‘Till Death Do We Part: Quality of Life, Autonomy, and Romantic Relationships in an Assisted Living Home

by

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Certificate of Approval

This is to certify that the accompanying thesis by Paige Wohlen Organick has been accepted in partial fulfillment of the requirements for graduation with Honors in Sociology.

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ABSTRACT

Through in-depth interviews with seniors in an assisted living home, this thesis explores how seniors describe and experience quality of life, autonomy as it relates to quality of life, and romantic relationships as they relate to both autonomy and quality of life. Using Goffman's theory of the asylum (1961) and Atchley's continuity theory (1989) as my theoretical framework, I conducted in-depth interviews of seniors in an assisted living home to best understand the nuance in which seniors describe, talk about, and experience their quality of life, autonomy, and romantic relationships. Some of my many findings are that there are more influences on seniors' quality of life than previously described (Custers et al. 2012), that participants described instances of low and high quality of life together, and that a described diminished sense of autonomy does not necessarily contribute to a described diminished quality of life, contrary to previous findings (Meyer and Roseamelia 2007; Plath 2008). Seniors in romantic relationships are willing to compromise some of their autonomy for their spouse, which does not necessarily lead them to describe a lower quality of life, and those widowed or divorced used autonomy to actively decline or seek out romantic relationships. My findings informed my policy recommendations in the hope that seniors will benefit from this thesis.

THESIS OBJECTIVES

When I began college, I volunteered with a program that paired Whitman students with residents in an assisted living home. I met with a woman with whom I developed a close relationship. She was sharp, intelligent, funny, and very, very lonely. She passed away two years ago, leaving me wondering what more could I have done to alleviate her loneliness. How would her life have been different if her late husband was with her? Although she could not tie her shoe or eat sticky food because of her ill-fitting dentures, she bossed the nursing staff around so everything she could not do for herself was still done to her incredibly high standards. She seemed to think she was very autonomous, yet she did not fit my definition of "autonomous". Why was that? How did her physical constraints play into her quality of life? Why did I not ask her what her life was really like and how she perceived herself?

I then took over running the weekly Bingo group, calling out numbers and letters to a group of about five women. As I grew to love their openness and sass, I was always curious about how they felt when the nursing staff would come around and feed them pills of all shapes and colors. The women would dutifully open their mouths, but what effect did being hand-fed have on their sense of individuality? To most visitors, it is hard to tell one curly white haired woman from the next; what kept them standing out in the crowd? Some days they would talk about their late husbands as if they were still walking around - was this a product of failing memories or do memories of their late husbands improve their day, bring them happiness? Does thinking about their late husbands render them more present and "there" for the women, bringing them comfort and closeness?

My experiences with romantic couples in the assisted living home has made me very interested in the impact of romantic relationships on the sense of autonomy and quality of life. This includes both past and present relationships and the memories and meanings residents attached to those relationships. I have chosen to focus on the institutionalized (in an assisted living home) because such homes influence the institutionalized seniors (also called "residents" by nursing staff) in unique ways. Institutions take away the ability for the resident to cook and clean for themselves, choose what time to wake up, and attend activities (Custers et al. 2012). I am curious about how seniors describe and experience their quality of life, autonomy, and romantic relationships within the assisted living facility, and if they describe any overlap. I have chosen these three areas of focus because asking about a person's entire life is too broad for this thesis and because romantic relationships, quality of life, and autonomy were what I most frequently wondered about in my experiences and seem to play significant roles in seniors' lives. By better understanding seniors' experiences, we can more readily address their needs and implement changes in our current system of nursing and assisted living homes to improve resident's quality of life, sense of autonomy, and support romantic relationships as seniors require.

My experience in, and questions about, assisted living homes have led me to my main research question: in what ways do seniors in assisted living homes talk about, describe, and experience quality of life, their autonomy as it relates to their quality of life, and their romantic relationships as they relate to autonomy and quality of life?

THESIS PROBLEM

My question guiding this thesis is, in what ways do seniors in assisted living homes talk about, describe, and experience quality of life, how their autonomy relates to their quality of life, and how their romantic relationships relates to autonomy and quality of life. In this thesis I will focus on how autonomy influences seniors' quality of life and how romantic relationships influence seniors' autonomy and quality of life. I will also focus on how seniors describe and experience their quality of life.

Quality of life is not solely determined by autonomy and romantic relationships. It is important to look at other factors that affect seniors' quality of life in an assisted living home, beyond autonomy and romantic relationships, though I do focus on the last two. Quality of life is an all-encompassing subject which looks holistically at resident's "physical well-being, quality of the environment, functional competence, meaningful activities, relationships and autonomy" (Custers et al. 2012:319). In my thesis, I will look at how residents define, describe, and experience their overall quality of life, and I will focus on how their quality of life is connected to their autonomy and romantic relationships.

Autonomy, defined by Collopy (1988) and Dickels (1990), is essentially a multidimensional concept that includes people having the ability and freedom to shape their long- and short-term goals. It is linked to seniors' quality of life; more autonomous people enjoy a higher quality of life and perceive themselves as more capable people (Heathcote 2000; Bryant, Corbett, and Kutner 2012; Custers et al. 2012; Sixsmith et al. 2014). Assisted living homes decrease a senior's sense of autonomy. They have certain rules that residents must follow, limiting their freedom and quality

of life (Goffman 1961; Dickles 1990; Gawande 2014). With 1.4 million seniors in the US in nursing homes (*National Center for Health Statistics* 2016), there is a need to improve quality of life and autonomy for those in nursing and assisted living homes (Custers et al. 2012), which my thesis attempts to address through a more complete and nuanced understanding of quality of life and autonomy.

Romantic relationships play a role in understanding the senior's experience in an institution. Marriage is a part of the senior's lived experience in the assisted living home, and widowhood and divorce must play an influence in seniors' quality of life. However, there is no research on how seniors talk about their lack of romantic relationships; research mainly focuses on married and dating couples (Dickles 1990; Lodge and Umberson 2012). By better understanding residents' romantic relationships, institutions can better support residents both in and outside of a romantic relationship, thus improving their quality of life regardless of their relationship status.

LITERATURE REVIEW

I will describe research on seniors living in assisted living or nursing homes, their quality of life, how autonomy relates to their quality of life, and how romantic relationships are described in relation to their autonomy and quality of life. I will also underline any gaps in literature that may be important to fill to answer my research question: in what ways do seniors in assisted living homes talk about, describe, and experience quality of life, their autonomy as it relates to their quality of life, and their romantic relationships as they relate to autonomy and quality of life?

Terms

Most sociological literature uses the term "elderly" to refer to the population over 65 (Heathcote 2000; Farquhar 2005; Loue 2005; Hjaltadottir and Gustafsdottir 2007). I, along with a few other scholars and seniors, believe this term is demeaning because it has connotations of people with physical disabilities needing care. "Seniors" is prefered by seniors as it is much more respectful because it does not fundamentally view people as in need of medical or professional care: "Personally, I prefer the term "senior,""; "'Elderly' is not generally accepted as a noun. To many of us, it's associated with social services, health programs, long-term care" (Graham 2012). In choosing to call seniors "seniors" or, if they live in an assisted living home, "residents", rather than "elderly", I use a different term than most of the sociological literature. As I intend for my participants to read my thesis and it is respectful to call the community what they wish to be called, I am justified in breaking from the small herd of sociologists studying seniors.

I will use the term “seniors”, or “residents” if I am specifically referring to people in an assisted living or nursing home, as nursing staff do, and I will use the even more specific term “oldest old” if I am specifically referring to the population that is above 85 and the term “young-old” for seniors between 65 and 85 years old (Johnson and Barber 2003).

The Population

People over 65 are considered ‘seniors’, and this population made up 12.2% of the US population in 2010. Seniors are expected to make up 18.5% of the population by 2025 due to improvements in health care leading to a longer life expectancy and the aging of the baby boomers (Binstock and George 2011). Of the 46.2 million seniors in the US, 1.4 million live in nursing or assisted living homes (*National Center for Health Statistics* 2016).

Baby boomers, a large and unusual group in their demands for autonomy compared to generations before them, are expected to dramatically change how nursing and assisted living facilities are laid out in the coming years, and more and more sociologists are studying the senior population because of the changes baby boomers are expected to make (Tirrito 2003).

Aging impacts people biologically, and this impacts their ability to function in society. For seniors, 46% of the population live with at least one chronic condition and “some limitation of activity” due to arthritis and disease, compared with 19% of those aged 45-64 (Atchley 1999:75). Aging generally, though certainly not always, comes with a decline in health and mobility, which are predictors for entering the assisted living or nursing home (Goffman 1961).

Seniors tend to hold on tight to their homes, and most (though not all) actively resist being placed in an institution because of their dislike of the decrease in autonomy, and the negative connotations surrounding the nursing and assisted living home (Tirrito 2003).

Autonomy matters to seniors in terms of their physical ability, household chores, and fear of being a burden on loved ones. Fear of being placed in a nursing home may exacerbate these concerns (Tirrito 2003). Regardless of reasons for entering the institution, seniors acknowledge that the institution decreases their autonomy, quality of life, and purpose in life; "in [this nursing home], you lose your sense of self-worth. You're fed and cared for, but you lose your freedom" (Barber and Johnson 2003:50).

Of those living independently, common activities are volunteering and participating in religious organizations (Cutler and Danigelis 1992). Compared to nursing and assisted living homes, seniors living independently have a broader amount and type of ability to pursue leisure activities than those in the total institution. Assisted living and nursing homes are what Goffman (1961) defines as total institutions; residents are cut off from society and do not have opportunities as frequently to go to church and volunteer outside the institution. Despite the lack of meaningful social interaction with the outside world, modern institutions are still packed with activity. Thomas (1996) described life in the institution:

> all phases of a resident's day are tightly scheduled with each activity leading, at a prearranged time, to the next. It is understood and accepted that the overall schedule is created and enforced from above. The typical day is so completely

> managed that most staff members can accurately predict what a particular resident is doing at any time of day or night (12).

The activities and lifestyles of residents and those outside the institution are quite different, due to both the biological processes of aging and the social influences of entering a total institution.

The Oldest Old versus the Young-Old

People over 85 are defined as the oldest old. Twenty-two percent of them live in assisted living or nursing homes. Compared to the young-old, they are significantly less likely to be married, are less able to perform daily living, have a lower quality of life, and feel more helpless. The oldest old who enter the institution of their own free will are more secure and have a higher quality of life than those who were forced to move in because of a disability. They are significantly more likely to believe that there is no way they can solve their problems, that they are helpless in dealing with their problems, and that there is no way that they can change large, important aspects of their life such as their living conditions and their ability to help their children through their problems (Barber and Johnson 2003).

