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A conceptual model for aging better together intentionally



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ABSTRACT

Social networks and improved health outcomes are strongly connected, yet many elders face isolation and loneliness. This article presents a study of an elder cohousing community in which residents are dealing with aging-related stresses as a group and creating positive outcomes for themselves. The article posits a conceptual model of how this phenomenon of “aging better together intentionally” occurs and the resulting benefits. **QUESTIONS:** What happens when elders choose to live together in a community in which they consciously address aging collectively? Is it possible to age better together intentionally? If so, what does it look like, under what circumstances does it blossom, and how does it improve the aging experience? **METHODS:** In-depth interviews were conducted with 26 residents of an elder cohousing community in 2009. Respondents were white, mostly female, and averaged 73 years in age. Thematic analysis of interview transcripts led to a conceptual model of aging better together intentionally. To further explore the model, quantitative survey data were collected from the residents three years later. **RESULTS:** The framework of communal coping provided the mechanism of aging better together intentionally. Quantitative data supported the existence of mutual support, increased acceptance of aging, and feelings of safety/less worry/lessening of social isolation as benefits of this type of living arrangement. **DISCUSSION:** This research demonstrates the agency of older adults, the heterogeneity of the aging experience, and the value of older adults sharing their knowledge of the aging process with each other. Our conceptual model of aging better together intentionally could serve as a basis for interventions in other settings to provide a new way for people to age together with enhanced quality of life.

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Introduction

The central premise of this paper is that for many older adults, choosing to age together in an intentional way can provide a better aging experience. The value of social connections is well established. There is a strong relationship between social networks and improved health outcomes (Christakis & Fowler, 2009; Fowler & Christakis, 2008), and friends, not just family members, can play a significant role in well-being and mental health (Adams, Blieszner, & de Vries, 2000; Blieszner, 2006; Fiori, Antonucci, & Akiyama, 2008). Many older people are

happily ensconced in a network of family and friends, enjoying meaningful activities, and already have the support they will need to facilitate their efforts to handle whatever challenges the future brings. For others, however, especially those without close family (whether physically or emotionally), the aging process can be unsettling if they see themselves facing it alone. There is an increasing number of elders who live in precarious situations in which one fall or hospitalization could mean spending the rest of their lives in a nursing home (Portacolone, 2013). Promoting living arrangements in which elders can help each other remain relatively self-reliant is important for an aging population, especially in light of reduced government resources and the resistance of upcoming cohorts to traditional long-term care settings (Glass & Skinner, 2013; Putnam, 2009). Using qualitative and quantitative data, we will describe an elder cohousing community in which residents are helping each other to age well, and we will share a conceptual model of

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how and why aging together intentionally provides a pathway to mutual support, cost-effective health promotion, and enhanced well-being.

Value of social connectedness

Loneliness and isolation among older adults are a growing public health issue, as these conditions can lead to serious health consequences (Cattan, White, Bond, & Learmouth, 2005; Cornwell & Waite, 2009; Hawkey & Cacioppo, 2007; Perissinotto, Cenzer, & Covinsky, 2012; Tomaka, Thompson, & Palacios, 2006). Older adults who have children generally do not desire to live with them (Harper & Bayer, 2000); the percentage of co-residence with children has been decreasing since the 1950s (Gilleard & Higgs, 2005). Almost 30% (29.3%) of those aged 65 and above who are non-institutionalized currently live alone (Administration on Aging, 2011). The prevalence of social isolation and loneliness among older adults is likely to increase with the aging of the Baby Boomers, as fewer have children (National Center for Health Statistics, 2005), and they are also more likely to be single. Recent data show that one third of them are unmarried, with most of these living alone and either never married or divorced (Lin & Brown, 2012). Increasingly, neighborhoods offer only superficial networks (Stafford, 2009), and many observers have voiced concerns about the lack of social interaction and sense of community in the U.S. (e.g., McPherson, Smith-Lovin, & Brashears, 2006; Putnam, 2001).

Loneliness has been clearly identified as a problem, especially for older adults, as it places individuals at risk of worsened health outcomes (Cacioppo & Hawkey, 2003; Cattan et al., 2005; Hawkey & Cacioppo, 2007), depression (Hughes, Waite, Hawkey, & Cacioppo, 2004), and even of dementia (Holwerda et al., 2012), functional decline, and mortality (Perissinotto et al., 2012). There is increasing evidence that isolation itself puts individuals at health risk (Kroenke, Kubzansky, Schemhammer, Holmes, & Kawachi, 2006; Tomaka et al., 2006), especially elders. A wide variety of living situations is needed for the diverse aging population (Folts & Muir, 2002; Glass & Skinner, 2013) to promote physical and mental health and avoid the deleterious effects of isolation and loneliness (Alpass & Neville, 2003; Paul, Ayis, & Ebrahim, 2006; Sorkin, Rook, & Lu, 2002).

Cohousing

One of the innovative ways that elders are attempting to address the issues of loneliness and social isolation is through intentional communities known as cohousing or “living groups.” Intergenerational cohousing communities have developed in more than 20 states, with more than 5000 Americans living in over 90 cohousing communities (Perrigan, 2006). The original cohousing concept began in northern Europe, and both intergenerational and adult-only cohousing communities are much more common in northern European countries than in the United States (Meltzer, 2005). The model usually features private units, common spaces, resident management, and resident participation in the development process.

Elder cohousing

In Denmark, elder cohousing communities are typically low-rise buildings organized around a common area and the common house, while in Sweden and the Netherlands, they are often high- or medium-rise buildings with a common space on the first floor (Choi, 2004). The number of units in a community range from 12 to 22 in Denmark and from 15 to 69 in the Netherlands and Sweden.

Only in the past decade has elder-only cohousing been built in the U.S., with the first three communities built between 2005 and 2007 (Abraham & Delagrang, 2006; Glass, 2012). Of these three, the first is the smallest with 8 units and 12 residents, who had an average age of 82 at move-in (Glass, 2012). The second is Parkside, the focus of this article. The third community targeted the “active adult” and had a younger average age at move-in of 64, with 25 residents living in the 16-unit community. Since then, three more communities have opened, one in 2010 and two in the past year, with others in various stages of planning and development.

In elder cohousing, older adults intentionally choose to live cooperatively in close community with each other. In accord with the desire of most older Americans to live in their own homes, cohousing residents each have their own households, but the units are built closer together than in traditional, single-family neighborhoods, and usually around a common green space. Residents can each find the balance between privacy and companionship that is appropriate for them. Cars are parked on the neighborhood perimeter to encourage contact among neighbors. Common meals and other activities, as well as regular meetings to make operational decisions, also bring residents together. The fact that the community is run by the residents, and there is no administrator setting policy and telling residents what to do, is in itself quite unusual among housing options for older adults in the U.S. Indeed, a fundamental difference between elder cohousing and many other housing options for older adults is that the safety net in the former is the residents themselves, while in other types of retirement communities, there is an internal organizational, service-oriented safety net.

Parkside

This research focuses on one of the first elder cohousing communities in the U.S., referred to henceforth as Parkside. Opened in 2006, Parkside was built with 29 units facing a common green space on a 3.7 acre lot. Of the 29 units, 13 owned houses are grouped in one story duplexes and triplexes on one side of the common area, while two separate two-story buildings on the other side contain 12 rental homes. The latter design was mandated due to the steepness of the site, and allows all units to be entered from ground level. The units on the upper level have parking at the door, while all other residents park in lots at either end of the community. The Common House includes four additional small rental units. The 16 rental homes are federally subsidized for low-income individuals; thus, residents have to qualify financially to live in these units. A house adjacent to the Parkside property houses two units that are also part of Parkside. While physically located slightly “up the hill,” the four residents are community members, in effect adding two more units and making the total

number 31 on site. Residents were all basically independent in their activities of daily living at the time they moved in. The hope is that residents could remain in their homes until death, with home care and hospice brought in as needed. There are no guarantees against possible assisted living or nursing home admission, however, if a resident's health deteriorates to the point that around-the-clock care becomes necessary. In fact, one resident has already chosen to move into an assisted living facility because she felt her care was becoming too onerous for her neighbors.

