Doing It My Way

Lisa E. Skemp, PhD, RN,* 1 Meridean L. Maas, PhD, RN, FAAN, 2 and Michelle Umbarger-Mackey, PhD, RN 3

1 School of Nursing, Our Lady of the Lake College, Baton Rouge, Louisiana.  
2 University of Iowa College of Nursing, Iowa City.  
3 Mount Mercy University, Cedar Rapids, Iowa.

*Address correspondence to Lisa E. Skemp, PhD, RN, School of Nursing, Our Lady of the Lake College, 7500 Hennessy Blvd, Baton Rouge, LA 70808. 
E-mail: lisa.skemp@ololcollege.edu

Received November 9, 2012; Accepted April 23, 2013

Decision Editor: Nancy Schoenberg, PhD

Purpose: Historically, hotels and single-room occupancy residences have provided room, board, and social support services to elders, in particular the poor and the disenfranchised. This article presents the results of a case study drawn from a larger ethnographic community study that set forth to describe how and why elders from one rural community chose to live in a motel in that same rural community. The focus of this study is a description of 7 middle-income and affluent rural elders living in a motel setting as a housing option that enabled them to remain independent in their community. Design and Methods: Using a community study ethnographic design and the strategies of formal and informal interviews, participant observation, and inductive comparative case study analysis, this study provides a description of why these elders decided to live in the motel and how this facilitated their living in the community. Results and Implications: Reasons that these elders decided to live at the motel included “saving my energy for living,” “safety,” “connections and privacy,” and “the freedom to come and go.” This study informs elder care policy, emphasizing the importance of naturally occurring networks to develop community capacity for healthy aging in one rural setting. Key Words: Self-care-related choices, Community, Motel, SRO, Case study

Aging of the United States’ (U.S.) population and concerns about current and future financing of elder care are well known (CMS, 2012). This demographic trend is especially significant in the rural Midwest, which is experiencing one of the largest increases in the proportion of elderly persons in the United States (Johnson & Carsey Institute, 2006). During the period of this research, Medicare and Medicaid expenditures for institutional elder care totaled $52.4 billion (Holtz-Eakin, 2005). Yet most of the assistance that is provided to elders continues to be informal, uncompensated care from family, friends, and neighbors (AARP, 2007; Administration on Aging, 2011). Community-based elder care services, home care, and assisted living programs are intended to assist elders and their family members with meeting needs, maintaining at least a minimal quality of life, and preventing more costly institutional care. In many rural areas, however, these care and living options are not available, and in both urban and rural communities, many older persons cannot afford these options or are required to be impoverished to qualify for federal assistance (Johnson & Carsey Institute, 2006). Further, some elders, even if they can afford to pay for institutional care privately, are unwilling to relinquish the degree of independence and self-control over their lives that would be required (Stafford, 2009). These circumstances prompt a substantial number of elders to seek and create other options, such as service cooperatives and senior cohousing, where elders are “taking hold of their own destiny” and organizing ways to age in place (Stafford, 2009). However, the ways elders have constructed and are constructing these natural systems of care made up of diverse
living arrangements with formal and informal care support, remains understudied (Skemp Kelley, 2005a, 2005b, 2005c; Stafford, 2009). The research reported here describes how some community-dwelling middle-income and affluent elders chose to live in a motel setting and construct their own system of care support. The research shows how this choice helped them remain independent in their local rural community and describes the advantages they perceive for the quality of their lives.

**Living in Hotels and Single Room Occupancy Buildings**

Hotels and boarding houses have provided residence for elders and others since the 1790s (Brownrigg, 2006). In a historical review of hotel living since the early 20th Century, Groth (1994) describes how hotels have provided both permanent and temporary housing to persons of financial means, as well as the poor and homeless. Different kinds of elder residence hotels were available for the different social classes. “Palace” hotels for the affluent anticipated residents’ needs, including servants to clean and maintain their rooms, sophisticated meals, and services to make social arrangements. At the other end of the spectrum, lower class hotels and “flophouses” provided little more than a place to sleep.

Single-room occupancy (SRO) hotels provide inexpensive single-room housing to transient laborers, urban elders, and with the deinstitutionalization movement in the 1960s, the chronically mentally ill. SRO housing is defined differently by state and local ordinance (for an extensive overview of hotel, motel, SRO, and different housing definitions, see Brownrigg, 2006). Generally, SROs, for a short-term rental fee, provide a room, in-room or shared bathrooms, and kitchen facilities (U.S. Department of Housing and Urban Development, 2012). The SRO may have 24-hr desk service, housekeeping, lounge, and a dining area (Groth, 1994; Linhorst, 1991). Building conditions range from well managed, clean, and safe to poorly managed, dilapidated, and dangerous. Historically, urban SRO districts have included Old Minneapolis’s Skid Row (Hart & Hirschoff, 2002), San Diego’s urban district and “skid row” (Eckert, 1980), San Francisco’s Tenderloin District and Gray Ghetto (Minkler, 1985, 2006), Manhattan’s West Side (Burnett & Walsh, 1973), and Chicago’s West Side Main Stem, or Skid Row (http://www.encyclopedia.chicagohistory.org/pages/613.html).