Defining the Nursing Home versus the Assisted Living Home

Both nursing homes and assisted living homes can be classified as total institutions, where residents are subjected to the home's rules and live, sleep, eat, and play all within its walls (Goffman 1961; Gawande 2014). Assisted living facilities house residents in private or shared rooms and claim to value the resident's autonomy. Nursing staff is available to help with bathing, eating, or toileting as well as assist in

any emergency that may occur. Shared meals, laundry services and light housekeeping are generally provided. The technical difference between the two homes is that nursing homes provide 24/7 nursing care, whereas assisted living does not necessarily provide this (*Guide to Nursing Homes* 2010). In reality, there is no clear line between assisted living homes and nursing homes;

> the concept of assisted living became so popular that developers began slapping the name on just about anything […] Assisted living [is] part of the now widespread idea of a 'continuum of care' which sounds perfectly nice and logical but manages to perpetuate conditions that treat the elderly like preschool children (Gawande 2014:101).

In sociological literature, the term "nursing home" is often conflated with "assisted living facility". Sociologists and gerontologists rarely define the difference and often include both terms in their article referring to the same place (Bradshaw et al. 2012). Despite the differences in the two types of long-term care facilities, there is no significant difference in quality of life between the residents (Brandi et al. 2003). This indicates that my thesis, which studies the assisted living facility, may have at least a slight parallel to the nursing home. However, due to my small sample size (11) I cannot generalize my findings to all assisted living homes, let alone nursing homes.

Quality of Life

Quality of life looks holistically at resident's "physical well-being, quality of the environment, functional competence, meaningful activities, relationships and autonomy" (Custers et al. 2012:319). Seniors are both willing and able to engage in

discussions about their quality of life, and provide their own assessment of what their current quality of life is (Farquhar 1995). Quality of life is a broad topic with many different aspects that seniors can describe, including autonomy and romantic relationships. Measuring and understanding quality of life is difficult as it is a complex phenomenon, but a common theme important to improving quality of life in an assisted living home is to feel respected as an individual and to perceive autonomy within daily life (Hjaltadottir and Gustafsdottir 2007).

Defining Autonomy

The broadest and most common definition of autonomy is described by Collopy (1988) and Dickels (1990). They describe autonomy as most closely related to self-determination, freedom, and liberty of choice. Essentially, it is a multidimensional concept that includes people having the ability and freedom to shape their long and short range goals and purposes. Autonomy can be, though is not necessarily, present when a person acts on their own will and feels competent in doing so (Dickles 1990). Autonomy is lost in the nursing home or assisted living center when the senior must share a room with a stranger, when they lack privacy because staff members enter rooms without knocking, when their actions like taking pills or food choice are restricted, and when they are placed on a mealtime schedule (Heathcote 2000). The institution acts on various levels to decrease a person's autonomy, though this does not leave them non-autonomous (Dickles 1990).

Even as nursing and assisted living facilities work towards improving autonomy by offering activities and listening to resident's problems in town-hall style

meetings, residents are aging, becoming less active, agile, and sharp than they were in their youth. This makes measuring autonomy difficult; autonomy becomes relative and fluid. Some residents may compare their sense of autonomy to how they were 20 years ago when they did not depend on nursing care, whereas others could compare it to how others in the home are feeling. Because autonomy is relative, it is important to understand and identify how each participant measures their own autonomy (Kasser and Ryan 1999). Seniors do not all experience the same amount of autonomy at any given time. Autonomy is fluid and changes over time based on fluctuations in health (Barbara and Johnson 2003).

Autonomy and Quality of Life

Autonomy is closely linked to an individual's quality of life; the most common theme with residents describing their quality of life is their ability to choose their activities and fate (Heathcote 2000; Bryant, Corbett, and Kutner 2012; Sixsmith et al. 2014). To seniors, it means having some form of control over life and the ability to make choices and use personal resources (Heathcote 2000). Some studies have found that it is more than simply utilizing resources to achieve wants; seniors utilize their control and choice-making ability to create or do something meaningful to them. This requires having something worthwhile to do, the ability to balance their personal abilities and challenges, access to required resources, and a personal attitude that allows this to occur (Bryant, Corbett, and Kutner 2001). All of these requirements make it difficult to obtain a sense of autonomy in an institutional setting (Goffman 1961; Heathcote 2000). However, seniors decrease their expectation for how much autonomy they are able to have when entering an assisted living home, and this

lowered expectation allows them to retain some life satisfaction (Bryant, Corbett, and Kutner 2001).

It is important for seniors' quality of life that they are regarded as autonomous individuals, able to seek out their own opportunities for entertainment, solitude, and privacy (Goffman 1961; Meyer and Roseamelia 2007; Plath 2008). However, entertainment and companionship is provided by staff to minimize loneliness, though this is rare for individuals (Plath 2008). Quality of life decreases when autonomy is lost, either through a low income and suffering financial limitation or through contracting diseases or injuries that decrease the ability for people to take care of themselves and thus become institutionalized (Georescu et al. 2015).

Klinenberg (2012) briefly mentions how the memories from the past, both of happy and harsh times, recalled by seniors impact their quality of life. Seniors have little influence over the memories they think about on a given day or time. Rather, their minds flit around and select the memories that influence their day; a senior does not have autonomy over the memories that impact their quality of life (Klinenberg 2012).

Romantic Relationships, Autonomy, and Quality of Life

As married couples move into an assisted living home or institution, the need for autonomy for the couple becomes increasingly important as they experience decreasing amounts of it through their increasing dependence on nursing and caregiving staff (Kasser and Ryan 1999). As a couple's partnership begins to lack formal structure, such as through selling their home and losing the ability to drive, the couple face an increased need to have an intimate, private relationship and feel autonomous in that relationship (Goodman 1999). Unfortunately, most assisted living

homes are not set up for this need. While homes value autonomy, nurses and staff rarely knock and freely barge into rooms, eliminating a couple's privacy; residents lack the autonomous capability to control who enters their room and when in the assisted living home (Dickels 1990).

The individual's desire for sexual intimacy does not stop at the institution's doors; these human needs continue throughout life, regardless of marital status (Loue 2005). Most facilities have policies regarding what to do if unmarried people are caught having sex, given that it is a frequent occurrence. While I do not equate romantic relationships with sexual intimacy, the two do sometimes (but not always) go together. Robinson and Molzahn found that sex in a partnership or marriage influences older couples' quality of life and relationship satisfaction (2007). It is expected that with the increasing number of baby boomers in institutions, as well as the rising disability movement stressing individual rights for autonomy and control over their life, engaging in private romantic or sexual activities will be more searched for in institutional settings (Meyer and Roseamelia 2007). However, for now, many institutions limit privacy. Being able to choose to have a physical relationship is important for maintaining an individual's sense of autonomy within a relationship, and institutions are not set up to best foster autonomy because of policies where residents share rooms and staff has power to enter rooms unannounced (Meyer and Roseamelia 2007).

The effect of romantic relationships on autonomy is largely unstudied, though marriage or couplehood in an individual home setting (as opposed to in a nursing home) can either be quite beneficial to the individual's sense of autonomy and quality

of life or unbeneficial, depending on the couple's circumstances. In some cases, one spouse has to stop doing hobbies that bring their life meaning to take care of an ill or dependent spouse, which decreases their sense of autonomy and ability to choose their own activities. In other cases, the spouses are able to work out a system of helping each other out in the ways they are physically or mentally able, and thus both can enjoy a partnership and maintain a sense of autonomy (Bryant, Corbett, and Kutner 2001). It seems as if the impact of marriage or romantic involvement on an individual's sense of autonomy is impacted partially by each person's physical and cognitive capabilities. However, marriage or a romantic relationship can increase seniors' quality of life because being in a relationship contributes to a sense of individuality, which is important for a sense of autonomy (Heathcote 2000).

Gaps in the Literature

Senior populations are not as studied as they could be; much is unknown or vague about their perceptions on the availability of romantic relationships and how they describe their autonomy. Most researchers study senior population's autonomy from a clinical perspective, aimed at understanding how well they can cope with certain life changes and handle medications, rather than from a qualitative perspective as I aim to do. Qualitative research better captures seniors' experiences than a quantitative approach does, providing needed nuance and understanding to better improve senior's quality of life and autonomy.

There is also a lack of research, as I discussed earlier, about the phenomenon of couples separated between independent homes and senior homes or separated within the home, which would help me understand how a wider variety of seniors experience

romantic relationships within assisted living homes. There is even less research on the effect this separation has on couples' closeness and quality of life, though it is assumed that separation decreases their quality of life. Goodman (1999) states that as couples no longer cohabitate, autonomy may become more important for the individual couples, but she does not go into further detail about what the impact on quality of life and autonomy that no longer cohabiting has on the couple.

Few scholars (Myerhoff 1978; Gawande 2014) use qualitative data, such as seniors' stories to describe aging and assisted living homes. The majority of scholars (Dickles 1990; Bowling et al. 2003; Meyer and Roseamelia 2007; Custers et al. 2012; Casey et al. 2016) studying seniors are much more clinical and quantitative and do not utilize seniors' stories as much to paint a vivid picture of life in the assisted living home. My thesis aims to fill this gap in the literature by describing seniors more personally, using their stories as a way to understand senior's quality of life, autonomy and romantic relationships in the assisted living home, and to find ways to best improve their quality of life and autonomy and support them in their romantic relationships if needed.

Research fails to explore impacts of long-past romantic relationships have on seniors' current quality of life. I have not found any data on the impact of divorce at some point in the seniors' life and the impact of this in the assisted living home, which would help me better understand romantic relationships and quality of life for seniors. No research exists tying autonomy and romantic relationships together under quality of life, which is what I aim to do in this thesis in order to better understand seniors' experiences in the assisted living facility.

As the baby boomer population ages and the number of seniors increases, there has been an increase of sociological studies on the senior population, though most are more clinical or quantitative in nature, and much is not understood (Tirrito 2003). My thesis aims to help fill this literature gap, thereby improving our knowledge of seniors living in assisted living facilities.

THEORETICAL APPROACH

I have chosen to utilize Goffman's theory of the asylum (1961) and Atchley's continuity theory (1989 and 1999) to develop and explore my research question, in what ways do seniors in assisted living homes talk about, describe, and experience quality of life, their autonomy as it relates to their quality of life, and their romantic relationships as they relate to autonomy and quality of life?

