Elder Orphans’ Experiences of Advance Planning and Informal Support Network

Sandra Thaggard¹ and Jed Montayre¹

Abstract
Literature reviews on elder orphans recommended the need for an in-depth exploration of health care and social issues from their actual experiences. This article explores the experiences of elder orphans living independently in the community on their own with no immediate or close family support. The study utilized a qualitative descriptive approach through face-to-face interviews. Two main themes emerged from the data. The first theme was “advance plans” with the subthemes (a) my to-do list and (b) the right timing. The second theme identified was “informal support network” with the subthemes (a) family is right here and (b) familiarized support system. These findings offered insights on how existing informal networks influence elder orphans’ consideration for advance directives in terms of timing. Moreover, the findings have identified the extent of which informal support network has been received by elder orphans. Currently, the support threshold of these informal networks is unknown, which warrants further research.

Keywords
advance planning, elder orphans, nursing, behavioral sciences, informal support networks, New Zealand

Background
New Zealand contributes to the fast global aging population. The 2013 Census recorded 607,032 older New Zealanders aged 65 and older (Statistics New Zealand, 2015). The population of older adults is the fastest growing group and is projected to double in the next 50 years. Together with the global aging trend are longer life expectancies, changing family/social structures, and new lifestyle preferences, particularly with preferred dwellings. These associated phenomena anticipate the prominent future profile of older adults, who for some, live longer years, outlived immediate or other family members, divorced or without children and those who consider living alone as a lifestyle preference (Koopman-Boyden & Moosa, 2014). Carney, Fujiwara, Emmert, Liberman, and Paris (2016) recently coined the term “elder orphan” to describe this increasing cohort of older people who have health and social vulnerabilities, yet almost unknown to most health care professionals.

There is a growing attention on “solo agers,” a term used interchangeably with “elder orphan” (Geber, 2018). Gray literature was filled with recommendations on how to prepare aging alone or solo-living with no immediate or nearby family support (Ianzito, 2016; Schlecht, 2018). These discussions cover preparation for health care crisis, personal issues, and wider social implications for orphancy in older age (Marak, 2017a, 2017b; Ziettlow & Cahn, 2015). A recent literature review on elder orphans revealed the need of an in-depth exploration of actual experiences, as data retrieved from the reviews were mostly theoretical conceptualizations (Montayre, Montayre, & Thaggard, 2018).

The identified issues gathered from the literature were based on theoretical discussions and social observations of elder orphans living in the community. To date, there is no published empirical evidence on experiences of elder orphans and their health and social needs. Although the issue of older adults with or at risk of impaired decision-making capacity for future health care has been noted in many legal dialogues (Pope, 2014), there is limited research emphasis on health care and social issues experienced by elder orphans. The literature has also identified the need to conceptualize the term “elder orphans” from older people’s viewpoints (Carney et al., 2016; Montayre et al., 2018). This article reports the qualitative data on the experiences of older adults who live alone with no immediate or geographically close relatives.

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Research Aims
The aim of this study was to explore the experience of elder orphans living independently in the community.

Method

Research Design
This research utilized a qualitative descriptive approach to understand the experiences of older adults who live on their own with no immediate or close family support. According to Sandelowski (2000), a descriptive qualitative approach is the “method of choice when straight descriptions of the phenomena are desired” (p. 339). Qualitative description presents findings that are as close to the participants’ actual words, referred to as “data-near.” It also enables researchers to gain an understanding of participants’ perceptions about real-life situations and the meanings that accompany descriptive narratives.

Participants
The selection of participants was undertaken using a purposive and snowballing sampling design. Purposive selection deploys inclusion and exclusion criteria to recruit participants who have the requisite socio-demographic background to address the aim of the study. Inclusion criteria for participation in the present study included (a) older person living independently in the community or own home (b) who do not have an available close family member or designated surrogate or caregiver in New Zealand.