Although some SRO residents historically reported feelings of social isolation (Eckert, 1980; Hoch & Slayton, 1989; Stephens, 1976), there is an extensive body of research on the sense of support, social engagement, improved health status, and sense of community that may develop for hotel-dwelling elders, including those with chronic mental illnesses (Cohen & Sokolovsky, 1979, 1980, 1983; Cohen, Teresi, & Holmes, 1985; Eckert, 1980; Greer, 1986; Hoch & Slayton, 1989; Minkler, 2006; Siegal, 1978; Sokolovsky & Cohen, 1978). In a survey of 485 New York SRO residents, Crystal and Beck (1992, p. 688) found that elders preferred to remain as SRO residents because they could stay in their downtown neighborhoods, maintain independence, and feel safe, “despite some adverse personal experiences.”

Typically, SROs are not regulated through special rules; instead they are an unregulated, low-cost housing option. Section 8 SROs are defined and regulated differently by each state and local government (Brownrigg, 2006), but many other SROs, those located in rural areas and those that serve elders with adequate income, are not regulated. Gentrification of inner cities destroyed many SROs, resulting in a simultaneous rise in homelessness, but this has not been the case in many rural communities.

In an ethnographic exploration of people who live in hotels, motels, and SROs, Brownrigg (2006, p. 10) describes two basic patterns of residence: (a) the person either settles in permanently or sojourns on open-ended stays where they believe the stay is temporary; or (b) the person moves between a particular hotel and other places. However, little is known about rural elders living in motels. It may be instructive to providers of current long-term care institutions and policy makers to learn more about why some rural elders choose to live in hotels, motels, or SROs.

This study reports on seven rural elders who chose to live in the motel and how this facilitated their living in the community. These elders also participated in a larger research project to describe the community care systems of rural elders in the Midwest. Specifically, analysis addressed the question: Why are the elders living in the motel?

**Methods**

**Design and Data Collection Procedures**

The first author was the primary researcher, who conducted a community-based ethnographic
field study that included in-depth within- and across-case comparative analyses of seven elders (Arensberg & Kimball, 1965; Miles & Huberman, 1994) from 2003 to 2005. Ethnographic strategies (Bernard, 1998) included mapping of the community and the motel, document review, ethnographic formal and informal person centered interviews (Levy & Hollan, 1998), focus groups, and participant observation (Dewalt, Dewalt, & Wayland, 1998) while the researcher was living at the motel and also while attending community events (e.g., holiday celebrations, religious services, congregate meals). Elders participated in 1–3 formal interviews (lasting from 1–4 hr) and multiple informal interviews over the course of the study. The 4-hr interview was at the suggestion of one of the participants and included a tour of the community, and introductions to other community persons whom the elder believed would also be interested in the research. For the formal interview, a guide was used that focused on questions such as strengths and needs of the community, strengths and needs of community-dwelling older persons, how older persons acquired the things that they needed to live, services available, and experiences with elder care. Participant observation focused on everyday interactions and observations (Dewalt, Dewalt, & Wayland, 1998) rather than direct systematic observation of behavior (Johnson & Sackett, 1998). Participant observation was recorded from field notes at the end of the day in the researcher’s Microsoft Word©, encrypted, password-protected database. The participant observation notes included the date, place, time, persons who were present (number, gender, other personal characteristics, as appropriate), situational description, and pictorial situational representation (as appropriate and consented). Participant observation included description and direct quotes, and on some occasions, the elders provided their verbal and/or written perspective on what was occurring.

The first author gained trust in the community by meeting and sharing the purpose of the study with formal and informal community leaders, including the Anglo and Hispanic business owners, pastors of the churches, the director of senior services, the editor of the paper, the director of public health, the sheriff, nursing home administrator, community members, and Mrs. Konick, the manager of the motel. After approximately 6 months, a key respected member of the Hispanic community was hired and trained to assist with the research in the Hispanic community. The research assistant did not stay at the motel or participate in the research conducted with the motel elders. The first author travelled back and forth to the community and visited the motel for 2–4 days each month while conducting fieldwork in the Midwestern rural community. The extended length of fieldwork was necessary to capture an ethnographic picture of the larger community and the life patterns of the elders at the motel during the different times of the year. Visits were made at various times of the day, ranging from early morning coffee at 6:00 a.m. to the midnight shift changes of the front desk manager. During these visits, the researcher became familiar with, conducted ongoing interviews with, and engaged in participant observation of the group of elders who had set up residence, some permanent and some intermittent, at the motel. One formal interview and ongoing informal interviews and participant observation with the motel manager, front desk workers, and housekeepers were also conducted, based on their understanding of strengths and care needs of community-dwelling elders and connections to the elders who live at the motel.