I will predominately use continuity theory. This means that, in my methods, I will treat participants as competent people, capable of both signing an informed consent form and able to tell me about their experiences. I seek to understand how they describe themselves as autonomous, and to what degree they are and believe themselves to be. In relation to quality of life, Goffman's theory of the asylum (1961) says that there is a fundamental decrease of autonomy that occurs upon entering the assisted living home. However, I hope to show that entering the assisted living home is not so crippling that seniors cannot choose relationships and actions that better their quality of life and act autonomously in some capacity as described by continuity theory (Atchley 1999).

Understanding the Theory of the Asylum

The assisted living facility where my interviews took place is a total institution, despite it existing some 55 years after Goffman's first description of nursing homes in his theory of the asylum. Even though Goffmans' theory predated the invention of assisted living homes by around 30 years, he would classify them and modern day nursing homes as total institutions (Goffman 1961; Gawande 2014). A total institution

is where a similar group of people, in this case people over the age of 65, live, sleep, and play. Most residents have minimal contact with the outside world, which decreases their ability to have autonomous interactions with people outside their institution; thus, both modern day assisted living homes and nursing homes are both total institutions. Goffman lays out specific forms of total institutions; one such form is "established to care for persons felt to be both incapable and harmless; homes for [...] the aged" (Goffman 1961:4). In this specific case, the assisted living homes as total institutions can also be classified as an asylum; the word "asylum" denotes the decrease in autonomy that happens for people who enter the home. Not all total institutions decrease autonomy, but asylums do. In this case, it is because residents entering the home are subjected to its rules, which limit their freedom to do what they want, become dependent on staff for care, and have minimal contact with the outside world.

Entering a total institution decreases the resident's sense of autonomy. Goffman describes how institutions undercut the individual's notion that they are "a person with 'adult' self-determination, autonomy and freedom of action" through forcing residents into a set schedule for meals and activities and requiring them to comply with the institution's rules to achieve the institution's goal of safety for the residents, even if residents value other goals (Goffman 1961:43). Institutions decrease resident autonomy, though this is not for malicious purposes, but rather for residents' safety, ease for the institution, or the resident's own well-being (Goffman 1961). Both in Goffman's time and in modern times, institutions put policies in place that force residents to give up their autonomy; common assisted living policies say residents must allow nursing staff to handle the dispersal of medications, and residents must sign out

in a log whenever they choose to leave the institution (Custers et al. 2012). Being monitored and regulated upon entering the institution fundamentally diminishes the resident's ability to act as fully autonomous individuals (Goffman 1961).

Individuals experience different physical and cognitive functioning at different stages of the aging process; not all residents enter assisted living facility for the same reasons. The aging process, progression of aging-related diseases such as Parkinson's or dementia, or falls are the most common reason seniors enter the total institution (Brandi et al. 2003). Diseases associated with old-age, as well as the aging process and falls, lead to a decreased ability of individuals to move around and perform necessary day-to-day activities such as bathing, fixing meals, and transporting oneself to the store. Such difficulties or inabilities for residents to perform these acts further decreases their sense of autonomy. These contribute to the decreased amount of autonomy experienced by seniors, especially affecting those living in an assisted living home. This decreases their quality of life because of the connection between quality of life and autonomy (Custers et al. 2012).

Continuity Theory

Atchley's continuity theory (1989) does not assume a total decline and onset of isolation in seniors, and, compared to Goffman's theory of the asylum (1961), is a much more nuanced and subtle view of aging that takes context of the senior's life and the senior's self-definition into account. Continuity theory sees seniors holistically, as individuals with the ability to be engaged and present in their life and at least some ability to act according to their wishes. Continuity theory celebrates successful aging for when seniors are active and social as opposed to withdrawn, choosing enjoyable

activities (Atchley 1999). Common activities include games as well as pursuing romantic relationships which keep them both social and active, either sexually, physically, and/or cognitively through shared activities (Johnson and Mutchler 2013).

Atchley (1989) developed continuity theory by arguing that older adults seek to maintain their sense of self and activities as they age, describing that while older adults do lose autonomy by entering an institutional setting, they are capable of maintaining and cultivating their own relationships. Atchley acknowledges that seniors undergo life changes, yet he argues that they are able to maintain their previous values and some version of the activities that they participated in their earlier years. This points to a spectrum of autonomy and ability rather than Goffman's more black-and-white view, in which seniors either have autonomy outside the institution or lack autonomy within the institution.

It is important to understand the spectrum of autonomy as a sliding scale where some seniors have more and some have less autonomy, depending not only on their living situation but also on their sense of empowerment, physical and mental health, and their financial and familial situation. While seniors may experience a decrease in autonomy as they enter the institution, this is not a total loss of autonomy as Goffman believed it to be. Rather, it is just a decrease, caused by one of many factors that decrease a person's autonomy; seniors inside the institution still have autonomy, just less of it. Atchley says that seniors aim to, and are capable of, maintaining continuity as they undergo life changes.

Atchley (1999) describes how changes in marital status, mainly in the form of widowhood, are the largest predictor of moving away from the home into a nursing

home or shared household with family or unrelated adults. However, this is all that continuity theory describes about the importance or influence of marital status. This is a potential flaw of me using continuity theory in my research. Continuity theory focuses on life changes and how seniors respond to those life changes, whereas I am focusing on the effects on the seniors after they move into a care facility.

Continuity theory: internal continuity.

Atchley's continuity theory (1989) accounts for the changes people undergo throughout the aging process and entering a nursing home. He describes that, even though aging fundamentally changes people's abilities and that people do change as they acquire new life experiences, they generally maintain their same values and beliefs throughout the aging process, pursuing and adapting their activities and personal goals to stay continuous with their values. For example, people over 70 tend to highly value family ties (Atchley 1999). Being able to stay connected with and updated on family member's activities is a personal goal among a lot of seniors that, if achieved, contributes to an increase in autonomy and quality of life. Continuity theory emphasizes both the importance of having personal goals and values and being able to follow through on them. It is important to note again that autonomy is a spectrum; seniors have varying abilities to accomplish their goals.

As people age and enter assisted living homes, sliding towards the "less autonomous" end of the spectrum, it becomes more difficult to participate in all the activities they once enjoyed. However, continuity theory says that seniors can still participate in activities that bring them joy and are similar to what they used to do. Some seniors are capable of adapting to their limitations throughout the aging process,

demonstrating their autonomy in order to actively improve their quality of life. Even though they may rely on the institution to provide activities for them, seniors are still autonomous in seeking out such activities to attend despite their constraints. For example, a senior may have gone to church regularly but has lost their driver's license because of any number of reasons. Now, they visit with the priest that comes to the nursing home monthly and participate in weekly bible study groups. Thus, the resident is able to maintain religion in their life and, as continuity theory says, successfully adapt to their changing situation and have a high quality of life in terms of their religion. They demonstrate autonomy by seeking out bible study groups and the visiting priest brought in by the institution. Simultaneously they improve their quality of life by continuing to practice religion and exert autonomy in seeking out opportunities the institution provides.

Continuity theory says that seniors aren't necessarily capable of continuing to perform the same activities throughout the aging process. Rather, they adjust the amount, time allotted, or activity to fit their own physical and mental needs. This ensures that there is a continuity of values in the senior's life, and they can take a significant role in their quality of life (Atchley 1989).

Continuity theory: aging as a barrier.

Atchley views seniors as independent, powerful, unique, complex, and able to shape their own destiny, provided that there are not too many barriers in their way. Under continuity theory, seniors are capable of adapting to life changes such as moving into assisted living homes, illness, and widowhood. Throughout these changes, as well as in daily life, it is assumed that seniors are able to consciously understand and explain what is happening around them and adapt to their changing world. Atchley

does acknowledge that this is difficult to do; most of the time, people's general goals and personal values stay the same throughout life changes. As people age, however, they are at an increased risk of falling and injuring themselves, or contracting age-related diseases like Multiple Sclerosis, Parkinson's, or Alzheimer's. Diseases and the aging process force people to slow down: requiring the use of a wheelchair or other walking aids, and help with once-basic daily activities such as toileting, eating, and driving. Disease and the aging process renders people less physically or cognitively autonomous than they once were, leading to a decreased quality of life due largely to a decreased sense of autonomy. However, Atchley says that most seniors are capable of navigating these barriers by adjusting the amount of time they take and what type of activity they do. Ultimately, this helps seniors maintain a greater sense of autonomy (Atchley 1989).

Continuity theory and theory of the asylum in discussion.

Goffman's theory of the asylum paints aging as a very isolating experience, with a decrease in autonomy associated with increased rates of depression and decreased quality of life. However, this line of thinking has been sharply criticized by more recent scholars (Lemon, Bengtson and Peterson 1972; Atchley 1989, 1999). These scholars argue that older adults are capable of continuing activities later on into their life, and that this increases life satisfaction (Lemon, Bengtson and Peterson 1972). Despite scholar's, and my own, criticisms of Goffman's theory of the asylum, I believe the theory still has relevance and importance in understanding the impact on senior's autonomy total institutions have, given that assisted living and nursing homes have not dramatically changed since Goffman's theory was created in 1961 (Gawande 2014).

I only utilize the part of Goffman's theory of the asylum where he describes a fundamental decrease in autonomy upon entering the assisted living home. Goffman does not allow, in his description of the nursing home as an asylum, an understanding of seniors as autonomous people. Rather, he describes the total loss of autonomy experienced through entering the nursing home. While there is a fundamental decrease in autonomy, continuity theory says this is not as complete in its effect as Goffman believes (Goffman 1961; Atchley 1989). Continuity theory celebrates individuals and believes that seniors are able to express and control their individuality and activities (Atchley 1989). Goffman does not leave room for this, instead describing seniors as people without agency who are acted upon, and therefore his depiction of seniors is incomplete.

Goffman asserts that entering nursing homes and the aging process itself is a force which seniors are unable to withstand; instead they experience a loss of autonomy and a transformation, essentially, into vegetables (Goffman 1961). This is not true, as continuity theory argues (Atchley 1989). Continuity theory underlines that while seniors may face a diminished quality of life and decreased autonomy, they are agents able to improve their own quality of life. Therefore, for the purposes of my thesis, Goffman's theory of the asylum is useful in defining assisted living facilities as total institutions, and thus seniors' autonomy and quality of life decrease upon entering. The implications of this are that seniors are subjected to rules of the facility and physically require assistance in some aspects of daily living, limiting their freedom and ability to travel and feel completely autonomous.