Data Collection
The study was undertaken in Auckland, New Zealand. Following an initial recruitment strategy of posting flyers in community centers and general practitioner (GP) clinics, participants were recruited from community organizations. Information regarding the study was thoroughly explained prior to the interview and participants were also given the explanation of the characteristics of an “elder orphan” to ensure that they identify themselves (for older adults). A face-to-face semi-structured interview was undertaken lasting from 30 to 45 min. The researcher asked open-ended questions and leads such as “Tell me about your typical day at home?” and “Describe your social and day to day activities.” Ample time was given to participants to answer questions.

Data Analysis
This research study is underpinned by a naturalist epistemology. An inductive analytical approach was used to identify repeated patterns of meaning, referred to as themes, within the data in a step-by-step process (Braun & Clarke, 2006). This method of analyzing qualitative data is an “accessible and theoretically flexible approach” suitable for thematic analysis (Braun & Clarke, 2006, p. 77). Patterns of meaning were found “within and across” the participants’ interview data that identified similarities in experiences, views, and perspectives (Clarke & Braun, 2017, p. 297). Language patterns found in the words that participants used were identified for the attached meanings to identify articulated constructs. This process of analysis followed the Braun and Clarke (2006) analysis framework. This framework involved the transcription of data, then repeatedly reading the transcribed data to capture the interesting features (coding) to begin identifying patterns or themes. Provisional themes were further refined for coding and analysis until the salient patterns repeated across and within transcripts (Braun & Clarke, 2006).

Ethics
Ethics was granted by affiliate university ethics committee with the reference number 18/225. All due respect was given to protect the identity of the participants, and to gain informed consent.

Results

Participant Demographics
Eleven older adults participated in the study comprising of nine females and two males. The participants’ age ranges from 67 to 87 years old. Seven participants have lived in New Zealand since birth. Three participants migrated from their country of origin. One female participant identified as a migrant from the United Kingdom in the early 1970s. One male participant arrived in New Zealand in the late 1980s. Another female participant originated from California, USA. Currently, all participants lived in a major metropolis in New Zealand and they all had been in paid employment. Typical to the definition of an “elder orphan,” they had no geographically close family members in New Zealand.

Themes
Two main themes emerged from the data. The first theme was “advance plans” with subthemes (a) my to-do list and (b) the right timing. The second theme noted was “informal support network” with the subthemes (a) family is right here and (b) familiarized support system.

Advance plans. The first theme identified in the interviews was about planning in advance. The main idea that participants pointed out was identifying the things that needed high priority in terms of planning. This cohort of older adults also talked about the timing when action plans need to be in place.
The first theme has two salient subthemes: “my to-do list” and “the right timing.”

My to-do list. This subtheme identified the major planning activities involved such as financial and legal planning. This has been narrowed down to making a will, enduring power of attorney (EPOA), and health care directives. An EPOA is a legal authority given to another person to act on behalf of someone else. This is essential for the “elder orphan,” and yet, all but two participants had put this in place.

I have sorted everything out beautifully. I keep meticulous records of all my affairs, my receipts of purchase from the last 30 years are on file and I have allocated my possessions to friends and caregivers. (Kerry, 78)

One participant had made a detailed list of all that she possessed and had allocated her possessions as well as an EPOA to her niece overseas. Likewise, participant Brian had his son as an EPOA who also lived overseas. Neither of them knew how a long-distance directive was going to work out.

I’m going to give power of attorney to my son, but I wonder if he has to have a separate one and I have a separate one over here. I need to take that up but I’m so busy. It’s one of the things on my list but God there is so many things I got to do. (Barry, 70)

The right timing. This subtheme highlighted the divided views as well as the thought process participants have considered when confronted with the question of when to start planning or finalizing advanced directives. Three female participants expressed the following:

It’s no use thinking about it just yet, but if I was very ill, I would think of it then. There no point in me making a will just yet because I’m not ready. (Dora, 70)

I think about it, but what have I got anyway? Not much. (Mildred, 69)

I have thought about it and started making a list of where my jewellery is going to but then I stopped. I’ll get back to it another day. (April, 72)

Barry reported making a will a long time ago but wishes to change it now as he felt that one of the beneficiaries had received a sufficient amount. However, he showed no urgency to do this. Three participants showed no desire to make a will or to put in place any directives for future health care planning.