Procedures for Analysis

Data collection and analysis were performed as concurrent iterative procedures among different sources of data. Field notes and interviews were transcribed into Microsoft Word©. Data collection was done by the first author, and all of the authors assisted with data analysis and write-up. Participants in the study, except Ms. Bowling, who had moved, did credibility checks of the analysis and themes. Content analysis with inductive coding focused on identifying recurring ideas that were grouped into common themes and relational patterns, focusing primarily on elders living in the motel and their informal and formal elder care systems (Bernard & Ryan, 1998; Miles & Huberman, 1994). Within-case analysis provided a description of each elder, whereas cross-case analysis (Miles & Huberman, 1994) identified the common themes that addressed the specific ethnographic question “Why are these elders living in the motel?”

Rigor was fostered by holding central the four aspects of (a) applicability, (b) truth value or credibility, (c) consistency, and (d) neutrality (Lincoln & Guba, 1985). For example, community representativeness was addressed through the description of the setting so that readers may judge applicability to other settings. Truth
value and credibility were determined for both the data and the data analysis. Truth is subject centered; therefore, credibility of the data was promoted by choosing participants who have experience of the phenomena under study. In addition, credibility of subjective observations was strengthened by verification procedures of time, place, intimacy, circumstance, and consensus (Bruyn, 1966). Credibility was promoted by the researcher establishing presence and trust in the community; providing faithful, rich descriptions of the phenomena over time; ensuring readers of the research recognized the experience; using multiple strategies to explore the phenomena; and confirming through independent sources of data. Consistency was promoted by maintaining an audit trail of fieldwork procedures and data analysis, whereas neutrality was fostered by extensive time spent in the field and the use of multiple strategies for confirmability of findings.

The Institutional Review Board of the University approved the study. All participants provided either written or oral consent. Names and critical identifying information (to include references) of the community and the informants have been changed to protect confidentiality.

Results
Setting

The rural Midwestern community was chosen for the larger study because 14% of the population is of age 65 or older, and it is one of the poorest counties in the Midwestern state (reference omitted to protect community confidentiality). It is a hilly community of approximately 2.2 square miles. Like many small rural communities, there are no means of public transportation. It has a population of approximately 2,000 people, having been settled in the mid-1800s by Anglo-European German, English, Welsh, and Irish settlers. It was a busy community until the decline of the railroads in the mid-1900s. Since the 1960s the community has an increasing Hispanic population (reference omitted to protect community confidentiality). According to Anglo residents, many of the downtown businesses had gone into decline until people from the Hispanic community bought or rented most of the four city blocks and started Hispanic businesses. Other local industries include farming, meatpacking, and service providers, including a locally owned newspaper. There are six churches (including one church that is exclusively Spanish, three exclusively English, and two churches that offer separate English and Spanish services). A community-owned 60-bed Medicare/Medicaid approved nursing home has all Anglo elderly residents and nursing staff. Other organizations that acknowledge provision of some elder services include all of the churches, seven Anglo community groups, a Community Action Center, a senior center, a physician, a dentist, and a pharmacist. No assisted living options are available in the community for elders. In-home elder services are available through the County Public Health Department located in another town. There is no local hospital; however, there are two hospitals within a 60-min drive.

The motel setting is located at the edge of town, three blocks from the senior center, Anglo grocery store, doctor, and pharmacy. A sandwich shop within a 10-min walk from the motel serves early morning coffee, and the senior center within a 15-min walk serves congregate meals Monday–Friday. The motel was recently “fixed up” and is managed by Mrs. Konick, one of the participant-identified, respected community women, from a long established family in the community. The motel has 25 rooms on two floors, including regular rooms, efficiencies, and two luxury suites. Although there is no elevator, there are carpeted well-lit steps with a handrail that provides access to the second floor and one small six-inch step to enter the motel. A variety of historic photographs of the community cover the mauve and off-white freshly painted walls. The motel provides 24-hr front desk assistance from primarily older women who are well known in the community and hired by Mrs. Konick to “look after the place” when she is not there. Mrs. Konick’s husband takes care of necessary “handyman jobs.” There is no restaurant; however, free coffee and doughnuts are provided every morning in the lobby. The lobby includes comfortable chairs, side tables, a television, a ready supply of coffee, and local conversation for those who are interested. The lobby is used as a gathering space around 7:00 a.m. when front desk personnel change, around 10:00 a.m. when the three cleaning ladies “take a break,” and during the early evening hours. Storage units available near the motel cost $25 (5’ × 10’) to $45 (10’ × 25’) per month. The motel provides rooms for customers at a rate of $40–49 per night, depending on whether the customer is a government employee or has a special rate. Customers include a variety of people who are “passing through and need a room,” people coming back home to visit family,
temporary workers at the meatpacking plant, road construction crews, and consultants. The monthly cost is $575 for an efficiency room that includes a private bathroom with shower, a small stove, and a refrigerator.

