The Social Location of Older New Zealanders' Housing Decisions

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Abstract

Older adults' housing decisions in later life are significant and complex. An older person's home can form a central part of their life, and has been shown to impact on health and wellbeing, and be connected to identity and sense of attachment. Housing decisions are complicated by the many factors requiring consideration, the reality that ageing is often accompanied by changes in health and physical ability, and the process being individualised to each person's unique life circumstances. Past literature, modelling the influencing factors on older adults' housing decisions, has assumed that decision-making has a clearly definable pathway and is both conscious and rational. These assumptions have been criticised, along with these models being deemed overly simplistic, by critics who call for an alternative approach to expand the understanding of housing decision-making. In response to this, the present study aimed to explore the social location of older New Zealanders' housing decisions by examining the socially available discursive resources that older adults draw on to construct their housing choices. Interviews were conducted in the homes of five individuals and two couples, aged over 65 years, who resided in a range of different housing situations. The interviews were audio recorded, typed verbatim and discursively analysed as guided by the phases outlined by Potter and Wetherell (1987). Five main interpretative repertoires used to talk about housing choices were identified, labelled 'Decline', 'Medical', 'Independence', 'Stability' and 'Familial', along with the subject positions provided by each of these discursive resources. There were a number of interactions between the repertoires that showed participants shifting back and forth between using the different repertoires, which provided a more nuanced understanding of how they constructed their housing decisions. The identified discursive resources came from outside of what is most commonly thought of as housing-related variables, demonstrating that these decisions are constructed using broader social resources. The study has implications for broadening the theoretical lens on the understanding of older adults' housing decisions, along with implications for housing decision-making and informing housing, health and ageing policies. Overall, the social location of participants' housing decisions highlighted that they are not fixed, causal, linear processes, but instead complex and dynamic, and located in people's broader social lives.

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Chapter 1: Introduction: Older Adults' Housing Decisions in the New Zealand Context

New Zealand, like many other countries, is experiencing an ageing population. New Zealand's population has undergone a major shift in its age structure, from being predominantly made up of younger people, to being increasingly represented by the older age group (Saville-Smith, James, Warren, & Coleman, 2009; Statistics New Zealand, 2012). Older adults aged 65 years and over currently comprise 14% of the population, which is expected to accelerate to an estimated 26% by 2061 (Statistics New Zealand, 2012).

A major consequence of our ageing population is the implication it has for older persons' housing (Saville-Smith et al., 2009). There is an increasing number of older adults contemplating their future housing options, to make housing decisions that enable living in suitable, affordable, and accessible homes, which meet their needs and support positive ageing (Davey, de Joux, Nana, & Arcus, 2004). While such a decision might seem straightforward to make, the reality is that housing decisions are complex and hold great significance for older adults (Clough, Leamy, Miller, & Bright, 2004).

With ageing, the home can carry particular importance to its occupants, as they have often lived there for many years and formed connections with the place and people associated with it. The home represents a physical location, but more importantly, a place of social connectedness (Clough et al., 2004), and is intimately tied to a person's identity, belonging and attachment (e.g., Sixsmith, 1986; Swenson, 1998). Additionally, people spend increasing amounts of time in their homes as they age, establishing it as a central part of the lives of older adults (Clough et al., 2004).

Housing has been recognised as influential to older people's health and wellbeing, impacting physical health (Howden-Chapman, Signal, & Crane, 1999), psychological wellbeing (Evans, Wells, Chan, & Saltzman, 2000), and social integration (Register & Scharer, 2010). Thus, when housing is inadequate, multiple aspects of older people's lives are compromised. Housing is recognised in New Zealand Governmental policy, such as the Health of Older People Strategy (Ministry of Health, 2002), as an important part of keeping elderly healthy.

Decisions about where to live require consideration of the reality that ageing is most often accompanied by changes in health, functionality and mobility. Aspects of the home, such as the maintenance and general upkeep, might become progressively more

difficult to manage with ageing (Clough et al., 2004) and may push people to relocate (e.g., Stimson & McCrea, 2004). As such, housing decisions involve accounting for current circumstances, as well as changes that might occur in the future (Clough et al., 2004). This, along with the unpredictable nature of these future changes, complicates the housing decision-making process.

Housing decisions involve the consideration of a myriad of factors, such as the practicality of access to services, and personal factors of health, mobility and proximity to family (e.g., Bäumker, Callaghan, Darton, Holder, Netten, & Towers, 2012). Many of these factors are available for conscious consideration during decision-making; however, many remain difficult to articulate, and therefore challenging to consider rationally (Clough et al., 2004). The intertwined nature of the home with people's life experiences contributes to a lack of objectivity when making housing decisions. Furthermore, people's experience of their homes and housing decisions are highly individualised and strongly influenced by their unique life context, making no two individuals' decision-making processes the same.

These layers of complexity involved in housing decisions mean that they should not be taken lightly. With an increasing number of older adults facing the decision of where to live in later life, and the role housing can play in facilitating successful and positive ageing, understanding more about the complexities of older persons' housing decisions is timely, and forms the focus of this thesis.

Housing in the New Zealand Context

Housing in New Zealand is driven by New Zealand's unique cultural, historical, political and economic context, which impinges on how older people make housing decisions for later life. Older New Zealanders' current housing experiences are informed by this context, and their views and understandings of future housing options are framed by it. Outlining this context establishes the environment in which this thesis is set.

The housing situation. The current housing situation of older New Zealanders is comprised of the majority occupying private dwellings, either detached or semi-detached, with only a small percentage living in non-private dwellings, such as rest homes (Saville-Smith et al., 2009). There is an undersupply of effectively modified housing that caters for the disability and mobility needs of elderly, and additionally is often poorly insulated. New houses built to overcome these issues often include other

factors that render the new homes inappropriate, such as excessive size, being inaccessible to elderly with limited mobility and providing limited access to public transport (Saville-Smith et al., 2009). Accreditation systems have begun to be implemented to monitor newly built properties; however, accreditation is not in place for existing rental properties, meaning many homes continue to be unsuitable for their elderly occupants (Saville-Smith et al., 2009).

Culture of homeownership. Housing in New Zealand is characterised by a history of homeownership that has been integral to developing an important aspect of New Zealand culture (Morrison, 2008). New Zealanders view homeownership as reflecting control and independence, and imparting a sense of security and autonomy in adult life (Howden-Chapman et al., 1999). The drive to become an owner-occupier has resulted in a high rate of New Zealanders owning their own homes and living mortgage-free when they reach 65 years of age (Howden- Chapman et al., 1999; Statistics New Zealand, 2000). The culture of homeownership plays an important role in older adults' future housing options, as this enables access to options requiring a considerable financial investment, such as buying into a retirement village. For those who are renting or have low financial security, the options are more limited (Davey et al., 2004).

Historical context. The housing options available to older people are markedly influenced by the historical legacy of separation of the old and frail from the rest of the community (Peterson & Warburton, 2012). Rest homes are model examples of this historical idea, stigmatising old age as a time of life that requires segregation (Hugman, 1999). Many retirement villages are designed as gated communities, physically separating the occupants from the rest of the community. Retirement villages often have the necessary services and facilities on-site, thus removing the need to continue involvement with the surrounding community.

There have been historical events that have influenced New Zealand's housing landscape and shaped policy development (Housing New Zealand Corporation, 2004). Beginning with the settlement of Polynesian and colonial people in New Zealand, to the national, and world, wars and the baby boom, housing policy has continued to evolve. The current Government housing policies have developed as a result of these historical, political and social events (Housing New Zealand Corporation, 2004).

Political context. Housing has been recognised in New Zealand Governmental policy as playing an important role in the lives of older people and impacting on their

heath. Two main policies that acknowledge this are: the New Zealand Positive Ageing Strategy and the Health of Older People Strategy.

The New Zealand Positive Ageing Strategy (NZPAS; Ministry of Social Development, 2001) is based on the principle that all New Zealanders should be allowed to age in a dignified manner. It supports the idea that older people need to be encouraged to participate in their communities in meaningful ways and that they should be empowered to choose how they live their lives to enable greater life satisfaction.

There are ten goals outlined in the NZPAS, of which two directly pertain to housing for older people. The first aims to provide homes that are affordable, available, secure and effectively designed. The second refers to ageing in place, where there is a push to enable older adults to remain in their homes with a sense of safety and security. Other relevant objectives include having sufficient income to afford adequate housing and providing equitable access to health services for rural-dwelling older adults (Ministry of Social Development, 2001).

The Health of Older People Strategy (HOPS; Ministry of Health, 2002) is the result of one of the key actions of the NZPAS and adds depth to the health component of the NZPAS. The focus of the HOPS is to ensure services and programmes available in communities are effectively delivered to enhance the health, wellbeing and quality of life of older adults. It recognises that the majority of older adults are in good health, but for those who are frail, ill or disabled, effective service delivery is paramount.

The relevance of the HOPS to older persons' housing is the prioritisation of designing and implementing successful health and support services to allow older adults to age in place and remain out of institutionalised care. A key aspect of enabling older adults to thrive while ageing in place is the provision of care services that meet the changing needs of older people as they age. The HOPS identifies that housing is a key factor for health, and that support services within the home are crucial to maintaining good health (Ministry of Health, 2002).

Economic context. The current economic climate influences the affordability of homes for older New Zealanders, who are often restricted to a pension as their only source of income. Following the introduction of The Old-Age Pensions Act 1989, those over the age of 65 years became eligible to receive a pension. However, for many, once the costs of daily living have been covered, the repair and maintenance costs of homes become unaffordable, potentially creating inadequate living environments for elderly (Howden-Chapman, et al., 1999).

In summary, New Zealand's culture of homeownership, the history of elderly housing and significant past events, current Governmental policy, and economic climate, provides the context within which older New Zealanders' make their housing decisions. This thesis recognises that these choices are inextricably linked to this context.

Definitions

Prior to commencing this explorative study of older adults' housing decisions, it is useful to outline key definitions. While many people may perceive that they hold an intrinsic understanding of terms that are relevant to housing for older people, such as *old age*, *older person*, *housing*, *home*, and *housing decisions*, there are often inconsistencies and overlap between these terms that require clarification for the purpose of this thesis.

Old age and older person. The definition of old age continues to evolve as attitudes towards older people and later life change with the ageing population (Statistics New Zealand, 2006). Being an *older person* or in *old age* is a socially and culturally bound term that is constructed for the purpose of categorising and organising people in research and our everyday lives. Similar to social and cultural ideologies, these terms do not carry a static definition and are expected to continue to change over time (Heywood, Oldman, & Means, 2002).

A common way researchers frame old age is by using chronological age (Heywood et al., 2002). This largely accepted method of organising people into life stages provides a useful way to establish a threshold for old age. In New Zealand, this is most often set at 65 years, which is the age people become eligible to receive superannuation (Vandeskog, Vandeskog, & Liddicoat, 2012). To remain congruent with the New Zealand superannuation age, the current study refers to older persons and those in old age or later life, as those of 65 years and older.

Housing and home. Within this thesis, the terms *housing* and *home* both refer to the collective physical, social and emotional aspects of a person's abode, as has been done elsewhere (Clough et al., 2004). However, *housing* is most often used when referring to the physicality of the residence, and *home* to the meaning and emotion derived from the place of living (Heywood et al., 2002).

Housing decisions. Given what is involved in making decisions about where to live in later life, *housing decisions* within this thesis are defined consistently with Clough et al. (2004, p. 43), who states that:

> "Housing decisions are an intricate web of people's hopes, expectations, aspirations, dreams and beliefs about the future. Choices are underpinned by emotional and biological reasons for staying put or moving: retaining one's dignity, respect for oneself, pride, ability to sustain and make new relationships, potential for retaining or developing new lifestyles. Selecting housing in later life is also about choosing a lifestyle, not just judging whether the house and its location can provide ageing-related needs."

Overview of Thesis

In this chapter, the multifaceted nature of these decisions has been outlined, along with the New Zealand housing context and key definitions. Chapter 2 locates older persons' housing decisions as a key area of study within Health Psychology, based on the well-established links between the physical, social and emotional aspects of housing and a person's health and wellbeing. In chapter 3, the literature on housing decisions is reviewed, including outlining the housing options available and which options are preferred, and the conceptual frameworks and predictive variables that have been used to understand housing decisions. A critique of the existing literature is then provided, and the chapter concludes with the aim of the present study. Chapter 4 details the methodology, including the social constructionist epistemology that forms the basis for discursively analysing the data, and the study's ethical considerations and research methods. Chapter 5 presents the study's results, beginning with an outline of the social context of the interviews, then describing the five main interpretative repertoires identified in the analysis, along with related subject positions, and finishes with a description of the interaction between the repertoires participants used. A discussion of each repertoire is provided alongside the findings. Chapter 6 offers a summary of the study's findings, reflections on the study and research process, and outlines the findings' theoretical implications and implications for informing housing decision-making and policy. Suggestions for future research directions are then provided, followed by an overall study conclusion.

Chapter 2: The Impact of Housing on Health and Wellbeing

The purpose of this chapter is to locate housing decisions as a relevant area of study in Health Psychology, based on the marked impact the physical, social and emotional aspects of housing can have for health and wellbeing (Oswald & Wahl, 2004). Considering the health and wellbeing implications of the homes people live in, adds a further level of complexity when older adults are making housing decisions.

The chapter begins with a review of the physical aspects of housing, encompassing the structure, environment and quality of the home, and the associated health consequences. The focus will be on housing dampness, temperature and quality, and the role of housing tenure in health outcomes. The impact of the social aspects of housing on health will follow, including the relationships with others within or outside the home. The presence of these relationships can bolster wellbeing through enhanced social networks or, when at a deficit, can lead to social isolation and loneliness. The link between the personal aspect of the home and health and wellbeing will then be outlined, particularly the meaning of home and the link this has to identity, belonging and attachment to place. The chapter will end with the literature on the decision to relocate in later life and the impact this process can have on health and wellbeing.

Physical Aspects of Housing and the Impact on Health and Wellbeing

Early housing research largely focused on establishing a relationship between physical housing conditions and health outcomes (e.g. Smith, Smith, Kearns, & Abbott, 1993; Hopton & Hunt, 1996; Howden-Chapman et al., 1999). In New Zealand homes, the most hazardous housing conditions are dampness and cold temperatures. Older people are at a greater risk of experiencing the ill effects of dampness and cold as they spend more of their time indoors. Dampness and high humidity caused by cold air promote the growth of mould, which has significant implications for the development, or worsening, of respiratory illness and asthma (Howden-Chapman et al., 1999).

Cold internal house temperatures are a particular issue for older people, as they do not judge temperature as accurately as younger people, and as a result, often inadequately heat their homes (Howden-Chapman et al., 1999; Davey et al., 2004). Additionally, a large proportion of New Zealand homes that elderly people occupy have insufficient thermal properties, making them difficult to heat and contributing to poorer health outcomes (Saville-Smith et al., 2009). An extended period of exposure to cold

temperatures within the home can lead to hypothermia and increase vulnerability to coronary heart disease and cerebral thrombosis, all of which can be fatal (Howden-Chapman et al., 1999).

The effect of housing quality on mental health has been shown to operate in two ways. Firstly, in an area of Scotland characterised by poor housing, it was found that occupants' mental health was compromised when housing conditions were inadequate (Hopton & Hunt, 1996). Secondly, Evans et al. (2000) found that when occupants moved to better quality housing, psychological distress ratings were lower following the move, an effect that remained after controlling for occupants' mental health status prior to relocation.

Physical housing conditions have been shown to indirectly affect health outcomes through increasing stress. Smith et al. (1993) found that depressing or dangerous homes that are inadequately insulated and maintained can induce heightened levels of stress that are significantly related to psychological distress and reduced wellbeing. Ellen, Mijanovich, and Dillman (2001) found a similar result when quality and resource deficient neighbourhoods created and maintained heightened stress levels. When this stress accumulated over time, it eventually eroded health and wellbeing and increased susceptibility to death.

This evidence suggests that people's internal housing environments need to be adequate to not run the risk of suffering the aforementioned ill health and wellbeing effects; however, finances are a complicating factor. Deficient physical housing conditions are not easily remedied, as pension-dependent elderly commonly have insufficient funds to cover housing maintenance costs, once living expenses have been paid (Howden-Chapman et al., 1999). This means that many elderly remain living in housing environments that continue to put their health at risk and threaten longevity.

The well-established link between a home's physical environment and the occupants' physical and mental health establishes it as an important factor to consider when older adults are deciding where to live in later life. Given that the physical characteristics of a home are relatively easy to assess, in comparison to the social and emotional aspects of the home, it is likely that the adequacy of the physical home environment would be taken into account.

Housing tenure. Housing tenure, the financial agreement that informs occupants' rights to live in a dwelling, has been shown to have an influence on psychological health and wellbeing. In New Zealand, and many other Western societies,

there is a strong desire to become a homeowner, which has been shown to have positive psychological effects (Kearns, Hiscock, Ellaway, & Macintyre, 2000; Howden-Chapman, Chandola, Stafford, & Marmot, 2011). In comparing tenants of rental properties to homeowners, homeowners have better current mental health that improves over their lifetime and into old age, as well as having lower mortality rates (Howden-Chapman et al., 1999; Howden-Chapman et al., 2011). Being an owner-occupier has been shown to provide a greater sense of security in comparison to renting, as the uncertainty of sudden forced relocation is not a concern (Kearns et al., 2000). Homeowners are able to express independence and autonomy by having the ability to make structural and authentic alterations to their houses (Kearns et al., 2000), helping with the establishment of a meaningful home (Dupuis & Thorns, 1996).