METHODS

I explain how I operationalized quality of life, autonomy, and romantic relationships and describe obtaining IRB approval and conducting interviews.

Operationalizing Quality of Life

Scholars have difficulty succinctly operationalizing quality of life in senior populations. No single indicator can comprehensively and totally describe all that goes into a person's perceptions of their quality of life. Some of the many components that influence a person's quality of life include personal perceptions of safety, physical well-being, the number and amount of meaningful activities, their relationships with others both romantically and not, and their ability to exercise autonomy (Brandi et al. 2003; Custers et al. 2012). To that end, I ask multiple questions about the participant's quality of life, most of them from previous research (Farquhar 1995; Bowling et al. 2003). These questions include: "How would you describe the quality of your life?", "What do you like about living here?", "What would improve your quality of life?", and "What would make your quality of life better?". I also pay attention to the answers the residents give to other seemingly unrelated questions, including noticing what is not given as an answer. I did not ask them to compare their current quality of life to the quality of life they had before entering the facility. Rather, I let them define their own quality of life as they saw it.

Operationalizing Autonomy

I operationalize autonomy using Kroemeke's definition (2015), which asks seniors about organizing their life based on their own ideas, making decisions, and coping with life without needing outside help. I adapted her measurements, along with Kasser and Ryan's (1999), into more in-depth, open-ended questions suitable for an interview setting, asking questions like "how do you spend your time here? Please describe a day in your life", "when do you wake up and do you wake yourself up?", "what was the decision process like for entering this assisted living facility?", "who was the major force in the decision?" and "you say you and your kids talk on the phone a lot - do you call your kids or do they call you?" These questions all aim to better understand how residents are autonomous in both their daily life and in the making of larger decisions. It is certainly not a given that seniors move themselves into assisted living or nursing homes, and asking who initiated and encouraged the move is important in getting a sense of a resident's autonomy for bigger decision-making (Gawande 2014). My questions still attempt to comprehend how individuals exercise their own autonomy, and within these questions I leave room for and acknowledge that autonomy is both individually defined and experienced, and influenced by the institution. In asking my questions, I tried to be broad enough to acknowledge individual's definitions of autonomy, while structuring it in such a way to acknowledge more sociological processes.

Operationalizing Romantic Relationships

I let participants decide if their relationship with someone else is in fact romantic in some form, and focus on that relationship. I do not conflate sexual intimacy with romantic relationships; rather, I will ask residents if their relationships are sexual, or if they have someone (or multiple people) with whom they are sexually active but have no romantic feelings towards. I will treat those relationships as different than romantic relationships, and ask for further clarification from the participants themselves.

The Interview Process

I was approved for commencing interviews at an assisted living home, which I have renamed Hamilton Home in order to preserve anonymity. I contacted the home's staff for a list of residents who were "decisionally competent" - the residents who could legally and cognitively give informed consent to be interviewed. While at Hamilton Home, I randomly selected a "decisionally competent" resident to interview; I would knock on their door and introduce myself and ask if they would consent to be interviewed. I asked 13 residents to interview, and 2 refused. Interviews took place wherever I found the residents, as this was most convenient for the residents and myself. Ten interviews were conducted in the resident's room, and one was conducted in a corner of an activity room. Interestingly, the two married couples I interviewed both preferred to be interviewed with their partner rather than separately.

Demographics of Interviewees

In total, five participants were married, of which two were couples. The other six residents were all single; four were widowed, and two were at one point divorced, though one divorcee had had a boyfriend for several years. Most residents fall in the category of the oldest old as all but one (age 82) are over the age of 85. Three interviewees were male, eight were female. All of the men interviewed were currently married to their life partner, though one had been widowed then remarried when he was in his 60's.

Interviews in Pairs or Solo?

I began interviews intending to conduct all of my interviews in person alone with one interviewee. I was hoping for this because one-on-one interviews allow the researcher to hear the interviewees' perspective without the interviewee having to tailor or alter their story because of the presence of someone else. However, two of the couples I interviewed expressed interest in me completing the interview with both of them in the room. In no way am I willing to go against the preferences of the interviewee, as this compromised my own and IRB's ethical standards. So I conducted two interviews, one for both couples. In doing so, I was able to witness the richness and depth of the couple's interactions, and I learned things about how the couple interacted and depended on each other that I wouldn't be able to in a one-on-one interview.

Saturation: Knowing When to Stop

Before starting my interviews, I set a goal to obtain 10-20 interviews. This is clearly a broad range, and as my interviews were generally 45 minutes to an hour in length, I spent a lot of time interviewing and transcribing. At my 11th interview, I felt I had reached saturation; I gleaned no new insight from the interview, and the resident spoke of similar experiences as other participants had. I decided, with help from my thesis committee, that it was time to conclude the interviews and move on to coding and analysis.

Coding and Analysis

Following Saldaña (2009), I coded for patterns and broad themes that emerged in my interviews, using his described simultaneous coding method; within one block of text, either one or multiple sentences, I would use more than one code (2009:16-17). In my coding, I did not prescribe quality of life or autonomy on the residents; rather, I simply looked for instances where participants described a high or low quality of life or sense of autonomy in relation to some other factor. As I was transcribing the interviews, I kept an eye out for these themes, and that was the baseline for my second round of coding. I ended up with a total of 30 themes and codes. When I noticed new themes emerge as I coded, I would write those down and went back through the transcripts a third time to code for the new themes.

FINDINGS AND DISCUSSION

I have broken up my findings into three main sections: quality of life; quality of life and autonomy; and quality of life, autonomy, and romantic relationships. Within each of the three sections, I have broken my findings into smaller subsections that help answer my research question, asking in what ways do seniors in assisted living homes talk about, describe, and experience quality of life, their autonomy as it relates to their quality of life, and their romantic relationships as they relate to autonomy and quality of life.

Throughout the interviews, I discovered overlap with the definition of quality of life provided by Custers et al. (2012), who described categories of autonomy, relationships, physical abilities, quality of the environment, and activities. I focused mainly on autonomy and romantic relationships as they relate to quality of life, but other aspects of quality of life came up as significant to residents that I will also discuss.

Quality of Life

Low quality of life: "Now I can't"

I coded instances of "low quality of life" when someone expressed dissatisfaction with their lives, described being sad, missed some aspect of their past life, or expressed regret or loneliness. I also included times when residents described sad stories or unfortunate life circumstances, or when remembering difficult times

diminishes their present quality of life; in the interview, I could visibly see the residents stop smiling as they recalled hard times, and withdraw into themselves.

Residents also described a loss physical mobility and cognitive "sharpness", the assisted living home's unappetizing food, lack of privacy, and rules. This overlaps with categories of quality of life described by Custers et al. (2012). Common themes that arose that do not align with scholars' working definition of low quality of life include being overworked, having negative experiences in their youth (experiencing World War Two, having terrible husbands, being orphaned at a young age), missing their late partner, feeling like they're wasting time in the home, and expressing concerns about their children's health and well-being.

Beila described her late husband: "we moved down here from Cashmere he got sick and he wasn't doing too good. And that's when he passed away. And I missed him because I tell you he was so good to me. And my girls, he was so good to them." Beila is obviously sad about her late husband's death and misses him; this is an instance of a description of a low quality of life. Beila mitigates her low quality of life by describing a fondness for how her late husband treated her children, but it is still an overall lower quality of life due to her husband's death.

Eliza said she does not feel like she's independent because she is in a wheelchair: "I'm not an independent person anymore for some reason my back went out when I was still at home and I don't remember why my legs went." Valerie, on the other hand, said, "I can't get out of this [wheelchair] so I pretty much push it myself." This is a fascinating comparison; these women have about the same physical ability (they are both confined to a wheelchair or else rely on staff for maneuvering), but while

Eliza does not believe she is independent and feels completely reliant on others, Valerie has compensated and paints her circumstance in a more positive, capable way. Both women experienced a decrease in autonomy, and this has a different impact on their quality of life, which complicates Goffman's (1961) assertion that a reduction in autonomy fundamentally reduces senior's quality of life.

High quality of life: "Very lucky"

Common themes that emerged when residents described a high quality of life were visiting with their children and family, spending time with spouse, memories of their late partner, leisure activities, careers, and describing material possessions indicating memories or accomplishments.

Eliza appreciates Hamilton Home's cleanliness, her roommate about whom she said "I'm very lucky to have", and her cozy part of the room, which was decorated with photographs, religious sayings, and stuffed bears. She was able to make her part of the room her own, reflecting her values and her likes, which contributed to a higher quality of life for her.

This broad array of descriptions of quality of life indicates that a more complicated and nuanced definition of quality of life is needed; the definition provided by Custers et al. (2012) does not include all the impacts on quality of life that exist, including memories, material possessions, and past careers, successes, and memories. Those few of us studying seniors are not taking into account all possible events that impact a seniors' quality of life, and therefore our view is too limited about both how to understand quality of life and how to improve it.

Past's impact on the present: "I had wonderful parents"

For both low and high quality of life, I realized how much the past impacts the residents: either in a positive or negative way. It isn't a person's immediate social network or even the institution that controls people's lives; the memories of the past, currently experienced, also have an impact.

Residents repeatedly told me stories from their past, either happy or fond memories, like Sarah's memories of her parents, which she eagerly shared with me, unprovoked: "I had wonderful parents. Really wonderful parents. Uh. My dad was as interested in the girls as he was the boys. Yeah he wanted my sister and I, who was 10 years older to know everything the boys do and to be able to handle business. Yeah, I think he was, uh, kind of ahead of his time." Sarah's fond memories of her happy childhood seemed to bring her comfort, and sharing and thinking about these times improved her quality of life.

Memories of the past can also be negative, like one woman's hard work experience, where she is still tired from all her days as a nurse: "I worked in the hospital and boy sometimes the weather would be bad and the nurses from the mountains couldn't get in and so there was a lot of work to do." This woman would get more tired and miserable thinking about all the work she had had to do.

As described by Klinenberg (2012), seniors generally lack autonomy in choosing what memories they think about, though their memories are still strong. This means that residents do not necessarily have the autonomy to control what memories influence them.

This finding has interesting implications for both Goffman's theory of the asylum (1961) and Atchley's continuity theory (1989). Neither Atchley nor Goffman mention memories of the past in their theories, rather only describing the present environment impacting resident's quality of life. Both of their theories need be nuanced to be more accurate.

Family visits and quality of life: "Oh it's good to see them"

Family visits are overwhelmingly positively talked about; all residents described enjoying visits and landline phone calls from their children and grandchildren. Family visits were largely talked about in regards to having a high quality of life.