A well-to-do local businessman owns the motel. Mrs. Konick requested that he “build on to the motel and make a place for more elderly people to live.” When interviewed, the motel owner declined building on to the motel explaining:

We aren’t a place for people that need help. We don’t have a nurse here or anything like that, so if they needed a nurse they would have to be somewhere else. But it is a good place for older people who are independent and need a place to live.

The motel residents, front desk personnel, and housekeepers all knew who was currently staying for extended stays at the motel. They helped residents with errands, medications (e.g., applying eye drops), and monitoring for falls and confusion. The motel owner explained how some questioned if the living arrangement of these elders should be regulated under the auspices of assisted living to protect the elders and owner. According to the State Code, assisted living includes the provision of housing and assistance with instrumental activities of daily living only if personal care or health-related care is also provided, and if response staff are available 24 hr per day to meet scheduled and unscheduled or unpredictable needs in a manner that promotes maximum dignity and independence and provides supervision, safety, and security to three or more tenants in a physical structure that provides a home-like environment (http://coolice.legis.iowa.gov/cool-ice/default.asp?category=billinfo&service=iowacode&cga=83&input=231C). The motel owner chose not to modify the motel, explaining that he was nearing retirement and he had received a request from someone to purchase the motel. After the study was completed, it was learned that the owner sold the motel. The new owners hired new personnel, raised the motel rates, and no longer offered extended stays.

Elder Participants

All of the elders age 65 and older, who stayed at the motel for more than 3 weeks during the study period, agreed to participate in the research. These participants included seven Anglos: a widow, a widower, one gentleman who had never married, and two couples. All individuals were retired, and all previously or currently owned single-family homes. The following within-case analysis provides a brief description of each elder/couple (Table 1).

Ms. Margo was an 83-year-old affluent woman who had lived in the motel for approximately 3 years. Although she had cardiac issues, Ms. Margo described herself as a “health nut” and attributed her health to a natural diet and natural health supplements. She had one son of her own and one stepson, and both lived in another state. Ms. Margo had been a realtor and owned a couple of houses elsewhere in the United States. She sold her house in town and moved into the motel after one of her own sons died of cancer and her second husband became ill. She said it was easier to care for him at the motel than at home because it was on one level, others were around if she needed help, and she did not have any responsibilities for house or yard upkeep. She had a first-floor luxury room. After her second husband’s death, she looked for apartments, but nothing in town was as good as staying at the motel. She liked the convenience and access to the around-the-clock staff at the front desk. The desk service gave Ms. Margo a sense of safety, knowing that if she fell or was ill and needed something she could call out, and someone would be there to help her. Also, the housekeepers cleaned her room daily and came in to change her sheets once a week. She said she could do the cleaning, but to get it really clean, washing the floors and all would take time and tire her out for a day or so afterwards. She usually had juice, toast with peanut butter, and coffee for breakfast, her lunch meal at the congregate center, and cereal with peanut butter, and coffee for breakfast, her lunch meal at the congregate center, and cereal for dinner. This arrangement was very convenient, especially because her cooking would require time to prepare a good meal and the expense of the ingredients. She continued to live at the motel for part of the year. She spent winters in Arizona,
returning to the motel for April through October, when she saw friends and family and took “care of business” (such as visits for her annual health care). Ms. Margo called the motel a “good place for the in-between time, a time when a person doesn’t need a nursing home, but don’t need all of the work of a large apartment or home.” She talked about a friend of hers who would do well living here because it was safe, and her friend would not be so frightened. Right now her friend is living alone on the farm. She is lonely since her husband died. Her children live down the road, and they feel she should not move but should stay close to them. However, Ms. Margo knows her friend is “lonely and frightened, all alone in the big farmhouse.”