In addition to the comparison of renters and homeowners, different types of dwellings have been linked to health outcomes. In a review comparing different housing types and mental health, Evans, Wells, and Moch (2003) concluded that multi-dwelling housing was predominantly linked to negative mental health outcomes and occupants of single-family detached homes had the best psychological health. However, very few of the studies reviewed particularly attended to the older demographic, leaving uncertainty as to whether this effect remains for older persons.

The role that housing tenure appears to play in people's mental health highlights it as a consideration when making housing decisions and may suggest that people should become homeowners of single detached homes due to the psychological benefits. However, given the significant cost of becoming an owner-occupier, this may be unattainable for many people.

Social Aspects of Housing and the Impact on Health and Wellbeing

Housing has been recognised as an important factor in the formation of social relationships with family, friends and the wider community (e.g., Clough et al., 2004; Sixsmith & Sixsmith, 2008; Sixsmith et al., 2014). These relationships have been shown to be significant in older people's health, wellbeing and quality of life (Victor, Scambler, & Bond, 2000), ranking second only to health in importance during old age (Bowling, 1995). The homes older adults inhabit can be socially enhancing by encouraging the formation and maintenance of social networks and interactions with others, or socially detrimental by fostering isolation and loneliness, all of which have consequences for wellbeing.

Social networks. The positive effect that social support and the presence of social networks have on health and psychological wellbeing has been demonstrated repeatedly in the literature (e.g., Smith et al., 1993; Holt-Lunstad, Smith, & Layton, 2010). In a meta-analytic review, Holt-Lunstad et al. (2010) found that the advantage of social relationships for physical health was demonstrated by a 50% greater likelihood of survival if strong social ties exist, which was equivalent to the benefits of smoking cessation. Additionally, when compared to common health risks, lacking social relationships was more of a risk to health than physical inactivity or being obese (Holt-Lunstad et al., 2010). Ellen et al. (2001) also found physical health benefits of social engagement within neighbourhoods, in the form of communicating health information to others and shaping norms of positive health behaviours, such as exercising and not smoking.

In a New Zealand study, Smith et al. (1993) demonstrated the mental health effects of social relationships by finding that social support from friends and relatives mitigated psychological distress from housing stressors, such as stress from the home's poor physical condition. However, when stress was severe and most detrimental to health, social support was ineffective in reducing psychological distress, raising questions as to its effectiveness as a health-enhancing intervention.

Nevertheless, health promoters have established interventions to improve social relationships of older people. Many traditional interventions are employed, such as support groups, organised social activity and home visits (Grenade & Boldy, 2008), as well as utilising modern technology to connect people via email and interactive websites (Findlay, 2003). However, the challenging aspect of deficits in social interaction is that they are often beyond the control of the older person and not easily remedied by interventions (Wenger, Davies, Shahtahmasebi, & Scott, 1996; Findlay, 2003).

Social isolation and loneliness. Housing factors can contribute to reduced social networks through older people living alone, widowhood, and reduced contact with the community due to health and mobility limitations that confine a person to their home (Victor et al., 2000; Savikko, Routasalo, Tilvis, Strandberg, & Pitkälä, 2005). These variables can lead to social isolation and loneliness and have been linked to negative health and wellbeing outcomes, especially in the older population (Findlay, 2003; Savikko et al., 2005; Golden, Conroy, Bruce, Denihan, Greene, Kirby, & Lawlor, 2009). An identified consequence of population ageing is a greater number of older

people living in houses on their own and at risk of social isolation (Findlay, 2003). Studies have reported social isolation in 12-20% of people over the age of 65 years, highlighting this as an issue facing the ageing population (Victor et al., 2000; Owen, 2001).

Loneliness among the aged population is also a major concern, with reports of elderly experiencing loneliness as high as 34% (Savikko et al., 2005). In New Zealand, 11% of older adults over 65 years of age experienced loneliness in the previous year (Statistics New Zealand, 2013). These percentages are lower than those found in the United Kingdom, where 21% were lonely some of the time and 6% were lonely most of the time (Victor & Yang, 2012). Grenade and Boldy (2008) suggested that inconsistencies could be due to a reluctance to admit loneliness, as it can carry a particular stigma.

Loneliness in later life is influenced by a number of housing factors. Firstly, loneliness is exacerbated by where people live geographically, with 64% of rurally located elderly experiencing loneliness, which is higher than what is commonly reported in other groups (Dugan & Kivett, 1994). Secondly, it is expected that the greater the number of people living in a household, the less lonely the occupants would be; however, New Zealand elderly were found to be least lonely in two-person homes than in households with greater or fewer individuals (Statistics New Zealand, 2013). Lastly, housing relocation can result in loneliness by disrupting people's sense of integration into the community, with Luanaigh and Lawlor (2008) suggesting that making new contacts could reduce this.

While research suggests that loneliness is a concern for older people, there may be a tendency to overemphasise this, as evidence indicates that old age itself is not directly related to loneliness. Instead, it is factors such as widowhood, ill health and housing circumstances of living alone or rurally that can make older people more susceptible to experiencing loneliness in their homes (Victor et al., 2000; Findlay, 2003; Savikko et al., 2005).

A psychological impact of loneliness has been suggested by linking it with depression, which is commonly reported following an extended period of loneliness (Adams, Sanders, & Auth, 2004; Victor et al., 2000; Luanaigh & Lawlor, 2008). Heikkinen and Kauppinen (2004) established that loneliness was one of two major predictors of depressive symptomology for both men and women, the other being perceived ill health. Even when loneliness was seldom experienced, the chance of

lonely older women experiencing depression increased three-fold in comparison to those who reported no loneliness in their lives (Heikkinen & Kauppinen, 2004). Golden et al. (2009) found that the greater the severity of loneliness, the greater the likelihood of elderly suffering from depressive symptoms.

With the literature suggesting the adverse physical and mental health outcomes of reduced social networks, social isolation, and loneliness that can be perpetuated by housing factors, the social aspect of a home should be a part of the housing decision-making process. However, as the social aspect of a home is not tangible and is likely to carry subjective value, it may be challenging to address when choosing where to live.

Personal Aspects of Housing and the Impact on Health and Wellbeing

A central component of the psychological implication of housing is that people ascribe personal meaning to the places in which they live (Easthope, 2004). People do not simply live in houses, they create homes, and in doing this, develop a meaningful place to belong. For older people, who have often remained in the same place for many years, attachment to home is intimately intertwined with their identity and can be viewed as an extension of the self (Sixsmith, 1986; Swenson, 1998; Bratt, 2002). The literature on the personal aspects of home branches into two main areas, the first focusing on the meaning of home to occupants, and the second, exploring attachment to place.

The meaning of home. The meaning people ascribe to their homes is multi-dimensional, highly individualised and constantly evolving. Older people's conceptualisations of home are driven by historical, social and cultural factors and their current ideas, beliefs and values (Dupuis & Thorns, 1996; Mallet, 2004). The meaning a home carries positions it as a fundamental component in people's lives and as much more than a physical structure (Leith, 2006).

Dupuis and Thorns (1996) investigated the meaning of home to older New Zealanders who owned their homes. The home was seen as a place of security, as it was the owner's property and could not be taken away. There was a sense of freedom that accompanied homeownership, allowing one to do as one pleases within the home. The home also meant family and togetherness, as a place where children were raised, bonds were formed between family members, and where symbols and family rituals could be displayed. The home was as much about individual identity to the participants as it was about family identity.

Similarly, Swenson (1998) found that the home was central to family, in the form of nurturing and caring for one another. The home also represented the way the participants identified and presented themselves to others and provided a secure home base from which to reach out into the surrounding environment. Taken together, home meant a physical and emotional rootedness and an expression of personal independence in the world.

The decision to relocate, especially to a new geographical location, can disrupt the meaning of home and relocatees are often left searching for meaning in their new environment. However, Leith (2006) found that there were a number of factors that allowed American women who had moved to congregate housing to continue to experience the benefits of having a meaningful home. These included autonomously deciding to move, deliberately pursuing a new place to feel at home and continuously working at feeling as though they belonged in their home and community. This active process led to the majority of the women feeling emotionally attached to their new homes and benefitting from the associated enhancement in wellbeing.

Place attachment. A well-established positive psychological outcome of having a meaningful home is a sense of attachment to place (Swenson, 1998; Leith, 2006; Wiles, Allen, Palmer, Hayman, Keeling, & Kerse, 2009). As people age and live longer in their homes, attachment to place becomes stronger and this has been shown to have a wellbeing enhancing effect (Evans, Kantrowitz, & Eshelman, 2002; Wiles et al., 2009). This indicates that the attachment to place experienced by older people may be important to consider when deciding whether to relocate in later life.

Evans et al. (2002) demonstrated the importance of place attachment to wellbeing, as assessed by older adults' levels of positive affect, by finding a significant association between these two variables. This relationship remained when variables known to influence psychological health were controlled for, such as gender, need for assistance with activities of daily living, homeownership, and residential status. Additionally, it was found that place attachment fully mediated the commonly found relationship between housing quality and psychological wellbeing, establishing it as an important consideration for older persons' mental health.

In the New Zealand context, ageing well in a home to which older people feel attached contributes to the Government's drive to support people to age in place in their homes rather than moving to institutional care (Ministry of Social Development, 2001). Wiles et al. (2009) conducted an investigation of place attachment and wellbeing among

New Zealanders and found that 77% of the sample had an attachment to their homes. Their positive feelings towards their homes, that they had lived in for many years, had positive effects on wellbeing and supported the push for the ageing in place policy.

The evidence for the role a meaningful home plays in people's sense of attachment and psychological wellbeing indicates that, even though less immediately apparent than the physical environment of a home, it is by no means less important to consider when deciding where to live.

Health and Wellbeing Implications of the Relocation Process

Housing relocation is a reality that many older people face during later life. Relocating can be a highly stressful and involved process that can have marked consequences for people's wellbeing (Schulz & Brenner, 1977; Rossen & Knafl, 2007; Clough et al., 2004). Relocation has multiple phases, with Young (1998) establishing that moving to congregate housing involved four phases: the decision to move, preparing to move, making the move and settling into the new location. Each stage presents unique challenges that can hinder wellbeing and positive ageing.

Choice and control over the moving decision have emerged as key factors for healthy and successful relocation. Older persons' perceived controllability of their move largely determines the outcome, with greater control leading to a more positive relocation experience (Schulz & Brenner, 1977). Quine, Wells, de Vaus, and Kendig (2007) found that control over relocation decisions was central to enhancing older Australians' post-relocation adjustment and wellbeing. Choice over the location of the home and personalisation of the environment builds a sense of personal efficacy and empowerment (Ridgway, Simpson, Wittman, & Wheeler, 1994). Rossen and Knafl (2007) found that Americans who chose where they wished to live had an enhanced sense of competence, greater involvement in their new community and were more socially active. Oswald and Wahl (2004) found that in contrast to those who chose relocation autonomously, older Germans who were subjected to involuntary relocation, such as to a nursing home facility, had rapidly diminished mental wellbeing, life satisfaction and physical health.

Tension exists in the literature as to whether relocation has positive or negative effects on elderly people. Positive psychological outcomes were found following relocation of American women to an independent living community, who felt they had significantly more social interactions and enhanced quality of life (Rossen & Knafl,

2007). Conversely, Colsher and Wallace (1990) found that relocated elderly in rural Iowa self-reported poorer health, more symptoms of depression and anxiety and had reduced life satisfaction than elderly people that had remained in their original homes. Additionally, moving from one environment to another can cause Relocation Stress Syndrome (RSS), which can lead to confusion, loneliness, anxiety and depression (Morse, 2000; Mallick & Whipple, 2000). A cascade of physical and mental health issues can follow the onset of RSS and cause a rapid decline until death (Morse, 2000). This inconsistency highlights the complexity of relocation and the many consequences moving can have on psychological wellbeing of older persons.

When older adults are faced with the decision to relocate, the evidence suggests that this decision is best made when people can make it for themselves and take control of this highly stressful process. Additionally, the inconclusive evidence for whether relocation is positive or negative may indicate that the appropriateness of relocating in later life should be carefully considered on an individual basis.

Chapter Summary

Overall, decisions about where to live in later life are implicated by the health and wellbeing consequences of the physical, social and emotional aspects of housing and the relocation process. The literature has shown that the physical home environment can contribute to illness and compromise mental health and wellbeing; the social aspect of housing can enhance social networks or perpetuate loneliness and social isolation; the emotional aspect of home can provide people with a meaningful place to feel attached to; and relocation can provide a sense of control, but can also lead to heightened stress and poorer health. The significant health and wellbeing ramifications of where one lives grounds housing decisions as an important area of enquiry within Health Psychology, and renders the health and wellbeing outcomes of housing an important consideration when older adults make their housing decisions.

Chapter 3: Literature Review of Housing Decisions for Later Life

Given the complexity of housing decisions and their consequences for health and wellbeing, it is not surprising that the last few decades have produced a corpus of literature dedicated to furthering the understanding of housing decisions of older adults. Literature for this review is mostly drawn from studies based in the United Kingdom, United States, Australia, Canada, Spain and New Zealand. The first section of this chapter looks at what the literature suggests are the available and suitable housing options for older adults and their preference for those options. The next section outlines the literature aimed at understanding how certain housing decisions are made, including four conceptual models of decision-making and studies that have established predictors of older adults' decisions to move house or stay put. The last section provides a critique of the existing literature and proposes an alternative approach to develop a deeper understanding of housing decisions in later life. The chapter concludes with the details of the present study's research aim.

Housing Options and Preferences

The majority of the housing literature establishes older adults' housing options as a binary decision between remaining in the home and relocating (Stimson & McCrea, 2004). Literature looking at those remaining in the place they feel at home is most often congruent with the concept of 'ageing in place', which can also lead to occupants being 'stuck in place', while relocation literature has commonly attended to moves to alternative forms of housing, such as retirement villages.

Remaining in your home.

Ageing in place. Enabling older people to choose to remain in their homes as they age is seen as upholding personal preferences and as a financially viable option for governments to manage the ageing population (Davey, 2006; Sixsmith & Sixsmith, 2008). Recently, much of the housing literature and policy internationally has focused on the concept of ageing in place, appearing in literature from the United Kingdom (Sixsmith & Sixsmith, 2008), Australia (Boldy, Grenade, Lewin, Karol, & Burton, 2011), United States (Tripple, McFadden, & Makela, 1993), New Zealand (Vandeskog et al., 2012), and Spain (Costa-Font, Elvira, & Mascarilla-Miro, 2009).

To 'age in place' is to give older people the choice to remain in their home environment and have the necessary support services available to continue to do so,

rather than relocating to a residential care facility (Davey, 2006). The location at which to age in place could be anywhere a person feels 'at home', which may be their original family home in the community, one that they have recently relocated to or some form of supportive housing (Davey, 2006). Home supports are fundamental to facilitating ageing in place and to meet the changing needs of elderly as they age, including services such as house cleaning, meals-on-wheels and personal care services. The dominance of ageing in place represents a shift in the conceptualisation of ageing from increasing dependency to an emphasis on maintaining the independence of older people as they age (Heywood et al., 2002). Ageing in place is an active, enabling and self-fulfilling process that promotes greater wellbeing and positive ageing, and can be a vehicle for older people to continue to exert their autonomy and independence (Sixsmith & Sixsmith, 2008; Boldy et al., 2011).

A common thread running through housing research from New Zealand and other Western countries is that the majority of older people report that they wish to age in place in their current home (e.g., Costa-Font et al., 2009; Saville-Smith et al., 2009; Vandeskog et al., 2012). In a sample of older Americans, Tripple et al. (1993) found that 62% believed they would age in place, while Costa-Font et al. (2009) reported that 78% of Spanish respondents preferred ageing in place. There is yet to be a study that reports uniform preference for ageing in place across all respondents, indicating that, while consistently the majority, ageing in place is not desirable to all older people.

Age plays a role in the preference for ageing in place, with a stronger desire shown by those of greater age (Robison & Moen, 2000; Boldy et al., 2011). Malroutu and Brant (1997) found that older American participants were less likely to move from their present homes, possibly reflecting stronger ties and attachment to their communities from an extended period of time spent in that location (Robison & Moen, 2000). Additionally, as people age it may become harder to envision relocating, as it is a highly stressful and involved process that requires uprooting established routines and social networks, and becoming settled in a new location (Schilz & Brenner, 1977; Schumacher, Jones, & Meleis, 1999).

Another factor that influences preference for ageing in place is affluence; however, its exact role is contested. Costa-Font et al. (2009) found that less affluent Spaniards preferred to age in place, while the wealthy opted for rest home care, whereas Malroutu and Brandt (1997) established that Americans with a higher income had a greater likelihood of remaining in their current homes. These inconsistencies may

reflect the costs involved in moving to institutional care in Costa-Font et al.'s (2009) study, and the cost of adapting and maintaining a suitable home to enable ageing in place in Malroutu and Brandt's (1997) study.

The 'baby boomer' cohort, comprised of people born in the post-war period between 1946 and 1965 (Statistics New Zealand, 2012), is often depicted as a group that is likely to adopt novel approaches to ageing. Based on older adults living in rural Australia, Rogers (2013) explored alternative residential arrangements that baby boomers are developing to prepare for later life. It was found that the 'baby boomers' reject the notion of moving to age-segregated facilities and preferred to age in place by forming 'friendship enclaves' to look after one another. The goal of this co-dependent living is to continue connections with like-minded people and prolong independence well into old age. This suggests that the 'baby boomers' are taking the initiative to develop alternative housing arrangements that enable them to age in place.