Several years earlier, before the construction of Parkside, the first author became acquainted with some of the original planners. It is important to note this earlier connection and the effect it may have had on the first author as a researcher there, as it must be recognized that this may bias the perspective of the researcher. Very few of these individuals became founding members of Parkside, however; most participants were strangers who did not know the researcher previously. The residents moved to Parkside from all over the country and generally did not know each other before moving there. There has also been some turnover through the years. In 2010, an analysis showed 61% ($n = 24$) of the original 39 founders were still living within the community (Glass, 2013). Despite these challenges, they have formed a community.

This study augments the literature related to environment and behavior, as it describes the evolution of benefits related to living in a new elder cohousing community. It also adds to the limited research on neighborhood social cohesion, which Bromell and Cagney (2013) define as related to neighbors' "mutual trust, solidarity, connectedness, shared values, and support" (p. 4). Although Bromell and Cagney's (2013) research focused on community-dwelling adults in a conventional, rather than age-segregated, setting, this definition of social cohesion describes what is occurring in Parkside. In addition, as will be explained in the results, after collecting data through interviews, we developed a conceptual model to explain the phenomenon we observed that indicated that these individuals were aging better because they were consciously doing it together.

Age segregation

Although elder cohousing communities are embedded in larger neighborhoods, it should be acknowledged that elder cohousing is a form of age segregation, an idea that has generated controversy over the years. Some argue that ageism is what allows age-segregated housing to exist (McHugh & Larson-Keagy, 2005), and underlies the upholding of laws permitting age-restrictive housing. Despite the ageist roots, however, living in age-segregated housing can provide benefits. Several classic studies have documented positive effects on quality of life (Carp, 1967; Carp & Carp, 1982; Hochschild, 1973; Rosow, 1967; Sherman, 1975), and some more recent studies have also shown positive outcomes for those living in age-specific housing (Folts & Streib, 1994; Grant, 2006; Kingston, Bernard, Biggs, & Nettleton, 2001; Phillips, Bernard, Biggs, & Kingston, 2001; Streib, 2002). There are pros and cons to living in age-segregated environments (see Addae-Dapaah (2008) and Glass and Skinner (2013) for lengthier discussions on this topic). The language surrounding the concept of elder cohousing,

however, has a positive connotation, and seems *not* to have a negative impact on residents. If anything, elder cohousing is adding positive images to society's view of older adults and the elders' view of themselves.

Communal coping

Although their research did not relate to aging, Lyons, Mickelson, Sullivan and Coyne's (1998) work on communal coping offers a way to explain the mechanism of aging better together intentionally. Most coping research has addressed coping from the individual's perspective as an isolated psychological phenomenon, as in Lazarus and Folkman's (1984) transactional model of stress and coping. The idea of communal coping is still relatively new and not well understood, note Afifi, Hutchinson, and Krouse (2006), who observe that researchers are still struggling with the conceptualization. Lyons, Mickelson, Sullivan, and Coyne (1998) were among the first to reconceptualize coping with a focus on collective coping and cooperative problem-solving. Berg, Meegan, and Deviney (1998) also worked in this area, but their research generally did not extend beyond the dyad. Indeed, much of the limited work that has been conducted on communal coping is similarly limited to couples rather than larger social groups (Afifi et al., 2006). Thus we chose to focus on Lyons et al.'s (1998) work as our starting point to discuss communal coping.

Three components comprise the process of communal coping: (a) communal coping orientation, (b) communication about the stressor, and (c) cooperative action to address the stressor (Lyons et al., 1998). Communal coping orientation refers to a belief held by at least one member of the social unit that "joining together to deal with a particular problem is beneficial, necessary and/or expected" (Lyons et al., 1998, p. 584). Communication about the stressor includes discussion of how the stressor currently affects the group as well as the anticipated impact (Lyons et al., 1998). Cooperative action occurs when individuals work together to develop strategies to reduce the "negative impact of the stressor and to address the adaptational demands of the circumstance" (Lyons et al., 1998, p. 584). Communal coping provides benefits that go beyond coping with stress, maintenance and quality of relationships, and the self (Lyons et al., 1998). These benefits include expanding resources and capacity for dealing with stressors, emotional support, increased chances of mutual support, reducing the perceived enormity of the stressor, maintaining and strengthening relationships, promoting the well-being of significant others, promoting the continuation and well-being of the social unit, personal validation, and excitement of overcoming adversity together (Lyons et al., 1998).

Lyons et al. (1998) define *communal coping* as "a cooperative problem-solving process salient in coping with both individual and collective stressors. It involves the appraisal of a stressor as 'our' issue and cooperative action to address it" (p. 579). These two aspects—appraisal and action—are key to communal coping. Communal coping requires that the problem be seen as both "our problem" and "our responsibility," rather than "my problem/my responsibility," which characterizes individual coping. This orientation also differs from "my problem/our responsibility" and "our problem/my responsibility." These latter two, according to Lyons et al.'s

(1998) model, are ways to understand and differentiate communal coping from social support, as social support does not require the helper and recipient to jointly identify a stressor as “ours,” nor does it require coordination or mutual benefit, which are hallmarks of communal coping. In communal coping, members of the social network think and act as if a stressor is shared regardless of whether the stressor impacts each member in the same way (Lyons et al., 1998). Members view the stressor as “our problem” and “our responsibility,” with each member owning and taking responsibility for the stressor and expecting the others to do the same. The result looks like what Afifi et al. (2006) describe: “Ownership and responsibility for the stressor are shared. They perceive themselves as one unit working in unison, rather than as separate individuals working in isolation” (p. 395).

Another distinction between social support and communal coping relates to resource allocation. In social support, resources are transferred from one person to another, whereas in communal coping, resources, such as information, are shared (Lyons et al., 1998). Lyons et al. (1998) also note the prominent role of solid relationships and interdependence as an essential part of communal coping. Building on Lyons et al.'s (1998) work on communal coping, Afifi et al. (2006) clarify that another way to distinguish communal coping is to recognize that it “requires that the members of a group assume mutual responsibility for a stressor and act on it together in a proactive manner” (p. 381). It therefore empowers older adults. They also note that the mere fact that relationships exist within an extended social infrastructure does not assure the existence of communal coping (Afifi et al., 2006). If elders assume that someone other than themselves or their group members will take responsibility for a problem, i.e., a case of “my problem/their responsibility” or “our problem/their responsibility,” it is akin to coping in an institutional setting (see Goffman, 1962). The proactive and intentional nature of communal coping is a key to perceiving the difference between communal and other forms of coping. (See Figs. 1 and 2 for an illustration of empowerment versus institutional models of coping described here.)

The concept of communal coping has been little studied in relation to aging, with one known exception. In a study of communal coping in a continuing care retirement community, Lawrence and Schiller Schigelone (2002) extended beyond the single events (e.g., natural disasters) and temporary circumstances (e.g., job loss) that Lyons et al. (1998) suggested as contexts. They broadened the scope to consider aging, with its associated chronic stressors, as a context in which communal coping may occur. The researchers noted that although the problems associated with aging, such as declining health, financial uncertainty, loss of independence, loss of support systems, and involuntary changes in social networks, are individual in nature, the aging process overall may be perceived as a stressor that is shared by all residents of an elder community (Lawrence & Schiller Schigelone, 2002). They used the term *solidarity in aging* to describe this shared sense of “being in the same boat” (p. 700). They categorized the types of assistance provided in aging-related communal coping as charitable, congenial, compensatory, empathic or sentimental, and group-oriented (Lawrence & Schiller Schigelone, 2002). While we did not use these categories to guide our research, the activities we looked for as evidence of aging-related