Beila described her enjoyment in seeing her children. Even though they mainly run errands together, she still attaches a significant amount of meaning to her interactions with her kids: "They take me for a ride, or go grocery shopping. Not for me but for them. [...] Oh it's good to see them. Visit with them." Beila is interested in simply seeing her children rather than doing important activities together. This seems to diminish her loneliness and keeps family ties alive and well.

Other residents described how they call their children as a way of connecting, either because their children do not live in town or are not available for visiting. Susan described, "I have a daughter in Nevada and she calls me quite often." She also has a son in Oregon she describes as "busy, but once in awhile he calls me." She seemed to enjoy talking with her children on the phone and acknowledges that, while her children are busy, they do make time to talk with her, which she appreciates.

Quality of life is definitely influenced by senior's ability to see and connect with their family in any way that works for both parties. This seems like it is not so much the event that matters, though events do play important sociological significance, but more that simply spending time together is important for seniors.

Emphasis on material possessions and high quality of life

An emphasis and pride in material possessions indicating a high quality of life emerged. Cathy and Chris, for example, went out of their way to show me a copy of their 60th anniversary announcement in the local paper. They took great pride in it and offered to have it photocopied for me. They were also quite proud of a beautiful clock presented upon retirement. This clock was well maintained and dusted, showing their pride in it and what it symbolized for Cathy's work, which she was proud of and referenced throughout the interview.

Several participants described their sadness about no longer living in their own home. Eliza said, "I miss, I miss the house, being in the house." Eliza put all her possessions into storage, even though she does not have easy access to it, and it seems comforting to her to know that she still owns the things she and her late husband once shared, rather than getting rid of the possessions and some of the memories objects seem to hold for her. It seems that, throughout the aging process, seniors become more attached to belongings that represent who they used to be or their memories of a happier time. This would fit with Atchley's continuity theory (1989), where people try to hold on to what matters for them both materially and through activities throughout the aging process, and seem to use their material possessions as ways to demonstrate and indicate their higher quality of life.

Low and high quality of life are frequently talked about together

Discussing low quality of life is commonly accompanied by an instance of a higher quality of life, though describing high quality of life is not frequently described with instances of lower quality of life.

For example, I asked Valerie what would decrease her quality of life, and she said being bed-stricken for an extended amount of time. I asked her why, and she replied: "Because I still am active in my mind and I want to go and see and visit and check on things and renew acquaintances, do the activities. I don't just want to sit, so I spend ¾ of my time outside when the weather is decent." Valerie described a hypothetical scenario where her quality of life would be decreased, but she did not dwell on this hypothetical very long, instead switching to talking about what she does currently that makes her happy.

Participants quickly move from discussing more unfortunate, frustrating, or less positive issues onto more positive subjects. This could be to demonstrate to me, the researcher, that they have a genuinely high quality of life. Or, this could be more for themselves, to tell themselves that they are doing well, to stay positive and not slip into depression so common in seniors. This phenomenon could relate to autonomy. If participants are intentionally keeping themselves from dwelling on their lower quality of life rather than subconsciously separating themselves from their material circumstances or institutional placement, then they are autonomously choosing the way they think about and describe their quality of life.

QUALITY OF LIFE AND AUTONOMY

Activities, autonomy, and quality of life: "I do whatever I want"

When discussing activities, residents asserted their own autonomy through demonstrating an active role in seeking out activities that improved their quality of life. Eunice, a divorcee, said "I go out to the VA and they do my pedicure, they do my glasses, they do my hearing when I put it on." Eunice actively calls Dial-A-Ride to take her to the VA for certain activities. Most residents tended to stay closer to home, preferring activities held through the activities department of Hamilton Home. This still demonstrates autonomy, however, because it takes a conscious desire and will to get to activities.

Eliza described the pleasure and freedom she gets from pursuing her own activities, independent of Bingo run by the staff. "I can read or I can write a letter or I'm doing bible study on my own and that I appreciate very much." These examples demonstrate that seniors are individuals with their own ideas and approaches to living life. This supports Atchley's continuity theory (1989); seniors are generally capable of creating and pursuing activities that give their life enjoyment and meaning.

Some participants described their love of Bingo, cards, and other activities put on by the nursing home staff. Susan said "I do whatever I want […] I love to play Bingo. So we get to play that four times a week." Susan described both her higher quality of life from her activities, as well as asserted her autonomy in saying she was able to do the things she enjoyed. Other participants also noted their enjoyment of parties put on: "The girl that's running the activities, she is so sweet and she is sooo good. And she just decorates everything, everything! She's always in there decorating for the next program, she spent yesterday decorating this dining room for the 90th

birthday today." While residents do depend on staff for a majority of their activities, they exercise autonomy in deciding when and what activities they attend.

Residents are able to exercise their autonomy to both decide to attend activities and participate in them, and they enjoyed attending the activities they did, describing them in positive terms and indicating that their ability to get to events and participate in them played a role in increasing their quality of life. This fits well with Atchley's continuity theory (1989), where he argues that seniors are both capable of and derive pleasure from pursuing activities that fit their personality and values.

Discussions on the future: "Maybe next spring"

One thing largely missing in the interviews was discussion about the future. If the future was raised, it was in terms of asking questions about what the future brought, rather than creating plans. This did not seem to lower senior's quality of life. Interestingly, participants would acknowledge their lack of autonomous control over their futures, but they did not frame this lack of autonomy as either decreasing or increasing their quality of life. Rather, they were flexible and adaptable to their uncertainties.

One couple described that they would probably sell their house in the spring: "But we're not ready to do anything you know maybe next spring we're going to get all together with our kids and family and you know talk about it." This was a possibility, but the inclusion of the word "maybe" indicated some uncertainty. This couple's future plans seemed to be the most certain out of all participants; most other discussions of the future were more rooted in uncertainty, indicating a loss of autonomous ability to plan the future. There did not seem to be any one theme of what was uncertain about the participant's long- and short-term futures; they ranged from

uncertainty to getting remarried to what their disease progression would look like to what friends they will see at activities.

Valerie, age 92, said: "When you get to be this age it doesn't matter much you just go with the flow and do what God's given you for the rest of your days." Her uncertainties about the future did not seem to bring her apprehension and unease; rather, she took comfort both in her faith and in her ability to be adaptable and flexible. She autonomously described her uncertainty, declaring that she was unclear and uncertain about her future, but she autonomously made the choice to not let this bother her. It seems that her lack of autonomy regarding the future had a relatively neutral impact on her quality of life.

I never asked questions about what people's futures would look like, nor did I ask questions regarding the past (besides asking seniors to describe their late husbands and how they moved into Hamilton Homes). However, a vast majority of respondents told stories and shared memories and events of times past, but rarely did they speculate or say with any certainty what their future would bring.

Autonomy from staff: Pills lead to friendships

Residents are dependent on staff to distribute pills to them; the institution's policy is that staff members are the only ones in charge of distributing pills, for the resident's safety and well-being. Forgotten or misplaced pills can be disastrous when regulating cholesterol, blood thickness, or other medical or mental issues. Seniors are forced into handing over their pills, regardless of their actual capabilities. The institutional rule assumes that residents are incompetent in handling their medication, no matter the individual, based on an assumed decline in physical and cognitive functioning.

Jean discussed her annoyance about how Hamilton Home handled pain patches for her back:

> I was so unhappy with the way my patches were handled, 'cause I had to order them, and I was sitting here waiting for them, I was supposed to run out on a Friday and I was out, and I didn't know that they had come in but they had. And the way the regs are, the office picks up anything that looks like medication and gives it to the nurses. So, it came but I didn't know it. And I was really upset about that. And I thought "how could they do that?" Open packages that are mailed to somebody else, you know with the post office.

Jean's frustration with not being able to personally open her mail and be independent from Hamilton Home is similar to how Goffman (1961) describes the fundamental decrease in autonomy people experience as they enter the nursing home. Institutional settings, usually with the best of intentions, fundamentally diminish the sense of autonomy residents feel.

Jean's frustrations were diminished slightly when a social worker came to talk to her about the incident, and her complaints about the dining area's food. "The social worker came down and she was very nice, I really liked her, and she listened [...] but anyway I thought that was neat, they have someone you can talk to and now I know who. And that was good."

That the institution has a method for Jean to feel heard and assuaged is important in understanding how institutions work. Being heard by someone in the institution seemed to make Jean feel better, because she was seen as more of an autonomous person who deserves to be heard and listened to. Jean wound up making friends with

the social worker. The institution values her opinion, affirming her importance as an individual and calming her frustrations about feeling non-autonomous when the post office intercepted her mail.

Not all residents describe the lack of autonomy created through not being able to handle their medications as an entirely bad thing. Cathy said "they come in here with our medication and you know they're wonderful, they're so good here. We like it. And they like us too." Cathy and her husband Chris intentionally use their lack of autonomy to improve their quality of life by forging friendships with staff members. This may give residents more dignity in how their pills are handled. With the staff as friends or at least acquaintances, there is less of a feeling of being helpless or useless, and they feel more autonomous in having developed a relationship with the staff, rather than being passive in accepting the pills. Making friends with staff members uses resident's autonomy.

While a lack of autonomy can create frustration and decreased quality of life, most seniors framed the lack of autonomy as a positive way to get to know the staff, which improved, or at least did not decrease, their quality of life. This indicates that residents are capable of adapting to new rules and reframing their experiences in a more positive way that does not impact their quality of life as much; they are capable of autonomously controlling how they frame and experience events.

Family visits: "We have a lot of help with our kids"

Through their loss of autonomy, residents require more help both from staff members and their children. Most residents described help from staff members as either decreasing or minimally improving their quality of life, as they utilized the time spent getting help from staff members to forge friendships. However, when describing

help received from their children, residents were overwhelmingly positive, though they use the time getting help the same way they do with staff members: bonding and catching up with their children. A decrease in autonomy affects seniors' quality of life depending on who is helping that resident.

Susan described her daughter: "She takes good care of me, if I need anything. She's so good to me. Don't know what I'd do without her." She expressed the love and devotion she feels for her daughter and acknowledged the help she gets from her. Rather than being frustrated by not being able to help herself, as some residents did when they could not take their own pills or pain patches, Susan appreciates the help she gets from her daughter. This indicates that a loss in autonomy does not necessarily decrease a person's quality of life. The effect on quality of life as to who is taking care of the senior matters. Susan did not mind her daughter helping out, though she seemed to mind the staff helping her walk again - helping her regain autonomy - after she broke her leg. She did not express nearly the same amount of warmth, love, or affection for the staff; "I can walk down to the end of the hall with a walker. [...] And if they let me rest a bit then I can walk back. Pretty painful."