On the surface, ageing in place appears to be a faultless concept that benefits both older people and governments in many countries. It is prized as being instrumental in older people retaining a sense of identity, social connection, security, privacy and independence (Sixsmith & Sixsmith, 2008). However, it is not as straightforward as this. Remaining in the home to age in place can have significant negative consequences for occupants as functional ability and health decline. Structural features of the home, such as stairs, can become tangible barriers to maintaining a high quality of life during ageing and can foster social isolation by preventing others from visiting if these obstacles cannot be overcome (Sixsmith & Sixsmith, 2008). There is a critique that has arisen of public policy that it puts too much emphasis on ageing in place, and that the diversity of older people's housing circumstances and preferences needs to be recognised to develop alternatives (Strohschein, 2012).

Stuck in place. The dominance in policy and literature of ageing in place can lead to an oversight of those who suffer from being 'stuck in place'. These are older people who do not have an equal choice between moving and staying, and are forced to remain in their present location regardless of their wish to relocate (Strohschein, 2012; Erickson, Call, & Brown 2012). These 'involuntary stayers' (Wiseman, 1980) are present in many communities, making it incorrect to assume that all who stay put are happy to do so. Being stuck in place can result from such circumstances as the inability to sell one's home or alternative housing options being unaffordable (Perry, Anderson, & Kaplan, 2014).

Strohschein (2012) investigated the prevalence and characteristics of involuntary stayers in Canada. It was found that nearly 10% considered themselves involuntary stayers, which accompanied higher levels of distress and lower self-rated health status than others in the sample. The typical profile of an involuntary stayer was a renter, who was in poor health, requiring assistance, and lacking social interaction. This indicates that involuntary stayers are likely to be deficient in a variety of important aspects of their health and wellbeing.

Erickson et al. (2012) explored whether rurally located elderly from Utah, United States remained in their communities as a result of choosing to age in place or being unwillingly stuck in place. Despite the expectation that some older people would be stuck in place due to the geographical and social isolation of the rural communities, respondents were content to age in place and had high levels of attachment to, and satisfaction with, their communities. This demonstrated that some people are motivated to age in place regardless of the challenges they face with rural living. The inconsistency between these findings and that of Strohschein (2012) indicates that involuntary stayers may not be present in all communities; however, they remain an important group to acknowledge in the midst of the current drive for ageing in place.

Relocating. Studies that have investigated relocation preferences commonly find that older people only perceive moving as an option when remaining in their original home is no longer possible (e.g., Baker & Prince, 1991; Neville & Henrickson, 2010). The housing options that exist in New Zealand and most other Western countries include supportive housing (Baker & Prince, 1991), extra care housing (Bäumker et al., 2012), retirement villages (Grant, 2006; 2007), naturally occurring retirement communities (Kennedy & Coates, 2008), continued care retirement communities (Groger & Kinney, 2007), Abbeyfield housing, and nursing homes (Davey et al., 2004), with retirement villages being the option that has received the greatest scholarly attention.

Retirement villages. Retirement villages are a housing option that is growing in popularity worldwide and is presented as one solution to housing the ageing population (Croucher, 2006; Grant, 2007; Crisp, Windsor, Butterworth, & Anstey, 2013). Retirement villages are becoming one of the more visible housing alternatives in communities given their rapid expansion, central locations, size and manicured appearance (Greenbrook 2005; Grant, 2006). Retirement villages are advertised as resort-like lifestyles that are worry-free and provide ample social engagement and

activities; a far cry from their stigmatised existence as ‘enclaves for the aged’ and places where old people go to sit and pass the time of day (Grant, 2003; 2006; 2007). In New Zealand, retirement villages are being developed country-wide, with the percentage of older adults living in retirement village at 4.5% of those in the 65 years and older age group, and 10.5% of those 75 years and older (Jones Lang LaSalle, 2014). This indicates that retirement villages are becoming a well-established housing option for many older New Zealanders.

In a recent study of community-dwelling older adults in Australia, Crisp et al. (2013) found that there were commonly held beliefs among the public about the positive and negative aspects of what retirement village living would be like. The main encouraging factors for moving to a retirement village were the availability of assistance as health declines, relieving the burden on family to provide care, being conveniently situated in the community and allowing assistance with household chores. The negative, discouraging factors were loss of independence and lack of privacy. The findings reflect those commonly found in this area of research (e.g., Gibler, Moschis, & Lee, 1998; Bohle, Rawlings-Way, Finn, Ang, & Kennedy, 2014), possibly due to the questionnaire being a predetermined list of factors that were rated, removing the opportunity for novel insights and perhaps typifying the findings. However, an interesting outcome of Crisp et al.’s (2013) study was that, contrary to what developers might think, luxury facilities were not an encouraging factor for moving to a retirement village.

Housing research has explored the positive and negative aspects of retirement villages for those who have relocated to them, finding that in most instances negative public perceptions of retirement villages are not congruent with how they are viewed by their residents. Based on a New Zealand sample, Grant (2007) found that retirement village dwellers refuted the negative stereotypes and instead proposed retirement villages as a location for positive ageing. Three main themes emerged from the data that suggested that retirement villages had a culture of rejuvenation of their personal identities and social connectedness, provided constant opportunities for activities, and promoted a sense of living rather than slowing down in retirement. Similarly, Graham and Tuffin (2004) found that New Zealand retirement village residents did not concur with the common perception that retirement villages diminished privacy. There was a discourse of a balance between companionship and privacy provided by retirement villages, which was reflected by Bohle et al. (2014), who found that there was

equilibrium between community togetherness and separation that suited Australian retirement village residents.

However, retirement villages are not without controversy over their suitability for older people, with some residents experiencing the negativity of loss of privacy, a restriction on their lives and difficulty with adjustment to a new way of living (Grant, 2007). Gardner, Browning, and Kendig (2005) found that retirement villages are not suited to everyone, with 5% of their Australian sample being unhappy with their choice to relocate to a retirement village due to deficiencies in their social environment. Additionally, Neville and Henrickson (2010) highlighted that retirement villages can uphold discriminative practices towards lesbian, gay and bisexual people, when they investigated this group's future housing preferences in New Zealand. Relocating to a retirement village was an option if lesbian, gay or bisexual individuals wanted or needed to move, but they would only relocate to a village that accommodated those whose sexual orientation was not heterosexual. This highlighted that having a supportive and person-centred environment to age in is of the utmost importance when deciding where to live in later life.

Overall, the literature suggests that there are many reasons retirement villages are an attractive option for older people, making it unsurprising that the number of villages and village residents are on the rise in New Zealand (Grant, 2003). However, the percentage of older people living in villages remains within the minority as moving to such an establishment can be financially unattainable for many (Grant, 2003) and comes with a lifestyle that does not suit every older person.

Nursing homes. While there is an indication that the majority of the relocation options receive some interest from older adults, nursing homes are not considered an option by choice (Löfqvist et al., 2013). There is a fear that moving into institutional care will mean a complete loss of independence and autonomy (Wiles, Leibing, Guberman, Reeve, & Allen, 2011), dissuading people to consider this as a possibility. Löfqvist et al. (2013) found that Swedish and German elderly over 80 years of age expressed difficulty imagining voluntarily moving to a nursing home based on their stereotyped negative perception of this option. A move to institutional care is seen as a drastic and final step that is only entertained when support services or family can no longer meet older people's care needs (Litwak & Longino, 1987). While nursing home level care is essential for many elderly, it remains an undesirable housing destination by choice.

In summary, the majority of older people's preferences and actual housing choices for later life appear to be to age in place. Older adults ageing in place in their homes can promote positive ageing, but consideration needs to be made in policy that recognises that this is not a uniform experience, and that some people are left stuck in place. Evidence indicates that relocation in later life is also a major consideration for older people, opening up the possibility of moving to housing options such as retirement villages, which are increasing in popularity.

Understanding Housing Decisions

To provide a greater understanding of older people's housing preferences and choices, there has been a significant body of literature dedicated to explaining the reasons why certain housing decisions are made, especially attending to what prompts relocation. To identify these influencing factors and understand how they interact, conceptual frameworks have been developed, including the concept of person-environment fit and environmental press (Lawton & Nahemow, 1973), the model of relocation typologies (Litwak & Longino, 1987), the retirement migration model (Wiseman, 1980) and proactive coping theory (Pope & Kang, 2010). Additionally, to discern whether people will relocate or remain in their homes, there are a group of studies that have looked at variables that predict older adults' housing movements.

Conceptual frameworks.

Person-environment fit and environmental press. Lawton and Nahemow (1973) developed an ecological conceptualisation of older adults' residential mobility that positions the environment as the main influencing factor. The basis of this theory is that older people age successfully in their current location if there is a fit between the demands of the housing environment and the person, buffered by the person's level of competence (Pope & King, 2010). Personal competence is an individual's physical and psychological ability that allows them to cope with their housing environment (Lovegreen, 2010). When competence declines with age-related impairment, a poor person-environment fit can result that undermines health and quality of life, and ultimately leads to a need to relocate. The tension between person and environment has been termed environmental press (Bäumker et al., 2012; Caro et al., 2012). There is continuous evaluation of the congruence between the environment and a person's competence to achieve a balance that promotes successful ageing (Lovegreen, 2010).

Studies, predominantly in the area of environmental gerontology, have applied the concept of person-environment fit to explain housing mobility in later life. In the United States, Caro et al. (2012) found that, out of five dimensions that influenced housing relocation, the functional status of older adults (ability to carry out tasks of daily living) was the most important when given hypothetical scenarios. This means that as functional status is compromised so is physical competency, which disrupts the balance between environmental demands and personal ability, and establishes a need to relocate to a more suitable housing environment. Kahana, Lovegreen, Kahana, and Kahana (2003) posited that residential satisfaction is predicted by person-environment fit in older adults living in the community. Older adults' satisfaction with their home environments influenced their wellbeing and impacted on whether it was appropriate to remain in their homes or relocate (Kahana et al., 2003).

Housing migration model: Push/pull factors. Wiseman (1980) developed a behavioural model to explain the reasons why certain housing decisions are made. Wiseman acknowledged that one of the central aspects of where older people live is the evaluation of trigger mechanisms for considering relocation, which fall into push and pull factors. Push factors are those that drive older adults away from their current homes, such as deteriorating health, difficulty with tasks of daily living and home maintenance, and widowhood. Pull factors are those that attract older adults to other housing arrangements, such as easier home maintenance, security, social networks and amenities (Wiseman, 1980; Stimson & McCrea, 2004). The push/pull dichotomy can be used as a tool to evaluate the suitability of older adults' current housing situations and the attractiveness of other housing options.

There are many studies that have been conducted worldwide that identify push and pull factors in decision-making about housing in later life. Stimson and McCrea (2004) used push/pull triggers to explain older Australians' decisions to move to a retirement village, based on a self-report questionnaire. The push factors away from their current residence were for a change in lifestyle, difficulty with home maintenance and cost, social isolation and declining health. Pull factors towards the retirement village were the attributes of the village environment and affordability. Also based on a questionnaire, Bäumker et al. (2012) found similar push factors of worsening health and mobility, and challenges with maintaining the home and garden, for older people in Britain. An additional push factor identified by Bäumker et al. (2012) was the lack of services and support available in the community. Interestingly, in comparison to

Stimson and McCrea's (2004) study, a different set of pull factors drew Bäumker et al.'s (2012) respondents to move to extra care housing, including tenancy rights that enabled residents to have a personal front door, flexible on-site care, security systems, and adequate unit size and accessibility.

Bekhet, Zauszniewski, and Nakhla (2009) used interviews with older Americans to establish push/pull factors that influenced decisions to relocate to retirement communities, which revealed some factors not identified in questionnaire studies. Consistent with other studies, failing health was the most important push factor; however, additional push factors found that were not previously identified were not getting help at home, loneliness and being forced to move due to current facility closure. The novel pull factors were joining friends in the retirement community and its reputation and familiarity. Groger and Kinney (2007) also conducted interviews with Americans and, once again, identified different push/pull factors. The push factors were a desire to autonomously choose where to live while still able to, being the right time for a change and the fear of being a burden to family. The unique pull factor they found to the new location was the close proximity to family. The variety of factors identified in interviews compared to questionnaires highlights the individualised nature of these factors and the value of a qualitative approach for this type of research.

A limitation of the majority of research aimed at finding push/pull factors is the neglect of factors that pull a person to decide to remain in their home (Longino, Perzynski, & Stoller, 2002). Boldy et al. (2011) are among the minority who included pull factors towards remaining in the home as well as relocating, and found that comfort derived from the home and financial viability motivated older Australians to stay put. This adds an additional level to Wiseman's (1980) original push/pull framework that helps with understanding the relocation decision-making process.

Life course model of moving typologies. Litwak and Longino (1987) identified that life course events experienced by older adults as they age prompted certain types of relocation decisions, and fell into three categories. The first type of move is initiated by retirement and is motivated by the amenities of the destination. Older adults are usually in good health and can move to locations away from family, as these relationships can be managed over long distances. The typical move at this stage is to a retirement village in a warmer climate that provides a resort-like lifestyle. The second type of move occurs with the onset of moderate illness and disability that makes the tasks of daily living difficult to manage independently. This move is often to be closer to children and

family so that they can provide assistance. The third type of move is to formal institutional care with the onset of severe chronic disability and illness, which requires care that is beyond the scope of what family can provide. Litwalk and Longino (1987) clarified that this model does not suggest that all older adults experience the three types sequentially, but rather that there are life events in old age that vary in severity that pre-empt different types of moves.

Speare and Meyer (1988) further explored the second moving typology, identifying that there are two subtypes of mobility. The first is a proactive, 'anticipatory' moving decision that highlights older adults' ability to anticipate worsening health and functionality in the future, and can be due to widowhood or distance from kin. The second subtype is a move for 'true assistance' in response to moderate health complications and disability with which family can assist. This suggests that within the three typologies, there are various levels that can be identified to better represent the complexity of the influences on older adults' relocation decisions. Despite the simplicity of Litwak and Longino's (1987) original model of the three moving typologies, it continues to be cited in housing literature as a useful way to conceptualise the various motivations for relocating (e.g. Pope & Kang, 2010; Bäumker et al., 2012; Perry et al., 2014).

Proactive coping theory: Proactive vs. reactive movers. Early frameworks of older adult migration have under-developed the role of proactive and reactive modes of relocation. Proactive movers are those who choose to relocate in anticipation of future declining health or disability, while reactive movers are those who are forced to move in response to sudden age-related decline or a health crisis (Pope & Kang, 2010). Aspinwall and Taylor (1997) proposed the theory of proactive coping to explain the impact of these two modes of relocation, which does not exclusively pertain to moving decisions, but is directly applicable. Proactive coping entails the ability to plan in advance of stressful events to prevent them occurring or modify their impact when they eventually happen (Aspinwall & Taylor, 1997).

The benefits of proactive planning for relocation are minimising the stress and burden of the move, having more coping resources, and a greater range of options (Aspinwall & Taylor, 1997). Walker and McNamara (2013) identified further benefits of proactive decision-making that gave older Australians control over their housing decisions and contributed to successful adjustment to their new environment. Proactive

movers embraced relocation as a new beginning with opportunities for engaging with new people and establishing new identities and routines.

Older adults' decisions about whether to relocate or stay put are influenced by whether their style of decision-making is proactive or reactive. Pope and Kang (2010) conducted a study in the United States comparing proactive and reactive movers over the age of 70 years. The profile of a proactive mover was younger with a higher education and income than reactive movers, with reactive movers being in worse physical health. They found that there is a greater likelihood that older people will move reactively than proactively, with double the number of people relocating following a major event, such as a health crisis, than relocating before such an event. Congruent with this finding, Löfqvist et al. (2013) established that very old Swedes and Germans over the age of 80 years were reactive rather than proactive movers. Overall, these studies pointed to age being a major variable in whether people are proactive or reactive movers and highlighted some of the benefits of deciding to move proactively in later life.

Predictors of moving. There are a group of studies that have endeavoured to explain housing decisions by establishing predictor variables for moving or staying put. Social support has emerged as an important predictor of older adults' housing choices and satisfaction with their current homes. Perks and Haan (2010) found that the social support received, especially from a partner, was a stronger predictor of the type of home Canadians lived in, over and above health and financial characteristics. Cho, Cook, and Bruin (2012) established that older Americans' perceptions of the social interaction and support gained from their neighbourhoods significantly predicted how satisfied they were with their current homes, which was to a greater extent than the neighbourhood's amenities. These studies suggest that older adults' social needs and desires have a considerable bearing on housing choices for later life.

The dominance of declining health, or a health crisis, as a major factor in the relocation decisions of older adults leads to the expectation that it would be a significant predictor of relocation; however, the following studies found other variables to have greater predictive power. Based on data from the United States, Robison and Moen (2000) established that physical health status of respondents or their partners was not predictive of their future housing choices. Instead, attachment to communities from a long history of living in the same location was a strong predictor of respondents' expectations to remain in their original homes to age. Similarly, Erickson, Krout, Ewen,

and Robison (2006) found that, regardless of some respondents' belief that their health was a main contributor to their housing choices, poor health status did not statistically predict intentions to relocate or actual moves. The fundamental predictors were being in close proximity to kin and older adults' satisfaction with their current residence. The consideration of both expectations to relocate, and actual moves, is fundamental to understanding moving decisions (Sergeant, Ekerdt, & Chapin, 2010), which both these studies attended to.

Lovegreen (2010) found that poorer health, older age, female gender and shorter time spent in the same home were important in predicting Americans' decisions to move. Surprisingly, support was not found for the predictive role of solo living, widowhood, distant proximity to family, renting and low income. These studies demonstrate that there is a range of predictor variables that have been identified, further supporting the complexity of the factors that influence moving decisions in later life.