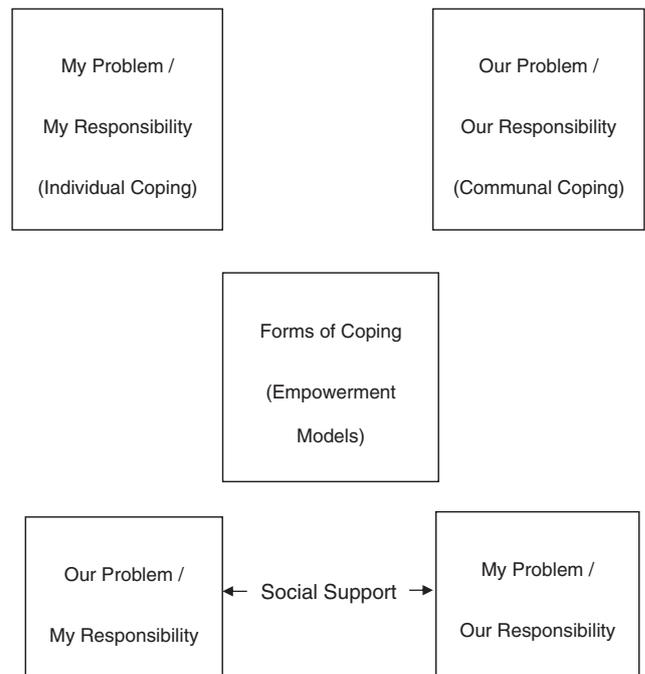


Fig. 1. Forms of coping: empowerment models. Adapted from Lyons, Mickelson, Sullivan & Coyne (1998).

communal coping could be considered *group-oriented*, defined as “residents participating in and helping one another in a way that reinforces a sense of ‘community’ and ‘security’ for all” (Lawrence & Schiller Schigelone, 2002, p. 698).

The current study addresses questions raised by Lawrence and Schiller Schigelone (2002), such as how a culture of communal coping manifests itself, who participates in communal coping and when, and beneficial outcomes of communal coping in relation to aging. The environment of elder cohousing and its associated values of an interdependent community were an ideal setting in which to test the concept of communal coping in relation to aging.

Design and methods

This study was conducted in two phases as part of an ongoing longitudinal research project in which data have been collected annually since Parkside opened in 2006. First, qualitative research was conducted in 2009 to hear from the residents themselves about their experiences, as well as to observe interactions among residents. Because little research exists on elder cohousing communities, a qualitative approach for Phase 1 was appropriate (Fraenkel & Wallen, 2009). Over

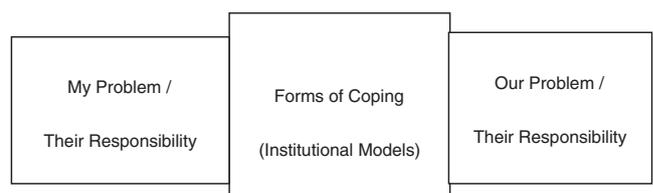


Fig. 2. Forms of coping: institutional models. Adapted from Lyons, Mickelson, Sullivan & Coyne (1998).

time, it was evident that something positive was evolving for the residents in this community. We determined the best fit to explain this process was the work by Lyons et al. (1998) on communal coping, which they describe as “the pooling of resources and efforts of several individuals (e.g., couples, families, or communities) to confront adversity” (p. 580). This line of reasoning led to the development of our conceptual model of aging better together intentionally, which incorporated communal coping as the mechanism that helps explain how the benefits accrue.

The second phase reported here occurred three years later in 2012, when quantitative survey data were collected to further explore our model. The rationale for combining mixed methods is “significance enhancement,” to add to the richness of the data and help in interpretation (Johnson, Onwuegbuzie, & Turner, 2007, p. 116), although the qualitative data could be said to be the dominant approach in this paper, with the quantitative data being used subsequently to “test” the model. Thus, after describing the samples, data collection and analysis, the results will be reported in this order: (1) findings from the qualitative interviews, (2) development of the conceptual model, and (3) results of testing the model quantitatively.

Phase 1

Sample

The 2009 sample consisted of Parkside residents ($n = 26$), all of whom were White, and predominantly female (85%). Unlike the other two elder cohousing communities that opened around the same time (Glass, 2012), there were very few married couples and almost no single men. There was also a higher rate of divorced and single residents than in the other two communities. The average age was 73 years (range = 64 to 87 years). Over half (54%) of the respondents were either divorced (31%) or never married (23%). The respondents were not free from common health problems such as hypertension, arthritis, and heart disease, and at least six

reported memory problems, indicating that the residents were not immune to these challenges either. The average annual income of participants was in the \$20,000 to \$35,000 range, even though they varied widely in occupations. Occupations included teacher, community developer/educator, professor, horticultural therapist, nurse, administrator, church membership coordinator, artist, researcher, librarian, clergy, social worker, attorney, and secretary. Table 1 contains a demographic profile of the study participants in both Phase 1 and Phase 2 of the study.

Data collection

To interview and collect baseline data on Parkside residents, the first author originally approached the Parkside Residents' Association in 2006 with the idea for a study. The author received full cooperation and stayed with a resident on site while conducting the research, allowing for additional opportunities to observe the community. The initial interview guide was developed with input from a team of Parkside residents through meetings prior to starting the on-site pilot study, which was conducted in the summer of 2006. A longitudinal study ensued, in which data have been collected by surveys yearly, and also through annual open-ended interviews during the period between 2006 and 2009. Approval to conduct this annual research was obtained through the University of Georgia Institutional Review Board, and the residents were informed about the project by the Parkside Residents' Association. All the participants received written information explaining the project and their voluntary choice to participate.

Face-to-face interviews were performed and audiotaped after review of the informed consent form. Phase 1 data analysis was based on non-participant observation and 26 in-depth, semi-structured interviews, as they reflect the community's evolution in the first three years of existence, between 2006 and 2009. Interviews lasted about 50 min on average; the maximum was 77 min. Participants were also asked to complete a short questionnaire. The interview questions that pertain to the topic of this article included:

Table 1
Demographic profile of respondents.

	Phase 1 (2009) number *	Percentage	Phase 2 (2012) number **	Percentage
Female	22	85	28	90
Age				
60–64	2	8	1	3
65–74	17	65	17	55
75+	7	27	13	42
Marital status				
Never married	6	23	9	29
Married	6	23	6	19
Divorced	8	31	10	32
Widowed	6	23	6	19
Occupational categories				
Commercial/business	13	50	6	19
Human services	13	50	22	71
Other	0	0	1	3
Annual household income				
<\$20,000	3	12	10	32
\$20,000 < \$35,000	11	44	7	23
\$35,000 < \$55,000	8	32	6	19
\$55,000 < \$75,000	2	8	4	13
>\$75,000	1	4	2	7

* $n = 26$, except for income, where $n = 25$.

** $n = 31$, except for occupation and income, where $n = 29$.

1. Why did you choose to move here?
2. Why did you choose an elder-only community?
3. Do you feel like there is more acceptance of aging or more discussion of it here compared to in the community at large?
4. Does living in this community affect how you think and feel about the aging process and any challenges that can come with that process? If so, how?
5. How is the mutual support working out? Have your expectations changed?

Data analysis

The interviews were transcribed and entered into N-Vivo. To promote accuracy, each of the two authors separately analyzed the data for meaningful phrases and then clustered them into themes. We then compared results and found concordance on the themes as outlined in the results section. Member checking was accomplished through multiple discussions with Parkside residents and through submitting this article for review by the Parkside Research Committee, which is composed of Parkside residents. Reflexivity was addressed in the multiple methods of triangulation and in the sharing of any biases, value systems, and experiences the researchers bring to the study. For example, the fact that the first author had been aware of this community several years before it was actually built allowed her to have a fuller understanding of the history and the early vision for the community. Both authors see the residents as pioneers who are creating a new type of intentional community, which is why documentation of their experiences, no matter what the outcome, was deemed important.

Phase 2

Sample

Slightly larger than the sample size in Phase 1, the sample in Phase 2 consisted of 31 Parkside residents, although most questions received 27 to 29 responses. Different respondents left varying items unanswered. Almost all participants were White, with the exception of one Hispanic resident. As in 2009, the residents in 2012 were predominantly female (90%). The average age was 75 years (range = 61 to 90 years). Slightly more residents were divorced (32%) or never married (29%) than in 2009. The other respondents were either married or widowed. Health concerns, yearly income, and occupations were similar among both groups of participants in 2009 and 2012, as 21 respondents participated in both 2009 and 2012, providing a largely identical sample (Leech & Onwuegbuzie, 2010).

