADLs derived from the Older Americans Resources and Services (OARS) Multidimensional Assessment Questionnaire (Pfeiffer, 1978).

³Measured on a scale of 1–30; > 26 = no cognitive impairment; 18–26 = mild cognitive impairment; 10–17 moderate impairment; 9 = severe cognitive impairment (Nastreddine et al., 2005).

⁴Maximum pull on a handheld dynamometer; 26 is frail for men 65 and older and 16 is frail for women 65 and older (Alley et al., 2014).

⁵Pain: 0–10 (1–3 = mild pain; 4–5 = moderate; 6–7 severe pain; 8–9 very severe; 10 = worst imaginable) measured using the Iowa Pain Thermometer (Herr, Spratt, Garand, & Li, 2007).

⁶Needs help to propel.

⁷Severe arthritis prevented test administration.

Table 4

Phenomenology of space themes and subthemes

Theme	Subtheme	Example
Shrinking space [The scope of resident's world becomes smaller with decline]	Reduced mobility [reduced capacity to move]	Well [my] thinking process slows down at times. Just you lose your concentration. That's the worst thing, 'cause that can cause falls. You just have to be more cautious. It just changes your whole concept of living. That you don't just go and do whatever comes to mind or something. You have to think about it. Like I have to think about when I go to the bathroom. I have to think about standing and holding on. Make sure I don't lose my balance and fall if I'm pulling up my pants. It just takes willpower, a lot of it. (Viv, Parkside resident)
	Being visited instead of visiting [staying at AL rather than going out]	I'm happy here. I don't even want to go anywhere. My son said the other day, he said, 'I need to take you out to dinner one night.' I said, 'Well, that'd be nice.' I don't really care that much about going out. I'm an old stick in the mud, stay at home. . . . I look forward to my son coming over visiting. (Maria, Summit Place resident)
	Sallience of body parts [preoccupation with parts of the body as spaces of agency, feeling, or communication]	Sometimes I have picked up something, and go to eat it, and I think I got it, and I don't have it. You can't hold it. You feel, they [her hands] stay cold most of all the time. But if you feel 'em this, they don't feel cold. At night, you may sleep under the covers with them, and then you may not. If you don't, they're gonna be just like ice. They'll be so cold. See, I exercise. Like this. Look at em shakin'. When I start movin' them, they start shakin'. Like that. Mash 'em hard. That helps. Sitting on my bed, doing this exercise. (Alice, Fairhaven resident, discussing her hands)
	Miniaturization of the world [incorporating the outer world into AL; making AL spaces stand for places in the outer world][e.g., hall as street]	I don't go to church any longer because if I'm in a crowded place, my breathing is so hard that I don't want to bother anymore. I try not to go to too many crowded places. (Ruby, Fairhaven resident, referring to chapel in assisted living)
Confinement [feeling trapped within environment]	Cut off from outer world [unable to access places and activities outside AL]	Upset at "Not being able to drive or to get out by myself. We go out to eat. That's about all I do because I can't do a lot for myself. . . . That's an activity I enjoy 'cause I'm stuck here all day." (Jean, Summit Place resident)
	Confined to an institution [trapped in a place that does not feel like home]	I want out. There's nothing here that I consider to be abusive, nothing like that, but it's not home. I imagine I'll get accustomed to it. I'm accustomed to having my children being around me, a home kind of setting. . . . I miss the intimacy, and so forth, that I'm accustomed to. (Harold, Parkside resident)
Vulnerability [threatened within environment]	Invasion of private space [interrupted or encroached upon in personal space by other people]	I wished I wasn't here. I think they're [the AL staff] too nosy. They have to stick their head in the door and they look at you and they ask you how they are. You say you're fine, and then they come in and they look at you closer, like you're under an examining glass. (Betty, Summit Place resident)
	Loss of possessions [theft or disorientation]	When I leave, they [AL staff] go in my room and do what they wanna do. . . . All you can do is try to hide it [her cash] and they can find it. . . . You'd be surprised what I have. Mostly on my body. Pin it up. Do something. Sometimes they go in and get [my] glasses. I just put 'em there. Then, they just disappeared. Things like that happen. (Sal, Fairhaven resident describing hiding her money in her bra)
Safety [feeling safe within environment]	Protective oversight [sense that people are watching over resident]	I'm safe. I've sold my house and closed on it. It was under water so I didn't really make anything on it. My kids didn't want me to move home 'cause I couldn't handle that. It's secure here. I have help if I need it. Occasionally, I fall. (Peter, Parkside resident)
	Ability to summon help [having the resources to get help when needed]	All you have to do is just, if you're not feeling good, press the little button there, and very next moment there will be a med tech coming in. 'What's your problem?' That's the greatest thing that I can think of. . . . You can get lost in this building. All you gotta do is just press that button and that button will light up that place. You know pinpoint accuracy for you to leave out. . . . It's just nice, you got so much control. You know that [you] got the hand on that button, where you [can get] help and you're safe. (James, Parkside resident)
Intimacy [enjoying relationships within environment]	Intimacy with present people [relationships with people in social space]	She had told me about her special sweetener for coffee. She said, 'look in my bag,' and I went over there and I found her sweetener sugar. . . . She didn't talk very much and I wish she had talked more, you know? She was a sad kind of person. . . . I don't have a worry about them if they are blind or something. I'm kind to them. (Harold, Parkside resident, describing rare personal contact where he helped a blind resident by moving his wheelchair around hers to get sugar out of her bag)

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Theme	Subtheme	Example
	Intimacy with nature [relationships with animals, plants, or natural elements like the sun]	I enjoy going out. She (daughter) takes me in the wheelchair, and I push a while, and she pushes a while. We always go as far as [the] little ponds and see if there are any tadpoles. Before this last fall, I was walking all the way and back to the doctor's offices back there (down the road from the AL home). They said about half a mile? We'd walk up through there and see all the pretty flowers and the water gushing, and rocks. (L.J.), Summit Place resident talking about taking walks outside her AL home)
	Intimacy with people in another dimension [relationships with people in mental spaces such as media or prayer space]	Sometimes when you get to the end of a book you actually grieve because the people you have come to know and love are no more. They were only a figment of the author's imagination and when that ended so did the imagination, but it's amazing how you can become entwined with the lives of the characters that just come out of somebody's mind and you just don't want to—it's like John Grisham can do that. He can make me grieve at the end of each book because the characters are gone; knowing that Christ is there [also] is very important. Knowing that I can reach him through prayer is very important. Knowing that I'm not alone. (Lucy, Sunbrite resident, who is without family)