Critique of Housing Literature

Studies that have applied explanatory models and have pursued predictive variables have made a significant contribution to advancing understanding of housing decisions for older adults. However, these approaches have been criticised for a number of reasons.

Firstly, there is an assumption that housing decisions can be made in a rational manner. This is particularly the case in studies that have modeled push/pull factors, whereby it is presumed that the best housing decision will be made by a conscious and deliberate weighing up of factors. This type of objective decision-making intuitively makes sense, but decisions are not commonly made in this way. Housing decisions are highly influenced by emotions and impulsivity, obscuring rational thinking (Clough et al., 2004).

While it has been identified that people are capable of rational decision-making (Morcol, 2006), the complex and subjective way in which housing decisions are made, makes such a conceptualisation of decision-making unrealistic (Clough et al., 2004). People assign subjective value to factors, such as one individual's struggle with the stairs in their home may prompt a move to a retirement village, while another person with the same physical concern may not move, due to the value they ascribe to the feeling of independence they experience in their home. Additionally, Weinstein (1984) showed that a person's perception of risk, particularly the risk of health complications,

is often unrealistically optimistic and thus, not open to rational consideration in the housing decision-making process.

A possible exception to the assumption of rationality may be Lawton and Nahemow's (1973) model of person-environment fit, which is less rational and acknowledges the dynamic interplay between the person and their housing environment. Importantly, the model does not prescribe a level of environmental press that necessitates a move, thus allowing for variation between individuals, and possibly contributing to its continuous application in housing research.

Secondly, while there is value in succinctly capturing common reasons why housing decisions are made, this can lead to an overly simplistic and reductionist way of explaining this complex phenomenon (Clough et al., 2004). Longino et al. (2002) supports this by suggesting that a diagram cannot capture the intricacies of housing migration decisions. This is an interesting assertion by Longino et al. (2002), as Litwak and Longino's (1987) model of moving typologies demonstrates this reductionist approach, simplifying older adults' life events and housing relocation into three generalised forms. This early model suggests that older people have similar life experiences and ignores the many other factors that make each case unique and complex.

While housing decision models have undoubtedly been valuable in laying a foundational understanding, studies based on these models must be interpreted in light of the shortcomings. Clough et al., (2004) cautioned that they should not be used rigidly, as this will narrow the outlook and misrepresent the complexity of these decisions. Congruent with this, Longino et al. (2002) called for housing researchers to step outside of these models to appreciate the 'messiness' of real-world housing decisions. Clough et al. (2004) and Perry (2012) have responded to this by conducting studies using mixed methods and ethnographic approaches, respectively.

Clough et al. (2004) set out to give older adults from the United Kingdom a voice on housing issues by allowing them to share their stories of how they made their housing decisions. A distinctive feature of the research design was the use of a participatory approach, which involved training older adults to conduct interviews with other older adults, enabling them to be directly involved in the research. The main themes of what influenced housing decisions were the meaning of home, personalities, the homes as part of constructing the self, the impact of neighbourhood, locality, and health changes, assumptions people and policy-makers make about old age, and anxiety

about the future. Clough et al., (2004) recognised that such a list could form a model; however, they did not wish to conform to previous housing research that had aimed to find a simplified, 'best-fit' solution, and rather preferred to leave their findings in their dynamic and complex form.

Perry (2012) explored how older Americans made voluntary housing decisions, using the conceptual lens of moving as gift giving. This ethnographic study looked at older adults who were at various stages of moving, including those contemplating and planning a move, those during the moving process and those already relocated. Drawing on Māori cultural ideas of gift giving as reciprocity, older adults viewed moving as a gift to themselves, in the form of improved quality of life and easier home maintenance; to their partners, in terms of upholding their wishes to move and honouring their late spouse; and to their kin, by providing them with peace of mind and relieving them of care duties. Moving was seen as much more than a practical decision based on physical needs, and one that provided an opportunity for gift giving and the expression of generosity to others.

These two studies provide a promising start towards a deeper understanding of housing decisions for older adults and overcoming some of the shortcomings identified in studies based on predetermined models; however, they remain in the minority and there is room for further exploration. By employing different methodological approaches, Clough et al. (2004) and Perry (2012) demonstrate that new insights can be made into the complexity of housing decisions. Congruent with this, housing researchers have proposed the adoption of alternative epistemological approaches to housing research to further broaden the lens of enquiry.

An Alternative Approach

A social constructionist perspective has been suggested to extend the parameters of housing research and provide an alternative perspective on the issue of housing decisions (Jacobs & Manzi, 2000; Hastings, 2000; Fopp, 2008). Social constructionism provides a critical lens and encourages a close examination of how language operates in creating our understandings of housing choices (Jacobs & Manzi, 2000).

The majority of housing research is based on a positivist epistemology, which purports that there are objective truths about housing and decisions (Jacobs & Manzi, 2000). Social constructionism rejects such a notion in favour of the stance that people construe their own social realities and that all claims hold equal importance (Burr, 2003;

see chapter 4 for full details). Given that the literature has established the individualised and complex nature of housing decisions, such a research approach would be appropriate and allow for this complexity to come to the fore.

Social constructionism has formed the basis of a number of areas of housing research, such as the analysis of housing policy (e.g., Hastings, 1996; Allen, 1997), the role of landlords, tenants, housing debt (Hunter & Nixon, 1999) and the management of housing (e.g., Clapham, Franklin, & Saugeres, 2000). Jacob and Manzi (2000) indicated that social constructionism would enable a deeper and more detailed understanding of the reasons why certain housing decisions are made; however, this area remains under-researched. This approach suggests a shift away from understanding housing decisions as a product of individual cognition, to look at the question of housing decisions from a completely different perspective.

Present Study

The aim of the present study is to explore the social location of older New Zealanders' housing decisions by examining the socially available discursive resources older adults draw on to construct their housing choices, within the context of interviews. This will be achieved by identifying the interpretative repertoires used by older adults when discussing their housing decisions and the subject positions provided by each of these discursive resources. As a result, this study steps outside the parameters of cognitive decision-making models and employs a social constructions epistemology to broaden the lens on housing decisions for later life.

Chapter 4: Methodology

This chapter begins by outlining the study's social constructionist epistemology and providing the rationale behind a discursive analytic approach. Recruitment and participant details are described followed by the procedure for collecting the interview data. Specifics are then provided on important ethical issues that are pertinent to this study. The last section explains the process of conducting a discursive analysis to identify interpretative repertoires in participants' talk about their housing decisions.

Epistemology

Social constructionism proposes a radically different perspective to a positivist research approach that has historically dominated much of mainstream housing research (Jacobs & Manzi, 2000). The central tenet of social constructionism is that there is no single truth or objective reality. Instead, our knowledge is a result of viewing the world from a certain perspective, which is only one among many possible worldviews, allowing multiple versions of reality to simultaneously exist (Burr, 2003).

There are four key assumptions of social constructionism, as outlined by Gergen (1985), that underlie how knowledge is perceived in this study. Firstly, assumptions about the world require critical examination in order to contest the dominance of conventional positivist knowledge. Secondly, understandings of the world are socially, culturally and historically located and represent the currently accepted ways of knowing, which are subject to change. No particular way of knowing is superior to, or more truthful than, another. Thirdly, social interaction is the site of knowledge construction, maintenance and renegotiation. Lastly, certain constructions of knowledge bring about particular actions, and when constructions change, so might the related action.

The essence of social constructionism is located in language, as the means by which our knowledge is constructed (Burr, 2003). People's worldviews are given structure and meaning through language and engaging in conversation with one another. Therefore, social constructionists reject the notion that language is simply a communication code that provides a window to a person's psychological state and cognitions, but rather these personal phenomena are performed through language (Burr, 2003). In other words, language is not used as a labelling system to describe, for

example, an attitude that a person would hold regardless of language; it is through language that this attitude is made possible and given structure.

Analytic Approach

Discourse analysis is a frequently utilised methodology to allow language to be attended to in a way that is consistent with social constructionism and works to uphold the key epistemological assumptions. Due to the pervasive and everyday use of language, it is often seen as transparent and dismissed as an important focus of inquiry. A discursive analytic approach, as outlined by Potter and Wetherell (1987), prioritises this taken-for-granted language by looking at how language is used and to what ends. They maintain that language is important to examine as it is central to social interaction and fundamental for knowledge construction. They suggest that language has an action-orientation, meaning people use language to perform certain functions, such as to persuade, justify, defend and request. Variation will be present in these discursive acts, based on the function people intend to achieve.

The principle component of the discursive approach described by Potter and Wetherell (1987) is the *interpretative repertoire*. Interpretative repertoires are constellations of linguistic terms, metaphors and images that are used together to construct versions of objects or phenomena in people's social worlds (Wetherell & Potter, 1988). Repertoires are understood to be social, rather than individualised, resources that are available to be drawn on by anyone of the same cultural and linguistic background. During the course of an interaction, people may use different, and at times opposing, repertoires based on the current purpose of their talk, and different people may also draw on the same repertoire for different purposes. Noting the presence of key components of each repertoire can identify the shift in the use of repertoires within people's talk. People draw on interpretative repertoires to build a particular understanding of the world, in this instance, understandings of housing decisions, to serve particular social functions.

Participants

The participants were a convenience sample of five individuals and two couples, recruited through the researcher's personal contacts and using a 'snowballing' technique. All nine participants were from the Wairarapa region, New Zealand, living in a community in which the researcher grew up. The researcher personally knew three of

the participants, who, along with her family, suggested the remaining six participants to contact for the study.

The rationale behind the inclusion of couples, as well as individuals, in the participant group, was based on the recognition that many older adults live with a spouse or partner. This means they are likely to engage in housing decision-making together, factoring in the views of both members of the partnership, and possibly including a process of negotiation (Clough et al., 2004). The two couples were interviewed together to capture this dual decision-making.

The study set out to conduct an initial exploration of the experiences of a group of middle-class homeowners, who reside in a range of different housing situations for later life and were older than the age of entitlement for New Zealand superannuation of 65 years (see Table 1). Given these sampling criteria, the findings will be interpreted with an awareness of the resources available to such participants and their socio-economic status. There was a near balance of genders within the respondent group, with four males and five females.

Table 1

Participants' Details and Current Housing Situation

	Pseudonym	Age	Current housing situation
Couple	Marg	68 years	Reside in the community Homeowners Relocated from family home of over 30 years
Couple	Jack	69 years	to current home in the past 3 months
Couple	Lyn	76 years	Reside in the community Homeowners
Couple	John	78 years	Lived in current home for over 30 years
	Mary	83 years	Resides in a retirement village Lived there for the past 8 years
	George	83 years	Resides in a retirement village Lived there for the past 10 years
	William	84 years	Resides in a rural community location Lived there for over 15 years Trialed a rest home for 7 weeks, but returned to community home
	Anna	87 years	Resides in a retirement village Relocated to the retirement village in the past 3 months

Procedure

Participant contact details were obtained from the local telephone directory. Potential participants were contacted to enquire as to their interest in participating in the study and if they were willing to have an information sheet delivered to their home address (see Appendix A). All the participants contacted were interested in reading the information sheet in hard copy, except for one couple that preferred to have it emailed to them. For those who were home when the information sheet was delivered, they were talked through the study details and given the opportunity to ask questions. For those who were not home and for the couple who received the emailed information sheet, a follow up phone call was made to discuss the details of the project and to answer any questions. All those contacted accepted the invitation to participate, and a date and time for a single interview was arranged.

All interviews were conducted in participants' homes, as this was the location in which they felt most comfortable and provided a relevant context for the topic of the discussion. Once there, the audio recorder was set up, and the researcher and participant(s) were seated comfortably across from one another. A short amount of time was spent chatting informally to make all parties feel more at ease. The information sheet was talked through once more, with emphasis given to the main points, participant rights, and answering any questions participants may have had. Informed consent forms (see Appendix B) were then signed and the audio recorder turned on. The interview involved establishing participants' background information and asking questions about their current living situation and what influenced the housing decisions they had made (see Appendix C). Each interview ran for 30 to 60 minutes. At the end of the interview, participants were asked if they had any questions or points to add to the discussion, and when the participants were satisfied, the recorder was turned off.

Participants were briefed as to what would happen next with the transcription and review process and a resource sheet on how to obtain further information on housing options was offered (see Appendix D). To close the interview, participants were thanked for their time and informed that a $25 gift token would be sent to them via post as a token of the researcher's appreciation. Participants were reminded to contact the researcher, or her supervisor, at any time if they had questions about the interview or the study.

The audio recordings were transferred from the recording device to the researcher's personal computer and stored in a password-protected folder.

Ethical Considerations

There were a number of ethical considerations that were identified by the researcher, her supervisor, and the Massey University Human Ethics Committee (MUHEC) that were important in the implementation of this study. These included issues of confidentiality and privacy, the dynamic of interviewing couples, safety precautions for interviews conducted in a private setting, and bicultural concerns.

Privacy and confidentiality of participants were upheld by allocating pseudonyms to participants at the transcription phase, which were carried through analysis and thesis write-up. During the interviews, each participant was given the opportunity to select a pseudonym, but the majority were willing to have one allocated on their behalf. All identifying information, such as names of towns and street addresses, was removed from extracts that appeared in the thesis. Participants were made aware that only the researcher and her supervisor would have access to the original recordings and transcripts containing identifiable information, and that hard copies would be stored securely at the Massey University Wellington campus.

As the study involved interviewing couples as well as individuals, special consideration needed to be given to the dynamic of interviewing a couple. It is acknowledged that, unlike individuals, couples construct their housing decisions as a unit, and this was taken into consideration in the analysis of the interviews. During interviewing, it was perceived that both members of the two couples made an equal contribution to the discussion, thus having one perspective more dominant than the other was not an issue. When enquiring as to the couples' interest in participating in the study, it was emphasised that both members of the partnership needed to read the information sheet and be willing to participate in the interview. It was evident that each person had thoroughly read and understood what participation involved and that none of them appeared to have been coerced into participating by their partner. Both members of the couples signed informed consent forms and were informed that they could withdraw from the study at any stage during or after the interview.

Interviews were conducted within the private setting of participants' homes, thus consideration had to be given to the researcher's safety, as she conducted the interviews alone. A family member of the researcher was made aware of the interview location, scheduled time and expected time of completion, and the researcher had a cellphone on her at all times. If the researcher had not returned or made contact with the family member at the scheduled end of the interview, they would take the necessary steps that

had been pre-arranged to ensure her safety. However, none of these precautions had to be put into effect, as there was never a point during the interviews that the researcher felt unsafe, or the interview ran over time without the family member being informed.

The collection of ethnicity data was not pertinent to achieving the research aims of the study, thus no ethnic group was targeted or excluded based on this factor. The exploratory and partial nature of the study meant the findings were not intended to represent the experiences of any specific ethnic group. However, it is important to recognise the bicultural society in New Zealand. In the event that consultation was necessary for Māori cultural matters, advice from a School of Psychology staff member could be sought.

Following clarification of these ethical considerations and minor amendments, the study was given ethical approval by the MUHEC on June 2014, Southern B application 14/23.

Data Analysis

Discourse analysis of the interview texts was guided by the phases outlined by Potter and Wetherell (1987). The analytic process is not a traditional recipe-like method, but a way of attending to the data that consists of cyclical phases rather than a series of linear steps. In other words, the phases outlined below were repeatedly revisited when working towards finding interpretative repertoires.

The first phase was transcription, which was an informative part of the analytic process, as it involved closely reading the text and becoming familiar with its content. Interviews were uploaded into transcribing software called *Transcribe* and typed verbatim (see Appendix E for transcription notation). The transcripts were printed and returned to participants for review to allow any content to be added or deleted. Participants were not required to return the transcript unless amendments were made. Once participants were satisfied with the content of the transcript, authority for the release of transcripts forms (see Appendix F) were signed and returned. Three participants made minor changes to the transcripts, with the remainder satisfied with the transcripts in their original form.

The transcripts were uploaded into *Dedoose*, a qualitative software programme to code and organise the transcripts into a manageable format for further analysis. This involved carefully reading through the transcripts and assigning codes based on aspects participants mentioned that contributed to their housing decisions, such as ‘family,’

'health,' and 'independence,' along with metaphors and images used to describe their homes and housing decisions. Sections of talk that made multiple references were given multiple codes. Coding was done in an inclusive manner, whereby all borderline cases were included to provide a comprehensive collection of extracts under each code.

Following preliminary coding, the next phase was what Potter and Wetherell (1987) refer to as 'analysis.' This involved repeated readings to discern patterns in the participants' talk, in the form of consistent features in accounts, or variation in what was said and its form. In discursive analysis, language needs to be considered in context, thus it was important to consider the talk of both the participant and the researcher during the interviews. To identify interpretative repertoires, the codes and data were closely read to establish the main linguistic units and metaphors used and the language that characterised each repertoire. The subject positions provided by the interpretative repertoires, along with interactions between the repertoires, were then ascertained through a process of hypothesising and searching for evidence in the data.

As Potter and Wetherell (1987) cautioned, the analysis required cycling back and forth between close readings of the data, finding patterns, hypothesising function and looking for evidence, which gave rise to new analytic directions, and rendered some breakthroughs, fruitless. Finally, the analytic process led to the identification of five main interpretative repertoires, which were labelled: 'Decline', 'Medical', 'Independence', 'Stability' and 'Familial'.

Chapter 5: Results and Discussion

This chapter begins by attending to the unique social context provided by the interviews, to offer a framework for understanding the interpretative repertoires identified in participants' discussions about their housing decisions. The five interpretative repertoires that participants drew on to construct their housing decisions will then be defined, and the words, metaphors and images that constitute each repertoire, identified. Subject positions provided by each repertoire will be outlined, accompanied by discursive passages demonstrating how these operate to construct decisions made. As participants may draw on multiple repertoires during an exchange, the final section of this chapter outlines the way the repertoires interact as either consistent with, or contradictory to, one another. A discussion will be provided alongside each interpretative repertoire relating these findings to previous literature on older persons' housing decisions and broader discursive work.