Data collection

The first author visited Parkside for the annual data collection via surveys in 2012. The survey had been revised to begin to include variables addressing the components of the conceptual model of aging better together intentionally, to capture items that were not already being collected. The nine-page survey instrument was distributed with an attached informational letter explaining the project to all those who attended the common meal on a particular day. They were asked to voluntarily complete the survey after the meal and return it to the researcher.

Data analysis

The data from the surveys were entered into SPSS, and basic descriptive statistics were run. Demographic items were analyzed as well as the indicators representing the conceptual model.

Results

The results from both phases of the study, as well as the description of the conceptual model, are reported below. We first report our analysis of the interviews, which indicated that aging was seen as a stressor by the residents of Parkside, that the residents exhibited solidarity in aging, and that what we came to recognize as communal coping was occurring. Additionally, the residents experienced several benefits from aging together in an intentional way. As most of our study participants were female, all interview quotations that follow were voiced by female residents unless otherwise noted. Regarding the lack of males, respondents volunteered a few different theories: (a) there were a lot of strong women; (b) women were more comfortable with living in community and helping each other, and thus more likely to choose this lifestyle; and (c) it was sometimes awkward to be a single man in such a community. Based on our findings from the interviews, we proposed a conceptual model of aging better together intentionally (Fig. 3). We then further explored the model quantitatively, and these results are reported last.

Phase 1: qualitative interviews

Aging as stressor

While health problems do not affect everyone equally as they age, many respondents had chronic health conditions that they viewed as limiting and annoying. In some cases, new conditions were diagnosed or existing conditions had worsened. One resident stated, "When I moved [here] my health was so much better. I didn't have to walk with a cane. I didn't have as much pain as I have now." Said another:

Nobody told me that my handwriting was going to get so bad or that my fine motor skills were going to start slipping away with my memory or whatever I've had physical problems since I came down here, which I didn't have before I retired, and I'm less capable of doing some things.

Respondents voiced aggravation due to the changes and limitations that accompanied worsening health, as in this male resident's comment:

Now I'm frustrated a lot of times because I can't do what I used to do, or I can't do it for as long as I did. You know, simple things, like I'm jealous of the, not necessarily younger, but younger-acting, more vigorous people in the community who can get out and do the things that I wish I could do.

Some residents mentioned the need to constantly make adjustments based on aging-related changes, such as the respondent who had recently decided to quit driving at night. She stated, "I have to keep re-balancing all the time. What

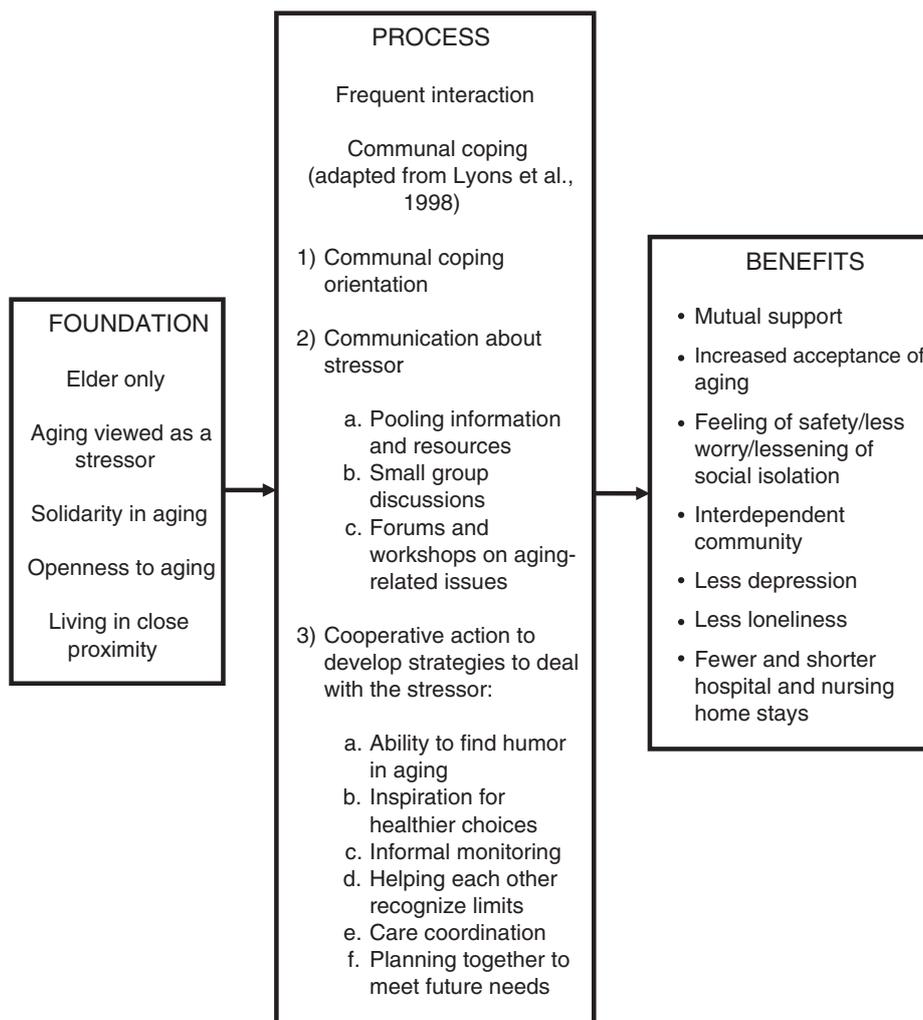


Fig. 3. Conceptual model of aging better together intentionally.

was appropriate last year is not necessarily now. I call it shifting gears, constantly being aware of what the challenges are.” Another respondent said, “I require more sleep, which annoys me.”

One respondent noted physical and financial issues, stating, “Aging is pretty painful physically. And it’s just, after working and having a good salary, all of a sudden you don’t have any money, and so aging sucks.” Other respondents also cited financial concerns as a source of stress, especially given the recent economic downturn. Another said she thinks of many older people “who live way out in the country and won’t go anywhere, but they’re so (a) lonely and (b) frustrated because they can’t manage.”

Solidarity in aging

We also found evidence of what Lawrence and Schiller Schigelone (2002) called *solidarity in aging*, that is, the extent to which residents “consciously identify themselves as facing a shared stressor” (p. 699). Lawrence and Schiller Schigelone (2002) suggest that this sense of “being in the same boat” can provide a foundation to facilitate a culture of communal coping. A clue to this sense of solidarity in aging is the use of “we” language.

There were several examples of solidarity in aging in the 2009 interviews. “Because we’re all aging,” was typical of these comments, along with, “I would have to say that I really wanted to move into a community where we were of a similar age I liked the idea of being in a group of people who were similar,” and, “It helps being with people who understand because the same things are happening to them.” Other comments included, “I think that’s helped because I see lots of other people in the same situation that I’m in. They’re not as strong as they used to be,” and the following observations:

- I think it does help being with other people your own age where they all understand, and we can say, “Oh, God, what did she say? I didn’t hear that,” or, “I forgot,” and everybody says, “Yep.” {laughter} People really understand each other, instead of people saying, “Oh, yeah, she’s just getting old.”
- Or if something or other happens and you think, “Oh my God, what’s happening to my big toe?” And then you find out that six other people have had the same thing happen to their big toe and they’re still walking around, it didn’t drop off. {laughter}

Another respondent stated:

We talk about death and dying and how to respect people’s feelings about it In cohousing that had

different age groups, it would be very different. I think that would be not a topic that anybody wanted to talk about, especially with kids around. You know, “We want to concentrate on the kids. We don't want to talk about what might happen to you next year.” So, I think that's one of the large benefits of having 55 and older.