Mr. Travelbee was a 76-year-old retired high-school teacher. Although he was not from the rural community, he had lived in town for the last 48 years. He never married and did not have children. Until recently he owned a large house and a good amount of farmland, much of which he restored to wetlands and donated to the State. Upon retiring, since he was generally healthy, despite chronic heart problems, he decided to rent his place and use his time to travel. After he found a buyer for his property, he moved his keepsakes into storage and himself into the second floor of the motel. Over the last 2 years, he spent part of the time at the motel, and when he was ready, he packed his bags and traveled. Having never traveled before retirement, he has now been to Mexico, Russia, Chicago, Peru, and on mission work with the Methodist Church. He calls the motel his homebase. It is a place he comes back to at least yearly for his annual medical exams and to visit friends and cousins. He explained that the people at the motel take good care of him. For example, at one of the visits, the first author found the manager “hunting him down.” Mr. Travelbee had accidentally left his bag containing his medicine on a train. Someone from the train company had found in his bag the motel’s telephone number identified as the place to contact in the case of loss. The manager knew his plans, so by the next day he and the bag were reconnected.

Mr. and Mrs. Jenkins were married and explained that they were in their late 80s. The couple had no children. The Jenkins’ had a century-old farm on the outskirts of town. Mrs. Jenkins reported that she had high blood pressure, and Mr. Jenkins suffered from severe arthritis, which necessitated walking slowly and cautiously in a slumped position with the use of a cane. A “few years back” he had hurt his leg and needed frequent dressing changes and nurse visits. Mr. and Mrs. Jenkins had decided to move into the motel because they had been having difficulties with their plumbing on their farm. They moved to the motel and have lived there for 5 years, finding it “suited them” well. “We like the motel; it’s a good place to stay . . . no hassle with heat, water, or other trivial things. And the housekeepers, those girls are nice, and they take good care of us.” At least twice a day they drive their old red truck out to their farm, spending 3-5 hr taking care of the animals. The couple expressed great pride in their ability to continue to work the land with help from the neighbors and to care for their animals. He continued to raise horses, and she raised sheep. Mr. and Mrs. Jenkins realized the house was in need of repair, but because of the motel, they had not needed to provide any upkeep on the home and were able to save their financial resources and personal time to look after themselves and their animals.

Mrs. Bowling was an 82-year-old retired local businesswoman who had been widowed for 10 years. She had one son, who lived in another town. Her son was concerned about Mrs. Bowling living alone at home, so she moved to the motel. Mrs. Bowling usually came to the early morning conversation and would sit quietly listening to others. She realized she was a bit “forgetful” and becoming easily agitated with others. Mrs. Konick believed that she was in an early stage dementia. Mrs. Bowling had the luxury room with a doorway that opened to the front desk area, so Mrs. Konick could help keep an eye on her. After living at the motel for approximately 1 year, Mrs. Bowling began to demonstrate more confusion. At that time other motel residents expressed concern that she was at risk for wandering off or maybe harming everyone by leaving a stove on or something like that. In response, Mrs. Konick called Mrs. Bowling’s son, and Mrs. Bowling moved, quite unhappily, to the local nursing home.

Mr. and Mrs. Neuhouse were in their early 70s, married, and had lived in the area all of their lives and at the motel for 8 months. After retiring from a local service job, Mrs. Neuhouse started working as what she identified were the “front desk ladies” at the motel, because “I don’t have a lot of friends. I don’t have clubs that I belong to.” She went on to explain, “That’s one reason why I went back to work. You know . . . I sat home and looked at the four walls and thought, ‘Gee, what am I gonna do
today? I just sit here and get fatter . . . grumpier!' So I went back to work.” Mr. Neuhouse had emphysema and asthma with repeated breathing problems, necessitating frequent hospitalization and increasing assistance from his wife. He had also become quite angry and agitated about his condition and consequently was not always pleasant to be around. Mrs. Neuhouse did not want to be home alone with him, so during the second year of the study period, they moved into Mrs. Bowling’s recently vacated room that was adjacent to the front desk. Mrs. Neuhouse found that it was convenient to continue her job at the front desk, and if she needed help, she knew she could depend on the other people at the motel to help her.

Mr. and Mrs. Neuhouse had two daughters who lived within an hour’s drive. Both daughters had offered to have their parents live with them; however, their parents did not want to move. Mr. Neuhouse liked his doctor in town, and Mrs. Neuhouse did not want to live with their children. After 40 years, with Mr. Neuhouse’s worsening condition, they decided to sell their house and four acres of land because “it was too much to keep up.” They were looking for a different house in town, “something to build or buy around $100,000–$300,000.” On the other hand, if the owner of the motel would build more apartment-like rooms at the motel, Mrs. Neuhouse explained that they would have liked to stay here at the motel. Mrs. Neuhouse found support from others at the motel. She could work the desk and still hear if her husband called out for assistance, or stop in to the attached room to check on him. If she wanted to leave, she knew she could count on the person at the desk to help out and let her know if she were needed. She also explained, “It is nice to have someone to visit with now and again. Knowing he is going to die, and I will be alone. I don’t want to be alone in some big house. I like to be around more people, . . . not live alone. And there are less responsibilities [at the motel than on the farm].”