The Social Context of the Interview

The nature of a verbal exchange and the language used is specific to a time and place, and thus to the social context in which it occurred (Adjei, 2013). To gain an understanding of the social location of the repertoires, it is important to be aware of the discursive context in which they arose (Van Dijk, 2009). Reflecting on the social context of the interviews, and the role this may have played in the repertoires identified, is engaging in a process of reflexivity, which is an important part of social constructionist research (Burr, 2003). There are a number of characteristics of the current study's social context that are helpful to outline to make sense of the repertoires utilised and their functionality. These include the knowledge and experience participants brought to the interview, their expectations of the nature of the interview and of me as the researcher, and the influence I had on the interview.

Firstly, participants came to the interviews with their own set of pre-understandings about housing that influenced the topics that were discussed. Participants were clearly aware of the housing options available and had strong ideas about where they would prefer to live as they aged. Lyn demonstrated this when she unmistakably stated her opinion on a retirement village and a rest home as housing options:

Lyn: I wouldn't like to live in a village situation- I am not into that and I wouldn't like to be institutionalised either unless I didn't know about it (laughs).

Participants were also knowledgeable about issues that were relevant to housing decisions that they themselves, and others, were facing as they age, which were spontaneously mentioned. When discussing the research topic, Marg and Jack demonstrated their awareness of key housing issues:

Marg: I was quite astonished when I read what you were doing it on, because this is going to be a huge issue in the next few years, because everyone- in [town] particularly, there is an older, a huge number of older people and um we are going to be part of a huge mass of people probably wanting to move into a village at the same time.

Jack: Well that is one of the main industries.

Marg: Well, I think it is.

And:

Marg: . . . . it's it's very sad though because a lot of people are choosing to go into places like these villages and they can't get in, everything is subject to the sale of their own house, so and with the booming you know with the baby boomers all coming to the age at the same time, it is taking, like it took [friend] a while to sell his house and he was absolutely overjoyed when they finally sold it and got the one they did.

While Lyn appeared to have a clear idea of where she wanted to live, John acknowledged the issue of changing circumstances with ageing on housing suitability that may require different housing decisions to be made:

Lyn: It's just that I don't think that I'd be an ideal person in a in a rest home or village and that.

Tamyra: Yeah.

John: It all depends because you don't know, you really don't know what type-what the circumstances will be and it could well be that you could well be totally disabled and not be able to care for yourself,

> meaning you have to look at something like that as as a place of care.

Secondly, the information sheet provided to participants prior to the interview (see Appendix A) would most likely have contributed to participants' expectations of the interview, and of me. The information sheet, describing me as a university level researcher with a specific topic of inquiry, may have positioned me as an expert on housing. It was apparent that Marg expected the interview to contain difficult or complex questions:

> Tamyra: Um so those are sort of all my questions.
> Marg: Oh well that was easy (laughs).

Consistent with the idea that I was perceived as being an expert, William looked to me for confirmation that his actions were appropriate:

> Tamyra: Hmm so you haven't made any formal plan for the future?
> William: No no.
> Tamyra: And is that just-
> William: Is that not a good idea?
> Tamyra: No no I think it is, taking it day by day is a fine approach
> William: Well someone said "aw who will make his mind up?" and I said "suppose the man upstairs might" is that a good move or is that leaving too much hanging in the breeze?
> Tamyra: I think it is a good move.
> William: Okay.

While my role was not one of an advisor on their places of living, participants frequently defended their housing choices to me, suggesting they perceived me to be in a position to suggest a more appropriate housing option. In the following passages, John concluded his statements by reiterating how much he enjoyed his home:

> John: . . . . the suitability of the accommodation overall um for all of us um it's not small and it is not excessively big but certainly it is far greater for both Lyn and I um but it's still, yeah, it's still lovely, it's a lovely little home.

And:

> Tamyra: How do you find living in this house? Does it meet your needs?

Lyn: Meets my needs yes.

Tamyra: What about you John?

John: In many ways yes, yeah um no its alright yeah, otherwise we wouldn't be here.

Tamyra: Yeah, yeah.

John: Na na it's alright yeah, it its really good lovely.

Lastly, as the interviewer and interviewees are both active in the construction of a certain reality (Potter & Wetherell, 1987), my own knowledge of housing decisions that I brought to the interviews may have contributed to the social context. My knowledge of what is involved in older adults' housing decisions largely came from reviewing the literature in this area. My influence is apparent in the passage below, when I have suggested ideas for participants to consider:

Tamyra: Well a lot of people when I have talked to them in their homes, they have chosen that home thinking about the future as well as the now, and I think you have done that.

Lyn: Yes.

Tamyra: All throughout with the renovations you have kept thinking ahead.

Lyn: Hmm.

Tamyra: You know, thinking what will be next and I think that shows that that was really important as well.

Lyn: Hm yes.

In summary, it is likely that participants' and my housing knowledge, along with their preconceptions of me as an expert on housing, shaped the interpretative repertoires participants drew on in discussing their housing decisions for later life. However, instead of being a limitation, the social context forms a key part of the discursive analysis and acknowledges the situated nature of language and discourse.

Interview Background

The interview questions and discussions focused on matters pertaining to participants' homes, how they came to live there and what influenced their housing decisions. During these discussions of their housing decisions, participants drew on dominant social constructions of ageing as decline and independence, and health as biomedical, and constructions of stability and family to talk about the choices they had made. The commonly used social constructions were identified as a set of different

interpretative repertoires that were labelled the ‘Decline’, ‘Medical’, ‘Independence’, ‘Stability’ and ‘Familial’ repertoires.

Decline Interpretative Repertoire

The decline interpretative repertoire constructs age-related decline as inevitable and with a predictable trajectory. Constructions of decline as ill health and increasing health complications are common, which is consistent with the dominance of biomedicine (e.g., Lyons & Chamberlain, 2006). However, decline was not limited to health and included talk about decline in physical ability to perform tasks around the home, mobility, cognition, and pace of living. A key component of the home was its ability to accommodate the reality of decline, such that participants’ decisions about where and how they lived were influenced by the knowledge that they, and/or their partner, had declined and that this would predictably continue with ageing. When talking about the decision to move into a retirement village, George described decline as an inevitable reality that contributed to his decision:

> George: . . . . you get to the stage when you have to make a decision, look at the whole picture, which is inevitable, there are certain things you are not going to change in life.

William had accepted that he would decline to a point where he was no longer able to remain in his rural country home and would have to make the decision to live elsewhere:

> William: I thought well I am very comfortable here and that that's why I thought well why would I want to leave it? But I can understand that inevitably I will have to go but, yes.

A range of language was used as part of the decline interpretative repertoire, including “inevitable”, “slowing down”, “increasingly worse”, “limits”, “downhill”, “get older”, “struggle”, “becoming dependent” and “progressive care”. This repertoire included descriptors of physical markers of decline, such as “rails”, “walking frame”, “sticks”, “wheelchairs” and “scooter”. A single subject position of ‘Frail Older Person’ was provided by the decline interpretative repertoire, which included talk about current frailty and frailty in the future.

Frail older person. The frail older person is someone who has experienced age-related decline that has reduced their ability to perform tasks they previously could.

This subject position involves the recognition of changes over time, which are understood to be progressive, and to which people have to accustom themselves rather than recover from. The frail older person is heading towards becoming dependent, and is required to make careful housing decisions that accommodate this frailty.

Present frailty. When positioned as a frail older person, participants talked about frailty they were currently experiencing that impinged on their abilities. This immediate experience of frailty meant that a certain type of housing situation was needed to support the declining person. George made an early decision to move to a retirement village in anticipation of decline, which allowed him to take up the position of the 'present frail older person' easily, as his environment supported this. In the following passages, George showed how he freely took up this frail geriatric position without resistance by referring to his use of assistive aids, his worsening memory and slowing down:

> George: . . . . I've got an answer machine that all the time you see and I said people ring up and chat, chat, chat and I think- but I've got a slow speed on that so I can play it back at slow- excellent, it is for geriatrics like me, by golly I am certain there are a lot of people that could do with something like that.

And:

> George: And I know I have got everything lined up, I need to go and consult the diary because my memory isn't all that (laughs).

And finally:

> George: . . . . it is a question of the more you go through life, there does come a time when you have just got to sit down and watch television.

Marg talked about the decline she experienced in her ability to perform the physical task of collecting firewood in her previous home that made it difficult to continue living there and contributed to the decision to relocate to a smaller, more decline-friendly home:

> Marg: . . . . I was getting to the stage where getting firewood was an absolute you know, I have got funny bones and things.

Likewise, Anna's decline with age resulted in her becoming weary from the physical demands of her home, necessitating her move to a retirement village:

Tamyra: What were some of the reasons why you decided um that now was the time to move here?

Anna: Because there were five steps up to the back door and the other house and I had to carry everything up, here I can drive the car into the garage and it's about that far (gestures small distance), it's very easy, I think in the end maybe I got tired.

Both Marg's and Anna's position as a frail older person reflect what is suggested in Lawton and Nahemow's (1973) model of person-environment fit, where age-related decline can result in a poor fit between the home environment and the person's ability to cope and often leads to relocation. The demands of physical tasks around the home for Marg, and the stairs for Anna, can be seen as creating environmental press that influenced their decisions to move to housing that did not have these physical demands.

Future frailty. Consistent with the notion of decline as inevitable, participants talked about frailty they expect to occur in the future. Participants discussed having to make housing decisions that prepared them for their anticipated future frailty. Mary's decision to move to a retirement village was influenced by the availability of progressive care in preparation for her own, and her husband's, forthcoming frailty:

Mary: . . . . we moved here because when we moved here it was the only retirement village that provided on-going care, so there was-there are apartments, there's rest home and there's hospital.

For Jack and Marg, the inevitable future frailty position was used to justify the selection of their current home. This was seen when Jack referenced being in close proximity to a hospital as an advantage for them as ageing people who will need this service as they decline:

Jack: . . . . that is actually one of the reasons that this place is still very close to the hospital, and that is a consideration for elderly people, well we are starting to get there aren't we? (laughs) Um you know, we may not say so very often, but it is a consideration.

For Jean, her strong desire to remain in her community home meant that anticipating future frailty, such as limited mobility, was important to ensure the home she chose could accommodate this:

Jean: . . . . it has got a little hill out there on the flat.

Tamyra: Yes.

Jean: So that when I have a... a scooter (laughs) when I can't drive anymore, it will be good for that as well.

Participants' use of age decline as a resource to explain their housing decisions was supported by a number of previous findings. Stimson and McCrea (2004) and Bäumker et al. (2012) found that health and mobility decline were push factors away from participants' current homes to alternative accommodation. Bekhet et al. (2009) and Crisp et al. (2013) found that the ability to get assistance that is needed when health declined was a main encouraging factor for moving to a retirement village. However, there are two major points of departure from these studies of housing decisions in the present study. Firstly, the present study found decline to be talked about in more aspects of the person's life than just health and mobility, including decline in ability to perform physical tasks around the home, cognition, and pace of living. This may be due to the way in which decline was measured in previous studies, such as only assessing decline in health and physicality, but details on how decline was assessed were not provided in the articles. Secondly, these studies were based on a cognitive theoretical approach and thus suggested health and physical decline as causal influences on housing decisions. In contrast, the current study's approach instead led to the identification of decline as a socially available discursive resource that participants drew on to construct housing decisions.

The frail older person position taken up by participants in the current study has been identified in other discursive work on ageing. Fealy, McNamara, Treacy, and Lyons (2012) found that older people were constructed as frail, infirm and vulnerable in print media texts. Of particular relevance to older adults' housing decisions, Fealy et al. (2012) went on to establish a link between the frail, infirm and vulnerable discourse and housing, suggesting it lead to the segregation of older people through their assignment into specialty housing, where they could be 'managed' and receive the care they needed. This was reflected in the present findings when participants used their frailty to justify their decision to move to more supportive housing, such as a retirement village. While this construction served a function for the current participants in their housing decisions, the assumption of frailty in later life can work to place older people in a separate group from the remainder of society, and perpetuate ageism (Hugman, 1999; Featherstone & Hepworth, 2005).

The reason the decline interpretative repertoire figured largely in participants' talk about their housing decisions is likely to be due to 'decline' being a dominant construction of ageing. This view of ageing is consistent with Western cultural ideology that equates ageing with increasing decline in the body (Featherstone & Hepworth, 2005; Westerhof & Tulle, 2007). Gullette (1997) identified this as the 'decline narrative', which starts in middle age and relentlessly continues until death. Through the examination of images of ageing, Featherstone and Hepworth (2005) suggested that this commonly held negative view of ageing is a result of emphasising biomedical decline in old age, and stereotyping decline as the experience of all ageing people. When participants used the decline repertoire to construct their housing decisions, they were ascribing to this powerful and pervasive construction of ageing that is common in Western society.

In summary, participants drew on the decline repertoire when discussing their housing decisions, which positioned them as a frail older person in the present and future. Participants' talk about their current experience of frailty and the inevitability of decline in the future placed emphasis on the ability of their homes to accommodate this reality. This resulted in participants justifying the appropriateness of their housing choices through referencing the ability of their homes to accommodate their decline and frailty.

Medical Interpretative Repertoire

The medical interpretative repertoire is a commonly utilised and powerful resource used to construct the ageing body that was used by participants when constructing their housing decisions. Ageing and ill health are understood to be located within the physical body, which is seen as an object for clinical examination (Lyons & Chamberlain, 2006). The increasing presence and significance of medicine and medical interventions in people's lives as they age means that the medical discursive resource is readily available and highly relevant to participants' daily experiences.

The construction of ageing in terms of increasing medical problems makes easy access to doctors, a hospital, medical treatments, and drugs, an important part of participants' talk about their housing decisions. Both Anna and George chose to live in retirement villages that had hospital level care on site. In the following passages, they demonstrated using the medical repertoire to explain that the hospital is the place they would eventually end up in as they decline towards the end of life:

Anna: One of the villas they showed me here was looking straight out onto the hospital and I said "no thank you I don't want to live there (laughs), I don't want to look at my future every day!"

And:

George: One of the difficult things is knowing that this will be my last move, my last bedroom, my last house, I won't be moving again unless it is the hospital adjoined, it's just a short walk away or ride away.

The medical interpretative repertoire included medical terminology, such as "doctor", "hospital", "appointment" and "interventions", and descriptors of symptoms, treatments, and medical conditions: "Parkinsonian shuffle", "drugs", "chemotherapy", "haemorrhaged", "leukemia", "TIA", "Alzheimer's", "stroke" and "cancer". The medical interpretative repertoire provides a number of well-established subject positions, such as 'doctor' and 'patient'; however, the main subject position taken up within the interview context was that of the 'Lay Medical Expert.'

Lay medical expert. The lay medical expert is someone who holds layman's knowledge of their own and others' health problems. Medical jargon was incorporated into the conversation to explain and justify housing decisions, indicating that participants were drawing on the medical repertoire.

Being a lay medical expert distances the person from taking up the role of the submissive patient, and instead positions them as in control of their health and able to make decisions, and talk, about diagnoses, symptoms and treatments. Mary demonstrated this by using her lay medical knowledge to enable her to participate in discussions of her husband's health and to formulate a diagnosis. Her lay expert position placed her husband as the passive patient, who received medical advice from experts, which in this case included both herself and the doctor:

Mary: And it wasn't until one time I went to talk to the doctor because I thought-dad had had Parkinson's…um but very differently, and um I went to the doctor and said "look, is there any early intervention, this is what I think I am seeing?" and she said "no, we just have to wait for it." So one day when he was comp- he wasn't a complainer, he mentioned and I said "have you thought of putting

> those things together?" and he said "yeah" and I said "what do you come up with?"

Mary's lay medical knowledge of her husband's condition was a significant part of her justification for making the decision to move to a retirement village on her husband's behalf. Her knowledge meant she was aware that his condition caused him to have poor perception of how unwell he was, necessitating her to make the moving decision so he could access the medical support he needed:

> Mary: It was horrible making all those decisions-having to make all those decisions for him because he didn't have the perception- they are- they are not aware of it, they are not aware of it, there perceptions of where they are themselves are just not there.

For Jean, her lay medical knowledge of her own medical condition and its prognosis based on her family's history of aneurysms, was used to justify her decision to remain in her current home until she dies:

> Jean: That's right, that's quite right, I say I am leaving here in a coffin (laughs), and I think I might because both my mother and my grandmother did that, they just died in bed one night, and they were only in their 70's and I'm in my 80's so…and I've got what they died of so one day I might just die, hm.

And:

> Jean: . . . . it seems we have aneurysms. I've got an aneurysm, [son] has got an aneurysm, yip, sometimes they just pop and that's it.

Previous studies have identified the influence of older people's medical illness and disease on their housing decisions (e.g., Litwak & Longino, 1987; Bäumker et al., 2012); however, the role of drawing on a medical discursive resource when discussing and justifying housing decisions has not previously been outlined in this area of research.