Openness to aging

As part of the foundation of the conceptual model of aging better together intentionally, in addition to seeing aging as a stressor and feeling solidarity in aging, we proposed that an initial openness to talking about aging is helpful. It is likely that many of the individuals who moved here did so because they had an interest in intentionally aging together. We based these observations on the following data. During the interviews, the individuals were asked about their reasons for moving to Parkside. Most indicated they chose it as a setting that would be comfortable as they aged, and many saw it as exciting to be part of something new. No one mentioned moving as a result of a negative situation or life change. In addition, a sense of community and mutual support were the top-rated reasons for moving, based on a question on this topic contained in the survey. One individual chose to move from a naturally-occurring retirement community (NORC) where services were provided, because it lacked a sense of community. Further, the community also has a “Goodness of Fit” questionnaire on its website for prospective residents to review if they are considering a move. One of the items included is, “I am willing to face the mysteries of aging and death.” This willingness to face aging together is reflected in the next section describing the process of communal coping.

Communal coping

This group lives in close proximity in a setting that promotes interaction. Having identified that the respondents saw aging as a stressor, demonstrated solidarity in aging, and were open to aging, we placed these key criteria as the foundation for aging-related communal coping, as defined by Lyons et al. (1998) and Lawrence and Schiller Schigelone (2002). Based on our interpretation of the interview data, we ultimately determined that the communal coping process was a good fit to describe the mechanism of aging better together intentionally, through the three essential components delineated by Lyons et al. (1998)—communal coping orientation, communication about the stressor, and cooperative action. Since our unit of study was the Parkside community, we focused on what Lawrence and Schiller Schigelone (2002) labeled *group-oriented* coping that reinforces a sense of community and security for all.

Communal coping orientation

Communal coping orientation requires “a belief that joining together to deal with a particular problem is beneficial, necessary and/or expected” (Lyons et al., 1998, p. 584). When asked if and how living together at Parkside had affected their experience with aging compared to the larger community, the response was positive:

- Yes, I think almost everybody here was kind of interested in [aging well], and it kind of feels like we were trying to do it, trying to improve the way we look at it and other people look at it.
- Sure. You're doing it sort of more of a lone wolf type thing [outside of Parkside]. Not that you don't have people or friends of yours that are all in the same age group, but here it's dealt with a lot more consciously and openly.

These thoughts also led to many comments reflecting the benefits of joining together to deal with aging-related changes.

- We want to make this as rich of a time as we can [Other elders are] not doing what we're doing. I think it is pretty rare. It's quite a gift.
- We're different from other communities because we are looking at those realities and helping each other, trying to help each other through them That could be a purpose—learning to age well together. (male)
- It's just for the good of everybody really, for the benefit of everybody.

Communication about the stressor

Many respondents spoke of the frequent exchange of information and opportunities to discuss aging. Some gave evidence of the “pooled resources” described by Lyons et al. (1998), noting for example, there was “lots of shared wisdom—we all contribute what we know,” and referring to an opportunity “to sit and just review what all of us knew or have heard or seen in one form or another, just opportunities like that which you don't get in other places.” A third respondent said, “I really appreciate the attitude that many of us [have about aging], there's a lot of wisdom here on that topic, and I think I've benefited. We seem to talk about aging a lot I think it has been really helpful to me.”

Many respondents emphasized that there was more “dealing with the realities and willingness to talk about aging and try to do it well” and attempting to get at important issues. Communication took place in many venues, which varied in levels of formality and participation. One avenue was the “pods,” the name they chose to describe small discussion groups in which people could voluntarily participate. Pod meetings were generally held in a member's home. The goal of having pods was to provide a safe forum for sharing personal information in order to get to know each other better. Not all the residents participated, but those who did found that pods were helpful, as in these examples: “In our pod, we talk a lot about aging and how we're doing it and what it all means,” and, “I have close friends where we discuss [aging] a lot. I'm in a really good pod where we are able to get into some depth.”

There were also larger forums that addressed aging-related topics. Periodically, the residents invited speakers from the larger community to come and discuss various topics, from explaining government benefits to providing hospice volunteer training. A more formal monthly forum was started in 2008 that is now called Aging Affirmation. Two residents have had Spiritual Eldering training (Schachter-Shalomi & Miller, 1995), which is a “conscious aging” program that can be offered in the community at large as well as at age-segregated settings. These two residents organized the monthly forums and are credited

with sharing excellent resources. Many residents cited it as being beneficial:

- The Aging Affirmation ...has been a big help to bring some focus on that without it being a downer Some really wonderful presentations, either videos or books or poems or quotations, whatever, there's a lot that comes through that. There's a wealth of learning, you know, that you can apply to your day-to-day life.
- I think it's called Aging Affirmation. We all come together at the Common House and we talk about different issues, and I think that's good because I'm probably younger than some of the people here, but I also have incapacities that are probably worse than some of the people here, and it's nice to hear how other people are, and you wonder what you're going to be like at say 80, 85, you know?

A more structured three-day "Positive Aging" workshop organized by the same couple was held in 2008 with about 25 residents in attendance. One of the leaders described it:

We start out with looking at our past, coming to terms with that, and with looking into the future, what we want to do now. It's very intense ...a lot of writing, journaling, meditation, small groups or dyads People seem to like it.

A person does not need to live in an elder cohousing community to attend workshops on spiritual eldering and positive aging, but the fact that the elders in Parkside were taking the initiative to coordinate such workshops for their community was significant. It was one of many ways in which these residents demonstrated a communal coping orientation and took cooperative action to develop strategies to deal with aging.

Cooperative action to address the stressor

We identified at least six examples of cooperative action from the interviews: sharing humor, influencing healthy behaviors, informal monitoring, helping each other recognize limitations, care coordination, and planning together to meet future needs. "Here it seems to be part of a program," one respondent summarized. Many respondents mentioned that the ability to laugh together and have a sense of humor about their limitations was an important aspect of living at Parkside. Reflecting on the prevalence of hearing impairments, for example, respondents frequently mentioned being able to get together after a meeting and compare notes on what each of them thought they had heard, which often led to much laughter. Other representative comments included:

- A lot of the stuff that comes with being old I find humorous To be with people who can laugh at that and not see it as some awful thing that's happened to me or to them or us is just, it's comforting. It makes it not seem some horrible thing, which I don't think it is. It is what it is.
- I forget more stuff, and when you talk about it in a sort of humorous way and you can see how people cope with it, that's very reinforcing.
- The physical pain no one can really help with, but I have fun with people, and that's distracting I mean I have fun here. I don't know about anybody else, but I think my one priority in aging is to have fun ...because if you have fun,

life is so good. Life is so sweet. So my goal is to have fun.

- I think it's very beneficial, and I'll tell you one reason is that we all have had the ability to laugh at what our lacks are about deafness and sight and lack of energy and strength, [so it] has become something that is humorous, and that would not happen with young people.

Respondents also reported that as a group they exerted positive influences on each other through gentle pressure to prepare healthier meals, demonstrated through the twice-weekly common meals, and encouragement to exercise through companionship and convenience. This influence was particularly noticeable in relation to eating better. The following comments illustrate:

- I think a lot of us here have come to the realization that what we eat is very important, so we're trying with our common meals and succeeding in doing highly nutritious meals.
- Like people don't want to come to meals because they don't believe in eating beef. Over time the people who cook want to have more acceptable meals, and we continue to talk about it more—less sugar and more fruits and vegetables. So I think we have influenced each other without being dogmatic.

A third component, informal monitoring, involved surreptitious observation, as this respondent described:

We can even notice a change in somebody, be aware of it, and kind of keep an eye on them, and I think that's happened once or twice where probably everybody has noticed something and we were all kind of watching to make sure that the person is all right or checking on them more frequently It's a very comforting feeling, a very family feeling.

A fourth, somewhat subtle, informal action was the idea of looking out for other residents and gently helping each other respect their limitations. This phenomenon is exemplified by the following quotes:

- And honoring, and trying to get people to honor their limitations. It's amazing how easy that is to see in somebody else and not in yourself But we're gently reminding each other "maybe you didn't want to go swimming this afternoon. You have been doing all of this stuff in the morning." It's a good idea.
- We learn from one another a lot, you know? I think I tend to need some people to say to me sometimes, there's a limit to what we can do in this situation, and I respect people who have identified those boundaries.