Cross-case analysis identified four interrelated themes that provide understanding for why these elders decided to live at the motel. These themes include “saving my energy for living,” “safety,” “connections and privacy,” and the “freedom to come and go.”

Saving My Energy for Living

Living at the motel allowed personal energy and financial resources to be “saved” by the elders and used for things they wanted to do, rather than had to do. Mr. Travelbee explained, “it was to the point where I wanted to be rid of the home-owner responsibilities: . . . house upkeep, yard, . . . property tax, utilities, . . . I don’t have any insurance to pay.” He enjoyed using his time and resources to travel the United States and had begun to travel internationally. After spending much of his life teaching high-school students, he felt he was “giving back” and “teaching the young” through his mission work and travels. Mainly he enjoyed being with people and living life each day in ways that made him happy.

Mr. and Mrs. Jenkins discussed how “We like the motel—it’s a good place to stay . . . no hassle with heat, water, or other trivial things. And the housekeepers, those girls are nice, and they take good care of us.” This allowed them to spend time caring for their animals on their farm with minimal upkeep of their own living environment. The motel staff observed and Mrs. Bowling confirmed that living at the motel provided a good degree of consistency in her daily routine. She had felt somewhat nervous living alone. The $575 monthly rent was significantly less expensive than if her son had moved her into the local nursing home or an assisted living facility in another town. In addition to relief from home-owner responsibilities, living at the motel enabled Mrs. Neuhouse to work at the motel desk and not become isolated in her rural home while she provided care for her husband. Although this theme encompassed both personal time, energy for living, and financial resources for the participants, Ms. Margo captured the essence of the theme when she stated, “I don’t waste my time on housework. I save my energy for living. And that’s why I can go and do things, like going to see the trumpeter swans that I heard are migrating.” The motel permitted Ms. Margo, and the others, to save their energy for living.

Safety

All of the elders identified safety related to health crises and safety related to crime as main reasons for moving into and continuing to live at the motel. If they were not living at the motel, these elders would be living in the rural countryside alone or with their spouses. Mrs. Jenkins explained that living in the country, especially in the unpredictable winter months, “could take forever for someone to get you if you needed help, a heart attack. There’s no ambulance, and sometimes that snow is hard to get through.” With Mr. Jenkins’ high risk for
falls, he identified the safety and “the convenience, no steps except one.” Mrs. Bowling’s son felt the motel was safe, according to Mrs. Konick. They “keep an eye on her; she is safer here than at her [own] home. Eventually I did need to call her [Ms. Bowling’s] son because of her problems.” Because of her agitation and increasing forgetfulness, her son moved her to the local nursing home.

Ms. Margo discussed how the town had changed because of the increase in immigrant workers, who were hired by the local meatpacking plant. She referred to a growing problem with drugs, such as methamphetamine, in the Midwest and described how a recent national magazine had attributed this to the increase of immigrants. The motel was also a perceived place of safety because, as explained by Mrs. Konick, Ms. Margo was known to have “called the town policeman every time there was a group of drug dealers around and the drug dealers, they don’t come around anymore.” For Ms. Margo “when I shut that door, and the entrance to the motel is locked at 11:00, and there’s someone here around the clock, if I need help, all I have to do is yell. And really, I’ve never heard of anyone completely losing their voice when they were in pain. I guess it’s possible, but, as a rule. And I, that’s why I like this location of this apartment. I can yell loud enough they would hear me out at the [front motel] desk.”

Connections and Privacy

All of the elders moved into the motel because they wanted to be around other people, yet the motel provided a nice balance of privacy as well. They all spoke about the importance of having their own space and privacy to live the way that they wanted to live; however, this was intricately linked to and balanced by a sense of connectedness. For example, Ms. Margo explained how she treasures her luxury apartment with her things right where she likes them and her control over what, when, and how she eats and lives her life. On the other hand, she spoke about how “The cleaning gals are great! And it’s just a pleasant place to live. We’ve been out there in the lobby in the morning. We sit out there and have coffee and chat. Visit, and it’s pleasant. And I’m a people person. I’m not a loner. I like people.” Mr. Jenkins explained that he and his wife were private people but the “People at the desk are friendly. We meet interesting people [that are just passing through].” He went on to explain, “those connections with other people keep a person active with mind and body. When young, more alone, but when older it’s more important to be with others.” Mr. Travelbee saw himself as “not much of a social person, but I enjoy the morning coffee group. They respect your privacy, but anyone is welcome.” The researcher participated in morning coffee with all of the elders at various times and in various group compositions over the course of the research. Often, Mrs. Bowling was present for at least part of the morning coffee group, and Mrs. Neuhouse, who also spoke of being more of a private person, liked having someone to visit with now and again. In particular, Mrs. Newhouse reported that she wasn’t confined to her home caring for her husband 24/7. Because she believed that her husband was going to die, living at the motel was one mechanism she used to prevent having to be alone. It was discussed how those who lived and worked at the motel respected each other’s privacy, but this was balanced with the social support connections that provided opportunities for social interaction and informal support and care. When requested or acted upon, social interaction and care support included morning coffee with information updates, assistance monitoring behavior and preventing injuries, assistance with some medications and treatments, shopping, and transportation. Examples of this support included Mr. Travelbee, who had a car and would provide elders such as Ms. Margo and Mrs. Bowling transportation to the senior center or to get groceries. If requested, the housekeepers and motel manager would “pick up” medications, groceries, or other supplies and leave them at the front desk for any of the elders. Ms. Margo also appreciated how the front desk ladies helped her when she needed to apply eye medications.