Jean described a similar relationship with Tim (her son-in-law) having Bob and Jean over to his house in Dayton: "tomorrow night Tim's going to either come down and get us or we're going to work out something because I don't like to drive at night, especially on the Palouse Country. So they shuffle us back and forth, times like that. And oh they're really good. And my daughter lives [nearby], she's helped us a lot with the moving, packing." Bob and Jean seemed to appreciate the help and compromise Bob's son-in-law makes and the help they received in the move to Hamilton Home.

Jean was up front about her limits with driving. In fact, she was more matter-of-fact about her limits in regards to how her children help her than she is about how the staff helps her. She and other residents obscured what the staff did for her but they were more explicit about the help they received from their children.

Visits by helping family members are welcome, and residents do not seem to dwell on the fact that they need help and are not entirely autonomous anymore. This nuances how we understand quality of life in relation to autonomy. A loss of autonomy does not always decrease a participant's quality of life as Goffman (1961) and Heathcote (2000) describe. This makes me question Goffman's blanket statement that all losses of autonomy decrease quality of life. The loss of autonomy can cause increased contact with loved ones because of that autonomy loss, which does not decrease resident's quality of life.

Rules and authority: "At first it made me mad"

Participants mentioned rules, set by Hamilton Homes staff members, and they viewed staff members as authority figures despite also describing making friends with staff members as they give care. This, according to Goffman (1961), is part of the definition of a total institution; residents are subjected to rules imposed by the institution. This is interesting, especially since participants are paying Hamilton Homes to live there, but they still feel subordinate to its rules. Rules and authority decrease a resident's autonomy, as they are no longer able to do what they want, and residents described this as decreasing their quality of life. However, in some way residents asserted their own autonomy to circumvent rules or find a way for a rule to not have such an effect on their quality of life. One resident, Eunice, seemed to actively enjoy

disobeying rules, flaunting her autonomy to the staff, which increased her quality of life.

Eunice, a divorcee and fiercely independent person, has no problems breaking institutional rules even if they are for her own safety. Eunice described when she first moved in: “I have to take my walker here in the building, if you stick your head out without it, it’s ‘where is your walker?’ (Laughs) ‘Go back in and get your walker’. They want to protect you and I understand that, but at first it made me mad. Because I wasn’t used to it, you know?”. Upon entering Hamilton Home, Eunice seemed to make almost a game out of leaving her room and seeing how long it would take staff members to make her get her walker, and while she stopped doing that as she got more used to the rules, she still goes out for walks outside of Hamilton Homes with just her cane, in a silent show of defiance for the institution’s rules which are supposed to protect her from falling. Eunice and other residents described the difficulty and frustration experienced in adjusting to Hamilton Home’s many rules when they first moved in. Over time, however, they became more accepting and forgiving of the rules, acknowledging their beneficent purpose.

Most rules described by the residents are rules that are in place to protect the resident’s safety, and, for the most part, the residents comply. Cathy was fairly obliging to the rule about no stoves in apartments, which limits resident’s abilities to cook meals for themselves:

> No we can’t cook here because they like for us to get our meals here. Because no stove. They worry of fire. I know I wouldn’t because I’m very cautious with all this. Every time I go I make sure my coffee pot is off and you know. Always

been that way so yeah, we watch it. But they don't know that, no. And that's fine. We have no problem with that.

It could be that she was agreeable to this rule because there was not much she could do; it's hard to smuggle and install a stove into a small apartment visited daily about staff members. However, Cathy acknowledged that this rule was for the benefit and safety of everybody. She still maintained her sense of autonomy and distinguished herself from those who may cause a fire by asserting that she was very careful with appliances and would never accidentally set her apartment on fire, implying that this rule that diminishes her ability to cook for herself was unnecessary for her. This also demonstrates how she is helping protect the institution, showing how she is a good, conscientious citizen. Ultimately, her quality of life did not decrease as a result of this rule, thanks to her asserting autonomy over the rule without breaking it, as Eunice does with other rules.

Valerie described not knowing the rules: "I don't know all the rules, so I don't intentionally break the rules." About rules, she also said: "well it's pretty much tell you what to do and have certain habits and rules, lots of rules, lots of rules, no privacy. I don't like that". This seems to meld Cathy's and others' initial annoyance with all the rules with Eunice's desires to break some of the rules. In intentionally not seeking out the rule book or learning the institution's policies, she exerts her autonomy and ability to do as she pleases, without intentionally breaking the rules.

On the surface, rules, as Goffman described, fundamentally decrease a person's autonomy (1961). However, as Atchley described (1989), residents are capable of

exerting autonomy over the institution and its rules to maintain a higher quality of life for themselves.

Lacking ability: "Can't do any much else"

Participants usually described lacking an ability to do something as a physical limitation rather than a lack of desire or want. Institutions are not the only cited reason seniors give of a decrease in autonomy; they also cite physical inabilities and a mental lack of motivation, though the latter reason was rarely cited.

Fred was frustrated by his lack of physical activity, as he used to be a laborer and misses that: "Right now I just play and read the papers and uh paint, and [I] can't do any much else." Fred mentioned his Multiple Sclerosis as the main reason why he cannot get out much, and his age as the second reason. He described a lower quality of life because of his lack of purpose, as he is unable to perform all the laborious tasks he used to do.

Sarah was the only participant who described not doing activities and events because of a mental lack of desire rather than a physical limitation. She described knowing that she should go out to events and meet people, but "sometimes I'm lazy and I just sit in this nice comfortable chair." Eventually, she said that "I was kind of doing too much of [sitting here] and I kind of kicked myself in the rear and said I'd better get down there and see what's going on." Getting out of bed or a comfortable chair, as any college student knows, was an accomplishment Sarah seemed to take pride in; she overcame her not wanting to leave, thus exerting her autonomy and overcoming her lack of ability with motivation to increase her quality of life.

That so few participants mentioned a lack of mental ability, is very interesting; they focus instead on what they physically could not do. I never asked questions

directly about their abilities or lack thereof; this theme emerged organically. The reason most participants wound up in Hamilton Home rather than remaining in their private homes (which most said they would prefer and miss), is because of their own physical lack of ability to take care of their homes or themselves. Hamilton Home, while most say is a great place to live, is still not their real home, and their quality of life suffers because of this. Participants describe their physical lack of ability to take care of themselves in interviews possibly because as they go about their day there are constant reminders of why they are in Hamilton Home; their pills are handed to them and they are not allowed to cook their own meals. The fact that Hamilton home diminishes their autonomy serves as a reminder of their physical lack of ability to do everything they would like to do.

Activities and depending on the institution: "I'm not going to make the effort"

A paradox emerges when describing activities and autonomy. Residents describe how they enjoy exerting their autonomy, and how feeling autonomous generally improves their quality of life. They also describe their enjoyment in participating in activities put on by staff, ranging from Bingo to crafts to exercise classes to music. Yet in describing how they participated in activities, residents did not exert their autonomy, instead depending on the institution to create activities that they could then choose to attend or not. Deciding which activities to attend allows residents to use some autonomy, but they would be more autonomous in creating their own favorite activities.

Sarah seemed to depend on the institution for such opportunities, actively declining to independently start a bridge group. "My son tries to get me to get some people together to play bridge but I'll be 93 in June, and I just don't, you know, I play

if somebody was playing but I'm not going to make the effort." This dependency on the institution to create opportunities for entertainment runs counter to her description of an improved quality of life from increased autonomy.

This seems to support Atchley's continuity theory (1989), which says that seniors will actively make the effort to participate in activities. While residents rely on the institution to supply most of the activities, they still do make the effort to attend games they are interested in. Activities are generally talked about positively, and viewed as an improvement to quality of life by all interviewees. Even if they do not go to all the activities, residents appreciate the choice, engagement, and socializing opportunities they offer.

QUALITY OF LIFE, AUTONOMY, AND ROMANTIC RELATIONSHIPS

Divorce – an early widowhood comparison?: "I was independent'

Two women, Eunice and Beila, had divorced earlier on in their life. Autonomy and self-reliance are woven throughout their narratives, occurring in their descriptions of their marriages. These women describe their current quality of life as generally good, sometimes because of their divorces.

When I asked Eunice to describe her relationship with her second husband, as she was initially widowed, she said, "well, he was, he was independent and I was independent." Eunice indicated that, even within their marriage, she was still an autonomous person who did not rely on her husband in any way, implying that her quality of life was not based on her relationship or her husband but on other factors entirely. Their marriage dissolved when he fell in love with someone else. Eunice's

response was: “I said Ok, I said listen here young man. I will have a job before I leave here because I can’t, well, I’d like to have a room and rent it!” Even when she was faced with a husband who had fallen in love with someone else, Eunice still gave him a piece of her mind and would not be told what to do. She eventually moved out and found a job, and she and her ex-partner have remained friends. This streak of stubborn self-reliance has transferred over into her stay at Hamilton Home. Eunice described herself as a highly autonomous person: “I want to stay as much independent as I can. I don’t want people waiting on me, you know?” Eunice frequently intentionally breaks Hamilton Home’s rules. She takes herself out shopping whenever she wants, saying: “they had a book for me to write my name in, the time I’m going and the time I get back, and I haven’t done it yet and they haven’t caught me.” Eunice takes great pleasure in doing what she pleases, autonomous from anyone else’s influence: a pattern she described as occurring in her romantic relationship.

Beila first divorced her husband because he “was no good,” autonomously distancing herself from him and breaking off their marriage because he did not positively contribute to her high quality of life. Beila then remarried her second husband whom she loved. A similar streak of autonomy follows Beila’s story. On reflecting on the influence of both of her relationships, she said the following:

> Well I feel like after I’ve been married to my first husband I was a little stronger. But when I was married to [my second husband] I felt weak. [My first husband] wasn’t a helpful person. But [my second husband] was a helpful person. Anyhow it’s over. And I don’t wish to get remarried. I feel like I’m happy just where I’m at.

Beila valued her autonomy and seemed to regret not being as strong and independent with her second husband, but expressed that she had a much higher quality of life. Both Beila and Eunice autonomously distanced themselves from their ex-husbands, making negative comments about them and saying that they were not dependent. This autonomy carried into the interview where they described their autonomy. Beila said "I think I'm independent [...] it makes me feel good." Here, she clearly describes her autonomy as connected and significant to her higher quality of life, and the two women who were divorced had very high levels of self-described autonomy compared to other women who were widowed.