A more formal organized action was the use of care coordinators. Parkside espouses mutual support as a value, and first tried a buddy system for each resident, formed by the two or three closest neighbors. In 2008, however, they changed to a plan for each resident to select one or two other residents to serve as their care coordinators if something happened and they needed help from the community:

We've come up with this health coordinator plan, which I think was just an inspiration, you know, a team kind of effort We have a caregivers' list, and those are people

Table 2

Interview excerpts describing aspects of the benefits of aging better together intentionally.

BENEFITS
<p>Mutual support</p> <ul style="list-style-type: none"> • One thing is we're kind of set up to help each other. • I mean it's happened already for some people if they fell or something and they needed some help, then at least you don't have to try to call people and ask them to do things for you. The care coordinator would do that for you. • The support and the understanding and seeing how other people struggle physically with the infirmities of age is a good thing for me. [male resident] • I think that the care coordinators concept is a really good thing for the singles for a lot of reasons, not the least of which is it's a clear and obvious expression of mutual support, but it's also evidence of our recognition of dependence. It gives us a reason and a comfortable way to reach out and ask, because I'm sure you know [you have] 40 very, very independent people, and the fact that we can get past that independent streak and recognize and be comfortable with reaching out to ask for help and accepting it, and the giving is the easy part. • The mutual support aspect is doing unbelievably well. I think you probably heard about [one resident's] broken arm? I was astonished at how the community pulled together and the process we have in place worked beautifully. I mean she became the poster child of what can be done. It was truly gratifying. Having the care coordinator idea is working well. • We're slowly understanding that it's okay to need help and it's okay to accept it. <p>Increased acceptance of aging</p> <ul style="list-style-type: none"> • Right now I still feel very healthy and I'm very active, but I see other people that are not and I know that down the road that's where I'll be, and it just helps me There's one resident in particular that I admire greatly because she's just willing to, sometimes unrealistically, but willing to take on most anything and just, it's "I can do, I can't do this, but I can do something," and I really admire that Learning about others' experiences has been helpful. • Well, no, I don't have any difficulty anymore accepting it. I did in the beginning. So, I think that's helped because I see lots of other people in the same situation that I'm in, you know, they're not as strong as they used to be, or they can't do this, or used to be able to do a job and work six hours at a time and then stop and have a break. Now if I do it for two hours I'm dead, that's it for the day and the next day I have to rest, you know, that kind of thing. So, I think it does help being with other people your own age where they all understand and we can say, oh, God, you know, what did she say? I didn't hear that or I forgot and everybody says, yep. {laughter} • I think [people] can be much more comfortable with the losses that [they] are facing because it's so non-competitive here and there's a lot of support and kind of general acknowledgement and acceptance that that's just part of life is losses. • Especially talking with the folks who are older than I, the ones in the 80s in particular, talking about how difficult it was for them to realize that maybe they can't run a marathon anymore and, boy, that is tough. You're so accustomed to going all day and all night, and it doesn't happen anymore. So, it's just listening to input from folks as to, "Hmm, I'll pay attention to that." So it's been very helpful Maybe [helps me] become more ready. • There's a whole bunch of people here where we can just make all kinds of jokes, so it takes all the stress and tension out or feeling of failure is just gone because of that. • A lot of things happen that you haven't thought about it before because all of a sudden here you are older and you haven't been older before. {laughter} <p>Feeling of safety/less worry/lessening of social isolation</p> <ul style="list-style-type: none"> • I feel safe here. If I fell over, someone would notice in four or five hours. If I have to go [somewhere else], that's not going to happen, so I'm going to be scared. I'd have to get one of these things or carry my cell phone with me or something. I feel so safe here and so cared about, I can't miss a meeting without someone checking on me: "Are you okay? Why did you miss the meeting?" • When you get older, I think everyone, one of their main concerns is, "Okay, something happens to me, I want to know for sure that I'm not going to be out there alone." And you can be sure you're not going to be alone here. You can have as much or as little help as you want if something happens to you. That's a good thing. • Knowing that people are around and if you needed something or something happened in the middle of the night, you'd have somebody to call. Because that would be different if you lived somewhere else in town. • I'm a pretty private person and like quiet and being on my own, yet I feel the security that I've got neighbors who really genuinely care.

who signed up who say they'll drive or get the mail or make a meal or clean the house, all those activities of daily living that need doing when the person can't. And it's worked beautifully because the person who isn't well only has to deal with the care coordinator, and that person coordinates the rest, so the person can really just turn it over and relax. So it's been a great plan.

In addition, there have also been planning discussions to jointly consider future needs and determine appropriate actions. There was contemplation of having an aide live on site at some point in the future, and they discussed concerns about "future-proofing," that is, having enough younger people continue to move in. As it happens, with the turnover and new residents moving in, the mean age in 2012 was 75, only slightly higher than in 2009 (73), with a range of 61 to 90. Almost three quarters of the respondents (74.2%, $n = 23$) were under age 80 in 2012. This question remains a concern that will continue to be monitored.

Benefits of aging better together intentionally

Beyond communication about aging and coordinated action to cope with challenges, which are advantageous in

themselves, our analysis of the interviews identified additional benefits that are specific to a group of elders who are attempting to age better together intentionally: (a) mutual support, (b) facilitating acceptance of aging, and (c) feeling of safety/less worry/lessening of social isolation. Table 2 contains representative interview excerpts.

Examples of assistance that residents provided for each other when the need arose included preparing meals and shopping for groceries, accompanying an individual to healthcare appointments, and several weeks of walking a resident's dog while she recovered from surgery. In a specific example, one woman fell and shattered her elbow. She reported that her Parkside neighbors visited her in the hospital, and that meals were provided when she returned home. Capes and ponchos were loaned to her. She was driven to the surgeon's office and even received personal care assistance with bathing and shampooing her hair. In another case, a hospitalized resident was able to avoid a six-week stay in a skilled nursing facility and return directly to Parkside because her neighbors were willing to help her with her personal care.

As suggested in some of the previous excerpts, several respondents indicated that being part of Parkside was helping them to accept their own aging. The solidarity in aging that is so prevalent was mentioned as a catalyst in

Table 3
Quantitative survey data from Phase 2 of the study.

Aspects of the model of aging better together intentionally	Survey items	Results
<i>Foundation</i>		
Aging viewed as stressor	"Aging can be stressful."	86% (n = 24) somewhat or strongly agree
Solidarity in aging	"Lots of people who live here are in the same situation that I am." "I feel like I am mostly dealing with my aging alone."	93% (n = 26) somewhat or strongly agree 72% (n = 21) somewhat or strongly disagree
Openness to aging	"We do not deny the realities of aging here."	97% (n = 28) somewhat or strongly agree
<i>Process</i>		
Communal coping orientation	"I feel like learning to age well together is a goal here."	97% (n = 27) somewhat or strongly agree
Communication about the stressor	"We have forums and other planned opportunities to talk about aging concerns and issues." "My neighbors and I share the information we have about aging." "I am learning about aging from others who live here." "Satisfaction with the quality of information I receive about aging issues."	100% (n = 29) somewhat or strongly agree 100% (n = 29) somewhat or strongly agree 97% (n = 28) somewhat or strongly agree 93% (n = 27) are somewhat or very satisfied
<i>Cooperative action to develop strategies to deal with the stressor</i>		
Sharing humor	"My neighbors and I can find and share humor related to aging."	93% (n = 27) somewhat or strongly agree
Inspiring healthier choices	"My friends and neighbors here inspire me to be healthier."	83% (n = 24) somewhat or strongly agree
Informal monitoring	"My neighbors and I look out for each other."	100% (n = 29) somewhat or strongly agree
Helping each other recognize their limits	"When I see a neighbor 'overdoing,' I try to say something."	92% (n = 24) somewhat or strongly agree
Care coordination	I have chosen a neighbor to be my care coordinator (not in survey; viewed list)	100% (n = 31) have selected one
Planning together for future needs	"Residents work together to make life better." "If there was a problem, we would work together to solve it."	96% (n = 27) somewhat or strongly agree 79% (n = 23) say many or all the neighbors would work together
<i>Benefits</i>		
Mutual support	"We depend on each other for support here." Comparing mutual support here to other housing situations	97% (n = 28) somewhat or strongly agree 89% (n = 25) say there is more mutual support in cohousing
Increased acceptance of aging	Satisfaction with "mutual support" "Living here helps me accept my own aging more than I did before." "Because of my friends and neighbors here, my experience with aging is"	93% (n = 25) are somewhat or very satisfied 89% (n = 25) somewhat or strongly agree 78% (n = 18) say it is "better"
Feeling of safety/less worry/lessening of social isolation	"Living here makes me feel safe." Satisfaction with "socializing and companionship" Satisfaction with having "someone close by to help in an emergency"	100% (n = 27) somewhat or strongly agree 93% (n = 27) are somewhat or very satisfied 97% (n = 28) are somewhat or very satisfied