Freedom to Come and Go

During one of the morning coffee discussions, Ms. Margo, Mr. Travelbee, Mrs. Bowling, the housekeepers, and Mrs. Konick were discussing nursing homes with the first author. There was strong consensus that nursing homes are a place that someday they may “have to go to”; however, all agreed no one wanted to move to a nursing home. Once in a nursing home, the elders explained, they would lose control and freedom over their own lives, even the simple act of leaving the nursing home to do what one pleases. Except for Mrs. Bowling, all had experienced a parent having to “go to a nursing home.” Mr. Travelbee’s
father and mother both moved into a nursing home when the father became ill. His father died during the first month, and his mother remained there (despite wanting to go home). Mrs. Konick explained, “People here don’t go to the nursing home until they absolutely have to, and so those at the nursing home are near death’s door, I’d say. Only because they’ve got a good heart, are they still alive. And it’s not a pleasant place to be. But we’ve got a fine nursing home, I mean, they try really hard.” The elders spoke about how it was “Worse than death. Because they can’t, they’re stuck there [in the nursing home]. And the only way you get out is you die.” Mrs. Konick said, “That’s what my husband says. He says, ‘You know when you go to nursing home you go there to die.’”

Conversely, it was observed that the motel enabled the elders to conserve personal resources, feel safe, and develop and maintain community connections, privacy, and the critically important freedom to come and go at will. Freedom to go to and from the farm throughout the day (Mr. and Mrs. Jenkins); to the front desk to work (Mrs. Neuhouse); to Arizona, Las Vegas, and New Mexico (Ms. Margo); to congregate meals (Ms. Bowling); and to take trips to Chicago, San Francisco, Eastern Europe, Mexico, and Peru (Mr. Travelbee), all while having the motel as a “home-base,” provided the elders with the living environment and freedom to control their own lives. Mr. Travelbee explained, “I had wanted to, my thought is that I wanted to live various places. I’ve always thought I would like to go and live two or three months in Chicago, two or three months in New York, two or three months in some other place, San Francisco, just get a place and live there for a short period of time. And then when I’m ready to leave I can just take what I have in the room to the storage unit, leave it there, and I don’t have any rent to pay. I can leave for two months, reserve a room where I, if I, want to come back at the end of the two months, and move back in.” Living at the motel allowed these elders, all with chronic health conditions, to age, with assistance from one another and the motel staff, and as identified by Mr. Travelbee, to “do it my way.”

Discussion

This case study of older persons living in one rural motel setting used an ethnographic approach to identify four themes of the elders’ choice of the setting: “saving my energy for living,” “safety,” “connections and privacy,” and “the freedom to come and go.” These four themes offer a beginning understanding of why this relatively homogeneous group of economically secure elders moved into the motel, and add to an understanding of elders’ choices in balancing their maintenance of autonomy, independence, and risk. The motel setting was a natural system of care that these elders developed for the “in-between” age when they needed assistance but did not desire the assistance provided by formal providers (e.g., nursing homes, assisted living, or home care). Ms. Margo’s and Mr. Travelbee’s reason for staying at the motel are consistent with pattern of Brownrigg’s (2006) patterns of “cycling” between the motel and traveling, whereas the others fit the category of “open-ended stays.” Similar to the findings of Stafford (2009), the motel was not only a geographic space for the elders but also a place that held meaning. It was a place where they felt safe and where they maintained their desired control and power over their relationships, the amount of their engagement in the motel rhythms and routines, and rural community life.

Although more research is needed to describe naturally occurring options chosen and created by elders (Stafford, 2009), the themes deserve consideration by communities and policy makers. Living at the motel allowed the elders to save and control their personal energy and financial resources. They chose to use their time, energy, and financial resources for doing things they enjoyed (e.g., travel) while also staying connected and engaged in their local community. In other words, they were able to optimize their independence and control over their lives while minimizing risk.