Participants' frequent use of the medical repertoire to construct their housing decisions is likely to be due to it being a discursive resource that runs parallel to the dominant Western cultural ideology of health as biomedical (Saltonstall, 1993; Lyons & Chamberlain, 2006). Within this perspective, health is viewed as having a physical basis, the body is considered as separate from social and psychological functioning, and

that examining the physical body will determine the physiological cause of ill health (Lyons & Chamberlain, 2006). The prominence of this perspective was seen when participants explained the suitability of their homes for their ageing bodies based on how close they were to a hospital, as this was seen as the place where they would eventually be towards the end of life. The hospital symbolically represents a hub for the biomedical constructions of health, where the ill physical body can be examined and treated. While there is often hospital involvement when a person ages and their health declines, it is not necessarily the place where all will die. Based on data from the United Kingdom, Ahmad and O'Mahony (2005) found an increase from 56.7% to 61.7% in the percentage of people dying in hospitals and a decrease from 37.6% to 22.1% of deaths in community homes over the previous 20 years. While this showed a shift towards hospital deaths, there were many people who did not die in hospitals, showing that participants' perception that their health would decline to the point of inevitable hospitalisation is a product of the biomedical construction of health, rather than a universal truth.

Overall, the medical repertoire was used when participants' talked about access to medical services as part of their housing decisions, and their lay medical knowledge of medical conditions was used to justify the choices they had made. While the role of the medical construction of health has not been identified in past research on housing decisions, the current findings show that biomedicine continues to dominate by being part of participants' constructions of their housing decisions, and as a powerful means of justifying their choices.

Independence Interpretative Repertoire

The independence interpretative repertoire was drawn on in participants' discussions of their housing decisions to indicate being an able and well-functioning member of society. Independence was constructed as a prized characteristic to hold, especially as one ages and becomes fearful that independence may be taken away. Retaining independence was a marker of positive ageing and coping well in the face of age-related changes. In an effort to be seen positively during ageing, participants constructed their housing choices as upholding the independence they desired.

The desire to retain independence was a readily available discursive resource that was used regardless of participants' housing situations. Jean, William and Anna demonstrated the cross-situational use of the independence repertoire in their decisions

to live in town, rurally, and in a retirement village, respectively. Jean's choice to remain in her community home was based on her belief that a retirement village would strip her of the independence she maintained in her community home by imposing strict financial arrangements:

> Jean: I think that I would hate to go into a village.
>
> Tamyra: Why do you think, why would you say that?
>
> Jean: Because they actually control you, you pay so much a week, you might as well live in your own house 'cos your rates aren't nearly as dear as that.

William viewed his independence as located within his rural home and used this as a way to justify why he wanted to remain living there:

> Tamyra: What particularly do you like about being in your own home compared to when you spent that time in the rest home?
>
> William: Well I think you retain your individuality, your ah independence.

On the other hand, Anna viewed her decision to move to a retirement village as enabling greater independence, as she was going to have to rely on an increasing number of services to maintain her large community home:

> Anna: . . . . um and the money I have been able to save was starting to run out and I think the crunch came was when I realised that if I was going to stay where I was living, I was going to have to pay a lot of people to do a lot of things for me, which I can do for myself here or if I don't the organisation will do.

There were a number of descriptors that characterised the independence interpretative repertoire, including: "individuality", "independence", "not reliant", "decisions", "choice", "freedom" and "do what you like", and included markers of an independent lifestyle: "busy", "exercises", "line dancing", "gardener", "fishing", "entertain" and "work to do." The independence interpretative repertoire provided one main subject position, labelled 'The Independent Person'.

The independent person. The independent person is someone who holds a respected and virtuous position in society, and who represents positive ageing. The desirability of being an independent person meant participants worked hard to uphold this position by strongly justifying it in their talk about their housing decisions. For

participants, their choice to be in the homes they were currently in enabled them to do a range of activities that gave them a sense of being an independent person. Jean demonstrated this when describing the benefits of being in her community home:

> Jean: I can cook and I can do everything and I can walk to town if only I need a little bit of groceries or milk or something like that, I can walk to town from here in just a few minutes, and post my letters and I make myself do that to have a bit of exercise.

Additionally, the maintenance Jean's home required was used as a way of demonstrating that she was still an independent person:

> Jean: And in between all that I do, I do manage to do a bit of housework and- but it doesn't get very dirty when you live on your own.
>
> Tamyra: You just keep it maintained all the time don't you?
>
> Jean: Yeah that's right, yeah, yeah. I clean my own windows, I still mow my own lawns.

For William, living rurally allowed him to continue attending livestock sales that he had done for much of his adult life, which contributed to him feeling he was still independent:

> William: I still had a livestock sale, I was at one at midday today and ah it's still in the blood to buy a bit of stock and have a punt with it, but um yes, it's in the blood, it's in the blood.

Even though George's decision to move to a retirement village meant that the exterior maintenance of the house was taken care of by services, he rejected this and continued to do his own lawns, demonstrating his physical independence around his home:

> George: . . . . people do the lawns, have a team to do the gardens- they don't do it to my satisfaction, so I do my own here. I go out and push my mower as exercise, I can go to the gym and spend money if I wanted, but I've got work to do.

Owning your own home was constructed as showing independence, as this allowed participants to exercise control and autonomy. In comparison to renting, John

and Lyn benefited from having the freedom to decide what they did with the home they owned:

> John: The only difference with a rented property was that it wasn't yours and you didn't have the freedom to make changes if you considered that changes should be done, um yeah the thing was that if you wanted any repairs to be done then you had to wait until the landlord carried out his role to do it, um and even those damages that were no fault of our own, um you know, you still have to wait, so it was just the fact of not being autonomous and not being able to do the things that you felt you could do. Like after we moved in here, we looked at it and we said we could do this, we could do that, and those were the things that certainly made it a lot, lot better, being able to own the property and be able to make the decisions as to what we are going to do with it.

Jean repeatedly emphasised the freedom of choice that arose from being a homeowner:

> Tamyra: So, um what were the reasons why you didn't go for the other options, the reasons why you wanted to stay here?
>
> Jean: um, independence… independence, to own your own home to do what you like when you like and how you like.

And:

> Tamyra: Um, so in-independence when you say you wanted independence, what kind of things are you looking to be independent in?
>
> Jean: Well, you know, if I want to entertain I don't have to worry... I don't have parties, but if I wanted one I could um but you know, if I have- I have got plenty of parking when people come for dinner or something um… and um when I want to go I can just lock the doors and go.

And finally:

> Jean: I can go to bed when I like, I can look at what tele I want to or play my music if I want to and I read lots of books and ... I can have people drop in and see me if I want to, it all works out all right.

Independence has previously been identified in housing literature as a part of older adults' moving decisions, particularly the fear of losing independence discouraging a move to a retirement village (Crisp et al., 2013) and to institutional care (Wiles et al., 2011). This was reflective of Jean's view that a village, and William's view that a rest home, would remove the independence they felt in their community homes. However, for Anna, her decision to move to a retirement village was to enable greater independence, which is contrary to what Crisp et al. (2013) found. This inconsistency may be explained by the identification of independence as a socially available discursive resource in the current study, as opposed to it being previously identified as a causal influence, enabling the identification of its use across William's, Jean's and Anna's different housing situations. This establishes independence as a dynamic social resource that was part of participants' constructions of their housing decisions, regardless of where they had chosen to live.

Participants' use of the independence repertoire in their talk of their housing decisions may have been due to independence being a prominent social construction of positive ageing. This is perpetuated by its presence in Governmental policy, both in New Zealand and abroad, and as a key concept for policy-makers. Secker, Hill, Villeneau, and Parkman (2003) outlined that independence is used extensively in policy in the United Kingdom, and the promotion of independence for older people is often the basis for the allocation of resources and grants. This is reflected in New Zealand Governmental policy, with the New Zealand Positive Ageing Strategy and the Health of Older Persons Strategy mentioning independence as a key benefit of positive ageing and being able to age in place. The widespread use of the term independence in housing and health policy to indicate successful ageing contributes to it being a widely accessible discursive resource for older people.

Independence has featured in discursive work involving older adults. Kaufman (1994) outlined that the discourse of autonomy, labelled in the current study as part of the independence repertoire, is a powerful discourse that drives older people's desire to be in full control of their lives. Additionally, Smith, Braunack-Mayer, Wittert and Warin (2007) established independence as a key part of the discourse of successful and positive ageing, in the context of older men's help seeking behaviours. While this shows the independence discourse is present in the literature on older persons and ageing, it has not previously been recognised as a main discursive resource that older people use to construct their housing decisions.

In summary, the presence of the independence repertoire established independence as a desirable characteristic and indicative of positive ageing, making it unsurprising that participants used it to construct their housing decisions. Participants justified their position as an independent person through the independent activities they were able to do in the homes they had chosen to be in and the autonomy afforded by being a homeowner. The emphasis of independence in participants' talk of their housing decisions suggested that they wished to be seen as ageing positively within their homes.

Stability Interpretative Repertoire

The stability interpretative repertoire was drawn on to establish a foundation of certainty on which to live life in the face of the uncertainty of the changes brought on by ageing. Having a sense of stability was understood to be desirable, leading participants to draw on this repertoire in their discussions of their current housing choices and future housing plans. As such, forward planning formed a fundamental component of this repertoire.

There were a number of instances where participants demonstrated simultaneously drawing on current and future stability. Jean unmistakably desired to remain in her current home until she died and rejected the notion of voluntarily moving to a rest home or to live with her children; however, in order to have future stability, she had arranged a contingency plan to go to a rest home:

> Jean: So…yes, I just have it in my brain that no-way would I go live with my children and I hope that I will be able to live here 'til I drop dead, but if I don't, I have it in my will to go to [rest home] (laughs).

Similarly, John and Lyn wanted to remain in their family home, but had the stability of knowing they could live with one of their children if necessary:

> John: Where ever possible, both Lyn and I would rather be here, stay here, and if we reached the stage where alternate care may be needed, then that's when hopefully my children will become involved and say you can do this and you can do that or we will take you with us. I know that one of our daughters would, yeah, she would take us.

Following a trial stay at a rest home, William asserted that he wanted to avoid going back there; however, he still acknowledged that the rest home he trialled would be the home he would return to if necessary:

> William: I readily would sell the property if um you know if I so wished, but now I think if I sold it where would I go? I'd go to where I wouldn't want to go, I'd have to wouldn't I? I can't see any kind woman taking me under her wing. That would be like winning the lottery!
>
> Tamyra: So would that be to [rest home]?
>
> William: I suppose it would.

The stability interpretative repertoire was made up of the following descriptors that indicated stability in their current homes: “here I stay”, “last move”, “carted out in a coffin” and “wouldn’t go anywhere”, and descriptors that denoted stability in planning for the future: “forward planning”, “be prepared”, “safeguards”, “sensible”, “being cautious” and “peace of mind”. The stability interpretative repertoire provided a single subject position: ‘The Sensible Planner’.

The sensible planner. The sensible planner is someone who has made a stable housing plan for the future. This position is constructed as virtuous and sensible, and as the right thing to do. George demonstrated this when he emphasised that being a forward planner is an important characteristic to have for those who are ageing:

> George: But one of the things my wife used to say was "why are you worried about retirement?" or "why are you thinking about it?" and I'd say, "well that's my nature to think years ahead, be prepared." And sometimes um it's a job to do that rationally, if you are an optimist you think everything will be right, she'll be right attitude, that's a bad attitude- not bad, it is an unsafe attitude, you must really think of what happens if there's a bad turn and it does in life, I'm afraid life's like that, so being cautious is a- comes second nature to me.

Positioning the self as a sensible planner was about managing the uncertainty of the future changes that accompany ageing, with the stability of a plan. Mary and her husband’s decision to move to a smaller home early in their retirement, and prior to moving to a retirement village, was constructed as a move for greater stability due to the sudden unexpected changes they saw others experiencing:

Mary: We had been incredibly cautious, one of the reasons we moved-downsized then was that we saw people come in and they had had all sorts of hopes and plans for their retirement and, you know, 18 months in one has a stroke. Life changes, turns upside down.

Participants positioned themselves as the ultimate sensible planners when they discussed how they proactively put into action the stable housing plan they had made, before it was too late. Being proactive about housing decisions was understood as a way to guarantee a sense of stability in later life. Jean demonstrated proactive planning when she carefully chose a home for her retirement when she was in her fifties:

Tamyra: Now, now you were telling me there's an interesting reason why you chose this house way back then, over the one across the road?

Jean: Yes, because the one across the road had stairs. I said to the land agent when he was taking me around, he just about got sick of me because I knew just what I wanted and I said to him "no, I won't buy the one over there, it's got stairs and when I am older it won't be any good." I said "when I move this time, this is my last move, this is my house, I am buying a house for my retirement."

In the following passage, Jack identified that the decision to move to their current home was earlier than planned, but the benefits it provided made the proactive move worthwhile:

Jack: It was an opportunity that presented itself probably earlier than we anticipated making a shift, but um we made the decision then because the situation here was exactly what we really wanted and it was too good of an opportunity to turn down… you know, we did like the place, the set up it was just exactly what we wanted at ah, maybe in five years, so we took the plunge early.

Tamyra: Yeah, so just a bit of forward planning there?

Jack: Yeah just made us move earlier than we anticipated; however um it was exactly what we wanted, it had everything-it ticked all the boxes.

Previous housing literature has identified the role of proactive planning by recognising that older adults engage in proactive housing decision-making. Proactive

moving features in Aspinwall and Taylor's (1997) and Speare and Meyer's (1988) conceptual frameworks of housing migration. Additionally, Aspinwall and Taylor (1997) found that moving proactively resulted in a less stressful and burdensome move, and Walker and McNamara (2013) found that moving proactively instilled a greater sense of control over housing decisions and allowed older adults to embrace their relocation as a new beginning. However, proactive planning in these studies was not understood as part of a socially available resource. Furthermore, proactive planning is only one component of the dynamic stability repertoire used by the current study participants.

The term stability is not new to housing research. Housing stability has been a main feature in studies on homelessness and transitions to stable housing (e.g., Pearson, Montgomery, & Locke, 2009; Shinn et al., 1998). However, occupants remaining in the same housing environment most often denote housing stability in these studies. For example, Shinn et al. (1998) deemed someone to be stable if they had not moved residence in the past 12 months. This conceptualisation of stability does not capture the way in which the current participants used the discursive resource of stability in their talk of their housing decisions. Thus, the current findings contribute a broader conceptualisation of stability than has previously been identified in housing literature.

Broader discursive research on older adults and later life has not identified the use of the stability repertoire; however, it is not surprising that the current participants drew on this, as stability is a common concern for older adults. Stability, often labelled security, has been found to be an important part of ageing. Reichstadt, Depp, Palinkas, Folsom, and Jeste (2007) found that a theme of successful ageing was stability/security in participants' living environments, social support and financial resources. Having stability and security meant knowing you would be looked after and did not have to worry about the future, had income security to gain access to better health care and more living options, and had a stable source of social support from family, friends and community. Additionally, Maslow (1970) supported the importance of a sense of stability in later life by positing that stability and certainty were primary safety needs once a person had achieved physical comfort.

Overall, participants used the stability repertoire to establish a greater sense of certainty during the ageing process. When participants drew on this repertoire to construct their housing decisions, it involved discussing the stability of their current housing situation and a stable housing plan for the future. Forward planning and making

proactive housing decisions were used to signify holding the virtuous position of a sensible planner, and indicated when the stability resource was present in participants' talk.

Familial Interpretative Repertoire

The familial interpretative repertoire highlighted the significance family carries for the ageing person. Drawing on the familial resource constructed the home as an important place of nurturing and caring for family. The home was understood as a foundation for all family to return to, and a place where they would receive care. Most often as people age, family expands with the introduction of grandchildren, and for some, great grandchildren, making family a readily available resource for older adults to use to construct their lives. Each of the participants referenced their families in their discussions of their housing decisions, especially the ability to accommodate their families in a temporary capacity within their homes. In the following passages, Lyn and Marg both indicated how their current homes enabled the hosting of family members:

> Lyn: We have done a lot of alterations, only just to enable us to live when we had the children here more comfortable and even then it wasn't, it's not huge, but we did have to build another bedroom on to accommodate the children and grandchildren.

And:

> Marg: . . . . we have got two bedrooms and they are big bedrooms, but the second bedroom is set up as the grandchildren's bedroom.

For John, Lyn and Anna, family played a large part in their justification of their housing decisions within the interviews:

> John: I would like to stay with my family adjacent.
>
> Lyn: Hmm it is really family that keeps us here I believe anyway.

And:

> Anna: . . . . given that one of my daughters was in Wellington and one was here, there didn't seem to be much point in going to Timbuktu or somewhere and isolating myself completely because I do love my family very much and I am quite family-oriented, I can't imagine living somewhere where there aren't family around, so the choice of [town] made itself really.

The language that constituted the familial interpretative repertoire included "family", "parents", "children", "grandchildren", "family-oriented", "accommodate", "care", "look after", "supporting them" and "networking system." There were two subject positions of 'The Family Carer' and 'The Caree' provided by the familial interpretative repertoire in the context of these interviews.

The family carer. The family carer is someone who is able to provide care for their immediate and extended family within their home. It is a valued position to hold and denotes someone whose own needs are met to the point where they have the capacity to meet the needs of others. John and Lyn justified their positions as carers by outlining the frequency with which they care for their family, and the adequacy of their home to cater for doing that:

Tamyra: So do your grandchildren often come around after school?

John: They usually stay here.

Lyn: Just about every day.

John: Every day.

Lyn: Except when they play sport.

And:

John: We have a number of grandchildren that we care for and we have always cared for them, and they still continue to come, yeah, you know the house is adequate, no it is quite suitable for that type of hard living. Um we also have members of our own family that come back from where ever they may be and they may stay overnight or they may stay for a while and shoot off and go off home.

Marg and Jack's position as carers extended to both the older and younger generations:

Marg: I am the sandwich lady- sandwich generation we're called, so I visit the old ones up there and I look after the grandchildren um and really we are very lucky because a lot of people have their family overseas… it is it is amazing, our generation, I think are the first they have called the sandwich generation?