I don’t care what happens to my belongings once I’m gone. (Grace, 88)

One of the male participants, Robert, was unconcerned with timing of advance planning or even the need for it.

I don’t have any problem with doctors and nurses making decisions. The only point when I probably wouldn’t trust them is when enough is enough. I wouldn’t want to extend my life when my life is miserable. If I’m unconscious I can’t say but if I’m conscious I’ll tell them. I have even gone on line and looked about the Swiss vacations where if you have enough money you put yourself on a plane and they take you out. I would almost rather do that then have something dragged out when it’s no use. No, I would rather just not extend it. If I’m going to die anyway and I’m miserable and in pain and don’t have any quality of life I would just as soon go, even if that required me to contact somebody, pay somebody, travel to Switzerland whatever it takes I would just as soon go out I don’t see any point. (Robert, 71)

Informal support network. The second theme from the interviews was about informal support networks identified by elder orphans themselves. This was highlighted by the participants in this study, who appeared to lean heavily upon socially supportive networks and the kindness of strangers.

There were two subthemes identified for this major theme.

Family is right here. This subtheme is about informal support networks that for a long period of time, elder orphans have considered people helping them as their family that they never had. One participant talked about the list of people who regularly were helping her even for minor concerns.

I actually have a big thing that sits on the refrigerator I have a card in my purse that says “my cat is home alone, please take care of my cat” I have a list of people that I can call and if the first one is not available, I’ll try the next one. Although not by blood, they are my family here in New Zealand. (June, 68)

Bella had the same interpretation of the act of kindness showed to her by other people.

I can go to the bank the girls in the bank are wonderful are absolutely wonderful and they take me out and I go to new world after that you know one of the girls takes me out of the bank across the pedestrian and into the supermarket. How lovely, you really cannot fault that. They are so nice. It’s so nice to have nice people who will help you like you’re their family. (Bella, 79)

Familiarized support systems. Elder orphans’ informal support networks have not only been a case-to-case basis but had been part of their day-to-day activities and routines. Elsa narrated how changes in the bus system have altered this familiar support of her mobility and her routine activities such as shopping and visiting friends.

I had a great bus driver before, he knew me and would call “I’m here, I’m here.” I had another one who did the same they were the only bus drivers that were good towards me not having a vision. It’s when you get a nice driver it makes such a difference. I don’t ask for help because I take a stick and feel for the step. I used to give my ticket to the driver and he used to do it for me.
but some of them can’t get into their thick head that I can’t see. You do get nice people though. (Elsa, 89)

Bella also mentioned about the similar familiarized support systems that she has been accustomed to.

About 9 years now and, I go to the eye clinic, and a friend takes me there. I ring my friend I just press number 5 every phone has a raised dot in the middle for the blind. I didn’t know that until a lady in the bank told me. (Bella, 79)

Mildred talked about the regular visit and support she receives from her church group.

I have my friends from the church visit me every fortnight and we have tea and scones and a prayer meeting, and everyone brings a plate we also pray for each other. (Mildred, 69)

**Discussion**

This study explored the experience of older adults who identified themselves as elder orphans, who live independently in their own homes without geographically close family support. The analysis of interview data identified two salient themes: advance planning and informal support networks.

The majority of older adults who participated in this study do not have advance directives or plans. Although it was noted that they have initiated steps to prepare for their future, there was uncertainty regarding the right time for these preparations. InterRAI New Zealand (2018) reports that 52% of older New Zealanders do not have EPOA, with 40% of this population living in their own homes. By and large, it is not known if the nonactivation of EPOAs was due to trusted, close presence of family members when unable to communicate decisions. However, the findings of this study suggested that even those without geographically close family members were not keen of initiating EPOAs. The issue of time to prepare for advance directive was also highlighted in earlier studies, where older adults tend to initiate this process when recognizing early symptoms of forgetfulness and cognitive decline (Fazel, Hope, & Jacoby, 1999; Levi & Green, 2010). For older orphans, it is also critical to consider who would be the trusted person to initiate these discussions on advance directives.