Note: Reported % is the number of respondents who answered as reported out of the total number who answered the question. Not all participants answered every question.

helping individuals realize that no one is exempt from aging and to move away from denying aging. Related to this notion was the idea of role models. Some respondents saw others in Parkside, especially some of the older residents, as excellent role models for how to age well, and they reported learning a lot from observing them. For example, a 70-year-old respondent mentioned how much she learned from residents in their 80s, and how it helped her in preparing to accept her own aging.

The sense that "everyone knows you" and, further, that they are looking out for each other brought respondents a feeling of safety. They expressed freedom from worry about many aspects of life. Similar to respondents in Dupuis-Blanchard, Neufeld, and Strang's (2009) research, they appreciated having their own homes but not being alone, with companionship easily accessible along with the security of knowing someone would notice if something happened to them.

A conceptual model of aging better together intentionally

We present the conceptual model of aging better together intentionally as seen in Fig. 3. The foundation of the model

requires an elder-only intentional community in which members live in close proximity to each other, view aging as a stressor, exhibit solidarity in aging, and are open to aging. We do not believe that it is restricted to an age-segregated community as long as people live close enough to each other to see each other frequently. Proximity has been identified as helping to promote social engagement (Shippee, 2012; Sugihara & Evans, 2000). The process, or mechanism, for achieving the benefits of aging together intentionally is communal coping, adapted from Lyons et al. (1998), and which requires frequent interaction. The three components of communal coping in the model are (1) the belief that dealing with aging together can be better than dealing with it alone (communal coping orientation); (2) sharing resources and information about aging (communication); and (3) collective action to deal with the stressor of aging. Benefits of aging together intentionally that surfaced in the interviews as described above are included as outcomes. From Phase 1, we identified the first three benefits listed in our conceptual model—mutual support, increased acceptance of aging, and feeling of safety/less worry/lessening of social isolation—and added corresponding measures to the

quantitative surveys administered as part of the longitudinal research plan in 2012. As the model has evolved, we propose to include four additional benefits that are projected based on the literature: increased interdependence, decreased depression and loneliness (e.g., [Hawkey & Cacioppo, 2007](#); [Hughes et al., 2004](#); [Paul et al., 2006](#)), and fewer days spent in the hospital or nursing home. The model is followed by the Phase 2 quantitative data that were used to explore support for the model.

Phase 2: quantitative data

The quantitative data collected through surveys in 2012 (see [Table 1](#) for demographics) provide support for the model (see [Table 3](#)). First, aging was identified as a stressor by these respondents. The majority (86%) somewhat agreed or strongly agreed with the statement that “aging can be stressful.” We also found support for the existence of solidarity in aging, with 72% somewhat disagreeing or strongly disagreeing that they were “dealing with my aging alone.”

As for the communal coping mechanism, we found support for each of the three components. For the communal coping orientation, 97% somewhat agreed or strongly agreed that “learning to age well together is a goal” at Parkside. Since we were particularly interested in the degree to which these participants talked about aging, four items related to communication about the stressor were included. The vast majority of respondents (93%) were satisfied with the quality of information they received about aging, and 100% somewhat agreed or strongly agreed with each of the following statements:

- “We have forums to talk about aging concerns.”
- “Neighbors share information about aging.”
- “I learn about aging from other residents.”

In another item not reported in the table, respondents were asked their preferences as far as the current amount of learning and talking about aging. Eighteen (62%) said “the same,” while another third (35%, $n = 10$) wanted “more.” Finally, for the “cooperative action” component, the majority of respondents strongly agreed or somewhat agreed with statements addressing sharing humor related to aging (93%), inspiration to be healthier (83%), and informal monitoring (100%). Regarding helping others respect limitations, 92% agreed they would say something if a neighbor was “overdoing.” It was further documented that every individual has named a care coordinator, and some individuals had also named a back-up person.

The first three proposed benefits presented in our conceptual model were similarly supported by the data (see [Table 3](#)). Three items addressed the mutual support aspect, with 89% reporting that there was more mutual support in cohousing than in other settings. Two items reflected increased acceptance of aging, again demonstrating strong agreement. Over 90% of respondents reported agreement or satisfaction (depending on the variable) on all three of the items reflecting feeling safe/less worry/lessening of social isolation.

Discussion

Almost one out of every three elders living in the larger community now lives alone ([Greenberg, 2009](#)). While many of these 11 million older adults are actively involved in their families and communities, they face increased vulnerability

due in part to the possibility of social isolation and the absence of stimulating interactions. Elder cohousing and other elder intentional communities can be catalysts for enhancing opportunities to deal together with the challenges that can accompany aging and help these individuals have a better aging experience. Previous research by Stack (as cited in [Lyons et al., 1998](#)) found that communal coping is more likely to occur in the context of ongoing relationships participating in a larger set of obligations of giving, accepting, and repaying. When individuals lack such a history, they may engage in communal coping if they perceive another person is dealing with a similar stressor. While [Lawrence and Schiller Schigelone's \(2002\)](#) research suggests that solidarity in aging in any setting may meet the second condition, elder intentional communities, such as Parkside, meet both conditions and thus increase the likelihood of communal coping beyond that found in traditional elder communities.

With parking typically on the perimeter, the cohousing model is physically designed to facilitate a sense of community and promote communication. Some “looking out for each other” and talking about experiences may exist among older people in other settings such as continuing care retirement communities (CCRCs) ([Shippee, 2012](#)), independent living facilities ([Dupuis-Blanchard, 2007](#); [Dupuis-Blanchard et al., 2009](#)), and in the community at large, but the full spectrum of aging-related communal coping described here is rare, according to the experiences reported by the residents themselves. In their proactive approach to aging, the Parkside residents strengthened their individual and group reserves by sharing information, providing mutual support, and creating systems to anticipate and deal with potential stressors. [Wadensten and Carlsson \(2003\)](#) address the fundamental issue of talking about these topics in their guidelines for elder care based on [Tornstam's \(2005\)](#) model of gerotranscendence, suggesting that older people be encouraged to have individual or group discussions about aging. The degree to which these individuals have confronted their own aging and chosen to make it the best they can by not denying it, but instead talking about it, is, we believe, a distinction from other elder housing arrangements. There is little either in the research or anecdotally that indicates that there is much talking about aging going on. We hear about “health literacy”—maybe it is time to start discussing and promoting “aging literacy.”

By being open to aging and accepting the consequences of old age, the residents were able to laugh in the face of increasing limitations. The reported sharing of humor about hearing impairments, for example, stands in stark contrast to the description of CCRC residents who were shunned or voluntarily withdrew as their hearing worsened ([Shippee, 2012](#)). At the same time, by dealing together with current and future needs, the residents felt safer and less anxious about growing older. The mutual support, the forums, and the other activities outlined here were entirely developed by the residents themselves; there was no professional from above or outside telling them what to do. It is worth noting, however, that this community had the benefit of at least a few residents who themselves had backgrounds in social work, counseling, and spiritual eldering.