Sarah is the notable exception to my finding that divorced women are highly autonomous and have a high quality of life although her narrative was very similar to Beila and Eunice's. All women I interviewed were widowed in the last 15 years except Sarah, who was widowed 50 years ago. She described that living without her husband for so long and raising her children alone and without help - as the other divorced women did - made her more autonomous. She "kind of kicked [her]self in the rear" to go to activities, further demonstrating that she knows what she wants and is capable of making herself do these things, demonstrating a high level of autonomy.

Beila, Eunice, and Sarah all were apart from their husbands, either emotionally or physically, and they tended to rely on themselves for their needs and quality of life rather than their partners; this seemed to transfer into how they operated inside the institution. This has interesting implications for Goffman's theory of the asylum (1961); the total institution does not fundamentally alter how a person interacts within it. Rather, much like Atchley's continuity theory (1989), seniors bring their own

experiences into the institution and are able to maintain their own values and beliefs about how to disobey authority or otherwise maintain their autonomy.

New relationships: "I don't want to be bothered with a man again"

My review of the literature told me that I would find residents forming new romantic relationships with each other: dating, or at least having sex or some form of hook ups. This was not at all the case, which could be due to my small sample size, but I thought this was interesting to note.

Eunice was the only person who had ever had a partner after a marriage. Their relationship largely consisted of him coming to the Home to have dinner with her every Tuesday, and then leaving. She did not want any more action, sexual or otherwise, or activities with him and liked him keeping to his business and she to hers. He passed away a few years ago, and when I asked her if she was interested in getting another boyfriend or remarrying, she said "Heavens forbid!" because, "I don't want to be bothered with a man again." This was in line with most participants responses when I asked if they were interested in dating or remarrying - they asserted their autonomy and described how their quality of life was just fine where it was, and a boyfriend or other romantic interest would not alter it too much.

Susan's reasoning was: "No, at my age? [...] I would never find anybody quite like [my husband]. Never. Never. I had the best. And I couldn't find anybody that was better than him." In describing her wonderful relationship with her late husband, she asserted that her quality of life would not improve much by finding someone else. She also described a lack of ability to find someone as great or better than her late husband. She did not use clear language in describing if she was interested in hook-ups or a

romantic relationship or something else, but she seemed to imply that it was romantic relationships she was thinking about, similar to what she and her late husband had.

Beila made a puking face and said: “I’m not looking. I’m pleasant right here where I’m at.” She seems to simply not be interested in looking, instead finding joy in being independent without having to deal with another person in any capacity, and she believes that her quality of life is high enough as it is that she does not need to alter it by finding a partner. In choosing not to be involved with anybody, she remains autonomous, able to decide what she wants for herself.

Residents exercised their autonomy in making a promise to themselves to not remarry, saying, “I said to myself I am not going to remarry,” or saying that they were not interested. If they did not exercise this autonomy, they talked in more helpless terms, describing how they did not have the opportunity to meet better people than their husbands in the institution, or they did not like the dating pool inside the institution, or that they did not think their quality of life would increase enough to go to the trouble of finding a romantic partner.

This complicates Goffman’s (1961) assertion that residents in institutions are lonely and isolated because of the institution. Instead, residents autonomously choose if they would like to date or enter romantic relationships on their own, acting independently from the institution rather than being subjected to it.

Long term marriage is described as important: “It would have been 60 years”

There was a general appreciation for long-term marriage and the positive role it has on a resident’s quality of life. While the women who divorced never claimed that they wished they had a longer marriage and nobody made disparaging comments on

divorce, those who had been married for over 50 years took their long-lasting marriage as a point of pride.

Chris and Cathy have been married for well over 60 years and made a point in bringing out their 60th anniversary wedding announcement for me to see before the interview was over. While the happiness of their marriage was important, they chose to demonstrate how happy they were by showing me a newspaper announcement saying that they had been married for 60 plus years. The number of years seemed to be a tool they used to help me understand how happy and wonderful their marriage is. They seem to take the longevity of their marriage as a point of pride and accomplishment; autonomously, both of them kept their marriage alive and happy for over 60 years.

Susan, a widower, mentioned the importance of the exact number of years she was married: ”We had been married almost 60 years. He died in May, end of May, and the first of June was when we were married. It would have been 60 years, we figured we were going to make it to 60. Just a few weeks, before he…” In describing her husband’s death, she kept bringing up the importance of reaching 60 and her regret that they were only two weeks away. Her lack of ability to keep the marriage lasting those final two weeks seemed to weigh on her. Her lack of autonomy in this aspect of her marriage did not allow her to attain the desired round “milestone” number on her marriage to further signify how long and happy a marriage it was. This connects long marriage with a high quality of life for this couple.

Spouse interactions: Depending on the partner and teasing

A benefit of interviewing couples together is that I was able to observe interactions between the partners, Jean and Bob and Cathy and Chris. Both couples tended to depend on each other for hearing what I said, rather than asking me directly,

asking “now what was the question?” to their partner. They would also tease each other in an easy back and forth manner and would back up what their partner said. They simultaneously relied on each other, showing a lack of autonomy and more interdependency, and teased each other, which asserts autonomy and individuality within the relationship. Both their lack of interdependency within the relationship and their autonomy from teasing was described or experienced as part of a high quality of life.

Chris said that Cathy was born in 1935; he immediately turned to Cathy to ask, “Was that right?” They did not assert their autonomy from each other by ignoring the other and only interacting with me; rather, the fact that Chris stopped to ask Cathy if what he said was right suggests that the couple was more interdependent than autonomous from each other. However, this interdependency came with a higher quality of life; the partners seemed to enjoy supporting each other by smiling and leaning toward each other.

Bob and Jean frequently teased each other, demonstrating how happy and comfortable they were together. Jean said that Bob was a type-A person, to which, with a wink, Bob said “now what does that mean?” to which Jean replied “You’re a go-getter” and they both laughed. Teasing, for this couple, seemed to be a form of expressing love and affection and asserting their own individuality between them. In teasing, they highlight how they are different, which exerts their autonomy while still enjoying a high quality of life from a joking, easy relationship.

It seems that having their partner reaffirm and clarify what the person says demonstrates interdependence as well as a high quality of life, complicating Goffman

and other scholars' assertions that a decreased amount of autonomy leads to a decreased quality of life (Goffman 1961; Meyer and Roseamelia 2007; Plath 2008).

Partner activities: "we are all the time together, always"

The couples I interviewed enjoyed some, though not all, activities together. It also seemed like there was a compromise in doing activities. Couples would go to separate activities, or one partner would go out of their way to do something with or for the other partner.

Fred's wife, for example, lives in the memory care unit, and he only gets to see her once or twice a week. They spend time doing whatever she is capable of, which is generally sitting and talking, although Fred prefers to be more active. She loves Taco Bell, so Fred goes out of his way to bring her Taco Bell, though he does not enjoy it as much as she does. However, they both enjoy seeing and spending time with each other and the type of activity they do together does not seem to impact Fred's quality of life so much as the ability to spend time with his wife. Fred described his enjoyment in spending time with his wife contributing to his higher quality of life. He asserted his own autonomy by depending on his wife to dictate their interactions; she loves Taco Bell, so he chooses to spend his time with her with Taco Bell food, as she wants to do. Fred does not describe doing things on his wife's terms as decreasing his quality of life.

This compromise indicates that couples willingly lose some of their autonomy to choose all of their activities because it either improves their spouse's or their own quality of life. Decreasing autonomy does not always necessarily lead to a decreased quality of life, contrary to Goffman's (1961) and other scholars' findings (Meyer and Roseamelia 2007; Plath 2008).

High quality of life frequently talked about with romantic relationships

When I asked married participants about their romantic relationships, the answers were overwhelmingly positive. Additionally, when I asked married couples what their quality of life was like, they said it was high and cited their partner as a reason for this. Romantic relationships seem to be a way for residents to, almost paradoxically, be both autonomous and interdependent. They are autonomous in their teasing and helping each other in the relationship, and interdependent in most (though not all) activities and interactions.

I asked Bob and Jean what they did in the home, and Bob said "pretty much attend to what the other needs, come to think of it. I feel that way. I'm very fortunate to have a woman like that." Bob's activities and quality of life revolve around Jean, and it's the same for Jean with Bob. Through helping each other, which asserts their autonomy and ability within the relationship, the couple experiences a high quality of life and an attentiveness and focus on the other partner.

Eliza, a widowed resident, said that if her husband were still here, her life would be a lot better because then she could still be living in her own home and be a more autonomous person with her husband. She believes that it is because she was alone that her children wanted to move her into Hamilton Home.

An absence of a romantic relationship is keenly felt by residents. Several residents brought up how much they miss their late husbands and took delight in telling me about them. This tells me that, while losing a loved one can and does definitely take a toll on someone's quality of life, having had the relationship at all seems to be a source of joy for residents who are widowed. Residents described their late husbands in

overwhelmingly positive terms: he was “a jewel”, “the grandest man ever”, “handsome, and he was good, smart”.

The residents who were divorced had harsher words to say about their exes. Beila had quite negative things to say about her ex-husband: “He was always wanting everything done for him.” Beila would frequently say negative things about her ex-husband, then quickly switch to talking about her more beloved late second husband. “I did divorce him. And the second husband, he was more like a father to my girls than their own father. And he had two girls, and I had four. And it was really a pleasant situation.” This tells me that memories of her ex-husband were less positive, and that this had a negative impact on her quality of life, so she preferred to dwell on the memories of her late husband more. The memories of romantic relationships for seniors impacts their quality of life, not just the physical presence of the loved ones.

FUTURE IMPLICATIONS

I present four key recommendations for assisted living homes to preserve resident's autonomy and quality of life and call for specific further research that would benefit both seniors and scholars.

1. I recommend that assisted living and nursing homes create support groups for seniors who are widowed. Many women I interviewed missed or were grieving their late husbands and lacked friends (which was mostly by choice) to discuss this with, and relied on the institution to create activities for them. This renders it up to the institution to fill the need of creating a support group of sort for those widowed and those interested in discussing their memories.
2. I recommend that assisted living and nursing homes decrease the imposed amount of rules, as rules such as signing residents out of the institution and banning stoves diminish resident's quality of life and sense of autonomy, especially considering that residents think the home's food is "inedible". I propose that institutions allow kitchenware such as small stoves or hot plates to preserve the resident's ability to cook for themselves, though taking reasonable precautions, such as an emergency sprinkler system, is recommended. This proposal requires assisted living homes to trust the residents and see them as autonomous, capable people until proven otherwise, rather than assuming residents are incapable upon entering the institution, as Goffman (1961) and Gawande (2014) extensively discuss.
3. I recommend that the very way assisted living and nursing homes operate and are laid out should be changed to be more home-like. One of the most common

complaints are that the assisted living home “isn’t home”. Residents should be able to control much of their apartment, including choosing paint colors for their room, bring their own bed and furniture, have privacy by only allowing staff to enter after express invitation from the resident, and have the opportunities to do chores for themselves like garden, cook, and clean. This would also entail a change in the layout of the institution to replace straight, hospital-like corridors with nursing stations sporadically interspersed throughout, with pod-like clusters of apartments situated around a common living and cooking area. This was described by Gawande (2014) as an improvement to make assisted living homes more homey, foster autonomy, and increase people’s quality of life as well as address resident’s specific complaints.