Jack: Hmm.

Marg: Because all the other generations have died a lot earlier.

Tamyra: Right, oh yes.

Jack: Well Marg's parents and um their parents or Marg's grandparents, they didn't have to worry about it did they?

Marg: No no.

Jack: So when they were our age they had no one to consider.

Marg: I didn't even know my grandfather.

Jack: They just did what they liked, they went off on trips and you know, we have to think twice before we go anywhere out of the district.

Jack explained that being in a carer position came with the responsibility of living in a location that allowed him and Marg to continue providing care:

Jack: We have a consideration for staying in [town] because um in the first instance, Marg's parents are still here and still alive in their nineties and so um we feel obliged to stay close to them until that, you know. Um but it was always a thought earlier on in our lives that maybe we could shift somewhere else, but then course…family come to you- my parents came here too from way up [city], and the kids are still sort of in the vicinity.

John and Lyn explained how holding the carer position had formed strong, caring relationships within their family that enabled the reciprocity of care:

John: Yeah we let our grandchildren or our children know that we love them and that we will care for them and we have always done that anyway for our grandchildren from the time of their birth, because their parents have had to go out working and ultimately their grandmother or their grandfather is the one that has been caring for them while their parents have been at work, and we have done that for all twelve of our grandchildren, so yeah I am sure they will do the same for us.

Tamyra: It develops a very nice support network doesn't it?

John: Yeah well that basically what it is, it is that type of networking that you need to do, but it's a networking system that is quite caring you know.

While being a carer is most often constructed as a positive position that brings great benefit to the carer, Marg described the challenge of caring for parents, as well as children and grandchildren:

> Marg: I found it, I found it actually emotionally exhausting because on the one hand you want the best for your parents and you love your parents, but I resented a huge amount of time that I was having to put into supporting them at the detriment of the grandchildren and my own children, so you are caught in a… I found it quite difficult.

Within the familial repertoire, being a family carer is an important role and a major component of the participants' daily lives. As such, it is expected that the participants readily took up this subject position as they construct their housing decisions.

The caree. The caree is someone who requires care from family to be able to continue living in their home and achieve the tasks of daily living. The caree position is reserved for children and dependent older persons, and is established in opposition to that of the family carer. Participants largely resisted taking up the caree position in their current lives, as it was viewed undesirably. Jean demonstrated this when she strongly resisted the housing plan to live with family for care and support, both now and in the future:

> Jean: . . . . [daughter in law] and [son] have said that I can come and live with them when I need to, I said, "no thank you very much" 'cos I will not go and spoil the lives of either of my children, I don't believe in that.

Marg resisted being a caree of family by expressing that she would prefer to move to a village than have family care for her:

> Marg: [mother] doesn't like people coming in either other than family, so I might be like that I don't know and I don't want my family having to go through that, so I would much rather be in a place where there is a community spirit, like a village, that's not reliant on family coming in to fill the void, if you know what I mean.

While John and Lyn did not position themselves as carees at the time of the interview, they welcomed this position in the future in the form of care from their children and grandchildren, based on the reciprocity of care they had established by being able to care for their family in their home:

> John: . . . . [the grandchildren] know us and they care as well about their grandparents and um we care about them so if we can continue that type of relationship then I am sure that is what actually would happen…it's lovely.

While family has not previously been identified as a socially available discursive resource in housing literature as it has in the present study, it has been found to be influential in older adults' housing decisions. Groger and Kinney (2007) identified the importance of older adults' new housing locations being in close proximity to family in order for the family to provide support to the ageing person. This was similar to Litwak and Longino's (1987) second type of move in their life course model of moving typologies, which was to be closer to children and family so they could provide assistance. However, for the current participants, being in close proximity to family operated to enable them to take up the position of family carer, rather than to enable the family to provide care for them.

For participants, an important aspect of the meaning of their homes was constructing them as places in which they could accommodate and care for their families. This is consistent with Dupuis and Thorn (1996), who found that participants' homes meant family togetherness and forming bonds between family members, which contributed to family identity. Additionally, with particular relevance to the value that the present participants' placed on being a family carer, Swenson (1998) found that the home was a central point for caring and nurturing family members.

It is not surprising that the participants drew on the familial repertoire when discussing their housing decisions, as family is a prominent discourse in Western culture, most often represented by the 'nuclear family' (Golden, 2000; Robinson & Jones Diaz, 2005). In everyday discourse, people often draw on a familial resource to explain who they are, their role in society, and as a means of justifying decisions. As such, family discourse has featured in previous discursive research. For example, Golden (2000) found that parents with young children drew on a family repertoire, labelled 'family first', to manage the conflict between work and family, whereby family

commitments were justifiably chosen over work. Additionally, Brotman (2003) identified family as a central tenet of elder care discourse for older ethnic women in Canada, based on the assumption that family will care for their elders. Therefore, the identification of the familial resource is not new to discursive work, but is novel in the context of older adults' housing decisions.

To summarise, participants frequently drew on the familial interpretative repertoire to establish the importance of family in their housing decisions and lives as they age. The participants placed great value on being able to provide care to their families, and their homes played an important part in accommodating that. Participants used this resource to position themselves as honourable family carers, who often cared for family from multiple generations, and resisted the currently unwanted position of being a caree. Accommodating family in participants' homes gave their homes meaning and established the familial repertoire as an important aspect of their construction of housing choices.

Interactions Between Interpretative Repertoires

The presentation of the findings as distinct interpretative repertoires is not an accurate representation of how they operate within people's talk, as discursive resources interact with one another. According to Potter and Wetherell (1987), understanding people's constructions of the world requires attention to both accounts that draw on resources that are consistent with one another, and to accounts in which these vary or are contradictory (see Figure 1).

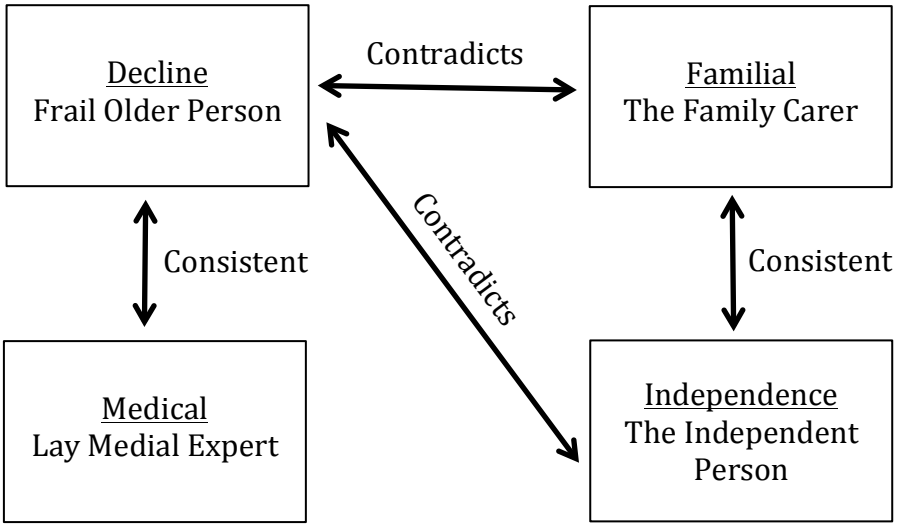

Figure 1. Depiction of the consistencies and contradictions among the interpretative repertoires.

Consistencies. During participant's discussions of their homes, consistencies were found among the repertoires and the various subject positions they provided.

Decline and medical interpretative repertoires. There were instances when participants simultaneously drew on the decline repertoire that positioned them as the frail older person and the medical repertoire to construct age-related decline as decline in health. The frail older person subject position and medical repertoire fit well together, as medical constructions of frailty take prominence in the biomedical view of ageing and the body. The following passage demonstrates that George's construction of his wife's decline to dependence was based on her worsening medical condition. Additionally, his anticipated decline in the future was also constructed as medical, indicated by the need to live close to a hospital to receive medical attention when this eventuates:

> George: The other providing factor came when my wife had the cancer and became dependent on me for so many things, now if anything happens to me, we talked about this, and they said um the best place would be to go is handy to a hospital, now this is very handy to a hospital, it is walking distance from here.

George also illustrated consistently drawing on the frail and a medical repertoire when he mentioned that health was the reason he and his wife became unable to cope with their previous home, justifying their move:

> George: So when it came to decisions of our health, we had to sell because we couldn't cope, I couldn't cope without my wife's help and we were running a home stay as well.

When justifying her move to a retirement village and her need for maintenance assistance provided by the organisation, Anna drew on the medical resource to explain how frail her physical condition had become, which necessitated the move:

> Anna: I, you see, I am really quite physically disabled, I have artificial hips and artificial shoulders and um and they seize up a bit in the winter.

Establishing the self as a frail older person by using the decline repertoire, and simultaneously drawing on a medical repertoire, gave weight to participants' justifications for the housing decisions they made.

Familial and independence interpretative repertoires. Participants consistently took up the positions of the family carer and the independent person by drawing on the familial and independence repertoires at the same time in a passage of talk. Holding the position of the family carer, rather than the caree, indicated that participants had a level of independence. Thus, participants could concurrently establish themselves as family carers and independent older people. This was demonstrated in three ways. Firstly, Marg's ability to drive independently allowed her to be a carer for her family:

> Marg: You know we do a lot of school runs and picking up and dropping off and especially when there is sickness, I feel like I am a taxi service at the moment.

Secondly, John and Lyn showed independence in being able to make autonomous decisions about the alterations they had made to their home, which enabled their children and grandchildren to be accommodated and cared for there:

> John: One of the things was we were prepared to actually live here all the time, so rather than get up and sell the property that we were occupying and then go and look for alternate accommodation, we decided that we would carry out alterations and renovations and those are the things that we have done to the dwelling it make it more comfortable for both Lyn and myself and our children, um but as the years have gone on and the children have gone their own-spread their own wings, but there are grandchildren as well.
>
> Tamyra: And you can accommodate them here, is that right?
>
> John: Yes.
>
> Lyn: Yes yes we can yes 'cos we've kind of extended both this dining room and the lounge.

Thirdly, Jean's physical independence allowed her to travel to visit family and care for them by providing company and engaging in activities with her great grandchild:

> Jean: Some days I go down on a Tuesday sometimes I'm free and I'll go down, get there at lunchtime and I'll come home on the 5 something or other, no I think it's 6:15 I get the train, something like that and spend the afternoon with [granddaughter] and we take

> [great grandchild] to the park and just give [granddaughter] some company.

Participants appeared to find it easy to be both positioned as carers and independent, given the congruence between these two positions. Participants' independent person position supported their justifications of being able to provide care for their families, and similarly, being positioned as the family carer contributed to establishing the desirable independent position.

Contradictions. During the flow of conversation, the subject positions that participants take up by drawing on the available repertoires can vary by a process of negotiation, whereby participants' standpoints are formulated and reformulated. The process of repositioning demonstrates the tension among these positions and can work to clarify a person's standing or leave it ambiguous (Wetherell, 1998).

Decline and independence interpretative repertoires. By drawing on the decline and independence repertoires, participants demonstrated the tension between the positions each repertoire provided that can be taken up during the ageing process: the frail older person and the independent person. While both positions were often present in the same passage of talk, it was contradictory for participants to be positioned as frail and independent. As Jolanki, Jylhä, and Hervonen (2000) posited, to have credibility as independent, one must work to distance oneself from being seen as old and frail. Therefore, the desirability of independence led participants to reinstate their independent position following disclosure of their frailty and dependence.

Anna demonstrated the contradiction between frailty and independence and used her ability to drive as the way to justify her continuing independence in the face of her limited mobility:

> Tamyra: Hmm do you still feel very integrated into the community?
>
> Anna: Into the community yes.
>
> Tamyra: Yeah and what do you think helps that?
>
> Anna: Being able to drive. That's the big one for me, because I don't walk very well, being able to drive makes a huge difference and I hate asking people to do things for me.

Even though others had suggested to George that he would have benefitted from services within his home, the following passage demonstrates how he rejected this marker of frailty to retain as much independence as possible:

George: Oh yes, I've only got to pick up the phone or call services, I've had a lady in to- they said "aw you are not going to manage the housework." Well, I am more than happy, so that only lasted a fortnight.

On three occasions, William demonstrated negotiating the frailty-independence contradiction. Firstly, the removal of William's driver's license marked the start of becoming frail and dependent on someone else for transport; however, as he did not see this as a positive change, he demonstrated his resistance by continuing to drive:

William: Um well I'm not driving a vehicle. Well, that was a bad, sad sort of performance. I supposedly had a bit of a blackout, I had not had one before and I have not had one since but I ended up down in Wellington to see a doctor, who said to me "I don't want you to drive." I said "I beg your pardon?" "I don't want you to drive" he said. I thought I had been shot! I said, "I've driven over the course of my working years thousands upon thousands of miles and have not ever had an accident nor caused one." I was shattered, anyway I put my own interpretation on it of course, I quietly tottled off down that road and came around the back way to the stock sale.

Secondly, William trialed a rest home based on his family's and doctor's advice; however, he experienced tension between accepting the frailty implicit in needing rest home level care, and retaining the independence he desired. The way William spoke about his experience suggested that being in the rest home positioned him solely as the frail older person, which he was not willing to be, indicated by his resistance. As a result, William used his return to his rural home to reinstate his position as an independent person:

Tamyra: So what influenced your decision to try out the [rest home]?

William: Well because you know, friends would say to me "aw you should be here, should be there" and I thought aw well I'll go test it out and see, but I just found it a shade blank and a bit bland. I actually after a while started to feel as, you know, what am I doing here? What is this achieving? You know I don't know. People are in more need of being there than I thought I did- I call those places there an abode of the needy, the seedy and the none too speedy (laughs).

And finally, William's daughter's offer of a caregiver indicated that his frailty meant requiring assistance with bathing. However, to reestablish his independent position during the conversation, William explained how he rejected this offer on the grounds of being shy, rather than on the grounds of being positioned as a frail older person:

> William: Now, there was a lady from, what was it? Um what do they term themselves? Caregivers or something? They say, "we will come out and shower you" and I said "nobody has ever showered me, I am very bashful, I don't think I need that. "You could knock on the door of the bathroom and say "are you alright?" and if you hear a dull thud you know I'm not" (laughs).
>
> Tamyra: So they offered you that service.
>
> William: Aw they said they would come out on Tuesday morning and Friday mornings and I said I don't need that, but aw I don't know?

The concluding part of William's comment indicated that he continued to negotiate the inconsistency between being positioned as a frail older person and as an independent person. Jolanki et al. (2000) suggested that this constant renegotiation of position may be due to the risk of not being able to request help from others or plea to physical inability if one has fully rejecting being old and frail. This may explain the unresolved tension between the frail and independent positions that was evident in William's talk. This left William in an ambiguous position, which he used humour to ease.

In summary, when participants were positioned as the frail older person, they often immediately flanked this by using the independence repertoire to re-formulate their position as an independent person, as this was the more desirable position. William is an apt example of the negotiation of this contradiction, as his account shifted him back and forth between the frail and independent positions. Additionally, his account included others, such as his family, positioning him as frail and requiring certain supportive housing conditions. Examining how this frailty-independence contradiction operated in participants' constructions of their housing decisions provides greater insight into the complexity of these decisions.

Decline and familial interpretative repertoires. Another contradiction featured in participants' talk when using the decline and familial repertoires to be positioned as a

frail older person and a family carer, respectively. There was tension when participants were positioned as needing care due to frailty, but were also positioned as the provider of care to others. Mary demonstrated how she resolved this contradiction by moving to a retirement village that provided hospital level care for her husband, so she could take up the position of being frail herself, and allow her husband to receive the necessary care she struggled to provide:

> Mary: It got to the point where um I was needing increasing lots of help with [husband], he was getting much more of a struggle…and it is a long traipse up to the hospital and if we were here, I could have him home for the day if it was okay and often did, and take him back again at nights, but it saved me getting up 6 times a night maybe.
>
> Tamyra: And you moved here while that was still going on, so you could easily get him to the hospital and get him back during the day?
>
> Mary: Yeah and we were here for 18 months before [husband] died… and it just got increasingly worse and worse at that stage, because you get to the stage where it runs you very ragged when you have to get up in the middle of the night and maybe change beds, or shower somebody or other and maybe get back into bed and then sleep with one ear up the whole time and because the jerks and the twitches I suppose wake him all the time… and I had a bad hip, I was having to have my hip replaced.

Unlike Mary, Marg demonstrated an on-going negotiation between taking the position of the family carer of her grandchildren and a frail older person. Following being positioned as the frail older person by becoming exhausted from her grandchildren visiting, Marg switched to draw on the familial repertoire to reposition herself as a willing carer. Her family carer position was then troubled by reinstating how tired she got from providing care:

> Jack: But the grandchildren are quite happy staying here too, which is good, and they want to.
>
> Marg: Oh they do they love it.
>
> Jack: You know, they don't want to stay one night, they want to stay two, ‘cos one’s not enough, can't get through everything (laughs).

Marg: Well I said to [Grandson] the other day though, you know "Granny is getting old" I couldn't have them for two nights because I am too exhausted (laughs).

Tamyra: Are they very busy little people?

Marg: Very busy.

Jack: They come straight in here and they go in the pantry (laughs).

Marg: Aw no they are an absolute joy, they really are, but gosh they certainly wear me out, I have to have a long lie down when they have gone home.

This continuous reformulation shows that Marg is uncertain whether she wants to be solely positioned as a frail older person or as a family carer, and continues to negotiate this tension during her discussion of her housing decisions.