This study’s findings resonated with the previous literature and have implications to preventing older people of becoming unbefriended when unable to make decisions. In countries like the United States and Canada, guardianship and surrogate representations were considered legal-ethical interventions for unbefriended older people (Chamberlain, Baik, & Estabrooks, 2018; Moye & Naik, 2011). These are costly procedures and also time-consuming processes for an older adult who might be experiencing significant physical health decline. The American Geriatric Society recognizes the importance of identifying those who are at risk of being “unbefriended,” part of this recognition they quoted the term “adult orphans” (Farrell et al., 2017). Unbefriended older adults lack the cognitive ability to make decisions for themselves and do not have contactable family or friends to represent important decisions to be made (Chamberlain et al., 2018). Moreover, majority of these population lack the advance directives or legal surrogates who will execute decisions for them (Kim & Song, 2018).

Another important finding that re-emerged from this study is the establishment of informal support networks with neighbors, community establishment employees (i.e., bank teller, bus drivers), and other members of the public. Similar to the case studies found in Soniat and Pollack (1994), the elder orphans in this study relied on informal support to manage day-to-day independent living. The only difference with Soniat and Pollack’s (1994) work was they have presented cases of older adults with dementia. However, intersectoral efforts to improve support and closer attention for elder orphans from their local communities closer to their homes (Montayre et al., 2018) still applies to this cohort of older New Zealanders. This highlights the need to think about the informal support networks that elder orphans receive from their communities, particularly when changes to transportation and mobility systems are implemented (i.e., bus timetabling). Carney et al. (2016) have outlined several social implications of being an elder orphan that extend from health to legal and security domains. This has been reiterated by the recent rise of self-help tips written in different platforms to support solo agers or those who identified themselves as an elder orphan.

The interplay between advance plans and available family support networks could be a potential reason for older adults to delay planning for health and social issues. However, it is interesting to note that informal support of nonfamily members to elder orphans could possibly contribute to decisions with advance planning. This particular cohort of older people did not have family members to discuss the decisions around advance planning. Such decisions require intimate conversations and could be challenging to elder orphans. The informal support network for these participants did not support that familial role.

The findings around lack of advance planning and reliance on informal support networks among elder orphans supported Lawton’s (1982) sociological theory of aging as person–environment fit, which asserts that functional competence contributes to an older adult’s adjustment and adaptation to his or her environment. Elder orphans in this cohort were all well and active and therefore had no thoughts of end of life planning and no family to influence them to making these decisions. Because of the lack of family and the orphan status, they had to rely on informal support networks. This was explained in Lawton’s theory as adjustments made in relation to their perception of available support. This support from informal networks was useful to enable independent functioning but insufficient to enable important life decisions such as advance planning.
Limitations

The current study has some limitations around gender representation among participants, having more females in the cohort. However, this is a reflection of greater longevity found in women than men worldwide. Moreover, the study was limited to a small sample size in a single metropolitan setting. The sampling and recruitment strategy could be strengthened to beyond homes with older adults living in care facilities.

Conclusion

The overall experience of elder orphans was described based on the need for advance plans and the existing informal support system. These two prominent findings offered insights on how existing informal networks influence elder orphans’ consideration for advance directives in terms of timing. Moreover, the findings have identified the extent of which informal support network has been received by elder orphans. Currently, the threshold of these informal support networks is unknown. Further research is needed for support services for elder orphans within their own communities to address the increasing cases of unbefriended older adults.

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Sandra Thaggard’s current research project is focused on exploring ‘Perceptions of Abuse in Older Pacific Island People Living in NZ’ communities. This is a pilot study that sits alongside the ongoing study of ‘Older Adult Orphans’, and their specific social and healthcare needs within healthcare settings.

Jed Montayre’s research areas include social gerontology, nursing education and nursing workforce development. His gerontology research focuses on ageing, older people living alone and immigration. He has written several research papers on influence of culture to health, transitions, adjustments and acculturation experience of older immigrants into the mainstream societies.