4. Contemporary society needs to alter how we treat and think about the senior population, which could be aided by government policy subsidizing assisted living and nursing homes that successfully integrate seniors into society. Seniors have a complex and nuanced web of stories and experiences surrounding their life experience as I found, yet my peer’s reactions to my thesis were generally along the lines of “aww that’s cute”. My fellow Whitman students fail to recognize the complexity and individuality within the senior population, possibly because they do not have much experience with the population. Instead, they reduce an entire vibrant, lively population down to the word “cute”, stigmatizing and labeling the senior population. I am calling for a society-wide shift in how we view and treat seniors, aided by policy that helps

people understand seniors better in a variety of ways. Government policy should subsidize assisted living homes that work with schools, humane societies, libraries, churches, or other areas of society that would get seniors to be more engaged and interact with society, destigmatizing them.

It is important to keep in mind that assisted living homes are not all bad. Participants attributed certain aspects of the home such as the rules and being unable to feed themselves to their decreased quality of life, but overall they appreciated the home. Many residents appreciated the number of opportunities for activities available in the home as well as the care and safety provided by the institution; residents do not fear intruders in the institution as one resident did at her own home, and they know that if they fall or need assistance, help will be readily available. However, this comfort and safety comes at a price, which is less autonomy.

For further research, more analysis needs to be conducted, especially qualitatively, that better understands seniors as a complex population with a lifetime's worth of experiences. Additionally, research specifically on place and assisted living home set ups should be conducted to better understand the ideal physical layout of assisted living homes, as well as proper rules and policies that best benefit residents. As I found residents overwhelmingly positively describing interactions with their families, research should be conducted to understand the impact these interactions have on the families, as well as what programs would best help families support their aging family members transition into and flourish in assisted living and nursing homes.

Currently, residents are viewed "autonomous" by researchers not by if they are contributing to society or feel their life has meaning, but rather if they get to wake

themselves up or are woken up by staff members. While I, along with other sociologists, use this as a way to measure autonomy, I think it reflects a darker nature of institutions and society if we view people as autonomous by the ability to pick out their own outfit. I am left wondering, where are the homes focused on creating a meaningful, productive final years at the resident's physical and mental capacity? What will it take to get institutions that seniors want to move into, rather than being forced to move into when their bodies or minds fail them? Seniors should be able to go visit other homes or meet seniors outside of their own institution to expand their dating pool if they want or feel more a part of society, and have guaranteed privacy in their rooms if they desire.

CONCLUSION

My relationship with Goffman's theory of the asylum is, as you may have noticed, complicated. However, throughout my findings and literature review, I kept debunking the part of his theories that says seniors are non-autonomous people. I believe that, through my thesis, I have demonstrated the need for Goffman's black-and-white view of seniors in institutions to be complicated and nuanced, as he paints all residents as having almost no autonomy and an exceedingly low quality of life, which is not the conclusion I have drawn from my findings or a majority of my literature reviews (Goffman 1961; Farquhar 1995; Heathcote 2000; Gawande 2014). His theory needs to be amended or nuanced because it is not holistic in its understanding of institutions, even though researchers and nursing homes and assisted living facilities still treat seniors as non-autonomous (Gawande 2014). True, Goffman's description of the nursing home as a total institution which fundamentally decreases a person's autonomy remains somewhat accurate, though this is nuanced by my finding that decreased autonomy coupled with romantic relationships or family interactions does not always result in a decreased quality of life.

Athcley's continuity theory (1989), while more modern than Goffman's theory of the asylum (1961), must also be nuanced. As discussed in my findings section, residents do not always have the autonomy to increase their quality of life; memories of their past still play an influence on the seniors, which Atchley fails to take into account. On the whole, however, Atchley did account for the challenges seniors face as they enter the institution, and his view of seniors as competent individuals with

autonomy remains accurate and serves as a useful counter-balance to Goffman's theory of the asylum (1961).

Goffman's dated theory (1961) raises a lot of questions about what the future of care looks like for seniors; assisted living homes were created as a reaction to nursing homes (Gawande 2014), so what will the next step in senior living be? I advocate for a place with nursing care (if needed), with a focus on making seniors feel like valued, contributing members to society, as this and a sense of autonomy are what is largely missing for seniors (Gawande 2014). I found that, while seniors told me that overall they were content or happy, this usually came with the caveat of "for someone my age". Some, like Fred, told me they felt they lacked purpose, and most said they just tried to fill time. While they may feel autonomous, this indication of not living for something is troubling to say the least. Why do residents feel the need to say "for someone my age"? This implies that they are relatively happy but that they have lower expectations for their own happiness simply because of how society treats seniors, or because of something seniors fundamentally lack. I question not only why this is so, as any history of aging can help me answer that question, but more what needs to be done to make seniors of the future say "I am happy because of my age" or "I have always been content – my age doesn't impact that." Advances in medicine and technology may help, but I think this is largely rooted in how assisted living and nursing homes treat and present seniors; as people to be protected and given fun but unmeaningful activities and shut away for their safety until the end.

Additionally, I call for a more nuanced and comprehensive definition of quality of life. Residents' quality of life was talked about with more than just the categories of

autonomy, relationships, physical abilities, quality of the environment, and activities described by Custers et al. (2012). It seemed like memories of the past, careers, family interactions, the assisted living home itself, missing late partners, and material possessions were all described in conjunction with quality of life. The working definition of quality of life is too focused for my findings, and I had to expand the definition to include the resident's experiences, indicating that the definition of quality of life is dated or needs to be revisited.

I found that residents' quality of life was described both in relation to the institution and the social world as well as the biological one. Most residents I interviewed said their lack of mobility, a failing memory, medical problems with their spouse or themselves, and other physical factors impacted their quality of life and sense of autonomy, limiting what they were able to do that brought them joy and meaning. It is important to acknowledge the biological factors on seniors' quality of life, autonomy, and romantic relationships, as I have attempted to do in this thesis by describing the impact of widowhood, lack of mobility, and help on residents. As geriatricians and other scientists continue to find cures and ways to slow or change the aging process, sociologists must follow in their wake, figuring out the implications of such changes.

One of my biggest takeaways from this research project was the question "who the heck is sociology for, anyway?" I have grappled with the notion of accessible public and the generally less accessible academic sociology, but the question of who sociology should be for was not very tangible to me until this thesis. As I conducted my interviews, I forged friendships and connections with my interviewees. They

trusted me with their stories; I became bound and determined to do those stories justice. As I spent more and more hours in the library, I realized why I wanted to do more than graduate; I had to do justice for my participants. I hoped to make their lives accessible to more people, to help break down stereotypes about the population. I wanted to help nursing and caregiving staff at institutions understand their residents in a way they simply do not have time to in everyday life. I wanted to help faculty and future sociology seniors understand why I love this population so much. So, who is sociology for, anyway? While I thoroughly enjoyed this process, I now believe it is predominately for those we study. For me, all the sweat and tears that went into this thesis was for the residents of Hamilton Home who gave me their time, energy, thoughts, and stories, and for the residents of thousands of other homes throughout the country whose stories are yet untold.

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APPENDIX A: APPROACHABILITY

I have chosen to write my thesis for as broad of an audience as I possibly can. Saldaña describes about the importance of writing with simplicity; this makes the presentation far more interesting and engaging. Additionally, writing with a bunch of scholarly jargon can make the reading more confusing and grave; I hope the stories I share in my thesis, and the thesis itself, will be so enjoyable a read that you will want to read it everywhere you go, in bed or on the ski slope, rather than feel that it is an academic text suited only for an ivory tower (Saldaña 2011).

While my thesis remains an academically rigorous body of research, I cannot forget those I interviewed and those at the assisted living home who have expressed interest in reading my work. I see no good reason to write from a stuffy "Ivory Tower", as this stifles discussion about my findings and minimizes the ability for a broad audience to read and look at my thesis. Many interviewees have expressed interest in reading my thesis, and I have an obligation and desire to ensure they can read this massive text with interest and knowledge, rather than having their understanding clouded with my use of excessive ivory jargon.

APPENDIX B

As my interviews were semi-structured, the exact questions I asked varied per interview, but below is the general questions or subjects I would ask about.

Personal background and demographic information

- How old are you?
- Are you currently married or in a relationship? When did you enter this relationship?

Relationship:

If interviewee is in a relationship:

- What is your partner like?
- What feelings do you have for your partner?
- Are you and your partner close?
- What do you do to stay close? Describe the distribution of who chooses what activities to do.
- How does this relationship transfer to other areas of life? Do you feel more empowered or independent because of this relationship?
- How do you make your relationship meaningful?
- Do you and your partner engage in sexual activities? How frequently?
- How do you benefit from being in this relationship?
- How does your partner benefit from being in this relationship?
- What are some drawbacks for you in this relationship?

If interviewee is not in a relationship:

- Were you ever in a relationship? When?

- What benefits and drawbacks are there to being single?
- What are some barriers that make you entering a relationship difficult?
- What are some meaningful relationships in your life?
- Do you enjoy spending time alone? What do you do?
- Do you enjoy spending time with people? What do you do with other people?
- Do you feel more empowered or independent from not being in a relationship?

Quality of Life:

- How would you describe the quality of your life? Why do you say that?
- What things give your life quality? Feel free to mention as many things as you wish to.
- What would make the quality of your life better?
- What would make the quality of your life worse?
- How does your relationship (or lack of) impact the quality of your life?
- What personal connections to people make you happy? Why do they make you happy?
- Is being independent important to you? Does feeling independent impact the quality of your life?

Autonomy:

- What things do you get to choose to do for yourself?
- What do you do for fun?
- How important is choosing your activities?
- Please describe your average day.
- What do you wish you had more control over?

- How do you choose to be in relationships with people?
- How do you express yourself?
- How are you different from other people?