The characteristic behaviors and benefits of intentionally aging better together, as exhibited by Parkside respondents, represent progressive change in the face of adverse macro-level

conditions, as Dannefer, Stein, Siders and Patterson (2008) describe in their article on the concept of care. Living in an intentional community allows elders to maintain their individual agency at the micro (interpersonal) level in the face of macro-level hindrances such as ageism and the medicalization of old age. Age segregation at Parkside means that the residents look to themselves and each other first as agents, rather than to those younger than themselves. They therefore maintain, or even build, their capacity more than they might in an inter-generational setting in which members of the younger generations, intentionally or unintentionally, could cause the elders to see themselves as incompetent. The confidence gained from micro-level agency could transform the way the elders of Parkside interact with people in the larger society and thus improve some of the problems older adults face at the macro-level.

According to our respondents, the advantages they gain from living at Parkside are substantial, and not the least is the ability to directly address aging issues and how to age well. In a society like the U.S. that is anti-aging and age-denying, many people, including elders themselves, never have opportunities like those described here. While there are those in this culture who labor under the hope that not talking about aging and pretending it will not happen will somehow make that so (Brehony & Stephens, 2012), it is clear from our respondents that there is another path that can be chosen—to look aging in the eye and improve the experience. These respondents are not sitting in rocking chairs; they are energized by the opportunity to be part of what many realize is a unique experiment.

This neighborhood is socially cohesive, even though it is comprised of individuals who for the most part did not know each other before moving here. There are other neighborhoods that are also very cohesive, from one like West Hagert Street in Philadelphia as described by Ball (2012) where neighbors have aged in place together in conventional housing, to other types of retirement communities (Cloutier-Fisher & Harvey, 2009). What is unique at Parkside, however, is the willingness to put the aging process out front and center and consciously work together to make the experience the best it can be. This willingness contrasts to the typical age-denying focus in our society, in which we shy away from even using the word “aging.” Further, unlike the other two early elder cohousing communities, which were mostly comprised of married couples (80% or higher, Glass, 2012), the fact that Parkside has attracted a high percentage of single people is significant as a demonstration that this kind of cohesive community can form for those who are most likely to need it, and even when there is turnover among residents.

In sum, the assurance that one is not isolated is no small thing for elders. Even though these respondents, like most of us, value their privacy and independence, they have a great appreciation for working together to age well. In fact, as one male resident stated, “That could be a purpose: learning to age well together.” A myriad of experiences that both challenge and enrich them clearly emerged. It is also exciting to feel that one is embarking on a new adventure, as these respondents have chosen to do, to have a better quality of life as they age.

The respondents say that this community is unlike anywhere else in their experiences, because of the clear focus on aging. But for those who would persist in arguing that this phenomenon

exists at other places, these results are still noteworthy as a first attempt to articulate the model of aging better together intentionally and explain the process so that it could have broader application. The potential gains from this type of intentional community for older adults, whether physically built or informally gathered, make this research worthwhile.

Our research is in line with critical gerontology's call for conceiving of aging as an active, rather than passive, process and the call to focus on the agency of older adults as they construct their experience of aging (Dannefer, 1989). Aging better together intentionally, by definition, fosters “proactive, engaged individuals” who actively construct their experience of aging, as Dannefer (1989, p. 3) described. Dannefer (1989) states that “intentional human action is an important force in the production of patterns of human aging” (p. 4). Individuals and groups of people, such as the residents of Parkside, are helping to shape society's views of aging by the choices they make every day. In Parkside, we see the power of older adults to create a housing environment that helps them to feel better about themselves and the process of aging. The residents there are adding to what is possible in the world—what is possible as a living arrangement for older adults and what is possible as an outlook on the aging process. The actions of Parkside residents can be seen as a form of “civic engagement,” broadly defined by Minkler and Holstein (2008) as including grassroots efforts to work toward a more just world.

As Dannefer et al. (2008) argued, we agree that critical gerontology can contribute through reframing a concept in a constructive, positive way and creating new possibilities that question the assumptions that old people are always frail and in need of care. Critical gerontology requires a “more value committed approach to social gerontology—a commitment not just to understand the social construction of aging but to change it” (Phillipson & Walker, 1987, p. 12). Critical gerontology emphasizes the heterogeneity of the aging experience (Katz, 1996), and our study contributes to the body of research in critical gerontology that illustrates such heterogeneity. Elder cohousing may not be ideal for everyone, but it offers significant advantages for people who want to co-create their aging experience with others and make it as positive as possible. The study also provides evidence of critical gerontologists' argument that older adults are the best source of knowledge about aging. The residents of Parkside are a wealth of knowledge for each other about the processes of aging, and they share their knowledge in formal (e.g., forums, workshops) and informal (e.g., pods, communal dinners) ways.

Some possible sources of bias must be considered when interpreting this study's results. There are clearly limitations to this study as it represents how residents of only one unique, mostly female, and mostly well-educated community are exhibiting and benefiting from intentionally going through the aging process together. The sample size was small and the ratio of female to male participants was unusually high. In this study, females comprised 85% of the population, whereas in the general U.S. population 60 years and older, they comprise 55% of the population (Howden & Meyer, 2011). Third, 96% of the participants were White, compared with 75% of the overall U.S. population (Hixson, Hepler & Kim, 2011). The annual income of participants was similar to the \$31,408 median income of Americans 65 years and older, however (DeNavas-Walt, Proctor & Smith, 2011).

Future directions

In our conceptual model of aging better together intentionally, we have identified ways by which elders can build a sense of community that enables them to foster resilience in dealing with the aging process. These findings are important because they present one of the first examinations of an intentional way to approach aging together. At this point, we know only that our model fits the particular community of Parkside. Possibly this socially formulated “world of meaning” is only locally applicable (Gubrium & Holstein, 2000). We believe, however, that what we have learned in this context could benefit others living in elder-rich settings, both in the United States and in other countries. In Parkside, there is an unusually high acceptance and willingness to deal with aging that is not seen in many other living arrangements. Thus this model may not currently apply for that reason, but rather serves more as a roadmap for an intervention to further develop such intentional communities. By identifying the ways of cooperatively dealing with aging that have helped these respondents, we now have the basis upon which an intervention program could be developed and transferred to other settings. We would also argue that this intervention could be implemented in other, non-age-segregated settings, such as an apartment building or a suburban neighborhood. Our future research is moving toward developing and testing this idea in other settings. This invention would entail identifying individuals who want to participate, live near each other—whether in an apartment building or a suburb—and commit to meeting regularly, perhaps weekly. They could organize to share information and choose another member as their care contact.

As some of the benefits delineated in our model came from previous literature and anecdotal evidence (Glass, 2013) and were not explicitly addressed by our study, we intend to incorporate quantitative measures of these benefits in future research at Parkside. Specifically, we will examine whether and to what degree residents experience interdependent community, less depression, less loneliness, and fewer and shorter hospital and nursing home stays. We will add measures, such as the UCLA three-item loneliness scale (Hughes et al., 2004) and a more formal social isolation measure, among others, to future surveys as we continue with longitudinal data collection. Further, the notion of interdependence warrants more exploration; as Portacolone (2011) notes, this concept has been largely neglected in the literature, yet when is it more essential than as we age? Instead, there has been an emphasis on being independent, sometimes to the detriment of the individual (Brehony & Stephens, 2012; Portacolone, 2011). The value placed on independence in our society supports the neo-liberal policies that encourage people to age in place, which are in turn driven to some extent by financial considerations and the lack of enough affordable alternative housing options (Golant, 2008) and can result in individuals remaining in suboptimal living situations. This analysis adds to the scant literature on this topic.

Additionally, future research should investigate whether this model of aging better together intentionally applies to other elder intentional communities besides Parkside. Can the same types of activities, such as intentionally talking about aging, be implemented in other existing communities to produce outcomes similar to those found in Parkside? Will

the reciprocal behaviors that residents of interdependent communities engage in, and the proactive planning, increase the likelihood that individuals will (a) offer, (b) seek, and (c) accept mutual support when it becomes their turn? Even more fundamental is the idea that elders should be given the opportunity to discuss the serious aging-related issues that are often ignored. Helping older adults maintain their health and independence through group coping behaviors and interdependence can facilitate their ability to remain in the community longer. “Learning to age well together” is a different goal from trying to pretend we are going to stay young and live forever, and, we would argue, a better one.

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