Overall, the interactions between the interpretative repertoires that produced consistencies and contradictions demonstrate the way participants used the available discursive resources to negotiate the different repertoires and subject positions within their talk. The decline and medical, and familial and independence, repertoires, were used in conjunction to establish a clearer overall position for participants during their ageing and housing decision-making processes. Conversely, contradictory positions of being frail and a family carer, and being frail and independent, highlighted that these positions are subject to on-going formulation and reformulation during participants' discussions. The interaction between the social resources participants used to construct their housing decisions indicated that these choices are far from straightforward.

Chapter Summary

The results were comprised of the description and illustration of the 'Decline', 'Medical', 'Independence', 'Stability' and 'Familial' interpretative repertoires, the subject positions provided by each repertoire, and the interaction between them. The influence of multiple, and interacting, interpretative repertoires in participants' constructions of their housing decisions highlighted the complexity of these decisions in later life. The results demonstrated the social location of housing decisions by illustrating how participants used socially available discursive resources to construct their housing choices within the interviews. On the whole, these findings provide a more nuanced understanding of participants' housing decisions that has not been

previously brought to the fore in research examining these decisions through the lens of cognitive decision-making.

Chapter 6: Conclusions

This chapter begins with a summary of the aim of the study and the main findings. Reflections on the study and research process will then be made, including considerations of the influence that my social location, and that of the participants', may have had on the interpretative repertoires that were identified. The theoretical implications of the findings for the understanding of older adults' housing decisions will be outlined, along with the implications the findings have for assisting older people with housing decision-making and informing housing, health and ageing policy. Suggestions for future research will follow, and the chapter will end with an overall conclusion of the study.

Summary

The present study aimed to explore the social location of older New Zealanders' housing decisions by examining the socially available discursive resources older adults draw on to construct their housing choices. This was achieved by identifying five main interpretative repertoires drawn on by participants, labelled 'Decline', 'Medical', 'Independence', 'Stability' and 'Familial' and the subject positions provided by each of those discursive resources.

Participants used the 'decline' interpretative repertoire and the subject position of 'frail older person' provided by this repertoire to establish the need for their homes to accommodate their age-related decline. Participants drew on the decline resource to explain and justify their housing choices as appropriate for their current and future frailty. The 'medical' interpretative repertoire and the 'lay medical expert' subject position were used to prioritise access to medical services and use lay medical knowledge to justify housing choices. The medical repertoire goes alongside the biomedical construction of health, thus demonstrating the dominance of a biomedical understanding of health within the participant group. The 'independence' interpretative repertoire provided 'the independent person' subject position. Participants viewed being independent as desirable and denoting positive ageing, and used this repertoire to construct their housing decisions as upholding their independence. The 'stability' interpretative repertoire gave rise to 'the sensible planner' position. Participants used this repertoire to construct their housing decisions as providing them with greater certainty in the face of ageing. This was done by explaining that they had a stable

current, and future, housing plan. For those positioned as sensible planners, this meant forward planning and moving proactively. The 'familial' interpretative repertoire established the importance of family in housing decisions and provided the opposing positions of 'the family carer' and 'the caree'. Participants used the familial resource to construct their housing decisions as accommodating family and enabling them to care for their family, while resisting the currently undesirable position of being a caree.

There were a number of interactions between the repertoires. Participants simultaneously drew on consistent resources of the decline and medical repertoires, and the familial and independence repertoires. By doing so within the same passage of talk, this offered greater weight to participants' justifications of their positions as frail older persons, independent persons and family carers within their discussions of their housing decisions. Participants used contradictory resources of the decline and independence, and the decline and familial, repertoires. The contradictory positions provided by these discursive resources were negotiated and reformulated during participants' talk of their housing choices. Participants shifted back and forth between being positioned as the various subject positions, which provided a more nuanced understanding of the social location of housing decisions that has not previously been identified in housing literature.

Reflections

There are a number of personal aspects worthy of reflection as possibly contributing to the progression and findings of the current study. Firstly, my background in Health Psychology may have driven the types of questions I asked in the interview and emphasis I gave to certain topics of discussion, such as the consideration of health in participants' housing decisions. Similarly, my background may have influenced the analysis, for example, identifying the decline and medical repertoires as main discursive resources used by participants, both having a health component. A researcher from a different background may have asked alternative questions, focused on other topics of discussion during the interview, and identified different main interpretative repertoires and subject positions.

Secondly, my stage of life is very different from that of my participants, as I am young and my participants were all over the age of 65 years. As such, the social resources that they used to construct their housing decisions may have been different from those that would have been available for me to draw on, and their housing

experiences would have not been directly relevant to my own. This may have impacted on the types of questions I asked in the interviews, and possibly meant I neglected to ask questions about areas that may have been pertinent to their housing decisions. Being in a different life stage to the participants may have also influenced the analysis; however, I discussed the findings with my supervisor who is closer in age to the participants than I am, and likely to have insight into what was important to the participants.

Thirdly, my inexperience as an interviewer influenced the way in which I asked participants questions. I often used a questioning style that involved making a statement, then asking if it was correct or not, which may have been leading and limited the response options to 'yes' or 'no'. This style of questioning is demonstrated in the following passages:

> Tamyra: Hmm that's fantastic support isn't it?
> George: Aww yes.
> Tamyra: So a good sense of community around here, would you say?
> George: Oh yes absolutely.

And:

> Tamyra: And usually first prize is staying in your home isn't it?
> Lyn: Yes isn't that true.
> John: Well yes, it is your castle.
> Tamyra: 'Cos it is where you are most comfortable isn't it in your own home?
> Lyn: Yes it is.

Additionally, the broader social location of the participant group could have contributed to the findings. The interpretative repertoires identified may have been constructions specific to a particular class of New Zealanders, as all participants were middle-class homeowners. Being from this group denotes a particular socioeconomic status and is accompanied by certain privileges not afforded to those of a lower socioeconomic status. For example, this group has a greater number of housing options to choose from in later life due to their level of affluence and owning a house as an asset. This means the current findings must be interpreted in light of the resources available to the participants and their status in society.

The homogeneity of a participant group is often a shortcoming of research; however, social constructionist research makes no claim to pursue generalisability (Gill, 1996). Generalising the findings to others would be in opposition to the main premise of social constructionism, which suggests that there is no one true way of knowing and that what is known is only provisional and open to negotiation (Burr, 2003). Therefore, the participant group is not a limiting factor for the current study and is not indicative of the quality or significance of the findings.

Implications

Having considered these reflections, the current study's findings have a number of implications. Firstly, and most notably, are the theoretical implications for the understanding of housing decisions that arose from the use of a social constructionist approach. The interpretative repertoires, subject positions and interactions identified broaden the theoretical lens on older adults' housing decisions by attending to the social location of these choices, which has previously been under-developed using a cognitive theoretical approach. Attending to the social location enabled examining how participants drew on what was happening around them in their social worlds to construct their housing choices, and by doing so, showed how important their social worlds are to understanding, explaining and justifying their decisions. Additionally, this sort of enquiry allowed for the identification of the dynamic way in which the socially available repertoires were used, resisted, negotiated and renegotiated within participants' talk.

Participants drew on discursive resources from outside of what is most commonly thought of as housing-related variables, such as the physicality of the home, location and amenities, to instead use constructions of ageing, health, stability and family in their talk about their housing decisions. This demonstrated that their constructions of their housing decisions had very little to do with their physical houses, and everything to do with the broader social world surrounding them. By attending to the social location, the present study showed that these choices are not fixed, causal, linear processes, but instead complex and dynamic, and located in people's social lives. Missing such a level of complexity may be one of the shortcomings of housing decisions research that remains focused on establishing a cognitive basis for decisions and making causal inferences.

As there has been an under-application of a social constructionist approach to investigating older adults housing decisions in previous literature, the current study can be seen as having opened up new academic territory. The theoretical broadening of the understanding of housing decisions suggested by the current study supports the proposition by Jacob and Manzi (2000) that taking a social constructionist approach in housing research would enable the extension of housing research parameters and the contribution of new insights on important housing issues.

The second implication of the current findings is for those advising and assisting older adults to decide where to live in later life, be it a family member or friend, or a formal service. Advisors would benefit from recognising that housing decisions are not just about obvious housing factors, such as the physicality of the home or its location. As the present findings indicate, housing decisions are also about how people see themselves in their social worlds and are constructed using resources available from their social surroundings. By understanding this, advisors may be able to provide more holistic guidance.

Finally, in regards to policy implications of the study's findings, it would be inappropriate to make practical suggestions for policy changes based on the small number of participants in this study, and given the study's contribution is largely theoretical. However, it is within its scope to suggest that the findings could inform housing, health and ageing policies relevant to older adults. This could be done by making policy-makers aware of the complexity of these decisions, their social location, and the limitations of cognitive theoretical models in explaining this complexity.

Future Research

The present study was intended to be a partial exploration of older adults' constructions of their housing decisions and, thus, presents as a starting point for further enquiry. Given that being a middle-class homeowner, as were the participants in the current study, affords greater choice of housing options from a financial and social perspective, future research could attend to older adults from different socioeconomic groups, to observe whether this alters which discursive resources are available to be used. For instance, it would be interesting to explore how lower socioeconomic groups, in particular those who reside in state housing, construct their housing decisions for later life. Such groups may have a different set of decisions to make that operate in the

context of particular social and economic limitations, and have an alternative set of discursive resources available to them to draw on to construct their housing decisions.

Another future research direction, to develop the current findings further, could be to conduct a similar study with older adults from different cultural backgrounds. Attending specifically to the role of culture was not a focus of the current study, but would be interesting to develop in future research, especially attending to Māori cultural groups. One of the participants, John, who identifies as Māori, supported this future research direction. At the end of the interview, John commented:

> John: I'm more curious about our cultural attachment and all that housing situation as applicable to Māori.

This calls for further research to be done with Māori and their housing decisions, and would enable establishing whether there is a cultural component to the repertoires that are used to construct housing decisions for later life.

Furthermore, it is possible that the identified interpretative repertoires in the current study could be causal, influential factors on older people's housing decisions. Future research could examine the decline, medical, independence, stability and familial repertoires within a causal framework to establish whether these social resources also operate as causal influences on the housing decisions made by older adults.

Conclusion

This study was a detailed exploration of older New Zealanders' constructions of their later life housing decisions within the present context of the interviews by identifying the interpretative repertoires participants drew on. By identifying participants' use of the decline, medical, independence, stability and familial repertoires, this study contributed the additional complexity of the social location of these decisions to the existing housing literature. Social resources that were used came from areas outside of housing, including constructions of ageing, health, family and stability, showing that housing decisions are constructed using broader social resources. By stepping outside of the parameters of cognitive decision-making frameworks to apply a social constructionist perspective allowed the social location of housing decisions to be attended to, and provided a basis for suggesting a broader theoretical lens on older adults' housing decisions to include the use of socially available repertoires in people's constructions of these decisions. While this study is only an initial exploration of how older New Zealanders socially construct their housing

decisions, it provides a promising start to understanding the full complexity of what is involved in older adults' housing decisions for later life.

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Appendix A: Participant Information Sheet

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

How do Older New Zealanders Understand Housing Decisions in Later Life?

PARTICIPANT INFORMATION SHEET

Thank you for expressing an interest in participating in this research. This sheet contains information about the nature and purpose of this research in order to assist you to make an informed decision about whether or not you wish to take part.

Researcher Introduction
My name is Tamyra Matthews and I am a student at Massey University, studying towards a Masters of Science majoring in Psychology with an endorsement in Health Psychology. This research project is under the supervision of Professor Christine Stephens (School of Psychology, Manawatu Campus).

What is the nature of the study?
I am interested in discussing people's current housing situation, their plans for future housing and how they are making decisions about where to live in later life. Discussing people's stories and experiences of housing will make a valuable contribution to understanding the way older New Zealanders make sense of these housing issues in later life.

Who can take part?
Adults aged 65 years and older are invited to participate in this research. Interviews can be held with individuals or couples; however, in the case of couple interviews, both individuals need to agree to take part.

What does participation involve?
If you agree to take part in this research, either as an individual or as a couple, you will be contacted about arranging a date, time and location for a single interview. The interviews could be conducted in your home or at a location in the community. During the interview, you will be asked about your current housing situation, your views on relocation and your plans for housing in the future. The interview is expected to take between 40 and 50 minutes of your

time and will be audio recorded. To thank you for taking the time to share your stories and experiences of housing, each participant will be given a $25 Prezzy card.

How will confidentiality be assured?
Participants will be allocated pseudonyms at the transcription phase that will be carried through the analysis and the writing up of the results. In any case where a name, location or organisation is mentioned, this will be deleted from the transcripts to ensure anonymity. All information shared in the interviews will be confidential and only my supervisor and myself will have access to the transcripts.

What will happen to the data once it is collected?
The audio recordings and written transcripts will be stored in password-protected files on my personal computer. Audio recordings are solely for transcription and will not be used for any other purpose. The recordings and transcripts will be kept securely for 5 years in the School of Psychology, Wellington Campus, after which they will be destroyed.

You will be given a copy of the transcripts to read, make amendments and delete content where necessary, prior to the commencement of the analysis. If changes are required, you will be given 2 weeks to complete and return these to me. All participants will be sent a summary of the research findings once analysis is completed.

How will the data from the study be used?
The primary use of the data will be in a Masters thesis; however, there is the possibility of its use for reports to government, publication in academic journals, and for dissemination at conferences. In all forms of data use, participants will not be able to be identified.

What are your rights?
You are under no obligation to accept this invitation to participate.
If you decide to participate, you have the right to:

- Contact me at any time to ask questions prior to, and following, the interview
- Ask any questions about the research during the interview
- Decline to answer any particular questions or discuss any particular topics
- Withdraw from the study prior to the interview, during the interview and up to two weeks following the interview
- Ask for the audio recorder to be turned off at any time during the interview
- Be given access to the written transcript of your interview and be able to make changes and delete content you wish to not be included in the analysis
- Provide information on the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the project findings when it is concluded.

Who do you contact?
For any questions or queries regarding the research project, please feel free to contact myself and/or my supervisor.

Tamyra Matthews (Researcher)
Email: tamyra.matthews@gmail.com
Phone: (04) 801-5799 extn 62528
Phone (Masterton): (06) 3709448

Professor Christine Stephens (Supervisor)
Email: C.V.Stephens@massey.ac.nz
Phone: (06) 356-9099 etxn 85059

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 14/23. If you have any concerns about the conduct of the research, please contact Prof John O'Neill, Acting Chair, Massey University Human Ethics Committee: Southern B, telephone 06 350 5799 x 81090, email humanethicsouthb@massey.ac.nz.

Appendix B: Informed Consent Form

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

How do Older New Zealanders Understand Housing Decisions in Later Life?

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: ..... **Date:** .....

Full Name - printed .....

Appendix C: Interview Schedule

SEMI-STRUCTURED INTERVIEW SCHEDULE

Background information
- Age(s)
- Relocation history
    - Are you still in your family home?
    - Have you relocated recently?
    - How many times have you moved in your adult life?

Tell me about your current living situation
- Do you own your own home or are you renting?
- How are you finding being in this home? What do you like/dislike about it?
- Does it meet your needs? How does it do this?
- How do you see your home meeting your needs in the future?
- What aspects of your home are particular important to you? Why?

Question 1:
Where do you want to live as you age?
Did you consider other options? What are your views on these other options?
How do you see this home comparing to other options?
What do you expect to happen with your housing situation in the future?

Question 2:
Why did you choose this option for your home as you age?

Question 3:
How did you make this decision?
What influenced your choice? What factors did you consider?

Appendix D: Additional Resources and Information Sheet

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ADDITIONAL RESOURCES AND INFORMATION

Organisation/group	**Website/contact details**
Age Concern	http://www.ageconcern.org.nz/ Phone: 04 801 9338 Fax: 04 801 9336 Email: national.office@ageconcern.org.nz
Agewell	http://www.agewell.org.nz/ Phone: (09) 489 4975 Email: ageconns@acns.co.nz
Eldernet	http://www.eldernet.co.nz/Home Phone: (03) 388 1204 Fax: (03) 388 1271 Email: team@eldernet.co.nz
The Retirement Village Association of New Zealand	http://www.retirementvillages.org.nz/ Phone: 04 499-7090 Fax: 04 499-4240 Email: info@retirementvillages.org.nz
Abbeyfield housing	http://www.abbeyfield.co.nz/ Phone: +64 3 5466459 Fax: +64 3 5466210 Mobile: +64 021 0795097 Email: office@abbeyfield.org.nz
Ministry of Social Development: The New Zealand Positive Ageing Strategy	http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/planning-strategy/positive-ageing/index.html
Ministry of Health: Health of Older People Strategy	http://www.health.govt.nz/publication/health-older-people-strategy

Appendix E: Transcription Notation

Round brackets indicate when there is non-verbal information or laughter that accompanied participants' utterances, e.g.: (gestures small distance) and (laughs).

Square brackets indicate when identifiable information, such as people's names and place names, has been omitted for confidentiality purposes, e.g.: [husband] and [town].

… indicates a notable pause, lasting longer than 1 second.

. . . . indicates when the passage written was preceded by a longer section of talk by the same speaker.

Quotation marks indicate when participants are quoting themselves or others within the story they are telling, e.g.:

> A: But one of the things my wife used to say was "why are you worried about retirement?" or "why are you thinking about it?" and I'd say, "well that's my nature to think years ahead, be prepared."

- indicates when a speaker's utterance comes to a sudden end and is immediately followed by another utterance without a pause, e.g.:

> A: So one day when he was comp- he wasn't a complainer.

Appendix F: Authority for the Release of Transcripts Form

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AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: ..... **Date:** .....

Full Name - printed .....