With SRO regulation becoming more complex (Brownrigg, 2006), this study informs gerontological research, practice, and policy making. It focuses on the multifarious and ethically sensitive issues inherent in balancing elders’ autonomy, independence, and risk, whereas spaces and places to grow old are determined. Research on natural systems of care and how older persons create models for “aging in place to aging in community” (Stafford, 2009, p. 156) is critically important so that emerging rules and regulations for elder care do not erode natural systems of care and limit the possibility of cost-effective living environments, created by and available to elders, that appropriately balance autonomy, independence, and risk.

Optimally enabling elders’ autonomy, independence, and control in living arrangements,
while fulfilling society’s responsibility to protect those citizens that are most at risk for abuse and injury, are key public policy and practice issues and enduring challenging concerns (Beauchamp & Childress, 2012; Clemens & Hayes, 1997; Collopy, 1988; Hogstel & Gaul, 1991; Horowitz, Silverstone, & Reinhardt, 1991; Lawrence & Murray, 2010; Norman, 1980). Although more personally autonomous elders tend to prefer greater independence relative to safety (Ford et al., 2000), and autonomy and independence are associated with successful aging (Ford et al., 2000; Pruchno, Wilson-Genderson, & Cartwright, 2010), societal responses, especially formal long-term care, have tended to emphasize safety more than autonomy and independence. This emphasis has been driven by cost concerns, manifested in fear of liability for elder harm. These circumstances underscore the need for more research describing natural living options for successful aging, developed by elders to better understand elder preferences for balancing autonomy, independence, and risk.

With the rapid change in the ethnic makeup of the study’s rural community and a concern about a rise in crime in the Midwest, the motel was also identified as a place of safety. This feeling of safety in the rural motel is similar to that expressed by urban SRO elders (Crystal & Beck, 1992; Eckert, 1980). Out-migration of the young to urban areas and immigration of workers for jobs in meatpacking plants have caused a rapid proportional increase in the ethnic minority population of rural communities (Martin, Taylor, & Fix, 2005). The effectiveness of culturally informed community assessment strategies (Dreher & Skemp, 2011) and community participation to promote dialogue, understanding, and the development of elder-friendly communities (Stafford, 2009) remain important areas of research.

The importance of social connections and support to healthy aging is increasingly well known (Cacioppo & Patrick, 2008). All of the elders moved into the motel because they needed a home base and support, either personally or as a caregiver for a spouse. Similar to research in assisted living facilities (Kemp, 2008), living in the motel facilitated aging in place both for the elder who had extended care needs, as well as the spousal caregiver. For the spousal caregiver, it included a sense that they were no longer living in isolation and did not have to provide care to their spouse alone. Rather than feeling socially isolated at the motel (Eckert, 1980; Hoch & Slayton, 1989; Stephens, 1976), they became part of the group. Although personal privacy was respected, there were shared expectations both for privacy and to “watch out” for and to help one another if requested. This sense of support included the closeness to their health care providers, family, and friends.

The 2-year length of the study helped to offset the limitation that the researcher did not live in the community but travelled back and forth to the community instead. To capture evening and early morning cultural patterns and activities, the researcher visited the motel for 2–4 days monthly. Although this research is limited to only one motel in a rural community that is more recently becoming ethnically diverse, it is not unique. The phenomenon of SROs has been prevalent in the United States since 1900s. In the SRO literature, building on the work of Sokolovsky and Cohen, much of the research has been about those who are vulnerable poor elders, the homeless, and single persons, typically men (Cohen & Sokolovsky, 1979, 1980, 1983; Cohen, Teresi, & Holmes, 1985; Greer, 1986; Hoch & Slayton, 1989; Siegal, 1978; Sokolovsky & Cohen, 1978; 1997). The group described here, however, included couples and women, and they were not economically vulnerable. Nevertheless, the themes “safety,” “connections and privacy,” and “freedom to come and go,” are congruent with findings of ethnographic research on socioeconomically disadvantaged single older men living in urban SROs (Eckert, 1980). This study is also important and adds to the literature because it validates a finding in wealthier adults. Because results by Eckert (1980) previously described poorer adults, the thematic resonances between his study and this research support relevance beyond economic vulnerability and help inform community strategies, public policy, and practices for successful aging. Although cognizant of the risk for harm when SROs provide poor-quality unlicensed care, research and public policy discussion are important to successful and meaningful aging so that safety is balanced with regard to independence, autonomy, and individual rights.

Funding

This work was supported by the John A. Hartford Foundation and the University of Iowa Social Science Funding Initiatives.

Acknowledgments

The authors thank those who participated in this study, in particular the seven elders whose stories are described in this manuscript. Thank you to three anonymous reviewers, Dr. Barbara Rakel, and Dr. Kathleen Buckwalter for their comments on an earlier draft of this manuscript. Shorter versions of this work were presented at the Society for
References


